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Research Article

Keeping up the morale of the foot soldiers of Indian public health: an appraisal of the economic aspects of ASHAs in Uttarakhand, India

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ABSTRACT

Background: Accredited social health activist (ASHA) is a voluntary community health worker and an important human resource for public health system of India. Their motivation to become a community health worker and continued efforts is a mix of monetary and non-monetary factors. Their motivation to work comes partly from desire to work for the community and prestige, but is furthered by the monetary compensation.
Objectives: To study the economic status of ASHAs in Uttarakhand, and their contribution to household income and the role the monetary incentives play in their work.
Methods: This cross sectional study was conducted in Haridwar and Dehradun districts of Uttarakhand. Eighty one ASHAs were interviewed using pre-piloted semi-structured questionnaire. Their economic status was assessed using Modified BG Prasad Classification.
Results: Majority of the ASHAs belonged to class 4 according to modified B G Prasad Classification. Mean monthly earning as ASHA was 1335 rupees (SD: 748) and the mean contribution to the total household income was 28%. Financial incentive was an important motivating factor with associated concerns about delay in payments. About 75% felt that the amount was inadequate considering the time and effort involved.
Conclusions: There is need to review the financial and non-financial incentives with due consideration to inflation and consumer price index.

Keywords: Accredited social health activist, Economic, Incentive, Motivation

INTRODUCTION

The concept of community health worker is an old one and Chinese barefoot doctor program is the best known example of early initiatives. Limitations and constraints in human resources for health, particularly in rural and hard to reach areas were recognized by the World Health Organization (WHO). As a strategy to address this, the concept of community health worker gained impetus.[1] These health workers are known by different names in different countries such as 'community health worker', 'village health worker', 'Shasthya Shebikas' (Bangladesh), 'Agentes de Sa'ude' (Brazil) and 'Lady Health Worker' (Pakistan), 'Health Extension Worker' (Ethiopia) and 'Accredited Social Health Activist' (India).[2] The WHO has defined community health workers as those workers who live in the community they serve, are selected by that community, are accountable to the community they work within, receive a short, defined training, and are not necessarily attached to any formal institution.[3]

The National Rural Health Mission (NRHM) was launched in 2005 in India to provide accessible, affordable and quality health care to the rural population. A key feature of the program was selection of a local

woman volunteer called an Accredited Social Health Activist (ASHA) to act as an interface between the public health system and the community.[4] It is almost a decade since it has been launched and now there are over 9 lakh ASHAs presently working under National Health Mission (NHM) in India and 11086 ASHAs in Uttarakhand.[5] The number of activities that they have been involved in has also evolved with gradual expansion from maternal and child health, to other activities relate to infectious diseases, sanitation. and nutrition etc. The activities of the ASHAs now range from the Janani Suraksha Yojana (JSY) program for improving institutional delivery to home based neo-natal care (HBNC), complete immunization of children, ensuring family planning, nutrition counseling, identification and ensuring treatment of cases of tuberculosis, leprosy and vector borne diseases, promoting construction of toilets etc. According to 7th Common Review Mission, ASHAs are playing an important role in improving institutional deliveries and reducing maternal mortality rates.[6] They are now a vital part of our public health system and have contributed significantly in improving credibility of public health services by improving awareness and linkage.

The factors that motivate the community health workers have always been a focus of debate. Their motivation to become a community health worker and continued efforts is a mix of monetary and non-monetary factors. Many of these ASHAs like community health workers elsewhere in the world come from poor socio-economic background. Their motivation to work comes partly from desire to work for the community and prestige, but is significantly furthered by the monetary compensation.[7] It is important therefore to understand the economic status of ASHAs as it stands now and how their incentives affect their work.

Objectives: The present study was done with the following objectives:

1. To assess the economic status of ASHAs in Uttarakhand, and their contribution to household income
2. To study the role of monetary incentives in motivation to work as ASHA.

METHODS

This observational cross sectional study was conducted at the Rural Development Institute, Himalayan Institute of Hospital Trust, Dehradun in May-July of 2015. The study objectives and the intended use of information collected were explained. A written informed consent was taken from each of the ASHA. They were explained about the voluntary nature of their participation and confidentiality. Primary data was collected from them through pre-piloted semi-structured interviews. Data on basic demographic characteristics, select economic characteristics and information regarding incentives and motivation were recorded. The study included 81 ASHAs, 40 from Haridwar and 41 from Dehradun district. Relevant information about activities and incentives for ASHAs was collected from National Health Mission website. Their socio-economic status was defined using modified BG Prasad classification.[8] All data was entered and analyzed in IBM SPSS Version 21.

RESULTS

The survey consisted of 81 ASHAs (Table 1). The mean age was 35 years with majority being the age-group 31-40 years of age. A majority were married (96%) and 58% lived in nuclear families. More than 72% had education up to high school or more and many were also graduates. While 69% of the ASHAs interviewed were from general category, 17% belonged to scheduled castes and 14% belonged to other backward classes. Majority of ASHAs were Hindus with one each belonging to Muslim and Sikh community. Most ASHAs followed a small family norm with more than 65% of them having two or less than two children. Of the 81 ASHAs interviewed, 68 had children of school-going age. Regarding the economic status of the interviewed ASHAs (Table 2) 65% belonged to above poverty line (APL) category while two ASHAs did not have any card stating their economic status. But surprisingly, only one ASHA had per capita monthly income of had per capita income monthly of class1 and five had per capita of class 2 of Modified B G Prasad Classification; all the rest had an income of Rs. 1767 or less per capita, per month. A majority (65%) gave information that the monthly per capita income was that of class 4. On an average they received a mean amount of 1355 rupees (SD: 748) as incentives from various activities (three had been newly enrolled and had not received any incentive till that time). As far as their percent contribution to overall household income was concerned, almost 42% contributed more than 25%, with mean contribution of 28%. Although all ASHAs now have a bank account under NRHM, only 27% of them had a personal bank account of their own and more than 64% did not have insurance of any kind. Those ASHAs with children of school-going age, 72% chose to send their children to private schools. In response to question about the motivating factors for becoming ASHA worker, more than 50% of them cited financial reasons, 17% expressed both financial and prestige as reasons and 16% expressed wish to improve health facilities of their village as prime reason to become ASHA. Some even reported that they became ASHA workers on suggestion by their families. Of the ASHAs interviewed, 64(79%) affirmed a sense of satisfaction and motivation to continue work as ASHAs. Financial incentives, prestige in the community and possibility of becoming a permanent worker in the health cadre were important factors contributing to their motivation.. They also saw being ASHA facilitator and ANM as a future career option (16, 19 respectively).

Table 1: Socio demographic characteristics of ASHAs.

Characteristics	Sub category	Number (N=81) and Percent
Age (years)	20-30	17 (21)
	31-40	48 (59.2)
	>41	16 (19.8)
Marital Status	Married	78 (96.3)
	Separated	1 (1.2)
	Widowed	2 (2.5)
Education Level	Middle school	22 (27.2)
	High School	36 (44.4)
	Graduate or more	23 (28.4)
Caste	General	56 (69.1)
	Scheduled Caste	14 (17.3)
	Scheduled tribes	Nil
	Other backward class	11 (13.6)
Religion	Hindu	79 (97.5)
	Muslim	1 (1.2)
	Sikh	1 (1.2)
Household type	Joint	34 (42)
	Nuclear	47 (58)
No. of children	≤ 2	53 (65.5)
	> 2	28 (34.5)
Type of house	Kuccha	3 (3.7)
	Pucca	70 (86.4)
	Semi-pucca	8 (9.9)

Table 2: Economic background of the ASHAs.

Characteristics	Subcategory	Number (N=81)	Percentage
Economic status	APL	53	65.4
	BPL	26	32.1
	Card not made	2	2.5
Avg. monthly per capita income^ (Rupees)	Class 1: Rs. 5889 and above	1	1.2
	Class 2: Rs. 2945 to Rs. 5888	5	6.2
	Class 3: Rs. 1767 to Rs. 2944	10	12.3
	Class 4: Rs. 883 to Rs. 1766	65	80.2
Monthly earnings as ASHA (Rupees)	Mean= 1355.5 (SD: 748)	78	Minimum: 200; Maximum: 4000
Percent contribution to household income	Less than 25%	47	58
	More than 25%	34	42
Any kind of Insurance	Yes	29	35.8
	No	52	64.2
Bank account	Personal account	22	27.2
	Opened under NRHM	59	72.8
Type of school for children (N=68)	Govt.:	10	14.7
	Private:	58	85.3

*3 new ASHAs interviewed who hadn't received any incentive yet. Class intervals for monthly family income based on modified BG Prasad classification.

Table 3: Incentives and Motivation for ASHAs.

Characteristics	Subcategory	Number(N=81)	Percent
Delay in receiving payments	Yes	80	98.8
	No	1	1.2
Is incentive amount given same as prescribed?	Same	51	63
	Less	27	33.3
	Don't know	3	3.7
Expense out of your own pocket for work purposes?	Yes	80	98.8
	No	1	1.2
If yes, reason (N=80)	Food	6	7.5
	Phone	2	2.5
	Transport	7	8.8
	Helping Patients	11	13.8
	Other	2	2.5
	> one of the above	52	65
Satisfied with the amount of incentive	Yes	11	13.6
	No	62	75.3
	Don't know	9	11.1
Are you in favor of a fixed salary every month?	Yes	76	93.8
	No	4	4.9
	Don't know	1	1.2
Will provision of cycle help improve work efficiency?	Yes	43	53.1
	No	38	46.9
Provision of waiting rooms in the hospitals for ASHA?	Yes*	45	55.6
	No	36	44.4
What was your motivation for becoming ASHA	Financial	41	50.6
	Prestige	9	11.1
	Financial & Prestige	14	17.3
	Improve healthcare in village	13	16.0
	Suggested by family member	4	4.9
Are you satisfied being an ASHA?	Yes	64	79
	No	17	21
If yes, what are the motivating factors for continuing to work as ASHA? (N=64)	Financial	23	28.4
	Prestige	13	16
	Financial & Prestige	9	11.1
	Improving healthcare	11	13.6
	Better future career options	39	61
	Likelihood of a permanent job	8	9.9
Better Future Career Options (N=39)	Facilitator	16	41
	ANM	19	48.7
	Private Practice	2	5.1
	Any other	2	5.1

*A lot of them state the waiting rooms as ill-maintained and thus uninhabitable

Regarding payment delays (Table: 3), 98.8% of the ASHAs interviewed stated that they did not receive their incentive payments on time. Of various activities, the timeliest payments were for Pulse Polio and Janani Suraksha Yojana. Some ASHAs felt that the amount they received was less than that prescribed by the government; often there were some cuts or bribes that they had to shell out in order to receive their incentive amount. Almost

99% of the ASHAs said that they had to spend out of their own pockets for their various job responsibilities. Important occasions that led to such expenditure were official phone calls, their food when they escorted patients and transport back from the hospital after institutional delivery was over.

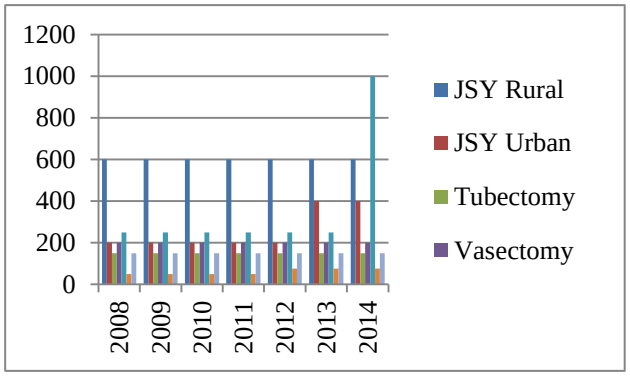

Figure 1: Performance based payment for ASHAs from 2008-14 (Source: based on information from National Rural Health Mission Website).

Some even reported spending for helping their patients by making phone calls or other emergency expenses during escort for institutional delivery. A significant number reported spending on photocopies of the various forms that are required to be filled by them. More than 75% of the participants interviewed felt that the amount of incentive that they receive for the activities is not adequate considering the time and the effort involved. Majority (94%) of the ASHAs were in favor of getting a fixed honorarium preferably on a monthly basis. On inquiring about waiting room facility, locally known as 'ASHA Ghar' almost 44% of the ASHAs reported no such provision when they accompany the patient to the hospital/health clinics. Though 56% ASHAs gave affirmative response regarding provision of a waiting room, it should be noted that lot of them mentioned that they were ill-maintained and thus uninhabitable.

DISCUSSION

The objective of the present study was to assess the economic status of ASHA workers and the context of incentives in motivation to work as ASHA. It was found that economic aspects do play an important role apart from other motivation factors in the lives of these foot soldiers who are contributing significantly to the Indian public health system.

A majority of these women were in the age group of 31 to 40 years, the most productive age in the life span of an adult. Also most were educated up to high school or more. Most of these women belonged to nuclear families and these women are not only doing the work as ASHA but are also doing their household activities. 45% of the ASHAs interviewed said that they did their household activities themselves and had no household help including any help from their family members. This raises questions about social support systems that all working women require to juggle between household work and profession. This puts much burden of the household work, child bearing and rearing and the field work they need to do for an approximate population of 1000. It has been aptly described as double or even triple burden of work for women from Third World where they cope with housework, childcare and paid employment by gender activists.[9] Majority of our participants had children of school-going age, with obvious problems when these women accompany the pregnant women for institutional deliveries which may even require overnight stays.

The mean monthly income of ASHAs was found to be 1355 rupees which is comparable to that found by Gopalan et al where 83% were earning between 1000 to 1500 rupees.[10] The latter study was published in 2012 which indicates that there has been no significant increase in average incentive per month in last 3 years for the ASHAs. While our study could not do time logging and calculate the amount of time spent by ASHAs in the field work, there are others who mention about an average 25 hours a week of work which is 12-13 days of work in a month.[7] This means that it is not commensurate with even minimum daily wages for unskilled workers as recommended by ministry of labour and employment, Government of India.

The ASHAs are currently on a performance based payment scheme where they are given certain incentives for a number of activities. Further analysis pointed out that the incentives for the major jobs that ASHAs do have never increased or increased only negligibly over the years (Figure 1). The figure shows that the incentives have remained almost the constant from the year 2008 to 2014. There is only a slight increase in the incentive given for construction of toilets from 50 rupees to 75 rupees for each toilet in the year 2012 and an increase in the incentive provided for detection and completion of treatment of a case of tuberculosis from 250 to 1000 rupees per case in the year 2014. When this is compared with the Consumer Price Index (CPI) over the years it is found that while CPI has constantly increased over the years, the amount of incentives has remained almost the same. This means that the purchasing power of the ASHA has gone down over the years implying a decrease in the standard of living of the ASHAs. This is an important issue as a significant number of the ASHAs contributed more than a quarter to the household income.

According to the ASHA guidelines given by the NRHM; the ASHA would be an honorary volunteer and would not receive any salary or honorarium. Her work would be so tailored that it does not interfere with her normal livelihood.[4] This should give enough time to these women for other income generating activities. However, out of the 81 ASHAs interviewed only 2 ASHAs said that they carried out any other income generating activities.

Most of those interviewed said that they had left such activities (like tailoring, helping in farms, etc.) due to the ASHA work. Thus although they are voluntary health workers, if this is their only source of income, it is not feasible to make them true volunteers without any regular income as pointed out by others in past.[11]

Over the years there has also been an increase in the number of activities that the ASHAs have been required to do. Though these also have incentives attached to them, it is difficult to assess whether they have led to actual increase in the income that an ASHA receives. It has been pointed out in past that while other tasks are only for namesake; the main task is of taking the women in labor for delivery and covering under-five in pulse polio campaigns.[12] One should also note that with an increasing number of activities the ASHAs also have a feeling of being overburdened.[10] Even the mode of payment across types of activities and states is not uniform.[13] As reported in this project report, there are states that have set up systems to pay ASHAs via cheque by mail or e-transfer. Of 11 states for which information is currently available 6 states pay ASHAs by cheque, which they receive by mail or pick up at the facility. Some states pay some incentives (such as those of the JSY program) by cheque and others (such as immunisation) in cash. In Rajasthan and Orissa, ANMs or Medical Officer in-charge usually make the cash payments to the ASHAs. Orissa also makes some payments via e-transfer of funds. Few states appear to use mobile phone banking for making payments to ASHAs.

The financial incentive that ASHAs receive is not sufficient to motivate and ensure that ASHAs will perform to their optimum level. With such a great proportion of workforce left unsatisfied with their compensation level, higher financial incentives per activity which has taken into account the CPI and rising inflation can be considered to ensure sustained motivation for ASHAs to perform in their jobs. As pointed out by Bajpai et al, potential for cuts and demands from ASHAs compensation is also a demotivation factor in the performance.[7] They went on to suggest that money transfer perhaps on a fixed schedule will be imperative for the growth and improvement of the ASHA program. There are other ways to give sustainable non-financial incentives; Panchayats in Chhattisgarh for example gave some land for cultivation to the health workers, the Mitanins called 'Mitanin land'. This land is not transferred in the name of Mitanin, but she and her family can cultivate it till she is working in the village.[14]

A number of ASHAs cited that there were no waiting rooms for them at the health facilities where they escorted their patients. For ASHAs to perform well in the most important activity of escorting pregnant women for delivery, they should be provided with a comfortable place to stay at the health facilities where they escort patients. These waiting rooms should also be maintained properly. Other than this provision of monetary credit for mobile phones to increase accessibility and communication should also be considered.

A finding which is not unique to this study is that the financial incentives are not the only motivational factors for ASHAs. A number of other factors like prestige in the society, willingness to improve healthcare facilities for the society also account for motivation to join and continue as ASHA. The incentives and disincentives for community health workers have been described by Bhattacharya et al in terms of monetary and community level factors.[15] The community level factors being community recognition and respect for community work, acquisition of valued skills, personal growth and development, status in the community and preferential treatment. These non-monetary incentives may have a long term impact on motivation and retention of our ASHAs. A significant number of participants in our study expressed a desire to become ASHA facilitators or auxiliary nurse midwife, etc. Thus they should also be provided with opportunities for their upward movement in their careers. This type of non-monetary incentive is likely to motivate continued engagement and better performance.[7]

According to Gopalan et al apart from the ASHAs earning as a CHW, sense of social responsibility and altruism and feeling of self-efficacy in undertaking responsibilities and recognition at the health system, community and family are some of the major determinants that motivate a ASHAs performance.[10] As a corollary to this, the original idea of ASHA being an activist should not be undermined by adding only health related activities. According to the famous Werner's phrase a community health worker should not have a polarized role of promoting state services.[16]

"As anyone who has broken bread with villagers or slum-dwellers knows only too well; the health of the people is far more influenced by politics and power groups and by the distribution of land and wealth than it is by the treatment or prevention of disease. Thus the village health worker becomes an integral agent of change, not only for health care but for the awakening of people to their human potential, an ultimately to their human rights".

But only if the non-monetary motivational factors are kept in letter and spirit alive, is it possible to have ASHAs as agents of change.

Lastly, ASHAs have been called voluntary workers but the kind of accountability that has been asked and expected of them is unlike that for voluntary workers but they are held accountable and supervised as if they were employees.[15]

CONCLUSION

The findings in the study reveal that most ASHAs are from poor socio-economic background and contribute in a major way to their household income. However the incentives that they get are either inadequate or at times delayed. Further, they are also not indexed according to CPI and inflation. Even though the ASHA guidelines mention that the ASHA program is tailored in such a way that the workers get time for other livelihood generating activities the present study revealed that this was not true. The issue of delays in incentive payments and cuts from the incentive amount needs to be resolved. In keeping with the dream of 'Digital India'; innovative mechanisms like digitization can eliminate some factors in the delay of payments and motivate and improve the economic standing of these foot soldiers of India. The government of Uttarakhand has taken positive steps in this direction by introducing the Annual "Protsahan Rashi" or annual incentive scheme of Rs 5000, paid in two half yearly installments and a monthly payment of Rs 650 for maintenance of diaries. In conclusion, incentives both financial and non-financial go a long way in motivating ASHAs to work.

Limitations

The present study was done in ASHAs of Haridwar and Dehradun districts, so the results cannot be generalized to rest of state of Uttarakhand. Also the likelihood of recall bias cannot be ruled out, especially in case of household income and incentives received.

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