

## Original Research Article

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# Social acceptance and job satisfaction of ASHA workers in the Garo Hills Division of Meghalaya: a cross-sectional study

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## ABSTRACT

**Background:** ASHAs were appointed by NRHM to provide preventive, promotive and curative healthcare services in the rural including tribal villages in Meghalaya. However, their social acceptance and job satisfaction remain less studied. Hence our study aimed at it.

**Methods:** A cross-sectional study was conducted among 140 ASHAs from randomly sampled 142 villages across 15 PHCs in five districts. To collect data, we used a semi-structured back-translated and validated questionnaire consisting socio-demographic profile of ASHAs, level of perceived social acceptance and job satisfaction. Data were analysed using SPSS version 22.0.

**Results:** Mean and median age of ASHAs were 33.29 and 32.00 years respectively. Over 63% belonged to Garo tribes, 67% studied high school, and 91% married. Village elders selected 76% of ASHAs, and 81% were as ASHAs for at least eight years. About 86% were trained in a minimum of three modules and all found their training effective. While 92% had the medical kit always filled, 100% had registers updated, and 94.3% facilitated VHND and FHD meetings. About 97% accompanied the pregnant women, 96.4% attended PHC meetings regularly and 83.6% organized VHSNC meeting. Though 93.5% reported a high acceptance of ASHAs' services, social acceptance of ASHAs was rather to some extent for 36.4%. Almost 52% of ASHAs were dissatisfied with job and 61% were unhappy with their performance-based remuneration.

**Conclusions:** Community must be aware of ASHAs' role, and their job satisfaction has to be increased with a corresponding increase in incentives while developing strategies to ease the process of payments.

**Keywords:** ASHA, Primary health centre, Work profile, Social acceptance, Job satisfaction

## INTRODUCTION

The National Rural Health Mission (NRHM), now under National Health Mission (NHM), was launched by the Government of India on 12<sup>th</sup> April 2005. The aim of NRHM was to make primary health care available, accessible, affordable, accountable and acceptable to the rural population and especially the poor and the vulnerable.<sup>1,2</sup> To achieve this objective one of the core strategies of NRHM was to strengthen the existing primary health centres (PHCs) and community health

centres (CHCs) in terms of both infrastructure and human resources besides specific goals to diminish infant and maternal mortality rate, and to decrease the incidence of several communicable diseases.<sup>3</sup>

Under the NRHM, the empowered action group (EAG) States, as well as the North Eastern States, Jammu and Kashmir and Himachal Pradesh, have been given special focus. The thrust of the mission was on establishing a fully functional, community owned, decentralized health delivery system with inter-sectoral convergence at all

levels, to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality. Institutional integration within the fragmented health sector was expected to provide a focus on outcomes, measured against Indian Public Health Standards for all health facilities. As per the 12<sup>th</sup> plan document of the planning commission, the flagship programme of NRHM will be strengthened under the umbrella of National Health Mission. The focus on covering rural areas and rural population will continue along with upscaling of NRHM to include non-communicable diseases and expanding health coverage to urban areas.

For the purpose, NRHM adopted synergy by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water.<sup>4</sup> A significant component of the mission was to create a group of female health volunteers known as "Accredited Social Health Activists" (ASHAs) in each village within the identified States.<sup>1</sup> As sub-centres started serving a much larger population than the expected, and auxiliary nurse midwives (ANMs) were heavily overworked, NRHM adopted a core strategy to promote access to improved healthcare at household level through ASHAs.<sup>3</sup> These village-level community health workers would act as a 'bridge' or an interface between the rural people and health service outlets, and they would also play a vital role in achieving national health and population policy goals.<sup>3,5</sup>

In the NRHM framework, ASHAs were considered as health activists in communities and they were meant to be selected by the villagers and to be accountable to them.<sup>5</sup> ASHA was expected to provide preventive, promotive and curative healthcare services in the villages including creation of awareness on health and its determinants, mobilizing the community towards local health planning, and increasing the utilization of the existing healthcare services.<sup>6,7</sup> At the beginning of the implementation period of NRHM, more emphasis was given on the enrolment and training of ASHAs. However, now there is a need to study the level of social acceptance ASHAs have in the tribal communities and how they perceive their job satisfaction. Despite the performance-based incentives and other benefits, there is a concern prevails among ASHAs about how far they are being accepted by the villagers where they serve and how good is their job satisfaction. As ASHAs still remain the backbone of NRHM, especially in the hard-to-reach areas of north-eastern states in India, it is imperative to study the level of social acceptance of ASHAs and their job satisfaction. Therefore, the present study was designed to investigate the level of social acceptance and job satisfaction among ASHAs in the West Garo Hills district of Meghalaya.

## METHODS

The present cross-sectional study was carried out in the Garo Hills Division of Meghalaya during the period of

May 2012 to September 2017. There are a total of five districts in the Garo Hills Division. The health program including NRHM is being implemented through the PHCs and community health centres (CHCs) in each of the districts covering a population of nearly 1.4 million people. As PHCs still remain as the primary healthcare service delivery mechanism in the tribal areas, we included only PHCs in this study. There were a total of 37 functioning PHCs across five districts of Garo Hills Division in 2012. Out of these 37 PHCs, a total of 15 PHCs were randomly sampled for the present study. The then medical officers of 15 PHCs, or their representatives in their absence, randomly sampled a total of 142 villages. All the 140 ASHAs worked in those sampled 142 villages were the respondents of our study. The Medical Officers in charge of the 15 PHCs were met and the meetings with ASHAs were ascertained. We got the ethical committee's approval to carry out the study. We obtained informed consent from each study participant.

The ASHA workers were interviewed by the principal investigator and the three co-investigators with the postgraduate degree in social work/psychology/public health/ rural development/tribal health and welfare, and an auxiliary nurse midwifery (ANM) using a semi-structured questionnaire. The survey tool was pilot tested on 14 subjects and then modified with the addition of a couple of answer options accordingly. We later finalized the edited version of the questionnaire to collect data. Initially, the questionnaire was written in English and then it was translated into the Garo language widely spoken in the Garo Hills Division of Meghalaya. Later, we back-translated the questionnaire into English to check the validity of the translated questionnaire. The finalized semi-structured interview schedule had a detailed proforma to record a socio-demographic profile of ASHAs, their perceived social acceptance, and their job satisfaction. The collected data was entered first in Microsoft Excel and then coding and analysis were done using SPSS version 22.0. We applied statistical methods like descriptive and inferential statistics to interpret data and to infer conclusions.

## RESULTS

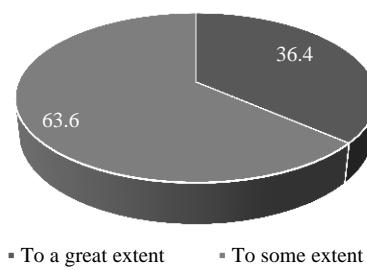
The analysis of 140 ASHAs found that a majority (49.3%) of them were between the age group of 29 and 38 years. The mean age of ASHAs was 33.29 years while the median was 32.00 years. About 63.3% of the respondents belonged to Garo tribes and 14.3% of them hailed from Rabha tribe. Most (85%) of ASHAs were Christians followed by Hindus (8.0%), and 67% of them completed high school and or higher educational qualification. Almost 81% of the ASHAs earned a monthly salary of Rs. 5000/ or below. Of the 140 ASHAs interviewed, 90.7% of them were married and living with their spouse and 9.3% of respondents were widows. About 76% of the ASHAs were selected by their village elders and 81.4% of them have been ASHAs for a period of 6-10 years. Among the respondents, 86% of them got

trained in all modules or in a minimum of three modules after they began functioning as ASHAs. Almost all ASHAs in this study found their training effective. A majority (61%) of the ASHAs reported that only to some extent they were satisfied with the receipt of their entitlements, namely performance-based remuneration.

**Table 1: Distribution of responsibilities carried out by ASHAs in the Garo Hills division of Meghalaya (n=140).**

Study variable	Frequency	%
Accompanying pregnant mother for check-ups	136	97.1
Accompanying pregnant mother for delivery	136	97.1
Has medical kit always filled for emergency	129	92.1
Facilitating VHND and FHD meetings	132	94.3
Attending a meeting at PHC	135	96.4
Reporting birth and death	135	96.4
Maintaining all registers	140	100.0
Creating awareness about malaria	133	95.0
Organizing VHSNC quarterly meeting	117	83.6

Out of the respondents, 92% of them agreed that they have had the medical kit filled for an emergency. Almost all the participants (100%) stated that they had the registers filled in with relevant data, and 94.3% of them facilitated VHND and FHD meetings. As regards awareness creation about malaria, 95% of the ASHAs did a good job. About 97% of ASHAs accompanied the pregnant women for check-ups and for delivery. Over 96.4% of them attended meetings at PHCs regularly. Only 83.6% of ASHAs organized the quarterly VHSNC meeting in their villages.



**Figure 1: Social acceptance of ASHAs.**

As seen in Figure 1, 63.6% of ASHAs stated that they were accepted by the villagers to a great extent. However, social acceptance was only to some extent for 36.4% of the respondents. Paradoxically, 93.5% of ASHAs reported that their services were accepted by the villagers and the villagers were also satisfied with their services of ASHAs. They have unanimously voiced that the kind of

service they render for very little monetary benefits they should have been better accepted and respected in the villages.



**Figure 2: Job satisfaction of ASHAs working in the state of Meghalaya.**

Almost 52% of ASHAs either had very low or low job satisfaction followed by 30.2% of them reporting neither low nor high satisfaction in their job. About 18% of ASHAs reported having high to very high job satisfaction. It is evident that a majority of ASHAs were dissatisfied with their job although almost all ASHAs carried out their responsibilities well most of the time.

## DISCUSSION

A total of 140 ASHAs from the randomly sampled 142 villages under the randomly selected 15 PHCs participated in this study. The median age of the ASHAs in our study was 32 years and the same finding was analogous to that of ASHAs in the studies carried out by Smitha et al and Bajpai et al.<sup>8,9</sup> In this study, 67% of them completed high school and or higher educational qualification which is similar to the studies by Smitha et al and Nagaraj et al.<sup>8,10</sup> However, a study by Waskel et al showed in contrast that 41.7% of them had studied up to 8<sup>th</sup> standard.<sup>11</sup> Studies by Waskel, Smitha et al and Nagaraj et al showed that 93.7% and 97% of ASHAs were married respectively and these findings were almost similar to our study findings where 91% of ASHAs were married and lived with their spouses.<sup>8,10,11</sup> A majority (63.3%) belonged to Garo tribes and 85% of Christians, which are different from the observations made in other studies.<sup>8-11</sup>

With regard to the functions of ASHAs, all the ASHAs (100%) in this study maintained the register meticulously and 92% of them had the medical kit filled all the time. Availability of drug kit helps ASHAs to attend some primary medical care needs, and it also builds the confidence of the community in ASHAs as someone who is readily available with the medical aid in the hour of need. This is very true especially in the tribal areas and hard-to-reach villages. Over 94% facilitated the VHND and FHD meetings; 97% accompanied the pregnant women for check-ups and for delivery, and 96% reported to attend the meetings at PHCs regularly. All these results

corroborate with the findings of another study conducted by Garg et al.<sup>12</sup> There is a need to improve the involvement of ASHAs in organizing the quarterly VHSNC meeting across the villages in Meghalaya.

In this study, self-perceived social acceptance of ASHAs was relatively low as 36.4% of them reported the same. On the other hand, services from 93.5% of ASHAs were well received by the villagers. The ASHAs felt this phenomenon as a contradiction because the villagers utilize the available services through ASHAs but they felt that they were not adequately accepted by the villagers. Though Meghalaya is a matriarchal society where women can exercise greater levels of power and influence, they are not given the due respect as men who still continue to have the control of day-to-day decision making in the households. Therefore, the lack of social acceptance of the ASHAs is the result of the role of women especially in rural areas in tribal society in general although women in general in tribal societies are perceived to be in control rather than being controlled. This is a concern to be addressed in the state of Meghalaya for the NRHM programme to be a success.

Concerning job satisfaction, a majority (52%) of them expressed dissatisfaction with their job; and 61% of ASHAs were dissatisfied with the kind of remuneration they have received for their job. This result validates the study findings of Kumar et al.<sup>13</sup> The entire Garo Hills Division has about 20 branches of banks. Most of the staff in these branches are either non-residents or belonging to the non-tribal communities who may be inconsiderate and demotivated to take proactive steps in making banking services acceptable to the rural population. Besides, most members in the indigenous communities here are yet to approach banking services in general as they do not have individual or group savings and deposits. Banks have been used only as a window for clearance of Government schemes and funds. So, the ASHAs who are ordinary women from the rural areas do not need to approach the banks for any service except to avail the performance-based incentives which have been routed through their individual bank accounts. At that time, many ASHAs did not even have bank accounts as the opening of bank accounts required multiple documents which were not available with them. Those who had bank accounts usually spent more than a day in travel to reach the bank to withdraw their incentives. Therefore, there has been an inordinate delay in accessing the incentives and Majority of the ASHAs did not get incentives on time and the same was reported in another study.<sup>14</sup> Thereby, fund utilisation at the PHC and subsequently at the districts tend to be lower and this again adds to the slower release of grants to the districts and to the PHCs. Therefore, the undue delay in receiving incentives seems to aggravate the job dissatisfaction in ASHAs. Hence the State has to consider relevant policy measures to address the gaps so that although the ASHAs are provided only performance-based incentives, whatever is their due entitlements, the same is paid

without inordinate delay and timely clearance of such dues will continually motivate them to work for the health and well-being of women and children which in turn will help in reducing maternal and child mortality. Thus, the critical role envisaged for the ASHAs in order to improve the health of people in rural and tribal areas especially with regard to reproductive health services will be meaningful and result oriented.

## CONCLUSION

In short, ASHAs were satisfied with their training and there was a high level of their service utilization by the villagers in the tribal belt. It was evident from the results that most of the ASHAs were very dutiful and had enough passion to carry out their responsibilities. However, there was comparatively a less social acceptance of ASHAs among the villagers, which calls for a change in strategy and awareness creation in those villagers with particular reference to the importance of ASHA's role. Their job satisfaction was also considerably low which needs to be further studied, and necessary psychosocial and economic interventions must be taken into account while enhancing the job satisfaction in ASHAs as they play a significant role in the promotion of primary healthcare in the State of Meghalaya.

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