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CHALLENGES OF ASHA WORKERS IN COMMUNITY PERCEPTIONS AND THEIR ROLE IN HEALTH PROMOTION

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ABSTRACT

This study investigates the obstacles encountered by Accredited Social Health Activists (ASHAs) and the community's opinions of their function in health promotion throughout rural India, specifically in Guntur district. A quantitative, descriptive research design was utilised, gathering data from 400 ASHA workers using stratified random sampling and structured questionnaires. The findings indicate multiple significant constraints, such as obstacles in reaching rural families, delays in incentive disbursements—particularly for novice workers and complications regarding work-life balance for individuals with less expertise. ASHAs with elevated educational qualifications and greater experience are perceived as more credible and efficient by the community, and they typically obtain more prompt information regarding health initiatives. The research reveals that enhanced training, mentorship, and improved infrastructure further augment the confidence and reliability of ASHA workers as essential health resources. The findings highlight the urgent necessity for enhancements in rural mobility, more effective incentive allocation, continuous training opportunities, improved communication channels, and consistent feedback mechanisms from the community. Addressing these operational and structural obstacles is crucial for empowering ASHA workers, maintaining their motivation, and improving their capacity to facilitate healthcare access and encourage healthy behaviours in rural communities.

KEYWORDS: Accredited Social Health Activists (ASHA), Rural Health, Health Promotion, Training, Incentives.

1. INTRODUCTION

India's healthcare system has significant obstacles in providing equal, high-quality services to its varied population, especially in rural and marginalised regions. In response, the National Rural Health Mission (NRHM) launched the Accredited Social Health Activist (ASHA) program in 2005, which has become a crucial element in revolutionising grassroots healthcare delivery. This effort involves approximately 1 million ASHA workers, who are community-selected women acting as vital intermediaries between rural communities and formal health services, thereby enhancing access to maternal and child healthcare, health education, and disease prevention.

Initially conceived as enablers of healthcare access, ASHA workers have subsequently broadened their jobs to encompass a diverse range of activities. This encompasses performing house visits for pregnancy counselling, providing birth escort services, spearheading immunisation campaigns, delivering healthcare education, supplying nutritional assistance, executing illness surveillance, and dispensing needed drugs. With India emerging as the most populated nation globally, the demand for efficient, culturally attuned, and accessible healthcare has intensified. The robust community connections, linguistic proficiency, and capacity to customise interventions of ASHA workers have rendered them beneficial in diminishing vital health metrics like as newborn and maternal mortality, while enhancing institutional delivery rates.

Nonetheless, notwithstanding these accomplishments, ASHA personnel persistently encounter considerable professional obstacles. These factors encompass excessive workloads, inadequate remuneration, poor training, and exposure to gender biases and societal norms, especially in conservative areas. Moreover, the absence of prompt incentive disbursements, evolving duties under programs such as Ayushman Bharat, and the necessity for ongoing skill enhancement further exacerbate their capacity constraints. These problems underscore the urgent necessity for policy reforms, more training, the digitisation of healthcare support, and increased financial and social acknowledgement for ASHA workers to augment their contributions and motivation.

This study seeks to analyse the distinct problems encountered by ASHA workers and to evaluate community opinions regarding their role in health promotion. The project aims to provide specific recommendations through the analysis of quantitative data to enhance the operational framework of ASHA workers, improve rural health outcomes, and promote sustainable, community-driven healthcare advancements throughout India.

2. Review of literature

A recent survey of 150 ASHA workers in Uttar Pradesh highlights significant issues, including delayed incentive payments (70%), excessive workloads (92%), and insufficient training (71.3%). Environmental problems such as inadequate access to sanitation facilities and potable water, along with transportation obstacles, impact 97% and 90.6% of workers, respectively. Moreover, occurrences of harassment, stress, and social stigma are prevalent, leading to diminished morale and decreased job satisfaction. The findings underscore the imperative to enhance working conditions, implement protective measures, and furnish robust administrative assistance to elevate ASHAs' performance and general well-being (Abrar & Malik, 2024).

A qualitative assessment indicates that ASHA workers experience job instability stemming from short-term or informal contracts, ambiguous career progression opportunities, and erratic oversight from healthcare officials. Adverse connections with hospital personnel, community scepticism, discriminatory practices, and inconsistent availability of work resources impede their efficacy. Moreover, difficult terrains, excessive workloads, and insufficient infrastructure constrain their outreach, especially in rural areas. The evaluation advocates for the implementation of standardised support systems, official acknowledgement, and effective grievance processes to mitigate these obstacles and guarantee ongoing participation in community health initiatives (Sharma et al., 2014).

Recent studies indicate that ASHA workers possessing better educational levels are more inclined to conduct regular awareness sessions and perceive their training as more helpful in enhancing public health knowledge. Ongoing training, mentorship, and professional growth are associated with enhanced community health knowledge and elevated regard for ASHAs. These considerations highlight the significance of continuous professional development in augmenting the effectiveness of ASHA workers in health outreach (Gupta et al., 2024).

A comprehensive assessment of ASHA programs in various Indian states reveals that competency-based training, mentoring, and well-defined roles are critical determinants of ASHA efficacy and sustainability. States that implement robust training and support systems for ASHAs have superior maternal, child, and overall health results compared to those lacking continuous capacity-building programs (Sundararaman, Ved, & Rao, 2012). Enhancements in training are directly linked to elevated community involvement and augmented health service use.

Moreover, extensive survey data indicates that active engagement of ASHAs markedly enhances institutional deliveries, especially within low-resource rural and tribal communities.

Quantitative examination of data from India's National Family Health Survey indicates that ASHA-facilitated maternal health interventions significantly enhance the probability of institutional delivery, particularly benefiting the most vulnerable populations (Mishra, Upadhyay, & Raj, 2024).

The depth and frequency of training significantly influence community attitudes and the motivation of ASHA workers, especially in complex domains such as mental health. Qualitative research indicates that although ASHAs possess intrinsic motivation and a desire to enhance their competencies, they underscore the necessity for more regular, specialised, and contextually relevant training, especially in mental health service provision (Bansal, Joshi, Kaur, & Mathur, 2021).

3. Objectives of the study

1. To identify challenges faced by ASHA workers in promoting community health.
2. To assess community perceptions regarding the effectiveness of ASHA interventions.

4. Research Methodology:

The research methodology for this study was and descriptive quantitative in nature. A structured questionnaire was administered to 400 ASHA workers selected using stratified random sampling based on experience and educational background. The survey assessed challenges such as workload, travel difficulties, delayed incentives, and access to scheme updates. Data collection adhered to ethical guidelines, ensuring voluntary participation and confidentiality. Descriptive statistics, chi-square tests, and ANOVA were used to analyze associations between variables like experience, education, and perceived community respect. The results provide insights into determinants of ASHA worker effectiveness and inform targeted policy recommendations for operational improvements.

5. Data analysis and interpretation:

Table 5.1.1 Chi-Square Tests for Do you face travel difficulties reaching some households? vs Years of Experience

Chi-Square Tests			
	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	4.414[a]	3	.220
Likelihood Ratio	4.426	3	.219
Linear-by-Linear Association	4.098	1	.043
N of Valid Cases	400		
a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 38.00.			

Interpretation: From the above table, the Chi-Square value is 4.414, with a p-value of 0.220. Since the p-value is greater than 0.05, the null hypothesis is accepted. This indicates that there is no significant association between years of experience and facing travel difficulties in reaching households. Both new and experienced workers encounter similar levels of difficulty when covering remote or hard-to-reach areas. The finding suggests that travel-related challenges are more related to geography, infrastructure, and transport availability rather than professional experience.

Table 5.1.2 Chi-Square Tests for Have you experienced delayed incentive payments? vs Years of Experience

Chi-Square Tests			
	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	10.504[a]	3	.015
Likelihood Ratio	10.563	3	.014
Linear-by-Linear Association	8.566	1	.003
N of Valid Cases	400		
a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 36.25.			

Interpretation: From the above table, the Chi-Square value is 10.504, with a p-value of 0.015. Since the p-value is less than 0.05, the null hypothesis is rejected. This indicates a significant association between years of experience and experiencing delayed incentive payments. The results suggest that delays in financial incentives are not uniformly distributed but vary with the length of service.

Table 5.1.3 Chi-Square Tests for I find it hard to balance work and personal life. vs Years of Experience.

Chi-Square Tests			
	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	204.741[a]	9	.000
Likelihood Ratio	237.294	9	.000
Linear-by-Linear Association	181.772	1	.000
N of Valid Cases	400		
a. 4 cells (25.0%) have expected count less than 5. The minimum expected count is 1.00.			

Interpretation: From the above table, the Chi-Square value is 204.741, with a p-value of 0.000. Since the p-value is less than 0.05, the null hypothesis is rejected. This indicates a significant association between years of experience and difficulty balancing personal and professional life. Less experienced workers report higher struggles in maintaining balance compared to those with more years of service.

Table 5.1.4 Chi-Square Tests for I receive timely updates on health schemes. vs Years of Experience

Chi-Square Tests			
	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	211.080[a]	9	.000
Likelihood Ratio	244.959	9	.000
Linear-by-Linear Association	186.687	1	.000
N of Valid Cases	400		
a. 4 cells (25.0%) have expected count less than 5. The minimum expected count is .75.			

Interpretation: From the above table, the Chi-Square value is 211.080, with a p-value of 0.000. Since the p-value is less than 0.05, the null hypothesis is rejected. This shows a significant association between years of experience and receiving timely updates on health schemes. Newer workers appear less likely to get timely updates compared to more experienced staff, who may have stronger networks and access to communication channels.

5.2 ANOVA

Table 5.2.1 ANOVA for I am approachable and trusted by community members.

ANOVA					
	Sum of Squares	**df**	**Mean Square**	**F**	**Sig.**
Between Groups	16.225	4	4.056	16.653	.000
Within Groups	96.213	395	.244		
Total	112.438	399			

Interpretation: The ANOVA results examine whether there is a significant difference in how approachable and trusted individuals are perceived by the community across different education levels. The F-value of 16.653 with a p-value of 0.000 indicates that the differences between the groups are statistically significant at the 0.05 level. Since the p-value is less than 0.05, the null hypothesis is rejected, suggesting that educational qualification has a significant impact on how community members perceive approachability and trustworthiness. This means that individuals with higher education levels are generally seen as more approachable and trusted, supporting the trend observed in the descriptive statistics.

Table 5.2.2 ANOVA for I am seen as a reliable health resource by the community.

ANOVA					
	Sum of Squares	**df**	**Mean Square**	**F**	**Sig.**
Between Groups	11.160	4	2.790	14.513	.000
Within Groups	75.938	395	.192		
Total	87.098	399			

Interpretation: The ANOVA results examine whether there is a statistically significant difference in the perception of being a reliable health resource among the community across different educational qualifications. The F-value is 14.513, and the p-value is 0.000, which is less than the 0.05 significance level. This indicates that there is a significant difference between the groups. In other words, educational qualification has a significant impact on how community members perceive an individual's reliability as a health resource.

Table 5.2.3 ANOVA for My work has improved health behavior in the community.

ANOVA					
	Sum of Squares	**df**	**Mean Square**	**F**	**Sig.**
Between Groups	14.325	4	3.581	15.101	.000
Within Groups	93.675	395	.237		
Total	108.000	399			

Interpretation: The ANOVA results examine whether there is a significant difference in perceptions of how much their work has improved health behavior in the community across different educational levels. The F-value is 15.101, and the p-value is 0.000, which is less than the significance threshold of 0.05. This indicates that the differences between the groups are statistically significant. Therefore, we reject the null hypothesis and conclude that educational level has a significant effect on how individuals perceive the impact of their work on community health behavior.

Table 5.2.4 ANOVA for I feel the villagers respect my advice and support.

ANOVA					
	Sum of Squares	**df**	**Mean Square**	**F**	**Sig.**
Between Groups	9.615	4	2.404	10.836	.000
Within Groups	87.625	395	.222		
Total	97.240	399			

Interpretation: The ANOVA results examine whether there is a significant difference in how participants perceive respect and support from villagers across different educational levels. The F-value is 10.836 and the p-value is .000, which is less than the 0.05 significance level. This indicates that the differences in mean perceptions among the educational groups are statistically significant. In other words, educational level has a significant impact on how respected and supported participants feel by the community. Participants with higher educational qualifications tend to report greater respect and support from villagers compared to those with lower educational levels.

Table 5.2.5 ANOVA for I am satisfied with how the community perceives my role

ANOVA					
	Sum of Squares	**df**	**Mean Square**	**F**	**Sig.**
Between Groups	15.985	4	3.996	17.325	.000
Within Groups	91.113	395	.231		
Total	107.098	399			

The ANOVA results examine whether satisfaction with how the community perceives participants' roles differs significantly across educational levels. The **between-groups sum of squares** is 15.985 with 4 degrees of freedom, giving a **mean square** of 3.996. The **within-groups sum of squares** is 91.113 with 395 degrees of freedom, yielding a mean square of 0.231. The resulting **F-value is 17.325**, and the significance level (**p = 0.000**) is well below the 0.05 threshold. This indicates a **statistically significant difference** in satisfaction among participants with different educational qualifications. In other words, educational level significantly influences how satisfied participants feel about the community's perception of their role.

Findings of the Study:

- A significant number of ASHA workers face travel difficulties reaching remote households.
- Delayed incentive payments show a significant association with years of experience, with newcomers facing more delays.
- Less experienced ASHA workers report higher difficulty in balancing work and personal life.
- More experienced workers receive timely updates on health schemes compared to new recruits.
- Higher educational qualifications correlate with better community perception of ASHA workers' approachability and trustworthiness.
- ASHA workers perceive their role has positively influenced community health behaviors.

Suggestions

- Improve rural transport infrastructure and provide travel support facilities.
- Streamline payment processes and ensure timely disbursement of incentives.
- Implement mentorship programs and provide flexible work schedules.
- Develop equitable communication systems to ensure all workers receive timely information.

- Offer continuous education and training to enhance ASHA workers' skills and credibility.
- Strengthen community engagement initiatives and provide regular feedback mechanisms.

CONCLUSION

ASHAs play an essential role in bridging healthcare gaps in rural India, significantly impacting maternal, child, and community health. Despite notable achievements, challenges like delayed payments, workload pressures, and communication disparities reduce their effectiveness and satisfaction. Educational level and experience positively influence community perceptions and role effectiveness. Addressing systemic barriers through policy reforms, infrastructure development, and capacity-building will strengthen ASHA workers' contributions. Empowering ASHAs with adequate resources, timely incentives, and continuous education ensures sustainable community health advancement, essential for meeting India's evolving health needs.

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