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Assessing Challenges and Sources of Dissatisfaction among Accredited Social Health Activists Employees

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ABSTRACT

Accredited Social Health Activists (ASHAs) are integral to India's healthcare system, particularly in rural and underserved areas like those in district Aligarh, Uttar Pradesh. They serve as community health workers who facilitate access to essential health services, but their roles often place them in vulnerable positions. Operating within patriarchal societies and situated at the lower levels of the healthcare hierarchy, ASHAs are prone to various forms of violence and harassment. Despite their crucial role, there is limited understanding of the specific challenges they face, particularly regarding harassment in their work environment. This study aims to identify the key challenges encountered by ASHA workers in the Aligarh district of Uttar Pradesh and sources of dissatisfaction faced by ASHAs. A cross-sectional survey was conducted involving a representative sample 150 of ASHAs across several blocks of in Aligarh of Uttar Pradesh. Data were collected through structured questionnaires and semi-structured interviews. The survey addressed various aspects, including working conditions, support from healthcare systems, remuneration, training, and community relations. In a study of 150 ASHA workers, key challenges include delays in incentives (70%), excessive workload (92%), and unsatisfactory training (71.3%). Many faces harsh working conditions (73.3%), harassment (95.3%), and high stress (89.3%). Issues like inadequate facilities (97%) and transportation difficulties (90.6%) further impact their performance and well-being. This study evaluates ASHA workers' duties, challenges, and well-being. Despite their critical role, they face financial instability, inadequate facilities, harsh conditions, and harassment, including from hospital staff. Long travel, stigma, and social discrimination further impact their effectiveness and morale, emphasizing the need for better support and protective measures.

Keywords: ASHA Employees, Job Challenges, Health System Challenges, Aligarh, India
JEL Classifications: M10, M59

1. INTRODUCTION

Health is essential for human survival and growth. Traditionally, it has been defined as the mere absence of disease or injury. However, the World Health Organization (WHO) offers a broader perspective, defining health as a state of complete physical, mental, and social well-being, rather than just the absence of illness or infirmity (Constitution of the World Health Organization, 2006). This holistic view encompasses not only the absence of disease but also a condition where individuals are able to pursue personal development and contribute to societal progress. While the concept of health applies universally to both men and women, women's health often receives secondary attention in many contexts, particularly in nations with traditional patriarchal structures. In India, the patriarchal social framework frequently places women's health on the periphery, exacerbating their vulnerability and limiting their access to adequate healthcare (Park, 2017). The significance of health extends beyond individual well-being to encompass national development. Health is recognized as a crucial component of human development, directly impacting socio-economic progress. Healthy communities are essential for sustainable development, as they contribute to a more productive workforce and reduced healthcare costs (Park, 2017).

To address the healthcare needs of underserved populations, India launched the National Rural Health Mission (NRHM) in 2005. This initiative introduced Accredited Social Health Activists (ASHAs) as a key component of the public health strategy. ASHAs serve as a critical link between the government and rural communities, particularly pregnant women. Their role includes promoting institutional deliveries, which involve giving birth in medical institutions under the supervision of trained professionals. This approach ensures the availability of essential amenities to manage childbirth safely and effectively (Vikaspedia, in).

The ASHA program is designed to enhance public health services by encouraging community participation, reducing the burden on the formal healthcare system, and improving local access to healthcare services (Scott and Shanker, 2010). By bridging gaps between the government and rural populations, ASHAs play a vital role in improving maternal and child health outcomes, thus contributing to overall community health and development.

The roles and responsibilities of an ASHA include acting as a healthcare facilitator, service provider, and health activist. Broadly, her duties encompass delivering preventive, promotional, and basic curative care in collaboration with other health workers. She plays a crucial role in educating and mobilizing communities, especially marginalized groups, to adopt healthier behaviors and raise awareness about social determinants of health. ASHAs also work to improve the utilization of health services, participate in health campaigns, and assist individuals in accessing their health entitlements. Additionally, they are responsible for providing a basic package of curative care as appropriate and feasible for their level, and making timely referrals for further treatment. Her roles and responsibilities are as follows.

1.1. Promoting Maternal and Child Health

- Antenatal and Postnatal Care: ASHAs educate and assist pregnant women in accessing antenatal care, ensuring they receive regular check-ups, vaccinations, and necessary supplements. They also support postnatal care by advising on breastfeeding, newborn care, and recognizing signs of complications
- Institutional Deliveries: They encourage and facilitate institutional deliveries by helping women access delivery services at health facilities, which ensures safer childbirth under medical supervision.

1.2. Health Education and Awareness

- Community Health Education: ASHAs provide information on various health topics, including hygiene, nutrition, family planning, and disease prevention. They conduct health education sessions and community meetings to raise awareness and promote healthy practices
- Disease Prevention: They disseminate information on preventing communicable diseases like malaria, tuberculosis, and diarrhea, and encourage vaccination against preventable diseases.

1.3. Facilitating Access to Healthcare Services

- Linkage to Healthcare Services: ASHAs act as a bridge between the community and the healthcare system, facilitating access to government health schemes and services. They assist individuals in reaching healthcare facilities and accessing entitlements under various health programs
- Referral Services: They identify and refer individuals with serious health conditions to appropriate healthcare providers for further diagnosis and treatment.

1.4. Implementation of Government Health Programs

- Vaccination Programs: ASHAs help in the implementation of immunization programs by ensuring that children and pregnant women receive their scheduled vaccinations
- Health Surveys and Data Collection**:** They participate in health surveys, data collection, and reporting activities to monitor community health status and the effectiveness of health programs.

1.5. Supporting Family Planning Services

- Counseling and Education: ASHAs provide counseling on family planning methods, help in disseminating information about contraceptive options, and support the adoption of family planning practices
- Facilitating Access: They assist couples in accessing family planning services and supplies from health facilities.

1.6. Encouraging Community Participation

- Mobilization: ASHAs mobilize the community to participate in health-related activities, such as sanitation drives and health camps. They encourage community involvement in maintaining a clean and healthy environment
- Advocacy: They advocate for improved health services and resources within the community and work to address local health issues through collective action.

1.7. Emergency Response and Support

- Emergency Assistance: In case of health emergencies or outbreaks, ASHAs provide immediate support and guidance to affected individuals and help coordinate with health authorities for appropriate responses
- Health Promotion Activities: They organize and participate in health promotion activities, such as health fairs, workshops, and campaigns to address pressing health issues.

1.8. Maintaining Records and Reporting

- Record Keeping: ASHAs maintain records of their activities, including health education sessions, referrals, and visits. Accurate record-keeping is essential for monitoring and evaluation purposes
- Reporting: They report health data and outcomes to health officials, contributing to the overall monitoring and evaluation of health programs
- Organization of Health Day: ASHAs and ANMs collaborate to organize Health Days once or twice a month in their communities. These days are dedicated to raising awareness about various health-related issues and promoting healthy practices among the population
- Awareness Campaigns: During Health Day events, ANMs deliver educational sessions to women and adolescent girls on topics such as personal hygiene, sanitation, and nutritious

food. This education aims to improve general health practices and reduce disease incidence (National Health Mission, 2020).

2. REVIEW OF LITERATURE

During the COVID-19 pandemic Upadhyaya (2022) explores their marginalization and invisibility, particularly due to their low-income and low-literacy backgrounds. Using both qualitative and quantitative methods, including interviews with 55 ASHAs and various reports, the study reveals critical policy and social gaps that must be addressed to support these essential workers effectively. Mohiuddin et al. (2023) found that most reported positive impacts on their social relationships, confidence, and overall health. However, two-thirds struggled to meet targets due to overlapping duties. Mental stress affected 43.3% and 20.7% faced harassment from hospital staff. Training was unsatisfactory for 40%, and only 59.3% had access to toilet facilities and 64.7% to safe drinking water. Satisfaction with monthly income was just 4.7%.

Bist et al. (2023) using purposive sampling, 150 ASHAs were used for quantitative analysis and 14 for qualitative analysis in an explanatory mixed-methods study conducted in Uttarakhand, India. The study's quantitative findings showed that 91% of ASHAs knew about colostrum milk, and that knowledge was next highest for Anganwadi centers (83%), vaccination (79%), general health (70%), and birth preparation (69%). ASHAs suffered from job overload and insufficient incentives, as evidenced by the major themes that emerged from the qualitative data, which included personal, psychological, economic, social, and environmental aspects. Jain and Yuan (2020) emphasized the critical role of ASHAs during the COVID-19 pandemic, despite facing poor treatment from institutions. Their involvement was crucial in controlling the pandemic and delivering essential services. The role of ASHA workers in India is critically examined by Mohsin et al. (2023), who highlight the vital role that these workers play in bridging the gaps that exist between underserved populations and healthcare facilities. In order to maximize their influence, it emphasizes the necessity of improved training, technology integration, and supportive policies. In the study, ASHAs are envisioned as empowered change agents in community-based healthcare, emphasizing improved compensation and skill development, by identifying obstacles and suggesting solutions.

Kaur et al. (2022) in this descriptive, cross-sectional study at RHTC Bhadson, we evaluated ASHA workers' knowledge of maternal and child health (MCH) services and their service delivery to mothers with infants aged 0-6 months. Among the 196 ASHA workers, 72 were randomly selected for knowledge assessment, and 100 mothers were interviewed to evaluate the services provided. Results showed that 65.2% of ASHAs were over 35 years old. Only 23.6% knew breastfeeding should start within the 1st h post-delivery. However, ASHAs provided counseling on nutrition, birth preparedness, institutional delivery, and birth registration to 75%-85% of mothers. Significant improvements were noted in maternal practices related to pre-lacteal feeding, family planning use, and delaying early bathing due to ASHA counseling. Manjunath et al. (2022) the study used a mixed-method approach with data triangulation, and it was carried out in the Karnataka districts of Koppala. Qualitative research investigated the perspectives of ASHAs and stakeholders by multi-stage random sampling, conducted theme analysis with NVivo-12, and evaluated ASHAs' quality of life using the WHO QOL-BREF. Results showed that ASHAs have a heavy workload because of their coverage of the population, long workdays, and extra responsibilities. Feelings of being overworked and underpaid are exacerbated by problems including limited access to transportation, insufficient assistance, and delayed incentives. The study emphasizes the necessity of redistributing tasks among frontline employees in accordance with task complexity and competencies.

Asha et al. (2022) in a survey conducted among 1770 respondents in Maharashtra, 82.9% demonstrated high knowledge about COVID-19, according to WHO guidelines. Despite this, 78.7% exhibited poor COVID-19-related practices. The pandemic significantly impacted psychological well-being in 81% of respondents and had socio-economic effects on 55%. Regression analysis revealed that women had higher knowledge levels than men, and educational qualifications influenced COVID-19 practices. Specifically, education impacted general practices, while both gender and education affected COVID-19-related practices. The findings highlight a knowledge-practice gap and the broader psychological and socio-economic impacts of the pandemic. In a cross-sectional study of 150 ASHA workers in Himachal Pradesh Rattu et al. (2022) findings revealed that most ASHAs felt their job positively impacted their social relationships, confidence, and overall health. However, about two-thirds struggled to meet targets due to overlapping responsibilities. Mental stress was reported by 43.3% of workers, and 20.7% experienced harassment from hospital staff. Training was deemed unsatisfactory by 40%, while only 59.3% had access to toilet facilities and 64.7% to safe drinking water. A mere 4.7% were satisfied with their monthly income. Closser and Shekhawat (2022) examine the function of Anganwadi Workers and ASHAs in rural Rajasthan, India, with a focus on the impact of family dynamics on their job. Based on participant observation and interviews with twenty workers and ten family members, the study finds that although these jobs pay little, there is a large demand for them since educated women finds it difficult to find other employment options. Family structures have a big influence on hiring, training, and working conditions, but the jobs are more flexible and provide you more freedom. But the prospect of long-term work is still elusive, which encourages the exploitation of gendered labor market disparities and their perpetuation.

Rajvanshi et al. (2021) identifies gaps in the knowledge and resources that ASHAs in the test district have about the identification and management of malaria parasite species, which is critical to the malaria elimination campaign. This highlights the necessity of providing more training on the use of Rapid Diagnostic Tests (RDT) and appropriate treatment plans for Plasmodium falciparum and Plasmodium vivax. In order to improve malaria management and meet program objectives, these gaps must be filled. Karasz et al. (2021) found a significant reduction in depression scores in the intervention group, with the mean PHQ-9 score dropping from 14.5 to 5.5 ($B \pm SE$, -9.2 ± 0.8, 95% CI -10.9, -7.5, $P < 0.01$), while the control group

showed no change. Improvements were also noted in tension, self-esteem, hope, social support, and economic decision-making. The integrated approach combining depression treatment with financial empowerment proved highly effective for rural low-income women. Future research should involve formal testing of this model in a larger trial. Deshpande et al. (2020) found that ASHAs working in tribal areas faced high levels of community opposition, irregular incentives, and transportation issues, affecting their job satisfaction. Yadav et al. (2021) ASHAs are an essential element of the institutional healthcare infrastructure in India, according to an exploratory study by to determine the role of ASHAs during the COVID-19 outbreak, but they are still treated poorly by the state and other institutions healthcare personnel. Currently, they are making a big help to the control of the COVID-19 pandemic that has almost completely paralyzed the country Panda et al. (2019): In Khordha district, ASHAs were effectively trained in first aid, DOTs, and vaccinations, demonstrating their significant role in supporting essential health services. Meena et al. (2020) observed that factors such as age, education, and socioeconomic status significantly influence ASHAs' performance, while caste, religion, and marital status have minimal impact.

Meena et al. (2019) and Sharma et al. (2014) found that excessive workload, inadequate transportation, and friction between different health departments are significant barriers to ASHAs' effectiveness Guha et al. (2018) and Kishore (2016) suggested that addressing issues such as job security, supervision, and clear role definitions can enhance ASHAs' effectiveness. Interdepartmental coordination and improved resources are necessary to support their roles better. Bhanderi et al. (2018) evaluations were used to assess knowledge and performance in a study involving 80 ASHAs from the Anand District. The majority of participants (61%) were between the ages of 30 and 40, 68% were OBC, and 91% had completed at least secondary school. High knowledge scores (84% between 12 and 15) were accompanied by low performance (51% rated ordinary, 49% rated poor, and none rated well). Only the amount of time since the last training was strongly correlated with performance; there was no correlation with age, caste, education, or length of service. Sarin et al. (2017) conducted analysis to find trends. As a result of their increased motivation and sense of self-worth, the results show that ASHAs' efforts improved community health. But cultural norms, attitudes, and ideas that were prevalent inside the health system limited their efficacy. In order to increase ASHAs' influence and effectiveness in health interventions, these issues should be addressed since they hindered their ability to effectively utilize their positions as community health workers. Shet et al. (2017) identified that financial compensation is a major factor affecting ASHAs' motivation. Delays in receiving incentives and inadequate activity-based performance incentives have been demotivating Eruthickal et al. (2016) demonstrated that ASHAs significantly improve health outcomes in rural areas by enhancing awareness of health issues and ensuring the delivery of key health services. NHSRC (2011): The National Health Systems Resource Centre (NHSRC) highlighted that relying solely on doctors and specialists is insufficient to address the nation's healthcare challenges. ASHAs are critical in providing preventive care and health promotion at the community level, significantly reducing the burden of illness by bringing healthcare services directly to the doorstep (NHSRCINDIA, 2011).

Eruthickal (2016): In the Kottayam district, ASHAs have had a notable impact on rural health, contributing to improved sanitation, effective implementation of healthcare programs, and increased awareness of nutrition and hygiene. Saprii et al. (2015) Despite their vital role, ASHA workers encounter numerous challenges. These include inadequate compensation, heavy workloads, and limited training opportunities Gosavi et al. (2011) revealed that many ASHAs lack comprehensive knowledge beyond maternal and child health, and there is a need for further training on various health determinants. Waskel et al. (2014) found that ASHAs typically fall within the 20-29 age range and have at least a middle school education, though these criteria are sometimes adjusted based on local needs. Kumar et al. (2012) In a descriptive cross-sectional study conducted at the Rural Health and Training Centre, Varanasi, 135 ASHAs from Chiraigaon Block were surveyed. Findings showed only 16.3% were aware of their role in motivating toilet construction, and 23% knew they should provide care for minor ailments. Knowledge gaps and delayed incentive payments adversely affected their performance, with better practices observed among more knowledgeable ASHAs.

Accredited Social Health Activists (ASHAs) are essential to the National Rural Health Mission (NRHM) in India, tasked with improving health outcomes in rural communities. Despite their critical role, there is a significant need to study the challenges and sources of dissatisfaction faced by ASHAs; especially in Uttar Pradesh. The study of challenges and sources of dissatisfaction among ASHAs in Uttar Pradesh is essential for several reasons. It will provide a detailed understanding of the difficulties they face, explore their coping strategies, and offer recommendations for improving their working conditions and effectiveness. This, in turn, will contribute to the overall success of health programs like NRHM and enhance health outcomes in rural communities.

2.1. Research Gap

A thorough review of existing literature reveals a significant research gap regarding Accredited Social Health Activists (ASHAs) in Uttar Pradesh. While numerous empirical studies have examined ASHA workers across India, there is a noticeable scarcity of research focused specifically on ASHAs in Uttar Pradesh. Most studies have concentrated on the general effectiveness and service delivery of ASHAs without delving deeply into the unique challenges faced by these workers in the Uttar Pradesh context. There is a particular lack of detailed investigations into the specific obstacles and sources of dissatisfaction encountered by ASHAs in this region. Addressing this gap is crucial for developing targeted interventions and improving the support systems tailored to the needs of ASHAs in Aligarh. This study aims to address this gap by providing a detailed examination of these issues, offering insights that can lead to more adapted and effective support strategies for ASHAs in Uttar Pradesh. In Aligarh district very few researchers have been found.

2.2. Objective of the Study

- To examine the socio-demographic determinants affecting ASHA workers
- To identify the key challenges encountered by ASHA workers in the Aligarh district of Uttar Pradesh
- To suggestion specific recommendations.

3. METHODOLOGY

The study aimed to assess the current status of ASHA workers in Aligarh district. A field-based, community cross-sectional study was conducted with 150 participants. Data was collected through in-depth interviews using a structured questionnaire. The extended research methodology is given below.

1. Study sampling size:150
2. Area of study: Aligarh
3. Selected block: In first stage five block were randomly selected using simple random sampling technique (SRS).
4. Primary Data Collection
   - Semi-Structured Schedules
     Interviews were conducted using pretested semi-structured questionnaires to gather the socio-economic profiles of ASHA workers.
   - In-Depth Interviews
     Conducted with ASHAs to obtain detailed, personal accounts of their work environment, challenges, and sources of dissatisfaction. This method helps in understanding the nuanced experiences of the respondents.
   - Survey Questionnaires
     Administered to a larger sample of ASHAs to collect quantitative data on job satisfaction, challenges faced, and other relevant metrics. The questionnaires included closed-ended questions for quantitative analysis and some open-ended questions to capture qualitative aspects.
5. Secondary data collection
   - Available Reports and Records: Secondary data was collected from district, block, Primary Health Centers (PHCs), and sub-center levels. This includes operational records, reports on ASHA activities, and any available performance evaluations or assessments. This data provides context and supports the primary data collected**.**
6. Data Handling and Processing
   - Data Entry and Cleaning: Data from fieldwork were carefully entered into the SPSS software (version 20.0) for analysis. During data entry, checks were made to identify and correct errors or inconsistencies. The data were classified into relevant categories for systematic analysis. Statistical techniques were applied to interpret the data, including calculating frequencies and percentages for various variables. Used to quantify the occurrence of specific responses or issues identified through surveys and interviews.
   - Data Analysis and Interpretation: Analyzed using SPSS to determine the frequency and percentage of responses related to challenges, job satisfaction, and other factors.

This analysis provides a broad overview of the main issues and patterns within the data**.** Insights from in-depth interviews and open-end survey responses were categorized and interpreted to identify recurring themes, personal experiences, and specific challenges faced by ASHAs.

4. RESULTS

A total of 150 ASHA workers were included in the study for evaluation purposes. The detailed findings are summarized in Table 1. The majority of ASHA workers fall into the 25-30 year age range (36.6%), indicating a relatively young workforce. The ASHA workforce tends to be relatively young, with the majority between 25 and 35 years old. Most ASHA workers have education up to higher secondary (32.6%) or graduation (23.3%). The proportion with primary education is relatively small (13.3%). A majority of ASHA workers are Hindu (70%) which could reflect the religious demographics of the region or community served. Muslims ASHA (30%) significant minorities are Muslims indicating some level of religious diversity within the ASHA workforce. The majority are married (73.3%)**,** unmarried (5.3%) a small proportion are unmarried, which may indicate that ASHA work is less common among single individuals, divorced (12.6%) A notable portion are divorced, a smaller group consists of widows (8.6%), Most ASHA workers are married, which might suggest stability and support systems in their personal lives. The presence of divorced and widowed individuals also highlights the diverse personal backgrounds of those in the role.

Table 2 in a study of 150 ASHA workers, several significant challenges were identified. A majority of ASHA workers (70%) face issues related to delays or obstructions in receiving their incentives. This problem can affect their motivation and financial stability, potentially leading to decreased job satisfaction and effectiveness. They have stated 92% of ASHA workers report being overloaded with work. This high level of workload can contribute to burnout, stress, and reduced job performance.

Table 1: Distribution of ASHA workers according to socio economic profile

Age 150 respondent	No	Percentage
<25	20	13.3
25-30	55	36.6
31-35	40	26.6
35-40	35	23.3
Education		
Primary	20	13.3
Up to secondary	47	31.3
Up to secondary	49	32.6
Graduation or more	35	23.3
Cast		
General	50	33.3
OBC	63	42
SC	37	24
Religion		
Hindu	105	70
Muslim	45	30
Marital status		
Married	110	73.3
Unmarried	8	5.3
Divorced	19	12.6
Widow	13	8.6

Researcher's compilation

Table 2: Challenges faced by ASHA workers during field work

S. No.	Variable	Respondent 150	Percentage
1	Obstruction incentive	Number	
	Yes	105	70%
	No	45	30
2	Overloaded of work		
	Yes	138	92
	No	12	8
3	Training session unsatisfactory		
	Yes	107	71.3
	No	43	28
4	Spending time on hot day on field		
	Yes	110	73.3
	No	40	26.6
5	Involvement multiple programme like, Covid		
	Yes	139	92.6
	No	11	7.3
6	Harassment by health staff, PHC, CHC, Violence, Physical, Mental		
	Yes	143	95.3
	No	7	4.6
7	Stress		
	Yes	134	89.3
	No	16	10.6
8	Toilet problem, clean drinking water		
	Yes	146	97
	No	5	3.3
9	Fear and stigma Job	107	71.3
10	Transport, Environmental challenges	136	90.6

A majority of ASHA workers (71.3%) find the training sessions unsatisfactory. ASHA workers stated that they (73.3%) have to work in challenging conditions, such as extreme heat. This can lead to physical discomfort and health issues, highlighting the need for better working conditions and possibly the provision of support measures to handle harsh weather conditions. A large majority (92.6%) of ASHA workers are involved in multiple programs, including high-priority ones like COVID-19 initiatives. This multifaceted role can add to their workload and stress, pointing to the need for better resource allocation and support to manage multiple responsibilities. A majority (92.6%) of ASHA workers are involved in multiple programs, including high-priority ones like COVID-19 initiatives. This multifaceted role can add to their workload and stress, pointing to the need for better resource allocation and support to manage multiple responsibilities. Table 2 shows the ASHA workers stated that (95.3%) harassment by hospital staff was a common experience for them. ASHA stated that this serious issue underscores the need for protective measures, safe working environments, and support systems to address and prevent harassment. Majority 89.3% of ASHA workers experience high levels of stress. The high stress levels may be attributed to the combination of heavy workload, inadequate incentives. Shows the facilities unavailable for ASHA at their workplace (97%) have issues with access to toilets and clean drinking water. A notable 71.3% of ASHA workers face fear and stigma related to their job. A significant proportion (90.6%) of ASHA workers encounters transportation and environmental challenges. These issues can hinder their ability to perform their duties efficiently and safely.

5. DISCUSSION

The study of 150 ASHA workers reveals several critical challenges affecting their job satisfaction, performance, and overall well-being. The study finding issues highlights areas that require urgent attention to improve the working conditions and support systems for ASHA workers. In this study the majority of ASHA workers were in the age group of (30-35) year. However, in two studies conducted by Pandy et al. (2019) and Srivastava et al. (2009). Almost all ASHA were married in present study, similar to Meena et al. (2019) and Jain et al. (2008) studies where more than 78% of ASHA were married.The issues related to incentive (70%) of ASHA workers experience delay or obstructions in receiving their incentives. Financial instability due to delayed incentives can undermine motivation and job satisfaction. Similar was reported by Meena et al. (2020) study and by various other studies Pandey et al. (2019). In a study Conducted by Saxena et al. (2012) and Wang et al. (2012) ASHA workers complained about delay in paying incentives. Finding from the present study 92% of ASHA workers report being overloaded with work, leading to burnout and high stress levels. During the COVID -19 force to work extra days due to extra COVID-19related activities. The high workload is consistent with findings in other research, which link excessive workload to increased stress and reduced job performance Rattu et al. (2022).

Effective training is essential for preparing health workers adequately for their roles and improving their performance Verma et al. (2023). The study indicates that 73.3% of ASHA workers face challenging conditions, such as extreme heat. These conditions can cause physical discomfort and health issues. Similar study by Chayal and Dagar (2017). Finding from the present study (92.6%) of ASHA workers are involved in multiple programs. Including high-priority ones like COVID-19 initiatives. They were also forced to work extra days due to extra COVID 19 related activities. These finding are similar to a study by Gupta et al. (2022). Mohiuddin et al. (2023). In this study we found prevalence of harassment with95.3% of ASHA workers experiencing harassment from hospital staff. The high levels of violence were contributed by economic violence, emotional, physical and sexual violence from their own husbands. Due to this sudden outbreak of the COVID 19 pandemic the violence against health care workers has increased to many folds from verbal abuse aggressive ASHA workers have also faced the issue verbal abuse and depression comments from their community members this finding is similar with the study by Mergenthaler et al. (2023). A significant proportion (89.3%) of ASHA workers experience high levels of stress, attributable to heavy workload, inadequate incentives, and challenging conditions.

ASHA workers project heavy work related stress which was a major challenge in their routine work Gupta et al. (2022) similar study addressing stress requires a comprehensive approach that

includes better workload management, improved incentives, and support for mental health. The study highlights that 97% of ASHA workers face issues with access to toilets and clean drinking water. ASHA workers were to travel long distances due to which they do not get access to toilets and clean drinking water. Basic facilities are fundamental for maintaining health and comfort at the workplace. These findings are similar to the study by Rattu et al. (2022) and other similar finding of the study by Panda et al. (2019). A notable 71.3% of ASHA workers face fear and stigma related to their job. Stigma can affect workers' morale and social interactions. During the lockdown all sector of the country were shut which led to the loss of job of daily wages workers leading to economic loss and financial crisis. These finding are similar to the study by Rao et al. (2021) and Upadhyaya (2022). Transportation and environmental challenges affect 90.6% of ASHA workers, hindering their ability to perform their duties efficiently and safely. Due to lockdown all forms of transport were paused ASHA workers faced many difficulties to reach the assigned area. This finding is similar to a study by Meena et al. (2020); Saprii et al. (2015); Patil and MubashirAngolkar (2023).

6. CONCLUSION AND RECOMMENDATIONS

The present study offers a comprehensive evaluation of the duties, responsibilities, and challenges faced by ASHA (Accredited Social Health Activist) workers. As primary grassroots-level health workers, ASHA workers play a crucial role in delivering essential healthcare services directly to the community's doorsteps. Despite their pivotal position in the healthcare system, they encounter a range of significant problems that impact their job satisfaction, performance, and overall well-being. ASHA workers face numerous issues stemming from their personal lives and the challenging conditions of their workplace. These include financial instability due to delays in receiving incentives, inadequate access to basic facilities like toilets and clean drinking water, and difficulties related to extreme environmental conditions. The geographical conditions of their work areas, often remote or underserved, pose significant challenges. Long travel distances and inadequate transportation facilities further complicate their ability to perform their duties effectively and safely.

The study highlights a high incidence of harassment from various sources, including hospital staff and community members. ASHA workers experience various forms of violence, economic, emotional, physical, and sexual. They also face stigma related to their roles, which affects their morale and social interactions. This harassment, combined with verbal abuse and mental health struggles, underscores the need for a supportive and protective work environment. A concerning finding is the prevalence of social discrimination based on caste and religion. ASHA workers are often overloaded with responsibilities, particularly during crises such as the COVID-19 pandemic.

To address these challenges and improve the working conditions for ASHA workers, several measures are recommended:

- Ensure prompt and regular disbursement of financial incentives to alleviate financial instability and enhance motivation
- Improve access to essential facilities such as toilets and clean drinking water, particularly in remote areas
- Enhance training programs to equip ASHA workers with the skills and knowledge necessary to perform their duties effectively. Provide additional support to manage the high workload and stress associated with their roles
- Implement protective measures and support systems to address and prevent various forms of harassment and discrimination, including providing legal and psychological support
- Improve transportation infrastructure and support systems to facilitate easier and safer travel to work areas.

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