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Exploring the Motivations and Barriers Affecting Community Health Workers' Performance in the Noida-Greater Noida Region

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Research Article

Keywords: Sexual & Reproductive Health, Community Health Workers, AAWs, ASHAs & ANMs, Performance Motivation

Posted Date: May 3rd, 2024

DOI: https://doi.org/10.21203/rs.3.rs-4190901/v1

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Additional Declarations: No competing interests reported.

Abstract

Community healthcare workers(CHWs) play acrucial role in providing vital healthcare services, particularly in the field of reproductiveand sexual health, as well as other healthcare issues such as maternal care, neonatal health, and child nutrition (RMNCHN) in India. By actively involving the community as healthcare recipients, CHWs contribute to increased acceptance and trust among individuals seeking healthcare services. Therefore, it is crucial to assess the performance motivations and the underlying factors that influence the effectiveness and efficiency of Accredited Social Health Activists (ASHA), Anganwadi Workers (AAW), and Auxiliary Nurse Midwives (ANM).

Objective: The objective of this study is to conduct a comprehensive assessment of the performance motivations and barriers that influence the effectiveness of community health workers, specifically focusing on the ASHAs, ANMs, and AAWs operating in the urban slum areas of Noida-Greater Noida, Uttar Pradesh, India.

Methodology: Thisresearch adopts a cross-sectional design, incorporating a qualitative approach featuring surveys and focus group discussions. The collected data were analysed through NVIVO to extract insights from qualitative data, shedding light on the underlying performance motivations and their determinants.

Conclusions: This study establishes that CHWs in India are overworked and underpaid while highlighting their contributions and relevance to the underserved marginalised masses of India. A high level of performance motivation was found among these frontline workers despite limited resources. However, the sources of motivation seemed to be rooted in concepts such as morality, religion, spirituality, identity, and autonomy. Organisational support, lack of recognition and appreciation from superiors, associated monetary benefits and infrastructure were found to be barriers and demotivators.

Introduction

This study focuses on the crucial role played by community healthcare workers in healthcare services in India. These dedicated individuals are responsible for providing preventive, promotive, and curative health services to under-resourced communities. Despite their vital contributions, they often face discrimination, limited employment rights, inadequate remuneration, and a lack of institutional support. India boasts a substantial workforce of approximately one million accredited social health activists (ASHAs) and 1.4 million Anganwadi workers, making it the largest in the world (Rajya Sabha Debate, 15th Nov 2022). Only females are eligible for ASHA, AAW or ANM (ICDS, 2006). India is home to a vast cohort of ASHAs and AAWs, with approximately one million ASHAs and 1.4 million AAWs, making it the largest workforce of its kind in the world. Notably, eligibility for these roles is restricted to females. ASHAs and AAWs serve as the government's street-level machinery, playing a crucial role in facilitating institutional health support and implementing central or state government health programs.

The role of ASHAs in ensuring reproductive, maternal, neonatal, and child health nutrition (RMNCHN) services is particularly significant. These dedicated workers act as a vital link between the community and healthcare services, promoting awareness, providing support, and ensuring access to essential healthcare. The active inclusion of the community in the recruitment of community health workers has been shown to have a positive impact on acceptance and trust among those seeking healthcare.

To further enhance the performance of ASHAs, AAWs, and ANMs, it is essential to assess the motivations that drive their work and the underlying determinants that shape their performance. By understanding these factors, we can identify strategies to make these community health workers even more effective and efficient at delivering healthcare services. This study aims to examine the performance motivations and determinants of ASHAs, AAWs, and ANMs within the context of India's Accredited Social Health Activists and Anganwadi Workers Program in the urban slum region of Noida-Greater Noida in Uttar Pradesh.

India has three cadres of CHWs. While defining CHWs, the WHO says that “they should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organisation, and have shorter training than professional workers” (WHO Study Group, 1989). The first type is the auxiliary nurse–midwife (ANM), which refers to village-level female health workers. In the 1950s and 1960s, ANMs were trained mostly in midwifery and child health. This expanded to child health immunisation and primary curative care for villagers. In 1986, the National Education Policy gave the ANM program vocational education status. The 2005 National Rural Health Mission (NHRM) highlighted the importance of the ANM as a link between health services and the community. The Accredited Social Health Activists (ASHAs) are supposed to report weekly or fortnightly with a review of their work to the ANMs. The ANMs, along with Anganwadi workers (AWWs), act as resource persons for the training of ASHAs. Anganwadi workers are a functionary of the Integrated Child Development Scheme (ICDS); they maintain *Anganwadi*, which is a mother and child healthcare centre. The ASHAs are all female cadres of CHWs who are constituted by the National Rural Health Mission (NHRM). They are the first point of contact for health services for the deprived sections of society.

With a focus on achieving universal health coverage (UHC), India is moving toward the implementation of sustainable development goals (SDGs). India has a four-tier public health infrastructure (See Fig. 1). According to the WHO-PHFI (World Health Organisation-Public Health Foundation of India) report 2022, the density of health worker stock in India stands at 24.4 per 10000 people, and including AYUSH (Ayurveda, Yoga & Naturopathy, Unani, Siddha, Sowa Rigpa and Homoeopathy) professionals, it stands at 30.2 per 10000 people. This reflects a shortage of a large number of health workers to achieve a density of 44.5 skilled health workers per 10,000 people by 2030 to meet the Sustainable Development Goals (SDGs). This is a space where task sharing becomes important and CHWs come into the picture. Attention to the health workforce is crucial to ensure its management, motivation, retention, competence, supply, equitable distribution, and appropriate skill development.

This study beside aiming to investigate the performance motivation in community health workers, also studies their concerns, issues, and barriers in the course of their service delivery. Thus, while studying what motivates CHWs, this study provides a 360-degree understanding by delving into studying what demotivates them.

Methods

In this study, a qualitative research approach was employed to gather data on the motivations, family support, work-family balance, community engagement, trust, institutional support, and training of community health workers in Noida and the Greater Noida region of Uttar Pradesh, India. The data collection took place through in-depth interviews and focus group discussions conducted from November to December 2023. The participants included accredited social health activists (ASHAs), anganwadi workers (AAWs), and auxiliary nurses (ANMs), who provide community health services, particularly to slum-dwelling women of reproductive age.

To ensure accurate documentation, the participants' narratives were recorded using smartphones and later transcribed and translated from Hindi to English for a wider audience. A total of six slums were selected for the study, with three from each location within Noida and Greater Noida. These slums were chosen as representative samples of established and emerging unplanned settlements characterised by overcrowding, unhygienic conditions, substance abuse, and violence. The selected slums included *JJ Colony* in *Sector 10*, *Chhalera in Sector 45*, and *Harola in Sector 5* from Noida, as well as *Marhara* village, *Naton ki Marhaiya in Kasna, Jewar*, and *Bironda* from Greater Noida.

This research aimed to gain insights into the factors influencing the performance and effectiveness of community health workers in delivering healthcare services to marginalised populations in urban slum areas.

The search for the target respondents began with the exploring institutional structure thread in the health administration of Gautam Buddha Nagar district, Uttar Pradesh (See Fig. 2). After many enquiries and deliberations with the district health administration, the research team connected to the Medical Officers In charge (MOIC) in various CHCs and PHCs across Noida-Greater Noida. Additionally, the block-level support team led us to interact with community health workers such as ASHAs, ANMs, and AAWs in the respective regions, namely, Marhara village, Naton ki Marhaiya in Kasna, Jewar, and Bironda of Greater Noida; JJ Colony in Sector 10; Chhalera in Sector 45; and Harola in Sector 5 of Noida.

Two Focus Group Discussions consisting of 8 and 5 community health workers one from each Noida and Greater Noida were held through established community connections (Refer Fig. 3). Purposive sampling with assistance from district and block-level health officers and snowball sampling were used. The focus group discussions were limited to one hour during the day at a private location selected by the respondents themselves, which were located within the area of their operation.

Fourteen in-depth personal interviews were conducted with key respondents active in the selected slum areas (Refer Fig. 3). A prior appointment was held with the respondents before the meeting for the interview. The moderator team consisted of either one male and one female or, on one occasion, two males along with one individual engaged in recording the statements. The respondents were selected either by direct reference to health officials in the Gautam Buddha District or by snowballing.

The team of interviewers tried to build a rapport by assuring and ensuring confidentiality and establishing trust. Our approach was to treat the respondents as situated elements in social worlds. The primary objective of these interviews and FGDs was, as Silverman puts, “to generate data which give an authentic insight into people’s experiences” (Silverman as cited in Miller & Glassner, 2004, p. 126). Researchers believe that research may not provide a mirror reflection of the social world but might provide access to the meanings people attribute to their experiences and social worlds (Miller & Glassner, 2004). Moreover, in FGDs and interviews, the respondents sometimes seem to enjoy the chance to “think aloud” about the questions or discussion topics to which the researchers have to be careful.

Prior to commencing the interviews and focus group discussions, all participants were provided with a comprehensive overview of the research project, including its objectives, scope, sponsors, and the identities of the interviewers and moderators. To ensure the confidentiality and integrity of the conversations, a disclaimer was presented, assuring participants that their identities would remain undisclosed. Additionally, verbal consent was obtained from each participant, who emphasised their voluntary participation in the study.

Notably, there was no preexisting relationship between the research team and the participants, ensuring an unbiased and impartial approach to data collection. The research design and methodology employed in this study have been ethically reviewed and approved by the Indian Council of Social Science Research, a reputable governing body established by the Government of India to facilitate and endorse research endeavors in the field of social sciences.

Data collection

After a great deal of deliberation, the topic guides for the interviews and focus groups were developed by the principal and coprincipal investigators and other research team members in consultation with a senior professor and expert on the topic.

Trained researchers with qualitative research experience facilitated each interview and focus group. Two members of the research team were involved in writing the field notes. The discussions with the participants occurred in Hindi, whose mother tongue was later translated by the research team (the same team who conducted/moderated the interviews and focused discussions) who was commanded in both languages.

The data were recorded, transcribed, translated and double-checked for accuracy by research team members. Triangulation with reflective notes was undertaken to reduce researcher bias.

Data analysis

The research data were coded by the investigation team using NVIVO (See Table 1). Transcripts were thematically analysed with the simultaneous use of inductive and deductive methods. All disputes and conflicts were handled through discussion and deliberations until they reached a common consensus. Finally, the findings were reported as per the Standards for Reporting Qualitative Research.

Results

A total of 35 participants were approached for interviews, and 27 participants agreed to participate in the focus group. A few declined because of their prior commitment and other engagements. Table 1 describes some relevant characteristics of the participants selected for the research. Table 1 presents the identified themes and subthemes. An additional file, annexure 1, includes some examples of illustrative quotes for each subtheme.

Table 1
Themes and Subthemes

Theme and Subtheme	Description
1. **Coordination among CHWs** 2. **Work Significance Perception**	The coordination among CHWs is deemed necessary for efficient performance of duties and successful accomplishment of the objectives set for the locality. Thus, it is important to gauge whether coordination happens at the grassroot level effectively or the challenges that are faced in coordination. What do CHWs feel about the work they do and how important do they perceive it?
3. **Difficulties and Challenges**	
A. Challenges faced by CHWs due to individual limitation	The issues faced by CHWs in their personal life like ageing, disease, financial concerns, domestic responsibilities, etc., became a roadblock in carrying out their job efficiently.
I. *Ageing*	CHWs face challenges due to the physical demands of the task.
II. *Digitalisation & Complex documentation process*	CHWs face difficulties in documentation processes due to digitalisation and compulsory usage of Smartphone apps
III. *Financial*	When finances became a hurdle in carrying out the job efficiently.
IV. *Household Responsibilities*	CHWs share their concerns about the dual burden of work as well as domestic responsibilities.
V. *Lack of Training*	The CHWs felt lack of training affected their job effectiveness.
B. Difficulties on the Professional Front	Difficulties and challenges faced by CHWs in performing their duties due to people's beliefs, knowledge, inhibitions, and constraints.
I. *Desire for Son*	When CHWs felt the desire for sons by people emerged as a major challenge in disseminating their services.
II. *Family will vs Woman's will*	When CHWs feel the major hurdle came when the desire of families did not coincide with that of the woman when it came to want of a kid.
III. *Family's and Individual's Reluctance*	When CHWs face challenges due to people's reluctance to enrol in different programmes or take the recommended measures due to their own beliefs, constraints or inhibitions
IV. *Infrastructure Issues*	When CHWs face infrastructural crunch like proper spaces to operate and function, furniture, other equipment etc.
V. *Sanitary Pads*	When use of sanitary pads was considered a concern by CHWs.
VI. *Substance Use*	When the CHWs felt that the major issue faced by them in their locality was the prevalence of substance use.
4. **Demands and Expectations**	For the successful accomplishment of all the assigned tasks and effective performance, many things come in handy to the CHWs such as their

Theme and Subtheme	Description
	personal motivation level, institutional support, salary and incentives, infrastructural support, appreciation and acknowledgement by the senior officials, availability of necessary tools and equipment etc.
A. Higher Officials Visit	They want officials to visit the field on certain occasions talk to CHWs and listen to their concerns.
B. Prior info about NGO visit	CHWs want a heads up about the NGO visit to streamline/efficient perform the work
C. Salary	Those who raised concerns over salary raise.
D. Trainings	Those who demand additional training.
5. **Ensuring Active Participation of Communities**	Active participation of communities is a necessary precondition for successfully meeting of the set goals. Thus, CHWs have to from time to time take some steps/initiatives for the promotion, sensitisation, and active participation of the masses in the programmes undertaken by the CHWs.
6. **Family Support**	CHWs in order to be efficient need to have a stress-free and supportive family background.
7. **Motivation & Factors of Joining**	Factors that motivated CHWs to join the work.
A. External Factors	External factors/pushes responsible for people to join as CHW such as financial crisis in the family, death of the earning member etc.
B. Internal Factors	Psychological/mental/Individual factors that were responsible for joining as CHW
8. **Recognitions**	Whether CHWs are recognised for their undertaken task and efforts towards the wellbeing of the people.
A. Recognition by Community	
B. Recognition by Higher Officials	
9. **Training**	CHWs whether received any training and what was the nature of the training.

Work significance perception

For individuals to be motivated in their job roles, it is crucial for them to comprehend the significance of their work and to value the tasks they are performing. Put simply, it is impossible to be motivated to carry out a task that is perceived as unnecessary or insignificant. Therefore, to assess the level of appreciation and understanding among individuals working as community health workers (CHWs), it was important to engage in discussions with them. Remarkably, every individual we encountered who agreed to participate in the discussions displayed exceptionally high regard for their work, without any exceptions.

They considered themselves duty-bound to serve the community, despite the limited salary and resources they received.

Their responsibilities encompassed a wide range of tasks, including administering vaccinations, providing assistance throughout pregnancy and delivery, offering counselling on family planning and the two-child policy, conducting awareness campaigns, and supplying basic medicines for both mothers and children. Additionally, they actively participated in public health initiatives addressing diseases such as polio, tuberculosis, and HIV. It was evident from our conversations that each individual possessed a comprehensive understanding of the broader impact of the work undertaken by Anganwadi Workers (AAWs), Accredited Social Health Activists (ASHAs), and Auxiliary Nurses (ANMs), as well as the significance of their interventions at both the macro and micro levels. One ASHA worker, in particular, elaborated on her specific duties and underscored their importance during our discussion.

“We perform duties such as counselling newly married couples regarding their reproductive and sexual health, children's vaccination, benefits of the two-child policy, Polio, etc. Therefore, if we were not there, the people would not receive important information on these issues. Our job is important not only for us and the people but also for the government, as ASHA workers are creating awareness among the people regarding pills, condoms, and abortion.” (FGD, Noida)

Similarly, another respondent who was an AAW explained the importance of her work to us in the following words.

“My role as AAW is very important in delivering health care services in the village as the villagers get vaccinated in time, distribution of rations, running day care.” (In-depth interview, Greater Noida)

Furthermore, AAWs also seemed very aware of the macro situation and their intervention in wider society and the potential effect that it might have.

“Because these children are the foundations of a nation. A good nation is one with morally upright citizens. Anganwadi takes care right from the infant stage up to 5 years old.” (In-depth interview, Noida)

An ANM respondent, while talking to us, apprised us of the changes that she was able to bring with her efforts.

“When I came here, I witnessed that women were dying during pregnancy, as no one was aware of how to treat them properly. Here, poverty and anaemia go hand in hand, and women used to die due to it.” (In-depth interview, Greater Noida)

Motivation and factors for joining

To gain a deeper understanding of the motivations behind individuals joining the field of community health work, inquiries were made regarding their reasons for pursuing such career paths. The responses provided by the participants were classified into two broad categories: external factors, referred to as "push factors," and internal factors, which encompassed more personal and intrinsic motivations, such

as personal ambitions and preferences. By categorising these reasons, we aimed to shed light on the diverse range of factors that influence individuals' decision to pursue a career in community health work.

1. External factors

A significant number of participants highlighted financial hardships as the primary motivating factor behind their decision to seek employment within the local community health workforce. Many respondents shared that they were the sole breadwinners in their families, as their husbands were either unemployed or had passed away, leaving them with the responsibility of supporting their households. Moreover, a few individuals expressed the need for additional income, as other family members did not earn substantial wages. By joining the CHW workforce, these individuals aimed to alleviate their poverty, provide education for their children, and afford necessary medical expenses for sick family members, among other financial obligations. When asked about their reasons for pursuing a career in community health work, respondents conveyed a sense of desperation and necessity.

"My husband had passed away, and my kids were very young. The family was economically weak, and so to support the family, I joined as an ASHA." (FGD, Noida)

"My husband's job was not that good, his income was inadequate to fulfil the needs of the family, family condition was also not that good." (FGD, Noida)

Another reason for joining the community health workforce was to avoid domestic issues that encircled the lives of respondents.

"There used to be 24-hour quarrels at my house; therefore, I decided to come out of home and work, so that I do not have to listen to family fights." (FGD, Noida)

1. Internal factors

The internal factors, including personal ambitions, preferences, and motivations, exhibited a diverse range among the respondents. A subset of participants who entered the workforce expressed a desire for independence and the opportunity to pursue their own ventures. These individuals possessed a level of education and demonstrated a notable degree of self-esteem. In their own words, they articulated

"I always dreamt of being independent since childhood, but I was married off at a very young age. Through the work of ASHA, I am now able to realise my dreams." (FGD, Greater Noida)

"I am a graduate; I did not want to sit back home and wanted to work for my family and myself." (FGD, Noida)

Several individuals were motivated to join the community health workforce based on their personal experiences and observations of the impactful work carried out by CHWs. For instance, one respondent, when reflecting on their decision to pursue this career path, expressed

"I came to this village in 2005; I saw people being vaccinated by ANMs, and I enjoyed being with them." (In-depth interview, Greater Noida)

However, others had some grim experience in their life that inspired them to do things for society, and despite knowing the low salary, they voluntarily joined.

"My husband died due to cancer, and while he was alive, I used to visit hospitals with him, and I observed that people were standing in long queues and that there was no one to listen to their issues, further motivating me to do something to benefit people in that stage. There was a vacancy and requested a senior in PHC, and he hired me there to become ASHA. Although my salary was less at that time, it did not affect me." (In-depth interview, Greater Noida)

Similarly, there were others who joined the workforce after leaving a better-paying private job after being inspired by things that they experienced in their own lifetime. They considered their work more spiritual and as a social service rather than just a profession.

"I was working with an export industry, and when I used to see children wandering on the road like cows do, it pained me a lot. I had this desire to do something for them. One day, someone told me that Anganwadi posts had been advertised and that they instantly attracted my attention." (In-depth interview, Noida)

In some cases, the motivation was not uni-causal and included economic or personal satisfaction.

"We joined this profession for a couple of reasons. Primarily, it is for economic reasons, and second, we have to engage children who are better than any other profession. However, there are meagre monetary benefits involved in doing this job. We are doing social service, and it gives us happiness to work with the children. (In-depth interview, Noida)

During the course of the discussion, a fascinating reason for joining the health workforce emerged from a conversation with a CHW. This particular individual expressed a concern for how she would be remembered after her life had ended. Throughout our conversation, it became evident that she held strong religious beliefs, as she frequently made references to God.

"When I will leave here, at least the villagers will remember me, for working for them." (In-depth interview, Greater Noida)

Ensuring active community participation

The core responsibility of community health workers lies in their community outreach efforts, which entail establishing rapport and building trust with individuals residing in the vicinity. In fact, one of the key determinants of successful and effective execution of their responsibilities is the extent to which health workers are connected with the broader community. Therefore, CHWs were asked about the specific measures they undertake to ensure active participation from community members. Their responses predominantly involved conducting door-to-door visits, engaging in follow-up visits, and

establishing personal connections. For instance, one respondent emphasised the importance of persistently following up with individuals, encouraging them to adhere to prescriptions and fostering awareness within the community.

“I do household visits and ask them to come for the meetings. We persistently follow them to join whenever any awareness meeting is held.” (In-depth interview, Noida)

A significant number of respondents highlighted the trust they had cultivated during their tenure of service within the local community. They exhibited confidence and assurance in the trust placed in them by community members to the extent that they claimed that individuals would consume any medication provided by them solely based on the rapport they had established. This testament to the level of trust and confidence in their abilities further underscored the impact of their work as community health workers.

“ I have built trust in the village; if we work properly, even the villagers trust us, and the people participate and listen to our calls. I have 26 registered kids thus far; it keeps increasing or decreasing.” (In-depth interview, Greater Noida)

“They trust us so much that if we give them any random thing to eat in the name of medicine given by the government, they would consume it without any questions.” (In-depth interview, Greater Noida)

Moreover, certain respondents went above and beyond by taking proactive measures to foster active participation and strengthen rapport. They engaged in periodic meetings focused on various awareness programs, organised local rallies, invited locally active nongovernmental organisations (NGOs) to participate, and involved respected and influential individuals from the community. Additionally, they made an effort to include individuals who had directly benefited from the programs, whether in terms of health or other aspects of their lives. These additional steps demonstrated the dedication and resourcefulness of these community health workers in their pursuit of community engagement and empowerment.

“We conduct meetings regularly, and the main or influential people of the village are called to the meeting along with the pregnant women and other residents … We also call NGOs to come, and they distribute food among the people.” (In-depth interview, Greater Noida)

“For that, I organise weekly or monthly meetings with them. Sometimes we stage rallies in which ASHA, supervisors, women and children participate. We write slogans for enrolling more children in Anganwadi. We visit communities and are aware of addiction and illiteracy.” (In-depth interview, Noida)

Respect and Recognition

The importance of recognition, acknowledgement, and appreciation of the work carried out by community health workers was emphasised during the discussions. This recognition holds significance on two fronts: first, from the individuals who receive the services, and second, from the reporting

authorities. Previous research has highlighted recognition as a strong motivating factor for individuals (Luthans, 2000). CHWs often expressed disappointment when asked about whether they received recognition and appreciation for their efforts. However, their demeanor and tone shifted noticeably when discussing the community members they served. Therefore, the analysis of recognition is divided into two parts: recognition from the community and recognition from their superiors.

1. Recognition by the community

In most of the cases, frontline health workers seemed contented for the respect and recognition they received in the community. Some of them discussed the graph and how it changed from nonacceptance and nonwelcoming to an attitude that was one of acceptance and welcome. They emphasised how well they were connected to people in the locality. They unequivocally claimed how much they were respected and supported by all age groups.

“Earlier, we were hardly recognised as no one opened their door for the ASHA workers, but gradually as time passed, people now recognised us and not only opened their doors for us but also offered tea and snacks.” (FGD, Noida)

One of the expected ANMs,

“Yes, they give me a lot of respect. Earlier, the old women in the families were against vaccination, but now, the new generation is accepting, and they engage in all events. Few people call me Doctor Didi, and they shower love and respect for me and listen to whatever I say and trust me.” (In-depth interview, Greater Noida)

Furthermore, they also mentioned how happy they were when they were known by their own names and not by their husband’s and father’s names, as was the case earlier. Everyone knew them by their name in the community. They seemed to be proud of their newfound identity and self-worth.

“The community recognises my work, earlier I was known by my husband's name, now I am known by my name, now the community even knows my husband by my name. I am respected by all the villagers …” (In-depth interview, Noida)

However, respect and recognition in the community were not taken for granted, as one of the participants also spoke otherwise. Sometimes respect and recognition were not common, as one of the workers felt that they were treated well by some people, but many of them did not support them as much as was expected.

“We don’t receive overwhelming support from the community. They have their own engagements. Whatever we can do on our own that’s what counts…. We are treated with dignity and respect by the community whenever we visit them for any purpose. They enquire with us about the doctor’s visit.” (In-depth interview, Noida)

1. Recognition by higher officials

The respondents sounded upset when asked about the recognition and appreciation they received from their superiors. They emphasised the need to visit the field by the superior more often and the need to meet the CHWs and listen to the issues that they were facing in the field. A similar emotion was shared by one of the respondents.

“Even a single word of appreciation is hard to come by their mouth. We accomplish all the tasks, and they take credit.” *(In-depth interview, Noida)*

Family support

The significance of family support in the realm of community health work cannot be overstated, particularly for women respondents who often have multiple familial obligations that cannot be disregarded. Balancing their job responsibilities with domestic duties often leads to direct conflicts. During such instances, they sought support from other family members, although it was not consistently received. All the women respondents unanimously underscored the importance of family support, but their responses varied in terms of the extent of support they actually received. Some of their statements carried an element of ambiguity and paradox, as they initially acknowledged receiving full support from their family but subsequently mentioned the burdensome nature of their lives, citing a lack of sufficient time for sleep. For example, many respondents affirmed receiving support from their family when asked about it.

“My family fully supports in pursuing this work.” (In-depth interview, Noida)

“ 100 percent. It was because of their support that I could join this profession.” (In-depth interview, Noida)

However, the conflict would come to the fore when they were asked to elaborate on their everyday family obligations. For instance, in an in-depth interview conducted in the region of Greater Noida, the respondent said

“My family helped me a lot since the very beginning, and they support me in my decisions, … though I have to wake up early to finish both of my responsibilities.” (In-depth interview, Greater Noida)

Similarly, in the FGD in Noida, the respondent described her life

“I have two daughters, and my husband supports me in household work and taking care of their kids. I have to wake up at 5:00 am daily in the morning, and I go to bed around midnight. I hardly get approximately 5 hours of sleep.” (FGD, Noida)

However, for some of the respondents who lived in a joint family and whose children had already married, their lives seemed less stressed on the family side, especially when the respondents had a daughter-in-law.

❝ I do not need to stress myself for my family (personal life) work, as my daughter-in-law takes care of the family. My husband and my kids support me in carrying out this job." (FGD, Noida)

"We now have daughters-in-law at home who take care of chores. That's how we manage both at home and here. Earlier, it used to be very difficult to juggle between home and work. Our children now ask us to leave this job, but coming to the centre and engaging with these children help us move and feel better." (In-depth interview, Noida)

At the same time, there were a few respondents who unambiguously accepted that she did not receive any help from her family, especially the male members, and that she was solely made responsible for household chores.

"Male members don't contribute much to the home chores, but we manage as we have been throughout these years." (In-depth interview, Noida)

Furthermore, a few respondents shared their experience of being compelled to leave their work due to a lack of family support. In their households, it was perceived as solely their duty to tend to household tasks and take care of family members. Consequently, this led to daily family quarrels, frequent taunts, and an overwhelming sense of burden. Despite facing such challenges and familial pressure, these respondents displayed resilience and determination, refusing to quit their roles as community health workers.

❝ My family members do not want me to be in a job; I have been told to resign from work and stay home and look after the family members. However, I refused to do so and fought with my family to continue working as an ASHA. Family members also complain that the whole day I work outside and fail to perform the household duties, that I am unable to dedicate myself to family life, and that I always remain outside for work. On reaching home in the evening, my family members complain and taunt that I make excuses like having knee pain and back pain to avoid household work." (FGD, Greater Noida)

Coordination among CHWs

Effective coordination plays a crucial role in enabling community health workers (CHWs) to fulfil their responsibilities competently. A lack of coordination can result in the failure to meet official targets and desired goals, rendering their efforts in the field ineffective and leading to frustration among workers. CHWs consistently highlight the importance of robust and coordinated efforts among all grassroots-level health service providers to ensure the efficient delivery of healthcare services. Findings from focus group discussions (FGDs) and in-depth interviews indicate that coordination among CHWs is generally characterised by cordiality and alignment with objectives. For instance, a respondent from Greater Noida mentioned

❝ It's a coordinated effort between ANM, AAW and ASHA workers. We (ASHA) mobilise people and identify pregnant women or children who need to be immunised and inform ANM, and ANM is

responsible for providing them with immunisation or the medical attention that is needed. Simultaneously, Anganwadi workers also work." CHW 1.

Community health workers (CHWs) have demonstrated a strong understanding of the significance of coordinated efforts and shared responsibilities. During the focus group discussion (FGD), when questioned about their work responsibilities and the corresponding coordination duties, a participant from Noida emphasised

It is very important for all to work and coordinate together. ASHA does all survey and mobilisation (of people) work and knows how to bring people to be involved in each activity. ANNs instruct ASHAs and advise them on what to do for specific programmes. Anganwadi workers mainly teach and distribute rations, etc.

Nevertheless, there were instances, particularly during the FGD, where it was observed that coordination did not always proceed as expected. Unforeseen circumstances such as unexpected leaves or absence necessitated adjustments in workload distribution among team members. However, overall, the coordination was effectively managed, and it did not appear to be a significant cause for concern among the health workers.

Difficulties and challenges

The life and professional journeys of community health workers are characterised by arduous challenges. These challenges encompass both personal and occupational aspects. Given that the workforce primarily consists of women, the burdens they face are often twofold – stemming from their work responsibilities and familial obligations. Consequently, the analysis was divided accordingly. On a personal level, the difficulties encountered by these individuals vary, ranging from physical limitations due to aging or mobility issues to encounters of resistance and unwelcoming attitudes from others in their professional interactions.

1. Challenges faced by CHWs due to individual limitations

I. Ageing/Mobility issue

Several of the interviewed health workers were in middle age, and a few expressed concerns about experiencing back pain, which impeded their mobility. In certain slum areas of Noida, the houses were multistory structures, with some reaching up to four or five floors. Climbing the stairs multiple times a day posed a significant challenge for the workers. This was particularly evident in at least two of the slums visited by the research team in Noida. On the other hand, houses in Greater Noida were predominantly low-rise, consisting mostly of one or two stories. One respondent shared their experience of encountering such difficulties.

"Climbing 5 stories every day is not an easy task." (in-depth interview, Noida)

II. Digitalisation & complex documentation process

The government recently digitised all the documentation work of health workers. Now, in addition to the paper documentation, the workers had to feed data into a smartphone application on a daily basis. However, for young and newly appointed workers, it was not so difficult that they could confidently operate their smartphones relatively easily; this was a daunting task for older workers who were currently operating smartphones for the first time. They expressed their pain following words; however, with the help of their colleagues, they were trying to learn the system.

"A lot of work these days is to be performed on tech gadgets like computers, smartphones which are difficult to learn and operate, as there is a lack of training. The newly joined young ASHAs can operate these devices very easily, but the old ones have to struggle with these smart devices." (FGD, Greater Noida)

"Digitalisation is trouble…" (In-depth interview, Noida)

III. Financial

In addition to the financial issues already mentioned, because of the nature of their job, health workers had to travel at odd hours, and many times, they lacked enough money to travel. This situation was especially frustrating for ASHA workers because their remuneration was incentive-based. For instance, one ASHA worker mentioned this problem

"Many a time we do not have enough money even to travel, to help women." (FGD, Greater Noida)

In such a situation, they had to walk or seek loans to reach out to people to serve and perform their duties. One of the workers in the Greater Noida region expressed her agonies

"…we receive phone calls for emergency help from distant areas, and there are no travelling facilities for them to conveniently reach that particular area within a short span of time. At times, they need to walk on foot for miles. (FGD, Greater Noida)

IV. Household Responsibilities

Several researchers have pointed out that with more economic participation of women, the masculinisation of the workplace was contained to an extent, but the feminisation of domestic work remained intact, resulting in a doubling of the burden on working women (Chen, Conconi & Perroni, 2007; Unni, 2013). It very well was reflected in the fieldwork. The health workers many a time seemed worried and had a sense of guilt while they lamented how the family suffered because of their choice.

"I have four kids, and my husband prefers to eat food early in the morning; my two kids are still studying, and it is my responsibility to cook food for them. After that, I report working, and I need to cook once I am back home in the evening." (FGD, Noida)

The majority of the interviewed individuals followed a consistent routine of waking up early in the morning, typically at approximately 5 am, or sometimes even earlier. It was evident from the discussions

that only a few of them managed to obtain a full eight hours of sleep on a regular basis. This aspect of their daily lives was exemplified by the response provided by one of the respondents.

“It is difficult to manage both professional and personal life; I wake up at 4:00 am, 4:30 am or until 5:00 am in the morning, as I need to take care of kids, household work, and 5 to 6 cows. My daily routine is after waking up and taking a bath, I sweep and mop the floor, perform puja, prepare lunch for the kids and the family, have my breakfast, complete some other important household work, and leave for work. After finishing the work of Anganwadi, I returned home, rested for one to two hours, prepared dinner, and finally went to sleep at approximately 8:00 pm or at 8:30 pm.” (In-depth interview, Greater Noida)

Despite managing household affairs and earning a living for the family, they were accused of lacking one or more household responsibilities. Ironically, when most of the respondents were asked whether they were supported by family members for health work, most of them responded affirmatively.

“Sometimes our husbands accuse us of not taking good care of our children due to work.” (FGD, Greater Noida)

1. Difficulties with professional front

In addition to personal difficulties and challenges faced by healthcare professionals, there were also professional challenges that hindered the attainment of desired objectives. These challenges encompassed various aspects, including the lack of essential infrastructure such as furniture, toilets, and suitable seating arrangements for both workers and clients. Furthermore, there were prevalent beliefs among the population regarding the use of prescribed medical treatments. Some health workers also expressed concerns about facing harassment and inappropriate comments from men on the streets or even within the households they visited to provide services. One such comment was mentioned in the discussion.

“… there are some people who try to avoid us, and others would pass comments that we don’t have any work apart from carrying our bags and visiting houses, and asking the same question repeatedly. At times, some men also tease them.” (FGD, Noida)

I. Desire of son

Desire for a son has been an age-old hurdle in Indian society that medical professionals as well as social demographers have been grappling with. Grassroot health professionals who deliver health services to their clientele faced similar problems. Many people avoided contraception or other measures of family planning. These emotions were raised by many people in society. For instance, one of the respondents expressed

“People are so obsessed with having a son that they end up having several daughters and only stop after having a son. (In-depth interview, Noida)

II. Family will vs Woman’s agency

Most of the time, the desire for a son or the decision of family planning is not a personal choice of a woman but a consolidative family decision that includes her in-law's parents and husband. Women's agency in such cases, as in most of the others, is rarely respected. Social demographers, sociologists, and feminists have long identified this issue as a major hurdle behind India's skewed sex ratio, baby boom, poor health of women as well as that of children, poor quality of human resources, etc. The ignorance of women's agency came to be at the forefront of all the challenges identified by the respondents. They mentioned how women's will was ignored or bypassed in the decision to use contraception, sterilisation surgery, etc.

"Even if women don't want kids, their in-laws force them to have kids." (In-depth interview, Greater Noida)

Many times, asking husbands to use contraceptives became the reason for domestic violence. An ASHA worker told us what she had observed.

"They also told us that their husbands don't use contraceptives, and if they tell them to use them, then their husbands end up beating them." (In-depth interview, Greater Noida)

Men and family members showed reluctance to use methods of family planning or other recommended practices.

"Although women want to follow recommended practices regarding sexual and reproductive health, their families prevent them from doing so." (In-depth interview, Noida)

1. The reluctance of families and individuals

Even in the cases of nonfamily planning measures, a strong sense of reluctance was observed on the family part because of numerous economic and imagined health grounds. This concern arose when a health worker noted that parents would avoid vaccinating their kids because kids develop fever after vaccination, which occurs in most cases. Therefore, parents fear that their children will become sick, and despite several counselling sessions, many will not be convinced.

"Many parents avoid taking vaccination to their children, as they get a fever for at least three days, and the parents become worried that their kids will fall sick because of the vaccination." (FGD, Noida)

Despite other complaints about the ineffectiveness of the general medicines that have been previously prescribed by doctors on the recommendation of health workers and on the ground, people also show reluctance to use other prescriptions, such as vaccines or general health drives, that health professionals undertake from time to time.

"Many people complain of various sorts of reactions from vaccines and in-effectivity of our prescription as an excuse of not participating in our call/programmes." (Noida, interview)

Others do not participate in vaccination programmes because of their destiny. They felt things that are in destiny will happen no matter what, irrespective of the measures humans undertake, or their educational

level. They were ready to leave things to destiny. An example of such a response that came into discussion

“We face reluctance during immunisation/vaccination programmes. Some people do not receive any vaccines. They think whatever is in their destiny it will happen. even if they are educated. They say neither our parents nor we have taken any vaccine, so we don’t believe in it.” (in-depth interview, Noida)

Resistance to family planning, desire of sons, want of more children or use of contraceptive measures or sterilisation surgery were not limited to men or family members. Many a time, it involved the consent of the woman of concern as well as the frontline health workers. The health workers noted how women resisted contraceptive measures or sterilisation measures. This became a major hurdle if both of the couples showed reluctance, and counselling them was particularly challenging. For instance, one of the health workers noted that copper T, a birth control device and an inexpensive and effective contraceptive measure that is placed in the uterus through an invasive procedure, used to be removed by the women themselves.

“They remove copper T in 3–4 days on their own and then complain about the doctor …” (in-depth interview, Greater Noida)

Furthermore, many workers complained that many people, including women, were not ready to be counselled on matters of family planning; instead, they offended, insulted and sometimes hurled abuses at workers who tried to counsel them. People would argue that it was their business to have as many children as they wanted.

“They would argue that it is not our business whether they have 8 or 9 children, and would ask us not to interfere.” (in-depth interview, Noida)

“They say whether we have three or four children that’s none of your concerns. We know how to raise children.” (in-depth interview, Noida)

Others consider children to be blessings of the almighty.

“Family planning is one such area where there are some challenges. They say children are the blessings of God.” (in-depth interview, Noida)

In a few instances of discussions that took place, workers mentioned the particular reluctance of the Muslim community living in the vicinity to accept the measures of family planning. However, it is doubtful whether the reluctance was rooted in ‘being Muslim’, as various other factors of a nonreligious nature affected the decisions in the matter of bearing children. Moreover, the workers’ emphasis on ‘Muslims’ may be exaggerated and may come from an individual bias. Additionally, emphasis on religion was absent in non-Muslim cases even though resistance and reluctance to adopt birth control measures were common to many families.

“In the Muslim community, it’s the major challenge. One Muslim parent told me that those who are destined to survive will survive. I tried to convince him, but he did not.” (in-depth interview, Noida)

Health workers noted that the distance between children was a major issue that was ignored by people. Many women become pregnant at a very short interval when their bodies are still recovering from the previous pregnancy.

“Most of the problems we face in dealing with them are related to spacing between children. Some women get pregnant again already having 3 months toddler to take care of.” (in-depth interview, Noida)

One of the AAW workers pointed to an interesting reason why some of the families were reluctant to send their kids to the day centre. As some of the families living in the vicinity are aspirational, they insist on sending their wards to private daycare schools despite having limited resources. However, many of them fail to sustain the expenses their children's names are eventually struck down from those schools.

“They don’t bother much even if we motivate them to send their children. Some parents think that private institutions are better for their children, and when they fail to manage admission due to their financial precarity, they do not even send their children to us. We instruct them that in addition to educational needs, we also provide food. Only a few enrollees their children.” (in-depth interview, Noida)

Another insight that the researchers gathered was related to people’s reluctance to share Aadhar cards. Since the Aadhar card has been made compulsory for accessing the benefits through health workers, they would ask for it. However, people are reluctant to share their Aadhar card details because of the fear that they might be duped, as their bank accounts are also linked with Aadhar cards.

“When we ask them for Aadhar card details, most of them are reluctant to provide the details. They refuse because everything is now linked to it, and the major concern is if someone gets held of their bank account. We have to put effort then to make them understand that we are not scammers. The details are essential for gaining access to government-sponsored programmes. Without Aadhar, we cannot enrol them either even if we know that they live there. The supervisors ask for it. Our incentives and women’s monetary assistance are disbursed only when an Aadhar number is provided”. (in-depth interview, Noida)

IV. Sanitary pads

The frontline workers in both the Noida and Greater Noida regions expressed unanimous concern regarding the lack of access to proper menstrual hygiene practices. They emphasised that awareness was not an issue, as individuals had access to television and other media platforms that provided education on the topic. However, the main obstacle is affordability. Although some NGOs or occasionally the PHCs distributed sanitary pads free of charge, the irregularity in distribution hindered the establishment of consistent habits. Consequently, the high out-of-pocket expenses associated with purchasing menstrual pads posed a financial constraint. The workers revealed that they had to spend approximately 40–50 rupees to acquire a few pads, and at least two packs were required per menstrual cycle for each individual.

"Not everyone uses sanitary pads because of money problems. Sometimes, PHC distributes sanitary pads, and few women receive them. However, it is of no use when it is distributed only sometimes." (In-depth interview, Greater Noida)

"One main reason for not using sanitary pads is their cost." (FGD, Noida)

V. Social Belief

Individuals hold diverse beliefs regarding diseases and associated social practices, drawing information from various sources such as their community, religion, culture, personal observations, taboos, and personal preferences. Overcoming these barriers rooted in personal beliefs becomes exceedingly challenging when the recommended practices of community health workers or healthcare professionals directly contradict them. This discussion sheds light on these beliefs and challenges present in the community. For instance, one frontline worker mentioned an issue regarding sterilisation practices, highlighting the clash between personal beliefs and prescribed guidelines.

"Even for sterilisation, many people have different concepts; people think, due to sterilisation, they might become fat or it might lead to some other complications." (FGD, Noida)

In relation to the utilisation of sanitary pads, participants expressed that individuals often develop a habit of using cloth as a substitute and even believe that cloth is more effective during menstruation. One respondent echoed a similar viewpoint when asked about the reasons behind the nonusage of sanitary pads.

"Those who use cloth material during periods do not like sanitary pads, as during heavy flow, they think cloth is more protective. PHC sometimes distributes pads, but women believe that it is of no use, as they distribute pads only once in a while." (FGD, Noida)

Similarly, there were prevalent beliefs within the community regarding vaccinations. Numerous working parents express concerns that vaccinating their children may result in additional medical problems, which could disrupt their daily work routines. Some health workers also expressed similar sentiments.

"… parents bring their child for vaccination, many parents think that if they get their child vaccinated, their feet will swell, or they will have pain and will cry, and therefore, parents have a fear that it will hamper their work whether to look after their crying child in pain because of vaccination or they will work for a living." (In-depth interview, Noida)

Demands and Expectations

The grassroots workers operated under challenging circumstances, relying on limited resources while facing a heavy workload. Consequently, they faced numerous demands and expectations. These expectations encompassed various factors, such as receiving recognition from higher-ranking officials, their presence in the field, engaging with other health workers, and being informed about active

nongovernmental organisations (NGOs) in the operational area to facilitate coordination and achieve improved outcomes. On the other hand, the workers also raised demands related to salary and training.

1. Higher-Official Visits/Appreciation

Several health workers expressed their anticipation for visits from higher-ranking officials to the field, as they believed that receiving words of appreciation and evaluating the resources provided would serve as a source of motivation and lead to improved performance. This sentiment was echoed by a worker in Greater Noida, highlighting the shared desire for recognition and support among the health workforce.

“When they want us to do something, they dictate to us what we are supposed to do, but they don’t come to help us if we need them. They just want the work and don’t actually provide us with the necessary support …” (Greater Noida, interview)

However, the majority of these suggestions and observations originated from the slums in Noida. This can likely be attributed to the fact that the slums in Noida are older and less organised than those in Greater Noida, where the slums are still in a transitional phase and undergoing development. Noida has a greater concentration of industrial workers, who are more susceptible to substance abuse and crime, as reported by health workers. Additionally, the infrastructural resources in these Noida slums were found to be inadequate compared to those in Greater Noida. Working in these challenging slum areas requires additional motivation for health workers. Consequently, they express greater expectations for senior officials to visit the field and offer words of appreciation.

“Higher Authorities support us verbally, whenever some people threaten us, the authorities would instruct us to return from the field and that the issue will be dealt with later. However, the higher authorities never leave their offices and come for help; eventually, we need to manage it on our own.” (Noida, interview)

“ In times of need or concerns raised by the community health workers, they should be heard, the higher officials should take their time out and visit the field for at least 10 minutes or so. That will encourage the workers.” (Noida, interview)

1. Salary/Monetary/Other Benefits

The issue of remuneration emerged as a significant factor influencing the motivation of health workers, as revealed in the discussions with respondents. Many, if not all, entered the workforce with the aim of attaining financial stability and independence. Some expressed their dissatisfaction with the absence of health security schemes available to other public sector employees. In fact, they highlighted instances where they had to personally bear expenses for transportation and other necessities.

“We do all the data collection, and those who are sitting in the offices are earning much more. They get TA, DA and whatnot. They receive bonuses and appraisals, and we don’t even get a single candy on Diwali.” (Noida, interview)

Similarly, another respondent articulated the need for health insurance to be made available to them.

"We also don't have an Ayushman card (Health Insurance programme of Government of India) or any other benefits that the government gives to other citizens." (Greater Noida, interview)

They, therefore, expected from the government that their salary should be fixed to a dignified level so that they could meet their bare minimum expenses. One of the respondents raised such a demand from the government.

"All we want from the administration is that after providing so many years of service, we must be given proper remuneration." (Noida, interview)

"The government should make us regular employees with a fixed salary that would further motivate us to work with more interest." (FGD, Greater Noida)

Many of them even felt that the salary that was being paid to them was unfair, as the work they performed was difficult and large.

"Salary is very less compared to work given to them." (FGD, Greater Noida)

Many of them, despite having low income from the job, stuck to it for personal autonomy, as the job brought to them individual dignity and provided a sense of self-worth.

1. Trainings

Training is one of the key components that can affect the level of motivation among CHWs, the adequacy of which may increase satisfaction, or a lack of training may lead to frustration. This emotion resonated in the words of many respondents, as one pointed out when asked about the training that she has received thus far in her career.

I would say regular training and workshops be conducted frequently so that we can execute our responsibilities effectively.

Similarly, many of them noted that an inadequate amount of training

"… joined as AAW Sahayika in 2007. Till now I have received training twice only." (She couldn't recollect when was the last time she received the training.) (Noida, interview)

Additionally, there were a few who also noted that they did not receive any training at all.

We don't get skill development training; it is been one year, but no training thus far.

However, in the survey, meetings were frequently held at primary health centres (PHCs) or community health centres (CHCs). In addition, information on several issues was disseminated in those meetings.

"The training was given when we were recruited. Since then, it has been through meetings that we have been provided with new information and how to implement new programmes. One week ago, we were provided information about the leprosy programme. A survey will be conducted from 17 December (2023) to trace leprosy patients." (Noida, interview)

1. Infrastructural Necessities

The availability of infrastructure is a crucial factor that directly impacts performance. In this context, infrastructure refers to essential amenities such as weather-resistant seating areas with tables and chairs, as well as clean toilets. Unlike Anganwadi workers, neither ASHAs nor ANMs received any substantial infrastructural support. The insufficiency of infrastructure was highlighted in both the Noida and Greater Noida regions. A respondent from Greater Noida expressed this concern.

"We need some infrastructure development for the betterment of work. We operate from houses of different people, and we face difficulties, as no one will allow us to sit in their house for the entire day, as they have their own personal life and we also face difficulties during rain and winters." (Greater Noida, interview)

Similar sentiments were observed in the slums of Noida.

"Not a single toilet facility is here." (Noida, in-depth interview)

"We don't have proper space for the centre. Somehow, we could manage to secure this space in front of the ration shop. At least it has an overhead shield. However, on rainy days, we ask children to return to their homes. The situation is the same everywhere." (in-depth interview, Noida)

The facilities provided to Anganwadi workers, particularly in the slums of Noida, were found to be inadequate. They raised several concerns regarding the working area, such as small spaces that were insufficient for the number of registered children and open areas without a roof, which hindered functionality during extreme weather conditions such as rain, intense sunlight, or cold winter days. For example, during a visit to one Anganwadi center, the research team discovered that there were no dedicated sitting spaces, and the center was operating on the side of the street outside a shop. At times, the Anganwadi workers expressed their concerns about the lack of sitting spaces, which forced the Auxiliary Nurse Midwife (ANM) to work from their own places. This poses a safety risk for children, as the ANM's work involved handling medicines and other related tasks.

"they must provide a separate space for ANM, as they don't have one. We have to accommodate them in our Anganwadi Centre. It's the same across India. They keep funds unused but won't construct a single room for them. The ANMs deal with all the medical things that might infect our children." (Noida, in-depth interview)

Discussion

The population of India recently surpassed that of China and is currently inhabited by 1.4 billion people. Singh & Kumar (2017) pointed out that healthcare expenditure in India is three times greater for noncommunicable diseases than for communicable diseases. Moreover, the rate of impoverishment is increasing by 1.61% every year (Singh & Kumar (2017)). In a scenario such as this, the role of grassroots health workers cannot be overstated; therefore, it is pertinent to know the performance motivations as well as the key barriers that affect their performance. This study attempted to assess the key performance indicators as well as barriers. This study establishes how overworked and underpaid CHWs are currently in India. It also establishes their contribution, relevance, and significance to the grassroots level, especially in regard to serving the underserved marginalised masses of India. These frontline workers, despite the limited resources they work with, appeared to be highly motivated towards the performance of the undertaken task; however, the sources of motivations seemed to be rooted in concepts such as morality, religion, spirituality, identity, autonomy, etc. Current working support from superiors, associated monetary benefits, and infrastructure were found to be barriers and demotivators.

This conclusion further supports and is aligned with the findings of Gopalan et al. (2012), who also pointed out that the highest level of motivational factor was related to personal and community satisfaction. They also observed that the least motivational factor was inadequate health delivery status and working modalities, which is also supported by the findings of this study. Similarly, Wahid et al.'s (2019) studies on ASHA's motivational factors revealed that they were mostly driven by a sense of autonomy and self-empowerment, connection and community service, and social recognition, which are aligned with and supported by the findings of this study. However, a small difference lies in the fact that their studies also found that the basic needs of ASHAs were met by the financial rewards received by them, which is considered one of the motivational factors that, in our study, comes differently. Although the monetary incentive was found to be one of the greatest motivations for joining, it later became a barrier because of the minimal pay. A possible explanation could be regional differences in living costs.

Conclusion

The data analysis highlights the motivating factors, barriers, and challenges experienced by community health workers (CHWs) working in the urban slums of Noida and Greater Noida. Based on the suggestions provided by the CHWs, areas for potential intervention were identified.

The study revealed that Community Health Workers (CHWs) who have effectively embraced their roles possess a profound understanding of the importance associated with their tasks. Irrespective of their initial motivations, which frequently centered around securing financial support for themselves and their families, nearly all CHWs demonstrated a notable level of dedication towards their work. The findings from the survey indicated that a significant majority of the participating CHWs exhibited exceptional commitment and industriousness, viewing their role as more than mere employment. Various motivational factors contributed to their enhanced performance, such as a sense of social responsibility, the pursuit of personal freedom and autonomy, the empowerment of their own agency, the acquisition of self-worth and identity, a perception of divine assignment, financial independence, and the ability to

manage household affairs. These factors elucidate why CHWs persist in fulfilling their responsibilities despite receiving meager or insufficient salaries that demand considerable effort on their part (See Fig. 4).

Moreover, the CHWs expressed their personal and professional concerns and articulated their expectations. These concerns primarily pertained to immediate matters that directly impacted their mental outlook, motivation, and approach to work in a negative manner. The raised demands were valid and well-founded, predominantly centered around factors that facilitate efficient performance and the attainment of predetermined objectives. These demands encompassed salary increments, consistent remuneration, regularization of work arrangements, provision of essential furniture and all-weather operational spaces, access to sanitary facilities, and the provision of regular training opportunities. In addition, certain other issues emerged during the discussions, including pressure arising from domestic responsibilities and the added burden faced by women who must juggle professional obligations alongside familial duties. These circumstances resulted in significant stress, reduced sleep, fatigue, and exhaustion. Nonetheless, despite these challenges, the CHWs persist in their role as the backbone and interface of the Indian healthcare system, driven by the reasons previously mentioned. They sometimes expected their superiors to visit the field and asked frontline workers to know the ground reality, difficulties and challenges. They expected that merely sharing a few words of appreciation could further inspire them and will fetch better results (See Fig. 4).

Declarations

Ethics approval and consent to participate

Due approval and 'informed consent' were procured from all the participants/respondents who agreed to participate in the survey. A brief of the purpose of this research and funding details were also shared with the participants.

Consent for publication

Not applicable

Availability of data and materials

An additional supporting file has been attached in journal portal as Annexure 1 that records some of the sample responses in a tabular form. The annexure 1 is anonymised for the privacy concerns of the participants.

Competing interests

There is no competing interest involved to the knowledge of authors involved.

Funding

This study has been carried out as a part of a funded project by Indian Council of Social Science Research (ICSSR), New Delhi, India titled “A Study of Reproductive and Sexual Health in Slum Dwelling Women in India: A Case Study of Noida-Greater Noida Region." ICSSR is not an Ethics Committee/IRB.

Authors' contributions

P.B.: Co-PI of the Project responsible for and involved in survey, writing, analysing, editing, dissemination of the research.

M.S.: PI and overall administration of the project, administering and conducting survey, writing, reviewing, editing and dissemination of the research.

W.B.: Co-PI of the Project responsible for and involved in survey, editing and reviewing of the research.

Acknowledgements

We would like to express our sincere gratitude to ICSSR, New Delhi for their invaluable support and trust in our research team. Additionally, we extend our heartfelt appreciation to Ms. Nungsangyula Imchen and Ms. Anna Imtiaz for their significant contributions and unwavering support in the successful execution of the survey.

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Figures

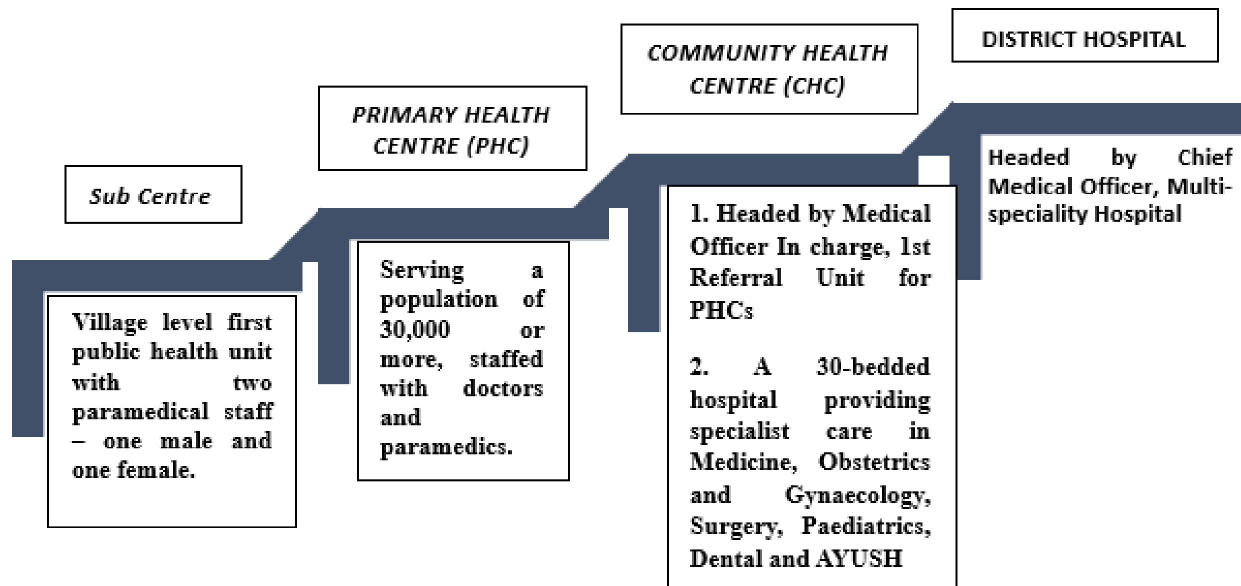

Figure 1

Grassroot Health Administration in India

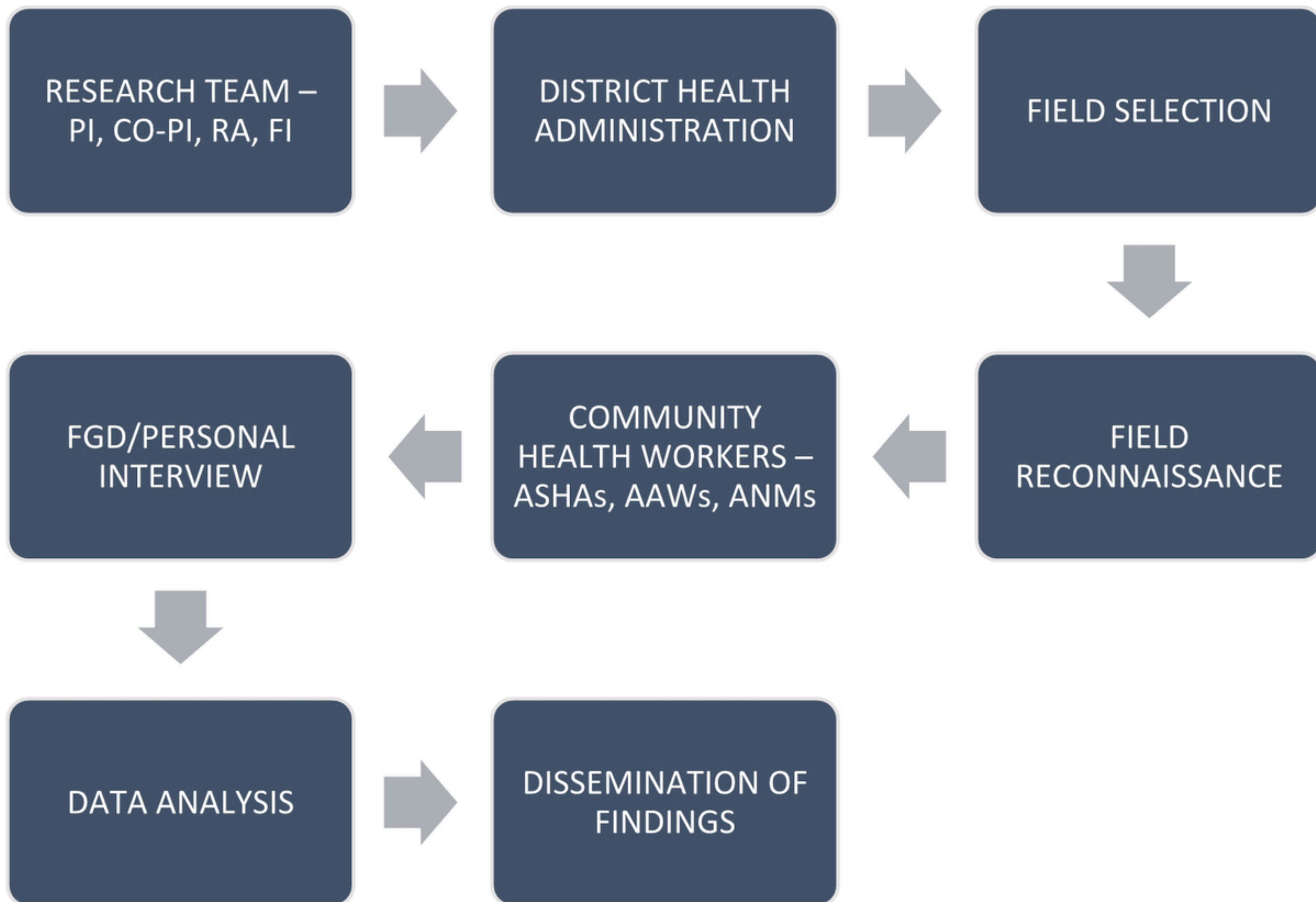

Figure 2

Research Design Flowchart

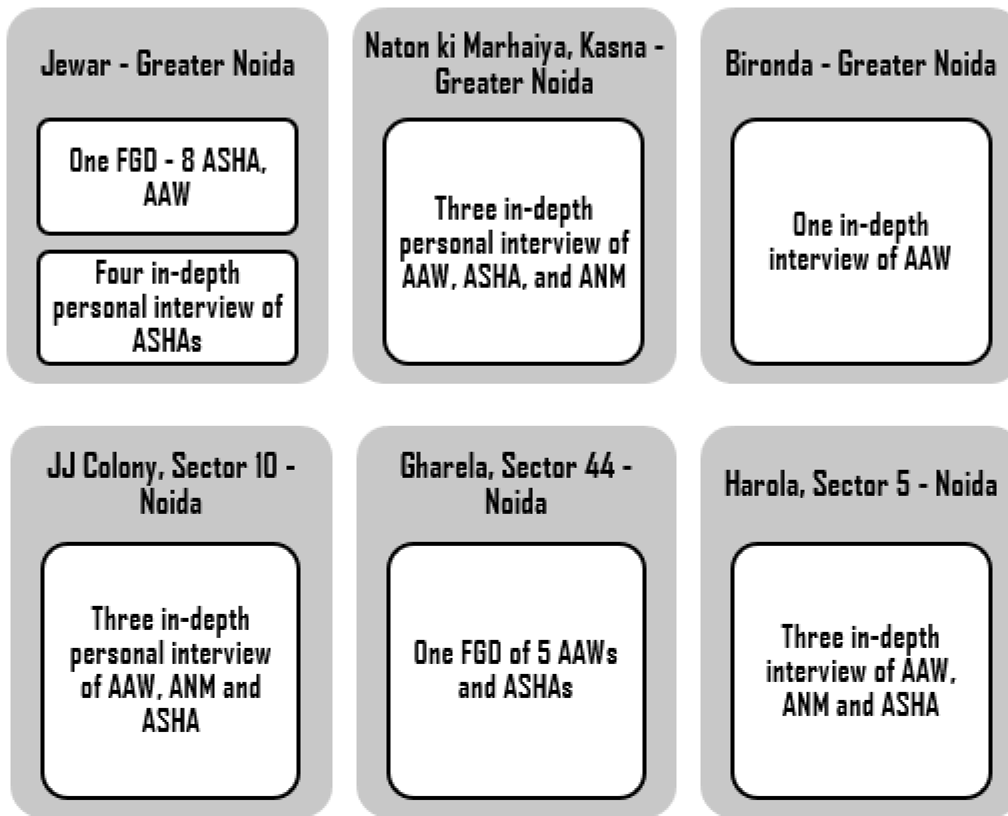

Figure 3

Selection of Participants and their representation from different areas

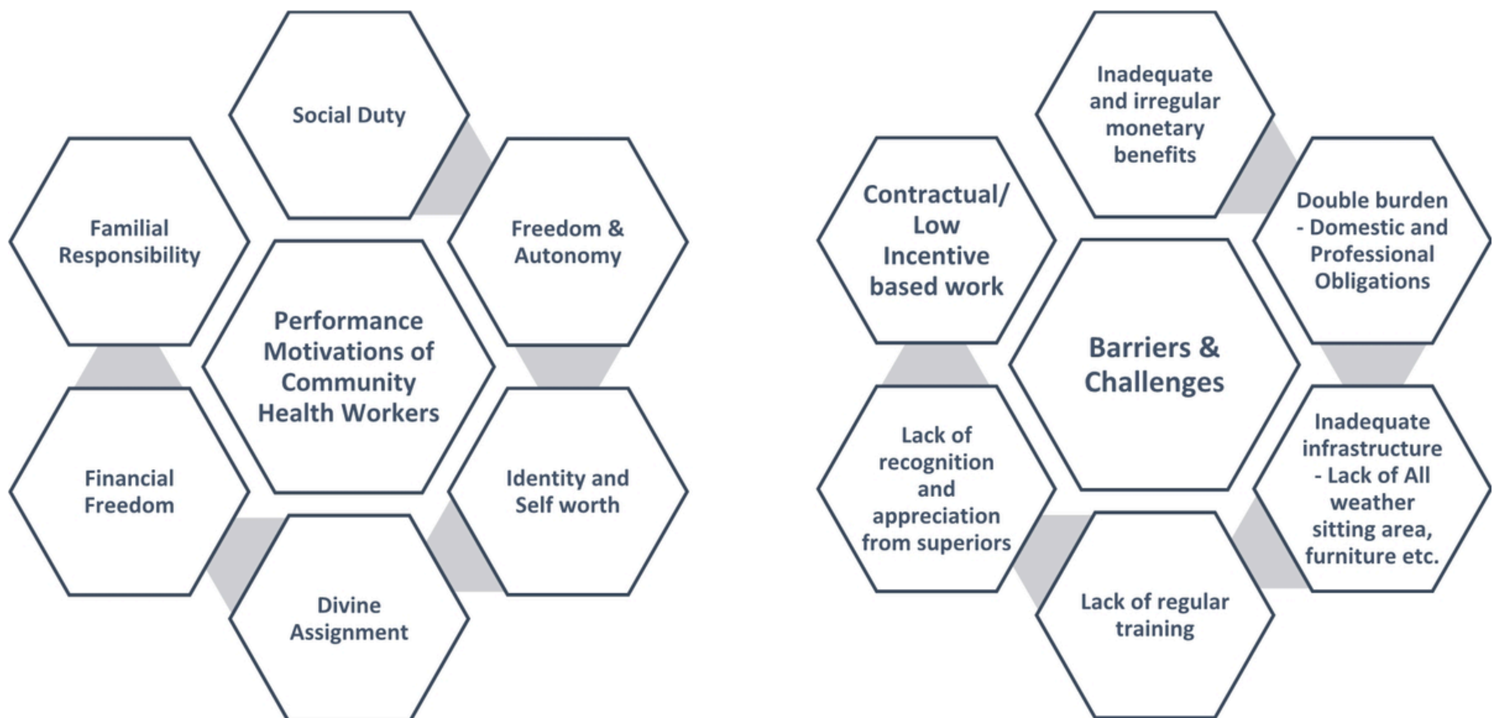

Figure 4

Performance Motivation Factors and Barriers & Challenges