INTRODUCTION
CHAPTER 1

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Statement of the Problem

It is a well known fact that one of the major criteria that indicate the development of a nation is the health of its citizens. Worldwide, all nations are striving towards developing a health system that is able to provide universal access to health care for its people. Health status of the underprivileged and marginalized population in many parts of India is very poor. Health care facilities are mainly concentrated in urban areas thus depriving the majority of rural people of even basic health services.¹

However, over the last six decades, India has made attempts to build up a public health system covering the primary, secondary and tertiary levels. The public health system consists of Sub-Centres and Primary Health Centres at primary level; Community Health Centres, sub district and District Hospitals at secondary level and teaching hospitals and specialty hospitals at tertiary level. The primary level is expected to provide basic minimum health service to the whole population of the country. In order to cater to the vast majority of rural population with basic primary health services, Government of India launched the National Rural Health Mission (NRHM) in 2005. The goal of the Mission is to provide accessible, affordable, accountable, effective and reliable primary health care to people residing in rural areas, with special emphasis on the poor, women and children.

The Panchayats are expected to play an important role in rural development in India, particularly after independence. Plan documents of both the Central and State Governments and various committees have emphasized the importance of PRIs in the polity.² Through the enactment of 73rd Constitutional Amendment, Panchayati Raj Institutions (PRIs) were strengthened as local government organizations with clear areas of jurisdiction, adequate power and authority and funds commensurate with responsibilities. Panchayats have been assigned 29 rural development activities among which family welfare, health and sanitation are included under Schedule XI and public health under Schedule XII. Thus Panchayats will have a significant influence on managing most of the public health issues.³ In a field based study linking primary health care and Panchayathi Raj Institutions in the States of Gujarat, Maharashtra, Karnataka
and West Bengal, it was found that there is a significant role for PRIs in improving the quality of health care services. Panchayats can identify the people’s health needs, in collaboration with the health system and monitor the village level health workers and the functioning of primary and secondary health facilities.

The National Rural Health Mission, designed to integrate health and family welfare related interventions, address health from a holistic preventive, promotive and curative view point, giving a very prominent role for Panchayati Raj Institutions. The fulcrum of NRHM is Accredited Social Health Activist (ASHA) at the village level, who will work with the village level resource team in providing preventive and promotive health care services. The selection of ASHA is the responsibility of Grama Panchayat and ASHA will be responsible to the Panchayat. At the village level, ASHA will receive support from Village Health Sanitation and Nutrition Committee (VHSNC) of the Gram Panchayat, peripheral health workers especially Auxilliary Nurse Midwives (ANMs), Anganwadi workers, and Panchayat members.3

Community Health Workers are called by a variety of names including health auxiliaries, barefoot doctors, health agents, health promoters, family welfare educators, health volunteers, village health workers and community health guides. These individuals can be enormously effective and they can perform preventive medical services, monitor the community's health, identify patients at particular risk, act as liaisons between the community and the health system, interpret the social climate, as well as provide basic curative services. According to WHO (World Health Organization) community health workers are defined as “Workers who live in the community they serve, are selected by that community, are accountable to the community they work with, receive a short defined training and are not necessarily attached to any formal institution”.

ASHAs are local women trained to act as a link between their own community and the health system. The Indian Ministry of Health describes them as health activist in the community who will create awareness on health and its social determinants and mobilize the community towards local health planning and increase the utilization and accountability of the existing health services. ASHA will be the first person to contact for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services. ASHA will counsel women on various aspects of maternal and child care, mobilize mothers and facilitate them in
accessing various services available at Anganwadies, Sub-Centres and Primary Health Centers.

The operational guidelines of NRHM under Government of Haryana\(^5\) state that the Gram Panchayat would lead the ASHA initiative in three ways:

1. Gram Sabha undertakes the selection of ASHA. It is involved in supporting the ASHA in their work and by itself undertakes many health related tasks through its statutory health committee.

2. All ASHA will be involved in the Village Heath Sanitation Committee (VHSC) of the Panchayat either as members or as special invitees (depending on the state laws). It develops the Village Health Plan in coordination with ASHA.

3. A part of the incentive to ASHA may be provided by/routed through Panchayat\(^5\).

In Kerala PRI members are part of Rogi Kalyan Samitis (Hospital Management Committees) and are involved in running Sub-Centres. There is active involvement of PRIs in improving facilities of Public Health Institutions with local funding and monitoring of services.\(^6\)

In India, the National Health Services have often neglected the tribal people in general and tribal women in particular. In addition to the social and economic factors contributing to the low health status of this underprivileged group, cultural factors might also play a role.\(^7\)

The concerted efforts for the development of these groups by the Central and State Governments have had only marginal impacts on their socio-economic conditions in spite of the various welfare measures and Constitutional protection.\(^8\)

In Kerala NRHM was launched in 2006 with the goal of improving availability and access to quality health care to people of rural and underprivileged areas. Even though Kerala has achieved first place in human development index among the Indian States, certain marginal groups like dalits, fisher folk and tribal people lagged behind in the development process.\(^9\) The rate of institutional deliveries is high in Kerala as compared to other Indian States. Wayanad District is having the lowest rate of institutional deliveries among the fourteen Districts in the State.\(^10\) This may be attributed
to the high concentration of tribal population in this district, who are generally reluctant to come out of their hamlets and avail health services from hospitals. The tribal population of Kerala is 484839 which accounts for 1.4 percent of the total population of the State. More than 60 percent of the Scheduled Tribes of the State are concentrated in three districts namely Wayanad (35.8 percent), Idukki (15.6 percent) and Palakkad (11.05 percent). Remaining are scattered in other parts of the State. Tribal population is vulnerable to various health problems that scale up maternal and infant mortality rates. Thirteen maternal deaths were reported from Wayanad in 2009-10. Within the District more than half of maternal deaths are being reported from among the tribes who constitute 17 per cent of its population.

The NRHM programme is covering the tribal areas as well. ASHAs are recruited in these areas also for serving the tribal population. With the poor health conditions of the tribes especially mothers and children, it is important to have a probe into the role and contribution of PRIs in the delivery of maternal health services in tribal areas through ASHAs. Hence the present study aims at making an analysis of the role of PRIs as facilitators of ASHA and performance of ASHA in relation to maternal health services in tribal areas. In this context the following questions are raised.

1. Do the Grama Panchayats facilitate provision of maternal health services in tribal areas through ASHAs?

2. To what extent ASHAs are able to discharge their responsibility of providing maternal health services at the grass roots?

3. What are the problems faced by ASHAs in providing maternal health services and do these problems affect their performance?

4. What types of maternal health services are received by tribal women from ASHAs and how do the tribal women perceive ASHAs’ performance in maternal health?

5. How do the guiding agencies of ASHAs perceive ASHAs’ performance in relation to maternal health services?

6. How do the elected representatives of Grama Panchayats perceive ASHAs’ performance in relation to maternal health services?
To find answers to the above listed questions, the present study make an attempt to assess the performance of ASHA in providing maternal health services to tribal women in Wayanad district and the problems faced by them in this area. This study also aims to explore the role of Grama Panchayats (GPs) in the provision of these services and the perceptions of the guiding agencies of ASHAs such as Junior Public Health Nurses (JPHNs) and Anganwadi Workers (AWWs) and the tribal women who are the beneficiaries of these services.

Review of Literature

The 73rd Constitutional Amendment makes Panchayati Raj Institutions (PRIs) responsible for the provision of primary health care including maternal and child health and family welfare services to the population. Developing a health system with the Panchayats being made responsible for supervising and monitoring health services is an ideal model to ensure coverage of the entire population with basic minimum health services.

National Health Policy 2002 also lays emphasis on placing public health programmes under the governance of Panchayat Raj Institutions. Provision of quality health care is not within the purview of health department alone even though it has a leading role. PRIs form the platform for the convergence and coordination of the agencies providing health and nutritional services, water supply and sanitation, education, poverty alleviation and empowerment schemes at the grass root level.

An attempt has been made to review the research reports covering the relevant areas of the present study and presented thematically under the following headings:

- Grassroot Governance and Health
- ASHA scheme under NRHM in India
- Maternal Health
- Tribal Health
Many studies have been undertaken to examine the role played by the PRIs in the provision of health care services in various States in India including the State of Kerala. Several studies indicate the advantages of decentralization in improving service delivery in the case of health care.

Karnataka became a path breaker in decentralized governance through the enactment of the Karnataka Zilla Parishads, Taluk Panchayat Samitis and Mandal Panchayats and Nyaya Panchayats Act in 1987, well before the 73rd and 74th Constitutional Amendment. Karnataka was one of the few states, which transferred all the 29 subjects to the PRIs. Health is one of the subjects, which has been transferred to PRIs in Karnataka. Karnataka has also transferred funds, functions and functionaries to PRIs.

Sekher T.V. (2004)\textsuperscript{13}, in his study entitled “Health Care for the Poor: Decentralization of Health Services in Karnataka, India” found that bringing the Health Services System under the control of PRIs in Karnataka has resulted in an overall improvement in the service delivery. The health personnel are found to be accountable to people and there is a significant improvement in attendance of doctors and paramedical staff in discharging their responsibilities. This has resulted in better functioning of PHCs and CHCs and improved utilization of public health care facilities. The researcher suggested the need for orientation training to the PRI members and health functionaries about their roles and responsibilities in providing better health services.

Sodhi S.S., Ramanujam M.S., Rawal K.L. and Pandey N.N.(2011)\textsuperscript{14} studied the Effectiveness of PRIs in the Healthcare Delivery System in the State of Madhya Pradesh; with Reference to Impact of Duality and Role of Bureaucracy in New Approaches. The study was conducted in July 2011 by Shri Ram Centre for Industrial Relations, Human Resources and Social Development. They analyzed the role of PRI’s at each of the three levels as facilitators in enhancing the effectiveness of health care service delivery and the impediments and constraints encountered in this regard. The perceived level of satisfaction of tribal women of rural health care was also sought.

Following were the main findings of the study:
There is gross inadequacy in the rural health care infrastructure and facilities and health manpower required especially lack of medical personnel in the peripheral health institutions. Monitoring and supervision are neglected as well.

- PRIs have a weak linkage with the Public Health Institutions (PHIs). VHSCs and RKSs were not functioning effectively. At district level, District Health Missions were observed to be functioning effectively. There was a high level of dissatisfaction among tribal women with the quality of health care services and reproductive health care. Availability and service of doctors was a major area of concern.

The study recommended devolving finance and executive power of the three levels of PRIs, especially Grama Panchayats (GP) along with implementation and monitoring and augments funding for health at the Grama Panchayat level. Gram Panchayat members are to be sensitized to consider health care also as an agenda of Panchayats and to ponder on their role in managing PHIs. Health functionaries are to be devolved to PRI institutions with powers for posting, transfer, appraisal and promotions.

Thomas M.B. and Rajesh K. (2011) in their paper named: “Decentralisation and Intervention in Health Sector: A Critical Inquiry into the Experience of Local Self Government (LSG) in Kerala” reports the improvements in the infrastructure facilities and equipment in primary and secondary health institutions, extent of health care delivery and provision of safe water and sanitation facilities to the local people. They also highlighted the enhancement in the accountability of the public health system after the initiation of people’s planning campaign in 1996. They identified issues such as nutritional problems, old age care, life style diseases and changing morbidity pattern in the state could not be addressed by the LSGs and calls for a comprehensive health policy to ensure functional autonomy for LSGs to address the emerging health care needs of Kerala.

John J. (2012) in his work “Study on Effectiveness of Panchayati Raj Institutions in Health Care Systems in the State of Kerala” examines how PRIs and Public Health Institutions (PHIs) have been performing their obligations in respect of the delivery of public health services. The results indicate that the public health institutions were transferred to the PRIs in Kerala in 1996. But the health personnel in PHI are not yet
transferred to PRIs. They are still under the respective departments of State Governments. PRIs have no role in selection, placement or promotion of regular employees of PHIs. Hospital Management Committee forms a common platform for the coordination of health officials and PRIs. The study result further showed that the dual control yielded good results when elected representatives of PRIs and medical officers are in good terms. There is substantial improvement in attendance of health officials, availability of medicines, quality of services and infrastructure facilities due to intervention of PRIs in 2012 as compared to 2005. But, when they are not in good terms the effectiveness of PRIs was adversely affected.

PRIs increased community participation in the management of PHIs. The researcher concluded the study with some suggestions for improvement which include responsibility mapping, need for providing technical expertise to PRIs on health issues, projects and programmes, and orientation and guidance to health officials.

Raut M.K. and Sekher T.V. (2013)\textsuperscript{17} in their study entitled “Decentralization of Health Care Systems: Findings from Odisha and Gujarat, India” made an attempt to construct an index of health systems decentralization using secondary data from the health facility survey of the DLHS-3 with inputs from the field from the primary study in the two States of Gujarat and Odisha. The results revealed that Gujarat fared higher in terms of health system decentralization compared to Odisha.

Kumara N. and Farooquee N.A. (2014)\textsuperscript{18} studied the “Role of Elected Representatives of Panchayat Raj Institutions (PRIs) in Enhancing Rural Health Services in Tumkur District, Karnataka State, India.” Study results revealed that majority (70 per cent) of the respondents were having low involvement and low knowledge about the Rural Health Services followed by medium level of involvement and knowledge for 20 per cent of respondents and only 10 per cent of the respondents were having high level of knowledge and involvement in providing the rural health services. The researchers suggested the need for organizing awareness programmes and capacity building initiatives to all Elected Representatives of Panchayat Raj Institutions (PRIs), to help them acquire knowledge about health services and their role in particular.

The IDPMS Bangalore (2015)\textsuperscript{19} conducted a study on “Effectiveness of Panchayati Raj Institutions (PRIs) in Health Care System: Impact of Duality and
Role of Bureaucracy in New Approach in the State of Karnataka.” The study results revealed that there is lack of coordination between PRIs and health functionaries. Panchayat Presidents are not capable enough to review the performance of health functionaries. Standing Committee meetings are not effective and they have not used the provisions available to monitor the performance of functionaries.

Kumar V. and Mishra A.J. (2016)20 conducted a study entitled “Healthcare under the Panchayati Raj Institutions (PRIs) in a decentralised health system: Experiences from Hardoi District of India.” This qualitative study aimed to explore the challenges and benefits arising from the involvement of Panchayati Raj Institutions (PRIs) in the provision of primary health care in a decentralised health system of India. The results indicate that there are several challenges resulting from involvement of PRIs, including prioritisation of service providers and users, coercive unethical work and lack of communication. However, there are some benefits associated with the involvement of the PRIs in health service provisioning, including improved availability and regularity of health care providers at the health centres. PRIs’ involvement is found to be less effective due to their partial capabilities and approach, which creates a non-conducive environment. The researchers suggest that recognising and addressing the grassroots challenges help to locate, and overcome the hindrances in the smooth provision of health care.

Rout S.K. and Nallala S. (2016)21, in their article “Catalyzing the Role of Panchayati Raj Institutions in Health Care Delivery in Odisha” analysed the role performed by the PRIs in improving the delivery of public health services. Village Health Sanitation and Nutrition Committees at the village level functions as a link between the Gram Panchayat and the Community. Rogi Kalyan Samitis (Hospital Management Committees) are also formed in which PRI members are playing active role. These committees are responsible to develop health plans for their coverage areas. Though the Odisha Government has taken initiatives to involve PRIs in health care, there is limited evidence regarding their role influencing the health services. There is a need to strengthen institutional mechanism to actively involve PRIs in improving the health status of the village poor.

Panda B., Thakur H.P. and Zodpey S.P.22 in their study entitled “Does Decentralization Influence Efficiency of Health Units? A Study of Opinion and
Perception of Health Workers in Odisha” made an attempt to assess the perception of health workers about influence of Rogi Kalyan Samiti (RKS) on improving efficiency of peripheral decision making health units, examining the differences between priority and non-priority districts. The result indicates that majority of respondents felt that Rogi Kalyan Samiti was efficient in decision making that resulted in improvement in all critical parameters of health service delivery including quality. This was significantly higher in priority districts. Work related factors, systemic factors, local accountability and patient’s involvement were found to be the key predictors of satisfaction of health work force. The study concludes with the remark that locally suitable capacity building measures at district and sub-district levels could be critical to equip the peripheral health units to achieve the universal health coverage goals.

Vayasalu P. and Vijayalakshmi V.23, in their study “Reproductive Health Services and the Role of Panchayats in Karnataka” made an analysis of the reproductive health care services available to women in rural areas of Karnataka and examines the role of PRIs in providing these services. They found that the resources available for health care are meager, particularly Reproductive and Child Health (RCH) in rural areas. Inadequate devolution of funds, functions and functionaries contributed to Panchayats not taking any significant initiatives to improve maternal health care.

Studies related to ASHA scheme under NRHM in India

Nandan D. et al (2008-2008)24 conducted a study entitled “Assessment of the Functioning of ASHAs under NRHM in Uttar Pradesh” as part of the Rapid Appraisal of Health Interventions (RAHI) project undertaken by the National Institute of Health and Family Welfare, New Delhi and the State Institute of Health and Family Welfare (UP) in collaboration with UNFPA. The report of this study highlights the support given by ASHAs in antenatal care (ANC) services and immunization and in improving the rate of institutional deliveries. The involvement of community, PRIs, NGOs and AWWs in the ASHA Programme was reported to be limited. The authors recommended designing appropriate communication strategy to create awareness on the ASHA scheme for PRI members, and at community level for better acceptance of ASHAs along with other recommendations for the efficiency of ASHA Programme.
Kanth V., Cherian A. and George J. (2010)\textsuperscript{25} in their study entitled “The Contribution of ASHA under National Rural Health Mission (NRHM) in the Implementation of Comprehensive Primary Health Care (CPHC) in East Champaran District, Bihar State” tried to examine the functioning of ASHA in providing comprehensive primary health care to the community. The study findings show that ASHAs’ understanding about their roles and responsibilities are very limited. The recruitment, training and support to ASHAs are inadequate for them to play comprehensive role as conceived by NRHM. Other stakeholders like ANMs, Anganwadi worker, Village Mukhiya and Panchayat representatives also have not been educated about the role of ASHA. So ASHAs are hardly supported by these stakeholders, in terms of participation and engagement of community towards overall CPHC approach. Based on the finding of their study, some important changes have already been implemented in the ASHA programme in Bihar state.

Singh M.K., Singh J.V., Ahmad N., Kumari R. and Khanna A. (2010)\textsuperscript{26} conducted a study entitled “Utilization of ASHA services under NRHM in relation to Maternal Health in Rural Lucknow, India” in which they analyzed the factors influencing the utilization of ASHA services in relation to maternal health by recently delivered women in Lucknow District, Uttar Pradesh. They found that young, educated women with less number of children, having educated husband and belonging to higher socio-economic class had utilized the services of ASHA for getting adequate ante natal care (care during pregnancy) and post natal check-up.

Bajpai N. and Dholakia R. (2011)\textsuperscript{27} in their study titled “Improving the Performance of ASHA in India” analyzed the issues related to the recruitment of ASHA and their responsibilities, training, incentives and supervision of ASHA, covering five states in India. The study results indicate that ASHA’s selection process and criteria specified under NRHM guidelines are not being met in several areas. The data also shows that the quantity and the quality of training need to be improved in order to improve performance of ASHA. Even though ASHAs claim to be aware about their roles and responsibilities, the qualitative data collected from the field proved otherwise. The researchers suggest that additional responsibilities within the scope of capabilities of ASHA need to be considered along with the increase in incentives.
The results also indicate that ASHAs lack adequate knowledge to perform their jobs, as most of them have not completed the stipulated 23 days of training. Pictorial job aids and frequent refresher trainings are suggested to retain their skills. It was also found that the success of ASHA initiative depends on regular and reliable supervision. Clear strategies and techniques for supervision need to be defined along with training the supervisors in specific supervisory methods and skills.

Bhatt H. (2012)\textsuperscript{28} in his study on “A Rapid Appraisal of Functioning of ASHA under NRHM in Uttarakhand, India” identified the roles played by ASHAs under NRHM, the problems that they are facing and further suggest measures to optimize ASHA’s functioning. In this study it was found that at many places ASHAs had to cater to a population more than the norm of 1000, thus compensation for ASHAs needs to be suitably increased. There is irregularity in the supply of medicine kits to ASHAs that need to be investigated. Also it is important to impart capacity building training to ASHAs as they are unable to conduct meetings in the community.

Joshi S.R. and George M. (2012)\textsuperscript{29} in their study titled “Health Care through Community Participation – Role of ASHAs” made a detailed analysis of how ASHA Programme is operating in a selected tribal block of Thane district, Maharashtra. They found that the performance based incentive system for ASHAs create a bias in their work activities and shift their attention from the community to the health service system. Moreover, the poor socio-economic background of ASHAs makes them depend on the incentives offered for their work, as this is their main source of income. It is also seen that ASHAs give more emphasis on curative services, and hence the community consider them as an extended arm of the health service system, rather than an activist or change agent as envisaged by NRHM.

Roy S. and Sahu B.(2013)\textsuperscript{30} explored the services provided by ASHA in maternal and child health dimension of NRHM in Odisha, which was cross checked with the perception of mothers who are the prime recipients of this service. The study also examined the problems faced by ASHA in rendering these services, and the strategies used by them to solve these problems. Finally the suggestions to solve these problems by ASHA and mother participants were also sought. The study revealed the following results:
• ASHAs have adequate knowledge about their duties in maternal health care

• Mothers have given positive feedbacks with regard to the services provided by ASHA

• ASHAs outlined certain problems in the delivery of services which include economic (lack of regular salary), logistical (lack of adequate transport) and work load related problems (more population to be catered)

• The strategies used by ASHAs to combat these problems include the use of network of auto rickshaws for transporting pregnant women to the hospital, and contributing money from their pocket during emergency situations.

• An important positive outcome from introduction of ASHA is that they provide psychological support to the mothers and their family in difficult times.

• ASHA, being less educated and disadvantaged women are empowered by the process, having a job and being useful to the community.

The following suggestions were put forward by ASHAs:

• Ensuring monthly regular salary

• Provision of Janani Suraksha Express or ambulance service at PHC level, since auto rickshaw is not appropriate to transport women in labour.

• New ASHAs to be selected to fill the vacancies of ASHA who leave the service.

Mother participants’ suggestions include:

• Giving moped to ASHAs so that ASHAs can better serve them in emergencies.

• Recruiting ASHAs in urban settings as well.

Karol G.S. and Pattanaik B.K. (2013) have made an attempt to assess ASHA’s Knowledge on Reproductive and Child Care in Rural Rajasthan. The results depict that ASHAs have scored 90.5, 86.7 and 86.62 per cent in general reproductive awareness, maternal health care and child health care respectively. However, their knowledge in family planning and HIV/AIDS is lower (64.16 per cent) as compared to maternal and child health care. The study results suggest the need for motivational and leadership training for ASHAs in the delivery of family planning services and dealing with problems
of STDs, HIV/AIDS. The full potential of ASHAs need to be used in all areas of reproductive and child health care, including motivation for immunisation of children and women and for institutional deliveries in order to prevent infant and maternal mortality. A positive finding of the study is that the representation of different communities as ASHA workers shows the adherence to affirmative action and inclusiveness principle in the selection process of ASHAs. The study concludes that, time to time training and taking appropriate steps in solving ASHAs’ grievances will go a long way to strengthen the delivery of reproductive and child health care services through ASHAs at the grass roots.

Garg P.K., Bharadwaj A., Singh A. and Ahluwalia S.R. (2013) attempted to assess the Knowledge, Awareness and Practice of ASHA’s Responsibilities in Rural Haryana. The study results indicate that majority of ASHA workers were aware about helping in immunisation, accompanying clients for delivery, providing antenatal care and family planning services as part of their responsibility. Only 17-19 per cent of ASHAs knew about registration of births and deaths, assisting ANM in village health planning, and creating awareness on basic sanitation and personal hygiene as part of their work. The study report concludes that ASHAs do provide constellation of services and play a potential role in providing primary health care but they still need to put into practice their knowledge about their responsibilities while providing services.

Prakash B., Srinivas N., Shrinivasa B.M. and Renuka M. (2014) conducted a cross sectional study among 216 ASHAs at Mysore district in Karnataka, to assess their Knowledge regarding their Roles and Responsibilities under NRHM. It was found from this study that majority of ASHAs (94.9 per cent) had knowledge about diarrhoea, few (38.8 per cent) had knowledge on neonatal care, and 81.5 per cent of them had a good knowledge about their roles and responsibilities as an ASHA worker. The conclusion is that despite the training given to ASHAs, lacunae still exists in their knowledge about their roles and responsibilities under NRHM. The researchers suggest that meetings and frequent refresher training can be used as an effective tool to improve ASHAs’ knowledge.

Sharma R., Webster P. and Bhattacharya S. (2014) in their study entitled “Factors Affecting the Performance of Community Health Workers in India: a Multi-Stakeholders Perspective”, tried to examine the factors associated with work performance of ASHAs from a multi-stakeholder perspective. In depth interviews were
conducted with ASHAs, their co-workers such as Auxiliary Nurse Midwives and AWWs and representatives from Health Department and Department of Women and Child Development. This study shows that ASHA’s motivation and performance are affected by a variety of factors that emerge from the complex context in which she works. These factors include ASHA’s family background and education, training and job security, incentives, relationship with co-workers, supervision of their work, infrastructure facilities and the work environment such as the place and people. The study concludes with remark that in order to improve the performance of ASHAs, apart from taking corrective actions at the professional and organizational level, it is also important to promote cordial work relationship amongst ASHAs and other community level workers from the two departments.

Saprii L., Richards E., Kokho P. and Theobold S. (2015)\textsuperscript{35} have done a “Qualitative Analysis of the Opportunities and Challenges ASHAs Face in Realizing their Multiple Roles in Rural Manipur”. The results suggested that ASHAs are valued as service providers acting as a link between health system and rural marginalized communities. But there are a number of challenges; ASHAs’ selection is influenced by power structures and inadequate community sensitization of ASHA. The programme presents a major risk to success and sustainability. The Primary Health Centers are ill-equipped and hence ASHAs find it difficult to inspire trust and credibility in the community. Small and irregular monetary incentives demotivate ASHAs. ASHAs had limited knowledge about their role as an ‘activist’, as envisioned in the ASHA programme.

Singh D., Negin J., Otim M., Orach C.G. and Cumming R. (2015)\textsuperscript{36} in their study on the “Effect of Payment and Incentives on Motivation and Focus of Community Health Workers” have made an attempt to review five case studies of CHW Programme from low and middle income countries such as Iran, Ethiopia, India, Bangladesh and Nepal, to gain an insight into the effect of remuneration and motivation and focus of CHWs. The results indicate that both volunteer and remunerated CHWs are potentially effective to engage the community in grassroots health related empowerment. Programmes with minimum economic incentives tend to limit their focus with financially incentivized activities becoming central. They can, however, improve the outcomes in well-circumscribed areas. It is suggested that governments and planners can benefit from
understanding the programme that can best be supported in their communities, thereby maximizing motivation and effectiveness.

Desai P.B. (2016)\(^{37}\) has conducted a study entitled “Role of ASHAs in Improvement of Health Status of Villagers under NRHM in Kolhapur District, Maharashtra” with the objective to examine the work done by ASHAs in the selected villages and the improvements in the rural health due to ASHA Scheme. The study results shows that while the rate of institutional deliveries increased with the skillful help of ASHAs, the malnutrition and infant mortality decreased and immunization coverage improved.

Kane S. et al (2016)\(^{38}\) have done a “Multi-Country Comparative Study on Limits and Opportunities to Community Health Workers Empowerment through a Systematic Review of Literature on CHW Programme in Low and Middle Income Countries and Six Country Case Studies”. The results indicate that the CHW programmes do empower CHWs by providing access to privileged medical knowledge, linking CHWs to the formal health system and providing them an opportunity to do meaningful and impactful work. However, CHWs expressed feelings of powerlessness and frustrations about how organizational processes and related arrangements hindered them from achieving the desired impact. The study highlighted the need for the CHW programme to move beyond an instrumentalist approach to CHWs, and take a developmental and empowerment perspective. It is necessary to identify the disempowering organizational arrangements and to take remedial steps. Doing so will not only improve the performance of CHWs, but will pave the way for CHWs to meet their potential as agents of social change, beyond their role as health promoters.

Sarin E. and Lunsford S.S. (2016)\(^{39}\) have conducted a qualitative study among ASHAs and their family members through which they examined “The Influence of the Family, Community and Health System on ASHA Workers’ Performance and Motivation”. The results of this study showed that, while the work of ASHAs led to some positive health changes in the community, thus providing ASHAs with a sense of self-worth and motivation, community norms and beliefs as well as health system attitudes and practice limited their capacity as Community Health Workers. The researchers concluded their report by suggesting certain potential measures for improving ASHAs capacity such as improved sensitization about religious, cultural and gender
norms, enhanced communication skills and sensitizing and advocating their work with health and state officials.

Mondal N. and Murukekar M.V. (2017) have conducted an unmatched case control study on “Factors Associated with Low Performance of Accredited Social Health Activist (ASHA) Regarding Maternal Care in Howrah District, West Bengal”, by comparing low performing ASHAs with adequately performing ASHAs. They found that low performance of ASHAs is associated with population overburden, not having IFA tablet stock, less field supervision by ANM and religious minority in Howrah District that is Muslim religion.

Kumar S., Kaishik A. and Kamsal S. attempted to identify the Factors Influencing the Work Performance of ASHAs in Chiraigaon Block of Varanasi, Uttar Pradesh by interviewing 135 ASHAs. They report less knowledge about ASHA’s responsibilities greatly influenced their work performance. Other factors like caste, incentive oriented practice and delayed and inadequate payment of incentives for ASHA also influences their work performance.

Studies in Maternal Health

Chandhiok N. Dhillan B.S., Kambo L. and Saxena N.C. (2006) conducted a Cross Sectional Study to identify the Determinants of Antenatal Care Utilization in Rural Areas of India, covering 28 districts. They found that among the participants 73.9 per cent had at least one antenatal contact with an Auxiliary Nurse Midwife and had visited a Government Health Facility for antenatal care. There is reduction in the proportion of women receiving antenatal care with increasing age, parity (number of deliveries) and number of living children. Awareness of care during pregnancy and knowledge of pregnancy related complications were associated with increased utilization of antenatal care services. No association was observed with outcome of previous pregnancy and presence of health facility in the village. 51.7 per cent of women with antenatal care preferred institutional delivery as compared to 27.6 per cent of those who had not availed antenatal care services. The findings indicate the need for creating awareness about maternal health and motivating women and their families for availing antenatal care services.
Vora K.S. et al (2009)\textsuperscript{43} in their study entitled “Maternal Health Situation in India: A Case Study” have described the present situation of maternal health in India and its national safe motherhood programmes and analyzed their impact. The study put forward some suggestions to improve maternal health in the country. The result of the study indicate that despite major initiatives taken by the Government to improve maternal health in the last 10 years, nearly half of the deliveries takes place at home, and coverage of antenatal care services is low. MMR still remains at around 300/ lakh live births. The study concludes with suggestions to improve safe motherhood strategies by strengthening emergency care at delivery to tackle complications and ensuring skilled care at all births. Policies and programmes to implement evidence based strategies and detailed micro-level programme planning is needed. Monitoring effective implementation and measuring progress is also essential for success.

Prakasamma M. (2009)\textsuperscript{44} in her study “Maternal Mortality Reduction Programme in Andra Pradesh” reported that four factors which contribute to persistently high maternal mortality in Andhra Pradesh as follows:

- Low priority to maternal health due to disproportionately heavy focus on population control through sterilization.
- Inadequate emphasis on strengthening health facility under public sector, compelled women to move away from Government facilities.
- Low priority to train midwifery personnel resulted in extreme shortage of skilled maternal care providers in hospital and community.
- Low status of women – low age at marriage and low literacy levels of girls –did not generate demand for high quality maternal health services at the periphery and delayed prompt care seeking.

Jat T.R., Nawi N. and Sebastian M.S. (2011)\textsuperscript{45}, in their study “Factors Affecting the Use of Maternal Health Services in Madhya Pradesh State of India –a Multilevel Analysis” made an attempt to identify the factors that influence the utilization of maternal health services by married women, aged 15-49 years residing in Madhya Pradesh. They found that 61.7 per cent of the respondents used ANC at least once during their most recent pregnancy and only 37.4 per cent of them received PNC within two
weeks of delivery. Only 49.8 per cent of mothers were assisted by skilled personnel
during their last delivery. The household socio-economic status and mother’s education
were the most important factors associated with the use of ANC and skilled attendance at
delivery.

Pandey N. (2011)\textsuperscript{46} in a study entitled “Perceived Barriers to Utilization of
Maternal Health and Child Health Services: Qualitative Insights from Rural Uttar
Pradesh, India” attempts to understand the individual and community factors and
perceptions that influence women’s behaviours and utilization of maternal and child
health care (MCH) provided by Government. The findings indicate that financial
obstacles, especially in relation to transportation, time constraints, and availability of
health care staff and services influence women’s utilization of ANC and delivery
services. While women who perceive prenatal and delivery care to be relevant overcome
the logistical barriers with the support of family members. Various factors facilitate
women’s utilization of institutional-based maternal health services, especially the ASHA
of the village who go with them at the time of delivery at well acquainted hospitals.
Support of household members, previous health care experiences and social networks in
the village and interaction with health workers affect women’s decision to seek care.

Regardless of physical accessibility, acceptability of maternal health services in
community emerges as critical avenue for the utilization of both maternal and child health
care services. The investigator suggested the need for more rigorous assessment of the
role of field workers like ANMs and ASHAs to know whether they are able to fulfill their
role and responsibility for which they are introduced in the existing public health system.

Chauhan P., Lagoo J. and Chauhan V.K.S. (2012)\textsuperscript{47} studied the Occurrence of
Maternal Mortality and its Related Factors Among Tribal Women at a Tertiary
Level of Care in Bastar, Chattisgarh, India. This hospital based retrospective study
examined the causes and related factors of 120 cases of maternal deaths among tribal
women between July 2007 and October 2011. Results indicate that 54.16 per cent deaths
occurred among mothers in their first delivery. Major cause of death (38.33 per cent) was
due to hypertensive disorders of pregnancy. Other common cause was rupture of uterus
(14.9 per cent). Other indirect causes were malaria, nutritional anaemia and sickle cell
anaemia. The percentage of maternal mortality among the tribal women who delivered in
this hospital was 85.7 per cent in 2008-09, and 100 per cent in 2009-10 and 2010-11. The
researchers conclude that a holistic approach is needed to organize health care delivery in a way to cater to the essential needs of the women in all tribal groups with emphasis on improving their health status.

**Sunita Sahi et al** reported the results of social audit of maternal health services in Uttaranchal. The audit members included Panchayat members, women group leaders and NGO staff. The major findings of social audit were:

- Lack of availability of documentation of services entitled to women.
- Lack of material or staff for health education and public awareness. Information gives focus only on female sterilization.
- No involvement of Panchayat in maternal health services.
- Lack of female doctors in PHCs and CHCs and poor system of referral in emergencies.
- Lack of essential equipments in sub centers for providing maternal health care.

Following the audit process, the service provided by the ANMs and ASHAs were improved. They are getting support from the women groups. Panchayats are actively involved in the issues related to maternal health services and they take up health issues as an agenda in Panchayat meetings.

**Studies related to Tribal Health**

**Maiti S., Unisa S. and Agarwal P.K. (2005)** have conducted a study on “Health Care and Health among Tribal Women in Jharkhand: A Situational Analysis”. This study investigates the maternal health care practices and health condition among tribal women in comparison to the non-tribal women in the state of Jharkhand based on the data from the National Family health Survey-2 conducted during 1998-99. The non-tribal women were better off than the tribal women in terms of standard of living, education and other socio-demographic indicators. Tribal women lagged behind their non-tribal counterparts in the utilization of maternal health care. Malnutrition is pervasive among tribal women. There is also a high prevalence of anaemia among the tribal women in Jharkhand. Use of modern methods of contraception is also significantly less among the tribal women than the non-tribal women.
The investigators highlighted the need for designing the health care delivery system effectively to cater to the specific needs of the tribal women during pregnancy and at childbirth by ensuring their personal involvement.

Chandraker R., Charabarty S., MitraM. And Bharati P. (2009) conducted a study of “Reproductive and Child Health among the Dhur Gond Tribal Community of Mahasamund District, Chattisgarh, India”. This was a cross sectional study among ever married women and under five children to understand the pregnancy related women’s health, infant and child mortality and nutritional status of mothers and children from the Dhur Gond Tribal community of Mahasamund District, Chattisgarh. The results revealed poor health status of women during child bearing period, low antenatal care, high rate of home deliveries and high prevalence of under nutrition among both mothers and under five children. The researchers attribute these conditions to the low socioeconomic condition, high illiteracy and lack of awareness among the Dhur Gond Tribal community.

Srinivasa B.M., Philip P.R., Krishnapal V.K., Suraj A. and Sreelakshmi P. R. (2010) conducted a study titled “Prevalence of Anemia among Tribal Women of Reproductive Age – Group in Wayanad District of Kerala”. The results revealed that the prevalence of anemia among the non-pregnant, non-lactating tribal women was 96.5 per cent with mean hemoglobin value of 9.04gm%. Among these women 30.5 per cent had mild anemia (Hb, 10-11.9gm %), 55.9 per cent had moderate anemia (Hb, 7-9.9%) and 10.1 per cent of tribal women had severe anemia (Hb <7gm %).

Varma G.R., Kusuma Y.S. and Babu B.V. (2011) studied the Antenatal Care Service Utilization in Tribal and Rural Areas in a South Indian District through Mixed Methods Approach. The aim was to report the utilization of ANC services by women having a child aged less than one year living in the tribal and rural areas in the District of Visakhapatnam, Andhra Pradesh, India. The results indicate higher utilization of ANC compared with the national average of India. Greater proportion of women living in tribal areas utilizes services from Government sources (92 per cent), whereas approximately 54 per cent of rural women seek services from private practitioners. Health workers’ visits match with the utilization of Government services. Though ANC services utilization was high, the rate of home deliveries conducted by untrained women was also high. The literacy levels of women, socioeconomic conditions and distance to the health
facilities also influence the utilization. The researchers suggested for community health need assessment along with attempts to develop community participation to improve access and utilization of antenatal care services.

Baiju K.C. (2011) in his paper titled “Tribal Development under Decentralized Governance in Kerala: Issues and Challenges”, analyses the various development and welfare programmes for tribal population and the extent of reach of these programmes to the target groups. He also discusses the policy implications and the ways of strengthening service delivery for this disadvantaged population. It was evident from this study that most of the health care, educational and development schemes for tribal population, that have a strong bearing upon their living conditions, fail in their efforts to reach the tribal people to which they are meant for. Considering the quality of the services, about 69 per cent of the tribal families have a good appreciation for the tribal development schemes implemented in their settlements. Only 24 per cent of tribal households are getting health care schemes.

In order to strengthen the public service delivery, the investigator suggests adequate involvement of Grama sabha, tribal extension leaders and Tribal Promoters in Oorukoottam meetings should be entertained along with increased participation in the discussion on project formulation and implementation. A new paradigm for tribal development is envisaged with formulation of programmes/schemes, implementation, monitoring and evaluation made based on the felt needs and involvement of tribal people, by joint efforts of Grama Panchayat and respective Oorukottams.

Jose J.A., Sarkar S., Kar S.S. and Kumar S.G. (2013) explored the Experiences of Junior Public Health Nurses (JPHN’s) in Providing Maternal Health Care Services to Tribal Women in Kerala. They reported that JPHNs experience various difficulties in delivering maternal health care services in tribal area which include lack of sufficient time for field work, problem of accessing the tribal mother due to hilly terrain and lack of public transport facilities. The extra time required for travelling which in turn reduces the available time for field work is yet another hindrance. Quite often, they are compelled to spend travelling expenses from their own pocket as well as their own time to fulfill their responsibility. Moreover, cultural and language barriers of tribal population demands extra efforts to convince these mothers about the need for maternal health services.
The findings revealed that the tribal women lag behind non-tribal women in terms of every socio-economic, demographic and health parameters. Malnutrition and anaemia are more prevalent among tribal women than non-tribal counterparts. The use of modern contraceptive methods is also less among tribal women than non-tribal women.

Kameth R., Majeed J.A., Chandrascharan V. and Patta shetty (2013) studied the Prevalence of Anaemia among Tribal Women of Reproductive Age in Udupi Taluk, Karnataka. They found that prevalence of anemia was 55.9 per cent with hemoglobin values below 12g/dl. Among these women 35 per cent were severely anemic, 19.4 per cent were moderately anemic and 32.9 per cent were mildly anemic.

Jose J.A., Sarkar S., Kumar S.G. and Kar S.S. (2014) in their study “Utilization of Maternal Care Services by Tribal Women in Kerala” tried to examine the factors contributing to better coverage of maternal care services among tribal women in Kerala and the reasons for differences in utilization of services between tribal and non-tribal pregnant women. They identified general awareness, affordability, accessibility, quality services and motivation by health workers as the determinants of utilization among tribal women. The rate of utilization among tribal women was 85 per cent as compared to 100 per cent in non-tribal women. Lower levels of education and lack of transport facilities were identified as the prime factors that contribute to the under utilization of services by tribal women.

Review of literature in the areas of grassroots governance and health, ASHA scheme under NRHM, maternal health and tribal health indicate that there is dearth of studies covering the role of PRIs in specific areas of health care delivery including maternal health for vulnerable groups such as tribal women, within the context of universal coverage of health service at grassroots through NRHM. Hence the present study is undertaken to fill this gap.

Conceptual Framework for the Study

A logic model is a graphic depiction of the logical relationship between the inputs, activities, outputs and outcomes/effects of a programme. Logic refers to the relationship among elements and between an element and the whole.
A logic model supports the work of health promotion and community development by charting the course of community transformation as it evolves. The components of logic model include the mission/purpose, context, inputs, activities, outputs and outcomes/effects.

ASHA scheme was introduced under NRHM with the aim of helping people to have access to basic minimum health care in rural areas. ASHAs in the tribal areas are expected to act as a link between health workers and tribal women.

Inputs in the ASHA programme include selection of ASHAs, their training and deployment in the tribal areas by the Health Sector and the Panchayat Raj System.

Activities include the services given by ASHAs to tribal women during their pregnancy, delivery and after delivery with the supportive supervision they receive from JPHNs and AWWs and the overall control and facilitation by Grama Panchayat members.

Output will be improvement in acceptance of maternal health services by tribal women as indicated by increasing antenatal registration, antenatal care, improved nutrition and increasing number of institutional delivery.

Outcome would be reduced maternal mortality among tribal women as a result of the inputs, activities and subsequent output. The present study tries to explore the inputs and activities in ASHA programme under NRHM.
Fig. 1.1

Conceptual Framework for the Study Based on Logic Model

Mission: Improved Access and Utilization of Maternal Health Services by Tribal Women at Grassroots

Inputs
ASHAs’ selection, training and deployment by Health Sector and Panchayati Raj System

Activities
Provision of maternal health services to tribal women through ASHAs, guided by JPHN, AWW and facilitated by PRIs Members

 Outputs
Improved Acceptance of maternal health services by tribal women leads to more institutional deliveries.

Effects
Reduction in maternal mortality and morbidity among tribal women

Context: Poor Maternal Health, Home Deliveries among Tribal Women

Source: Developing a Logic Model or Theory of Change. Community Tool Box-Models for Community Health and Development
Methodology

Objectives of the Study

1. To examine the role of Grama Panchayats in facilitating provision of maternal health services to tribal women through ASHAs.

2. To assess the performance of ASHAs in the delivery of maternal health services in tribal areas.

3. To trace the problems faced by ASHAs in providing maternal health services in tribal areas.

4. To identify the maternal health services received by tribal women from ASHA.

5. To find out the perceptions of tribal women regarding the performance of ASHA in relation to maternal health services.

6. To find out the perceptions of the guiding agencies of ASHA regarding ASHAs’ performance in relation to maternal health services in tribal areas.

7. To find out the perceptions of the elected representatives of Grama Panchayats regarding ASHAs’ performance in relation to maternal health services in tribal areas.

Hypotheses

1. The Grama Panchayat facilitates provision of maternal health services in tribal areas through ASHAs.

2. The problems faced by ASHAs affect their performance in the delivery of maternal health services to tribal women.

3. The services rendered by the ASHAs fulfill all the maternal health needs of the tribal women during pregnancy.

4. The services rendered by the ASHAs fulfill all the maternal health needs of the tribal women during delivery and postnatal period.

5. The perception of the guiding agencies of ASHAs about ASHAs’ service in relation to maternal health is positive.

6. The perception of the elected representatives of Grama Panchayats about ASHAs’ service in relation to maternal health is positive.
Operational Definition of Key Terms

1. **Grassroot Governance**: Governance at Grama Panchayat level

2. **Performance**: Services given by ASHAs to tribal women as reported by JPHNs, measured by a performance rating scale.

3. **Maternal health services**: Services given to tribal women by ASHA during pregnancy, at the time of child birth and within six weeks after child birth.

4. **Tribal women**: Women belonging to the tribal community in Wayanad district having the youngest child below one year age.

5. **ASHA**: Accredited Social Health Activist (ASHA) is a village level woman health volunteer acting as a link between the tribal community and the primary level health system (Primary Health Centres and Sub-Centres) in the selected study area.

6. **Guiding agencies**: Junior Public Health Nurse (JPHN) and Anganwadi Worker (AWW)

7. **JPHN**: Junior Public Health Nurse is a female health worker at the sub centre employed by the Dept. of Health and Family Welfare, Government of Kerala.


9. **Perceptions of tribal women**: Views or opinions of tribal women about the maternal health services received by them from ASHA.

10. **Perceptions of guiding agencies**: Views or opinions of JPHNs/AWWs about provision of maternal health services to tribal women by ASHA.

11. **Perceptions of elected representatives of Grama Panchayats**: Views or opinions of elected representatives of Grama Panchayats about provision of maternal health services to tribal women by ASHA.

12. **Facilitators**: Members of Grama Panchayats in the study area.
Study Design

The present study is descriptive in nature with two components – quantitative and qualitative. The quantitative component seeks to assess the performance of ASHAs in maternal health services, the problems faced by ASHAs in providing maternal health services in tribal areas and the maternal health services received by the tribal women (beneficiaries) from ASHAs. The qualitative component deals with examining the role of Grama Panchayats in facilitating provision of maternal health services in tribal areas and finding out the perceptions of tribal women, the guiding agencies of ASHAs (JPHNs AWWs) and elected representatives of Grama Panchayats about ASHAs’ performance.

Universe of the Study

The study population consists of five categories of personnel selected from the jurisdiction of five Grama Panchayats and six Primary Health Centres under Pulpally Health Block in Wayanad district. They include:

- ASHAs- 150 ASHAs under six PHCs in the selected health block.
- Tribal women having the youngest child below one year age in the selected health block.
- Grama Panchayat members-99 (2010-2015) in five Grama Panchayats under Pulpally Health Block
- JPHNs – 39 in Pulpally Health Block
- AWWs - 103 in Pulpally Health Block

Sample and Sampling Technique

There are six Health Blocks in Wayanad District among which two blocks have more concentration of tribal population. They are Porunnanure and Pulpally blocks. Appapara PHC from Porunnanure Block which comes under Thirunelly Panchayat was selected purposively for conducting a pilot study.

Pulpally Health Block was purposively selected for conducting the main study. There are six PHCs in Pulpally health block which comes under the area of five Grama Panchayats. All the six PHCs under the selected health block were included in the study.
Sample size

ASHAs: 100 ASHAs were selected proportionately from 6 PHCs

Tribal women: 200 tribal women from the entire area of Pulpally health block – representing the mothers having the youngest child below one year of age were selected from the area of each ASHA.

Sample Size for In Depth Interviews and Focus Group Discussions

<table>
<thead>
<tr>
<th>In depth Interviews</th>
<th>Focus Group Discussions (FGDs)</th>
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</thead>
<tbody>
<tr>
<td>Gram Panchayat members -20</td>
<td></td>
</tr>
<tr>
<td>ASHAs -15</td>
<td>ASHAs - 2 FGDs (9+8)</td>
</tr>
<tr>
<td>JPHNs – 6</td>
<td>JPHNs – 1 FGD (9)</td>
</tr>
<tr>
<td>AWWs -9</td>
<td>AWWs – 1 FGD (9)</td>
</tr>
<tr>
<td><strong>Total 50</strong></td>
<td><strong>35</strong></td>
</tr>
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</table>

A sample of fifty participants was selected for in depth interview which include twenty Gram Panchayat members, fifteen ASHAs, six JPHNs (one from each PHC) and nine AWWs. Four Focus Group Discussions were planned- two with ASHAs having group size of nine and eight each, one with JPHNs and one with AWWs, both having nine members each. The samples for in depth interview and Focus Group Discussions were selected purposively based on their willingness.
### Data Collection Methods and Tools

<table>
<thead>
<tr>
<th>Respondents</th>
<th>Method of data collection</th>
<th>Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASHAs</td>
<td>Questioning</td>
<td>Questionnaire</td>
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<td>JPHNs</td>
<td></td>
<td>Performance rating scale</td>
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<tr>
<td>Tribal women</td>
<td>Interview</td>
<td>Interview schedule</td>
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<td>ASHAs</td>
<td>In depth interview</td>
<td>Interview guide</td>
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<td></td>
<td>Focus Group Discussion</td>
<td>FGD guidelines</td>
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<td>JPHNs</td>
<td>In depth interview</td>
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<td></td>
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<tr>
<td></td>
<td>Focus Group Discussion</td>
<td>FGD guidelines</td>
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<tr>
<td>PRI members</td>
<td>In depth interview</td>
<td>Interview guide</td>
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</tbody>
</table>

The data regarding socio personal aspects and problems of ASHAs was collected by questioning using questionnaire and ASHAs’ performance was measured by JPHNs using a performance rating scale. Data from tribal women were collected by interview using interview schedule. While In depth interviews and Focus Group Discussion were used for collecting qualitative data from JPHNs and AWWs, only in depth interview was conducted for PRI members.

### Description of the Tools

There are totally nine tools used for collecting primary data from various categories of respondents. The types of tool include questionnaire, rating scale, interview guide and focus group discussion guidelines.

**Tool-1:** Interview guide for Grama Panchayat members to examine the role of Grama Panchayats in facilitating ASHA programme in relation to provision of maternal health services in tribal areas and to find out their perceptions about ASHAs’ services.
**Tool-2:** Questionnaire to collect the socio personal information about ASHAs and the problems faced by ASHAs in providing maternal health services to tribal women with two sections.

**Section A** contains eleven questions to collect socio-personal information about ASHAs.

**Section B** provides a list of possible problems which ASHA may face in providing maternal health services to tribal women.

**Tool-3:** This tool is a rating scale for JPHNs to rate the performance of ASHAs working in their area in relation to provision of maternal health services in tribal areas. This rating scale contain twenty statements indicating the activities expected to be carried out by ASHAs for the provision of service to tribal women during the period of their pregnancy, delivery and post delivery period (period following delivery). The performance of ASHA is rated on a four point scale with options such as always, sometimes, rarely and never against each statement, indicating the frequency with which ASHA is performing these activities. These options are scored as: Always-3, Sometimes-2, Rarely-1 and Never-0. The maximum possible score is 60.

**Tool-4:** This is an interview schedule for tribal women to collect information regarding the maternal health services received by them from their ASHA during their last pregnancy and delivery. This tool contains a list of services that ASHAs are expected to provide to a woman during pregnancy, delivery and post delivery period, with Yes/No options. The respondents are asked to tell whether they have received each service from their ASHA during the period of their last pregnancy and delivery. These questions do not carry any score; they are analyzed using the frequency and percentage. Their interview schedule also contains few questions to explore the perceptions of the respondents about ASHAs’ service in the area of maternal health and the role of Grama Panchayats in facilitating provision of maternal health services to them.

**Tool-5:** This tool is an interview guide for ASHAs with open ended questions to explore the problems faced by the ASHA in providing maternal health services to tribal women and the ASHAs’ perceptions about the role of Grama Panchayats in facilitating the provision of maternal health services in tribal areas.
**Tool-6:** Interview guide for JPHNs to collect data regarding the perceptions of JPHNs about the provision of maternal health services by the ASHAs to tribal women and the role of Grama Panchayats in facilitating the provision of maternal health services in tribal areas.

**Tool-7:** Interview guide for AWWs to explore their perceptions about the provision of maternal health services by ASHAs to tribal women and the role of Grama Panchayats in facilitating the provision of maternal health services in tribal areas.

**Tool-8:** Guideline for Focus Group Discussion with ASHAs to explore their problems in relation to provision of maternal health services to tribal women and the role of Grama Panchayats in facilitating the provision of maternal health services in tribal areas.

**Tool-9:** Guideline for Focus Group Discussion with JPHNs / AWWs to explore their perceptions about ASHAs’ services to tribal women and the role of Grama Panchayats in facilitating the provision of maternal health services in tribal areas.

**The Procedure of Data Collection**

In order to collect primary data on ASHA’s socio personal characteristics and the problems faced by ASHAs in providing maternal health services, the selected ASHAs from each PHC were met by the investigator at the time of ASHAs’ monthly meeting at the PHC. After obtaining individual consent for participation, the questionnaire was distributed to them and explained how to fill up. Performance rating scale was given individually to JPHNs in charge of the selected ASHAs to get their evaluation on performance of ASHAs in the area of maternal health.

Tribal women were interviewed by visiting their houses. After taking appointment, interview with PRI members, ASHAs, JPHNs and AWWs were conducted at the Panchayat office, Sub centers and Anganwadis respectively. Focus Group Discussions with JPHNs and ASHAs were convened at PHC and that with AWWs in a Panchayat Hall. The period of data collection was from January 2015 to December 2015.
Methods and Tools for Data Analysis

ASHAs’ performance in providing maternal health services is analyzed by frequency and percentage. ASHAs’ performance is compared with selected socio-personal variables using Kruskal Wallis (Chi square) test.

The data regarding the problems faced by ASHAs is analyzed by frequencies and percentages. The number of problems and types of problems are compared with ASHAs’ performance using Chi-square test. The services received by tribal women and their perceptions are analyzed by frequency and percentage.

The qualitative component of the primary data obtained through in depth interviews and FGDs are recorded in local language, transcribed and translated to English and analyzed by identifying major themes. Semi quantitative analyses with frequency distribution and percentage are used wherever possible.

Delimitations

National Rural Health Mission envisages provision of various primary health services including maternal and child health, family planning, nutrition, control and prevention communicable and non communicable diseases, treatment of minor ailments and health counseling through ASHAs. ASHA is a local woman trained to act as a link between the community and the health system at village level to reach out to the poor and disadvantaged sections of the community with basic primary health services. Married women are preferred as ASHA according to NRHM guidelines.\(^{56}\)

Tribal population is marginalized and disadvantaged which make them vulnerable to various health problems that scale up maternal and infant mortality rates among this group.

Hence the present study is delimited to the analysis of maternal health services provided by ASHAs to tribal women under the grassroots governance of Pulpally Health Block which includes five Grama Panchayats.

The present study is geographically delimited to Wayanad District in Kerala State, India because this district has the highest density of tribal population among 14 districts in Kerala.
Chapterisation

The study has been divided into seven chapters.

The introductory chapter presents the statement of the problem, review of related literature, theoretical framework, objectives, hypotheses, methodology and delimitations.

Chapter two explains the evolution and pattern of Panhayati Raj system in India and Kerala, functions of PRIs in the area of health within the context of the 73rd Constitutional Amendment Act, structure of health care system in India and Kerala including National Rural Health Mission, tribal population of Kerala and Wayanad district and the profile of the study area namely Wayanad district in Kerala.

Chapter three explores the role of Grama Panhayats in facilitating provision of maternal health services to tribal women through ASHAs.

Chapter four is devoted to the analysis of the performance of ASHAs in the provision of maternal health services and the problems reported by them.

Chapter five explains the maternal health services received by tribal women from ASHAs and the perceptions of these women about ASHAs’ services.

Chapter six gives an account of the perceptions of JPHNs, AWWs and the elected representatives of Grama Panchayats regarding ASHAs’ services in relation to maternal health in tribal areas.

Chapter seven presents the major findings, conclusions and suggestions.
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