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AN ASSESSMENT OF INCENTIVE RELATED SATISFACTION AMONG ACCREDITED SOCIAL HEALTH ACTIVISTS (ASHA) AND ITS CORRELATION WITH EDUCATION QUALIFICATION IN MAHARASHTRA

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Abstract

National Rural Health Mission was launched in April 2005 by GOI. Mission, seeks to provide effective healthcare to rural population, especially the vulnerable sections of the society. One of the core strategies proposed in this mission was to create a village level social activist, designated as ASHA (Accredited Social Health Activist) for every village and she is expected to create awareness on health and its determinants, mobilize the community towards local health planning and increase utilization of the existing health services. The present study has been conducted to know the educational qualification; average incentive per month; level of satisfaction about incentive; understand correlation among satisfaction about incentive and their qualification. Descriptive research design is used for the study. Primary data for the study is collected from the 280 sample from Nandurbar and Sangli districts. The present paper argues that the educational qualification of ASHAs of the study area is majority of (59.6%) ASHAs have completed their education up to secondary school and (0.4%) found illiterate among the selected sample. Majority of ASHAs (76.1%) getting incentive in the rage of Rs. 1001 to Rs. 3000/- per month and (1.1%) ASHAs are getting incentive more than Rs. 5000/-. Majority (84.3%) ASHAs are not satisfied with the incentive they are getting per month for various jobs they have done. Whereas (15.7%) ASHAs are satisfied about incentives they are getting. In case of reason of dissatisfaction among ASHAs about the incentive they are getting per month for performing various jobs. Majority of (91.1%) are giving reason for dissatisfaction is payment is quite less. Pertaining to satisfaction level according to their qualification. Maximum ASAHs are satisfied among the Secondary school is 11% and total satisfaction among all levels of education is 15.7%. Whereas, maximum 48.6% dissatisfaction is also in the qualification of secondary school is noticed and total dissatisfaction among all levels of education is 84.3%.

INTRODUCTION

National Rural Health Mission was launched in April 2005 by GOI. Mission, seeks to provide effective healthcare to rural population, especially the vulnerable sections of the society. Under National Rural Health Mission (NRHM) many innovations have been introduced in the states to deliver healthcare services in an effective manner. One of the core strategies proposed in this mission was to create a village level social activist, designated as ASHA (Accredited Social Health Activist) for every village and she is expected to create awareness on health and its determinants, mobilize the community towards local health planning and increase utilization of the existing health services.

NRHM conceived ASHA as a mobilizer, facilitator and a link between primary health care through ANM at sub-center, Anganwadi's through Anganwadi worker under ICDS and the community. She is expected to play a major role in forging ownership of the community for the health programme. ASHA is being a first port of call for anybody in health care need[i].

OBJECTIVES

I. To study the educational qualification and incentive being received by ASHAs.
II. To understand the level of satisfaction about incentives and its association with education status of ASHAs.

PROFILE OF THE STUDY AREA

This study is being conducted in Nandurbar and Sangli districts of Maharashtra.

The Maharashtra government health department appointed 58902 ASHAs up to May, 2013. There are eight administrative circles of the health department in the state. For the purpose of this study, the researcher has selected two districts on the basis of performance of health indicators. One district was Nandurbar, which is low performing and listed as a high priority district; another is Sangli, which is a better performing and not listed as high priority district.

Nandurbar is an administrative district in the northwest corner (Khandesh Region) of Maharashtra bordering with Gujarat. Nandurbar district was bifurcated from Dhule district in 1998. The district headquarter is located at Nandurbar city. The district occupies an area of 5034 kms^2 and has a population of 16, 48,295 as per 2011 census. The northern boundary of the district is defined by the great Narmada River. Ahirani, Bhili, Pardhi, Marathi, Hindi and Gujari are the dialects/languages spoken in the district. Nandurbar is well connected with railways and surface transport. Nandurbar is one of most backward districts of the state with high Infant and maternal mortality rates, high level of malnutrition of children and high concentration of tribal population. The district comprises 6 talukas i.e. Akkalkuwa, Akrani Mahal (also called Dhadgaon), Taloda, Shahada, Nandurbar and Navapur.

Sangli is an administrative district located in western of Maharashtra and situated in the river basins of the Warna and Krishna. It is bounded by Satara and Solapur districts to the north, Vijapur district to the east, Kolhapur and Belgum districts to the south and Ratnagiri district to the west. The physical setting of Sangli district show a contrast of immense dimensions and reveals a variety of landscapes influenced by relief, climate and vegetation. The climate ranges from the rainiest in the Chandoli (Shirala) region, which has an average annual all of over 4000 mm to the driest in Atpadi and Jath tehsils, where the average annual rainfall is

about 500 mm. According to the 2011 Census, Sangli district has a population of 2,822,143. The district has a population density of 329 inhabitants per square kilometer. Its population growth rate over the decade 2001-2011 was 9.18%. Sangli has a sex ratio of 964 (Census 2011) females for every 1000 males, and a literacy rate of 82.62%. Marathi is the main language, Kannada is also spoken widely.

DATA AND METHOD

The researcher has used the descriptive research design for the study. The stratified sampling method has been used for data collection. Data has been collected from various sources, such as supervisors at various levels, and ASHAs.280 ASHAs have been interviewed from Nandurbar and Sangli districts. A total of 140 ASHAs were interviewed from each district.ASHAs were selected using the simple random method. One block from each district was selected through the lottery technique by random process. All PHCs from the selected blocks and 140 ASHAs have been covered from the jurisdictions of the concerned PHCs.

REVIEW OF LITERATURE

HermenOrmel, MaryseKok, Sumit Kane, Rukhsana Ahmed, Kingsley Chikaphupha, Sabina Faiz Rashid, Daniel Gemechu, LilianOtiso, MohsinSidat, Sally Theobald, Miriam Taegtmeyer and Korrie de Koning, "Salaried and voluntary community health workers: Exploring how incentives and expectation gaps influence motivation", published in Human Resources for Health, 2019, 17:59 https://doi.org/10.1186/s12960-019-0387-z

Studies have shown that a factor that determines the performance of CHWs is the incentives they receive. The guidelines of the WHO with regard to the support to be given to CHWs to optimise CHW programmes highlight the need to strengthen their performance. For this, they need to be motivated, which invariably depends on incentives. The above mentioned paper discusses the role of incentives in improving CHW motivation. The study used comparative analysis to understand the connection between incentives and motivation based on available data of qualitative studies in six countries. They relied on a conceptual framework of factors that influenced CHW performance. The studies defined motivational factors as financial, material, non-material and intrinsic. It included semi-structured interviews and FGDs with CHWs, supervisors, health managers, and select members of the community.

It was found that a combination of incentives determined motivation in similar and sometimes different ways. The manner in which CHWs were engaged for work – that is, whether employed or volunteering – determined how various types of incentives affected

each other, and also the motivation of CHWs. It was observed that the "expectation gaps" that influenced motivation negatively include lower than expected financial incentives, delayed payments, smaller than expected material incentives and job enablers, and unequal distribution of incentives across groups of CHWs. The studies also observed that incentives could be a cause for friction for the interface role of CHWs between communities and the health sector.

The study results showed that whether CHWs were employed or were volunteering had a bearing on the way incentives influenced motivation. Intrinsic motivational factors were seen, and were therefore significant to the employed CHWs as well as the volunteers. In the case of many salaried CHWs, they did not compensate for the de-motivation caused by the perceived lower financial rewards. Therefore, introducing and/or sustaining a form of financial incentive is important to strengthening their motivation. Managing their expectations appropriately with regard to financial and material incentives is necessary to avoid frustration caused by expectation gaps or "broken promises", which are seen to affect motivation. To sustain their motivation, a steady amount as incentives promised seems to be as important as increasing the absolute level of incentives. This is significant also because CHWs are, as the study notes, often from low socio-economic backgrounds. Besides, the WHO has suggested that CHWs should be supported by the health system even when they are not a formal cadre.

The article also stresses the importance of extrinsic factors, which include financial, material or non-material incentives. Fixed salaries for those employed formally, allowances for volunteer CHWs, and performance-based incentives are the possible financial incentives. Among material incentives are health insurance, clothes, or tools required for carrying out their work. Non-material incentives include recognition in community, preferential treatment and acquiring new skills. Providing CHWs vehicles is also considered as a motivating incentive. The study authors call these "job enablers" as these provisions are basic resources that help create an enabling environment for CHWs to perform well.

Vandana Kanth, Anil Cherian, Jameela George, article "The contribution of Accredited Social Health Activist (ASHA) under National Rural Health Mission (NRHM) in the implementation of Comprehensive Primary Health Care in East Champaran district, Bihar (State) India (2010)", published in Health and Medicine, December 15, 2015.

The cited study attempts to explore the contribution of ASHAs in strengthening comprehensive primary health care. A sample of 497 was selected from Purbi Champaran

district in north Bihar, of which 199 were ASHAs, 17 auxiliary nurse midwives (ANMs), 255 Anganwadi workers (AWWs), 15 panchayat members, and 11 *mukhiyas* (village chiefs), among others. The data reflects contradiction in the role played by ASHAs working under the guidelines of NRHM. There were lacunae in understanding the role of ASHAs and other stakeholders. ASHA workers were not involved in any health planning and health promotion activities. The selection of ASHA workers was done by the village headman (*mukhiya*) and the training seems not to be attended by ASHAs. The feedback of ASHAs' contributions in comprehensive primary health care appears negative due to improper selection, poor equipment training, and lack of assistance given to them.

Shashank K. J., M. M. Angadi, K. A. Masali, PrashantWajantri, Sowmya Bhat, Arun P. Jose, article "A Study to Evaluate Working Profile of Accredited Social Health Activist (Asha) And To Assess Their Knowledge About Infant Health Care", published in International Journal of Health Sciences and Research 2013; 5(12): 97-103.

This study dwelt on the coverage population of ASHA workers and their knowledge of infant care. The study shows that each ASHA covers a population of 1078. According to the study, knowledge among ASHAs about infant care was as follows: 34% of ASHAs said that breast feeding should be stopped after one year, and 25% said mothers should discontinue breast feeding when the child has diarrhoea. About oral pills, 43.9% ASHAs conveyed that mothers should take pills while lactating. A majority of them were unaware of their role in modifying the behaviour of women with regard to infant feeding.

Saji SaraswathyGopalan, Satyanarayan Mohanty, Ashis Das (2012), "Assessing community health workers' performance motivation: A mixed-methods approach on India's Accredited Social Health Activists (ASHA) programme", published in the BMJ Publishing Group Limited, http://group.bmj.com/group/rights-licensing/permissions.

This study was conducted in the state of Orissa and discusses the motivation of community health workers (CHWs). It shows that the motivation level is high; whereas, it also points to the weakness of the system and suggests parameters for improvement. The CHWs are seen to be more motivated by individual and community level factors, than by health system determinants. The qualitative findings also support the survey outcomes that the healthcare delivery status and the human resource management modalities for CHWs are not satisfactory for them. The study recommends that CHW management requires changes to ensure adequate supportive supervision, skill and knowledge enhancement, and enabling working modalities.

The above literature review provides significant background inputs for the present research on ASHAs, which also looks into motivational and incentive aspects of the ASHAs. This researcher has discussed these aspects in detail in this paper in the context of ASHAs in Maharashtra

DISCUSSION

Chart No. 1Educational Qualification of ASHAs

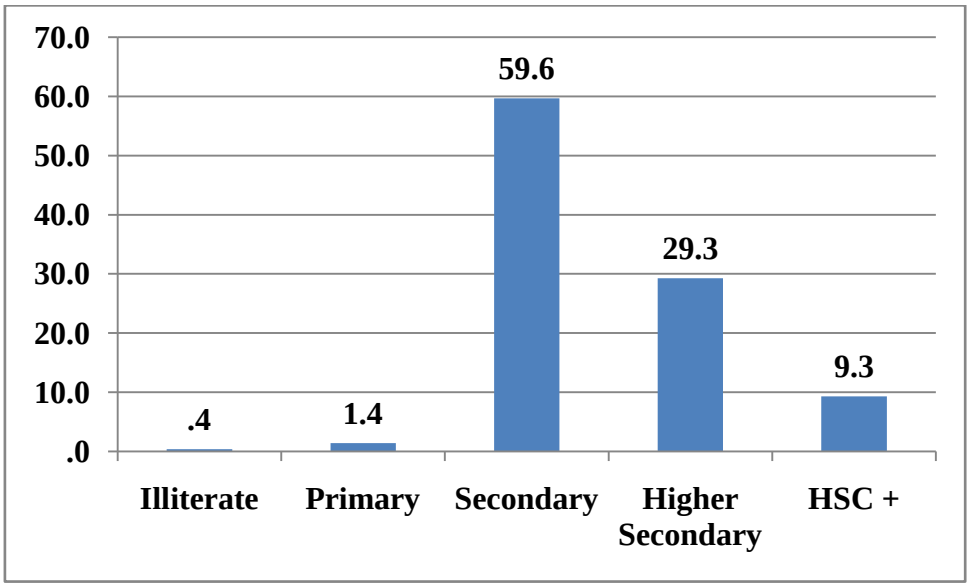

Chart No. 1 depict about educational qualification of ASHAs.To assess their educational qualification researcher have made five broad categories. Illiterate, Primary, Secondary, Higher Secondary, HSC plus. Majority of (59.6%) ASHAs have completed their education upto secondary school followed by (29.3%) ASHAs have done their higher secondary school education. (9.3%) ASHAs obtained education of HSC plus.(1.4%) of them have educated upto primary and (0.4%) found illiterate among the selected sample.

It is clear from the chart that a good number of ASHAs has taken education up to secondary and higher secondary level which may affect on their work.

Chart No. 2Average Incentive Received by ASHAs

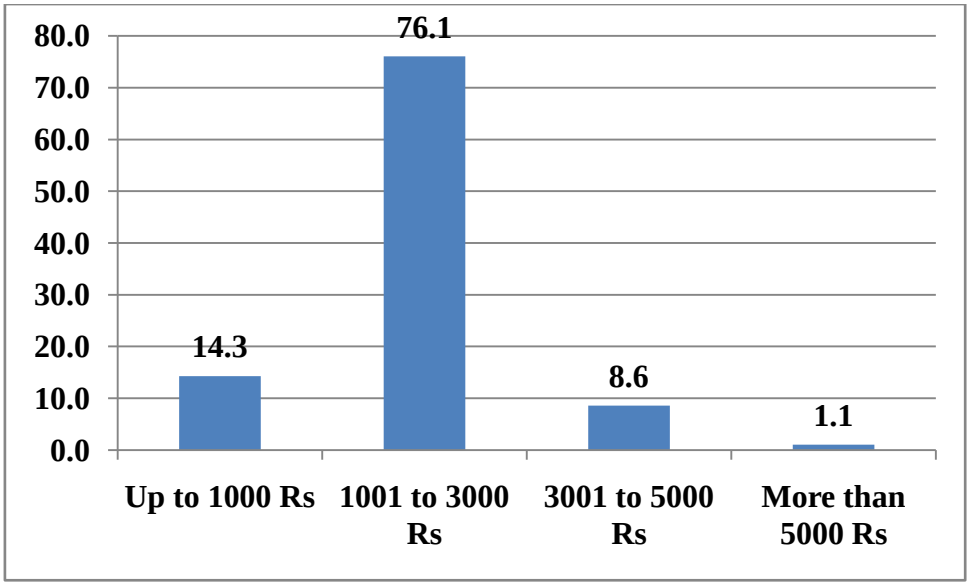

Chart No. 2 speaks about monthly average incentive received by ASHAs. To know their average monthly income researcher have made four broad categories of incentive they are getting. One is upto Rs. 1000, second Rs. 1001 to 3000, third is Rs. 3001 to 5000 and fourth is more than Rs. 5000. More than three fourth of ASHAs (76.1%) getting incentive in the rage of Rs. 1001 to Rs. 3000/- per month, followed by (14.3%) ASHAs are getting incentive of Rs. 1000/- per month. ASHAs are getting incentive of Rs. 3001 to Rs. 5000/- are (8.6%) and (1.1%) ASHAs are getting incentive more than Rs. 5000/-

It is clear from the chart that incentive to ASHA worker is varies and they receive up to Rs. 3000/- only.

Chart No. 3: Satisfaction of ASHAs about incentive they are received

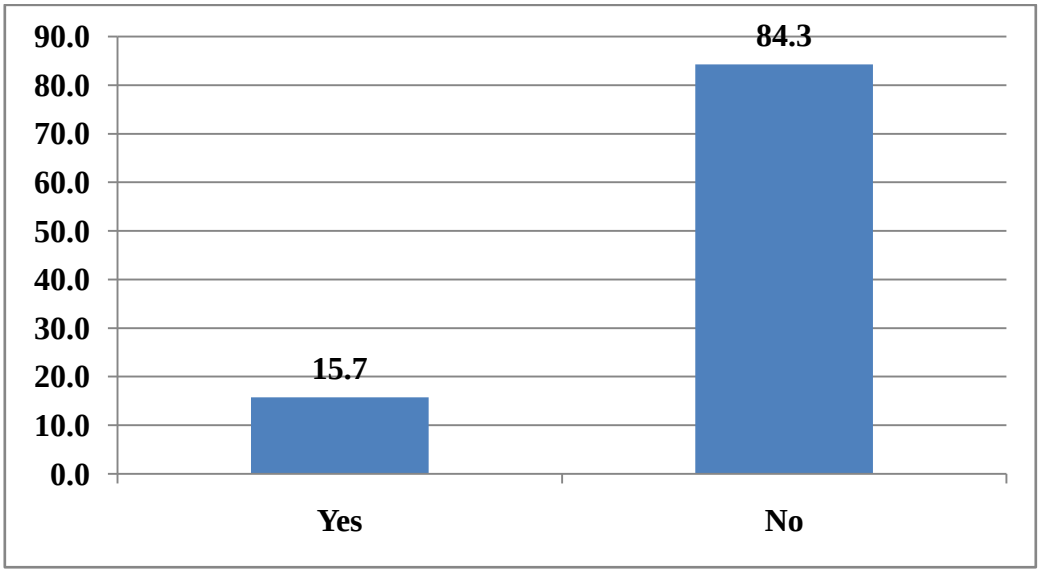

Chart No 3 shows the satisfaction of ASHAs about inventive they are getting per month. Majority (84.3%) ASHAs are reported that they are not satisfied with the incentive they are getting per month for various jobs they have done. Whereas (15.7%) ASHAs are satisfied about incentives they are getting.

It is clear from the chart that the ASHAs are not satisfied with the incentive they are getting. If we see the kind of work and number of activity that supposed to be performed by the ASHAs the incentive paid to them is very less that might be affect on the quality of work performed by them.

Chart No 4: Reason for Dissatisfaction of ASHAs about incentive they are received

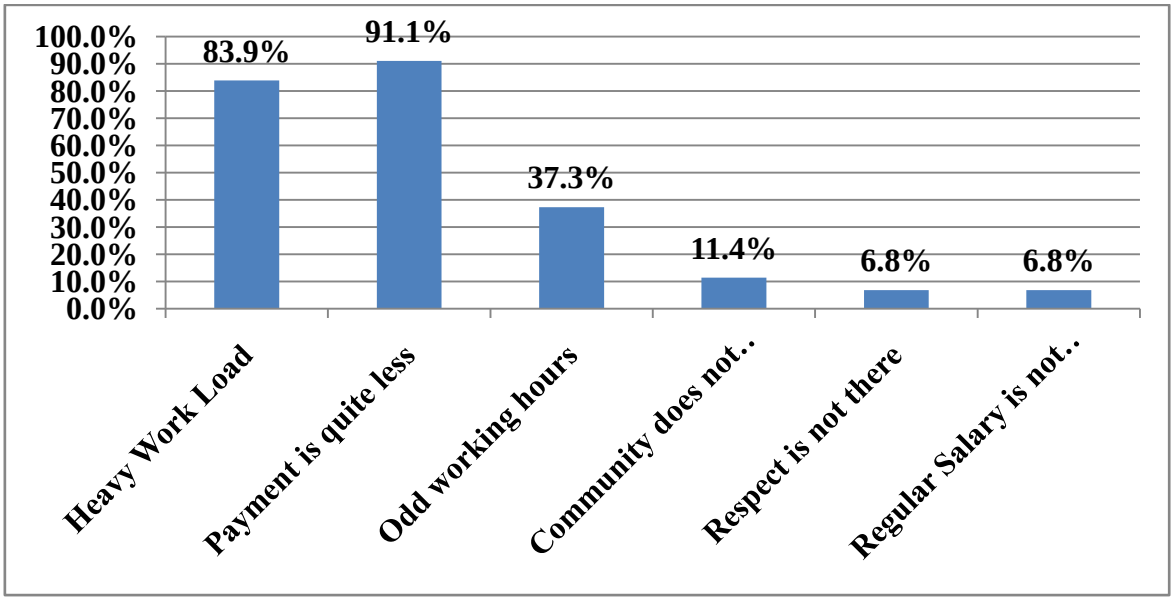

Chart No. 4 speaks about reason of dissatisfaction among ASHAs about the incentive they are getting per month for performing various jobs. This is multiple answer question. Researcher have made six reasons i.e. heavy work load, payments is quite less, odd working hours, community does not consider the efforts, respect is not there, regular salary is not being paid. Most of (91.1%) are giving reason for dissatisfaction is payment is quite less. About (83.9%) ASHAs are replied heavy work load is one of the reasons for dissatisfaction. (37.3%) are having reason for dissatisfaction is odd working hours. Non consideration from community is one of the reasons given by (11.4%) ASHAs. Whereas (6.8%) ASHAs are

giving reason for dissatisfaction and Regular salary is not being paid is one of the reasons for (6.8%) ASHAs.

The chart itself says that the less payment and heavy workload is the reason behind dissatisfaction about the amount of incentive they are getting. So here is need of intervention to pay the incentive according to the workload allotted to them.

Table No. 1Qualification of ASAHs and Their Satisfaction About Incentive

Qualification	**Satisfaction about incentive**		
	Yes	**No**	**Total**
Illiterate	1(100%)	0 (0.0%)	1(100%)
Primary	2(50%)	2(50%)	4(100%)
Secondary	31(18.6%)	136(81.4%)	167(100%)
Higher Secondary	8(9.8%)	74(90.2%)	82(100%)
HSC +	2(7.7%)	24(92.3%)	26(100%)
Total	44 (15.7%)	236 (84.3%)	280 (100%)

Table No. 1 depicts that satisfaction level according to their qualification. Researcher has made five broad categories of qualification they have possess i.e. Illiterate; Primary; Secondary; Higher Secondary and HSC plus for the purpose of analysis. Maximum of satisfaction among the Secondary school is 11% and total satisfaction among all levels of education is 15.7%. Whereas, maximum 48.6% dissatisfaction is also in the qualification of secondary school is there and total dissatisfaction among all levels of education is 84.3%.

It is clear from the table that education qualification is related to the satisfaction about the incentive. It seems that less the qualification more is the satisfaction about incentive. .

CONCLUSION

The ASHAs are working at ground level on a huge important work. The incentive paid to them is inappropriate which affects on the quality of work assigned to them. It is essential to pay the good amount of incentive according to their work load and educational qualification. The study concludes that educational qualification of ASHAs, majority ofASHAs have completed their education up to secondary school followed by higher secondary school education. ASHAs obtained education of HSC plus. Few of them have educated up to primary and only one found illiterate among the selected sample. It has come up that monthly average incentive received by ASHAsis in the rage of Rs. 1001 to Rs. 3000/- per month, very few ASHAs are getting incentive of Rs. 3001 to Rs. 5000/- and negligible amount of ASHAs are getting incentive more than Rs. 5000/-

Pertaining to the satisfaction of ASHAs about inventive it is noticed that majority ASHAs are not satisfied with the incentive they are getting per month for various jobs they have done. Whereas less than one fourth of ASHAs are satisfied about incentives they are getting.

Here are multiple reasons behind the dissatisfaction among ASHAs about the incentive they are getting per month for performing various jobsi.e. less payment, heavy work load and odd working hours, non-consideration from community.Regular salary is not being paid is also one of the reason given by ASHAs for dissatisfaction.

In case of satisfaction level according to their qualification, it is clearly noticed that in all categories of education most of the ASHAs are having dissatisfaction regarding incentive.

It is clear that maximum ASHAs are not satisfied with incentive they are getting and there is no any correlation is exists among the education and level of satisfaction about incentives received. Other research paper are also support the findings of the researcher.[1]Researcher has discussed these aspects in detail in this paper in the context of ASHAs in Maharashtra.

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