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Donning the mask: effects of emotional labour strategies on burnout and job satisfaction in community healthcare

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Abstract

Emotional labour involves management of one's emotions to match the demands of their roles. This emotion display involves just expression (surface-level emotional labour) or experience in addition to expression (deep-level emotional labour) of the desired emotions. Emotional labour is required in the effective, efficient and successful healthcare service delivery. Burnout associated with emotional labour is an important factor that decides how satisfied frontline service providers with their job are. This empirical study investigates the link between surface and deep-level emotional labour, burnout and job satisfaction in women community health workers from India. Our results from the structural equation modelling of 177 accredited social health activists (ASHAs) indicate a negative relation between surface and deep-level emotional labour, clearly demarcating them as two different strategies for performance of emotional labour in community health care setting. Surface-level emotional labour is associated with higher job satisfaction, and burnout partially mediates this relation. Deep-level emotional labour is associated with lower job satisfaction; burnout fully mediates this relation. Qualitative *post hoc* analysis based on interviews of 10 ASHAs was done to understand the findings of the quantitative study. Surface-level emotional labour was found to be a more desirable strategy for community health care workers for the effective and efficient performance of their work roles. Our results have a significant contribution to design, redesign, and improvement of employment practices in community healthcare. This study brings forth the neglected issues of emotions and their implications for these healthcare workers in low and middle-income countries who are a vital link that delivers healthcare to weaker section of the society. The findings have relevance not merely for the individual providing this service but the beneficiary and the organization that facilitates this delivery. Interventions based on demographic, community, national and occupational factors have also been presented.

Key words: Accredited Social Health Activist; burnout; community health workers; emotional labour; job satisfaction

Key Messages

- We have empirically tested our conceptual model in which the conventional understanding of the emotional labour strategies for service roles is challenged in community healthcare sector.
- We have studied the nuances of emotional management for a category of community healthcare workers who are not full-time employees, have received minimal training, and work in close proximity of their residence in a closely knit society.
- We have looked at emotional labour strategies of ASHA workers who are women community health workers, with low educational qualifications, based in rural setting of a developing country.

Introduction

Community health care enhances the scope of healthcare service from classes to masses. Their presence at grass-roots enables effective, democratic and sustainable delivery of healthcare services to every nook and corner of country (Nambiar *et al.* 2012). The human resource requirement in the health sector in India is influenced by the demand and supply mismatch wherein few healthcare professionals exist to supply healthcare services to a 1.2 billion people (Hazarika 2013). Accredited Social Health Activists (ASHAs) are community health workers instituted as part of the National Rural Health Mission of government of India to bridge this gap of health care service deficit especially in rural setting (Paul *et al.* 2011; Reddy *et al.* 2011) where nurses and doctors are in scarcity. By December 2014, there were ~904 195 ASHAs ('ASHA Status of Selection and Training' 2015). The satisfaction of these workers plays a significant role in deciding the continuity, effectiveness and efficiency of these programmes. Out of the several factors that influence the satisfaction of community healthcare workers (Curtis and Glacken 2014), emotional demands are usually neglected in low- and middle-income countries (LMICs). We try to fill this lacuna by taking into account the bi-dimensional construct of surface and deep-level emotional labour and its impact on job satisfaction through burnout for ASHAs. Our study is also interesting because it indicates that theoretical underpinnings linking these variables for community healthcare workers might be different from the ones for workers in other settings (Hochschild 1983; Mann 2005).

ASHAs for community healthcare

Community healthcare in India is the need of the hour and ASHAs have been instituted to serve the purpose of providing healthcare to the rural population (Pandey and Singh 2015). It has the added benefit of providing employment to rural women. ASHAs are married/ widowed/ divorced women, preferably in the age group of 25–45 years, who are residents of the village they serve. Their educational qualification is preferred to be at least high school certification. However, this criterion is relaxed in case of non-availability of women having this qualification. They are mainly required to motivate pregnant women to utilize hospital facilities. Other expectations from them involve aiding in child immunization, using first aid to treat basic illness and injury, demographic record keeping, village sanitation improvement, etc. An important aspect, which is not explicitly stated is the emotional investment needed in such jobs. This study addresses the issue of the psychological well-being of community healthcare workers in general and women community health workers in particular due to the performance of emotional labour as part of their job roles.

Emotional labour and its strategies

Jobs rich in 'people work' are researched to be emotionally taxing in the form of emotional labour (Maslach and Jackson 1984). Emotional labour is the 'process of regulating both feelings and expressions for the organizational goals' (Grandey 2003, p. 97).

Emotional labour in healthcare

Emotional labour in healthcare has been a topic of interest to many scholars; however, its existence though informally acknowledged is not explicitly taken into account when designing and evaluating healthcare jobs specifically in community healthcare in LMIC countries. For example, in the context of nursing (emergency, community health, community mental health and maternity) it has been seen as an 'under-appreciated aspect of caring work' (Henderson 2001, p. 130) and involving a tussle of 'being ordered to care in a society that refuses to value caring' (Reverby 1987, p. 5). Emotional labour has also been seen as work predominantly done by females, and traditionally male-dominated professions have not accepted this wholeheartedly (Smith and Gray 2000). Nurses have been studied as emotional jugglers who change faces as per emotional requirement (Bolton 2001).

Surface and deep-level emotional labour

Emotional labour is expressed through two strategies of surface and deep-level (Brotheridge and Lee 2003). Surface-level involves 'putting on a mask' to show or fake emotions rather than feeling them (Grandey 2003, p. 32) and deep-level is done wherein service providers endeavour to alter their felt emotions genuinely to match the ones desired by organization (Hochschild 1983). In surface-level the effort is to manage the visible or surface aspects of emotions mainly expressions, voice tone etc. and in essence employee's inner feelings are not changed (Song and Liu 2010) whereas in deep-level employees try to 'become' the role they are asked to play (Zapf *et al.* 1999). An example of deep-level in practice would be when a nurse genuinely feels the pain of patient and displays empathy whereas in the case of surface-level nurse portrays concern through sympathy. In both cases, the desired emotions are expressed but the shaping of inner feelings is done in deep-level whereas the inner feelings are not disturbed in surface-level (Grandey 2003).

Emotional labour strategies in context of ASHAs

ASHAs counsel people on health aspects and create awareness on health issues. Their work is a combination of nurse and counsellor. Their display of emotional spectrum may range from joy in the case of the birth of a new-born to sorrow in case of serious illness. This display is done irrespective of their felt emotional state which may be contrary to what is desired of them. The beneficiaries of the healthcare services are underserved and indigenous to their community (Love *et al.* 1997); therefore, there is an expectation of the display of appropriate emotions (e.g. concern and empathy) (Smollan 2006) and the suppression of inappropriate emotional (e.g. anger and irritation) displays (Groth *et al.* 2009).

Theory and hypotheses

Like physical labour takes its toll in the form of physical exhaustion and thus affects the productivity of workers, similarly emotional labour takes its toll in work environment in the form of change in work attitudes and thus affecting productivity (Baruch-Feldman *et al.* 2002). We base our arguments on the affective events theory that states that the nature of the job and the requirements for emotional labour have effects on work attitudes and behaviours (Weiss and Cropanzano 1996). Because emotional labour involves the use of one's emotions, its effect can be seen in the psychological well-being of the employees. Two important variables of psychological well-being are burnout and job satisfaction (Morris and Feldman 1996). We study emotional labour in terms of two distinct strategies of surface-level and deep-level emotional labour (Brotheridge and Grandey 2002) and link them to job satisfaction and burnout for community health workers.

Emotional labour and job satisfaction

Individual's satisfaction with her/his job has been a major area of enquiry for researchers worldwide. Job satisfaction has been defined as 'pleasurable emotional state resulting from the appraisal of one's job as achieving or facilitating one's job values' (Locke 1969, p. 317). Because job satisfaction is an affective outcome (Cranny *et al.* 1992), emotional labour should have an effect on job satisfaction.

Job satisfaction in healthcare

We reviewed studies related to job satisfaction in the healthcare sector in general and community healthcare sector in particular to present the conceptual foundation of factors affecting job satisfaction. In our review of the relevant literature, we found that two individual level factors, namely age and education influence job satisfaction in the context of community healthcare workers (Mpembeni *et al.* 2015). In addition to individual factors, job-level factors are also important. Job-level factors can be categorized into three main sub-factors: job rewards; job environment and job investment.

The job rewards are the tangible and intangible outcomes associated with the performance of the job. These include extrinsic rewards/punishment like pay (Delobelle *et al.* 2011), holidays (Ruggiero 2005), fringe benefits (Li *et al.* 2014a,b) to name a few and intrinsic rewards/punishment like fear of job loss (Denton *et al.* 2002) personal accomplishment (Ozyurt *et al.* 2006), recognition (Li *et al.* 2014a,b) helping people (Salyers *et al.* 2013), promotional opportunities and 'the feeling of caring for women and children in the community' (Adegoke *et al.* 2015) as sources of satisfaction.

The job environment factors are those variables associated with the workplace like behaviour of physician (Rosenstein 2002), peer support (Denton *et al.* 2002), relationship with co-worker (Delobelle *et al.* 2011), respect and fair treatment (Adegoke *et al.* 2015), working with people (Prosser *et al.* 1997), the type of leadership style (Nielsen *et al.* 2009), management (Prosser *et al.* 1997), flow of communication (Lampinen *et al.* 2015), empowerment provided (Morrison *et al.* 1997), development opportunity (Li *et al.* 2014a,b), professional status (Curtis and Glacken 2014) job autonomy (Lin *et al.* 2013), person-job fit (Skinner *et al.* 2012).

Job investment can be seen as physical like workload (Denton *et al.* 2002), work life balance (Haar *et al.* 2014) etc. and emotional which comprise emotional labour (Erickson and Grove 2008; Bagdasarov and Connelly 2013). Care is said to be the investment of physical labour and emotional labour in healthcare organization (James 1992). We are looking at the interplay of emotional investment in work and its impact on job satisfaction.

Linking emotional labour to job satisfaction

Because emotional labour requires an effort on the part of employees, it has been proposed that surface-level may lead to dissatisfaction as there is a dissonance between felt and projected emotions whereas deep-level may result in satisfaction as the projected and perceived emotions are same (Hochschild 1983; Pugliesi 1999; Yang and Chang 2008). This relation is however not universal. The importance of this dissonance might be far less than other psychological benefits attached to the job. Women who had been housewives and confined to their domestic sphere of lives before becoming ASHAs, may value associated benefits of the job and prestige related to the work (Glenton *et al.* 2013).

Some studies have viewed emotional labour as a one-dimensional construct and found that emotional labour is positively associated with job satisfaction in case of retail employees and (Cho *et al.* 2013) and hotel employees (Chu *et al.* 2012; Lee and Ok 2012). Predominantly it has been considered as a 2D construct (Brotheridge and Grandey 2002), and we have considered it as such. The type of service industry is an important factor that determines the relation between emotional labour strategies and job satisfaction. The action theory is of the view that surface-level is more of conventional activity thus requires less psychological resources whereas deep-level being an intrinsic process consumes greater psychological resources (Zapf 2002). Research on lay health workers which includes community health workers have brought forth that their job is associated with factors that foster job satisfaction like social recognition, general sense of empowerment (Glenton *et al.* 2013) and financial security. Research (Bajpai and Dholakia 2011) have brought forth that financial incentives are not the lone factor for motivating ASHAs and an aspiration to increase healthcare in their village and social prestige linked with the job are also important. Our initial interaction with ASHAs also brought forth that they value their job. Although performing surface-level emotional labour the inner emotional makeup of ASHAs is not changed (Grandey 2003) and the positives associated with working as ASHAs are predominant and thus a sense of satisfaction might prevail. However, the inner makeup is disturbed when performing deep-level emotional labour and this might subdue the positives associated with working as ASHAs. We, therefore, propose

> Hypothesis 1a: Higher surface-level emotional labour is associated with higher job satisfaction.
>
> Hypothesis 1b: Higher deep-level emotional labour is associated with lower job satisfaction.

However, studies done in different settings have shown results opposite to the above hypotheses. For example, teachers in China (Cheung *et al.* 2011), hotel employees in China (Chen *et al.* 2012) and customer service employees in USA (Judge *et al.* 2009). This makes this study a useful one to highlight the interaction of these variables for community healthcare workers, since their profession is different from the above professions in terms of job requirements and the emotional demands of the role.

Emotional labour and burnout

Burnout is the 'degree of physical and psychological fatigue and exhaustion experienced by the person' (Kristensen *et al.* 2005, p. 197). It has been linked to professions that involved caring like teachers, nurses etc. ASHAs, like nurses, are in proximity of people who are in need of healthcare services and are thus are expected to maintain emotional composure.

Burnout in healthcare

The importance of burnout as a variable of concern in a health care delivery setting has been significant because it affects service quality and care rendered, job performance, absenteeism, turnover, morale and psychological well-being (Cherniss 1980; Grandey *et al.* 2004; Halbesleben and Bowler 2007). It has been observed that burnout leads to tiredness, non-involvement and loss of effectiveness (Leiter 2010). Further, it has been associated with negative consequences for patients, institutions and, especially the medical personnel involved (Arora *et al.* 2013). Such consequences in healthcare settings could be detrimental to healthcare personnel as well as to patients being treated (Le Blanc *et al.* 2007).

The work of ASHA can draw parallels to the nurse home visitation programme for young, low-income, first-time mothers. These nurses have described their home visits after crises to be emotionally draining (Dmytryshyn *et al.* 2015). Nurses outside hospital settings are found to feel less strenuous work conditions (Sveinsdóttir *et al.* 2006) and a greater sense of personal accomplishment (McTiernan and McDonald 2015) but cross-sectional (Rossi *et al.* 2012) as well as longitudinal studies (Prosser *et al.* 1997) show community nurses and social workers experience high levels of burnout.

For community health services the mismatch created due to high demands (in terms of workload) and low resources have been found to be associated with stress (Edwards *et al.* 2000; Dollard *et al.* 2007). The other organizational and job-related factors are autonomy for work (Arches 1991), physical exertion (Landsbergis 1988), number of face to face encounters (Lasalvia *et al.* 2009), working hours (Yoshida and Sandall 2013) and workload (Edwards *et al.* 2000) to name a few. These coupled with psychological factors like feelings of frustration and loss of meaning of one's life (Iacovides *et al.* 2003), fear of job loss and perceived lack of support from peers and organization (Denton *et al.* 2002) accelerate burnout in community healthcare settings. The role conflicts experienced by donning multiple hats have been found to be positively associated with burnout (Green *et al.* 2014). Demographic factor like age in community-based mental health service providers have been found to be related to burnout (Green *et al.* 2014).

Job demands resources model of burnout (Demerouti *et al.* 2001) proposes that job demands lead to burnout. The effort is involved in terms of psychological costs in the performance of emotional labour. Review for lay health workers have shown that 'LHWs sometimes found it difficult to manage emotional relationships and boundaries with recipients' (Glenton *et al.* 2013, p. 2). The psychological cost in case of surface-level emotional labour might be minimal as no shaping of inner feelings takes place and a clean boundary is maintained with the recipient thus leading to a possible reduction in burnout. However, in case of deep-level emotional labour where shaping of inner feelings takes place they might not able to manage emotional boundaries with patients. In such scenarios, psychological costs could be high and thus paving the way for an increase in burnout. We, therefore, propose

> Hypothesis 2a: Higher surface-level emotional labour is associated with lower burnout.
>
> Hypothesis 2b: Higher deep-level emotional labour is associated with higher burnout.

Studies have shown that higher level of burnout is associated with lower satisfaction (Bacharach *et al.* 1991; Baruch-Feldman *et al.* 2002). Burnout, in particular, has been found to predict job satisfaction (Happell *et al.* 2003; Ge *et al.* 2011). Burnout's effect on job satisfaction have been established in the domain of healthcare (Ramirez *et al.* 1996) as well as social service workers (Um and Harrison 1998), thus supporting the same in case of ASHAs.

The Conservation of Resources Theory (Hobfoll 1989; Hobfoll and Freedy 1993) brings forth that depletion of a valued resource is a source of burnout (Halbesleben and Buckley 2004). Deep-level emotional labour might drain emotional resources due to the change in inner feelings whereas this is not the case with surface-level. Deep-level emotional labour's positive association with burnout leads to decreased job satisfaction. In case of ASHAs when they use deep-level emotional labour to perform emotional labour in adverse situations their inner feelings are changed which results in decreased satisfaction with their jobs. Surface-level emotional labour's negative association to burnout in turn leads to increased job satisfaction. Burnout is thus

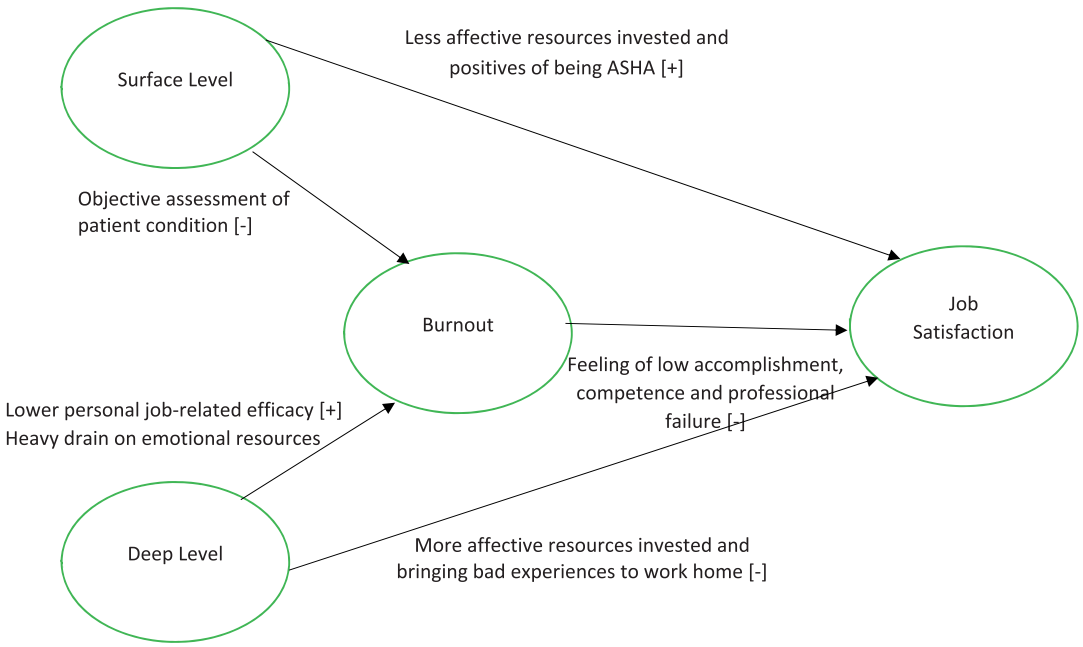

Figure 1. Conceptual model.

impacted by emotional labour and affects job satisfaction. It directs the effect of the emotional labour strategies on job satisfaction. We, therefore, propose

> Hypothesis 3a: Burnout mediates the relation between surface-level emotional labour and job satisfaction.
>
> Hypothesis 3b: Burnout mediates the relation between deep-level emotional labour and job satisfaction.

Figure 1 shows the conceptual model of all the hypotheses.

Methods

Research design and participants

This study was conducted in Uttarakhand, a hilly state in the central Himalayan region of India. The difficult geography of this region is prone to natural disasters which impacts roads which are major and at times sole form of physical connectivity (rails, roads and commercial flights are not present in the hilly regions) to the outside world. This difficult geography coupled with poor infrastructure makes access to healthcare for people a difficult task, and it is in this context that community healthcare workers gain prominence as they live in the same villages they serve. Overall, the characteristics of this region (Uttarakhand) reflected the characteristics that were suitable for this study. During pre-test prior to quantitative study we found that ASHAs' work entailed emotional labour when they counselled people and took care of pregnant women and sick villagers.

We have used two-stage cluster sampling in our study. In the first stage, 13 districts of Uttarakhand were considered, and we randomly selected (using lottery method) Almora district. In the second stage, 11 rural blocks of Almora were considered and we randomly selected 3 blocks. There were 792 ASHAs in these blocks, and we randomly selected 200 ASHAs for our study. This random selection allowed applicability of the statistical analysis to the population.

A survey instrument composed of established scales was made. After slight changes in language, the Hindi questionnaire was given to two experts for content validity and to 5 ASHA to interpret the items for face validity. Based on their inputs suitable contextualization of questions was done. The major change was the use of word beneficiary in place of the customer, since ASHAs did not feel beneficiary of their service as a customer.

We received back 177 usable questionnaires after the exercise. In this sample mean age of the ASHAs was 31.9 years (SD = 6.7 years) and among them 121 (68.4%) had passed class 8, 23 (13%) high school, 25 (14.1%) higher secondary and 8 (4.5%) held bachelors' degree; all of them were married. After our analysis, we again conducted interviews of ten ASHAs for deeper understanding and better interpretation of our findings. The participation in the study was voluntary. The respondents were explained the purpose of the study and explicit verbal consent was obtained from the respondents before interviews and survey administration, and personal anonymity was assured.

Measures

Established scales were used in the study with slight modification and translation. The instrument was anchored on a seven-point scale ranging from 1 = never to 7 = always.

The measure of burnout was contextualized version of the Copenhagen Burnout Inventory (Kristensen *et al.* 2005). We used the two dimensions of work related and client-related burnout from this inventory. Surface-level and deep-level emotional labour were measured by five-item measures and three-item measures respectively of (Grandey 2003). Job satisfaction was measured by the three items developed as part of the Michigan Organizational Assessment Questionnaire (Cammann *et al.* 1983). Age was measured in years, and education was codified into four options.

Preliminary analysis

Anderson and Gerbing's (1988), two-stage approach was followed: the first stage warrants examination of the convergent as well as discriminant validity of the measurement model by means of confirmatory factor analysis and the second phase involves investigating the model that have been hypothesized (Anderson and Gerbing 1988). Tests for convergent and discriminant validities and common method bias (Singh and Sarkar 2012) showed satisfactory results (see Table 1).

Analyses

The dependent variable in our study is job satisfaction; independent variables are surface and deep emotional labour. Burnout is a mediating variable. The control variables are age and educational qualification. Among the demographic variables, gender and marital status are same for all the participants since all are married women. Income level was dropped after the pre-test since respondents were not willing to share this information. The major variable in the work environment is generally number of hours of work per day, which was not strictly applicable here as ASHAs have to work as and when needed. Similarly, some other control variables for work environment were not applicable in this case due to the unstructured nature of their work. AMOS 20 was used to test our hypotheses through structural equation modelling (SEM) with maximum likelihood estimation.

Table 1. Mean, SD, correlation, Cronbach's alpha, construct reliability and average variance extracted

Variables	Mean	SD	Surface	Deep	Job satisfaction	Burnout	Age	CR	AVE
Surface	4.06	1.83	(0.92)					0.92	0.69
Deep	3.59	1.81	−0.65***	(0.84)				0.84	0.64
Job satisfaction	3.60	1.40	0.65***	−0.45***	(0.83)			0.84	0.63
Burnout	4.04	1.44	−0.58***	0.58***	−0.58***	(0.94)		0.94	0.53
Age	31.90	6.67	−0.18*	0.27**	−0.04	−0.09			
Education	1.55	0.90	−0.12	−0.09	0.18*	−0.23**	0.20**		

Notes: $n = 177$.

***$P \leq 0.001$; **$P \leq 0.01$; *$P \leq 0.05$, two-tailed tests.

SD, standard deviation; CR, construct reliability is above the desirable cut-off of 0.7 (Hair *et al.* 2010); AVE, average variance extracted is above the desirable cut-off of 0.5 (Fornell and Larcker 1981).

Cronbach's alphas in parentheses for multi-item variables are above the desirable cut-off of 0.7 (Nunnally *et al.* 1967).

Results

Table 1 presents the means, SD and zero-order correlations for the study variables. All hypothesized variables are significantly correlated with each other at $P < 0.001$ except control variables. Multiple fit measures are examined in SEM to mitigate the problems associated with using a single index. Table 2 shows fit measures.

Figure 2 shows the standardized effect of surface-level emotional labour on job satisfaction ($\beta = 0.513$ at $P \leq 0.001$) is significant and positive. Hypothesis 1a is therefore supported. Standardized effect of surface-level emotional labour on burnout ($\beta = -0.348$ at $P \leq 0.001$) is significant and negative. Hypothesis 2a is therefore supported. The above results along with the negative and significant effect of burnout on job satisfaction ($\beta = -0.327$ at $P \leq 0.001$) indicate partial mediation. Partial mediation was verified by the Sobel test (Sobel test statistic = 2.45 at $P \leq 0.01$). Hypothesis 3a is therefore supported. Standardized effect of deep-level emotional labour on burnout ($\beta = 0.355$ at $P \leq 0.001$) is significant and positive. Hypothesis 2b is therefore supported. Standardized effect of deep-level emotional labour on job satisfaction, removing other variables, was negative and significant effect ($\beta = -0.434$ at $P \leq 0.001$). Hypothesis 1b is therefore supported. Standardized effect of deep-level emotional labour on job satisfaction in the presence of burnout (mediator) is not significant thus, indicating full mediation (Baron and Kenny 1986), Hypothesis 3b is therefore supported.

Table 2. Fit measures for structural model

χ^2/df	Normed chi square	1.663
SRMR	standardized root mean-square residual	0.058
RMSEA	root mean-square error of approximation	0.061
TLI	Tucker-Lewis index	0.921
CFI	comparative fit index	0.931

Note: $n = 177$.

Normed chi-square < 3, TLI and CFI > 0.9, RMSEA and SRMR < 0.08 indicating a good fit (Hu and Bentler 1999).

Post-hoc analysis

Our *post-hoc* analysis supported the findings of the quantitative study and provided insights for the linkages found. For example, the interviews revealed that ASHAs who had scored high on deep-level revealed that while working with patients it was common for them to resonate with a patient's sorrow, and they tend to feel this pain and carry associated negative feelings to their personal lives as well. On the other hand, ASHAs who had high rating on surface-level scores, narrated that they dealt with patients effectively without disturbing their inner feelings and felt a sense of service. More details of *post-hoc* analysis are given in Table 3.

Discussion

Our study on community health care workers indicated that emotional labour is a 2D construct, which are distinct and opposite. This contradicts two aspects regarding emotional labour studies done in other settings: one, it is 1D (Chu *et al.* 2012; Lee and Ok 2012) and two, the dimensions are positively related (Brotheridge and Grandey 2002; Song and Liu 2010). The negative relation relationship is also supported by (Grant 2013). This contradiction, naturally, has implications for the linkage of emotional labour with other variables.

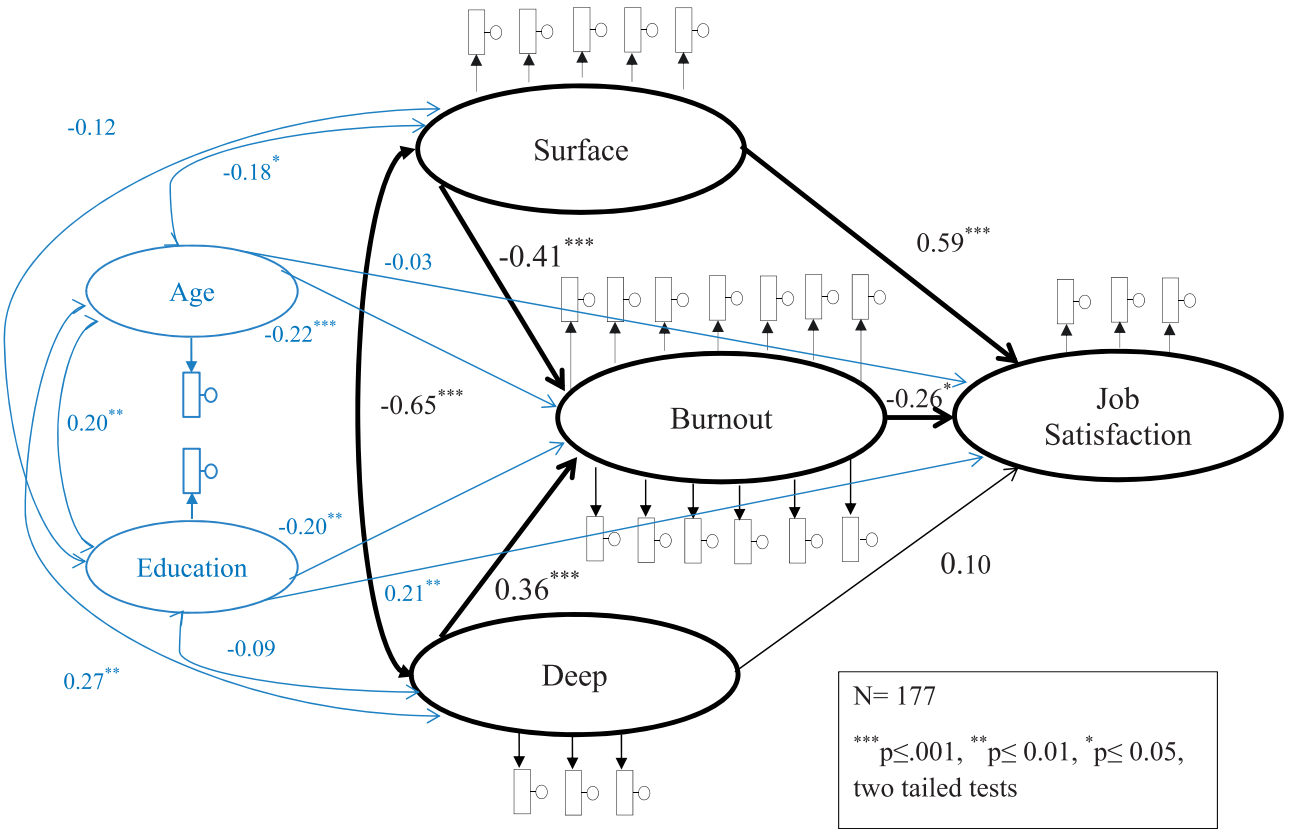

Figure 2. Results of the structural model.

Table 3. *Post-hoc* analysis

Sample selection:	After arranging the cases based on descending order of surface level sores we selected the first five ASHAs similarly procedure was followed for deep level scores. Because surface level scores were high when deep level scores were low and vice versa there was no overlap. In this manner we selected a total of 10 ASHA for *post-hoc* analysis.
Interview process:	The interview process consisted of semi-structured interviews of 45–90 min individually for each ASHA. The interviews took place in the residences of selected ASHAs. We briefed them about our research and obtained their explicit verbal permission. They were assured of the anonymity of their responses.
Analysis:	After the interview process, we transcribed the recordings and then both authors analysed the interviews independently. There was high degree of agreement. Each author analysed the responses of ASHAs and classified them based on our Hypotheses 1a to 3b. We tried to identify the responses that would help in explaining the findings of our quantitative study. The approach was more towards finding reasons for the observed phenomenon.
Summary of findings and representative quotes:	Interviews brought forth that ASHAs tend to adopt and then use either surface or deep level. This supports the negative relationship between surface and deep level found in our quantitative study. Hochschild hints at the existence of situational and individual factors that impact the way people perform emotional labour (Hochschild 1983). The choice between the two emotional labour strategies might be attributed to national, community, work and demographic/individual level factors discussed in policy implications. The positive relation between deep acting and burnout can be attributed to the depleting effect deep level emotional labour has on the inner feelings of ASHAs. ASHAs who had scored high on deep acting revealed that while working with patients it was common for them to resonate with a patient's sorrow and they tend to feel this pain and carry associated negative feelings to their personal lives as well. On the other hand, ASHAs who had high rating on surface level narrated that they dealt with patients effectively without disturbing their inner feelings and felt a sense of service. Deep level emotional labour ended in ASHAs resonating with the feelings of patient whereas surface acting ended with a positive feeling of helping some and a sense of accomplishment. All 10 ASHAs They seemed to feel a sense of empowerment after working as ASHAs; they perceive that they have gained respect in family and society. 'I feel that after this job people have started respecting me.' 'I have been confined to my house since marriage but now (after becoming ASHA) I get more say in the family decisions.' 'Five ASHAs who had high surface level scores' They seemed to value extrinsic rewards (monetary incentive) of the job and seemed to be more professional in their approach to patients. They saw themselves as healthcare professionals, thus seem to understand the importance of objectivity in their jobs and not feeling emotionally drained. 'If I get attached to them (villagers) how can I treat them? It is a job, and I get paid for it . . . I have to be objective.' 'I actually feel happy when I come home, I helped bring a new life to earth and brought happiness to the family.' 'It is a job where I can make a difference.' 'Five ASHAs who had high deep level scores' They seemed to value intrinsic rewards (feeling of helping others) of the job and were concerned about social relations. They may feel burnt out when they were not able to manage emotional boundaries with the patients and were changing their emotional states to that of the patients'. This burnout may lead to their negative feelings regarding their job. 'They (villagers) are my people how can I not be affected by their sorrow or joy?' 'Many times when I come home after work, I feel my well of emotions have dried up.' 'At times, I feel like having some other job.'

Emotional labour may not always have negative consequences as perceived by some scholars (Wharton 1993). It has been seen that display of positive emotions and sensitivity requirements has positive effects on personal accomplishment (Zapf and Holz 2006). The positive emotions when a child is born and when a sick is cured is a source of pleasant emotions for these ASHAs and amplification of pleasant emotions increases their job satisfaction (Cote and Morgan 2002). The positive relations of surface-level to job satisfaction and negative relation to burnout make high surface-level a more desirable strategy to be adopted by community health care workers.

Our findings with respect to the surface and deep-level emotional labour have similarities with the detachment and engagement approach to emotional labour in healthcare. The value of detachment (objectivity or surface-level) versus engagement (subjectivity or deep-level) is central to our research. In case of community healthcare nurses research shows that detachment/ objectivity/surface-level ensures their effectiveness and sound judgement whereas high degree of emotional engagement/deep-level might make them incapable of doing their job (Henderson 2001). Thus 'advocates of "technical" approaches to professional acting (akin to surface-level) believe their approach is superior to "method" acting (akin to deep-level)' (Mann 2004, p. 210). The surface-level phenomenon in our study has parallels to the 'detached concern' (Mann 2004, p. 210) approach in which healthcare workers give the impression of concerned while actually remaining fairly aloof. The deep-level phenomenon in our study also has parallels to the 'emotional labour performance' construct of healthcare model of emotional labour given by (Mann 2005), which involves suppression of unwanted emotions to match the emotional display rules. This has been conceptually linked to more adverse effects like burnout which we have tried to establish empirically.

The partial mediation of burnout indicates that while surface-level helps in conserving emotional resource the objectivity and detachment shown in surface-level also directly affects job satisfaction

positively. Full mediation in case of deep-level indicates that the decrease in job satisfaction is because of drainage of emotional resources (i.e. burnout) associated with the deep-level. The critical role played by burnout in the relation between emotional labour strategies and job satisfaction has not been explored earlier. Job satisfaction becomes important in the case of health care workers as it affects not only their well-being but might also pose a threat to well-being of patients whom these workers are serving.

Looking at the relationship between the emotional labour strategies and burnout in the context of healthcare workers is particularly interesting because our study shows that conceptual underpinnings might be different from those seen in another context. In the context of customer-facing roles in profit-making organizations, surface-level is done by employees to maintain/strengthen customer relationship which may create emotional dissonance in these employees (Grandey 2003). In such context, deep-level is said to reduce burnout through low emotional dissonance (Hochschild 1983). However, in the particular context of community healthcare workers such as ASHAs deep emotional labour can be associated with the emotional connection with patients' suffering and may lead to higher burnout. ASHAs generally may not have the training received by doctors and nurses to maintain desired emotional distance with patient's condition. By following deep-level strategy, not only an ASHA worker may get emotionally drained out, but she may also not be conveying the desired confidence and comfort to the patient. Our study brings to light that contrary to previous studies in other settings 'donning the mask' decreases burnout and increases job satisfaction.

Policy implications

One of the likely contributions of this research can be to widen the horizons of policy makers in LMICs to take into account softer aspects such as attitudinal variables (Harrison *et al.* 1998) in conjunction with structural issues. In the case of ASHAs, the structural issues of qualification and position of ASHAs are very well thought of but consideration of their emotional work requirements can go a long way in sustaining the programme. It is said that 'the world turns to women for mothering, and this fact silently attaches itself to many job requirements' (Hochschild 1983:182); however, these efforts by women are often overlooked and under-compensated despite their important role (Meier *et al.* 2006).

The facet of emotional labour put forth by these ASHAs must also be taken into account and formally recognized as an important skill that is required to perform their job and innovative ways needs to be developed to teach emotions management (Mann 2005). Institutional limitations exist for ASHAs existed in terms of outcome-based remuneration structure; poor institutional support; rigid hierarchical structure of the health system; and a dearth of participation at the community level (Scott and Shanker 2010, p. 1606). A consideration of emotional labour in addition to improvement of the same can have long-lasting implications. This can be institutionalized by reflecting emotional labour in the job description, induction and training etc.

The image of ASHA as a professional healthcare worker by positioning this job as an important constituent in the healthcare supply chain. They must be involved in major policy decisions, this has also been recommended for nurses in India (Sheikh *et al.* 2012) as opposed to the top-down approach used for universal health coverage in India (Raman *et al.* 2012). The design and calibration of employment practices to meet the affective demands of community healthcare workers must be looked into. The fit between the person and work environment in service setting is important as it affects work behaviour and attitudes (Lauver and Kristof-Brown 2001). Theory of work adjustment links this person–environment fit to desired outcomes like satisfaction, tenure and career success (Bretz and Judge 1994), job involvement and organizational commitment (Blau 1987). In a service set-up the work demands for emotional labour should be supplied by individuals capable in this exercise, therefore the choice of deep and surface-level is dictated by work. Hence, there needs to be a conscious hiring strategy to select those individuals that possess the attributes to select the appropriate emotional labour strategy. It has been recommended that hard educational criteria alone should not be the basis for selection of ASHAs, soft criteria like aptitude, motivation, communication skills, leadership qualities and the ability to reach out to the community members must also be taken into account (Bajpai and Dholakia 2011, p. 40). Issues affecting motivation such as work environment, development of career and a supportive system aid the retention of these personnel in the system of community health (Satpathy and Venkatesh 2006).

After the selection, proper mechanisms to teach emotional management techniques during induction can lead to long-term benefits and retention. Improvement of their skills and knowledge and enabling them to deal with work demands may go far way in enhancing their performance (Gopalan *et al.* 2012). However researchers are of the view that training currently being given to ASHAs is focused on medical procedures and practices and is not enough to deal high levels of stress generated while handling high-risk cases (Mahyavanshi *et al.* 2011; Shrivastava *et al.* 2012). This is also echoed for lay health workers (Glenton *et al.* 2013).

Policies and practices that affect economic and emotional well-being need to be reviewed. This job as ASHA worker brings a sense of empowerment, feeling of helping others (Salyers *et al.* 2013), social recognition (Li *et al.* 2014a,b) and economic incentive for them. This might aid in explaining the positive relation of surface-level (since their positive inner state is not influenced) to job satisfaction. Because they are not trained in how to manage emotions boundaries with patients (Glenton *et al.* 2013) in a transaction with patients burnout leads to lowering of this satisfaction. Looking at the demographic factors, community-level issues, national context and occupational characteristics, the propensity is more towards deep-level emotional labour (see Table 4). The challenge is to strengthen the drivers for surface-level in order to reduce burnout and increase job satisfaction. This is more important in case of ASHAs considering that many of the traditional approaches to reduce employee burnout [e.g. establishing clear lines of authority (Schwab *et al.* 1986), higher autonomy (Castanheira and Chambel 2010) might not be feasible given the structure and the nature of their job]. In addition, emotional management might require interventions of a continuous nature and might not be possible to impart in classroom settings.

A series of workshops, where emotional labour can be practically demonstrated, needs to be designed. In addition, new interventions like mentorship (Schwab *et al.* 1986; Kalish *et al.* 2015) and forums are required. Mentorship and forums would provide a platform for the needed continuous interaction. Training would provide guidance on maintaining a proper balance in terms of usage of emotional labour strategies. Service scripts could help in cases when workshop, mentors and trainers are not around. These interventions to be effective warrant active participation from ASHAs, which should be facilitated, encouraged and incentivized.

Limitations and future research

This study was confined to a particular region of the country and might have limitations of generalizability in terms of wide socio-cultural

Table 4. Policy implications based on individual, community, national and occupational factors

Level	Factor	Implications	Policy recommendations
Demographic/ individual	Gender, marital status and education.	The demographic composition of ASHAs represents women, married/divorced community health workers with low educational qualifications. They are usually from the lower to lower middle-class strata and operate in villages. The hardships those are prevalent in rural India leads to self-selection of those women who take up the job due to financial circumstances. Their job is a pivotal point in their lives, and their social and economic well-being hinges on it.	Workshop: practical and subtle nuances on how to handle emotions without affecting patient sentiments can be taught. Visits by female emotional management trainers: it might not be easy for ASHAs to move out of their villages on a regular basis so female trainers can visit them and guide them at work. They might be more receptive to women trainers.
Community	Close-knit community	They work for a close knit community (in this case village) of which they are a part of and are responsible for it. This leads to closer bond with members of community which is further reinforced by the joint family structure existing there. Hence, there is a higher likelihood of deep level emotional labour.	Forums: the collectivist orientation indicates need for forums where ASHAs could come and share their feelings and receive guidance on emotional management practices. This would foster a close bonding among them and provide much needed emotional support.
National	Collectivist orientation	Collectivist orientation fosters closer identification with patients and hence a tendency to use deep level strategy. This is also reinforced by the higher dependency of the rural populace on ASHAs for healthcare needs due to lack of alternative resources.	
Occupational	Part-time and un-structured work	The part-time nature of their work leads to less allocation of their resources into their work. In addition, their jobs are not strictly structured which might imply that they have less clarity about their role and low understanding about which emotional labour strategy to adopt.	Explicit service scripts: this would allow ASHAs to better understand the course to be followed in an emotionally demanding situation. This would be particularly helpful where ASHAs are in far-off geographies and so other recommendations are difficult to implement.
	Resource constraint	They might face constraints on resources for patient care such as availability of medicines, communicating serious emergencies to higher officials, vehicles for transporting patients (especially from villages to the nearest available road head) etc. This constraint may either prove to be a distraction or may further aggravate their emotional state. There is higher likelihood of their adopting an undesirable labour in a scenario like this.	The resource constraints should be addressed using a feedback mechanism for bottom-up approach. Regular suggestions should be sought from ASHAs separately or during group meetings. Properly designed feedback mechanisms might help in providing a much needed emotional bolster.
	Occupational role models	The existence of occupational role models like doctors and nurses whose objectivity they try to simulate. This encourages them to adopt surface level emotional labour.	Mentorship: a well-designed mentorship programme (or buddy programme) would guide them to display appropriate emotional responses.
	Payment for work	They perceive their work as a paid job and so they have rational attitude towards negative situations arising at work. This helps in the adoption of surface level emotional labour.	Positioning the ASHAs as healthcare professionals could aid in development of more professional attitude towards work by them.

coordinates of the country. ASHAs might not be representative of nurses who work a typical brick and mortar organizational setting. They belong to only one gender and predominantly belong to the lower and middle-income group functional in rural settings. Therefore generalizing our results for the male community healthcare workers, healthcare workers in organizational contexts and urban community healthcare workers should be done with caution. These limitations warrant further research with comparison across these variables. We have also not looked at variables that influence the usage of surface and deep-level emotional labour. Future studies might also look at the effect of individual, community, national and occupational factors and the resource constraint faced by ASHAs on emotional labour strategies, burnout and/or job satisfaction. Above suggestions could be interesting areas of study and could open many doors for refinement of our understanding of emotions in healthcare.

Conclusion

Healthcare service delivery as an important arena where emotional labour plays its role. We looked at the interaction among emotional labour strategies, burnout and job satisfaction for community health workers. In a country like India, ASHAs play a significant role in ensuring that healthcare reach from classes to masses. An important finding was the negative relation between surface and deep-level strategies of emotional labour. Further, findings also indicate that high surface-level emotional labour is associated with reduced burnout and increased job satisfaction. The perspectives offered through conservation of resource theory and affective events theory help us better understand our results. This has important implication for the emotional labour strategy that community health worker should use when dealing with patients. Our findings also indicate that soft aspects of emotional management are critical for community healthcare and needs to be strengthened at grassroots.

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