

CHAPTER -2
REVIEW OF LITERATURE

Chapter 2

Review of literature

Relevant literatures related to the present study have been reviewed to gain insight into the scope and significance of the study and to guide in designing and conducting the study, which are presented in this chapter under the following themes.

2.1 Health policies in India,

2.2 Status of public health in India, North-East and Assam,

2.3 Effectiveness of community health workers,

2.4 Health workers knowledge, Attitude, Motivation and their skills,

2.5 Approaches adopted by community health workers to perform their work,

2.6 Conceptual frame work of this study

2.1 Health policies in India

National Health Policy (NHP) is a strategy for controlling and optimizing the social uses of a nation's health knowledge and health resources. A health policy is the expression of what the health care system should be like so that it can meet the health care needs of the people (Ravi Duggal 2001, 16-19).

In India NHP was started in 1983 to achieve 'Health for all by 2000'. This was in response to the declaration of Alma-Ata by World Health Organization (WHO) in 1978. It defined that primary health care is essential to individuals and made it universally accessible to and acceptable to them, through their full participation and at the cost of community. It was the initiation to recognize the importance of health care and call upon the world community to protect and promote the health of all peoples (National health policy report, 2002).

In India NHP was the first attempt at ensuring the universal provision of comprehensive Primary Health Care (PHC), with special emphasis on prevention, promotion and rehabilitation. It emphasizes access to health services, nutrition, and prevention of food adulteration and maintenance of the quality of drugs, water supply and sanitation, environment protection,

immunization programme, maternal health, child health services and school health programme to meet the actual need and priorities of the population at a price that they can afford.

Since the declaration of the NHP 1983 there have been marked changes in the health areas such as diseases like smallpox and guinea worm have been eradicated from the country. Polio is on the verge of eradication. There has been a substantial drop in the total fertility rate and infant mortality rate. But there are some other health areas where the outcomes have not been achieved as per Indian Public Health Standard. Morbidity and mortality are unacceptably high. Macro and micro nutrient deficiencies among women and children, common water borne infectious diseases, diabetes, cancer, cardiovascular diseases and increase in life expectancy which increased the requirement for geriatric care. NHP 1983 was failing to some extent to achieve an ambitious and holistic goal. (National health policy report, 2002).

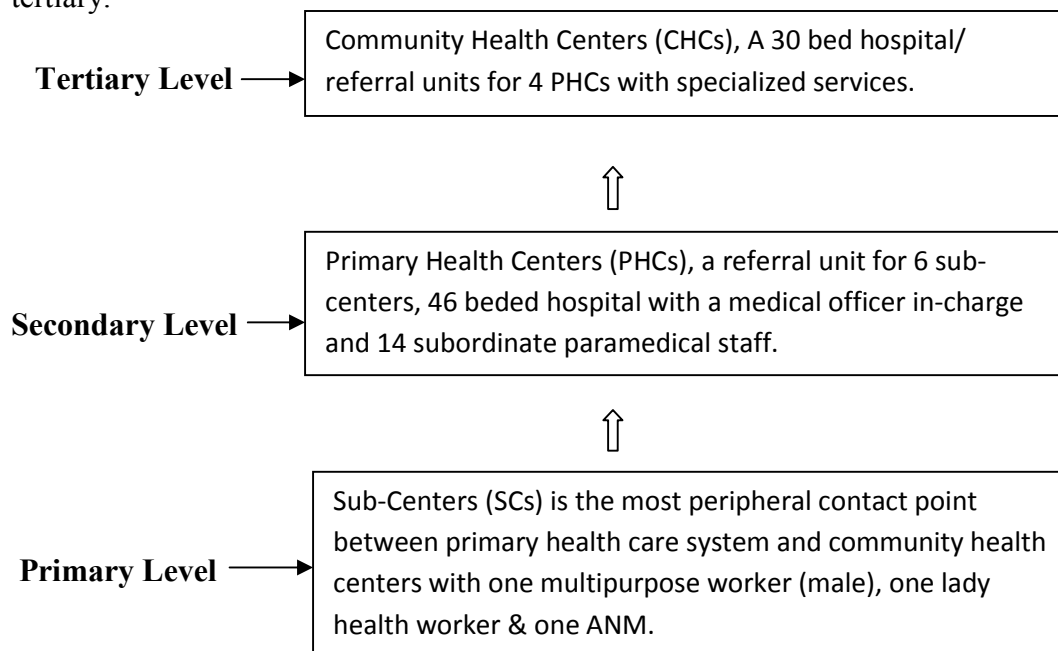
Nineteen year after 1983, the Government of India passed a changed form of National Health Policy (NHP) in 2002, which prioritizes equitable access to health services across the social and geographical expanse of India. It called for decentralizing PHC services by upgrading the infrastructure of existing medical institutions. It also encouraged the private sector in providing health care services to people who can afford to pay. The NHP emphasized increasing aggregate public health investment and the Central government with increasing health expenditure by 2% in 2012 which was 0.95% in 2008. It also increased the share of the Central grant to constitute at least 25% of total health spending and increased the state health budget up to 8% of the total state budget (Chaudhuri A 2012, 368-369).

To bring more systematic reformation in the health system, Government of India launched National Rural Health Mission on 5th April 2005. The mission seeks to improve rural health care services by providing accessible affordable , accountable, effective and reliable primary healthcare, and bridging the gap in the rural health care through creation of a cadre of Accredited social health activities (ASHA). The mission integrates with multiple vertical programmers along with their funds at the district level. Following programmes are integrated with the mission- Reproductive Child Health, National Vector Born Disease Control Programme, National Leprosy Eradication Programme, and National TB Control Programme, National Programme for Control of Blindness, Iodine Deficiency Disorder Control Programme, and

Integrated Disease Surveillance Project. Plan of action for NRHM is creation of cadre of ASHA Strengthening sub centers, by supply of essential drugs, multipurpose worker , sanction of new sub centre , upgrading existing sub centre, strengthening of PHCs, provision for 24 hours service, following standard treatment guide lines, up gradation of all PHCs for 24 hours referral service and provision of a second doctor on the basis of need, strengthening the ongoing disease control programme and new programme for control of non communicable diseases.

2.2 Status of public health in India, North-East and Assam

The health services in India provided through a three-tier setup namely primary, secondary and tertiary.



(Source: National health policy report, 2002)

The sub centers are the most peripheral institution and the first contact point between the primary health care system and the community. The health workers of the sub centers are provided basic drugs for minor ailments and are expected to provide services in relation to maternal and child health, family welfare, nutrition, immunization, diarrhea control and control of communicable diseases. Primary health centers comprise the second tier in rural healthcare structure envisaged to provide integrated curative and preventive health care to the rural population with emphasis on preventive and promotional aspects. Community health centers forming the upper most tiers are established and maintained by the state government. Cases

which are more complex and need specialized care are referred to the tertiary level, regional or national hospitals.

Ghill and Ghuman (2000) were stated that, the primary prevention and health promotion are non-existent in rural India. Since the majority of Indian population (almost 70%) lives in rural areas. Thus the rural areas in India require special attention in primary health care services and rural population needs to be the focus of the state, they also revealed that rural hospital and dispensaries continue to be starved of essential medicines, first aid and materials, test facilities etc. Thus their study indicated that health care facilities are mostly underfunded. Lack of funds, short of drugs and essential supplies reduces the work motivation of health workers in the rural areas and they suffer from low morale.

After review of the health scenario in India, Kapilashrami (2000, 1-10) mentioned that the communicable diseases such as malaria, tuberculosis, kalaazar and Japanese encephalitis and HIV/ AIDS are the biggest challenges to the country. Non communicable diseases will become a major public health problem in the country due to changing life styles, increasing stress and tensions due to changes in social and cultural systems in the society. There is also likelihood of higher incidence and prevalence of diseases like hypertension, diabetes and cancer and the whole range of geriatrics problems. Further study revealed that the stabilization of population is the first and foremost requirement. The location of health services and facilities should be such that they are easily accessible and available to people especially the under- privileged sections of the society. Moreover, human resource planning, human resource development, performance appraisal system, work culture, rational transfer- policies, incentives and career development opportunities for health man power would ensure a motivated workforce. Therefore, the mentioned aspects would need adequate attention. Hence the concerted efforts have to be made by the government and the community for improving the quality of life of people.

The rural health system of India is plagued by serious resource shortfall and under development of infrastructure leading to deficient health care for a majority of Indian. The differences in urban-rural health indicators are a harsh reality even today. Infant mortality rate is 62/1000 live births for rural areas as compared to 39/1000 live births for urban areas in 2007. Only 31.9% of all the government hospitals beds are available in rural areas as compared to 68% for urban population. Apart from the shortfall in infrastructure, shortfall in trained medical

practitioners is also one of the factors responsible for poor health care delivery. A total of 74% of the graduate doctors live in urban areas, serving only 28% of the national population while the rural population remains largely unserved. (Yadav et al. 2009, 3-5).

Study conducted by Indian Council for Research on International Economics Relation (ICRIER), in collaboration with the commission of Macroeconomics and health (CMH) set up by the WHO in 2003 reveals the fact about the inequities in Indian's health status. Report pointed that the richest 20% enjoy the three times the share of public subsidy for health, compared with the poorest quintile. The poorest 20% of Indians have more than double the mortality rate, fertility rate and under nutrition levels, compared to the richest 20%. The poor suffer disproportionately more from pre-transition diseases such as malaria and tuberculosis. On average they spend 12% of their incomes on health care as opposed to only 2% spent by the rich. Again mortality rate is higher in rural as compared to the urban mainly due to lack of timely healthcare. Delineating the fact that India has the world's lowest health budget, the report holds the government responsible for lack of resources and improper implementation of schemes and policies. The gross mismatch between objectives and resources is at the heart of both the inadequacies and the inequities of the Indian health system. The report says that the state's role in health care has fallen well short of its declared intentions and poor people are forced into a situation where they have to avail private healthcare at unaffordable prices.

Agrawal and Sanger (2005, 1-9) conducted a study on "need for dedicated focus on urban health within National rural health mission" where they found in their study that urban poor population constitutes nearly a third of Indian's urban population and is growing at three times the national population growth rate. Health status and access of reproductive and child health services of slum dwellers is poor. They suffer from adverse health conditions, owing to insufficient services, low awareness and poor environment. Infant and neonatal mortality rates are considerably higher among urban poor as compared to urban average. More than half of Indian's urban poor children are under weight and under nutrition which is worse in rural areas. The existing urban health delivery system is far from adequately responding to needs of escalating urban poor population. The author pointed the other factors contributing to inadequate reach of services as illegality, social exclusion of slums, hidden slum pockets, lacking coordination among various stakeholders and neglected political consciousness opportunities.

Efforts has been given to improve the condition of health delivery system, coordinating among multiple stakeholders, improving private sector, strengthening municipal functioning and building community capacities. Author suggested that NRHM should not be restricted to rural areas. It should include the people of urban areas also.

Satpathy and Venkatesh (2006, 29-37) stated that after independence India has gradually developed a vast public health infrastructure, which currently includes 1,42,655 sub centers, 23,109 primary health centers (PHCs) and 3,222 community health centers (CHCs), providing services to 742.49 million population. Despite the well developed administrative system, good technical skills in many fields and an extensive network of public health institutions for training, research, diagnostics and other services, the health outcome is still behind the set goals. Despite the vast instructional network and diverse human resource, that includes physicians, nurses, midwives, pharmacists, technicians and community health worker, the public health system in India suffers from shortages, imbalances, misdistribution, poor work environment, low productivity of personnel.

Prinjal et al. (2012, 421-431) carried out study to ascertain inequities in self reported health status, services utilization and out of pocket health care expenditure in two states of Haryana and Punjab and Union Territory of Chandigarh in north India. Analysis indicates that morbidity and hospitalization rate had a pro-rich distribution in all three states indicating poor utilization of health services by low income household. Nearly 57% and 60% household from poorest income quintile in Haryana and Punjab respectively faced catastrophic out of pocket hospitalization expenditure at 10% threshold. Lower prevalence of catastrophic expenditure was recorded in higher income group. Public sector also incurred high cost and hospitalization had a poor distribution in selected three states.

Choudhary B. (2004), conducted a study with the objectives to look at the status of health care system in the state of Assam, particularly in the rural areas. He tried to find out the access of the rural people to the health care system from case studies in two remote villages in Assam. The study revealed that a large section of people under study area was living under poverty line. The poverty stricken households always find it difficult to receive health facilities be it in the public sector or in the private sector. The poor people in those areas do not seek medical facilities in minor cases of illness. Many of them also approach traditional practitioners because this type of

treatment is cheaper than medical treatment. Household expenditure is always more than their earnings for which they cannot think of spending some extra money on health care. Most of the women have delivered their babies at home without the presence of a doctor or trained personnel. The study found deplorable conditions of public health care system in rural areas of the country that had pushed people either to seek traditional health care providers or remained unattended. Thus it pointed out the need for provisions of infrastructure for health as well as transport and communication so that people can get access to the health care service when the need arises.

Jyoti Rao (2007), reported in her study that Assam has one of the highest maternal mortality rates in India, 407/100,000 live births. Less than 60% of women receive antenatal checkup. Institutional delivery is extremely low at 17.6% and skill attendants conduct only 21.4% of non institutional deliveries. The infant mortality rate is 69.5/1000 live births, remain very high. Besides high neonatal mortality, infectious diseases and vaccine preventable diseases are also responsible for high level of infant deaths. Only 17% of children receive full immunization. Further, it was stated that development of Assam is intricately linked with the development of entire north east of India. Hence in 2006 a full-fledged Assam state-UNICEF cooperation office started to focus on the critical issues related to children and women as UNICEF is strategically poised to play a catalytic role in advocating and securing the rights of children and women in this sensitive area of India in the new millennium.

Saikia & Das (2012, 34-38) reviewed the current status of rural health care infrastructure in north- east region of India. The study found that after implementation of NRHM in 2005 there has been significant improvement in the rural health infrastructure, especially in case of health centers, but the quality of rural health services has remained an issue of concern. In the north-eastern region all states except Mizoram have suffered acute shortage of Community health centers and primary health centers. The major concern is that Assam and Tripura have suffered more than 50% shortage of Community Health Centers. There is acute shortage of man power in health centers across the north eastern states. All the states have suffered shortage of Health Workers, Specialist, Radiographers and supporting staffs in Community health centers along with the inadequacy of other facilities.

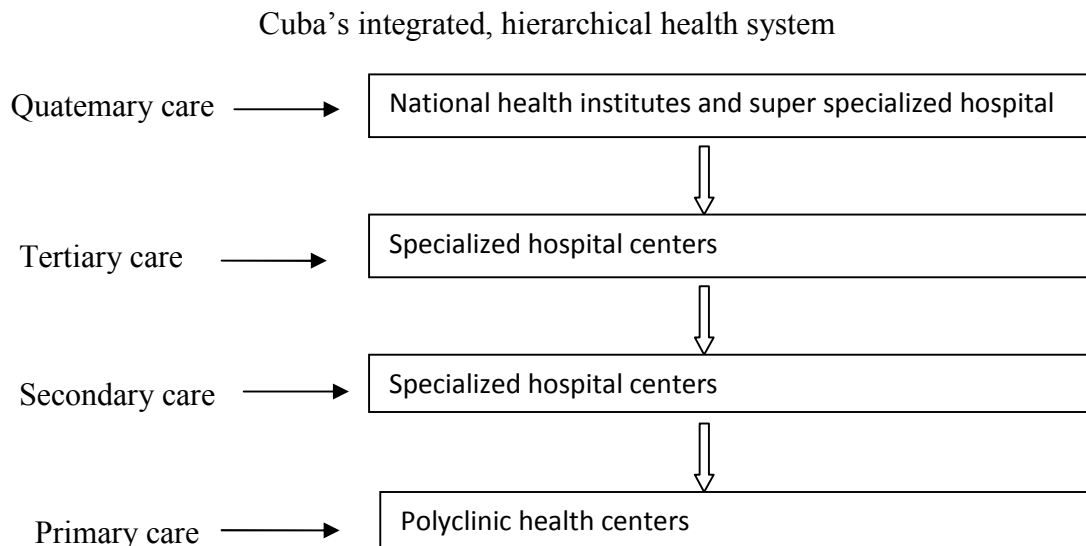
2.3 Effectiveness of Community Health Workers

Brazil's Family Health Program (PSF) uniquely integrates its CHW program within health teams comprised of four to six CHWs, with a physician, nurse, and nurse assistant assigned to distinct geographical regions of no more than 5000 people. Over the past 15 years the PSF has emerged as the pivotal component of Brazil's Unified Health System, which was created to shift the healthcare system to a free health care including MNH services. The PSF's well integrated health teams including CHWs provide a comprehensive approach to healthcare by not only delivering Primary health care, but also by providing the community with health education and preventative medicine to further improve health outcomes. CHWs specifically support home health promotion, disease surveillance and population registries, and identify and care for those acute problems that can be dealt with in the home. Not only is PSF cost effective, costing only the equivalent of between thirty-five and fifty U.S. dollars per individual covered, it also reduces the burden on public hospitals and clinics. The important fact is that fifteen to twenty years ago Brazil' health and economic profile was comparable to many African and Asian countries struggling today with maternal and new born mortality. Brazil's PSF is an example of the accomplishments that can be achieved through local and national support.

The Cuban health system is recognized worldwide for its excellence and its efficiency. "Despite extremely limited resources and economic handicaps Cuba has managed to guarantee access to care for all segment of the population and obtain results similar to those of the most developed nation. It is fully integrated and controlled directly by the government and its ministers. The system is under constant evaluation to meet the needs of the population in the most cost efficient manner" (Lee et al. 2005, 297-303).

Cuba's health care system is based on preventing people from getting diseases and treating them as rapidly as possible. "The most revolutionary idea of the Cuban system is doctor living in the neighbourhoods they serve. A doctor, nurse team are part of the community and know their patients well because they live near to the health centers and also provide services during off hours and offer a wide variety of specialist. This has made Cuba extremely effective in control of everyday issues" (Cooper et al. 2006, 817-824). Cuba is one of the best performers

in the health sector in the American continent and in the third world with a life expectancy of 78 years and lowest infant mortality rate (Oscar A. 2014).



Jacobson (1991, 5-6) reported in his study about the traditional Midwives programme of Zimbabwe that improved access to better health care with a 50% and 66% reduction in maternal health and infant mortality rates, respectively. The programme contributed to increases in the use of contraceptive and the number of women receiving prenatal care.

The Planned Parenthood association of Ghana (PPAG) formed strategy for helping poor communities, which includes concrete and practical health education; community involvement; encouragement of voluntary activities; use of the skills of the community; self reliance including family planning that gained wide acceptance. The practice rate of family planning among 9 intervention villages ranged from 24.6%- 43.6% that is far higher than the national average of 5.2%. Immunization coverage rates in nine villages ranged from 74.7% to 87.0%. The villages have themselves begun promoting maternal and child health and family planning. Results indicate that the community project has been successful in improving the living conditions of the villagers by mobilizing local resources (Lehmann et al. 2004).

The SEARCH NGO (Society for Education, Action, and Research) pioneered home-based neonatal care in tribal districts of Maharashtra in the 1980s. Village health workers (VHW) conducted antenatal and postnatal counselling, birth attendance, and growth monitoring;

research results (e.g. Bang et al 2005) indicated decreased neonatal mortality up to 20% compared to the control population. The nutrition counselling interventions led to a significant decrease in the birth of low birth weight babies, and other interventions resulted in a significant decrease in case fatality (60% decrease for preterm, 70% decrease for LBW babies) with a substantial decrease in the incidence of co-morbidities such as sepsis, asphyxia, hypothermia, and feeding problems.

Norris et al. (2006, 544-556) examined the effectiveness of diabetes-related interventions involving community health workers and reported outcomes in persons with diabetes. Studies focused on minority populations in the USA. The roles and duties of community health workers in diabetes care were varied, ranging from substantial involvement in patient care to providing instrumental assistance in education sessions taught by other health professionals. Participants were generally satisfied with their contacts with community health workers and participant knowledge increased. Improvements in physiological measures were noted for some interventions and positive changes in lifestyle and self-care were noted. The authors acknowledge that while CHW programs may contribute to diabetes health literacy, the knowledge must translate to improved physiological measures, health behaviors, and quality of life.

The Celletti et al. (2010, 45-47) study, which compiled data from Brazil, Ethiopia, Malawi, Namibia, and Uganda, found that 39% of HIV-positive patients' first contacts with the healthcare system were with CHWs, and only 24% of patients' first contacts were with doctors. In Ethiopia, the number of people being tested and counseled rose from 500,000 in 2006 to 1,600,000 in 2007 due to the training of CHWs on the provision of these services. In Namibia, after only having 2,000 total patients on antiretroviral therapy (ART) since 2002, the number of patients starting ART increased to 160 per month after the CHW program was implemented (i.e. close to 2,000 new patients in a single year). Moreover, out of 200 people surveyed regarding the CHW program, 90% reported being satisfied or extremely satisfied with their assigned CHW. This study concluded that "the inclusion of CHW in health teams allows frequent service-user interaction at the community level, which improved adherence, patient follow-up and psychosocial support. They therefore contribute to better outcomes than that can be achieved through services delivered only by doctors and nurses.

Baqui et al. (2010, 304-310) evaluated home-care and community-care for maternal and neonatal health interventions in rural Bangladesh in order to understand effectiveness of CHWs in facilitating health care services. In the home-care intervention, CHWs assessed neonates for infection and referred sick neonates to higher levels of care. For the 34% of who did not comply with the referral, but consented to home treatment, CHWs administered injectable antibiotics. As a result of this intervention, neonatal mortality decreased from the initial state of 46.9 deaths per 1,000 live births to 29.2 per 1,000 live births after 30-month of implementation of the program. This measure of output indicates that CHWs may divert patients from harmful practices, thereby contributing to better health outcomes for neonates.

The government of Chhattisgarh, in partnership with civil society, launched the Mitanin programme in 2002. Mitanins were trained and supported to conduct household outreach, including essential care of newborns, nutritional counseling, case management of childhood illness, and women's empowerment activities, and mobilization around ICDS and mid-day meal. Mitanin are not salaried, but receive a piece of land for cultivation or some other means for their service, as decided by the villagers. Over 60,000 Mitanin now serve in over 70,000 hamlets, and are supported by 3,000 women engaged as middle-level supervisors. The Mitanin is widely credited for lowering state IMR from 85 in 2002 (the second highest in the country) to 65 in 2005. During the same time period, the state's proportion of underweight children has dropped from 61% to 52%, and full immunizations have risen from 22% to 49% in the 12-24 month age group. Mitanin programme served as a model to the ASHA programme.

2.4 Health workers knowledge, Attitude, Motivation and their skills

M. J Sengwana et al. (2004) conducted a study on knowledge, beliefs and attitudes of community health workers about hypertension in the cape Peninsula, South Africa. Forty-three CHWs were included in the study. Firstly a group discussion was conducted to explore attitudes, beliefs and perceptions of hypertensions; secondly an interview was conducted to assess their basic knowledge about cases, prevention and control of hypertensions. Findings of the study conclude that CHWs' responses highlighted their insufficient knowledge about hypertension as a chronic disease of lifestyle. They also found difficult to grasp the fact that people without risk factors, such as overweight or a family history of hypertension could be hypertensive. CHWs

believe traditional medicines are the best treatment for hypertension. Further the study suggested that training programme for the primary prevention of cardiovascular disease should be initiated and also education and information should be provided.

Government of Pakistan launched National Family Planning and Primary Health Care in 1994. Lady Health Worker has a key role in providing these services. M.H. Khan et al. (2006, 37-47) conducted a study for assessment of knowledge, attitude and skills of lady health workers in 2005 at Kohat district. Fifty lady health workers were interviewed. The study reveals that knowledge of lady health workers was above 36%, attitude score above 88% and skill assessment score above 86%. Sixty four percent lady health workers had established their health houses. Seven lady health workers showed non-satisfactory results with poor health house management. Much improvement in skills was required in the use of contraceptives. There was poor display of knowledge regarding vaccination schedule and insufficient knowledge regarding the doses of common medicines.

Mahyavanshi et al. (2011, 50-55) conducted a study on knowledge, attitude and practice of ASHA workers regarding child health in Surendranagar district of Uttar Pradesh. Sample size was 130 ASHA workers. Study reveals that 86.2% of ASHA workers had improper knowledge regarding newborn care and 90% ASHA workers did not know as what advice to give to mother for prevention of hypothermia and how to give kangaroo mother care. 70% knew the causes of diarrhoea but 91.5% of them had no idea about signs of dehydration. About 68.46% and 68.47% lack knowledge about measles and pneumonia respectively. Approximately 80.77% knew about signs/ symptoms of malaria but 59.23% among them did not know what to do if the child suffered from it. Study depict that amongst ASHA workers, 96.92% had good attitude. Further they suggested that in spite of training which was given to ASHAs, there is still a lacuna left in their knowledge regarding the various aspects of morbidity and mortality of children less than 5 years of age. So frequency and quality of training for ASHAs must be strengthened.

According to Khan et al (1998, 37-47), there are various motivational factors for becoming a Shastho Sevika in Bangladesh, such as to do some work for children, to earn a profitable income, to have access to medicine, to make people aware about contraception and immunization to learn about health and hygiene of her own children and neighbour. Namgyal (1994) mentioned in his study that in Bhutan apart from remuneration and incentives the other

motive that derives the Village Health Workers to continue is the central Buddhist tenet of service for the sake of improving ones “karma”. VHWs feel that the good that they have done will certainly shape a better karma for next life.

In addition to remuneration and incentives, community recognition and public appreciation for the contribution of volunteers in the form of awards, certificates, ceremonies etc was desired especially by community health volunteers. The recognition was identified by volunteers as an important factor in their own sense of satisfaction and motivation to continue as a volunteer. (Government of Nepal and Maternal and Neonatal Health 2003).

Dieleman et al. (2003) reported in their study to provide good quality health care services, it is important to develop strategies influencing staff motivation for better performance. The study indicates that although financial incentives are important, they are not sufficient to motivate personnel to perform better. To achieve better staff motivation, attention should also be paid to incentives that focus on showing appreciation and respect. This can be achieved through performance management such as supervision, training, performance appraisal, career development and feedback from the community.

To support the Health Extension Programme of the Ethiopian Government, JSI Research and Training Institute implemented the Gates Foundation funded project “Last Ten Kilometers (LK10)”. The L10k project explores the potential of non-financial incentives in strengthening volunteerism among CHWs with the view that such incentives can improve and sustain household health practices. The study reveals that CHWs have positive attitude towards their work. Volunteers were also strongly motivated by the responsibility and acceptance they received from the community, as well as the recognition, respect, credibility and political status they have gained. CHWs can therefore be further motivated by promoting community understanding and recognition of their work. Their aspirations for learning and employment opportunities can also be considered in relation to ways of sustaining volunteerism.

2.5 Approaches adopted by community health workers to perform their work

V A Ware (2013), reported in his study, to provide accessible health services to the community the Australian Government adapted the approaches such as- providing services locally, providing transport to health services, having flexibility in setting appointments, using

home visit as part of a multifaceted engagement strategy, increasing services that do not require co-payment and improving access to private health insurance and private health services.

In Seattle King County's Healthy Homes program, Community Health Workers visit low-income children with asthma, conduct a home environmental assessment to identify asthma triggers and assess caretaker's knowledge and management of asthma. The CHW supports families in reducing triggers and improving asthma self management through follow-up visits. They provide allergen control resources; make referrals to additional resources and links families to medical homes. Home visits make a big impact on asthma outcomes. Compared to a comparison group, children who received home visits had less urgent need of health care. In 2003, the Secretary of the US Department of Health and Human Services recognized the program with its "Innovation in Prevention" Award. In 2005, the program received the US EPA Children's Environmental Health Excellence Award.

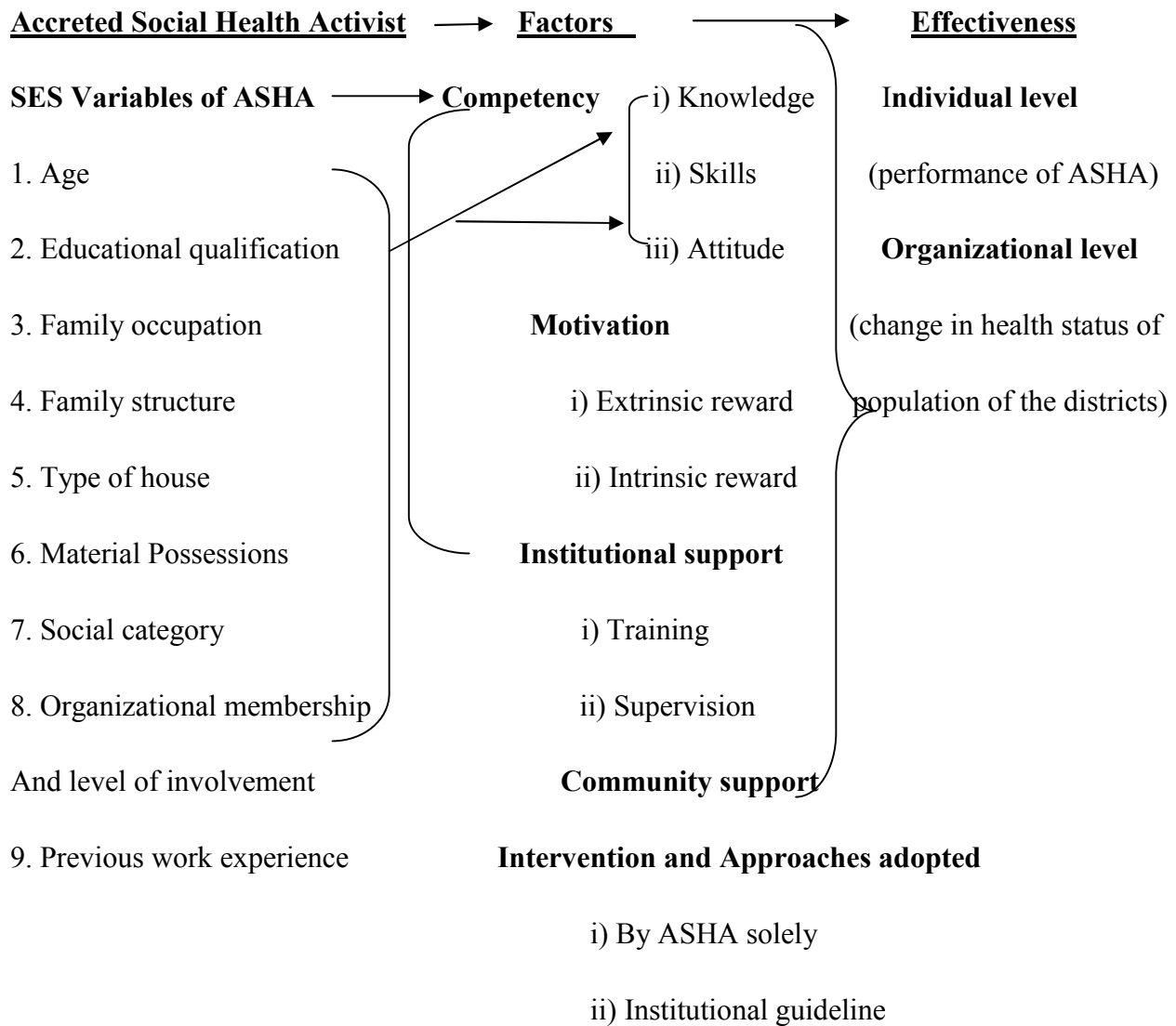
In Namibia Community Based Health Care (CBHC) is adapted by the government to achieve national health. CBHC is a community programme on health care, in which the community is actively involved in identifying their problem and needs, prioritizing them and mobilizing their own resources to meet those needs. A huge part of CBHC is the provision of home based care as an essential component of the continuum of care for person living with HIV/AIDS and other terminal diseases. Home based care is the holistic, comprehensive care of clients that is extended from the health facility to the client's home through family participation and community involvement within available resources and in collaboration with health care workers. It encompasses clinical care, counseling, psycho spiritual care and social support. (Ministry of Health and Social Service, 2007).

Kerry Taylor (2000, 168-173) in his study describe using drama to raise some of the main health issues faced by young people, inform them about local services and provide them opportunity to explore their fears and anxieties about accessing services in rural areas. The drama was targeted at 14-15 years old on two consecutive years. In the first year, the drama was performed by the actors and in the second year, script was re-written and performed by college students. The dramas were designed to complement and extend existing information and education. The effectiveness of each year's production was evaluated. In both year, evaluation showed that the drama was successful in informing young people about local health services and

addressed their main anxieties. As a result, the drama has become a regular yearly event in the secondary schools in this rural area (Wyon et al 2002 13).

2.6 Conceptual Framework:

Based on the literature review the following conceptual framework was drawn.



For this study effectiveness of CHW (ASHA) are determined at the individual level i.e. performance of ASHA (which contributed increase in coverage of services like antenatal care, postnatal care, immunization, institutional delivery and adoption of household sanitation, clean surrounding) and at the organizational level i.e. change in health status of people district wise

realized by NRHM (improved children health, women health, immunization and reduced diseases).

The factors such as competency, motivation, institutional support, community support, intervention and approaches adopted and the SES of ASHA influences the effectiveness of their performance.

The SES of ASHA in the study area is determined from the different demographic variables such as age, educational level, marital status, family structure, family income, social category, occupation, land holding, organizational membership and previous work experience. The study of SES helps to understand the ASHAs behaviour, their social participation, pattern of leadership, motivation for improvement and communication in a community because it might have bearing on their functional efficiency.

According to the Vichita Vathanophas (2007) motivation, attitude and competency are very crucial to the effective outcomes. The above framework also suggested that ASHA should have good competency and motivational level to perform their role to bring out effective outcomes in the health of population. Competency is studied in terms of Knowledge, Skill, and attitude of ASHA. Neeraj Kak et al. (2001) stated that CHW should be competent to perform better and measuring competency is essential for determining the ability and readiness of health workers to provide quality services. According to them competency encompasses knowledge, skills abilities and attitudes. National Community Health Advisory study (1998) reported that CHW should have a good communication skill, teaching/presentation skill, advocacy, organization, service coordination, interpersonal and capacity building skills. They should have a good knowledge about their community, specific health issues, knowledge of health and social service system. They also require formal training on an ongoing basis and consistent supportive supervision to ensure that they can meet the community changing health care needs in time of calm and crises.

Sometimes health worker may be competent to perform but may not be willing to expand the effort to perform their entire required task because of the lack of work motivation. Worker motivation refers to an unobservable process that determines the direction intensity and persistence of action (Vroom, 1964). Financial, nonfinancial and social incentives provided to

workers are most likely to facilitate workers motivation. (Kanfer 1987, 237-264). Factors like personal motivation, adequate support of the authorities, colleagues can affect workers performance (Salazar Lindo et al. 1991, 227-234). Dieleman et.al (2003, 9) mentioned in his study that recognition for the work from health workers managers, colleagues and community is of great importance. UNICEF (2004, 23) reported that Female Community Health Volunteers need to be remunerated or receive regular incentives. These could be in the form of financial allowances or non monetary benefits such as bicycles, radios, saris, umbrella etc. Such benefits were considered to have a positive influence on the family's willingness to give permission for women to serve as volunteers and also improve the volunteer's status in the community. In addition to remuneration and incentives, community recognition and public appreciation for the contribution of volunteers in the form of awards, certificates, ceremonies etc. was desired especially by volunteers.

According to Mundhra (2010, 277) motivation are of two types 'extrinsic motivation' and 'intrinsic motivation'. Extrinsic motivation refers to external factors which can be measured in monetary terms such as salary and bonus etc. intrinsic motivation refers to internal factors such as interest, enjoyment, choice, perceived competence etc.

Apart from competency, motivation, institutional and community support, the approaches and interventions adopted by CHW (ASHA) to transmit health messages are also important. Therefore, the convincing and appropriate method to deliver health related message at a right time to the target segment is necessary to avoid distortion of information and make it more effective and acceptable. Some approaches are instructed to ASHA by the NRHM office/ institution whereas some interventions / approaches are adopted by the ASHAs on their own to inform and convince their target segment.

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