Original research

Motivating and demotivating factors for community health workers: a qualitative study in urban slums of Delhi, India

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Abstract

Background Community health workers play an important role in delivering health-care services, especially to underserved populations in low- and middle-income countries. They have been shown to be successful in providing a range of preventive, promotive and curative services. This qualitative study investigated the factors motivating or demotivating community health workers in urban settings in Delhi, India.

Methods In this sub-study of the ANCHUL (Ante Natal and Child Healthcare in Urban Slums) implementation research project, four focus-group discussions and nine in-depth interviews were conducted with community health workers and medical officers. Utilizing a reflexive and inductive qualitative methodology, the data set was coded, to allow categories of motivating and demotivating factors to emerge.

Results Motivating factors identified were: support from family members for their work, improved self-identity, job satisfaction and a sense of social responsibility, prior experiences of ill health, the opportunity to acquire new skills and knowledge, social recognition and status conferred by the community, and flexible work and timings. Negative experiences in the community and at health centres, constraints in the local health system in response to the demand generated by the community health workers, and poor pay demotivated community health workers in this study, even causing some to quit their jobs.

Conclusion Community-health-worker programmes that focus on ensuring the technical capacity of their staff may not give adequate attention to the factors that motivate or discourage these workers. As efforts get under way to ensure universal access to health care, it is important that these issues are recognized and addressed, to ensure that community health worker programmes are effective and sustainable.

Keywords: community health workers, demotivation, India, job satisfaction, motivation, urban

Background

For several decades, community health workers have been playing an important role in the delivery of health-care services, especially to underserved populations in low- and middle-income countries.[1] With the emphasis on universal health coverage, many countries have begun to focus on utilization of community health workers to improve population health.[2,3] While community health workers have primarily been used as motivators and link workers, who increase the demand for health services in their communities by encouraging patients to attend health facilities, successful examples of community health workers providing a range of curative services for malaria, tuberculosis and the care of the elderly have also been established.[4] Despite the positive effects that community-health-worker programmes have shown on the health of the populations they serve, high dropout rates, and hence the sustainability of such programmes, has been a concern. Some of the key factors that have been shown to contribute to attrition among community health workers are low motivation and lack of job satisfaction.[5] Several factors have been shown to influence motivation and satisfaction among health-care providers. These include provision of both financial and non-financial incentives.[2,6] As governments in low- and middle-income countries increasingly use the services of community health workers to strengthen their health systems and deliver services, there is a greater need to understand the factors that might influence the performance of these workers.

In 2013, India launched the National Urban Health Mission (NUHM) as a sub-mission of the National Health Mission, to meet the health needs of the urban poor.[7] Currently, both the National Rural Health Mission (NRHM) and NUHM are part of a larger single programme, the National Health Mission. Following on the experience of the accredited social health activist (ASHA) programme under NRHM, NUHM introduced the concept of the urban community health worker, or urban social health activist, who would provide services similar to those of the rural counterpart, the ASHA. Currently this intervention is being rolled out across several states but is in its initial stages.

This paper discusses some of the key motivating and demotivating factors reported by community health workers who worked on the Ante Natal and Child Healthcare in Urban Slums (ANCHUL) implementation research project,[8] which

was carried out to assess the effectiveness of a complex intervention targeted at community health workers under Delhi State Health Mission, in improving utilization of maternal, neonatal and child health services in urban-poor settlements of Delhi. The data for the study findings were collected as part of a qualitative sub-study that was carried out among community health workers in both the intervention and the control arms of the study, to understand what motivated and demotivated them during their work.

Methods

Study setting

Sarita Vihar subdivision of the south-east district of the state of Delhi was assigned by the Delhi State Health Mission, the government body tasked with the implementation of the National Health Mission in the state of Delhi, for the implementation of the ANCHUL project. Within Sarita Vihar, Lal Kuan, which consisted of 11 administrative blocks of varying sizes, was selected to be the control arm of the study, while Sangam Vihar, which also consisted of 11 administrative blocks, was chosen to be the interventional arm of the study. As per the household listing conducted during the baseline survey, the intervention area in Sangam Vihar consisted of 8607 households, while in Lal Kuan there were 7614 households. In both arms, families had been living in the area for a considerable period of time (more than 10 years) and consisted of households whose members belonged to different castes and followed various religious traditions. Both areas were found to be similar on a range of factors related to maternal health, such as literacy, number of children in a household, age of marriage, etc. In terms of infrastructure, Sangam Vihar was rated better than Lal Kuan in, for example, the number of *pucca* households, houses with toilets located within the house, as well as households having a piped water supply. Both Sangam Vihar and Lal Kuan had a primary urban health centre located within their respective areas. In addition to the primary urban health centre, these two areas each had several private practitioners who operated in the area.

In the control arm of the study, the National Health Mission was responsible for selection, training and induction of community health workers, called ASHAs, while in the interventional arm of the study the ANCHUL team was responsible for selection, training and induction of ASHAs. These administrative blocks were further demarcated into clusters with a single community health worker, called an ASHA (modelled after the ASHA from the NRHM), expected to cover the area and provide services. Each ASHA service formed a cluster with approximately 400 households. Such a cluster mapping led to 19 clusters under Lal Kuan and 20 clusters in Sangam Vihar. The purpose of collecting data from both the intervention and control arms of this sub-study was not to compare the two but to understand key motivators and demotivators among all the community health workers working across the two areas.

Data collection

The duration of the entire ANCHUL project, starting from the baseline survey, was from April 2011 to November 2015. The data for this sub-study were gathered between October 2014 and July 2015. Community health workers in both arms of the study were informed about the focus-group discussions and invited to participate and share their views. Initially, two focus-group discussions with community health workers were conducted in each of the study arms, each with 8–10 community health workers who had been working for a period of over 6 months. Following the focus-group discussions, seven in-depth interviews were conducted with a subsample of community health workers in both arms, to further explore the key issues that had arisen in the focus-group discussions. Out of the seven in-depth interviews, three were conducted with community health workers who had left the programme, in order to understand the reasons why they dropped out. In-depth interviews were also conducted with the medical officer in the intervention and control arms of the study. A team of two was tasked with the collection of data. One of the team members with prior experience in conducting interviews and focus-group discussions (SP) facilitated the discussions with the community health workers and the medical officers, while the second team member (MSG) took down detailed notes during the focus-group discussions and in-depth interviews. The focus-group discussions were conducted at the primary urban health centres in a separate area that was allotted for this purpose. Care was taken to ensure that other staff members of the primary urban health centre were not around during the discussion.

The topic guides used for the focus-group discussions were organized around the themes of understanding the community health workers' knowledge of the health profile of the area in which they worked, their experience of functioning as a community health worker, what motivated them and demotivated them during their work, and finally their assessment of the impact of their work on the community. During the data-collection process, the key issues that emerged were noted and maintained in the field diary by a team member who led the data collection (SP). This was reviewed by the second person on the team (MSG) as the data collection progressed, to check for saturation. At the point where no more new issues were brought up by the participants, it was assumed that saturation had been achieved and data collection was stopped.

Data management and analysis

All audio-recorded interviews in Hindi were transcribed and checked by the person who conducted the data collection, to ensure accuracy. The Hindi transcripts were then translated into English and cross-checked for any errors or loss of meaning, by another member of the team well versed in both Hindi and English. This was done by listening to the original recording in Hindi and reviewing the English transcript. The final translated transcripts were produced as a result of this collaborative effort between the transcriber and the team member who reviewed the English transcript. The translated transcripts were coded using the software package Atlas ti 7, employing a reflexive and inductive approach to allow codes and categories to emerge from within the data. Both members of the study team who were carrying out the qualitative data collection separately coded a representative sample of the transcripts. Codes that emerged were compared and discussed to ensure that there was internal validity in the coding process. After an initial round of coding with the sample of transcripts, the list of codes that were generated was reviewed, in order to develop a structured code list, which was then applied to the remaining transcripts. Illustrative quotations that captured the key issues reported by the participants have been included in the results.

Ethical approval

The nature of the study was explained to each participant in detail and written informed consent was obtained before the start of any focus-group discussion or in-depth interview. The study protocol of the ANCHUL project was approved by the Health Ministry Screening Committee of the Government of India, and institutional ethics committees of the Public Health Foundation of India, New Delhi; All India Institute of Medical Sciences, New Delhi; World Health Organization (WHO), Geneva, Switzerland; and Harvard School of Public Health, Boston, United States of America. In addition to approval for the original protocol that contained details of the qualitative study, annual approvals were obtained from WHO in Geneva for specific phases of the study.

Results

This section presents the study results grouped into three broad categories based on the level at which the motivating and the inhibiting factors were experienced, namely the personal level, the community level and the health-system level.

The profile of the community health workers was similar in both arms of the study. Their mean age was 33 years (range 22–45 years). Most were educated between the 10th and the 12th classes, with a small minority of participants having only education below the 10th standard. Nearly half of the participants in the intervention arm had some form of vocational training after their schooling, whereas most in the control arm did not report this. All ASHAs were married and were members of the local community who had lived in the area for more than 8 years. Except for one participant in each of the arms, none of the community health workers had any experience relevant to maternal or child health prior to joining the ASHA programme.

Factors at the personal level

Family support

The work of a community health worker involved being available right through the day and sometimes even round the clock, depending on any health-related emergency that arose in the community. Many of the ASHAs felt that they were able to work in this manner and respond to calls for help only because of the support they received from their family members, especially their husbands and in-laws. ASHAs narrated instances of how husbands accompanied them when they had to attend a call late in the evening or at night and how other family members (mother-in-law) supported them by stepping in to take care of household chores that were the responsibility of the ASHA during days when she had to go to make field visits or accompany someone to the hospital.

> My husband is also very supportive. His work is also related to health. He is a chemist. He has his own shop. I have a problem. My children are very small now but then my mother-in-law takes care of them when I go for work. I have complete support of my family. (ASHA worker, control arm)

> If my sister do[es] not look after my son then it would be impossible for me to work as an ASHA. My mother also completely supports me. Now my husband also has no objection because I have to work in the area where we live. (ASHA worker, intervention arm)

Self-identity

While describing their functions as ASHAs, participants referred to the feeling of being independent and how their work had enabled them to value themselves more. Being recognized for their work in the field enabled them to feel a sense of independent identity that they did not experience when they were confined to their homes. Being able to contribute something to the household income, and making productive use of their time, were also reported as positive factors about their work and motivated them to continue working even if conditions were difficult and the incentives they received were meagre.

> Actually, I wanted to have any part-time job because I was just sitting idle at home at that time. So I thought that I could serve the society and I will have my own identity too. (ASHA worker, control arm)

> But now the biggest achievement is that we are serving people, we are self-dependent whether we earn more or less. But we are doing something very fruitful and that makes me feel good about myself. (ASHA worker, intervention arm)

Job satisfaction and social responsibility

Most of the ASHAs looked at their work as a form of social service that they were rendering to their community. The valued highly the feeling of saving lives and improving the health of their community members, and this was referred to repeatedly in focus-group discussions and in-depth interviews as one of the key motivating factors that inspired them to continue their work as a community health worker. They felt this was different from and more valuable than doing any other job that would have given them a salary.

> If we are working in a company they make us work for their own interest and we work for our own interest. That means we get money for the work that they make us do. But in this job of being an ASHA, we help the community. Therefore, we are able to help people and also we are able to earn. This motivates me a lot to work because when we help someone in the community to get well, it makes lot of difference. (ASHA worker, control arm)

The value that they attached to their work made them feel responsible for the improved health of the community that they served. This, in turn, motivated ASHAs to go the extra mile to ensure that their services were made available to all and that the quality of the services they provided was good.

> Yes. We are more concerned about the people than other things. So if we don't get enough benefit it's fine. But if we get to hear from the field that we have given them some wrong information then we won't feel good for sure. So we want to work for their health. We don't bother much about monetary benefits as such. (ASHA worker, intervention arm)

Personal experience of ill health

While discussing their experiences as community health workers, many of the ASHAs made repeated references to their

own experience of pregnancy or as a young mother. Those who had negative experiences or lacked the appropriate knowledge about caring for themselves or their newborn children felt that they should ensure that such situations do not occur in the lives of other women, and this acted as a motivating factor in delivering services to the community. ASHAs with such experiences reported feeling far more compassionate about the situation of the community they served than those who did not have such experiences.

> My child had pneumonia. He was very weak and I gave him a bath. I still remember that scene when my child was serious. I fainted after looking at him. So I especially convince mothers of small children to keep your child in such a way that he should not get any disease. (ASHA worker, intervention arm)

> We didn't know that we should go for registration in [the] third month and this check-up should be done during pregnancy. Now we have got knowledge and we want to give such knowledge to them. Whatever facilities we couldn't get, we want to give to them. (ASHA worker, intervention arm)

Upgradation of skills and knowledge

The training received by the ASHAs, as well as constant interaction with the community and the health system, increased their knowledge about various issues and changed their perceptions about life. Training that they received, and regular visits to the dispensary, increased their technical knowledge in the field and also gave them higher credibility The life experiences and stories shared by the community during their household visits helped them to see things from a different perspective and some felt that this even helped them as an individual and aided their personal development.

> I have learnt many new things. Such as what to eat during pregnancy, how a pregnant woman should sleep during the night, about antenatal check-ups, etc. I didn't have so much knowledge when I was pregnant myself ... so this motivates me about being an ASHA. (ASHA worker, intervention arm)

> Even we have learnt many things from the people here too. These women have taught us so many things. Like how someone is keeping her family, how someone is handling his family. So we learnt a lot from there which we were not aware of. (ASHA worker, intervention arm)

The role of new knowledge and skills in motivating ASHAs in their work was confirmed by medical officers in the intervention arm, who remarked that they found the ASHAs to be very curious to know more about their health and about how they could use the information they received in their training to serve the community and also their own family.

Factors at the community level

Social recognition and status

Social recognition of ASHAs, and the work that they did, emerged as the most important motivating factor and was referred to by all ASHAs from both the arms of the study. The respect and trust that the community gave them was regarded as the greatest incentive to continue as an ASHA. While describing their work, all ASHAs described in detail how they met with resistance during their initial days in the community and how this changed with time. Initially, they were denied access to any information and some households were even inimical to their presence. Later on, this changed as a result of the community understanding the value of their work and they were welcomed. Further, ASHAs were considered as valuable sources of information on matters related to health and some were also consulted in general, even when the issue at hand was not directly related to health. Some of the ASHAs mentioned being recognized publicly by the community for their work, while others mentioned that when they went on leave and returned to work later, community members told them that they were missed during the period when they were absent, which gave them a feeling of being valued by the community.

All of this meant that young mothers, who were mostly confined to their homes before they began their work as an ASHA, came to be known and respected in their communities and began to interact in a much broader social network. This, in turn, made them value themselves and the work they did.

> People from my community look up to me for my opinion regarding their problems. People feel that my opinion would be very useful to them, because they think we have knowledge about various things. When people of my community think about me in such a manner, it feels good. (ASHA worker, control arm)

The role of social recognition and status as a strong motivator for ASHAs was confirmed by other stakeholders from the health system, who felt that ASHAs valued the respect and recognition they received from the community far more than any monetary incentives.

> They get recognition, they receive I-card and bag, and they have the authority to come directly inside of the dispensary. They get respect and recognition in their locality and community and dispensary. They get their community people with authority to the dispensary and get a sense of pride in doing some work for their community. (medical officer, intervention arm)

Negative experiences in the field

When ASHAs went to deliver their services in the community, not all of them experienced positive and welcoming households who valued their services. Quite a few of the ASHAs referred to instances where they were not allowed to enter a house or when community members spoke to them rudely and questioned their role and utility. This was especially the case when they began their work in an area and were relatively unknown. Negative experiences were also reported from other established stakeholders in the health systems, such as medical officers, nurses and auxiliary nurse midwives. ASHAs referred to doctors and other staff treating them with disdain and speaking to them rudely in front of the patients whom they had brought to the health centre.

> Once an elderly person was sitting outside a house. When I was asked his permission to enter the

house, he shouted very rudely and told me not to enter his house. At that moment I was so upset and demotivated. I felt that I had joined the wrong job. (ASHA worker, intervention arm)

Factors at the health-system level

Flexible work and timings

Most ASHAs were young women with household responsibilities, and in many cases this included taking care of their children. Some of the ASHAs felt that the flexible nature and relative autonomy of the work that they did was a factor in their continuing to work as an ASHA. Given the flexible nature of their jobs, and as they were mostly working in the same community where they lived, the ASHAs felt it gave them the flexibility to work and, if the need arose, to attend to urgent tasks at their home during the day. Some of them stated that, given this advantage, they chose to work as an ASHA despite getting other opportunities with a higher salary but requiring more uncompromising working schedules.

> Salary doesn't matter a lot. Timing suits us. We can manage home and outside work also. (ASHA worker, control arm)

Lack of recognition as valuable partners

Some of the ASHAs described instances where they felt that others in the health system did not value them or the work they did. This did not occur at the health centre where they worked but was an issue especially when they accompanied community members to the referral centres to seek treatment.

> Nurses in hospitals get irritated when they see ID card of ASHA. Not in the dispensary. Everyone in dispensary knows us. As soon as they see the I-card they start shouting, "You are an ASHA worker? Why have you come? Who called you here? What work do you have here? Go from here!" They misbehave a lot. Don't ASHAs deserve respect? Are ASHAs useless? Why do they misbehave with us? (ASHA worker, control arm)

Health-system constraints

The work of the ASHAs involved not only providing health education and information but also facilitating access to services for the community, especially in the field of maternal and child health. Many of the ASHAs referred to how they had taken people or referred people to health facilities, only to realize that the services that they were meant to receive were not available. This was referred to as a demotivator, since they felt that their efforts to motivate the community to come forward and access the health system were fruitless, owing to the poor infrastructure at these facilities.

> The biggest problem is the dispensary which is our place of work. I can motivate people in community but the place where I am referring them cannot provide the required services, I have to face problems then. (ASHA worker, control arm)

> There is no provision of drinking water for the patients that come to the dispensary. There is no toilet for patients. Also there is no fan in the room outside where patients stand for their turn. When we take pregnant ladies, their weight is not measured, as the weighing machine is not working. The blood pressure instrument sometimes it stops working. (ASHA worker, intervention arm)

Inadequate remuneration

Poor remuneration came up almost universally as a demotivating factor for ASHAs to continue in their work. Even those who mentioned that they were happy with the nature of their work did feel that the remuneration they received was low for the type of work that they were expected to do. Low pay meant that ASHAs who had to augment the family income faced additional pressure to give up their jobs and look for other avenues that provided better financial compensation. More significantly, this came up as a key reason why some of those who trained to be ASHAs left their jobs.

> Yes, four of them left the job because they felt the amount we get as salary was very low. (ASHA worker, control arm)

> I come to know from many ladies who come from village that ASHA workers in villages get a fixed salary. They tell us that for institutional delivery ASHA workers in village get ₹600 and here we get ₹200. I feel weird as to why such differences exist. (ASHA worker, intervention arm)

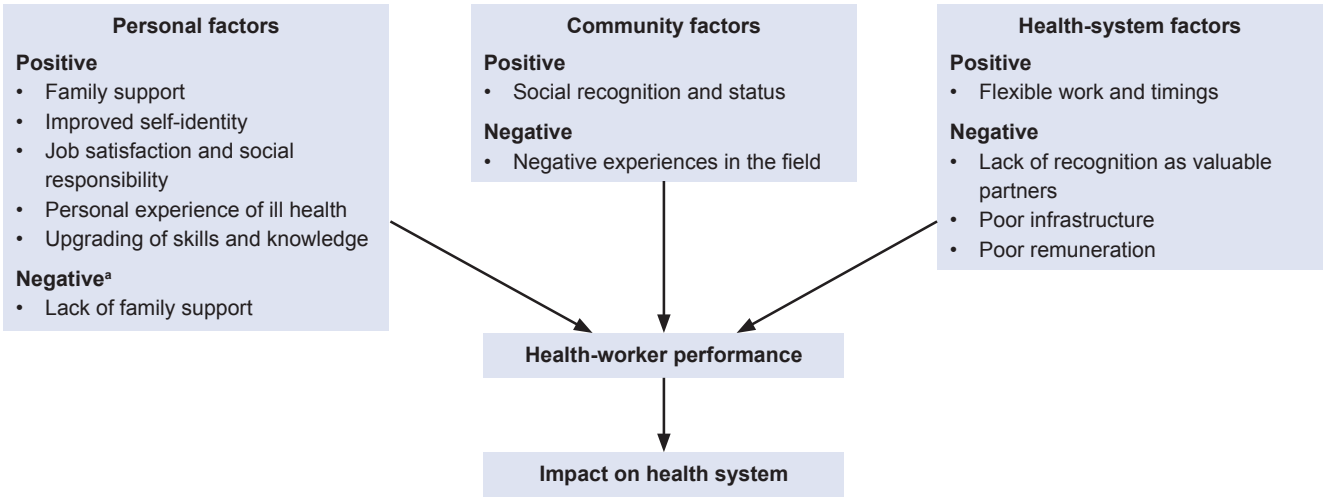
Discussion

Community health workers discharge their duties in a complex context that involves the interplay of personal, professional and systemic factors, and these factors have an impact on whether they feel satisfied in their work or are dissatisfied and choose to leave (see Fig. 1). At the personal level, a host of factors determine whether an individual community health worker feels motivated or demotivated about the performance of her duty, such as the role played by her family, the new identity that she feels during the performance of her tasks, job satisfaction, prior experience of ill health in her family, and upgradation of skills and knowledge.

Family support

A key finding in the study was the role played by the families of the community health workers. Community health workers with supportive families who valued their work described how this was a key element in their effective discharge of duties. Previous studies across various settings have shown that one of the factors that motivate community health workers is the support they receive from their own families.[9–14] Family support reported from these studies included moral support received for the work that they did, as well as helping community health workers with household work, in order to reduce their workload at home and enable them to spend more time delivering health services. The findings of the current study reaffirm this as an important factor in motivation. However, the study did not find either explicit or implicit recognition of this aspect anywhere in the ongoing ASHA programme. Hence, policy-makers and programme managers would do well to take this into account

Fig. 1. Factors affecting the performance of community health workers in urban settings



[a]Lack of family support was not explicitly identified as a negative factor in the study but was implied as such. It has therefore been included in this conceptual framework, given the importance that family support played in the ability of accredited social health activists to function effectively.

and consider ways in which the families of the community health workers can be considered to be allies in the larger effort to improve health in the community. It is important to come up with simple ways of recognizing the important role of the families of the community health workers and appreciating their support. This could involve simple measures such as periodic recognition of the families of community health workers at the level of the health centre where they are based. Such measures would also motivate family members to provide the required support to the community health workers to discharge their duties effectively.

Self-identity

Participants in this study also pointed to the satisfaction and the new identify that they felt as health workers as key motivating factors that were enabling at the personal level. These factors have also been reported in the past in multiple studies,[3,10,15,16] and have been the focus of various programmes that have looked at retaining and improving community health workers' motivation.

Social recognition

Social recognition has been shown to be a key factor motivating health workers across various contexts.[3,17,18] This was also found to be true in the present study sample. Appreciation of the work carried out by members of the community, and being recognized personally because of their home visits, proved to be motivating factors for the community health workers. At the same time, negative experiences, both at the community level and at health centres, made the community health workers in this study feel let down. Such negative experiences were reported more during the initial period after the community health workers were inducted into their respective areas. Hence, training programmes for community health workers need to specifically address this component and teach them strategies to cope with initial disappointments in the field. In addition to initial training, this should be inbuilt into periodic assessments by the health system, so that community health workers are able to share and learn from each other's experience on how best they could handle such negative experiences without letting them affect their work. Another avenue where community health workers felt let down was during their interaction with other established stakeholders in the health system, such as medical officers, nurses etc. At present there are no formal channels of communication, and many misconceptions exist about the role and nature of the community health workers. Instead of seeing them as partners, established health-care workers see them more as competitors who do not add real value to the health system. Hence, there is an urgent need to sensitize health-system staff to the role and importance of community health workers and to consider them as valuable allies.

Incentives

The payments made to community health workers, and their role in motivating or demotivating these workers, has been the focus of several studies. In the past, the concept of community health workers being volunteers motivated by a spirit of idealism has been reported,[19] with some arguing that they cannot be paid full salaries by ministries of health as they are not full-time employees.[6] However, most recent studies have stressed the fact that adequate remuneration is an important factor that motivates community health workers.[2,3,10,19–22] In the present study, it was found that the payments made to the community health workers were an important aspect of whether they felt satisfied about their work or not. Even those who mentioned that their salaries did not matter made it a point to mention that they did consider they were not on par with the extent of the work that they had to do. Given that community health workers provide very important functions and are key to achieving universal health coverage, especially for the poor, policy-makers and programme managers need to periodically review the financial incentives that are offered to these workers and whether they are in keeping with the extent of the work they are expected to perform. While community health workers have been shown to perform their tasks motivated by a sense of social responsibility,

it might be unsustainable and even unfair to expect them to work primarily out of a sense of social responsibility. There is also a need to formalize and improve upon the existing systems of performance monitoring that are directly linked to the amount of remuneration a community health worker receives, such as records of the number of immunizations that she has facilitated, the number of deliveries that she has accompanied, etc.

Supply side

While community health workers work on the demand side of the health system, it is equally crucial that adequate attention is given to the supply side. As shown in other contexts,[2,21] situations where the community health workers motivate community members and accompany them to the health centre, only to find that basic infrastructure or personnel needed to deliver services is lacking, not only demotivate them but also dent their credibility within the community, thereby also affecting their future work.

Limitations of the study

The study findings need to be interpreted while keeping the following limitations in mind. The study district was allocated by the Delhi State Health Mission, the government body in charge of the delivery of health services and the deployment of ASHAs in the state of Delhi. Hence, it is possible that the population in which the study was carried out had certain characteristics that impose limits on the generalization of the study findings. Further, the ASHA programme was comparatively new when the study was carried out; as it stabilizes, some of the factors that have been discussed might be addressed, while other new factors that motivate or demotivate community health workers might emerge, which it has not been possible to capture in this study. Nevertheless, the authors believe that their findings add to the existing knowledge on what motivates community health workers, and adds value to policy-makers and programme managers who utilize community health workers for the delivery of health-care services to the urban poor

Conclusion

Community health workers play an important role in reaching underserved populations and providing them with health services that they would otherwise be unable to access. This study has shown that factors at the personal, community and health-systems levels interplay to either motivate or demotivate community health workers in their discharge of duties in urban areas. As efforts get under way to ensure universal access to health care, it is important that these issues are addressed, to ensure that the urban community health worker programme is effectively able to deliver services through its community health workers and is sustainable in the long run.

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