

**CHAPTER –1**  
**INTRODUCTION**

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In India 68.4 percent of the population live in the rural areas (census 2011). “Their economy is primarily dominated by agriculture and 40 percent of people belong to below poverty line. Their health status is below Indian Public Health Standard. Health, sanitation and education are the important areas that need to be addressed in order to improve living standard of population residing in the rural areas. In order to develop a nation like India, rural development is mandatory and a better rural health is the first key step towards development” (Hota & Dobe 2005, 107-110). To provide basic health care facilities and protection to the rural population, government of India has implemented the National Rural Health Mission (NRHM). The mission ensures universal coverage of primary health care services to the rural population. The NRHM has mainly focused on strengthening the rural health infrastructure including the physical manpower and other facilities. One of the important interventions of NRHM is the creation of Accredited Social Health Activist (ASHA), who works as a link between the community and the health system. Thus, this study was undertaken to find out the effectiveness of community health workers in facilitating health care services in Assam. The different concepts related to this study are discussed in the following sections.

#### **1.1 Concept of Community Health Workers**

Community Health Workers (CHWs) are members of the community, who work for payment or voluntarily provide primary health care services to their communities with the local health care system. They are the frontline health workers of health care system and work with a good knowledge of the community they serve. Now a days CHW is an important part of the health care system. “They provide the critical link between the health care service system and their communities” (Ballester 2005, 7)”. CHWs contribute to community development by improving access to health services in remote areas and can undertake actions that lead to improved health outcomes.

“The concept of CHWs has developed with community based health care programmes where the frontline workers played a crucial role in making health care service accessible to all”

(WHO 1978). In the year 1975 World Health Organization the Alma Ata established CHWs as a generic title and defined their role internationally and highlighted the importance of primary health care. WHO declared that CHWs would contribute to “Health for All” through direct provision of health care, by creating awareness of health services and their value to the community, and by acting as an agent for community development”.

A definition for “Community Health Workers” proposed by “World Health Organization study group in 1989 was that CHWs should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily part of its organization, and have shorter training than professional workers”. According to Walt (1989,1-21) “Community Health Worker are generally local inhabitants who are given a limited amount of training to provide specific basic and nutrition services to the mothers of their surrounding communities. They are expected to remain in their village or neighborhood and usually only work part- time as health workers. They may be volunteers or receive a salary; they are generally not civil servants or professional employee of Ministry of Health”. Witmer et al. (1995, 155-58) define “CHWs as community member who work almost exclusively in community settings and who serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked access to adequate care by identifying community problems, developing innovative solution and translating them into practice. CHWs can respond creatively to the local needs”.

“CHWs develop a connection between the health care system and their community (Eng and Smith 1995, 23-29)”. “Their interventions may also be more appropriate than professional driven approaches for affirming and strengthening a community’s own assets to improve health” (Bishop et al. 2002, 233-44) because Community Health Workers can understand, control and make use of community strength to promote better health by providing outreach and cultural linkages to traditionally underserved population. “They also reduce expenses of health cares to both providers and patients by providing preventive services through health education and screening early detection of disease. “CHWs can improve quality of care by adding patient-providers communication, facilitating continuity of care (by providing follow up) and by acting as a patient navigator and advocate within the health care system” (Keane et al. 2004).

CHWs are working all over the world in every country and have different names in different places such as Village Level Health Workers, Sevika, Shastho Karmi, Rural Health Motivators, Health Promoters, Paramedical Workers, Community Resource Person, Community Health Agent, Promoters Paramedical, Health Auxiliaries, Barefoot Doctors, Family Health Educator, Community Health Volunteers etc. “With the varying demands and differing levels of health within countries, regions, districts and villages, each community has its own versions of community health workers. The use of CHW has been a great help to overcome the growing shortage of health workers, particularly in low income countries. One CHW render health services to every 1000 population in order to provide adequate health care to rural population and to educate them in matters related to preventive and promotive health care.” (Bhatteracharyya 2001, 1-68).

## **1.2 Evolution of Community Health Workers**

Every country has its own unique history of the origins of CHW Programme. It first started in Russia in late 1800. The health workers were known as Feldsher who received training and were educated non physicians to carry out duties as paramedics to assist physicians. They were authorized by the state to function in rural areas where physicians were not present to provide primary health care services. Thus it indicates the development of Community Health Worker movement. Later a similar model arose in Ding Xian, China in the 1920s. “The first CHWs in Ding Xian were illiterate and only received three months training. They learned to record birth and death, vaccinate against small pox and other diseases, they provided first aid and lecture on health education and helped communities to keep well and clean” (Henry P and Rose Z. 2012, 1-78). “These CHWs were the initiation of barefoot doctors programme, which was established by Chinese leader Mao Tse Tung after Chinese revolution of 1949. Under this programme CHWs brought basic health care to rural population and addressed issues such as nutrition, vaccinations, and sanitation” (Love and Gardner 2007, 510-522). The concept of barefoot doctor moved around the world. It gained attention because of unavailability of trained professional physicians who were unable to serve the rural and poor population when needed. Thus it led to emergence of CHW programmes in many developing countries at the national scale including Indonesia, India, Tanzania, Venezuela, Mozambique, Malawi, Bangladesh, Nepal and Brazil as well as in other Latin American countries.

In the year 1975 WHO published a book entitled “Health by the people”. The book consists of number of case studies regarding foundation of CHWs under innovative Community Health Programme from different countries. “It based on the new approaches for the provisions of medical care, community participation, disease prevention, justice, equity and the use of appropriate technology” (Newell K W, 1975). “Later this book became the part of an intellectual foundation for international conference on primary health care at Alma – Ata, Kazakhstan in 1978, sponsored by WHO and UNICEF. The conference resulted in the declaration of Alma Ata, which called for the achievement of health for all by the year 2000 through primary health care. The declaration clearly defined the role of Community health workers, which was needed for the community development throughout the world” (UNICEF, 2004).

The most successful examples of CHW program emerged during the mid 1980s. “Among the most notable was community based family planning programme that started in Bangladesh in the mid 1970s with the CHWs as family welfare assistant, locally known as Shashtya Shebikas. This programme was expanded in the mid 1980s and it has been widely regarded as one of the world’s most successful family planning programme in a developing country” (Perry H.B 2000, 354). Another example was the “Brazil national health care programme (i.e, Special Service for Public Health – Servico and Special de Saude Publica) which started in 1987. Since then the programme has been able to gradually achieve universal coverage of PHC services and marked improvement of population health status. The programme utilizes health teams that include one of the largest CHW networks in the world, composed of 222, 280 CHW called Visitdora, who provide home visit and services to 110 million people” (Gottelib J 2007, 25-31). Another notable program emerged in the late 1980s in Nepal’s Female Community Health Volunteers (FCHVs) programme, it was established in 1988. The engaged female volunteers had been trained under the CHW programme. Their role consisted of family planning promotion, first aid and some dispensary functions. In the year 1993 government of Nepal progressively introduced distribution of vitamin A with FCHVs programme. Over the past decades 40,000 FCHVs have taken the responsibilities that include detection and treatment of common childhood diseases, distribution of oral contraceptives and promotion of available health services for first aid, antenatal care, family planning and immunization (Thapa S et al. 2005, 782-789).

“Bangladesh, Brazil and Nepal had made vital contribution in CHW programme. They had most rapid achievements in reducing under- five mortality in the world since 1990” (Rohele J et al. 2008, 950-961). “Iranian government established in 1979 CHW Programme with female workers called ‘behdanst yar’ and male worker called ‘behyraz’, that set an example regarding training of CHWs that has resulted positive outcomes like reducing maternal mortality and increased life expectancy. Ethiopia began its CHW program to train Health Extension Workers who numbered more than 30,000. The workers were literate, adult females who completed 10<sup>th</sup> grade and who were from local community and provided services that included provision of basic first aid, contraceptive, immunization, diagnosis and treatment of malaria and diarrhea” (Bhutta ZA et al. 2010). In 1992 the government of Pakistan initiated the Lady Health Workers Programme with more than 90,000 female workers to serve their rural population. Uganda started a national CHW programme as part of its village health team strategy in 2003. India initiated National Rural Health Mission in 2005 that involved support for more than 800,000 female health workers with a new name called Accredited Social Health Activist (ASHA).

The exact role and responsibilities of CHWs varies from country to country. It depends on the program that is launched to upgrade health status of the population within the countries. A proper planning, secure funding, community support and active government leadership is needed for success of a CHW programme. For an effective functioning of CHW it also needs regular training, supervision and reliable logistical support. Hence a CHW program offers one of the most important opportunities for improving the health of population, especially in low income countries.

### **1.3 Roles of Community Health Workers**

CHWs perform different types of tasks, which generally include culturally appropriate health education; conduct home visits, work for environment and sanitation, provision of water supply, provide first aid and treatment of common ailments, health education and disseminate information on nutrition, maternal and child health. “CHWs are responsible for control of communicable diseases, malaria and community development activities. They also do referrals, keep record and collection data on vital events” (Ofosu-Amaah 1983, 1-49). “CHW builds individual and community capacity by increasing health knowledge and self- sufficiency through a range of activities such as outreach, community education, informal counseling, social support

and advocacy” (Ballester 2005). To perform their job effectively in different types of work environments, CHWs should have certain level of knowledge, skills and positive attitude, which depends on the quality, duration and types of training provided to them. Therefore CHWs to be able to make an effective outcome in the health scenario through their contribution, need to be carefully selected, appropriately trained and continuously supported. CHWs system requires sustainable increase in support for training, management and supervision because an outcome of any Community Development Programme depends a lot on CHW performance and their efforts to mobilize their community for a social change. Indeed CHWs are uniquely qualified to provide services to the most isolated and vulnerable residents.

Rosenthal et al. (1998, 330-341) identified seven core roles that are performed by CHWs

- i) Bridging cultural mediation between communities and health care system.
- ii) Providing informal counseling and social support
- iii) Providing culturally appropriate health education and information
- iv) Advocating for individual and community capacity.
- v) Ensuring that people obtain necessary services
- vi) Building individual and community capacity.
- vii) Providing basic screen services.

#### **1.4 Concept of National Rural Health Mission (NRHM)**

NRHM was launched in India in April 2005 and approved till the year 2017. The NRHM is a national effort to bring about dramatic improvement in the health system and the health status of the people, especially those who lived in the rural areas of the country. “The mission seeks to provide universal access to equitable, affordable and quality health care which is accountable, at the same time responsive to the needs of the people, reduction of child and maternal death as well as population stabilization, gender and demographic balance” (swathya samwad 2009). “Assam is one of the high focus states under NRHM, which have weak public health indicators and weak infrastructure” (NFHS-III).

#### **1.5 Coverage of NRHM**

“NRHM covers the entire country with special focus on states where lie the challenges of strengthening poor health systems. These are- Uttar Pradesh, Bihar, Assam, Arunachal

Pradesh, Manipur, Mizoram, Tripura, Meghalaya, Nagaland, Rajasthan, Sikkim, Himachal Pradesh, Jammu and Kashmir, Chhattisgarh, Uttaranchal, Tripura, West Bengal, Tamilnadu etc. NRHM not only provide access to basic services of health care but also create awareness regarding sanitation, nutrition, safe drinking water, social, hygiene and gender equality. In addition there is a huge component for infrastructure development of health institutions in terms of civil work and equipment on one hand and additional man power on the other. Institutional integration within the fragmented health sector was expected to provide a focus on outcomes measured against Indian public Health standards or health facilities”. (Hota and Dobe 2005, 107-110). The state of Assam was covered on 11<sup>th</sup> of November 2005 with the programme.

### **1.6 Activities of NRHM**

Emphasis was given to strengthen the rural health infrastructure, including the physical manpower so that rural community can easily access primary health care services. NRHM mainly addresses the needs of the mother and children. It is focused on “universal immunization and various disease control programmes such as programme for control of malaria, tuberculosis, vector bone diseases, iodine deficiency disorder, Janani Suraksha Yojana, mobile medical unit, boat clinic, Mamoni, Majoni, providing dots to the TB patients, mainstreaming AYUSH and creation of ASHA worker. Now ASHAs are an important part of health systems for translation of services to often isolated and underserved areas of rural places” (Ministry of H&FW, DLH-3. 17-23). From narrowly defined schemes the NRHM is shifting the focus to a science based health care which treats illness and promotes wellness by focusing on the unique aspects of each patient to restore physiological and structural balance.

### **1.7 Concepts of National Health Mission (NHM)**

As per census 2011, population of India has crossed 121 cores with the urban population at 37.7 cores which is 31.6% of the population. Access to health facilities by urban poor is very limited because of inadequacy of urban public health delivery system. To achieve the Millennium Development Goal and to improve the health status of the population of India it is important to make available health services to urban people along with the rural community. The services provided by NRHM were meant to serve the people of rural areas and it is limited to rural health care system.



Considering the positive impact of NRHM, government of India converted NRHM into National Health Mission (NHM) in May 2013 to provide health care to the urban poor under National Urban Health Mission (NUHM) in the course of 12<sup>th</sup> year plan. NUHM envisages to meet health care needs of the urban population with the focus on urban poor by making available to them essential primary health care services and reducing their out of pocket expenses for treatment. Now NUHM and NRHM are functioning as submissions of NHM.

### **1.8 Concepts of effectiveness**

“Effectiveness is about doing the right things for achieving the set goals. It is a useful management tool used concurrently for monitoring and evaluation of employees output. It helps to have a clear mind for creativity and innovative ideas” (F. Nyarko 2014). It is a performance indicator of the workers and its study helps to improve the ability of workers to get things done, on time and to avoid mistakes.

“Effectiveness is the capacity of producing successfully a desired result or the degree to which objectives are achieved, and the extent to which targeted problems are solved. (Oxford Webster dictionary 2011, 261)”. “Effectiveness relates to getting the right thing done. (P.F. Druker 2006, 10-25).”

Effectiveness in the health sector is conceptualized as outcomes of National Health Service and effective delivery of appropriate health care to the target segment on time. This would reflect the set priorities for the health system and help to measure progress against pre defined key standards and targets of a nation. (Report by Dept. of Health, London 1998).

“Effectiveness is also conceptualized as a domain of health system performance where the care/ service, intervention or action achieves the desired results. This concept is operationalized to better track information on major, recent and emerging health issues in keeping with the overarching aim for better health among population and improved health care by using comparable quality data on key indicators for health and health services (Arah et al. 2003, 377-98 )”.

Performance, competencies and outcomes of health indicators are measured to find effectiveness of any health programme. “Effectiveness often implies nationally the achievement

of high quality outcomes of care or internationally the efficient achievement of system objectives. Its indicators are mainly outcomes of programmes, initiatives to stimulate and manage performance and quality improvement (Arah et al. 2003, 377-398)".

### **1.9 Concepts of competency**

The term competency has been defined as "the capacity to get in touch with the environment in a constructive way" (J.Ingalls 1979, 32-34).

"Competency is defined in the context of particular knowledge, traits, skills and abilities. Knowledge involves understanding of facts and procedures. Traits are personality characteristics (e.g., self- control, self- confidence) that predispose a person to behave or respond in a certain way. Skill is the capacity to perform specific actions: a person's skill is a function of both knowledge and particular strategies used to apply knowledge. Abilities are the attributes that a person has inherited or acquired through previous experience and brings to a new task" (landy 1985). "Competency also can be defined as the ability to perform a specific task in a manner that yields desirable outcomes (Lane and Ross 1998, 229-236)." It implies the ability to apply knowledge, skills and abilities to work successfully to a new situation as well as to familiar tasks for which prescribed standards exist. Health workers acquire competence over time (Benner 1984). "Pre service education or an initial training opportunity, hands on experience, reaches a level that can be certified as competent (Neeraj Kak et al. 2001, 3)".

According to Sui (1998, 253-273) "competency means having the ability, being capable, possessing certain skills and the knowledge to do what one is supposed to do". "L. Pickett (1998, 103-115) defined competencies as the sum of experiences and knowledge, skills and attitude that a person acquired during life time". "Predue, et al. (2002, 142-146) pointed out certain motives, traits; skills and abilities that are attributed to people and their knowledge to behave in a competent way". "Mittal & Khera (2009, 30-43) pointed out: a competency is an underlying characteristic of an individual, which is casually related to effective or superior performance in a job".

For this study competency encompasses knowledge, skills and attitude of CHWs which is needed by them to facilitate primary health care services to the community. They acquire competency through pre service education, in service training and work experiences. Measuring

competency is essential for determining the potentiality and preparedness of CHWs for an effective outcome in the health scenario in a desired manner. Here knowledge refers to the in depth information about primary health care services, schemes that available for the benefits of community and health issues. Skills refer to the action or ability of ASHAs to perform the assigned task. Skills are improved through proper training. Attitude is the expression or the state of mind of ASHAs towards their work. Positive attitude of ASHAs play an important role in convincing their community about various advantages of different schemes and health policies and to adopt better health practices.

### **1.10 Concepts of motivation:**

“Motivation is the willingness to exert high levels of effort toward organizational goal (Stephen P. Robbins)”. According to (Campbell 1993) “motivation is reflected in the completeness, the intensity and the persistence of effort. For example, a healthcare worker may be competent to perform the procedure but may not be willing to expend the effort to perform all the required behavior”. According to the goal setting theory of motivation of Locke and Latham (1990), there is a relationship between goals and performance, the most effective performance seems to result when goals are specific and challenging.

ASHA worker’s willingness to come to work regularly, work diligently and carry out the necessary task, retaining their role and urge to perform effectively is a key component in improving people’s health status and reducing their mortality and mobility rate.

“Incentives are made available to influence the willingness of workers to exert and maintain an effort towards attaining organizational goals” (Mathauer and Imhoff 2006, 1-17). There are two types of motivation; extrinsic and intrinsic motivation. In extrinsic motivation, outcomes come from outside the person and intrinsic motivation is a function of an individual’s values and relate to interest and enjoyment of the work itself. Salary, incentives, availability of equipment, certificate, holiday etc are called extrinsic motivational factor or extrinsic reward, and the factors such as supervision, access to training, reorganization, appreciation, etc are intrinsic reward. The term reward means an inducement which stimulates one to act in a desired direction. A reward has a motivational power.

Kanfer (1990, 75-170) states that “employees are constantly involved in a social exchange for rewards. They also compared the effort or contribution that they put in towards accomplishing a certain task and acquiring rewards in exchange for the former”. Since, the ASHA workers are not financially compensated for their work in the form of salary, the spirit of volunteerism is crucial, this implies workers should be highly motivated towards their work for sustaining in poor communities. The rewards delivered to ASHA workers are to inspire and create a sense of competition among them, and will determine its effect on their work motivation.

### 1.11 Overview of the chapters

To study effectiveness of CHWs (ASHA) in the three districts of Assam, the study has been divided into **eleven** interrelated chapters.

The **first chapter** is introductory in nature which contains introduction to the concept of CHWs, their evolution, roles and responsibilities. Further the concepts of NRHM, work effectiveness, competency and motivation have been placed.

**Second chapter** comprises of review of literature.

After a brief review of existing literature, problem under study and the need for the study have been stated in **third chapter**. Objectives of the study, its scope and limitations have also been presented in this chapter.

Research methodology has been discussed in detail in the **fourth chapter**. Fifth chapter includes various policies undertaken by GOI for improving the health status of its population. Formation of ASHA workers, ASHA workers in Assam their roles and responsibilities are also discussed in this chapter.

In **chapter six**, job profiles of ASHAs their selection criteria and socio economic status of ASHA workers has been discussed. Hypothesis are formulated and tested with their SES score across different demographic variables to find out whether it has any influence on SES of ASHAs.

**Chapter seventh** discusses about the beneficiaries dealt by ASHAs and the methods and interventions used by them to convey health messages and information to their target segment in order to make them aware about available health facilities and schemes.

**Chapter eighth** deal with the competency and motivation of ASHA workers. It includes knowledge test, test for skill, attitude and training imparted. Motivational levels of ASHAs have also been measured. Both descriptive and quantitative analytical methods have been used to analyze the primary data collected through survey and logical conclusions are attempted to derive in this chapter.

**In chapter ninth** work effectiveness of ASHAs has been evaluated. It is done by analyzing the data collected from beneficiaries, community representative and health officials on the performance of ASHAs of their localities. Further a comparative analysis among the three districts regarding ASHA's competency, training imparted, motivational level, their satisfaction and the activities dealt and the outcomes have been placed. Also gaps related to ASHAs competency, performance and institutional support found in the study have been documented in this chapter.

Major findings of this study have been presented in the **tenth chapter**.

The concluding chapter i.e. **eleventh chapter** deals with the conclusion derived from the findings of the study. An attempt is also made to put forward suggestion for effectiveness of CHWs in the state for future research in the area and contribution to the body of knowledge is documented. Further, published papers of the researcher are placed in the appendices.

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