Perception and Performance: Impact of “ASHA-soft” on ASHA Workers in Rural Field Practice Area of a Medical College in Central Karnataka

Antao Faye Rose, Aswin Kumar

Department of Community Medicine, SSIMS & RC, Davangere, Karnataka, India

ABSTRACT

Introduction: “ASHA-soft” is an online system which captures the details of all the incentives received by the ASHAs for the activities done under various health-care services. The most motivating factor for the ASHA is the financial incentives that they get from government. Therefore, it is very important to overcome the hindrances of providing the timely incentives. To ensure this, “ASHA-soft” was launched. It was started in Karnataka in 2016. This study was conducted to know the perception of the ASHA workers about its introduction and the impact that it had on their performance. Objectives: The objectives are as follows: (1) To describe the perceptions of ASHA workers about the usefulness of “ASHA-soft,” (2) to explore the pattern of incentives received by the ASHA workers, and (3) to determine the impact of “ASHA-soft” on performance of ASHA. Methodology: A mixed method approach study was conducted. Two-year data available on “ASHA-soft” was analyzed and was compared with the data and reports of ASHAs 2 years before launch of “ASHA-soft.” Focus group discussion was conducted for ASHA workers to collect the information about their perception about “ASHA-soft” and the impact it has made on their work. Results: Except for the technical difficulty of not being able to enter data at the PHC level, “ASHA-soft” has been well accepted by the ASHAs. There is a steady increase in activities and incentives year by year after implementation of “ASHA-soft,” especially with regard to Family Planning Services and National Programmes and has shown a positive impact on their performance. Conclusion: Implementation of “ASHA-soft” has increased the satisfaction levels of ASHAs especially with regard to incentives received and has a positive effect on the performance of ASHAs.

Key words: ASHA-soft, perception, incentives, activity
Rose and Kumar: Impact of “ASHA-soft” on ASHA workers

As the performance of ASHA is crucial in community health care, we took up this study to know the perception of the ASHA workers about the introduction of “ASHA-soft” and the impact that it had on their performance.OBJECTIVES

The objectives are as follows:
1. To describe the perceptions of ASHA workers about the usefulness of “ASHA-soft.”
2. To explore the pattern of incentives received by the ASHA workers.
3. To determine the impact of “ASHA-soft” on performance of ASHA.

METHODOLOGY

This study was done among the ASHA workers, during the months of July–August 2018.

Study Design

A mixed method approach, with a combination of quantitative and qualitative research methods, was used.

Study Population

All ASHA workers working in the rural field practice area of SSIM & RC, Davangere (Lokikere PHC), and the neighboring Shyagale PHC, who were willing to participate in the study were included after taking informed consent. The ASHAs who were currently not working at the selected PHCs were excluded from the study. A total of 20 ASHAs (ten from each PHC) participated in the study.

Data Collection

Socio-demographic details, background characteristics, and working environment information were collected from study subjects.

For qualitative data, two focus group discussions were conducted, at the respective PHCs, consisting of ten ASHAs each. A guide was prepared to facilitate the FGD and was translated in the local language (Kannada). It was reviewed by staff of our community medicine department to ensure content validity. Eight open-ended questions were used to gather data about the role of ASHAs, the perceived benefits of the “ASHA-soft” and factors that enable or hinder the program.

The FGD was led by the authors of this study and a medical social worker (MSW). The team ensured that they established good rapport before and during the FGDs. Each FGD lasted for around 50–60 min. The principal investigators facilitated the discussions and MSW acted as a note taker. The notes were translated from Kannada to English and back-translated to check for quality.

For quantitative data, record based information collection was done to explore pattern of incentives received and activities done. Reports of ASHAs for 5 months each for the financial years 2014–15 and 2015–16 were reviewed and compared with 5 months data, each for the year 2016–17 and 2017–18 available on “ASHA-soft.” (5 months were considered because – only 5 months data were available on “ASHA-soft” for baseline financial years 2016–17).

Analysis

Data were entered into MS-Excel and presented in the form of frequency and percentages. For the qualitative component, thematic framework approach was used in data analysis.

RESULTS

Out of the total 20 ASHAs, ten ASHAs were in the age group of 30–34 years, followed by six in the age group of 40–45 years. Nine ASHAs belonged to other backward class and six to schedule caste and five to schedule tribe. All were married and most of them had completed secondary level of education [Table 1].

Major category of services activities performed by ASHA for which they were getting incentives were Maternal Health Services, Child Health Services, Immunization Services,

<table>
<thead>
<tr>
<th>Demographic variables</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age group (In years)</strong></td>
<td></td>
</tr>
<tr>
<td>30–34</td>
<td>10 (50)</td>
</tr>
<tr>
<td>35–39</td>
<td>4 (20)</td>
</tr>
<tr>
<td>40–45</td>
<td>6 (30)</td>
</tr>
<tr>
<td><strong>Caste</strong></td>
<td></td>
</tr>
<tr>
<td>OBC</td>
<td>9 (45)</td>
</tr>
<tr>
<td>SC</td>
<td>6 (30)</td>
</tr>
<tr>
<td>ST</td>
<td>5 (25)</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>20 (100)</td>
</tr>
<tr>
<td>Unmarried</td>
<td>0 (0)</td>
</tr>
<tr>
<td><strong>Educational status</strong></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>3 (15)</td>
</tr>
<tr>
<td>Secondary</td>
<td>14 (70)</td>
</tr>
<tr>
<td>Higher secondary</td>
<td>3 (15)</td>
</tr>
</tbody>
</table>
Family Planning Services, National Health Programmes, and Meetings.

The factors shaping ASHAs’ perception about “ASHA-soft” are presented under four key themes from the analysis. Illustrative quotes depict key experiences and themes said by multiple respondents.

1. Awareness about “ASHA-soft”
   In our discussion with ASHAs, it was noted that most of them were well aware about “ASHA-soft.” They knew that it was an online service through which they received their incentives after entering their monthly activities in the software.
   a) “All our monthly activities are entered in the software through which we receive our incentives.” (ASHA#2.3)
   b) “All ASHA workers activities are available in the software.” (ASHA#1.7)

2. Changes in activities and incentives after “ASHA-soft”
   After “ASHA-soft,” the ASHAs became aware of additional activities for which they could receive incentives. This motivated them to do some extra work. However, regarding MCH, even though the activities done by the ASHAs increased, they received less incentives, because in this part of Karnataka, most pregnant women go to their parents’ house for delivery.
   a) “Number Activities done has increased after “ASHA-soft” because of increased awareness about incentives for different activities.” (ASHA#1.5)
   b) “Before “ASHA-soft” things were better in terms of ANC (MCH) since we used to get paid more for registering ANC mother.” (ASHA#2.9)

3. Advantages of “ASHA-soft”
   Most of the ASHA workers felt that ‘ASHA-soft’ was useful. They could go back and check for their data on the various activities done and incentives received, since it is all stored safely in the system. They were also happy about the SMS notification for the transfer of money in their bank accounts.
   a) “All our documents are safe in “ASHA-soft” and all the data that is entered is verified and confirmed. We can check it again whenever required.” (ASHA#2.2)
   b) “We get a SMS notification once the money is transferred to our account.” (ASHA#1.8)

4. Difficulties faced due to “ASHA-soft”
   The ASHAs expressed their dissatisfaction regarding the non-availability of a computer and internet facility at the PHC level. The ASHA has to travel a long distance for doing the data entry. In addition, they also felt frustrated and said it was unfair that they did not receive the incentives for ANC if the women went to their parents’ place for delivery, which was a benefit for the ASHA of the other village.
   a) “We find it difficult to go to other place for data entry since there is no facility for it at PHC level.” (ASHA#1.6)
   b) “If the ANC goes to her mother’s house for delivery, the ASHA worker of that village gets the money if she enters the data first, even though the ANC services were provided by us.” (ASHA#1.3)

Pattern of incentives received and activities done

For incentives to be paid through “ASHA-soft,” department has listed out all components in which ASHA can get incentives, in ASHA claim form and also uploaded on “ASHA-soft” that makes ASHA and supervisor aware that there is much more scope of incentives to ASHA.

There was an increase seen in the payment released to ASHAs from 2014 to 2018 as seen in Figure 1. This includes incentives for the various health-care services. There was an increase from Rs. 62.3 thousand at baseline to Rs. 111.55 thousand after “ASHA-soft.”

Figure 2 shows that the overall performance of ASHAs too increased year after year from 2014 to 2018. This includes activities done in various health services, i.e., Maternal Health, Child Health, Immunization, Family Planning Services, National Programs, and Monthly Meetings. Overall, there was an increase in the activities seen after “ASHA-soft”
implementation from 2016 to 2018 [Figure 3]. With regard to maternal and child health, there was a slight decrease in the activities seen from 2016 to 2017, which increased to almost double for the financial years 2017–18. Family planning services were almost nil before “ASHA-soft,” increased after “ASHA-soft” implementation. There was increase in the activities seen with regard to National Programmes too. After “ASHA-soft,” the highest increase was seen with regard to participating in the monthly meetings. This increase was almost thrice more than baseline.

Comparison of distribution of incentives before and after “ASHA-soft”

There was an increase in the proportion of incentives received for Family Planning Services and National Programs after the implementation of “ASHA-soft.” The proportion of incentives for maternal health services was found to be less after “ASHA-soft” [Figure 4].

DISCUSSION

This mixed method approach study showed that “ASHA soft” has been well accepted by the ASHA workers of the two villages included in our study. The ASHAs perceived it as a good tool for monitoring their activities and getting the payment on time for the various activities done, with an additional advantage of getting an SMS notification about their payment. However, they were displeased about the technical difficulty of not being able to enter data at the PHC level and about decrease in incentives for MCH even after doing the activities. Similar perception was seen in a study by Rathore et al., among ASHAs of Jasol and Pachpadra region of Rajasthan, which concluded that this performance monitoring and online payment system have improved their quality of work life and motivational level. But still, there are some challenges perceived by them – such as errors in entry by ANM’s or by data entry operators, corruption in the system, lack of top management support, and many more that affected the working of “ASHA-soft.”[10]

Our study showed an increment in the payment released to ASHAs from 2014 to 2018. Before “ASHA-soft,” most of the ASHA workers were not aware of the various programs for which they could receive the incentives. This changed after “ASHA-soft” implementation. Since the ASHAs were now more aware of the activities for which they could receive incentives, they were more motivated to carry out the activities. Being able to review and compare their incentives with their peers motivated them to compete and perform better. Therefore, it was seen that the overall performance of ASHAs too increased year after year.

There was a slight decrease in the activities seen from 2016 to 2017 with regard to maternal and child health, this is because “ASHA-soft” had just started, and the ASHA workers were not quite aware of the proper reporting process and difficulty as stated in FGD (theme 4b). As a result of which, most of their activities were not reported.

The incentives for maternal health services were found to be less after implementation of “ASHA-soft,” even though the number of activities done in this area was more [Figure 4]. This is because the incentives given for maternal health services was reduced from 2016 onwards (which coincides with ASHA soft implementation) i.e., incentives for institutional delivery was reduced from Rs. 300 to Rs. 200.

Family planning services increased from 2016 to 2018 when ASHA workers motivated and accompanied completed families to undergo sterilization. There was increase in the activities seen with regard to National Programmes, when the ASHAs became aware that they could receive incentives for reporting cases of TB and leprosy. Since the ASHAs were now more zealous to review their work and to submit their claim forms, their participation in monthly meetings too increased.

In a similar study by Jain et al., done in Rajasthan in 2015, it was concluded that “ASHA-soft” had a positive effect on the performance of ASHAs within 1 year. The amount of incentives released increased from 4.1 crore to 7.3 crore, showing an increase of 77% from baseline. Activities for maternal health – such as institutional delivery and maternal death reporting also increased. The total payments for overall child health increased more than double as compared to base month. It also showed an increase in the activities with regard to Family Planning and National Programs.[11]
CONCLUSION

Except for the technical difficulty of not being able to enter data at the PHC level, “ASHA-soft” has been well accepted by the ASHAs. Implementation of “ASHA-soft” has increased the satisfaction and motivation levels of ASHAs as they were now better aware of the other activities that can be done for which they can receive incentives. There is a steady increase in activities and incentives received year by year after implementation of “ASHA-soft” and has shown a positive impact on the performance of ASHAs.

REFERENCES