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ORIGINAL ARTICLE

Evidence to Practice for Mental Health Task-Sharing: Understanding Readiness for Change among Accredited Social Health Activists in Sehore District, Madhya Pradesh, India

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Abstract

Involvement of community health workers (CHWs) within task-sharing to bridge the mental health treatment gap has been proven to be efficacious in randomized controlled trials. The impact of mental health programs based on task-sharing paradigm greatly depends on the performance of CHWs which, in-turn, is influenced by their *readiness for change*. However, there is dearth of literature assessing the role of readiness for change as an important predicator of CHW performance. The aim of this study is to examine the applicability of the readiness for change model and investigate its cultural and contextual nuances among Accredited Social Health Activists (ASHAs), a cadre of CHWs in India, to understand their engagement in mental health task-sharing. We conducted in-depth, semi-structured interviews with a purposive sample of $n=12$ key informants including ASHAs and other healthcare professionals in Sehore district, India. The interview guide consisted of open-ended questions based on the readiness for change factors including ASHAs' attitudes towards their role in mental health care, perception of capability to implement mental health task-sharing, of support from the public health system, etc. Framework analysis with a combined inductive-deductive approach was employed to code the data and generate themes. Participants endorsed three readiness for change themes relevant to task-sharing among ASHAs including change valence or value ascribed to task-sharing, change-efficacy or the perceived ability to implement task-sharing, and job valence or value ascribed to their regular job role. In addition, they provided insights into the culturally and contextually salient aspects of these factors. Themes of personal empowerment, gaining respect and trust from community, professional duty, relationship with supervisors, and lack of resources availability were majorly highlighted. This is the first study to qualitatively investigate the applicability of the readiness for change model and its culture- and context-specific nuances among a cadre of non-specialist health workers in India. Our findings posit that implementation science models should strongly consider the culture and context within which they are being applied to enhance fit and relevance. Further, our results should be taken into consideration to adapt and validate measurement tools and build readiness for change in this population.

Keywords Readiness for change · Task-sharing · Community health worker · Implementation · Global mental health

Background

Task-sharing, or the involvement of Non-Specialists Health Workers (NSHWs) to deliver mental health services, has been at the forefront of efficacy trials for bridging the mental health treatment gap across the globe (van Ginneken et al., 2013). Community health workers (CHW) are an integral part of these efforts, however, there is a current dearth of studies on how to enhance the performance of CHWs in delivering task-sharing based mental health services in routine care settings in low and middle-income countries (LMICs). Some lessons have been learned from a significant body of research as well as practice guidelines that have focused on enhancing the knowledge, skills, supervision, and incentive structure for CHWs for ensuring successful implementation of health services through task-sharing (World Health Organization (WHO 2008; Rowe et al., 2018). However, little attention has been paid to another critical precursor- '*readiness for change*' or CHWs' beliefs,

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attitudes, and willingness towards accepting, adopting, and implementing a proposed change in their duties and responsibilities (Holt et al., 2010).

Task Sharing and Readiness for Change

Since most CHWs are not traditionally trained with a mental health focus, introduction of mental health task-sharing related roles marks a significant change in what and how work is done by them. Consequently, when this change is actively introduced, it may produce negative feelings among the CHWs, ranging from resentment, low motivation, preference for stability, to insecurity, ultimately leading to inadequate levels of engagement with the change intervention (Armenakis et al., 1993; Jones et al., 2008). Previous research has shown higher individual-level readiness for change to be associated with higher levels of initiative and cooperation that ultimately supports the successful implementation of change (George & Jones, 2001; Milella et al., 2021). Moreover, studies have found that knowledge- and skills-based training alone was insufficient in improving CHWs' performance in implementing health care services (Charlson et al., 2019; Heller et al., 2019; Rowe et al., 2018). In other words, even when CHWs are trained and skilled, they won't take on new responsibilities if they are not ready. Hence, readiness for change among CHWs' is crucial to ensure that they engage within mental health task-sharing and perform the shared tasks well (such as screening and diagnosis of mental illnesses or delivering low-intensity psychological treatments) and subsequently cater to the mental health needs of a community. It is of utmost importance to know how '*ready*' the CHWs are for the proposed change before implementing a task-sharing based mental health intervention.

Research on mental health task-sharing has not adequately considered CHW's readiness for change (Raviola et al., 2019), although a few studies have investigated readiness for change at an organizational or structural level (Scaccia et al., 2015; Walker et al., 2020) (for example, Dorsey et al., 2020; Esponda et al., 2020; Myers et al., 2019). Individual readiness for change has been only partly considered by some (for example, Kottai & Ranganathan, 2020; Ravitz et al., 2013; Wall et al., 2020), and thus remains yet to be explored and understood.

Cultural and Contextual Influences on Readiness for Change

Towards our efforts to study readiness for change within task-sharing, it is imperative to acknowledge that the current knowledge of readiness for change is largely based on handful research done in high-income countries (for example, Holt et al. (2007), Choi and Ruona (2013) and Vakola (2013, 2014). Little is known about how this framework applies to other settings. Moreover, previous research has found that culture and the associated values, as well as structural variables such as the characteristics of the intervention, impacts how individuals feel about their job roles, what motivates them, and whether they accept change (Aldulaimi, 2018; Aldulaimi & Sailan, 2012; Neves, 2009; Qamar et al., 2013; Savolainen, 2013).

The current study aims to examine the applicability of the readiness for change model among CHWs participating in task-sharing based mental health services delivery in Madhya Pradesh, India and investigate its cultural and context specific nuances. This can contribute towards its reliable measurement, and advance scientific understanding, along with investigation of strategies to create or enhance readiness for mental health task-sharing in the context of global mental health.

Methodology

Study Setting

This study was carried out following the implementation of the Programme for Improving Mental Health Care (PRIME) that aimed at integrating evidence-based mental health interventions into the primary care system in India (Shidhaye et al., 2016). PRIME's mental health care plan was implemented in Sehore district, a predominantly rural area in the state of Madhya Pradesh, between 2014 and 2016. Sehore was chosen as the study site for PRIME since India's National Health Mission-funded District Mental Health Plan (DMHP) had already been implemented there which provided infrastructural support to PRIME.

ASHAs: The Backbone of Primary and Community Health Care in India

ASHAs are female, volunteer CHWs who are residents of the village that they have been selected to serve. Women, preferably in the age group of 25–45 years who have had education at least up to the 10th grade, are married, divorced, or widowed, and reside within the village are selected by the *gram panchayat*[1] and community groups. Their role entails creating awareness on determinants of health, mobilizing community towards local health planning, and increasing the use of existing health services.

[1] formalized local self-government system in India at the village or small town level.

Table 1 Sample Composition

Key Informant	*n*
ASHAs	3
ASHA Supervisor	2
ANM	2
Primary Care Doctor	3
Primary Care Nurse	2
Total	12

motivation, and duties. The diversity of key informants ensured data triangulation by identifying consistencies and contradictions beyond the experiences of ASHAs, thereby minimizing the potential bias due to social desirability (Patton, 1999).

Interviews were conducted in local language, Hindi, by the first author [first author initials] in August 2018. All participants provided written informed consent. Following an intensive literature review and discussion with PRIME team,

Table 2 Readiness for Change Factors by Holt and Colleagues (2007)

Holt's Model	
Factor	Definition
Appropriateness	Perceived appropriateness of the change for the organization
Management Support	Perceived commitment of leaders for the change
Personal Valence	Perceived benefit to self
Change Self-Efficacy	Perceived capability to implement the change

ASHAs are not traditionally trained to provide mental health care. However, being familiar with the community and its culture, they afford a unique opportunity for extending mental health care closer to the communities (Karol & Pattanaik, 2014). ASHAs usually receive outcome-based remuneration (for example, ₹600(~ USD 8) for facilitating institutional delivery), along with ₹2000(~ USD 27) per month for satisfactory performance of routine tasks (USAID, 2020). Although PRIME's mental health care plan was primarily delivered by case managers (or lay counsellors), ASHAs received public mental health training to screen patients in the community, provide mental health first aid, refer them to community health centers, and provide follow-up care). However, they could not be meaningfully engaged within PRIME given the lack of funds to provide incentives (Shidhaye et al., 2019).

Sampling and Data Collection

Face-to-face semi-structured interviews were conducted with n = 12 key informants (KI). In consultation with PRIME's field staff, KIs were purposefully sampled from a range of service providers, namely ASHAs, ASHAs' supervisors (officially titled ASHA *Sahyoginis*), Auxiliary Nurse Midwife[2] (ANMs), primary care doctors, and nurses (see, Table 1). Eligible participants had received mental health training within PRIME and have had some experience with implementing task-sharing. Participants other than ASHAs had also worked closely with ASHAs over at least the past 3 years so as to be well-versed with their attitudes, the interview guide included open-ended questions based on the readiness for change factors outlined by Holt et al. (2007) (see, Table 2 for a list of these factors). Data were collected until data saturation was achieved (Isaacs, 2014). There were also frequent check-ins with the field support staff and the senior author (senior author initials) to discuss the progress of fieldwork and reflect on data collection.

One participant (an ASHA *Sahyogini*) was invited for a second interview because of the rich experience she had working as and with ASHAs. Interviews lasted between 8 and 45 min and were audio-recorded. One participant did not consent for the interview to be recorded and hand-written notes were taken instead. ASHAs and ANMs were reimbursed for the expenses they incurred to travel to the CHC for the interview.

Ethical approval was obtained from Northeastern University and Sangath's Institutional Review Board.

Data Analysis

Framework analysis with a combined deductive and inductive approach was employed for analyzing interview data (Gale et al., 2013). Familiarity with the data was first obtained through verbatim transcription and translation from Hindi to English by SD. Next, a working codebook was developed using the readiness for change factors reported by Holt et al. (2007) that were utilized to develop the interview guide. These factors were also corroborated with the readiness for change model presented by Weiner (2009) which was selected among others through a comprehensive literature review. Although Weiner's is an organizational-level readiness for change model, two of its constructs i.e., change valence and change efficacy overlap with Holt et al.'s

[2] a village-level midwife and mother and child health worker, each supported by 4–5 ASHAs.

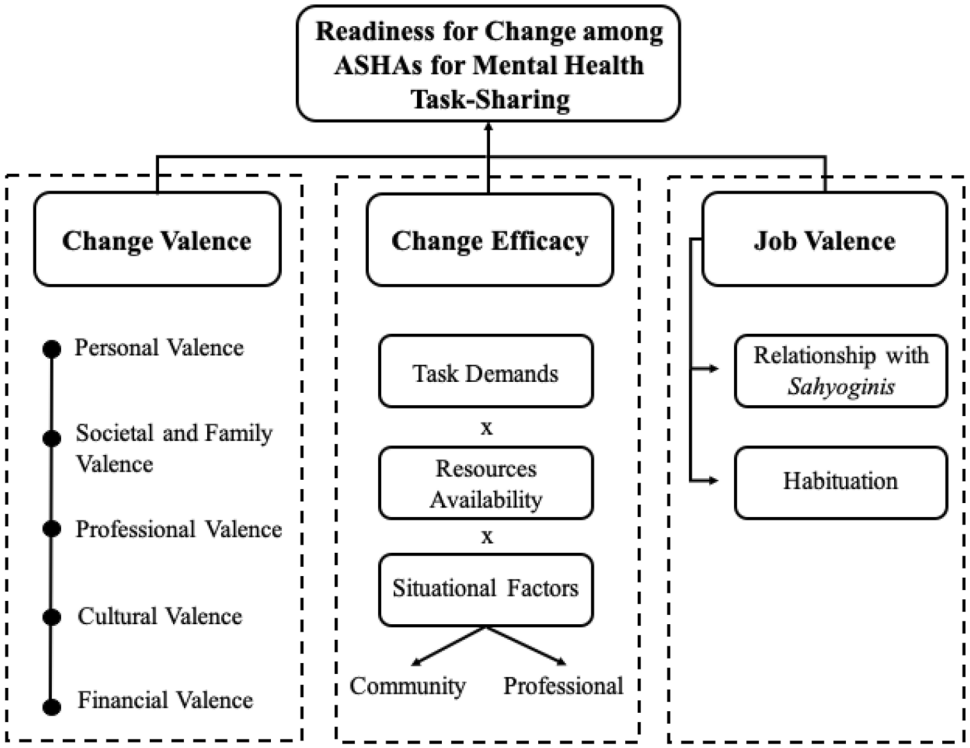

Fig. 1 Factors Corresponding Readiness for Change among ASHAs for Mental Health Task-Sharing

model thereby substantiating their inclusion for the current analysis at the individual level. Subsequently, these preliminary codes were applied to two transcripts whereby model-driven codes were revised within the context of the data, and data-driven codes that did not fit with the initial codes were added. The revised codebook was then reviewed for usability and henceforth applied to the rest of the transcripts. New codes were noted as they emerged and were later applied to the initial transcripts. A second coder (a doctoral trainee) analyzed 25% of the data (three transcripts) using the revised codebook. Along with ensuring the reliability of codebook, this process helped in cross-verifying the interpretation of data, thereby adding conceptual clarity. Codes for one of the transcripts were reviewed by SD and differences in coding styles and inconsistencies were discussed. Finally, coded data was summarized in a matrix where each row represented a participant and each column represented the codes. Excerpts across codes were compared within and between participants to explore participants' peculiar perspectives and experiences along with investigating key elements of readiness for change. All analysis was done in NVivo 12 (released 2018).

The data collection and analysis involved a reflexive process. To reduce the social distance between interviewer and interviewees, interviews were conducted at local CHCs where interviewees felt comfortable. Frequent check-ins with the field staff were also scheduled to discuss progress and reflect on data collection. While analyzing data, reflective memos were written. During the early stages of coding, check-ins among authors further helped in keeping the interpretations and codebook relevant. The final codebook was informed by insights stemming from a deep understanding of contextual and methodological issues.

Results

We present the results of our analysis within three readiness for change themes endorsed by the participants including ASHAs' change valence or value ascribed to task-sharing, change-efficacy or the perceived ability to implement task-sharing, and job valence or value ascribed to their regular job role. In addition, we present their culturally and contextually salient aspects (see, Fig. 1).

Change Valence

Change valence refers to the extent to which implementing a change is perceived as resulting in benefit (Holt et al., 2007; Weiner, 2009). Participants' responses highlighted some distinct valence factors among ASHAs with respect to implementing task-sharing.

Personal Valence

While engaging in task-sharing, ASHAs anticipated to gain praise, respect, and trust of her community members. One of the ASHAs (Participant #01; P01) explained:

> The only gain that we have is…they will praise us more and they will tell their neighbors/friends that, "she's good, she gave good advice"[…]"We should agree with what she says […]".

Improving mental health status of her community led ASHAs to feel satisfied and proud of their accomplishments. Further, in absence of a guaranteed financial incentives, empowerment emerged as a major theme. Making an impact on people's lives and gaining new knowledge were important amidst expectations from ASHAs to be home-makers.

> "Especially when they don't get respect in their families…they all think that if they go out and do something they'll get respect. If we tell them that they'll [be acknowledged], that'll make them feel good." (P10; Primary Care Nurse)

In contrast, some participants outlined scenarios that hindered ASHAs' participation in task-sharing such as being disrespected by the community members for hinting that their family members may have a mental illness, or for "*interfering*" in their private affair.

Societal and Family Valence

Participants highlighted ASHAs sense of belongingness to their community and the desire for it to be free of mental illness. ASHAs also valued their ability to share their knowledge and contribute towards the welfare of families of those with mental illness.

> Our society will get better, […]a change will come about[…] Suppose there is a patient...he can slowly go mad and that will be painful for the village,[…]and so we must get him to be better, we should not let this aggravate. (P04, Second Interview; ASHA Sahyogini)

Of note, ASHAs' societal valence was identified to be informed by mental health stigma. Hence, mental health care was seen as a means to the *"betterment"* of their community. Furthermore, participants also suggested that ASHAs' goals towards societal betterment may take a back-seat in the context of their personal problems, lack of financial incentives, and burn-out.

Professional Valence

Some ASHAs valued their task-sharing roles out of a sense of duty and purpose. Being an ASHA was perceived to entail social work and addressing community members' healthcare problems. With this, engaging in mental health care was rather seen as their duty. An ASHA *Sahyogini* (P06) explained,

> [An ASHA] does a lot of work. For example, she goes house-to-house for surveys. Doing that is in her routine […] Like, she won't just go to the houses where there is a pregnant woman or a 5-year old. If there is a [potential] patient, she would ask about them […] and then she would remember about the training she got and she would share about the services available in the hospital.

Furthermore, ASHAs' professional valence overlapped with their personal and societal valence. Career-related achievements such as receiving a training-completion certificate was also tied to gaining respect in the society. And, knowledge gained through the training was seen as a pathway to help their community.

Cultural Valence

ASHAs work ethics were guided by two Hinduism-centric concepts– "*dharma"*, the religious and moral law governing individual conduct, and *"karma",* the law of cause and effect that holds a person responsible for their action and its effects. They considered it to be their duty to help others and believed that when they helped others, God will take a note of it, as explained by P04 in their first interview,

> Dharma...helping is in our culture, it is in our scriptures. If we do this then God will do good things to us, I mean, God will help us if we help someone.

Further, a culture-centric notion of collectivism and shared-responsibility for better public health was highlighted whereby some ASHAs saw themselves as active stakeholders in their community.

Financial Valence

Participants quoted financial incentives as an important valence factor impacting ASHAs' engagement in task-sharing. They highlighted a continuum of conditions ranging from where ASHAs saw income as a primary reason to be on their jobs to where personal or professional valence preceded the financial value they ascribed to their jobs.

> "There are only a few who think about altruism[…] but not all. Like those who belong to poor households, how would she [work without any pay]." (P10; Primary Care Nurse)

Most importantly, financial remuneration was seen as a tool among ASHAs to trade their freedom and ability to work with their families. Being able to make independent financial decisions was also considered important among ASHAs.

> You should just know that ASHAs are upset only because of one thing—because they get less money. […]And if any peron is working, they work with the hope that they will gain something. […] Otherwise her family members put her down by asking why she is roaming around all day and when would she do the household work, when would she take care of the kids. And so, if we get money, our families would not say anything. (P03; ASHA)

Synergism of Valence Factors

When asked about what made the ASHAs 'ready', participants' responses reflected that no one valence factor may be considered the most important. They all function in synergy and how each factor is prioritized by an ASHA may vary. An ASHA (P04) explained,

> If we talk about benefits, like, first it is that [the ASHAs] get freedom. Secondly, they get an opportunity to step out [of their house], get around, socialize, help [others]. Additionally, they get some financial help as well—whatever work they do, they get an honorarium for it. They get all kinds of knowledge.

Change Efficacy

Change efficacy refers to individuals' perceived ability to implement a change. Participants endorsed that change efficacy was a function of three factors as outlined by Weiner (Weiner, 2009): task demands or appraisal of tasks involved in implementing the change; resource availability or evaluation of the resources needed for implementing the change; and situational factors or assessing how the change can be implemented given the prevailing situational factors.

Task Demands

Participants reflected a clear and favorable appraisal of the actions ASHAs needed to take to implement task-sharing. It entailed being empathetic and providing emotional support, and recommending them to visit the CHC for treatment. Task-sharing also involved engaging in dialogue with the community to share knowledge and to help them navigate their perceived challenges to seeking treatment such as mental health stigma or being busy with income-generating activities. An ANM (P07) recalled how once an ASHA dealt with the family of a patient who were reluctant to send them to the CHC,

> [She] explained to them a couple of times. "You can just get a consultation [at the CHC]; you don't have to take the medicines or do anything else. […] You don't even have to pay for the consultation. Just tell them what you are going through, and if they don't [find anything] just come back.""

However, ASHAs expressed feeling helpless when community members did not cooperate despite their persistence. ASHAs also agreed on the importance of seeking support from supervisors when needed.

Resources Availability

Participants identified both internal and external resources that may impact ASHAs' change efficacy. Internal resources included adequate knowledge about mental health and relevant skills acquired through training. External resources, or the resources provided by the public health system, included having peer, supervisor, and other CHW support. An ASHA Sahyogini (P06) described how "teamwork" led to easier implementation,

> [ASHAs] ask us about what they can do. And then either we go with them, or tell them that the ANM would accompany them[…] So, we all work as a team. At times, Aanganwadi workers can help, so everyone collaborates. Because this [task] cannot be undertaken by just one person.

At the same time, lack of infrastructural resources with the CHC were discussed as a challenge. ASHAs hesitated to refer patients to CHC because of unavailability of overburdened doctors and nurses, inactive dedicated spaces for mental health consultation, and the unavailability of medicines. Additionally, lack of time on the part of ASHAs led to a decreased sense of change-efficacy. To combat some of these challenges, participants suggested building more internal resources such as training ASHAs to be able to fully support their patients, or helping them brainstorm and devise solutions on their own.

Situational Factors

Situational or contextual factors that impacted ASHAs change efficacy largely fell under two categories: community and professional.

Community Mistrust against the public health system and prevalent stigma and taboos against mental illness among the community were identified as major barriers to change efficacy. Families often denied the existence of mental illness or treated it as a very personal matter and did not appreciate ASHAs' 'interference'. Further, some attributed it to demonic possession rendering medical treatment irrelevant.

On the other hand, community's familiarity with and trust for ASHAs facilitated efficacy through disclosure of mental health symptoms by patients and their families.

> They are able to explain their problems better to the ASHA since we are strangers for them. And they trust the ASHA more. A person only shares with the ones they trust the most, especially when it comes to sharing private and personal information. (P11; Primary Care Doctor)

Lastly, ASHAs' socio-cultural characteristics such as belonging to a particular social class or an income-group impacted how easily they were able to interact with the community-members.

Professional Professional hierarchy was also quoted as having an important impact on ASHAs' change efficacy. Primary care nurses and doctors expressed that authority figures such as themselves who might be taken more seriously by the community than ASHAs would be able to advise patients and their families, thereby enhancing efficacy.

> Even if [ASHAs] are good at motivating [patients], but generally people [take them for granted] since they live in the same community and visit them frequently. So, they won't be able to make an impact as much as the nursing staff or doctor can make. (P12; Primary Care Doctor)

Job Valence

Apart from endorsing the model-based elements of readiness for change, participants also highlighted other factors that warrant attention for implementing task-sharing in the longer run, specifically the reasons why ASHAs valued their overall job roles. While many overlapped with the change valence factors such as garnering respect in the community, becoming financially independent, and personal empowerment, there were a couple that were distinct.

Relationship with Sahyoginis

ASHAs' accounts and anecdotes were reflective of the high regard they hold for the *Sahyoginis*. They addressed them as their elder sister and when the *Sahyogini* asked them to do something, it was considered done.

> Whatever Didi [meaning elder sister] orders us to do, it is natural for us [to do that]. Whenever they call us [somewhere], it is our habit to reach there. And so I am ready for anything. (P03; ASHA)

The *Sahyoginis* were able to encourage ASHAs when they were hesitant to take action, and supported them in navigating challenging situations, at work or in daily life.

Habituation

ASHAs also highlighted how their job duties had become habits over time. Though they struggled with their jobs initially but it had now become their routine which they are able to comfortably carry out.

> In early days, [this job] was scary since I had been a house-wife[…]The first year was a bit challenging, but slowly…now everyone knows me. Now it is in my habit. (P02; ASHA)

Discussion

Our findings demonstrate the applicability of readiness for change model among ASHAs implementing task-sharing in India. They also highlight its culture- and context-specific dimensions that particularly draw attention to enhancing the fit of this model among ASHAs and other NSHWs for task-sharing as well as in the context of broader healthcare change initiatives in India and other LMICs.

Diversions and Overlaps with Current Models

In line with Holt et al.'s (2007) model, participants highlighted ASHAs' perception of the benefits to themselves attributable to the change to be an independent factor of readiness for change (i.e., change valence). Furthermore, our results expand the model to include culture- and context-specific nuances within change valence among ASHAs (that we discuss later) which enhance the applicability of the model to the setting. This has important implications for how task-sharing is introduced to ASHAs; if the change message explicitly aligns with what they value, it is likely that they would feel more commitment towards implementing the change. Additionally, Holt et al.'s analysis recognized "appropriateness" and "management support" as distinct factors, however, participants in our sample hinted that these two closely aligned and impacted their change efficacy (in the form of availability of resources). For example, support received from their supervisors was impacted by the importance placed by the public health system on task-sharing. Hence, it is also imperative to ensure that supervisors as well as administrators are delivered consistent messaging regarding task-sharing and other change initiatives while highlighting the benefits it would bring to them to build readiness. Lastly, in line with Holt et al., "change self-efficacy" stood as an independent factor. Findings indicated that support from leaders and the public health system can lead to a

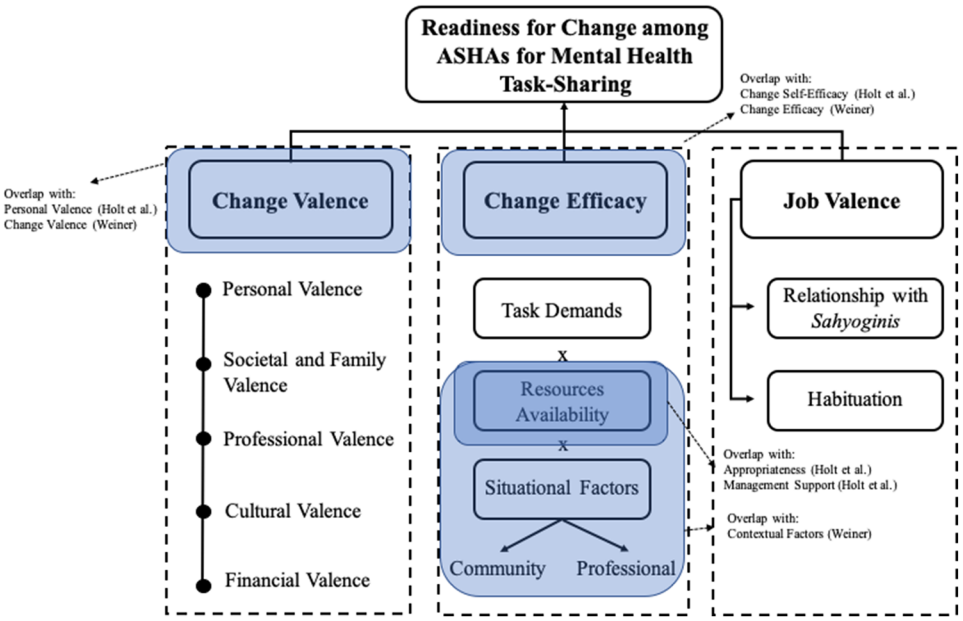

Fig. 2 Adapted Readiness for Change Model among ASHAs for Mental Health Task-Sharing and Overlaps with Factors from other Models

favorable assessment of self-efficacy by ASHAs, leading to appropriate action and persistence.

Furthermore, Weiner (2009) suggested that change valence may also be impacted by a range of contextual factors such as organizational culture, policies, structures, past experiences, etc. On the other hand, in our analysis, valence almost exclusively incorporated ASHAs personal needs, which were influenced by the local culture and context, while contextual factors were assessed by ASHAs to evaluate their self-efficacy. Attempts to assess and build change self-efficacy would need to consider factors such as ASHAs perception of what it will take to implement task-sharing, availability of resources needed to do the same, and if the community and organizational conditions support the implementation of task-sharing.

Finally, job valence, or the value ASHAs placed on their regular job role, emerged as an important aspect of their readiness for change for mental health task-sharing and is a factor that is missing from current readiness for change models. Figure 2 displays the adapted readiness for change model, the factors that overlap with those proposed by Holt et al. and Weiner's models (in blue boxes), and the factors specific to ASHAs participating in mental health task-sharing in India.

Our comparative analysis reveals the most relevant and important readiness for change constructs to be assessed in this population for task-sharing i.e., change valence and its culture- and context-specific nuances, and change self-efficacy including perceived task-demands, resources availability, and situational factors. This also has implications of the larger field of implementation science since readiness for change and other implementation science models are context specific. Such models need to be a '*work in progress*' and constantly consider the culture and context within which they are being applied.

Cultural and Contextual Nuances in Readiness for Change

Our analysis also provides insights into important cultural and contextual influences which may be integral to assessing and building readiness for change among ASHAs.

Modalities in the Value ASHAs' Associated with Mental Health Task-Sharing

Cultural Influences ASHAs gained new knowledge and skills and became change-agents in their communities through task-sharing, thereby bringing a sense of personal empowerment amidst conventional social gender norms in India and expectations from married women to be homemakers. In addition, cultural values such as *dharma*, *karma,* collectivism, and shared responsibility emerged as integral elements of their readiness for change. These results align with previous research that found that such personal and community-level factors impacted the motivation and job performance of ASHAs (Gopalan et al., 2012). It would be essential to include these factors in the assessment of their readiness of change, and to highlight them towards building readiness in this population.

Mental Health Stigma Prevalent mental health stigma in the community impacted the extent to which the community members respected and praised ASHAs for engaging in

task-sharing. Furthermore, ASHAs' negative perception of mental health was reflected in their view that their communities can be saved from "bad influence" through treatment which may further perpetuate stigmatizing attitudes in the community. Hence, measurement of mental health stigma would be imperative for accurate assessment of readiness for change. Further, training and supervision for task-sharing would need to be coupled with stigma reduction programs at the provider and the community level to build readiness. Although there is a dearth of research on reducing mental health stigma among providers, recent interventions such as RESHAPE by Kohrt et al. (2020) have shown promising results. For community-level stigma reduction, social contact or first-person narratives have been found to be most effective (Thornicroft et al., 2016).

Contextual Influences

Identification with the Profession ASHAs valued task-sharing out of a sense of duty and identification with their profession. This has also been identified as an important factor by widely used implementation science models such as the Consolidated Framework for Implementation Research (Damschroder et al., 2009). Further, since task-sharing resonated with one of ASHAs' guiding principles (i.e., addressing the health concerns of their community), they did not see it as distinct from what they had already been doing. Assessing ASHAs' extent of identification with their profession would be integral to measurement of readiness for change rather than focusing solely on the aspects of change in their job role. Furthermore, it may be advantageous to ensure that task-sharing is integrated within their job roles and not introduced as a novel addition.

Role of Monetary Incentives ASHAs valued financial incentives for meeting their needs, for feeling a sense of accomplishment, and for "trading" their freedom from their families. Its implications are crucial given that there is little known about if and how ASHAs or other NSHWs are financially incentivized for engaging in mental health task-sharing. Towards building readiness among ASHAs for task-sharing, it is imperative to highlight that volunteerism is a privilege that ASHAs may be deprived of. This is also highlighted by the WHO's (2008) recommendation that "stipends, travel allowances and other non-financial incentives are not enough to ensure the livelihood of health workers". There is an urgent need to install standard remuneration practices for ASHAs engaging in mental health task-sharing (and otherwise) in alignment with a rights-based approach (Bhatia, 2014). Ballard et al. (2021) recommend some impactful approaches and compensation models for CHWs such as a strong legal framework and public-sector wage floors. However, we acknowledge that providing financial incentives may be especially challenging given limited available funding and possible challenges associated with the dependence of CHWs on monetary remuneration (Bhattacharyya et al., 2001). As a first step, there is a dire need for authors to include information on remuneration models, if any, that are incorporated in task-sharing-based studies. Additionally, their impact on the implementation of task-sharing models needs to be systematically investigated. Furthermore, approaches to fund the CHW programs internally e.g. via self-help groups may be explored. Once financial remuneration mechanisms are in place, readiness assessments would need to measure ASHAs perception of the monetary incentives they receive for engaging in task-sharing.

The Continuum of ASHAs' Needs and Values Relevant to Mental Health Task-Sharing Participants highlighted that the value ASHAs placed on mental health task-sharing varied depending on the needs of ASHAs. For one, financial incentives may be the most valuable, while for another, personal empowerment or societal-valence may take priority. Sometimes, the factors may overlap such as when professional needs aligned with personal and societal needs in our sample. One of these needs may not be the most important, nor every ASHA may endorse all the factors. Hence, categorization and sole focus on any of the factors may not be the panacea for the successful implementation and may ignore that there exists a continuum of valence factors where an ASHA may lie.

Along the same lines, Maes et al. (2010) points out that the various sources of incentives for CHWs are not mutually exclusive. Further, Greenspan and colleagues (2013) posit that intrinsic sources do not preclude CHWs' desire for external rewards and vice-versa. It may indeed be possible to pay ASHAs modest wages and capitalize on factors/needs most important to ASHAs for building their readiness for task-sharing.

Modalities in ASHAs' Perceived Ability to Implement Mental Health Task-Sharing

Change efficacy was expressed to be a function of ASHAs' understanding of the task-sharing roles, assessment of available resources, and prevalent community and organizational conditions. Participants also reflected on some distinctive elements within that are important to be assessed and further researched to build readiness for change in this among ASHAs for task-sharing.

The Interaction of Task Demands, Resources Availability, and Context ASHAs not only educated people in their community and provided referrals, but also helped them navigate logistical challenges. However, they occasionally felt

helpless owing to the prevalent mental health stigma and mistrust against the public health system in the community. While public- and self-stigma have been previously found to impact self-efficacy among those suffering from a mental illness (Jahn et al., 2020; Lian et al., 2020), this needs to be further studied among mental health care providers. Secondly, the trainings helped ASHAs garner knowledge and skills to undertake mental health task-sharing-related tasks, and receiving support from their supervisors enhanced their efficacy. On the other hand, work-burden, lack of supply of medications and infrastructure, and inadequate support from other CHWs and CHC staff negatively impacted it. This further highlights the previously reported important role of effective leadership and peer-support in improving individual, especially health-care providers' job-performance (Afsar & Masood, 2018; Goggin et al., 2015; Pillai & Williams, 2004). In the same vain, the influence of perceived professional hierarchy by community members on ASHAs self-efficacy would also need to be understood further to best delineate task-sharing roles. Lastly, the trust and familiarity ASHAs gained over time in the community enhanced their overall ability to persevere in the mental health task-sharing roles. Measurement of readiness would need to capture such factors.

Socio-Economic Influences The caste and economic divide had a strong impact on how ASHAs carried out their roles. For example, an ASHA belonging to a minority/backward caste was unlikely to visit community members from the majority/upper caste. Such caste-based pattern has been noted by Agrawal (2016) where women belonging to backward groups and who were the less "wealthy" were more likely to receive maternity services by ASHAs. Mishra (2014) also reported that in multi-caste villages, the caste and class status of ASHA impacted the relationship she had with the community-members which further impacted services delivery. It is, thus, important to pay attention to patient-provider match and intentionally plan mental health task-sharing activities within the population sub-groups that an ASHA might belong to.

Building Readiness for Change

Our findings also highlight important processes within ASHAs' routine work that could be capitalized upon to build readiness for change for mental health task-sharing. First, even when ASHAs were not particularly motivated to perform tasks, ASHAs' personal bonds with the ASHA *Sahyoginis* provided them with support and encouragement to navigate barriers. Supervision structures and ASHAs' relationship with their co-workers have been previously found to impact their performance (Sharma et al., 2014). However, further investigation is warranted on how the role of ASHA *Sahyoginis* could be capitalized upon to build readiness among ASHAs for mental health task-sharing.

Second, when task-sharing activities gradually became embedded into ASHAs' routine, their self-efficacy enhanced. The Normalization Process Theory (Murray et al., 2010) may serve as an important framework to further study this. NPT outlines the factors that promote integration of interventions into routine work so that it is normalized. Promotion of normalization of task-sharing through meaning making, collective action, etc. may further build readiness for change.

Of note, building readiness for change should not be considered a solitary, pre-implementation effort but needs to be given constantly facilitated and monitored throughout the entire period of implementation and scale-up (Hemme et al., 2018).

Implications for Future Research

Overall, we suggest future directions to strengthen the evidence base for NSHWs' readiness for change for task-sharing. Our results address the current dearth of systematically developed and tested individual-readiness for change measures and call for considering both cultural and contextual influences while adapting and validating measurement tools. Second, our findings point to the need to quantitatively test the impact of readiness for change on NSHWs' performance within the task-sharing model. This would be crucial to inform their selection for task-sharing and enhance their performance and retention (WHO, 2005). Furthermore, accurate measurement of readiness for change and investigation of its association with the range of implementation outcomes can help us make recommendations for implementation practices.

Strengths and Limitations

To our knowledge, this is the first study to qualitatively investigate the applicability of the readiness for change model and its culture and context specific nuances among NSHWs in India. Moreover, this is the first attempt to study provider-readiness for change within the task-sharing approach. This study also involved primary data collection which afforded an opportunity to collect relevant data and directly answer the research question. Additionally, semi-structured nature of data collection and triangulation of data sources minimized the potential social desirability bias. Lastly, this study serves as a guide to investigate the readiness for change model as a local one with contextual and cultural influences that are important to account when measuring and building readiness.

Nonetheless, our findings should be considered preliminary considering several limitations. First, due to the sample being drawn from a single district, these results may not be representative of all ASHAs perspectives. Further, our findings are generalizable only to those ASHAs and CHWs who have received public mental health training in some capacity. In absence of training or any formal involvement with mental health task-sharing, it is difficult to assess the readiness to change, at least in the way we have operationalized it. Second, we selected a purposive sample and hence, the possibility of researcher bias cannot be ignored. However, a clearly defined eligibility and inclusion criteria might have helped in dissuading it. Third, the cultural and contextual influences presented here are based on the endorsements made by the participants; there is a possibility of other socio-cultural-contextual influences not captured here that would need to be explored further. Future studies should seek to include a larger sample, possibly from diverse geographic areas/sites implementing task-sharing to address these limitations.

Conclusions

Our findings suggest that readiness for change is an applicable model among ASHAs implementing task-sharing. The culture specific elements of personal empowerment, professional duty, *dharma* and *karma*, collectivism, and social responsibility, as well as the context-specific aspects related to financial valence, mental health stigma, availability of resources and community support, are significant when assessing and building readiness for change. We suggest future research to focus on adapting and validating readiness for change measures for this population. This would further contribute towards quantitatively investigating these elements to guide the ASHA-selection process and build interventions to improve readiness for change.

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Declarations

Conflict of interest The Authors declare that there is no conflict of interest.

Ethical Standards The data collection and analyses performed in our study were in accordance with the ethical standards of the institutional ethics committee. All study procedures were approved by the Institutional Review Board (IRB) at Northeastern University (Boston, USA) and Sangath (Goa, India). Informed consent was obtained from all individual participants included in the study. Standards for Reporting Qualitative Research were followed in the preparation of this manuscript.

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