

CHAPTER- 3

OBJECTIVES, SCOPE AND LIMITATION

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3.1 Statement of the Problem

“India has the largest number of births per year (27 million) in the world” (Ronsmans 2006, 368). “With its high maternal mortality of about 300–500 per 100 000 births, about 75,000 to 1,50,000 maternal deaths occur every year in India” (NFHS-II). “This is about 20% of the global burden hence India's progress in reducing maternal deaths is crucial to the global achievement of Millennium Development Goal 5” (Mavalankar et al. 2008, 412-415).

“India has 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 rural people (72.2% of the country's population). Besides, over 5,479 sub divisional and district hospitals and other specialized hospitals are in the public sector. The population coverage norms are 3000/ 5000 per sub-centers, 2,00,000/3,00,000 per PHC and 80,000/1,20,000 per CHC respectively, depending on whether the center is in a hilly, tribal, difficult area or in the plains. The private sector plays a big role in the delivery of health care, catering to 46% of hospital inpatients and 81% of out patients” (S.K Satpathy and S Venkatesh 2006, 19-37). 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. The existence and quality of services to promote health prevent illness or to cure and rehabilitate depends on knowledge, skills and motivation of human resources for health. For attaining any health goal, the health system requires getting the right number of service providers with the right skills at the right place at the right time. Despite the vast institutional network and diverse human resource, that includes physicians, nurses, midwives, pharmacists, technicians and community health workers, the public health system in India suffers from shortages, imbalances, misdistribution, poor work environments and low productivity of personnel.

“In India 40% of people belong to poverty line and their health status is below Indian Public Health Standard, in order to develop a nation like India, rural development is mandatory and a better rural health is the first key steps towards development” (Hota & Dobe 2005, 107-110). “Ghill and Ghuman (2002, 4474-77) state that primary prevention and health promotion are nonexistent in rural India, since the majority of Indian population (almost 70%) lives in rural areas, therefore rural health needs to be focus of the state”. Community health workers can play an important role in providing basic health care services in rural areas and undertake actions that lead to improved health outcomes. “But in India success of community health workers programme was marginal and remains unsuccessful in achieving health status of the population. To be successful and to carry their work successfully community health programme needs careful planning, regular supervision and training, secure funding, active leadership and community support”. “CHW services are likely to have a substantial health impact, but the quality of services they provide is sometimes poor (Lehmann and Sandes 2007, 1-30)”. Quality and productivity of work depends on Competency of community health workers and quality of training and support received by them.

Recognizing the importance of health in the process of economic and social development and improving the quality of life of citizens, the government of India launched NRHM on 5th April 2005 as a major new reformative initiative to undertake systematic correction of the health system and basic health care deliveries for sustainable outcomes. To provide quality health care especially to women, children and weaker section of the society a band of community base functionary’s activist name as Accredited Social Health Activist (ASHA) has been positioned to serve the population living in the unreached and un served areas.” The Auxiliary Nurse Midwives (ANMs) are heavily overworked that affected outreach services in rural areas. Currently Anganwadi workers (AWWs) under the Integrated Child Development Scheme (ICDS) are engaged in organizing supplementary nutrition programmes and other supportive activities in the rural areas. The very nature of the job responsibilities does not allow an Anganwadi Workers to take up the responsibility of a change agent on health in a village. Thus, a new band of community based functionaries ‘Accredited Social Health Activist’ was created to fill the void” (News letter of NRHM, 2008). “ASHA is a health activist in the community for 1,000 populations who has to create awareness on health and its social determinants, and

mobilize the community towards local health planning and increased utilization of the existing health services. ASHA have been the ‘cog in the wheel’ as far as the implementation of various programmes under NRHM is concerned, as they are the ones who communicate with the target audience on one- to- one basis” (Mission Document 2005).

“Assam is one of the high focused states under NRHM and is the most populated state in the North East. Despite its high involvement in income generating activities and rich in natural resource among the Northeastern state, Assam has not been able to achieve the desired health outcomes. This is may be due to the poor literacy rate, low per capita income, high density of population, improper water and sanitation facilities etc contributed to the under developed health sector” (Dutta & Bawaris 2007). Assam was covered under NRHM programme on 11th November 2005. In Assam ASHA was created in the year 2006 and so far 25,975 ASHAs were recruited against its target of 26,693. She was supposed to work at the grass root level and act as the link between the community and the health care provider.

“Bajpai and Dholakia (2011, 40) reveal in their study that the selection process and criteria are not being met in several areas during recruitment of ASHAs thus many of the selected one may not be able to perform up to the level necessary. They also revealed that ASHAs have no clear idea about their roles and responsibilities and the quantity and quality of training provided to ASHAs must be improved”. In Assam too several news paper reports have expressed public sentiments regarding services provided under NRHM that lack in meeting the health care needs of rural people (refer appendix no. 12).“Gogoi (2009) reveals that ASHA workers have been entrusted with lots of responsibilities such as institutional delivery, immunization, village health sanitation, health day organization etc. but they are given training for only 23 days. Thus it seems ASHA workers are not properly empowered to play an active role in the whole process”.

The success of NRHM depends a lot on the role played by ASHAs. Therefore ASHA workers have to be competent to bring about desirable changes in the health scenario. Hence competency among ASHAs is an important component. It reflects the attitude, knowledge and skills that ASHAs may need to possess in order to promote and provide health services in the community. It is very important to determine the level of competency of ASHAs, because

department of health or health care organizations must ensure that appropriate levels of competency are set for ASHAs and the latter conform to the standard. Competency assessment can help to identify the health workers who are competent to provide health care services and also who need improvements in specific knowledge or skill areas. Competence assessment can also determine the efficacy of training interventions in closing knowledge and skills gap. Low score on competence assessment after training may indicate that the training was ineffective, poorly designed, poorly presented or inappropriate. Trainers can use this information to improve training content of delivery. Competence assessment can also guide health care manager while recruiting new health workers to ensure that they can do the job they are hired for. It is a fact that a competent and motivated individual who is able to play an effective role can contribute positively to developing health care scenario in rural areas and while incompetent persons can give no good results. Therefore it was felt necessary to understand the role played by ASHAs in Assam in facilitating health care services effectively and the competency they possess in order to play their role aptly.

3.2 Need for the study

It is discussed in detail in the section (2.2 and 2.3) in chapter 2 under literature review, and it is observed that most of the studies are concentrated in the health status of population, impact and evaluation of CHW programme. However very little study has been carried out on the work effectiveness of CHWs. Swider (2002 11-20), reveals that CHWs appear to be effective in increasing access to health care and recommend further evaluation to document and understand how CHWs are effective to understand key elements of their activities and the communities that are most open and responsive to CHW interactions.

Levien et.al (1992, 312-323) reported that very few studies had been done so far regarding knowledge and attitude of CHWs and suggested that the effectiveness of CHWs in numerous areas requires further research. Lewin et.al (2005) has suggested there is a need to understand of how CHWs should best provide services and how training of CHWs contributes to their work effectiveness. Gogoi (2009) has studied health related issues of community on the role of NRHM in safe guarding health security of people in Lakhimpur district of Assam where

communicable diseases occurs more during flood and suggested a scope of conducting study on performance of ASHA workers.

Moreover studies with respect to competency and approaches adapted by CHWs to fulfill their objectives in North East India particularly in Assam are almost nonexistent. Hence it is felt that the need for this kind of study is essential in determining the competency of CHWs and their outcomes. At the same time it is important to identify the approaches/ interventions adopted, problem faced and role played by CHWs in facilitating health care services. Furthermore this study could contribute to modification or strengthening of the programmes designed for CHWs like those related to training, recruitment and addressing different health related issues of the community. It also could help to understand the level of ASHA's motivation, and their satisfaction and dissatisfaction regarding intrinsic as well as extrinsic rewards that they receive. Finally this study would try to determine the gaps between the desired state of health care and what it exist at present.

3.3 Objectives of the study

- i. To study interventions and methods adopted by ASHA for community mobilization to attain a better health care amongst its target populace and compare it with that of institutional approaches.
- ii. To determine competency and motivational level of ASHA in conducting their role effectively.
- iii. To carry out a comparative analysis amongst the three districts as chosen for the research study with reference to competency and motivational level of ASHA, the interventions and activities carried out by ASHA, and the outcomes.

3.4 Scope of the study

- i. The study has been conducted in the three districts of Assam namely Sonitpur, Nagaon and Sivsagar district. These three districts are chosen for the study based on certain health parameters, which indicated the health status of the population as low, moderate and high of a particular district. (refer chapter 4, section 4.2)

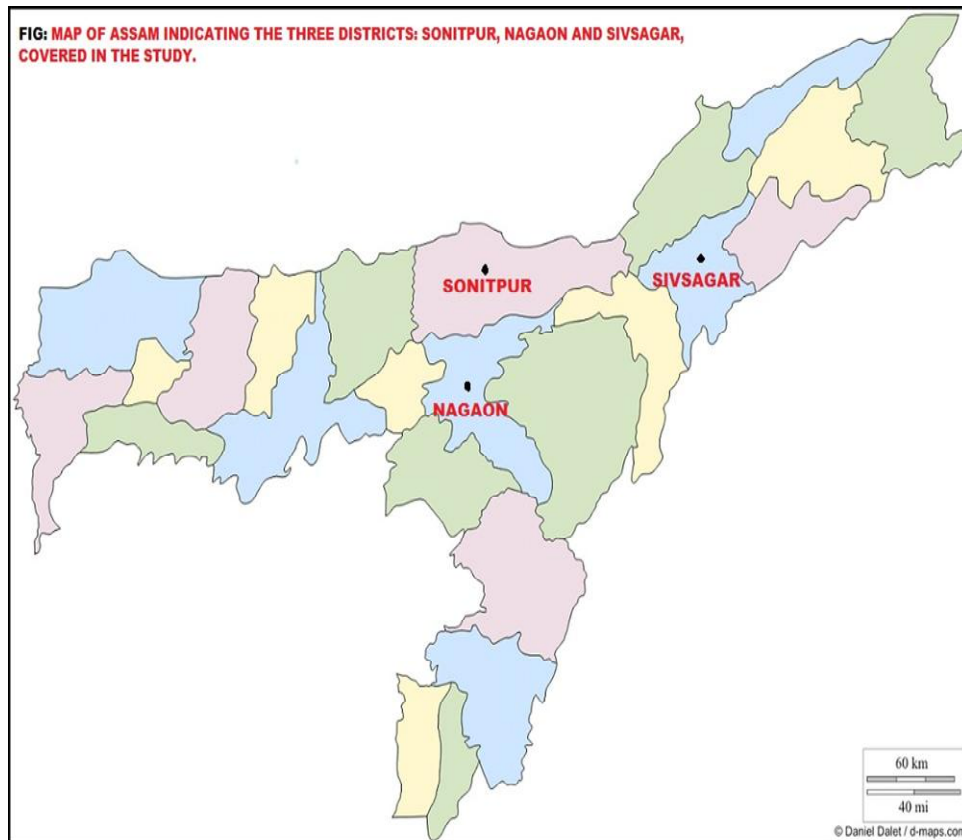


Fig. 3.1, Districts covered in the study

ii. Present study is conducted among four different groups of respondents such as CHWs (ASHA), Beneficiaries (rural people), Community representatives (Members of gram panchayat) and Health Officials of Health Department/ NRHM both from the districts and state level.

3.5 Limitation of the study

Study is confined to understand the delivery of health care services in rural areas only as “ASHA workers” was created to provide health care services to the rural community under National Rural Health Mission.

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