

ORIGINAL ARTICLE

What motivates an ASHA? Narratives from Ramanagara district, Karnataka

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Abstract

Background: The National Rural Health Mission (NRHM) aimed to bridge the gap in rural health care with the introduction of the Accredited Social Health Activist (ASHA) in 2005. It is essential to identify the motivators and barriers to work performance by the ASHAs in order to facilitate better health care in the community. **Objective:** To identify the motivators and barriers to the work performance of ASHAs in the Solur PHC area, Ramanagara district, Karnataka. **Material & Methods:** A qualitative study was conducted in one PHC area of Ramanagara District, Karnataka. Four KIs with government health functionaries and one FGD with nine ASHAs were conducted. A thematic frame-work approach was used for data analysis. **Results:** The main personal motivators were altruism and intrinsic satisfaction, while social support and team-work were important environmental motivators. Demotivating factors were financial problems such as insufficient pay and irregular financial incentives, as well as logistic difficulties, including transportation and safety. **Conclusion:** Personal, cultural, financial considerations and working conditions affect the performance of an ASHA. It is essential to address relevant issues faced by these health workers in order to improve their work satisfaction and efficiency.

Keywords

ASHA; Motivation; Barriers; Work Performance; Qualitative Research

Introduction

The World Health Organization (WHO) defines community health workers (CHWs) as "members of the communities where they work, selected by the communities... supported by the health system... and have shorter training than professional workers". (1) In the past, CHWs have made significant

contributions towards reducing the infant mortality rate and the incidence of pneumonia in under-five children, in boosting immunization rates and breast-feeding practices.(2,3,4,5) In India, the National Rural Health Mission (NRHM) of 2005, aimed to provide accessible, affordable and reliable primary health care with the help of an Accredited Social

Health Activist (ASHA), who would be a health-care facilitator, health activist and service provider. (4) Motivated health workers are a requisite for successful health care provision. Factors that affect the performance of a CHW include personal, cultural, financial considerations, working conditions and professional advancement opportunities.(1) With ASHAs conducting protests about their workload and pay, it is important that their work barriers and motivators are identified and corrective action be taken.(5) This will ensure a highly motivated work-force and will also encourage capable individuals to volunteer to become part of this workforce.

Aims & Objectives

To identify the motivators and barriers to the work performance of ASHAs in the Solur PHC area, Ramanagara district, Karnataka.

Material & Methods

Study area and duration: This study was conducted during June to July 2018 in the area under the Solur Primary Health Centre (PHC) of Magadi Taluk, Ramanagara district, Karnataka.

Study design: A qualitative study design was selected due to its flexibility and ability to provide explanations and insights into the experiences and attitudes of the researched subjects.

Ethical approval and consent process: Required governmental permissions and approval by the Institutional Ethics Committee was obtained. Written informed consent was obtained from all participants prior to enrolment.

Study population: All the nine ASHAs serving the villages under Solur PHC were selected to participate in the FGD. In order to obtain a deeper understanding of the factors influencing the performance of the ASHAs, the Solur PHC medical officer, Anganwadi worker (AWW) and the ASHA supervisor were also included in the study.

Data collection: Key Informant Interviews (KIIs) and a Focus Group Discussion (FGD) were conducted in the local language of Kannada with the help of a topic guide, having built-in probes to explore the participants' perceptions and attitudes, motivating factors and difficulties they faced. The topic guides were developed within the light of existing literature and face-validated under the guidance of two experts. KIIs were conducted with the Solur PHC Medical Officer, AWW, the ASHA supervisor and the

ASHA worker of Solur village, each lasting for 60-90 minutes. Notes were taken down at the interview. The FGD lasted for 90 minutes and was moderated by one researcher while the second researcher made notes. Participants were encouraged to express their opinions and discuss issues. A sociogram was drawn to document participation in the discussion. The KIIs and FGD were conducted at the participant's work place, in a quiet, private area, and were audio-recorded after obtaining participant permission. Socio-demographic details of the ASHAs were also noted.

Data analysis: The audio-recordings of the KIIs and FGD were transcribed ad verbatim and then translated into English by an investigator fluent in both Kannada and English. Anonymity was maintained by assigning unique numbers to the subjects. A thematic framework approach was used to analyze the data. The translated transcripts were coded and then grouped into themes and subthemes. The primary themes that were identified were: motivators of ASHA's work performance, barriers to ASHA's work performance and possible solutions. One new theme that emerged was that of 'financial barriers'. A thematic chart was then created, to streamline and interpret the data [Figure 1].

Results

Socio-demographic background of the ASHAs: There were nine ASHAs who participated in the study, their mean age being 32.57 years (SD +/-3.77). All the ASHAs belonged to the Hindu religion and had received formal schooling up to 10th standard. Their mean family monthly income was INR 7938 (SD +/-2957). None of the participants had an alternate source of income. Each ASHA covered a population ranging from 700 to 1228. The median years of work experience was eight years (Range: 1 – 12 years).

Motivators of work performance of ASHA

The ASHAs expressed that they had volunteered for the post out of altruism. "We wanted to spread awareness in the community about health...we had the desire to make a change."

The ASHAs said that the regular training courses gave them confidence to perform their duties. The knowledge empowered the ASHAs and increased their self-esteem. "The training given by the district mentor and the ASHA supervisor made us confident...we also have been trained in how to

communicate with people and counsel/advise them...the ASHA supervisor has shown us how to do home visits.”

The respect and recognition accorded to the ASHAs, by the community as well as their superiors, was another motivating factor for the ASHAs. It made them feel that the work they were doing was important and was helpful to their community members. “When we (ASHAs) accompany the patient to the hospital, the hospital staff look after those patients well...the ASHA supervisor and the people appreciate our work, they say that we work hard.”

Earning the trust of the community and being accepted played an integral role in motivating the ASHAs. The ASHAs reported that the community would approach them in case of need. Moreover, it was a source of pride when the community accepted the advice they gave. “...the community trusts us...women listen to the family planning advice we give...when a woman becomes pregnant, she comes to us (ASHAs) first and asks how to get a Thai card...” The concern and affection shown to the ASHAs by the community and their superiors was also identified as a work motivator. “When we are sick they (the doctors) examine us and don’t force us to work...”

The family of the ASHAs took care of the household and of their children while they were out doing their duty. This made the ASHAs feel secure and motivated. “Without their (family) support we wouldn’t be able to do what we are doing.” Cooperation by the activists’ peers and superiors was one of the other identified factors for work motivation. “The doctors, nurses, mentors help us...if we have any doubts about health, they guide us.”

The AWW reported that the ASHA, ANM and herself work well together as a team. The financial incentives given to the ASHAs was also a key motivator. Some of the ASHAs admitted that the monetary incentives helped them contribute to the family purse. Other government functionaries felt that due to their poor financial situation, the ASHAs are forced to do work despite the poor pay. This was confirmed by some of the ASHAs. “...because we are getting a salary, we are doing this job...we are nearing middle age, if we leave this job we won’t get another.”

Barriers to work performance of ASHA

The absence of fixed duty timings and the lack of holidays were factors that proved to be stressful and de-motivated the ASHAs. “They make us work on Sunday also... it doesn’t matter if it is a public holiday, we have to work...any time of the night or early morning we may have to go.”

Another barrier identified was the incomplete job description given to them before they took up the post and the new tasks that were added periodically to their workload. All the ASHAs were vocal about the heavy workload and the large population expected to be covered by a single ASHA worker.

“They didn’t tell us so much work will be there, but now we have so many more things to do....”

Another interesting finding was that the medical officer was of the opinion that unless the ASHAs were routinely supervised, they did not make the necessary house visits, even though they would diligently enter the details into their records/diary. The issue of transportation was another barrier that arose in the FGD and that was collectively voiced by all the ASHAs.

“We don’t feel secure travelling in the night...we have to wait a long time for buses in the night...we are not given place to rest or given food...we go in the ambulance with the patient, but to return from the hospital in the middle of the night, we have to find our own means of travel.”

However, none of the other government health functionaries seemed to be aware about such an issue. Another factor that prevented the ASHAs from executing their duties was the lack of concern and empathy from the government and Panchayat. “The Government seems to turn a blind eye and a deaf ear to our issues...when we complain to the Gram Panchayat they don’t respond...we have been asking for a raise, but nothing happens.”

The community’s distrust in the public healthcare system also seemed to be a stumbling block which the ASHAs found hard to overcome and which prevented the receipt the incentives due to them. “We refer antenatal mothers to PHC/CHC... but there are no doctors available at night to do deliveries, so they go to a private center and our service is not counted.”

Even though the ASHAs are government health functionaries, they are not provided with health coverage, for themselves or their families, in contrast to the other government employees who receive health benefits. “One of the ASHA’s developed a kidney disease and she had to bear all the

expenses...if something bad were to happen to us or our family, there is no security.”

Just as some of the ASHAs stated social support as a performance motivator, the lack of social support was cited by others as an obstacle to their work performance. “Sometimes we have to take our children with us for work ...one of the ASHAs has a troublesome husband, one child to educate and this is her only means of income.”

Financial barriers to the work performance of ASHAs

The ASHAs were disturbed about the issue of finance. This topic was recurrent in the KIIs as well as the FGD and become a new domain. They perceived that in spite of the heavy workload, the remuneration received was far below their expectation. “Salary is too little for so much work...the government just wants the job to be done.”

This was seconded by the other health functionaries. “ASHA workers have to do lot of work for very little salary...they are given a very small honorarium for their work... in spite of the hard work of the ASHAs, they are paid so little.”

The ASHAs also complained that they do not receive their incentives on time. They expressed dissatisfaction that they did not draw a regular salary from the government. “They pay us only after 5 months... only if we run around for our pay check do we get it... we have so many financial hardships and we are dependent on this money to get us through.” Each financial incentive is coupled with criteria that are stringent and difficult to achieve. To compound matters, these criteria are often influenced by external factors. “We pay regular home visits to the above-poverty-line (APL) families having antenatal women, but they choose to deliver in a private set-up...we get paid only if the woman delivers in a government facility, no matter how many home visits were conducted.”

This issue was supported by other government functionaries too. “The ASHAs are given money after the baby takes the 9th month vaccine, but if the family migrates or shifts houses, their services are not considered.”

The out-of-pocket expenses incurred by the ASHAs also proved to be a drain on their finances, especially in the light of insufficient and irregular payments. “We have to pay the bus charge from our own pockets to travel for the monthly ASHA meetings...we are not provided with pen, pencils,

papers...expenditure is from our pockets for any survey work.”

Possible solutions

The ASHAs discussed about what could be done to address the barriers that were identified and to increase their work motivation. The first unanimous response was to give them a higher fixed salary. “They should increase our salary...at least 5000 rupees a month.”

“...the government should give the ASHAs a good monthly salary.”

The other suggestions were to provide health coverage for ASHAs and to increase the number of ASHAs for better and effective division of labor.

Discussion

The ASHAs play an integral role in our healthcare system and are an essential component of community processes intervention.(4) This holds true in India, where there is a scarcity of health personnel and healthcare facilities, especially in remote areas. The findings of this study emphasize the interplay of multiple factors on the work performance of the ASHA. As the post of an ASHA is voluntary, major motivators to work performance were altruism, community respect and recognition. This was similarly found in a systematic review by Tripathy *et al* as well as in a study conducted by Sarin *et al* in Gurdaspur and Mewat.(6,7) Inclusion of volunteers from the community is backed by evidence that the community of origin plays a role in gaining trust.(8) This is one of the strengths of the ASHA programme. The absence of alternate job opportunities was a less commonly cited reason in this study, in contrast to a study by Gopalan *et al* (9). These factors positively reflect on the high degree of self-motivation of the participants in this study.

The ASHAs were unanimous about training sessions and support from health personnel as motivators.(8) The practical knowledge gained, helped these women perform their duties effectively. Also, their self-esteem was improved when the community accepted and followed the advice they gave. This was similarly documented in a study in Udupi, coastal Karnataka.(10) Community satisfaction and increased community engagement have been attributed to more years of experience.(8) In our study the median years of experience is eight years, which is a sufficient amount of time to understand in depth, the duties expected of the ASHAs. In addition, a supportive family structure played an integral role

in motivating the ASHAs especially for those who had children. However, ASHAs who did not have a supportive family, had to take their children when they performed house visits, which caused them dissatisfaction. It is possible that the ASHAs might not be able to fulfill all the duties, especially if it entailed walking for long distances, when their children are with them. In a systematic review conducted by Kok *et al*, curative duties were found to be high performance motivators as the community saw them as equivalent to physicians.(8) This was however, not captured in this study.

Financial incentives were found to be a double-edged sword. While a few of the ASHAs were motivated to execute duties as a result of performance-based incentives, as corroborated by a study done in North-Eastern India, a significant demotivator was the inadequate and delayed remuneration.(11) The incentivizing of certain duties might lead to a focus only on those activities and limit involvement in the non-incentivized roles, which might prove detrimental to the programme in the long run. This is supported by the findings in studies conducted in multiple states which found that the number of home visits made was inadequate (which is a non-incentivized duty).(8,12,13)

One of the barriers recurrently cited, was the inadequate remuneration being paid for the work done. In addition, ASHAs complained that, the remuneration was given at irregular intervals ranging from 3 – 5 months.(7) ASHAs hailing from the lower socio-economic strata, admitted that monetary incentives were important in running their homes. Thus, not only are the incentivized duties being focused upon, but their sincere execution becomes questionable. Though incentives had to be paid to ASHAs on a monthly basis, this was not the case most of the time.

Excessive workload was also a discouraging factor, as was the lack of holidays, similarly seen in studies conducted in Orissa and Karnataka.(9,10) This added to the stress and dissatisfaction of the ASHAs who felt that they were being over-worked. The addition of new duties might result in the inability to fulfill the existing duties expected of an ASHA. Even though one ASHA is assigned to a population of 1000, larger populations can result in diminished performance and higher loss to follow-up.(8) This study found that one ASHA was assigned 700- 1228 population which heavily contributed to an increased work-load.

Another barrier that was faced by the participants was that they had not been given a thorough description of what their work would entail. It was only after they joined as ASHAs, that they realized the extent of the work expected of them. This led to a feeling of being overwhelmed and dis-interest in the execution of their duties.

In the present study, ASHAs brought up the problem of the lack of transportation facilities, especially at night.(7,8) They felt insecure when travelling at night and were unable to secure safe transportation, although they were on duty. The absence of a room to spend the night in at the hospital or the lack of food arrangements during night-time escort of antenatal women also posed as significant barriers. This is in contrast to the national guidelines that state that restrooms have to be provided to the ASHAs in all District hospitals as well as Sub-Divisional hospitals of the country.(4)

In this study, all the participants had received formal education up to 10th grade which made the simple arithmetic required to calculate the expected date of delivery in pregnancy and report writing easier, as compared to activists in other regions of the country who had not received formal education and found these simple tasks difficult.(7) It has been found that higher levels of formal education are linked with good record keeping, efficient use of job-aids and effective counselling.(8) However, in a systematic review it was also found that higher levels of education might result in higher rates of drop-out.(8) This could be due to better job opportunities available to those with higher education. The cooperation given to the ASHAs by their peers and their superiors seem to serve as motivators in this study, rather than as barriers as was identified elsewhere.(7)

Conclusion

This study reveals that the main work performance motivators for ASHAs were financial needs, community respect and trust, cooperation by the health care personnel and family support. However, there are also multiple barriers such as insufficient and irregular remuneration, lack of health amenities and transportation, safety issues, out of pocket expenses and non-redressal of problems. More research is however, required in order to understand the multitude of factors, in diverse settings across India, that influence the performance of the ASHA.

Recommendation

Our study raises the question of whether the ASHA is truly fulfilling her role as an activist and advocate of community participation. The duties that have been described in this study seem like an extension of the work of an auxiliary nurse midwife and/or the anganwadi worker. The findings of this study are important and will contribute much in the larger picture of policy-making, implementation and programme strengthening. Introduction of non-monetary incentives such as free health care and health insurance can motivate the ASHA and aid in their retention.(8) A mix of financial and non-financial incentives should be considered at the policy level. It is also important to monitor job satisfaction, identify factors that hinder performance and ensure that these are addressed in a timely fashion.

Limitations of the study

The present study has a few limitations. The ASHAs have been selected from a single PHC area and therefore, the findings of this study may not be generalizable to the entire ASHA workforce.

Relevance of the study

The ASHA programme is a proven value addition to the grass-root health workforce of India. Although guidelines have been set, they are not often followed at the ground level. Enhancing motivators and reducing barriers will boost work performance and job satisfaction of the ASHA. This in turn will be reflected in the improved health status of local communities.

Authors Contribution

AMT, AJ, TS: Concept and design; AMT, PT, RD, JM: Literature review, data acquisition, data transcription, data analysis and interpretation; AMT: Writing of the first draft; AJ, TS: Coding of data, reviewing and editing of manuscript

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Figures

FIGURE 1 THEMATIC CHART DEPICTING PRIMARY THEMES AND SUB-THEMES

