Performance-based incentives of the ASHA scheme stakeholders' perspectives

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Performance-Based Incentives of the ASHA Scheme
Stakeholders' Perspectives

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A study of Accredited Social Health Activists in Shahapur taluka of Maharashtra, a drought-prone adivasi-inhabited area, shows that the remuneration of ASHAs is a growing concern both for them, as well as their families. Recognising their contribution to public health services, the government should provide fixed payment to them, beyond which task-based incentives should continue to be given, though at a revised rate. The current system of remuneration is making it difficult for ASHAs to meet their family's needs and the community's expectations. Further, payment and reimbursement procedures need to be simplified.

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The Accredited Social Health Activist (ASHA) scheme began under the National Rural Health Mission (NRHM) 2005-12 and currently there are 8.8 lakh ASHAs working (all women) in villages across India. Various studies (NHSRC 2011; IIPS 2011; Bajpai, Sachs and Dholakia 2010) have found ASHAs to be successful in escorting pregnant women for institutionalised deliveries and facilitating immunisation. They have been active in giving information, facilitating curative care and making home visits but performance has been uneven. The first phase of NRHM is over and ASHAs have been retained as an integral part of the rural public health service under the Twelfth Five-Year Plan (2012-17) as well.

The ASHA scheme is the latest and largest community health worker's (CHW) scheme but India has a very long history of CHW programmes in rural healthcare, particularly in the voluntary sector. In the public health sector, CHWs were recommended for villages by several successive health committees starting with the Sokhey Committee in 1940.

However, the first major national CHW scheme was introduced in the country in 1977. Under the Swasthya Rakshak Scheme, around four lakh male CHWs were selected, trained and engaged to work in their villages (Chatterjee 1993). The scheme ran into difficulties within a few years and dwindled to a halt. One major reason was the decision to replace the male CHWs with women. Since men were the targets of family planning programmes in the 1970s and the early 1980s, male CHWs were initially selected.

Subsequently with a change in government, more importance was placed on maternal and child health and attempts were made to phase out the men, and replace them with women. This resulted in unionisation and litigation against their removal by the male CHWs (Chatterjee 1993). The programme continued until 1985, although in some states it went on into the 1990s. There was no formal closure of the programme and it became gradually dysfunctional.

If a retrospective analysis is done, then although the male CHWs were paid a fixed sum of Rs 50 per month, this amount was important enough for them to agitate against their being replaced, which indicates a need for stable positions despite being volunteers. However, the legitimacy of the CHWs' demands was not a consideration at the macro level. The response of the health services at that time was to simply allow this national CHW programme to wither away by denying it funds, training and supplies (Banerji 1985). Years later when CHW schemes were reintroduced at the state level in the form of *mitanin* (Chhattisgarh), *sahiyya* (Jharkhand), *pada sevika* (Maharashtra) and *jan swasthya rakshak* (Madhya Pradesh), except for the latter, all the schemes have women as CHWs. The ASHA scheme also has women.

The importance of understanding the perspectives of CHWs and stakeholders at the implementation level is highlighted by the experiences of 1977. This study therefore explored village-level perspectives regarding the ASHA scheme. The three stakeholder groups included were the ASHAs, the community and local representatives of public health services.

Methodology

The study was conducted in Shahapur taluka. It is the largest of the adivasi-inhabited talukas of Thane district in the state of Maharashtra. Shahapur supplies drinking water to Mumbai but is drought-prone. Despite a high literacy rate and some industrial presence, the dominant economic activity is agriculture. There are several adivasi groups in the area besides a sizeable presence of Kunbis Other Backward Classes (OBCs). Shahapur taluka has a subdivisional

hospital located at the taluka headquarters, and nine primary health centres (PHCs). The ASHA scheme is fully functional in the area.

Data was collected from three stakeholder groups which were covered in six sequential phases of data collection using mixed methods (Table 1). The first stakeholder group was the ASHAs. All the ASHAs in the taluka were planned to be covered in the first phase of data collection. However feasibility was a factor because the ASHAs only met in smaller groups at their own PHCs and sub-centres for ASHA monthly meetings. Finally, a self-administered questionnaire in the local language (Marathi) was administered to all the ASHAs during the monthly meetings at the nine PHCs in nine separate data collection sessions. This tool was chosen as it was participatory and gave the ASHAs the space to reflect and express. More importantly it retained the "language" of the ASHAs. The emergent data was analysed before sampling for the second phase of data collection with ASHAs.

Table 1: Stakeholders, Sampling Method, Sample Size and Research Methods

Phase - Stakeholder Group	Sampling Method	Sample Size	Method
One – ASHAs	Census	244 ASHAs	Self-answered questionnaire
Two – ASHAs	Purposive	24 ASHAs	Semi-structured interviews
Three – health services	Census	29 ASHA facilitators	Self-answered questionnaire
Four – health services	Convenience	20 interviews from three levels of the health services	Open interviews
Five – community (sarpanch/ VWSHC* members)	Convenience	Five group and individual interviews	Open interviews
Six – community (households)	Multi-level cluster and systematic	120 households	Household survey

* VWSHC: Village water supply, sanitation and health committee.

In the second phase with ASHAs, a purposive sampling method was used to get a divergent sample of ASHAs. The criteria was firstly representation of ASHAs across nine PHCs; second the demographic profile; and third the reasons written for joining. Semi-structured interviews were conducted with 24 ASHAs until saturation was reached. The interviews were conducted in the local language (Marathi) and care was taken to retain the ASHAs' expressions.

All the data from the ASHAs was analysed before exploring the perspectives of the second group of stakeholders, namely, the local representatives of the health services. Two phases of data collection were conducted.

It was observed that the functions of the ASHAs were associated with the health services at four levels: ASHA facilitators at the villages; multipurpose workers (MPW) and auxiliary nurse-midwives (ANMs) at the sub-centres; lady health visitors or senior ANMs, health assistants and medical officers at the PHCs; and the block facilitator and block medical officers at the taluka headquarters.

The ASHA facilitators were first administered the same self-answered questionnaire as the ASHAs, for comparability. The responses were analysed immediately, before the second phase of data collection with the stakeholders at the sub-centre, PHC and block level. The convenience sampling method was used where stakeholders who were accessible and willing to be interviewed were included in the sample. Although aware of confidentiality, the health staff were reluctant to give formal structured interviews, therefore open interviews using a research guide were conducted. Individual and joint interviews were conducted until saturation was reached at 20 interviews.

The data from the stakeholders of the health services was analysed before embarking on the exploration at the community level. Here in the first phase, five open interviews were held with sarpanches and members of the village water supply, sanitation and health committee from different villages until saturation. The convenience sampling method was used.

Finally, a household survey was conducted at the final phase of data collection. The sample size was 120 households. The decision to have a sample size of 120 households was based upon the predominantly qualitative nature of the research design manifested by several open questions in the questionnaire.

The priority was to select as divergent a sample of households as possible from across the taluka. Multistage cluster sampling was done at PHCs, sub-centres and village levels. The PHCs were first clustered in terms of distance from the subdivisional hospital at the taluka headquarters. One PHC was selected randomly from nearby (up to 10 kms); middle distance (11 to 20 kms); and distant PHCs (21 to 30 or more kms). The sub-centres under each selected PHC were then divided into two clusters each: one with more adivasi households and one with less adivasi households, making a total of six clusters. Each sub-centre covered a number of villages. One village was selected randomly from each sub-centre and a total of six villages were selected. Finally 20 households were selected from each of the six villages by systematic sampling. This is how the sample of 120 households was taken. There were totally 661 households in the six villages.

In this study the analysis of the preceding phases informed the sampling and instrument development of the next phase. The findings were presented in the form of thematic analysis using constant comparison across stakeholders and methods. This study used the technique of juxtaposition to highlight the distinct perspectives of the stakeholders.

Findings

There were 340 ASHAs in the taluka according to the records of the block medical officer's office. However, only 244 ASHAs were present on the monthly ASHA meeting days in the nine PHCs when the self-administered questionnaire was used. The common reasons given by the PHC staff were "absent today", "gone on leave", and "gone for delivery". In some PHCs, there was no response to a query on the reason for the absenteeism of ASHAs.

A second round of data collection was done in the following month in two PHCs, one located near the block headquarters and the local railway station and one located at a distance from the block headquarters. In the second round too, only three out of 15 and one out of eight of the originally absent ASHAs respectively, were present in the two PHCs. Otherwise, the same ASHAs were found absent again. At this point the total sample size of ASHAs was accepted as 244.

High Rate of Absenteeism/Attrition: The data pointed to a high rate of absenteeism/attrition as 96 ASHAs (28.2%) listed in the taluka records were missing during data collection. Another reason could be over-reporting due to mismanagement. Higher numbers of ASHAs might also have been listed under instructions to maintain the required numbers of ASHAs coming from the top to the taluka. Dropouts might also not have been cut out from the list in order to maintain numbers. The response of a taluka level official (designation withheld for anonymity) gave a hint of the kind of pressures faced at the lower levels to maintain the numbers. As I was asked, "Can there be some way of showing 340 ASHAs in the study?"

The data also showed linkages of absenteeism/attrition with the ASHAs' remuneration. An early indication of these linkages came from the health service officials when presented with the numbers. Futher, I was told, "Some months down the line, more ASHAs will not be there from this list. There is nothing for them."

There is low acknowledgement of absenteeism/attrition among ASHAs in existing reports or policy documents, for example, attrition is recorded at 5% to 15% in the Report of the Working Group on NRHM (2012-17) (Planning Commission 2011). The findings of this study however indicated the possibility of a higher incidence of absenteeism/attrition as there were 96 (28.2%) missing ASHAs during data collection.

Remuneration Concerns: The data of this study also showed linkages between absenteeism/attrition and remuneration. The broad aim of this study was to explore perspectives of stakeholders about the ASHAs. Not a single question about the perspectives of remuneration was included in any tool. However concerns of remuneration emerged prominently among stakeholders from the findings. This was first seen in several voluntary observations written by the ASHAs while doing the self-administered questionnaire.

"All this service (*seva*) is for the village. Agreed it is social service but we have to run our families (*kutumb chaalvayache aahe*)." These linkages were found even among motivated ASHAs. An ASHA who shared with pride that she was praised by the lady health visitor (LHV) in the monthly meeting, for her role in an epidemic in her village said: "People in the village should understand that it is not that I work because I get money. My condition is such... If nothing happens then I too will leave."

The ASHAs were asked to self-report demographic details in the self-answered questionnaires. The data showed that there were several influences of their backgrounds on the perspectives of their remuneration.

Age of ASHAs: Out of 244 ASHAs, about one-fourth of the ASHAs or 62 ASHAs (25.4%) were in the age group of 18-24 years, below the mandated age of 25 to 45 years in the ASHA scheme. They were all women in their child-bearing years. Observation at PHCs showed that some ASHAs had come with their breast-feeding infants and some were accompanied by older women who waited outside the meeting hall with their toddlers. It indicated that the post was a coveted one as even new mothers had accepted the responsibility.

A national study (NHSRC 2011) also showed that the states of Rajasthan (24.0%) and Jharkhand (28.9%) had ASHAs in this age group. Thus the data of both the studies reflected not only an early age of marriage, but also indicated that women were expected to work regardless of their stage in life. This was the rural culture where every adult member was engaged in whatever work was available to them for income generation.

The largest number of 120 ASHAs (49.2%) were in the age group of 25-30 years; 55 ASHAs (22.5%) were in the age group of 31-35 years; six ASHAs (2.5%) were in the age group of 36-40 years and one ASHA did not write her age. Thus, the ASHAs in the sample were all in their productive years making it likely that the post had financial expectations attached to it.

Educational Qualifications: The mandate of the ASHA scheme is that the women working as ASHAs must have a minimum qualification of 8th class pass with a relaxation in qualifications where this is not possible. This study found that the 244 ASHAs had a wide range of qualifications starting from fourth standard to graduates and diploma holders, reflecting the diversity of the women enrolled as ASHAs. As many as 150 ASHAs (61.5%) were between eighth and 12th standard, and there were three (1.2%) undergraduates and three (1.2%) graduates. Such a high percentage of educated women indicated aspirations from holding the post. It highlighted the fact that there is a pool of educated rural women willing to work, but there are few opportunities for them.

The rest of the women, that is 88 (36.1%) ASHAs, had qualifications below the 8th standard. An important reason was that many of these women were already pada sevikas (a state-level scheme preceding the ASHA scheme), where educational criterion was not the 8th standard, and were later absorbed as ASHAs. Interviews showed that the post was seen as a step upwards within health services by the former pada sevikas. Their enhanced income from the ASHA post as well as the manner in which they were convinced to join by the ANMs or multipurpose workers was responsible for this. As one respondent said, "I was already *pada* worker and for that I was getting Rs 300...The doctor (multipurpose worker) enrolled me (as ASHA), he told me I will get a few rupees more".

Marital Status: A predominant number of ASHAs, 228 (93.4%), were married. Details of their family backgrounds indicated that they were not main earners.

However, they were accountable to their marital families for their activities during the day. Thirteen (5.3%) of the ASHAs were widowed, one (0.4%) was unmarried, and two ASHAs (0.8%) did not report their marital status.

Family as an 'Uncounted' Stakeholder

An important finding from the in-depth interviews was that the family of the ASHA was a key stakeholder in the ASHAs' understanding of their work. The ASHAs shared that the foremost challenge after joining was to step out of their homes for a purpose that was not related to their domestic requirements. They had to negotiate with their families to join and to continue and the family's perceptions of their remuneration were crucial in these negotiations.

A perception of the task-incentive balance being a one-on-one equation made the post less worthwhile for their families because most of the incentives were seen as being low. Several of the responsibilities, like basic curative care given by medical kit did not receive any incentives but did impinge upon their daily routine. The ASHAs in the area said they were escorting pregnant women who were not from BPL families and seriously ill persons without incentives. They were told to make daily rounds of their villages and *anganwadis*. Such gratis tasks were considered as "free tasks". The ASHAs said they were facing pressures from their families to discontinue because of the difficulties with the remuneration.

VS had been an ASHA for three years at the time of the interview. She said that she liked the work. Her husband is a daily wage labourer. Their family income per month is Rs 1,000 according to VS. She shared her experiences as an ASHA.

> I have no problem in getting cooperation from my village. At home my mother-in-law says 'this one just gets up and goes. She goes out for work but there is no money to be seen. She gets a phone call and she goes. She just gets up and goes.' My husband says 'you go here and there but get nothing'. We are trained and are unable to ignore the village people's needs but we are in the same poverty as them. We too...our condition too is like theirs.

There were also process-related difficulties which brought on pressure. For example, the manner in which the current remuneration system is structured requires the ASHAs to pay for their travel expenses in advance for several regular activities like escorting patients and meetings. In a gendered environment where few women have any money for their personal disposal, there was resistance from their families for giving these women the money for travel payments that were compounded by the delays and difficulties of reimbursement. This was another point resistance from the families regarding the remuneration of the ASHAs.

DM had been an ASHA for one year at the time of the interview. She lives in Karjat, a distant area, and has to travel by the local train to reach the block subdivisional hospital. Her joint family including her husband work and survive on a common landholding.

> My husband does not say anything about my work. We have to ask my father-in-law. Even for my *tikli baangdee* (bindis and bangles which are compulsory apparel for married women and must be replaced immediately). Once when I asked for money to take the patient for delivery, my father-in-law said, 'you take money from home for delivery, for meetings, for training, what's the use of such work?' I just left home without any money, I travelled 'without' (ticket) and went to Asangaon*.

(*Asangaon is a local train station which connects Karjat to the taluka headquarters. On that day she was escorting a patient to the subdivisional hospital.)

Lastly, the irregular timings and amounts exposed the ASHAs to pressure from their families. These linkages were confirmed by the ASHAs' immediate seniors within the health services system too.

Sister B K, a LHV, ASHA trainer and supervisor working from a PHC reported, "One of the ASHAs shared this with us. Her husband called her out to the front room of the house and introduced her to his friend, saying 'Ask my wife her salary – it is 150*.' Can he possibly be saying this with appreciation?"
(*The amount of rupees 150 is the only fixed part of the ASHAs' remuneration in the study location. This is the compensation for attending the ASHA monthly meeting. The rest of the remuneration changes each month according to the incentives.)

Perspectives of the Community

According to the ASHAs, the community did appreciate their work. However, not all were appreciative of the voluntary aspects of the post. BJ works as an ASHA. She has passed fourth standard and comes from an adivasi family. Her family depends upon their own landholding and her husband also works as watchman. She said she faced no opposition from her family for doing the work but yet felt the pressure for remuneration because the community did not value her voluntarism. One respondent said, "When I leave my home the neighbours say, 'look the lady is leaving for doing social work (samaaj seva)'."

Shahapur is a backward area with poor infrastructural facilities. The household survey (120 households), where largely male heads of the households were interviewed, showed that the status of social determinants of health was very poor. Distance from the PHC/hospital, poor transportation facilities and poor roads emerged as a key concern among the community as well as the ASHAs. Given the conditions, there was rejection of voluntarism in this community where several households depended upon daily wage labour for survival.

ASHAs shared that there was mistrust among the community regarding the incentives received and this affected the response given to ASHAs. One of the ASHAs shared that a pregnant woman asked whether she should get registered just for the ASHA to get her incentive? (The ASHA incentive for registration is Rs 10.) She said, "They feel we are getting a salary like the MPW and ANM". They say, "Why do you do so much if you are only getting incentive (*mobadalla*)?" Another said, "They say you must be getting money that is why you go from door to door."

The situation was compounded by the fact that the community had a poor understanding of the remuneration system of the ASHAs. Most of the heads of the households interviewed in the household survey in this study were aware of

the ASHA in their village as 106 (88.3%) respondents out of the total of 120 said there was an ASHA in their village while 14 (11.7%) said there was no ASHA. Some of these 14 respondents said there was no ASHA but two women worked in the village for delivery and immunisation.

However when the 106 heads of households that were aware of ASHAs in their villages were asked about the payments of the ASHAs, only seven respondents said something about performance-based incentives. Otherwise the responses showed complete ignorance among the community about the payments received by the ASHAs in words like "I don't know", "she gets *maan dhan* (token amount)" or "she gets very little".

The members of the village water supply, sanitation and health committee also generally held the view that ASHAs were paid less but did not know the details. This was despite the fact that some of the incentives for tasks (like 100% immunisation achievement and some travel allowances) were mandated to be routed through these committees. In one of the villages, a woman sarpanch thought that the ASHAs receive salaries from the government. The ASHAs were deprived of a source of support from the community due to their understanding of remuneration, which in turn affected their perspectives. Experiences at work regarding incentives also affected views on remuneration.

Vulnerability and Remuneration

It is now a well-documented fact that there are delays in the payments of the ASHAs, which has been mentioned in the Draft Twelfth Five-Year Plan as well. In this study, the ASHAs were asked when they had received their last payment. Out of 244 ASHAs, 32 (13.1%) had received the payment that month; 114 (46.7%) had received payment last month; 47 (19.3%) had received the payment two months ago; and 33 (13.5%) had received the payment more than two months ago, while 18 (7.4%) ASHAs did not respond to this question.

The question of delay was explored from the perspectives of the stakeholders. Interviews with the ANMs who were in charge of processing the remunerations revealed that they were aware of the delays but explained that they were often pressed for time to be able to process incentives. The ANMs also said there was a lengthy administrative procedure for processing the incentives as money came under different administrative heads, resulting in delays and payments in instalments.

Lengthy procedures were also mandated for the ASHAs to process incentives at the village level. ASHAs had to get signatures from the attendant ANMs/nurses/doctors and also the LHVs to get paid for escorting women for institutionalised deliveries under the Janani Suraksha Yojana (JSY). The village sarpanch and the anganwadi worker had to sign to claim the incentive of 100% immunisation of children in their village. The MPW was needed to confirm the referral and completion of treatment of tuberculosis and leprosy patients and the pathologist was also required to confirm the number of blood slides submitted for malaria detection. Additionally, the anganwadi workers/ANMs were required to sanction travel expenses for delivery cases not covered under the JSY and for escorting ill patients. All the records had to be signed by the ASHA facilitators. An earlier study (Bajpai, Sachs and Dholakia 2010) has also mentioned the lengthy procedures as a difficulty expressed by ASHAs.

Further, from the standpoint of the ASHAs, the channels of processing were also humiliating. As one of the respondents said:

> The procedure of getting the payment is lengthy but the procedure also reduces the feeling of doing social service. The respect the ASHA gains in her own eyes is lost when she goes after facilitators and then the ANMs for signatures and then waits so long for such small amount of money. The family does not agree to support us due to the lack of income and delayed payments and there is further loss of respect of the ASHA in her own eyes.

The difficulties of the ASHAs to claim incentives were compounded by a lack of clarity about the entitled incentives for each task. ASHAs had been given charts of task-incentive entitlements, which were misplaced by some women. Except for one PHC, none of the nine PHCs and sub-centres that were visited had displayed the rate chart for incentives. The ASHAs also felt there were no avenues to address their difficulties.

Janani Suraksha Yojana

The ASHAs in the sample of this study had expressed their dependency on the JSY to getting an acceptable amount because the incentives of the other tasks were too low and there were "free" tasks. However, this did not necessarily imply that other tasks were not conducted. In this study, both the ASHAs and the ASHA facilitators had done a free listing of the responsibilities of the ASHA. The 244 ASHAs had collectively listed 20 responsibilities. Just five tasks were paid incentives as per the task-incentive entitlements, the rest were gratis.

The 29 ASHA facilitators had collectively mentioned 24 responsibilities with the same five paid tasks. Several unpaid sub-tasks were mentioned in these free listings. The community also was asked about the ASHA responsibilities during the household survey. The 106, largely male heads of the households, had collectively listed nine ASHA tasks of which three were paid tasks.

This finding is in confirmation with the other studies as well. JSY was found to be the main source of incentives for the ASHAs in two studies (NHSRC 2011 and IIPS 2011) but the ASHAs were found to be doing a total of 13 and 15 tasks respectively in these studies as well. The task-incentive balance is thus tilted in favour of the health services and there is scope for exploitation of ASHAs.

Sexual Harassment

Sexual harassment is the extreme manifestation of the ASHAs' vulnerability. In this study, one medical officer from one of the nine PHCs in the taluka was reported to be sexually harassing ASHAs and ANMs. This was shared collectively by the ASHAs, ASHA facilitators and the ANMs of that PHC. They said that it was related to the sanctioning of the ASHAs' incentives.

The roots of this problem lie in the tradition of seeing the medical officers as "heads" of the PHCs leaving avenues for

exploitation. The inherent patriarchy is evident. This "leadership" also puts a burden on the conscientious medical officers. The other side of the story is the essential vulnerability of the women personnel in the public health services.

Inadequate Policy Responses

Several existing studies on the ASHA scheme have similarly noted the current task-incentive imbalance and suggested changes. IIPS (2011) has noted that ASHAs have asked for fixed and timely incentives. National Health Systems Resource Centre (NHSRC) (2011) has advised to change the pattern of payment with a fixed-plus-incentives system. Bajpai, Sachs and Dholakia (2010) have noted that 33% of the sampled ASHAs were happy with incentives but 88% wanted regular salaries. Thus all major studies on the ASHA scheme have suggested some form of fixed payment for the ASHAs.

It has also been suggested that the tasks of the ASHAs be limited. Considering the fact that the ASHAs have been doing several tasks so far, to now limit their tasks will leave them vulnerable to pressures from the community. The data of this study showed the likelihood that there will also be no compliance to limiting the tasks from the local health personnel. In this study their immediate seniors namely the MPWs and ANMs, who were also their trainers and supervisors, said the ASHAs were their "helpers".

Despite major reports, the policy-level response is inadequate. The revised list of ASHA incentives announced in January 2013 (NRHM 2013) has not reduced the tasks as there are 24 ASHA tasks. It has retained the performance-based incentives. Therefore, the ASHAs will continue to receive irregular amounts. The amounts have been modified, but the incentives for routine tasks have low incentives like Rs 5 per malaria slide and Re 1 each for social marketing of contraceptives. There are also no provisions made for advance expenses in the updated list. Thus, the aspirations and the difficulties of the ASHAs with the performance-based incentives have not been sufficiently addressed even in the second phase of the ASHA scheme, as it moved from the Eleventh Five-Year Plan (2005-12) to the Twelfth Five-Year Plan (2012-17). The biggest fallout is the vulnerability of ASHAs to exploitation, humiliation and pressures due to the remuneration system. However, the ASHAs in the study location did not consider attrition alone as a coping mechanism to unsatisfactory remuneration.

A Sense of Entitlement

There were several points of identification of the ASHAs with the public health services. The selection of ASHAs in the early years of the scheme was made by the stakeholders from the health services. The training, ongoing supervision and payments were from the health services. Every task conducted by the ASHAs was associated with the public health services. The ASHAs were given a uniform just like the salaried anganwadi workers and ANMs.

More importantly, the ASHAs were the first point of contact in the village for the visiting health personnel. In times of illness, epidemics and deliveries, they were also the first point of contact for the community. All these factors served to strengthen the association of ASHAs with the public health services among the stakeholders and created a sense of entitlement among and for the ASHAs.

Another factor to create a sense of entitlement among the ASHAs was the increased responsibilities handed to them as the training modules had progressed. None of the ASHAs who were interviewed expressed any reluctance to take on the responsibilities. In fact, the desire to serve was the topmost reason given by the ASHAs in this as well as another study (NHSRC 2011). However, they did say that while the tasks had increased with time, there was no commensurate payment.

The findings of this study showed that the ASHAs were not asking for jobs, as also seen in the NHSRC (2011) study where just 3% wanted a job. This was however also not indicative of their acceptance of the performance-based incentives as they were most vocal that they wanted some stability of payment. In interviews the ASHAs asked for "something fixed" (*kaahi tari fix*) in order to sustain themselves, for space to continue and to meet their own aspirations.

This study showed that from the perspectives of the ASHAs and their families, there were several difficulties with the performance-based incentive system like lengthy and complex procedures, delays, low incentives, gratis tasks and irregular incomes. The current remuneration system also left the ASHA vulnerable to exploitation and humiliation. The ASHAs were also facing pressure from their families and misunderstandings of the community due to the nature of the current remuneration system. Performance-based incentives had given rise to a one-on-one task-incentive perception, and a rejection of voluntarism, which was contextualised in the backdrop of the practice of daily wage labour that was common in the area.

The family had expectations but the ASHAs had their own as well. A key finding of the study was that growth motivations were not inimical to feelings of altruism among CHWs like the ASHAs. Several altruistic reasons and intangible motivations inspired the ASHAs but the common concern was remuneration. This was not only to sustain themselves but also to convince their families and communities and continue to work.

Rights-Based Perspective

A point of consideration with regard to the ASHA scheme is that every aspect of the ASHAs' functioning from selection to payment is through the health services, leading to an identification of the ASHAs with the health services and a sense of entitlement. All the mandated tasks of the ASHA are towards accomplishing the goals of the national health programmes. This is in common with all the health functionaries within the health services. Yet, none of the others involved in the national health programmes receive their payment according to their performance that month. The reluctance of the health services to take full ownership of the ASHAs while extending her functions revealed a gender-hierarchical bias. Ironically, the ASHA scheme has selected these women due to the advantages of their gender and location within the community.

The central dilemma of any CHW programme is the broad and undefined nature of the CHW's contributions where

working hours, hardships of efforts and several contributions like providing referrals or giving information are intangibles. Therefore, performance-based incentives will invariably not factor in some contributions. On the other hand, a performance-based incentive system is also not a substitute for a monitoring system. To enhance the performance, effective monitoring systems can be put into place by strengthening the ASHA facilitators on one hand and the village committees on the other hand.

Some immediate steps are required to support the women. First, the performance of all ASHAs in all states needs to be delinked from payment at least partially by providing some fixed amount every month. Second, the lengthy procedures must be simplified to avoid the humiliating experiences while claiming incentives. Third, the difficulties in making advance travel expenses must be addressed by providing for a travel allowance. Fourth, charts of incentives must be displayed for ASHAs and finally there should be a telephonic helpline and redressal committee available for ASHAs with representation from the voluntary sector. Any non-monetary incentives must be in addition to these measures. Some states in the country have already provided for a combination of fixed and incentive-based systems and are providing a fixed sum in addition to the incentives as also suggested by NHSRC (2011).

The Future

There was a union of ASHA and ASHA facilitators functioning in the study area. Such movements have been noted across the country (ibid). They raise valid questions about the expectations of CHWs from the public health services and from the civil society that took the initiative for them to get engaged in the first place. The country has seen organised struggles of women anganwadi workers and anganwadi helpers for stability and benefits over the past decades. Today there are 11.71 lakh anganwadi workers and 10.97 lakh helpers who are also village women and are receiving a fixed amount and benefits. Extending the same to 8.8 lakh ASHAs and also the ASHA facilitators is a logical step forward.

On meeting the ASHAs face-to-face, the most remarkable aspect was their energy and impetus towards the tangible and intangible growth offered by this opportunity. The ASHAs have demonstrated their potential. This massive effort towards sustaining a national CHW scheme should not be allowed to get dissipated by a lack of support for the ASHAs. There must be an institutionalised response to the aspirations and the vulnerabilities of these women. The anxiety to sustain the ASHA scheme and their heartfelt expressions of intangible gains from the work might lead to undermining the difficulties and the aspirations of these women.

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