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# EMPOWERING HEROES: ENHANCING THE QUALITY OF WORK LIFE OF ASHA WARRIORS IN KERALA

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## ABSTRACT

This paper throws light on the factors enhancing the quality of work life of ASHA workers in the Global Economy. Today, all the sector of economy is witnessing a sea- change, which are challenging. Accredited Social Health Activists women and their health care activities are considered as one of the key components of National Health Mission. ASHA workers were seen working as the frontline warriors during COVID-19 Pandemic. Balancing work and life are considered to be an on-going challenge in the contemporary times. The integration of information and technology, demands conflicting responsibilities. In this context, the study on empowering the heroes, with the objective of enhancing the quality of work life need to be explored. It examines the role of ASHA WORKERS IN THE KOZHIKODE AND MALAPPURAM DISTRICTS of Kerala. A survey was conducted using a set of established questionnaires. By using exploratory factor analysis, seven factors affecting the quality of work life of ASHA workers were identified. The major challenge that the workers of Kerala face is the irregularity in the payment of honorarium.

**KEYWORDS:** Quality of Work Life, ASHA Workers, Working Environment, Honorarium,

## 1. INTRODUCTION

Quality of Work Life (QWL) is an increasingly popular concept and a generic term which makes a change in the traditional working environment by humanizing the work by taking into account social and psychological needs of the employees. It is a generic term which covers a person's feelings about

every dimension of work like remuneration, job security, working conditions, social integrations etc. In order to measure QWL of employees, different parameters are developed by different researchers. Walton R.E in 1973 had taken up extensive research on QWL and developed 8-point criteria to measure QWL. They are adequate and fair compensation, safe and healthy working environment, opportunity to develop human capabilities, growth and security, social integration, constitutionalisation, total life space and social relevance. Community health workers are men and women chosen by the community, trained to deal with the health problem of individuals and community and to work in close relationship with the health services. They should have a primary education that enables them to read, write and do simple mathematical calculations(Panda et al., 2019). Globally community health workers are known by different names such as health auxiliaries, health agent, health promoters, health volunteers, barefoot doctors, family welfare educators, village health workers, community health volunteers, community health aids and community health workers(Nkonki et al., 2011). A study by Lehman and Sanders in 2007 lists around 40 different names used to denote community health workers in the world(Haines et al., 2007). In India they are called Accredited Social Health Activist (ASHA worker). When we look up on the history of community health workers in India, there are two national schemes, Community Health Worker Scheme (Swasthya Rakshak scheme) introduced in 1977 and ASHA scheme introduced in 2005, both for rural India.

National Rural Health Mission (NRHM) was introduced in 2005 which provides effective health care to rural India with special focus on 18 states. The main strategy of NRHM is to provide access to improved health care at house hold level through a community health worker called ASHA worker in every village of the country. The main objectives of NRHM are reduction in child and maternal mortality, increasing the access of food, nutrition and sanitation of rural people, universal immunization and prevention and control of communicable and non-communicable diseases(National Rural Health Mission, 2005). They provide basic information about the health like nutrition, sanitation and hygiene, healthy living and working condition, information on the present health services and need for the timely use of health and family welfare services. They are acting as a link between community and health facilities (Mahyavanshi et al., 2011). Majority of ASHAs are aware and capable of immunization, accompanying clint for delivery, providing Auxiliary Nurse Midwife and family planning services as a part of their responsibilities. But they still need to put into practice their knowledge about health services while providing advice to poor women and children (Garg et al., n.d.). ANM and GNM courses, together with PIP (age relaxation) support, should be made available to aspirant ASHAs for higher education. Less emphasis should be placed on theory in training modules so that participants can gain a deep understanding of the driving forces behind improving ASHA's performance.(Panda et al., 2019).

Though NRHM was started in 2005, it was implemented in Kerala in August 2006 as ‘AROGYA

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KERALAM'. The goal of the mission is to improve the availability of and access to quality health care to people, especially for those residing in rural area, the poor women and children(Anju et al., 2023). The objectives and strategies of both central and state projects are the same. As a part of AROGYA KERALAM project, ASHA scheme was implemented in Kerala to bridge the gap between health team and rural population on an honorarium basis. One ASHA is for 1000 population selected from the same community and given 23 days training on basic concepts of maternal health, child health, family planning, nutrition, communicable diseases and life style disease management. They work in co-operation with health workers at primary health sub-centers and Anganwadi workers(Saxena & Kumari, 2014). Niti Ayog Health Index Report 2019-20 shows that Kerala's health outcomes are comparable with some upper middle-income countries and high-income countries. For example, Neonatal Mortality Rate of Kerala is similar to Brazil or Argentina. As per this report, Kerala is the champion among the large states by scoring 74.01 overall health index which is two and half times more than the least performing state (UP) (*Health Performance : NITI Aayog, National Institution for Transforming India, Government of India*, n.d.). The state has already reached 2030 Sustainable Development Goal (SDG) target for NMR, which is 12 neonatal deaths per 1000 live birth. In the matter of under-five mortality rate the state is under the target which is 25 births per 1000 live birth.(*THE 17 GOALS | Sustainable Development*, n.d.)

## 2. LITERATURE REVIEW

A number of studies related to quality of work life of different categories of workers are done in different part of the world. An organisation having high quality of work life will attract new talented employees to that organisation and at the same time existing workers will have an intention to continue in their existing firm(Saraji & Dargahi, 2006). The factors affecting the QWL of the workers are different in different organisation depending upon the nature of the working environment of that organisation and these factors have substantial role in satisfying the need of employees(Sinha, 2012). In the field of IT industry the normal working hours of 8 to 9 has no relevance; they are ready to work around 10-12 hours in a day and therefore their QWL factors are extremely different from other employees(Rai & Tripathi, 2015). The factors affecting the QWL of workers in different organisation are different based on the nature of their work, their working atmosphere etc. Community health workers in Kerala make a continuous surveillance study on non-communicable diseases like myocardial infarction, stroke, respiratory diseases and cancer and they have a clear data about the diseases of their locality(Menon et al., 2014). Inadequate and delayed payments, heavy work load, absence of follow up after the training, lack of recognition, no fixed salary, insecurity in health, no travelling allowance, large population to serve and irregular supply of drug kits are the major challenges faced by community health workers in Kerala(Joseph, 2015). The job satisfaction of ASHA workers in Kerala is not adequate especially in the period of Covid 19 in the matters of increased work load for an already under paid work, lack of social security measures and consistent remuneration

delay (Raj,2022). Several studies related to both QWL and community health workers were done but study about the QWL of community health workers are not seen in my literature reviews. So, this study has the aim to go through the factors affecting the QWL of community health workers in Kerala.

## 3. STATEMENT OF THE PROBLEM

As per the new health policy of government of Kerala, the state is planning to establish a publicly funded, free, universal and comprehensive health care system which can bring infant child and maternal mortality rates to the level of developed countries and to increase healthy life expectancy of the population. For the successful implementation of such a policy in the grass root level, the health system should be capable of and willing to do the work honestly(Kutty, 2000). Employees who are provided with high QWL are more productive and no doubt they will be ready to do more work(Nadler & Lawler, 1983). ASHAs, the foot soldiers of Kerala health system have a usual work of spreading awareness about health issues to every family in her ward, which comprises around 500 houses. She has to visit each house at least once in every week. Besides the usual work, they have a lot of additional works at the time of natural calamities and communicable diseases(Mane Abhay & Khandekar Sanjay, 2014). ASHAs have took up this job with a lot of aspirations and expectations and they feel that they are able to manage both their family and work life. As per the normal family customs prevailing in the state, she has to look after the family affairs and it can create many challenges for her, both at home and works place. They are getting only around Rs 8500 per month as honorarium and are at the mercy of junior health inspectors based on the report given by junior health nurse or inspector(Jisha, 2015). During the time of pandemic, they had made door to door survey of families and recorded health status of individuals, monitored returners, people under quarantine and their close contact and ensured supply of medicines and food. She caters to various needs of the society even without proper security measures. These undue pressure causes stress and sense of depression. This study has an intention to enquire about what are the major factors that influence the quality of work life of community health workers and major work life challenges they face in their working environment.

## 4. OBJECTIVES OF THE STUDY

1. To evaluate the factors affecting the quality of work life of community health workers in Kerala
2. To identify the major work life challenges faced by community health workers in Kerala

## 5. METHODOLOGY

A self-designed structured questionnaire was developed to collect primary data. The data were collected from 96 ASHA workers from among 26448 ASHA workers of Kerala (George, 2023) during the month of June 2023. Before collecting data, a pilot study was carried out on 10 workers who were not included in the sample, to identify the possible errors in the questionnaire so as to improve

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reliability (Cronbach's alpha>0.7) and improve clarity with additions of some options and deletions of certain questions. The questionnaire was designed in English initially and latter translated to Malayalam and back translated to English to check the validity of translated questionnaire contained. SPSS version 26 was used for analysis. The study uses Exploratory Factor Analysis (EFA) to examine the data set to identify the complicated interrelationship among items and group items that are part of integrated concepts. EFA does not discriminate independent and dependent variables but clusters similar variables into the same factor to identify underline variables and it only uses data correlation matrix.

## 6. RESULTS AND DISCUSSION

### a. Socio-demographic Characteristics of Respondents

The results of the questionnaire given out to each ASHA workers to fill, in order to collect data on their socio-demographic characteristics reveal that 97% of the workers belong to the age category of 46 to 55 and have working experience of more than 10 years. Regarding educational qualification, around 98% have completed their matriculation even though the basic qualification to become an ASHA is the ability to read and write. It shows the importance the state has given to education. Majority of the workers are married (89%), all of them belong to BPL category and 68% of the respondents are having monthly family income of less than Rs 10000. Demographic characteristics are summarised in Table 1.

**Table 1. Socio- demographic Characteristics of Participants**

| Variable | Frequency (n=96) | Percentage (100) |
|---|---|---|
| **Age** | | |
| 26- 45 | 2 | 2.08 |
| 46-55 | 94 | 97.92 |
| Total | 96 | 100 |
| **Education** | | |
| Below Matriculation | 2 | 2.08 |
| Matriculation | 53 | 55.22 |
| Higher Secondary | 28 | 29.16 |
| Bachelor Degree | 13 | 13.54 |
| Total | 96 | 100 |
| **Marital Status** | | |
| Married | 86 | 89.58 |
| Widow | 4 | 4.17 |
| Separated | 6 | 6.25 |

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| | | |
|---|---|---|
| Total | 96 | 100 |
| **Financial Status** | | |
| BPL | 96 | 100 |
| APL | 0 | 0 |
| Total | 96 | 100 |
| **Monthly Family Income** | | |
| Below 10000 | 66 | 68.75 |
| 10000-20000 | 30 | 31.25 |
| Above 20000 | 0 | 0 |
| Total | 96 | 100 |
| **Working Experience** | | |
| 2-5 Years | 1 | 1.04 |
| 5-10 Years | 2 | 2.08 |
| Above 10 Years | 93 | 96.88 |
| Total | 96 | 100 |

*(Source: Primary Data)*

### 6.2 Cronbach's Alpha

The reliability of the questionnaire was tested using Cronbach's Alpha, which is a simple method to measure whether a score is reliable or not. Here, the researcher has an assumption that there are multiple items measuring the same underlying construct. Job satisfaction of ASHA workers, are affected by different factors of QWL, each signifying different feeling, but when combined, could be said to measure overall satisfaction. If the Cronbach's Alpha is >=0.7 the questionnaire are said to be acceptable/ reliable. The idea is that if the instrument is reliable, there should be a greater deal of covariance among items relative to the variance. A high level of alpha shows that the items in the test are highly correlated (Lavrakas, 2008) [(1).] The Cronbach's Alpha of the questionnaire used for the study is 0.899 so it is said to be reliable.

### 6.3 Factor Analysis

Generally a large sample is recommended for factor analysis but a smaller sample size can also be considered sufficient if solution has several high loading marker variables <0.80(Shrestha, 2021). To determine the strength of relationship among the items, there must be coefficient of correlation >0.3 in the correlation matrix. In this study, correlation matrix shows that there is sufficient correlation to justify the decision of application of factor analysis and can be concluded that the hypothesised factor model appear to be suitable. Kaiser-Mayer-Olkin(KMO) test is used to measure the suitability of data for factor analysis. The KMO value between 0.8 to 1 indicates that the sampling is adequate, value between 0.7 to 0.79 is middling value, value between 0.6 to 0.69 shows that the sampling is mediocre

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and value less than 0.6 indicates that sampling is not adequate and remedial action should be taken. If the sample size is < 300, the average communality of the retained items has to be tested(Tabachnick et al., 2019)and(Kaiser, 1970). An average value > 0.6 is acceptable for sample size < 100, an average value between 0.5 and 0.6 is acceptable for sample sizes between 100 and 200 (Guttman, 1954). Table 2 shows that KMO value of this study is 0.764 which lies between 0.7 to 0.79. Therefore, the sample size is middling and average value >0.6 is acceptable for sample size< 100, since here sample size is 96 ASHA workers. From KMO value point of view the sample is adequate for making EFA. In the matter of Bartlett's Test of Sphericity, the $H_0$: the variables are orthogonal, that is the original correlation matrix is an identity matrix indicating that variables are unrelated and therefore unsuitable for structure detection. Table 1 shows that the Bartlett's test of Sphericity is highly significant at $p < 0.001$ which shows that the correlation matrix has significant correlations among at least some of the variables. Here, test value is 1876.807 and associated degree of significance is less than 0.0001. Hence, the hypothesis that the correlation matrix is an identity matrix is rejected. To be specific, the variables are not orthogonal. The significant value < 0.05 indicates that a factor analysis may be worthwhile for the data set.

**Table 2. KMO and Bartlett's Test**

| | | |
|---|---|---|
| Kaiser-Meyer-Olkin Measure of Sampling Adequacy. | | .764 |
| Bartlett's Test of Sphericity | Approx. Chi-Square | 1876.807 |
| | Df | 378 |
| | Sig. | .000 |

*Source: Primary Data*

### 6.4 Factor Extraction

Table 3 (Total Variance Explained) shows the eigenvalues and total variance explained. Principal Component Analysis is used for factor extraction in this study. 28 linear components are identified within the data set before extraction and after the extraction and rotation only seven distinct linear components within the data set have the eigenvalue >1. These seven factors account for a combined 68.987% of the total variance. The retained factors should at least account 50% of the total variance and here 68.987% of the common variance shared by the 28 variables can be accounted by seven factors. The first component explains 15.297% of total variance with eigenvalue 8.625, second component explains 11.862% with eigenvalue 3.138, third component accounts for 11.531% variance with 2.103 eigenvalue, fourth factor records 8.2% variation with eigenvalue 1.714, fifth factor has 8.1% variance with eigenvalue 1.410, sixth component has the variance of 7.785% with 1.237 eigenvalue and the seventh factor accounts for 6.121% of variance with 1.065 eigenvalue.

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**Table 3. Total Variance Explained**

**Total Variance Explained**

| Component | Initial Eigenvalues | | | Rotation Sums of Squared Loadings | | |
|---|---|---|---|---|---|---|
| | Total | % of Variance | Cumulative % | Total | % of Variance | Cumulative % |
| 1 | 8.625 | 30.802 | 30.802 | 4.283 | 15.297 | 15.297 |
| 2 | 3.138 | 11.208 | 42.010 | 3.321 | 11.862 | 27.159 |
| 3 | 2.103 | 7.511 | 49.521 | 3.229 | 11.531 | 38.690 |
| 4 | 1.714 | 6.121 | 55.641 | 2.296 | 8.200 | 46.890 |
| 5 | 1.410 | 5.034 | 60.676 | 2.268 | 8.102 | 54.992 |
| 6 | 1.237 | 4.418 | 65.094 | 2.180 | 7.785 | 62.776 |
| 7 | 1.065 | 3.803 | 68.897 | 1.714 | 6.121 | 68.897 |
| 8 | .954 | 3.408 | 72.305 | | | |
| 9 | .858 | 3.063 | 75.369 | | | |
| 10 | .755 | 2.697 | 78.066 | | | |
| 11 | .719 | 2.568 | 80.634 | | | |
| 12 | .669 | 2.391 | 83.024 | | | |
| 13 | .620 | 2.216 | 85.240 | | | |
| 14 | .551 | 1.969 | 87.209 | | | |
| 15 | .528 | 1.886 | 89.095 | | | |
| 16 | .478 | 1.706 | 90.801 | | | |
| 17 | .461 | 1.648 | 92.449 | | | |
| 18 | .369 | 1.317 | 93.766 | | | |
| 19 | .322 | 1.148 | 94.915 | | | |
| 20 | .318 | 1.136 | 96.051 | | | |
| 21 | .277 | .989 | 97.040 | | | |
| 22 | .245 | .874 | 97.914 | | | |
| 23 | .221 | .788 | 98.702 | | | |
| 24 | .168 | .601 | 99.303 | | | |
| 25 | .121 | .434 | 99.737 | | | |
| 26 | .035 | .125 | 99.862 | | | |
| 27 | .029 | .102 | 99.965 | | | |
| 28 | .010 | .035 | 100.000 | | | |

Extraction Method: Principal Component Analysis.

*(Source: Primary Data)*

Figure 1 below shows scree test, a graph plotted with component number on x-axis and eigenvalue on the y-axis. There are 28 components on x-axis, the initial factor which has a larger eigenvalue are followed by the smaller factors. The first 7 factors have eigenvalue more than one and remaining factors show a very small portion of variability and are not considered important.

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Figure 1

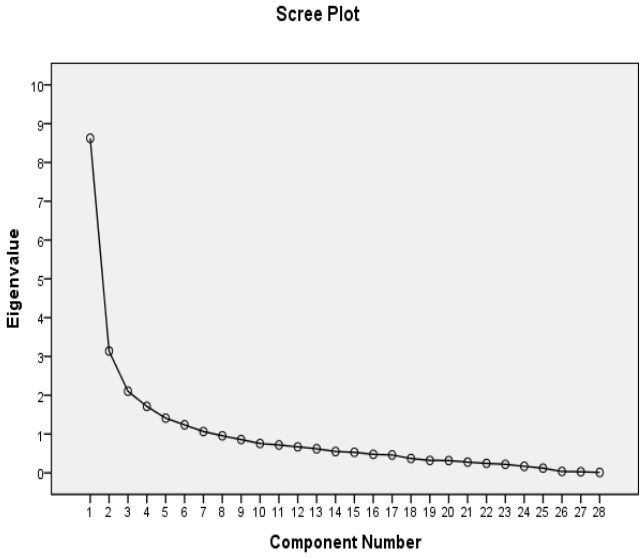


Table 4

**Rotated Component Matrix[a]**

| | Component | | | | | | |
|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Works very fast | .759 | | | | | | |
| Position in the society | .736 | | .422 | | | | |
| Number of different works | .723 | | | | | | |
| Keep learning new things | .707 | | | | | | |
| Authority treats me on equitable basis | .705 | | .427 | | | | |
| Trade union | .692 | | | | | | |
| Motivating environment | .515 | .322 | | | | .310 | |

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| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Opportunity to develop own abilities | | .778 | | | | | |
| Supervisor helps in getting job done | | .704 | | | | | |
| Facilities to give complaint | | .699 | | | .308 | | |
| Insurance is provided by the employer | | .680 | | | | | |
| Dispute settlement mechanism | | .560 | | | | | |
| Appreciation from superior | | .461 | | | | .429 | |
| Social relevance of work | | | .906 | | | | |
| Never felt to quit my job | | | .905 | | | | |
| Job has given me an identity in the work | .335 | | .735 | | | | |
| Supervisor treats me fairly | .353 | | .500 | | | | |
| I am emotionally attached to this work | | | | .879 | | | |
| Proud of myself as ASHA | | | | .876 | | | |
| Reward on time | | | | | .746 | | |
| Fair and adequate pay | | | | | .739 | | |
| Chances of promotion | | | | | .624 | | |
| Working environment is healthy and hygienic | .327 | | | | .313 | .676 | |
| Health and safety | .343 | | | | | .669 | |
| Employees and Mgt. work together to ensure safe working condition | | .433 | | | .322 | .579 | |
| Reward on the basis of performance | | | | | | | .764 |

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| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Time for personal affairs | | | | | .353 | | .603 |
| No fear of loss of job | .323 | | | | | .420 | .528 |

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.
a. Rotation converged in 10 iterations.

*(Source: Primary Data)*

### 6.5 Factor Rotation and Interpretation

Table 4 shows the communality of factor after extraction. The variables with large loadings values > 0.40 indicate that they are representative of the factor. The components which have a communality value more than 0.4 should be taken together and a common name should be given. The component 1 is labelled as **Working Environment** which contains seven items having value more than 0.4. The second component is labelled as **Superior Subordinate Relationship** and has 6 items, component 3 is labelled as **Social Relevance of Work** and has 4 items, component 4 labelled as **Emotional Pride** has two items, component 5 labelled as **Compensation** has 3 items, 6$^{th}$ component labelled as **Health and Safety** is having 3 items and component 7 named as **Job Satisfaction** is having 3 items.

## 7. CONCLUSION

The main objective of the study was to find out the factors affecting the QWL of community health workers, the real Heroes of Kerala's incredible heath system. By using EFA, seven factors were identified. They are working environment, superior subordinate relationship, social relevance of work, emotional pride, compensation, health and safety and job satisfaction. The major challenge faced by the ASHA workers in Kerala is related to the honorarium. Since a portion of their honorarium is paid by the union government and the other portion by state government, the honorarium is not regularly credited to their account. The government orders for sanctioning their honorarium will reach the concerned district authority only after two weeks of publishing. During the last June, one of the trade unions of ASHA named ASHA Workers Federation, conducted a secretariat march with the demand of regular monthly distribution of honorarium. Both the central and state government should take into account the working atmosphere, health and safety measures and wellbeing of the real heroes of the grass root level of our public health system to increase and maintain their efficiency.

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