Motivation Matters: Findings from Studies of CHWs and their motivation and work climate from India

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OVERVIEW

- Pay for performance is seen as a critical HRH management and efficiency strategy

- Findings from a survey of health and nutrition community health workers in Bihar to understand the role of payments in motivation against other factors
ASHAS IN INDIA

ASHAs are among the world’s largest community-based health ‘volunteers’

The earn activity-based incentives

- Incentives in all states for Janani Suraksha Yojana (JSY), immunization and participation in review meetings – comprise highest component of ASHA incentives (NIHFW, 2011)

- Alternative models: Rajasthan offers fixed honorarium plus incentives linked to certain tasks (Nandan et al., 2009); ASHAs in West Bengal earn fixed amount

India’s experience suggests P4P could contribute to positive health outcomes:

- **Institutional delivery rates** increased in Bihar, MP, UP, Odisha and Rajasthan (MPR, 2014, 2016; UNFPA, 2008); rise in ANC and PNC visits also witnessed (Gopalan and Durairaj, 2012)

- Breastfeeding rates increased (MPR 2014)

- Pilot study in Gadhchiroli district, Maharashtra: linking ASHA incentives to new-born care activities (such as home visits, monitoring, and managing sickness) reduced neonatal mortality by 70 percentage between 1993 and 2003 (Wang et al., 2012)

- Incentivising promotion of female sterilisation in Surendranagar district, Gujarat saw increase in service uptake – ASHA contribution higher than other health workers (Nimavat et al., 2016)
State Resource Group, District Resource Group, Block Resource Group provide planning platforms

Health Sub-Centre is the primary focus for convergence because it is the first point of outreach service delivery
## HEALTH AND NUTRITION FRONTLINE WORKERS IN INDIA

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>ASHA</th>
<th>AWW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nature of contract</td>
<td>• Part-time female workers recruited from local communities</td>
<td>• Part-time female workers recruited from local communities</td>
</tr>
<tr>
<td></td>
<td>• Employed by the National Rural Health Mission</td>
<td>• Employed by the Integrated Child Development Services</td>
</tr>
<tr>
<td></td>
<td>• Non-salaried but receive monetary incentives for specific activities</td>
<td>• Receive fixed monthly honorarium based on educational qualifications</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• May receive monetary incentives for specific activities</td>
</tr>
<tr>
<td>Amount of financial incentives or</td>
<td>• Varied by state</td>
<td>~INR 3000 from central funds In addition, states/UTs can provide</td>
</tr>
<tr>
<td>honorariums earned (monthly)</td>
<td>• Some states have incentives tied to the volume of services, others</td>
<td>additional honorarium from their own resources. For e.g. Rajasthan</td>
</tr>
<tr>
<td></td>
<td>• Some states have incentives tied to the volume of services, others</td>
<td>provides an addition</td>
</tr>
<tr>
<td></td>
<td>• For e.g. Rajasthan has the latter and if an ASHA performs as per</td>
<td>INR 1330 from state funds</td>
</tr>
<tr>
<td></td>
<td>the benchmark, she is expected to earn INR 1067.</td>
<td></td>
</tr>
<tr>
<td>Any other incentive</td>
<td></td>
<td>Insurance cover, annual award schemes at the state and central level</td>
</tr>
<tr>
<td>Supervisor</td>
<td>• A Block Community Mobilizer, and ASHA facilitators at cluster</td>
<td>• About 20-25 AWWs are supervised by a Supervisor</td>
</tr>
<tr>
<td></td>
<td>level (one ASHA Facilitator for 10 to 20 ASHAs) are expected to</td>
<td>• Four supervisors are headed by a Child Development Project Officer (CDPO)</td>
</tr>
<tr>
<td></td>
<td>provide support and supervision at block levels and below</td>
<td></td>
</tr>
</tbody>
</table>
### MONETARY INCENTIVES FOR ASHAS IN BIHAR

<table>
<thead>
<tr>
<th>Domain</th>
<th>Incentive</th>
<th>Amount</th>
<th>Per</th>
<th>Source of Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent Health</td>
<td>Social marketing of sanitary napkins for adolescent girls</td>
<td>1</td>
<td>Pack of 6</td>
<td>Menstrual hygiene - ARSH</td>
</tr>
<tr>
<td>Adolescent Health</td>
<td>Monthly meeting with adolescent girls on menstrual hygiene</td>
<td>50</td>
<td>Meeting</td>
<td>VHSNC untied fund</td>
</tr>
<tr>
<td>Child Health</td>
<td>Successful follow up of children after discharge from SAM management</td>
<td>150</td>
<td>Case</td>
<td>CH - RCH Flexi Pool</td>
</tr>
<tr>
<td>Child Health</td>
<td>Monthly follow ups of LBW babies until age 2</td>
<td>150</td>
<td>Case</td>
<td>CH - RCH Flexi Pool</td>
</tr>
<tr>
<td>Child Health</td>
<td>Monthly follow ups of SNCU discharged babies until aged 1</td>
<td>50</td>
<td>Case</td>
<td>CH - RCH Flexi Pool</td>
</tr>
<tr>
<td>Child Health</td>
<td>HBNC home visits (complete set)</td>
<td>250</td>
<td>Child</td>
<td>CH - RCH Flexi Pool</td>
</tr>
<tr>
<td>Communitisation</td>
<td>Convening and guiding VHSNC</td>
<td>150</td>
<td>VHSNC</td>
<td>VHSNC untied fund</td>
</tr>
<tr>
<td>Communitisation</td>
<td>Line Listing of Households</td>
<td>100</td>
<td>Event</td>
<td>VHSNC untied fund</td>
</tr>
<tr>
<td>Communitisation</td>
<td>Maintaining village health register and registration of births and deaths</td>
<td>100</td>
<td>Month</td>
<td>VHSNC untied fund</td>
</tr>
<tr>
<td>Communitisation</td>
<td>Preparation of due list of children to be immunised</td>
<td>100</td>
<td>Month</td>
<td>VHSNC untied fund</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Escorting/facilitating clients to facility for PPIUCD</td>
<td>150</td>
<td>Case</td>
<td>FP compensation funds</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Preparation of list of eligible couples for FP</td>
<td>100</td>
<td>Month</td>
<td>VHSNC untied fund</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Spacing for 2 years after marriage</td>
<td>500</td>
<td>Couple</td>
<td>FP compensation funds</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Spacing for 3 years after first birth</td>
<td>500</td>
<td>Couple</td>
<td>FP compensation funds</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Couples adopt permanent limiting method after two children</td>
<td>1000</td>
<td>Couple</td>
<td>FP compensation funds</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Counselling, motivation and follow up for tubectomy</td>
<td>150</td>
<td>Couple</td>
<td>FP sterilisation compensation funds</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Counselling, motivation and follow up for vasectomy/NSV</td>
<td>200</td>
<td>Couple</td>
<td>FP sterilisation compensation funds</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Social marketing of condoms</td>
<td>1</td>
<td>Pack of 3</td>
<td>Family planning fund</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Social marketing of OCPs</td>
<td>1</td>
<td>1 cycle</td>
<td>Family planning fund</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Social marketing of ECPs</td>
<td>2</td>
<td></td>
<td>Family planning fund</td>
</tr>
<tr>
<td>Immunisation</td>
<td>Mobilising and attending VHND</td>
<td>200</td>
<td>VHND</td>
<td>Routine immunisation pool</td>
</tr>
<tr>
<td>Immunisation</td>
<td>Mobilising children for OPV immunisation under pulse polio programme</td>
<td>100</td>
<td>Day</td>
<td>IPPI Funds</td>
</tr>
<tr>
<td>Immunisation</td>
<td>Complete immunisation of children under 1 year</td>
<td>100</td>
<td>Child</td>
<td>Routine immunisation pool</td>
</tr>
<tr>
<td>Immunisation</td>
<td>Complete immunisation of children under 2 years</td>
<td>50</td>
<td>Child</td>
<td>Routine immunisation pool</td>
</tr>
<tr>
<td>Maternal Health</td>
<td>JSY - ensuring ANC</td>
<td>300</td>
<td>Patient</td>
<td>MH - RCH Flexi Pool</td>
</tr>
<tr>
<td>Maternal Health</td>
<td>JSY - facilitating institutional delivery</td>
<td>300</td>
<td>Patient</td>
<td>MH - RCH Flexi Pool</td>
</tr>
<tr>
<td>Maternal Health</td>
<td>Reporting death of women 15-49 to PHC within 24 hrs</td>
<td>200</td>
<td>Patient</td>
<td>HSC untied fund</td>
</tr>
</tbody>
</table>

- A wide gamut of incentive payments targeting outcomes, outputs and process indicators from different sources of funds using different reporting mechanisms
- Findings from two districts confirm that payments for all programmes were not made last fiscal year
- Overall dissatisfaction (over 70% among 350 ASHAs) with amount of incentives and delays in receiving them (OPM, 2016)
- Understanding of these incentives very low among ASHAs and Block Community Mobilisers
P4P FOR ASHAS IN INDIA

Incentives in line with NRHM guidelines to states (Public Health Resource Society, 2009)

Several issues in P4P implementation:

- **Payments not commensurate with level of effort, out-of-pocket expenses** and expectations (Wang et al., 2012, Sarin et al., 2016)
- **Irregular, non-timely** payments – for 79% ASHAs in Bihar, 50% in UP and MP (UNFPA, 2009, Wang et al., 2012)
- **Lack of awareness among ASHAs** on payers (“who will pay?”) and incentive amounts for different activities (“how much for what job?”) (Sharma et al., 2014, Gosavi et al., 2009)
- Health service promotion and provision **focus shifting to activities yielding highest incentive payments**; to the detriment of other tasks, health determinants (Wang et al., 2012, Sarin et al., 2016)
  - Study in Udaipur district, Rajasthan: Lower than expected work output of ASHAs. Did not conduct mobilization for latrine construction, cataract surgery; small proportion of urban ASHAs completed DOTS programme (Nandan et al., 2009)
- Incentives released after furnishing informal payments (Wang et al., 2012)
- Uncertainty persists among PHC MOICs on disbursal, reporting related to payments (Wang et al., 2012)

There is an absence of comparison between fixed-pay and P4P models. Even if P4P engenders increased service delivery, impact on quality not known (Wang et al., 2012)
SURVEY OF MOTIVATION OF ASHA (AND OTHER CHWS) IN BIHAR IN 2016

~ 1200 Community Health Workers across cadres
Self-assessment of motivation, work climate, and practice

Tools adapted from different sources, including MSH

Outreach workers were asked to rate to what extent a series of job attributes were important for them on a four-point Likert scale (1 = Completely Unimportant, 2 = Unimportant, 3=Important 4 = Completely Important). These answers were then analyzed (using Exploratory Factor Analysis) to derive domains of motivation as well as an aggregate score.
MOTIVATION: KEY INSIGHTS - 1/2

A mix of intrinsic factors and external rewards emerge as the most important reason that outreach workers in health and nutrition systems to work in their respective settings.

External Rewards:
- (i) Payment for work,
- (ii) Fair remuneration and
- (iii) Long-term security,

Intrinsic Factors:
- Shouldering responsibility
- Contributing to health and well-being/sense of purpose
- non-financial rewards such as trainings
- having sufficient resources to work with
KEY RESULTS - MOTIVATION

- Each motivation domain score and aggregate motivation scores are outcome variables in the five specifications displayed in the table above.

- **Training is positively associated** with Motivation Domain Scores for ‘Self Identity’ and ‘Self Worth’.

- After controlling for individual, job, supervision, and other factors we find that **ASHAs have lower motivation scores (overall) compared to other outreach workers (AWW, for example)**.

- Supervision that is procedural in that it consists of checking registers is negatively associated with Motivation Domain Scores for ‘Self Identity’ and ‘External Rewards’.

- Punitive Actions were categorized into mild (e.g.: Encouraging to improve performance), moderate (e.g. Giving an official warning) and severe actions (e.g. Withholding salary). A composite score was created based on respondents answers on which ones their supervisors are likely to use if they do not turn up for work.

- More severe punitive actions were positively associated with Amotivation – since the statements that formed the Amotivation were negative the scoring was reversed for inclusion into EFA and our multivariate regression analysis.

- Salary amounts were negatively associated with the Motivation.

- Motivating actions are categorized into motivation through (i) Encouragement, Support and Recognition, (ii) Financial Rewards and (iii) Non-financial Rewards. Composite index is created based on responses on which actions supervisors are most likely to use to motivate outreach workers.
KEY RESULTS – WORK CLIMATE

- Salary amounts were \textit{positively associated} with the Work Climate attributable to ‘Monetary Rewards and Resources’ – outreach workers with higher salaries were more satisfied with this attribute of their work climate.

- Supervisors’ motivating actions consisting of encouragement, support and recognition is \textit{positively associated} with Work Climate.

- Drugs, equipment, tools and resource availability was positively associated with work climate scores.

- \textit{Personal safety was ranked as important to work climate}
EVIDENCE ON OTHER FACTORS MOTIVATING ASHAS

ASHA motivation also determined by factors apart from remuneration:

- Odisha study: Level of motivation highest on intrinsic job satisfaction factors (such as self-efficacy, social responsibility and altruism).
  - Remuneration through activity-based incentives seems to motivate performance despite feeling of under-remuneration (Gopalan et al., 2012)

- Lack of ‘employee status’ (unlike other frontline worker cadres), defined career path, promotion or recognition for positive performance gives rise to job insecurity and de-motivation (Sharma et al., 2014)
This study examined the predictors of use of 4 services: (1) immunization information and services, (2) food supplements, (3) pregnancy care information, and (4) general nutrition information using data from a cross-sectional survey of 377 AWWs and 383 ASHAs from 400 randomly selected villages in one district in Bihar.

- Monetary immunization incentives for AWWs (OR = 1.55, CI = 1.02–2.36) was a statistically significant predictor of household receipt of immunization services.

- ASHAs receiving incentives for institutional delivery (OR = 1.52, CI = 0.99–2.33) was marginally associated with higher odds of receiving pregnancy care information.

- AWWs receiving immunization incentives was associated with significantly higher odds of households receiving general nutrition information (OR = 1.92, CI = 1.08–3.41)

- Providing performance-based incentives for product-oriented services is associated with improved delivery of those services and may also have important spillover effects on information-oriented services.
CONCLUSIONS AND QUESTIONS

Motivation Matters

Money matters

But, supervision, recognition (non-cash), and community recognition, investment in capacity, and timely and ‘fair’ payments matter.

How do we address demotivation?

Other models to augment P4P?

Other goals like equity?
WORKING WITH OTHERS? WOMEN AND CHILDREN HAVE INTERACTIONS WITH MULTIPLE STAKEHOLDERS FOR SERVICE ACCESS AND ADOPTION OF LIFE-SAVING PRACTICES

To address NMR, IMR, and MMR, our systems are tailored to reach...

These target groups are often strongly influenced by many others for different behaviors...

Pregnant women

Eligible couples (primarily married women, regardless of parity)

Recently delivered women (RDW)

Husbands

Mothers-in-law

Front-line workers: ASHAs, AWWs & ANMs

Women and their institutions like SHGs

Facility-based qualified staff

Trusted informal providers

Local political, religious and community leaders

Mass-media/ Pan-regional/national icons
Indicating for measuring types of motivation

Source: Gagne and Deci, 2005
<table>
<thead>
<tr>
<th>Construct</th>
<th>Scale Items</th>
</tr>
</thead>
</table>
| AMOTIVATION               | • I sometimes feel my work here is meaningless  
• It is hard for me to care very much about whether or not the work gets done right  
• I frequently think of quitting this job  
• I don’t know why I work in this job, too much is expected of me |
| EXTERNAL REGULATION       | Rewards only  
• I only work here so that I get paid at the end of the month  
• I work here because of training opportunities  
• I work here because of opportunities for promotion  
• I work here because it provides long term security for me  
• I work here because the pay reflects each individual worker's contribution fairly  
• I work in this facility/hospital because it has sufficient resources I need to do my job (medicine, equipment, infrastructure) |
| INTROJECTED REGULATION    | Self-worth contingencies  
• My opinion of myself goes up when I do my job well  
• It is important for me that I get respect from the community for my work (modified)  
• It is important for me that I get recognition from my supervisor  
• If I didn’t have supportive colleagues, I would not like this job. |
## Indicating for measuring types of motivation

<table>
<thead>
<tr>
<th>Construct</th>
<th>Scale Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDENTIFIED REGULATION</td>
<td>• I feel a great deal of personal satisfaction when I am able to ensure better health/nutrition in the community (modified)</td>
</tr>
<tr>
<td></td>
<td>• The work I do in this job is very meaningful to me</td>
</tr>
<tr>
<td></td>
<td>• I feel a very high degree of personal responsibility for the work I do on this job</td>
</tr>
<tr>
<td></td>
<td>• I feel I should personally take the blame if we do not get high coverage of health/nutrition services</td>
</tr>
<tr>
<td></td>
<td>• I am glad that I work in this facility/hospital/block/district rather than any other in the state</td>
</tr>
<tr>
<td>INTEGRATED REGULATION</td>
<td>• Whether or not this job gets done right is clearly my responsibility</td>
</tr>
<tr>
<td></td>
<td>• I work in this job because it is part of the way in which I have chosen to live my life</td>
</tr>
<tr>
<td></td>
<td>• I work in this job because it allows me to use my skills (modified)</td>
</tr>
<tr>
<td></td>
<td>• I work in this job because I can accomplish something worthwhile in this job (modified)</td>
</tr>
<tr>
<td>INTRINSIC MOTIVATION</td>
<td>• I work here because I am doing the work I always liked</td>
</tr>
<tr>
<td></td>
<td>• I work here because I simply enjoy doing this work</td>
</tr>
</tbody>
</table>
## Indicating for measuring work climate

<table>
<thead>
<tr>
<th>Construct</th>
<th>Definition</th>
<th>Scale Items</th>
</tr>
</thead>
</table>
| Job design        | Is the work doable, interesting, worthwhile, well-paid, etc. You have quite a few factors here. | • Amount of your salary  
• Job security  
• Opportunities for training  
• Opportunities to use skills  
• Amount of other allowances (housing, transport, uniform)  
• Frequency of salary payments  
• Amount of annual leave  
• The amount of work you have to do |
| Job feedback      | Is there sufficient feedback from supervisors, colleagues and other stakeholders, is terms of suggestions and recognition. | • Frequency of supervision visits/meetings  
• Recognition received from co-workers on performing well  
• Recognition received supervisors on performing well  
• Fairness and transparency with which your performance is measured  
• Level of accountability you feel from supervisors and co-workers  
• Appreciation of your ideas by the management  
• Clarity with which your role and responsibilities are described to you |
| Job empowerment   | Not only does one have enough autonomy, but also the resources to make it happen and a lack of needless rules and reporting. | • Autonomy to take decisions at work  
• Availability of drugs, supplies and equipment  
• The condition of the facility building  
• Opportunities to participate in decision-making  
• Personal safety at work |
## Indicating for measuring work climate

<table>
<thead>
<tr>
<th>Construct</th>
<th>Definition</th>
<th>Scale Items</th>
</tr>
</thead>
</table>
| Team composition              | Does one have competent colleagues with complementary skills.             | • The number of staff available  
• Capability of team members to carry out work  
• Attitude of team members |
| Team decision-making          | Are decision made quickly, fairly and effectively, and implemented adequately. | • Process of decision-making here  
• Means of communication to disseminate information about decisions made  
• Speed with which decisions made at meetings are implemented into practice |
| Team spirit                   | Is there strong mutual support and trust.                                 | • Support your co-workers give you in your work  
• Support your direct supervisor gives you in your work  
• Mutual trust team members have for each other  
• Cooperation amongst team members here |
| Leadership/management confidence | Do people feel that the leaders/managers are competent and trustworthy. | • Leadership/direction that you receive from higher authorities  
• Support received from higher authorities  
• Management of the work in your facility/block/district  
• Motivation received from higher authorities to achieve goals of better health/nutrition outcomes |
THANK YOU