# A Situation Assessment Study on Knowledge, Skills and Challenges Faced by Accredited Social Health Activists (ASHAs) in Maharashtra

**A research report submitted to the Government of Maharashtra**

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## ABSTRACT

**Background**: The National Rural Health Mission (NRHM) programme in 2005 formulated a new cadre of Accredited Social Health Workers (ASHAs). Initially, ASHAs focused on maternal and child health, family planning, and primary health care delivery. However, as the programme has evolved, ASHAs have been entrusted with additional responsibilities to meet emerging health challenges. National Urban Health Mission (NUHM) in 2013 led to the expanded role of ASHAs in urban areas. During COVID-19 pandemic ASHAs important role in ensuring healthcare delivery services during emergency situations, right at the doorsteps of pandemic-affected rural and urban communities has been widely acknowledged globally as well as nationally. The World Health Organization (WHO) conferred the WHO Director-General's Global Health Leaders Award to ASHAs for their outstanding contribution towards protecting and promoting health during difficult pandemic situations. However, post-COVID-19 period witnessed several challenges and protests in different parts of the country including Maharashtra. These post-COVID developments provided the necessary impetus to investigate the present knowledge, skills and challenges faced by ASHAs while performing their role as ASHAs in urban and rural communities of Maharashtra.

**Methodology**: This multicentric cross-sectional descriptive mixed-methods study was carried out in 8 NHM headquarters districts of Maharashtra. The sample size consisted of 956 ASHAs and 56 stakeholders. Data collection tools were semi-structured interview schedules for ASHAs and interview guides for stakeholders. Qualitative and quantitative data analysis was done using MAXQDA-24 and SPSS, respectively.

**Results:** Over half (52%) of urban ASHAs have had low knowledge scores, while 90% of rural ASHAs have had high knowledge scores. The induction training of ASHAs comprised a variety of topics ranging from MCH to sanitation. However, more emphasis is placed on MCH training. Over three-fourths (82%) of ASHAs were given online data entry training; however, the training lacked practical hands-on. More than half (51%) of ASHAs responses were not affirmative when asked about a reduction in data entry time due to online data entry as they had to do dual entry-online as well as in written reports. Irregular payments have proven to be a factor in the dissatisfaction of ASHAs. Almost two-thirds (64%) of ASHAs worked for more than 20 hours weekly. Two-thirds (67%) of ASHAs were union members, influencing their day-to-day functioning. Over three-fourths (85%) of ASHAs voiced the need for a grievance redressal system.

**Conclusion**: There is an emerged need for more practical and periodical reorientation training for ASHAs. The training should focus on MCH and other health areas like NCDs, Nutrition and sanitation. There is a demand for fixed working hours and regular payments by ASHAs. More emphasis should be placed on establishing ASHA-friendly grievance redressal system which will be receptive to the day-to-day problems of ASHAs and thereby would try to mitigate the unmet needs of ASHA and would support them in their day-to-day tasks.

# INTRODUCTION

**Background and rationale:** In 2005, India launched the Accredited Social Health Activist (ASHA) programme as a critical component of the National Rural Health Mission (NRHM) to strengthen rural government service delivery, community engagement and ownership in health programmes. The ASHA programme involved the selection of one woman per village (approximately 1 per 1000 population) who would receive an initial 23 days of training on basic health topics and link community members to health services, provide basic first aid and supplies, and mobilize the community around water, sanitation, nutrition and health issues. The NRHM programme envisaged ASHAs as honorary volunteers who would be remunerated through performance-based payment (PBP). ASHAs are recognized as female honorary volunteers compensated based on an honorarium' under different national health programmes and earn from the social marketing of various healthcare products.

In the second phase of NRHM, under the revised guidelines for community processes, it was emphasized that ASHAs' voluntary nature should be maintained, assuming that it does not interfere with their other source of livelihood. Earning from their contribution to various health programme activities was considered a 'monetary compensation' for ASHAs' time, and in consonance, ASHAs are supposed to work as 'link workers', 'service providers' and 'health activists'. The NRHM gradually transformed into the National Health Mission in 2015 and was extended to marginalized urban areas. With almost one million ASHAs now selected and trained, it has grown to become one of the most extensive Community Health Worker programmes in the world. Thus, significant changes have occurred in the working context, health system, and community dynamics since 2005. Post COVID-19 pandemic, the World Health Organization (WHO) acknowledged the pivotal role ASHAs played during the COVID-19 pandemic and recognized their contribution by conferring the "Global Health Leaders Award".

**Understanding the context of ASHAs' incentives and benefits:** ASHAs are envisaged as community health volunteers entitled to task/activity-based incentives. ASHAs receive a fixed monthly incentive of Rs. 2000 from the Central Government for routine and recurring activities. Additionally, they are provided performance-based incentives for various activities under various National Health Programmes. States/UTs, in their programme implementation plans, have also been given flexibility to provide a range of monetary incentives to the ASHAs. After the launch of the Ayushman Bharat scheme with the operationalization of Ayushman Bharat- Health and Wellness Centres (AB-HWCs), ASHAs are now additionally eligible for Team-Based Incentives (TBIs) along with ANMs based on monitored performance indicators (up to Rs. 1000 per month). The Government has also approved a cash award of Rs. 20,000/- and a citation to ASHAs who leave the programme after working as ASHAs for a minimum of 10 years to acknowledge their contribution. The Central Government introduced the ASHA benefit package to acknowledge the significant contribution and commitment of ASHAs.

**ASHAs' Knowledge and Skill-Sets:** After becoming ASHAs, all ASHAs need to undergo 23 days of training on introductory health topics. After this training, there have been efforts to impart skills in monthly meetings and feedback sessions, but do these trainings suffice for their present needs? No comprehensive assessment of the knowledge and skill sets of ASHAs has been done periodically in India.

**ASHAs in Maharashtra:** There are a total of 62,090 ASHAs appointed for rural areas in Maharashtra, and 10,320 ASHAs were appointed for urban areas. In addition, 3604 ASHA Group Coordinators have been appointed in rural areas. Out of the total 72412 ASHAs in the State of Maharashtra, 86% of ASHAs are assigned to rural areas, and the rest, 14%, are assigned duties in urban areas.

**ASHAs incentives in Maharashtra:** ASHAs tasks for which they can claim incentives reached 64 in Maharashtra State. ASHAs received 8000 Rs as monthly compensation, 5000 Rupees from the State Government and 3000 Rs from the Central Government. In addition, depending on their performance, they are eligible to receive a Rs. 14,975/- travel allowance. Meanwhile, ASHA group coordinators would receive monthly compensation of Rs. 6,200 depending on their field visits (Rs. 168 per field visit) and travel allowance compensation of Rs. 500 for COVID-related work.

**ASHAs insurance coverage and beneficiaries in Maharashtra:** Under the Pradhan Mantri Jeevan Jyoti Beema Yojana (PMJJBY) with a benefit of Rs. 2.00 Lakh in case of death of the insured (annual premium of Rs. 330 contributed by GOI), so far 1190 ASHAs received benefits. Under Pradhan Mantri Suraksha Bima Yojana (PMSBY) with a benefit of Rs. 2.00 lakh for accidental death or permanent disability; Rs. 1.00 lakh for partial disability (annual premium of Rs. 12 contributed by GOI), so far, 1285 ASHAs got benefitted. Moreover, Pradhan Mantri Shram Yogi Maan Dhan (PM-SYM) with a pension benefit of Rs. 3000 pm after the age of 60 years (50% contribution of premium by GOI and 50% by beneficiaries), so far, 952 ASHAs have benefitted. In addition, under the Atal Pension Scheme, pension benefits between Rs. 1000 to Rs 5000/- were received by 403 ASHAs after the age of 60 years. Furthermore, under the Pradhan Mantri Garib Kalyan Pension Scheme, insurance coverage of Rs. 50.00 Lakhs in case of loss of life due to COVID-19-related duty was provided to 13 ASHAs in Maharashtra.

**Statement of Problem:** No regular and comprehensive assessment of knowledge and skill sets of ASHAs has been done in Maharashtra. Further, concerning ASHAs, six major issues are observed as challenges at the State Headquarters. The first challenge is that ASHA's association or union influences ASHA's present work or contribution, facilitating frequent strikes, protests and demands for regularising and increasing salaries. Second is ASHAs' resistance to online data entry. Third is delays in following instructions, leading to late implementation of assigned tasks/ activities. These delays could be due to issues in communication between higher authorities and ASHA. Fourth is non-performing ASHAs – a sizeable number of ASHAs are satisfied with receiving 8000 Rs fixed monthly compensation and choose not to perform assigned tasks and get incentives. The fifth striking issue concerns the use of ASHAs by other non-health departments. Other non-health departments' priorities come in the way of ASHA, and there are increased problems when other departments do not pay ASHAs for their work. Sixth and last but not least, a critical challenge is around ASHAs' social security and safety while doing community outreach work. The six challenges stated by ASHAs are classified into three key challenges. First is organizational challenges, which encompass salary, performance-based payments, communication issues from higher authorities leading to delays and gaps in performance, working with other departments and not getting compensation, and online data entry on computers or smartphones.

On the other hand, contextual challenges would be the social security and safety of ASHAs and non-performing ASHAs. The individual challenges encompass age, marital status, family background, family support, respect and self-esteem received in the community, attitude towards work, and familiarity with rural settings. Against this background and problems, we have conducted a situation assessment study of ASHAs in Maharashtra with the following aims and objectives.

**Aim of the Study:** To assess knowledge, skills and challenges in the day-to-day functioning of ASHAs in Maharashtra.

**Objectives of the Study**

1) To obtain a multi-stakeholder perspective on individual, organizational and contextual challenges that ASHAs face in their day-to-day functioning.

2) To identify leads for strengthening ASHAs' service provision concerning primary health care activities.

**SIGNIFICANCE OF THE STUDY**

Firstly, the study aims to fill a critical gap in understanding the evolving role of ASHAs and the impact of recent health system changes in Maharashtra. As frontline healthcare workers, ASHAs are pivotal in delivering essential healthcare services and promoting community health awareness. However, with evolving healthcare needs and policy changes, assessing the challenges, knowledge gaps, and skill deficiencies ASHAs face is imperative to ensure they remain effective.

Secondly, the findings from this study will serve as a baseline for implementation research to develop interventions aimed at strengthening the functioning of ASHAs in Maharashtra. By identifying specific challenges and areas for improvement, State-level policymakers, the SHSRC and the Department of Health Sciences SPPU Team authorities can design targeted strategies and capacity-building initiatives to enhance ASHAs' performance and effectiveness in delivering healthcare services. These interventions, in turn, can lead to improved health outcomes and healthcare delivery for the population of Maharashtra.

Furthermore, if required, the study will provide valuable feedback for designing re-orientation training for ASHAs. Re-orientation training can help address knowledge gaps and skill deficiencies identified during the assessment, ensuring that ASHAs are equipped with the necessary competencies to meet the evolving healthcare needs of their communities.

Additionally, the study has the potential to provide leads for further interventions to address systemic issues and barriers faced by ASHAs in Maharashtra. By understanding the root causes of ASHAs' challenges, policymakers can develop comprehensive strategies to overcome obstacles and create an enabling environment for ASHAs to thrive in their roles.

## METHODOLOGY

### STUDY SITES

The study site for our research encompasses 8 circles of Maharashtra, strategically selected to provide a comprehensive understanding of ASHA activities across diverse geographic, economic, and cultural contexts. These circles include Thane, Pune, Kolhapur, Nagpur, Aurangabad, Latur, Nashik, and Akola. By including headquarters and municipal corporations within these circles, we ensure a mix of urban and rural settings, reflecting the varied environments in which ASHAs operate. Each selected circle represents a distinct region of Maharashtra, characterized by unique economic activities, cultural heritage, and developmental contexts. For instance, Pune, being a major urban center, presents challenges and opportunities distinct from those in rural areas like Latur. Nagpur, known for its industrial and commercial significance, offers insights into the impact of urbanization on healthcare delivery. Meanwhile, places like Aurangabad and Nashik, with their historical significance and cultural diversity, provide a rich backdrop for understanding community health dynamics. The inclusion of circles with diverse economic and cultural profiles enriches our study by capturing the complexities of ASHA work in Maharashtra. Economic disparities, cultural practices, and developmental priorities vary across these regions, influencing healthcare access and utilization. By exploring ASHA activities within these varied contexts, we can identify region-specific challenges and successes, offering valuable insights for policy and

practice. Overall, the strategic selection of these 8 circles ensures a broad spectrum of experiences and challenges faced by ASHAs in Maharashtra. This approach enhances the study's ability to provide meaningful conclusions and recommendations that cater to the diverse needs of the state's ASHA workforce and the communities they serve.

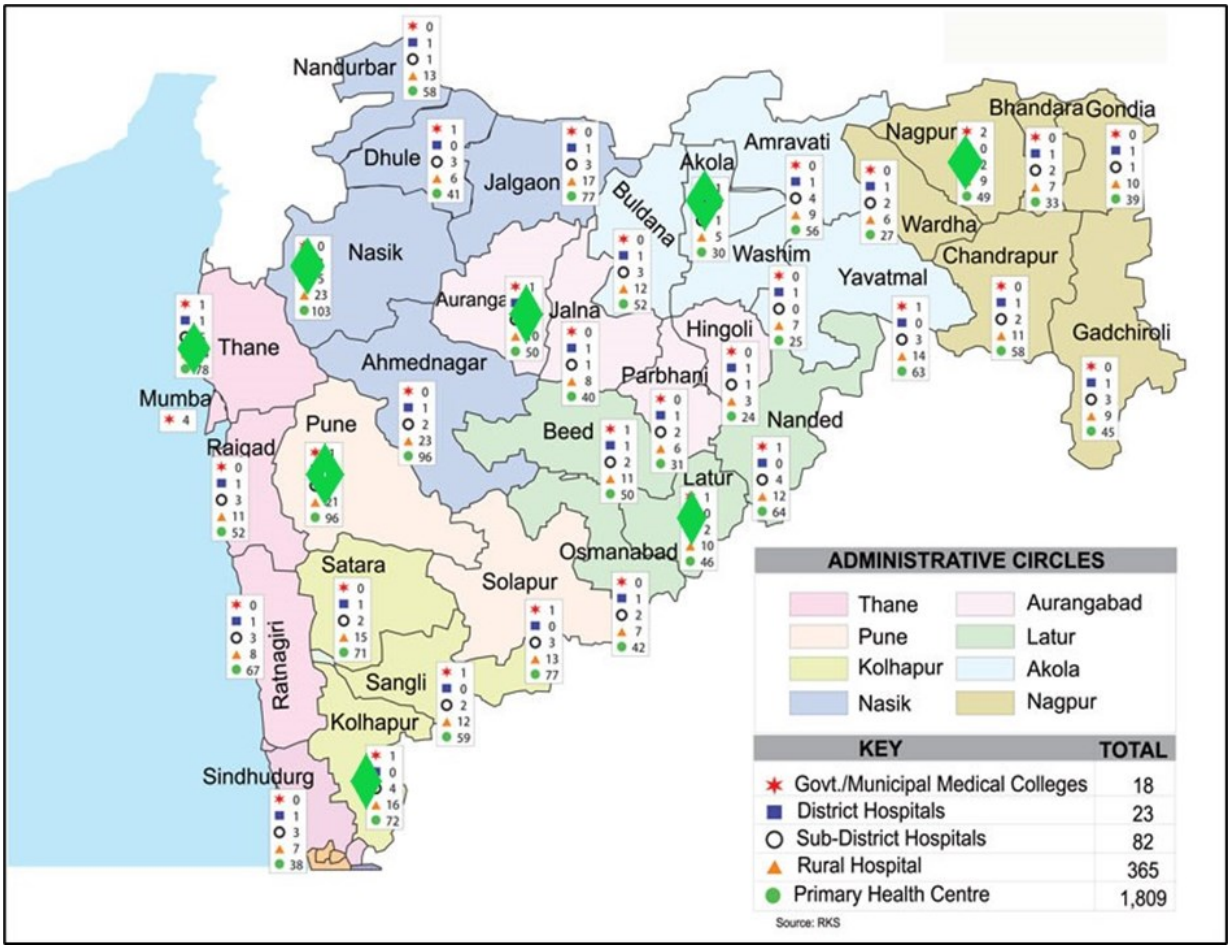


***Fig 1- Maharashtra District Map Showing 8 NHM Headquarters***

**STUDY DESIGN**

The research employs a **cross-sectional descriptive study design** to delve into the challenges encountered by Accredited Social Health Activists (ASHAs) in Maharashtra. This methodology is

chosen to provide a snapshot of the current situation and gain insights into various aspects of ASHAs' experiences and perceptions. The primary data collection method involves conducting semi-structured interviews with ASHA workers. These interviews allow for open-ended questions that encourage participants to express their thoughts, experiences, and challenges freely. By engaging directly with ASHAs, researchers can gather firsthand accounts of their daily realities, including their experiences with honorarium, performance-based payments, and future aspirations. Additionally, qualitative interviews are conducted with stakeholders involved in the ASHA program, such as healthcare officials, community leaders, and representatives from non-governmental organizations (NGOs). These interviews offer a broader perspective on ASHA-related issues and provide insights into how various stakeholders perceived ASHA roles, challenges, and support mechanisms.

## SAMPLING METHODS AND APPROACH

### *Sampling Frame:*

The sampling frame for this study covers every Accredited Social Health Activist (ASHA) operating within the eight National Health Mission (NHM) circles in Maharashtra. This ensures that ASHAs from various areas across the state are included, offering a comprehensive view of their roles and contributions to healthcare.

We identified stakeholders at different levels of the healthcare system within the NHM Circle where ASHAs were interviewed. This included individuals from primary health centers, block or taluk levels, and district-level health departments. By involving stakeholders associated with ASHAs directly or indirectly, we aimed to gather diverse perspectives on ASHA-related activities and challenges.

### *Sub - Sample*

For our study, we adopted a stratified sampling approach, which involves selecting participants based on specific criteria relevant to various stratums, namely urban and rural ASHAs working in urban health centres and rural primary health centres. In our case, we aimed to explore the roles and contributions of ASHAs within both rural and urban contexts across Maharashtra's NHM

Circles. Recognizing that the majority of ASHAs primarily serve in rural regions, we opted for a distribution of 80% rural ASHAs and 20% urban ASHAs within each NHM Circle. This distribution was intended to accurately reflect the typical distribution of ASHAs and ensure that our findings were representative of their rural and urban work environments. To implement this sampling strategy, we identified four rural primary health centers and two urban health centers within each NHM headquarter districts. By selecting multiple centers in both rural and urban areas, we aimed to capture the diversity of ASHA activities across different settings. By balancing our sample between rural and urban areas and across NHM headquarter districts, we aimed to generate insights that are applicable and relevant to the diverse contexts in which ASHAs operate throughout Maharashtra.

At the primary health center level, we interviewed Medical Officers who oversee medical services, ANMs who work closely with ASHAs in maternal and child healthcare, and ASHA Coordinators who supervise and support ASHAs in their areas. At the block level, interviews included Block Community Mobilizers (BCMs) responsible for community mobilization and Block Facilitators (BFs) who support ASHAs and other frontline health workers. Moving to the district level, we engaged with District Community Mobilizers (DCMs) overseeing community mobilization efforts and District Health Officers (DHOs) responsible for overall healthcare management and policy implementation. These stakeholders provided detailed insights into ASHA-related activities and challenges within their respective levels of the healthcare system.

### *3.3.3 Sample Size Calculation*

The sample size for the ASHAs was calculated using the Sample size formula where we took 95% to not have a prior estimate of p, so we can assume the worst case scenario and use p = 0.5 (maximum variability). The corresponding Z Score for a 95% confidence interval is 1.96. Plugging these values into the formulae gives:

***n = (1.96^2*0.5*0.5)/0.05^2 = 384.16***

The sample size which was calculated was found to be 384, An ideal design effect of 2 would double the sample size, So the sample size of 768 ASHAs was proposed for the study with a ratio of 80:20 Rural and urban ASHAs. The design effect of 2 signifies that the sampling design

increases the standard error by a factor of 2 compared to a simple random sample of the same size. Additional data was collected on the field which made the final sample as 956 ASHAs.

***Written Informed Consent:***

Before commencing data collection within a specific NHM Headquarter District, the District Community Mobilizer (DCM) received prior notification from the State Health Systems Resource Centre (SHSRC). This proactive step ensured coordination and transparency in the data collection process. Additionally, the DCM liaised with the Medical Officers of the designated primary health centers (PHCs) within the targeted NHM Headquarter Districts. The Medical Officers, in turn, communicated this information to all ASHAs operating under their jurisdiction. Furthermore, prior to conducting interviews, informed written consent was diligently obtained from each participant. This crucial step ensured that the ASHAs fully understood the purpose and implications of their involvement in the study. Any questions or concerns raised by the ASHAs were thoroughly addressed during the consent process, promoting clarity and mutual understanding. To safeguard the confidentiality of the collected data, stringent measures were implemented. Each participant was assigned a unique code, thereby anonymizing their identity. This coding system ensured that participant names remained undisclosed throughout the study. By prioritizing confidentiality, the integrity of the data was upheld, fostering trust and respect within the research process.

We thoroughly briefed each stakeholder about the purpose and significance of our study, elucidating why their insights were invaluable to our research. Only upon their agreement to participate did we proceed with the interviews.

***Total Interviews Completed:***

In Maharashtra, a comprehensive data collection effort was undertaken within the NHM Headquarter Districts. Interviews were conducted with a representative number of ASHAs, totaling 956 across the 8 circles. This highlights the importance placed on understanding the experiences of these frontline rural healthcare workers. Additionally, 56 stakeholders were interviewed, with representation across different levels of the healthcare system. This multi-layered approach ensures a well-rounded perspective by capturing insights from those directly

involved in healthcare delivery (ASHAs) as well as those managing healthcare at various administrative levels.

***Final sample size considered for the Analysis***

The sample size of 956 ASHAs which was collected was considered totally for the analysis whereas, total 56 stakeholders were interviewed which was totally considered for the analysis including different levels of health system (PHC Level, Block Level, District level, State level

**DATA COLLECTION METHOD**

***Interview:***

One-on-one interviews were conducted with the ASHAs at the primary health centers. Teams of four interviewers would visit each center and conduct the interviews. Within each center, approximately 20 ASHAs were called in one by one for a private interview, ensuring no outside influence. The interview procedure involved asking questions from a semi-structured questionnaire and recording the ASHAs' responses on mobile phones. Whenever necessary, interviewers probed further with additional questions to extract the maximum details about challenges, knowledge, and skills.

During stakeholder interviews, participants were accommodated in settings where they felt at ease, such as medical officers' offices or nurses' stations. Each stakeholder was interviewed individually, allowing for focused attention and ensuring that pertinent information could be extracted effectively. Throughout the interviews, probing techniques were employed as needed to delve deeper into specific topics and to ensure the accuracy and completeness of the information gathered.

***Average Interview time (Range):***

The designated interview duration for ASHAs was initially set at 40-50 minutes. However, the actual interview durations ranged from 28 minutes to 1 hour and 50 minutes, with an average interview time of 52 minutes.

***Experiences during data collection:***

During the data collection phase, several significant challenges were encountered. One of the primary issues was the lack of prioritization of the ASHA study by District Community Mobilizer. This resulted in delays in the allocation of dates for data collection by the DCMs, further complicating the process. Additionally, a notable obstacle arose when ASHAs went on strike starting from January 12th. Although data collection proceeded relatively smoothly in Nagpur and Akola, other regions were significantly impacted by the strike, leading to disruptions in the data collection process. Another challenge stemmed from ASHAs' reluctance to respond openly during interviews due to apprehension about upcoming exams. This fear hindered the free flow of information and affected the quality of data collected. Despite these challenges, efforts were made to navigate through these obstacles and gather as much relevant information as possible to ensure the integrity and comprehensiveness of the study.

**STUDY INSTRUMENTS**

A semi-structured interview schedule in Marathi was utilized for collecting data from ASHAs. This schedule comprised various sections, including sociodemographic characteristics, primary duties at the village level, ASHAs' training, online data entry processes, delays in messages from higher authorities, social security concerns, weekly working hours, awards and recognition received, payment-based incentives, levels of motivation and satisfaction, skills and knowledge, workload from other departments, and suggestions from ASHAs.

An interview guide was employed for conducting stakeholder interviews during the data collection process. Four distinct interview guides were utilized, tailored to different administrative levels: PHC level, block level, district level, and state level. These guides encompassed various sections, including the adequacy of induction training, discussions held during monthly meetings, factors contributing to ASHA strikes, strategies for enhancing the ASHA program, levels of support from the health department, and issues related to payments.

## DATA MANAGEMENT AND ANALYSIS

### *MAXQDA (Data Management and analysis Software)*

MAXQDA Software was used to analyze qualitative data of ASHAs and Stakeholders both.

### *Code system/Code tree*

For ASHAs the code system was generated according to color based codes in the order of sections. A total of 30 codes were derived under different sections.

1. ASHA Profile
2. Primary duties village level
3. Motivation for ASHAs
4. Family Support for ASHAs
5. Induction Training
6. Use of Induction Training
7. Last year ASHA Training
8. Skill not taught in Training
9. Delay in Message from Higher authorities
10. Last week working hours
11. Last report
12. Training using mobile phones
13. Time reduced due to online data entry
14. Fixed hours work
15. Incentives
16. Other departments work
17. ANM/GNM Courses
18. Global Health leaders award
19. Grievance Redressal System
20. Difficulty in communication
21. Misunderstanding by community
22. Mishappening in the community

23. Safety
24. Association with union
25. Peer support
26. Pressure from higher authorities
27. Behavior of PHC Staff
28. Satisfaction as an ASHA
29. Village level action/Suggestions
30. Knowledge (Included 10 questions on Diarrhea, Pregnancy kit, fitness, ORS, HBNC, Tubectomy, Breastfeeding, Sickle cell anemia, NCDs, Immunization)

For Stakeholders The code system was generated according to color-based codes in the order of sections. A total of 22 codes were derived under different sections.

1. ASHA Induction Training Adequacy
2. ASHA Additional Training
3. ASHA Online data entry
4. ANM Task Shifting
5. Payment related issues
6. Additional workload
7. Monthly meeting discussions
8. Problems of ASHAs
9. Higher Authority Message delays
10. Help from ASHAs
11. Safety of ASHAs
12. ASHA Program Enhancement
13. Other departments work
14. Non performance of ASHAs
15. Influence of union
16. Reasons behind ASHA Strike
17. Performance of ASHAs

18. Health Department support
19. ASHA Salary Increment
20. Behavior of ANM and MO with ASHAs
21. Reasons behind ASHA Strike
22. View on Online data entry

Following the importation of data files into the MAXQDA software, manual coding was conducted. This process involved extracting meaningful excerpts from both ASHAs and stakeholders' responses and associating them with relevant codes. The purpose of this coding endeavor was to systematically organize the qualitative data based on predetermined thematic categories. By employing this method, the study aimed to derive insights, identify patterns, and elucidate themes from the narratives and observations of ASHAs and Stakeholders pertaining to various aspects of challenges, knowledge, and skills. Through this systematic approach, the study sought to uncover nuanced information that could contribute to a deeper understanding of the challenges, knowledge, and skills of ASHAs in Maharashtra.

***SPSS DATA ANALYSIS (ASHAs)***

***Data entry of quantitative variables***

The quantitative data, the responses to the questions which was used in the interview schedule was then entered into the SPSS software version 23 for further analysis, Descriptive statistics were computed to study population characteristics. The variable sheet was made in the variable view with all the Independent and dependent variables which we had in the semi structured questionnaire and then according to the particular variable the responses were entered for further analysis and statistical tests.

### *Data Analysis*

The interview schedule encompassed a multitude of variables, covering a broad spectrum of challenges and knowledge areas relevant to ASHAs. This systematic arrangement facilitated a nuanced understanding of respondents' varying levels of confidence in their answers. Following the data collection phase, a thorough analysis was conducted using SPSS software. This analysis entailed calculating both the mean, representing the average response, and the standard deviation for each question presented on the scale. With a dataset comprising a total of 956 responses, the software effectively performed these calculations. The mean provided insights into the collective viewpoint of participants on each question, while the standard deviation illuminated the degree of variability in their responses from the mean, thus enriching the understanding of the data.

### *Tests Used*

After determining the median of each variable, the data were divided into categories below and above the median. This division helped in further bivariate analysis based on the relative positioning of each variable. Chi-square tests were then utilized to examine the association between two categorical variables. A significance level of $p < 0.05$ was chosen, indicating a statistically significant relationship between variables. To explore these relationships further, relevant cross tables were created, comparing independent and dependent variables. Additionally, descriptive statistics were employed, incorporating various graphical representations such as graphs and pie charts. These visuals aided in presenting a clear and concise overview of the data distribution and relationships between variables, enhancing the understanding of the study findings.

## ETHICS

Permission to carry out the study was obtained from DCMs (District Community Mobilizers) prior to data collection. It was made sure that the participants understood the objectives of the study, which was done by explaining it to them in a local language. Any queries or questions raised by the participants were answered and written informed consent was taken before proceeding with the study. Confidentiality of collected data was maintained, to ensure that participant's privacy was maintained.

# RESULTS

The section covers the analysis of the Qualitative and Quantitative variables which include Knowledge, Skills and Challenges faced by ASHAs in 8 NHM Headquarters of Maharashtra. This section also consists of stakeholders' perspectives on the knowledge, skills and challenges faced by ASHAs in Maharashtra.

## SOCIODEMOGRAPHIC CHARACTERISTICS

| Sociodemographic Characteristics | | Rural (%) | Urban (%) | *P* - Value |
|---|---|---|---|---|
| **Study Sites (NHM Circles)** | **Nagpur** | 82 (8.6%) | 40 (4.2%) | 0.063 |
| | **Akola** | 79 (8.3%) | 33 (3.5%) | |
| | **Nashik** | 87 (9.1%) | 25 (2.6%) | |
| | **Latur** | 82 (8.6%) | 44 (4.6%) | |
| | **Kolhapur** | 79 (8.3%) | 37 (3.9%) | |
| | **Aurangabad** | 82 (8.6%) | 36 (3.8%) | |
| | **Pune** | 110 (11.5%) | 25 (2.6%) | |
| | **Thane** | 80 (8.4%) | 35 (3.7%) | |

| Sociodemographic Characteristics | | Rural (%) | Urban (%) | *P* - Value |
|---|---|---|---|---|
| **Social Category** | **General** | 170 (17.8%) | 56 (5.9%) | 0.130 |
| | **Others** | 511 (53.5%) | 219 (22.9%) | |
| **Marital Status** | **Married** | 593 (62%) | 247 (25.8%) | 0.132 |
| | **Separated/Divorced** | 19 (2%) | 9 (0.9%) | |
| | **Widowed** | 68 (7.1%) | 17 (1.8%) | |
| | **Unmarried** | 1 (0.1%) | 2 (0.2%) | |
| **Age** | **<39 Years** | 314 (32.8%) | 165 (17.3%) | **0.00*** |
| | **>=39 Years** | 367 (38.4%) | 110 (11.5%) | |
| **Education** | **<12 Years** | 332 (34.7%) | 106 (11.1%) | **0.004*** |
| | **>=12 Years** | 349 (36.5%) | 169 (17.7%) | |
| **ASHA Cohort** | **Old ASHAs** | 471 (49.3%) | 31 (3.2%) | **0.00*** |
| | **New ASHAs** | 210 (22%) | 244 (25.5%) | |
| **Family Type** | **Nuclear** | 343 (35.9) | 156 (16.3%) | 0.075 |
| | **Extended** | 338 (35.4) | 119 (12.4%) | |
| **Earning members** | **<2** | 583 (61%) | 228 (23.8%) | 0.292 |
| | **>=2** | 98 (10.3%) | 47 (4.9%) | |
| **Secondary occupation of ASHA** | **Housewife** | 344 (36%) | 215 (22.5%) | **0.00*** |
| | **Doing Secondary job** | 337 (35.3%) | 60 (6.3%) | |

***Table 1: Sociodemographic Characteristics***

The total sample size comprised 956 ASHAs. Sociodemographic characteristics such as age, education, ASHA cohort, and secondary occupation were found to have a significant association with the study sites, distinguishing between urban and rural ASHAs.

The study sites encompassed eight NHM Headquarter districts across Maharashtra: Nagpur, Akola, Nashik, Latur, Kolhapur, Aurangabad, Pune, and Thane. These sites maintained an approximate 80:20 ratio of urban to rural ASHAs distribution. The largest proportion of data was collected from Pune (14.1%), followed by Latur (13.2%), Nagpur (12.8%), Aurangabad (12.3%), Kolhapur (12.1%), Thane (12.0%), Akola (11.7%), and Nashik (11.7%).

The majority of ASHAs were married, as required for eligibility to become an ASHA. However, a small percentage were separated/divorced (2.9%), widowed (8.9%), and surprisingly, unmarried (0.3%). According to NRHM guidelines, ASHAs are typically married females. However, in certain challenging circumstances, such as during the COVID-19 pandemic when there was a shortage of ASHAs in villages, unmarried individuals were recruited to ensure the community's healthcare needs were met and to prevent suffering among the population.

The median age of ASHAs was 39 years, with 50.1% of ASHAs falling below the median age and 49.9% above it. Regarding years of education, the median was 12 years. ASHAs with less than 12 years of education constituted 45.8%, while those with more than 12 years comprised the majority at 54.2%. In terms of years of experience, the median was also 12 years. ASHAs with more than 12 years of experience were categorized as "Old ASHAs," while those with less than 12 years were termed "New ASHAs." In our study, the majority of ASHAs were "Old ASHAs," accounting for 52.5% of the total sample.

The majority of ASHAs were residing in nuclear families, with a total family size of 4 members, representing 52.2% of the ASHA population. Furthermore, 84.8% of ASHAs reported having less than 2 earning members in their families. Regarding occupation, 58.5% of ASHAs identified themselves as housewives, while 41.5% stated that they engaged in secondary jobs such as farming, managing grocery shops, or working in shops.

## KNOWLEDGE OF ASHAs

The ASHAs were asked about the different questions about different domains like, non-communicable diseases, communicable diseases, Nutrition, Genetic Diseases, Maternal and Child Health, Vaccination, Physical Fitness etc. There was total 10 questions which covered all the above domains, nine Questions were considered for one mark each while there was one question for 5 marks, so the ASHAs were assessed for their knowledge for 14 Marks.

During the analysis of this score in SPSS, the scores were divided into 4 Quartiles and based on that the scores from 0 - 6 Marks were considered as the Low Knowledge, scores from 7 - 10 were considered as medium knowledge and scores from 11 - 14 Marks were considered as High Knowledge. Out of 956 ASHAs, the percentage of ASHAs with low, medium and high knowledge scores are shown in the Table 2 as shown below:

| Category (Performance) | Percentage of ASHAs |
|---|---|
| Low Knowledge score ASHAs | 30.1 % |
| Medium knowledge score ASHAs | 42.9 % |
| High knowledge score ASHAs | 27 % |

***Table 2- Levels of knowledge of ASHAs***

According to the Knowledge questions asked, 86% of ASHAs were having knowledge about Diarrhea and 15 Days celebrated for diarrhea in the month of July, 57% Of ASHAs were having knowledge about the Nischay pregnancy kit, 80% of ASHAs had knowledge about the HBNC Visits (Home based newborn care), only 25% of ASHAs were having knowledge about the physical fitness / activity domains. Surprisingly only 10% of ASHAs knew about the time range of tubectomy to be conducted after the delivery of the Child. Only 23% of ASHAs knew about Sickle cell Anaemia; others mentioned that they were not given training on the Genetic disorders. 97% of ASHAs knew that compulsory breastfeeding should be done till the child gets 6 months old. 64% of ASHAs were knowledgeable about non-communicable diseases. 73% ASHAs had knowledge about the immunization doses which should be given to the child in the first 24 Hours period from birth.

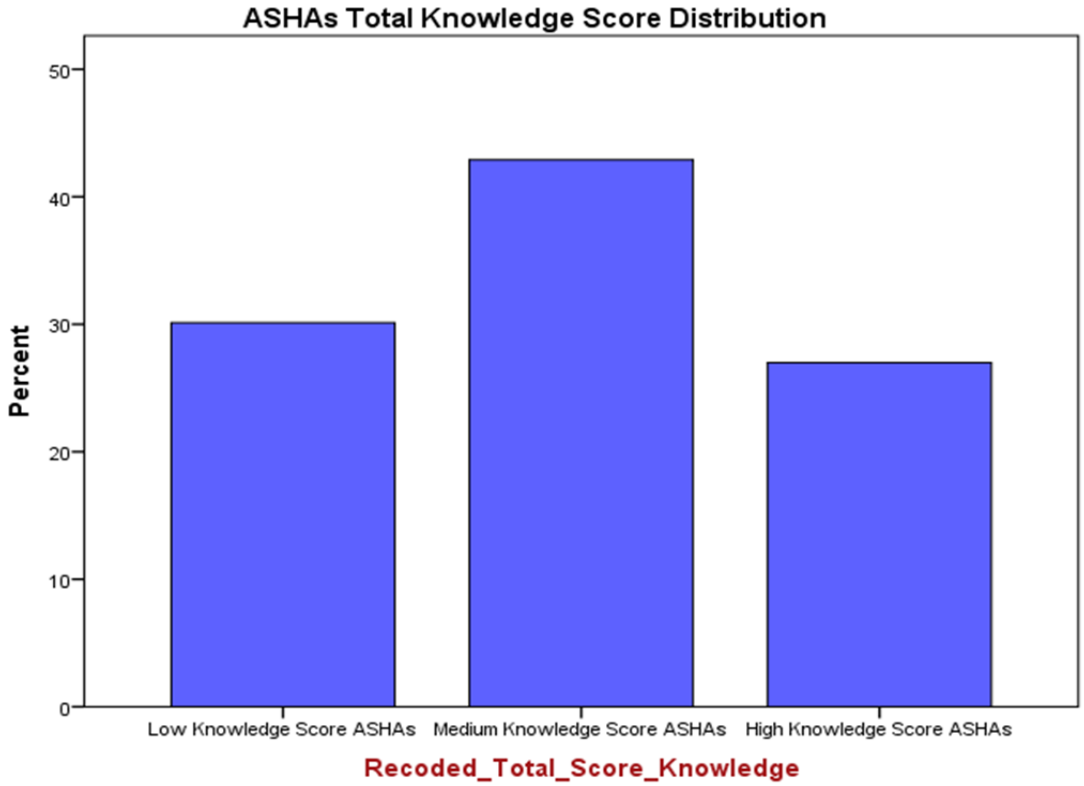


***Fig 4 - Knowledge score of ASHAs***

***Association of Knowledge of ASHAs with Study Site (Urban and Rural)***

| **Total Knowledge score of ASHAs (Category)** | **Study Site where they are working (Urban/Rural)** | | |
|---|---|---|---|
| | ***Urban*** | ***Rural*** | ***P - value*** |
| Low Knowledge Score ASHAs | 150 (16%) | 138 (14%) | ***0.00**** |
| Medium Knowledge score ASHAs | 101 (11%) | 309 (32%) | |
| High knowledge score ASHAs | 24 (2 %) | 234 (25%) | |

***Table 3: Association between levels of knowledge of ASHA and study site***

The table 3 shows significant association between the knowledge levels of Accredited Social Health Activists (ASHAs) and the areas they work in, highlighting disparities between knowledge levels of ASHAs working in urban and rural regions.

**Low Knowledge Scores among ASHAs in Urban Areas**: The data indicates that a relatively more ASHAs in urban areas (16%) showed low knowledge scores. However, urban ASHAs struggling performance in medium and high knowledge score levels vis-à-vis to their counterparts in rural areas is worrisome. This could be attributed to frequency and quality of training, relatively less experience and exposure to various knowledge domains among urban ASHAs.

**High Knowledge Scores among ASHAs in Rural Areas**: Conversely, around 25% of ASHAs in rural areas showed high knowledge scores. One reason for this could be the more exposure and experience accompanied with training and could be because of exposure to knowledge questions which were asked during monthly meetings.

***Association of Knowledge of ASHAs with ASHA Cohort based on experience***

In our study majority i.e 52 % of ASHAs were old ASHAs whereas 48% were new ASHAs.

| **Total Knowledge score of ASHAs (Category)** | **ASHA Cohort (on Basis of years of experience)** | | |
|---|---|---|---|
| | ***New ASHAs*** | ***Old ASHAs*** | ***P - value*** |
| Low Knowledge score ASHAs | 171 (18%) | 117 (12%) | ***0.00**** |
| Medium knowledge score ASHAs | 187 (20%) | 223 (23%) | |
| High Knowledge score ASHAs | 96 (10%) | 162 (17%) | |

***Table 4: Association between Levels of knowledge of ASHA and ASHA cohort***

The table 4 revealed that ASHAs with more years of experience demonstrated higher levels of knowledge. This relation aligns with the notion that experience often leads to a deeper understanding of the subject and improved competency in addressing healthcare needs and challenges. On the other hand, ASHAs having less than 12 years of experience showed low knowledge scores. This suggests that novice ASHAs may face challenges in effectively fulfilling their roles due to a lack of practical experience and exposure to diverse health issues. Conversely, the majority of high-performing ASHAs are those with more than 12 years of experience. This

indicates that experienced ASHAs, with years of hands-on training and engagement with beneficiaries and communities, have developed a robust knowledge base and skill sets, enabling them to deliver more effective healthcare services.

***Knowledge Parameters of ASHAs***

The knowledge of ASHAs was tested on 10 Parameters, 9 parameters were given 1 mark each whereas 1 parameter was given 5 marks. After that each ASHA was marked out of 14 Marks. Followed by that all the scores were divided into Quartiles as shown in Figure 5, to have the distribution of Low, Medium and High knowledge scores of ASHAs.

*(Total Marks: 14 = 9 Questions for 1 Mark + 5 Questions for 5 Marks)*

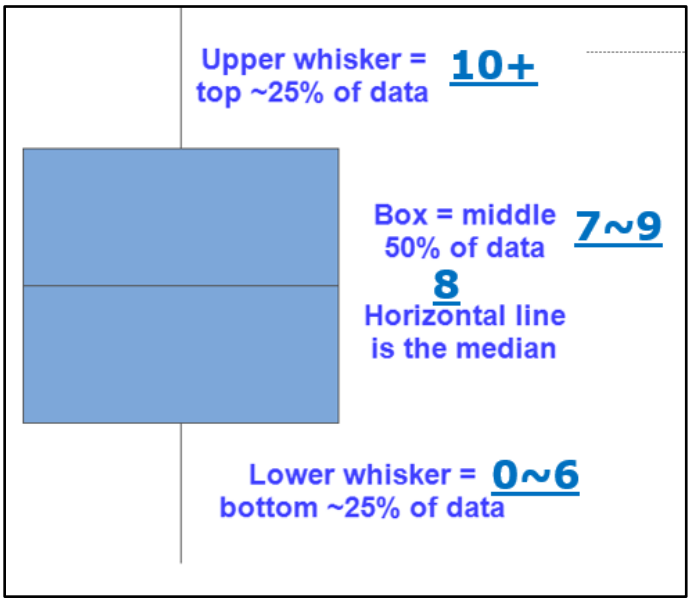


***Fig 5 - Quartiles of Knowledge Score***

➔ **97%** of ASHAs were aware of the recommendation for **compulsory breastfeeding** until the child reaches 6 months of age.

➔ **86%** of ASHAs were knowledgeable about **diarrhea** and the 15-day campaign celebrated for diarrhea in July.

➔ **80%** of ASHAs were aware of **Home Based Newborn Care (HBNC) visits.**

- **73%** of ASHAs were knowledgeable about the **immunization doses** that should be given to a child within 24 hours from birth.
- **64%** of ASHAs had knowledge about **non-communicable diseases.**
- **57%** of ASHAs had knowledge about the **Nischay pregnancy kit.**
- **25%** of ASHAs had knowledge about **physical fitness domains.**
- **23%** of ASHAs were knowledgeable about **sickle cell anemia,** with some mentioning a lack of training on genetic disorders.
- **10%** of ASHAs knew about the time range for **tubectomy** to be conducted after childbirth.

***Association of Total Knowledge Scores and ASHAs Profile Characteristics (Multi Variable Logistic Regression)***

| Profile of ASHA | AOR (95% CI) | p-value |
|---|---|---|
| **Social category** | | |
| General (Ref) | 1.00 | |
| Others | 1.37 (0.946-1.996) | 0.095 |
| **Study site** | | |
| Urban (Ref) | 1.00 | |
| Rural | 5.55 (3.576-8.607) | <0.0001 |
| **Age** | | |
| < 40 years (Ref) | 1.00 | |
| ≥ 40 years | 0.71 (0.503-0.992) | 0.045 |
| **Occupation** | | |
| Housewife (Ref) | 1.00 | |
| Other | 0.66 (0.467-0.925) | 0.016 |
| **Total family members** | | |
| ≤ 4 (Ref) | 1.00 | |
| > 4 | 0.68 (0.475-0.965) | 0.031 |
| **Earning family members** | | |
| ≤ 2 (Ref) | 1.00 | |
| > 2 | 1.71 (1.05-2.797) | 0.031 |
| **No. of children** | | |
| ≤ 2 (Ref) | 1.00 | |
| > 2 | 1.51 (0.953-2.382) | 0.080 |
| **Constant** | 0.16 | <0.0001 |

**Table 5:Multivariable Regression**

***Multi Variable Logistic Regression Interpretation***

The knowledge of rural ASHAs was significantly 5.5 times higher compared to Urban ASHAs (AOR=5.55, 95% CI=3.576-8.607). The knowledge was more than 1.5 significantly higher among ASHAs who have more than 2 earning family members (AOR=1.71, 95% CI=1.05-2.797) and number of children (AOR=1.52, 95% CI=0.953-2.382). The knowledge in ASHAs from other social category was significantly 1.3 times higher compared to the ASHAs of general category. The knowledge of ASHAs who are engaged in other occupation was significantly 34% lower compared to the ASHAs who are housewife (AOR=0.66, 95% CI=0.467-0.925).

**SKILLS OF ASHAs**

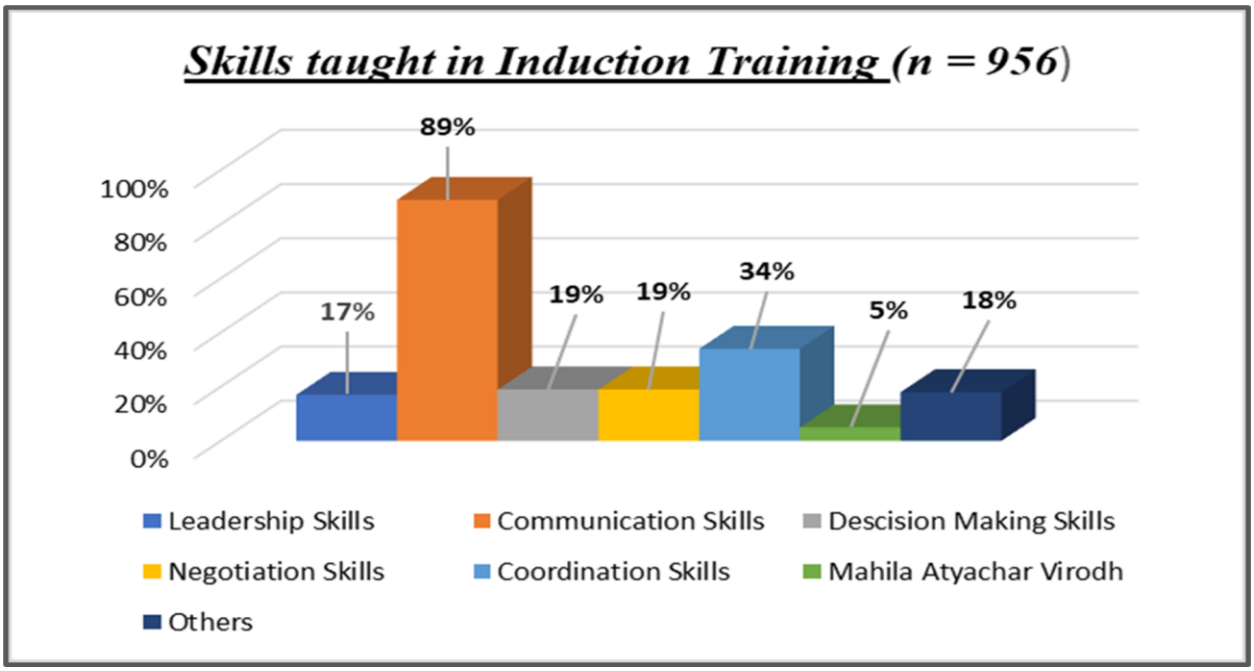


***Fig 6 - Skills Taught in Induction Training***

As shown in the above Figure 6, during induction training, ASHAs are equipped with skills that empowered them to communicate effectively with the community, promote health initiatives, and encourage cooperation for achieving goals.

**LEADERSHIP SKILLS**: ASHAs are trained to become leaders, fostering the ability to mobilize people towards the common objective of improved healthcare. While most individuals possess the potential for leadership development, ASHAs frequently find themselves in leadership roles. Therefore, honing these skills is crucial for their effectiveness. However, only 18% of ASHAs reported receiving specific leadership training.

**COMMUNICATION SKILLS:** A significant 89% of ASHAs mentioned receiving training in communication skills. This training focuses on establishing a two-way flow of information and ideas between themselves and the community. Effective communication is vital because poor communication can lead to confusion. Conversely, strong communication skills enable ASHAs to counsel women and families on health promotion, encourage healthier practices, and mobilize

them to utilize health services. Additionally, they are trained to build rapport with stakeholders and other healthcare workers.

**DECISION MAKING SKILLS**: ASHAs are often called upon to make decisions that impact the entire community. Recognizing this, they are trained in participatory decision-making, which emphasizes involving the community at all levels. However, only 20% of ASHAs reported receiving training in this specific skill.

**NEGOTIATION SKILLS:** Negotiation skills are crucial for ASHAs as they constantly interact with people and navigate various situations. Fortunately, 19% of ASHAs mentioned receiving training in negotiation to effectively resolve differences and achieve the broader goals of village health programs.

**COORDINATION SKILLS:** ASHAs serve as a bridge between healthcare services and the community. As a result, they are expected to maintain regular coordination with various stakeholders and the community itself. Only 34% of ASHAs recalled receiving training in coordination skills, which are essential for collaborating with ANMs (Auxiliary Nurse Midwives) and Anganwadi workers to foster a healthy community.

**MAHILA HINSACHAR VIRODH (Violence Against Women):** A disappointingly low number, only 5% of ASHAs, mentioned receiving training on handling cases of Mahila Hinsachar Virodh (violence against women).

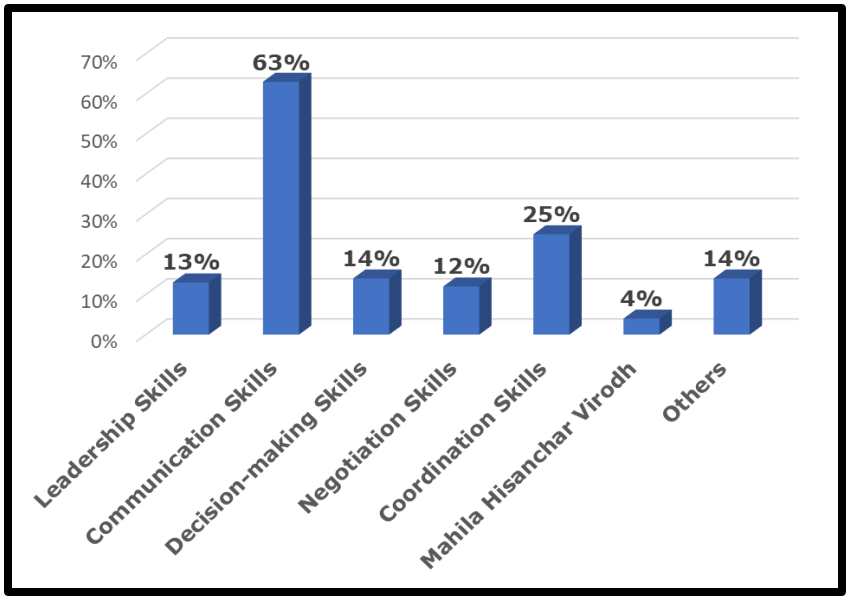


***Fig 7 - Skills of Rural ASHAs ( n = 685)***

The 12% of ASHAs in Rural area were taught Negotiation skills which was found to be highly significant as mentioned in (Figure 7) where as only 7% of ASHAs in Urban area were taught Negotiation Skills which was again found to be highly significant as shown in (Figure 8). In Both rural and urban ASHAs Communications skills were taught majorly followed by Coordination skills.

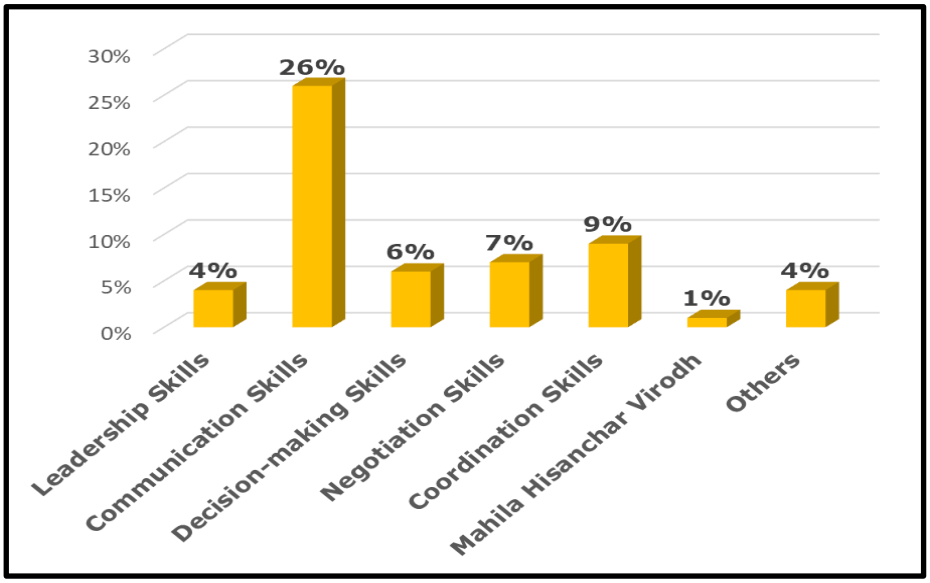


***Fig 8 - Skills of Urban ASHAs ( n = 275)***

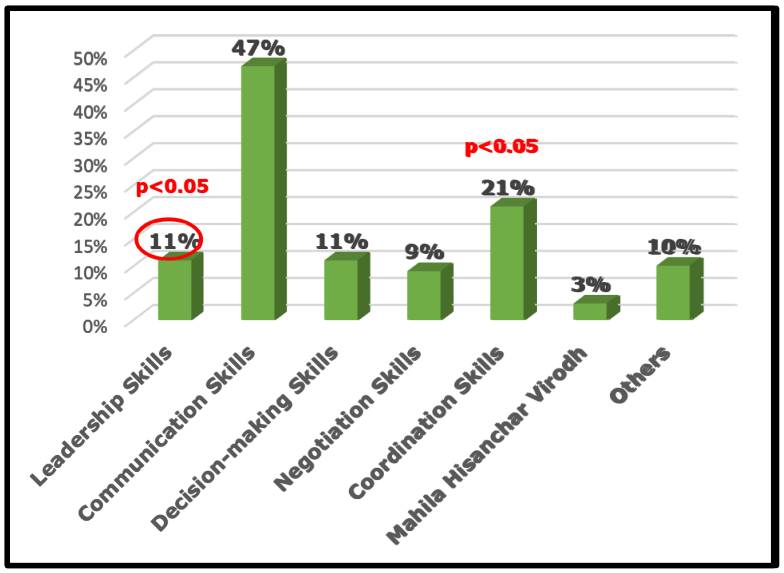


*Fig 9 - Skills of Old ASHAs (n = 502)*

According to (Figure 9) the leadership skills taught to old ASHAs were significant as compared to urban ASHAs, whereas Coordination skills were also significant i.e 21% in old ASHAs whereas 14 % in New ASHAs as shown in (Figure 10).

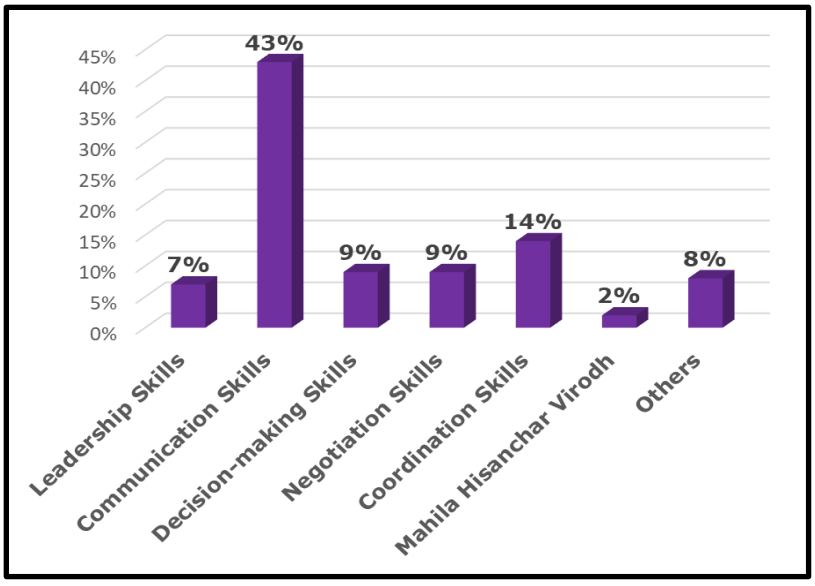


*Fig 10 - Skills of Urban ASHAs (n = 454)*

***Problems while communicating with the community***

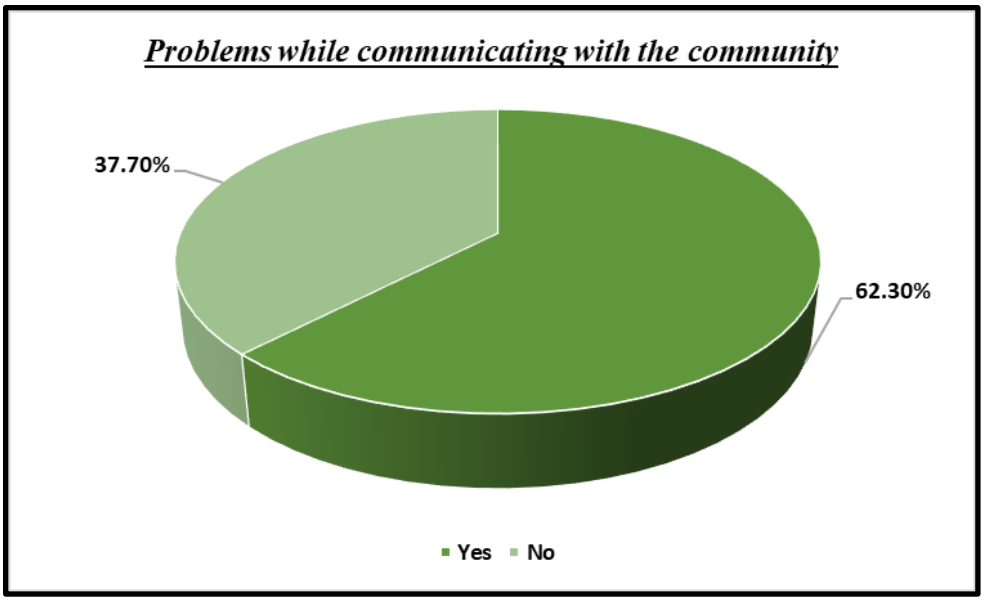


**Fig 11: Problems While Communicating With The Community**

According to Figure 11 as shown above, it was found that 62.30% of respondents reported facing challenges in communication during their fieldwork duties. These challenges were elaborated upon, revealing various scenarios.

During the COVID-19 pandemic, ASHAs encountered resistance from community members who expressed concerns about potential infection spread due to ASHAs' frequent household visits. Additionally, negative attitudes towards COVID-19 vaccination were observed among certain individuals, posing further communication barriers.

Another significant challenge arose when ASHAs suspected cases of tuberculosis (TB) or leprosy within the community. Convincing affected individuals to undergo testing was difficult due to the stigma associated with these diseases, as people feared disclosure of their health status.

Furthermore, ASHAs faced resistance and irritation from community members during surveys, particularly when soliciting personal information such as phone numbers. Some individuals refused vaccination for their infants, adding to the communication challenges.

ASHAs endeavored to address these issues by explaining the importance of various health interventions and seeking community cooperation. However, when challenges persisted, ASHAs sought assistance from Block Facilitators (BF) or Auxiliary Nurse Midwives (ANMs) who accompanied them during fieldwork. These allied healthcare professionals provided additional explanations and attempted to persuade community members to cooperate.

***Misunderstanding in the Community as Experienced by ASHAs:***

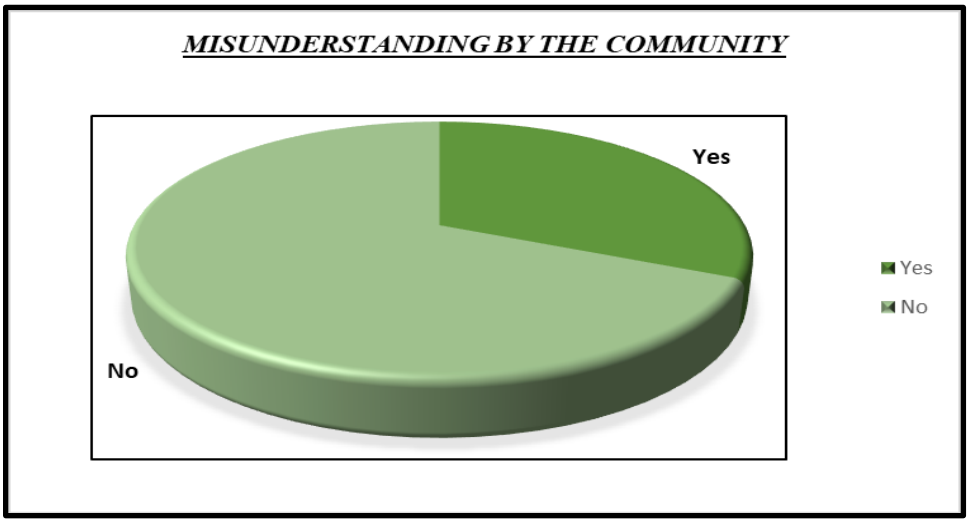


***Fig 12: Misunderstanding By The Community***

According to (Figure 12) It was found that 68.40% of respondents reported no instances of misunderstanding about them within the community. However, 31.6% of respondents acknowledged experiencing misunderstandings.

Among those who reported misunderstandings, common misconceptions included the belief that ASHAs receive substantial salaries from the government, which is not so true. Additionally, some community members wrongly perceived ASHAs as responsible for withholding funds or benefits from government schemes, such as the Pradhan Mantri Jan Arogya Yojana (PMJAY), when they did not receive expected payments in due times.

***Mishappenings in the Community***

In response to inquiries regarding the witnessing of distressing incidents such as maternal mortality, abortion cases, or neonatal deaths during their work, only a few ASHAs reported such occurrences. Further investigation revealed their approaches to handling these challenging situations and managing the resulting mental stress while maintaining relations with the community.

> *" She was 7 months pregnant and had high BP. Baby died inside the womb. After two days it was removed by performing a cesarean section. At that time I felt really bad. But then i gave moral support to the mother"* ***(ASHA: 29 Years of age, 11 Years of education, 5 Years of experience)***

> *"A baby was suffering from Diarrhea and they did not take him to the hospital although I told them to do so. Then that baby died. I got scared as it was the first death since I joined. I consulted with ANM then she explained to the parents that why did you not listen to her; if you would have visited the hospital earlier we could have saved your baby."* ***( ASHA: Rural, 32 Years of age, 10 Years of education, 7 years of experience)***

ASHAs shared their experiences regarding certain tragic events, despite efforts to prevent them, may occasionally occur during their work. Despite this, they remain committed to providing necessary medical care and information to individuals beforehand. Following such incidents, ASHAs continue their duties, offering support to affected individuals to help them recover from trauma. They encourage a return to healthy living and maintain a positive attitude towards their work.

These responses highlight ASHAs' resilience and dedication to their responsibilities, demonstrating their commitment to supporting community members during difficult times while maintaining their role as trusted healthcare advocates.

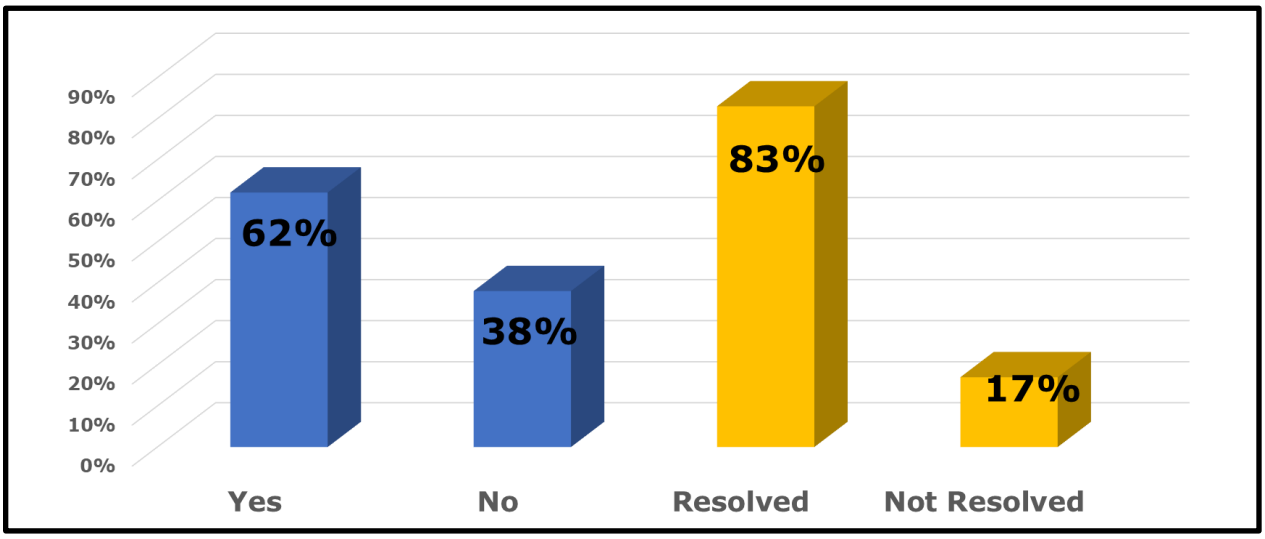


***Fig 13 - Communication Problems Faced by ASHAs in the Community and Resolved by using Communication Skills (n=596)***

## CHALLENGES RELATED TO TRAINING

### *Induction Training:*

The ASHAs undergo a training of 23 days spread across a span of 12 months. These trainings are conducted in the district hospitals or NHM centers.

Majority of ASHAs reported that the time duration for their first induction training ranged from 5 days to 8 days. The responses varied according to the year of recruitment, Place of training, and residential or non-residential training.

Significant number of ASHA mentioned these induction training being conducted in the initial months of their joining. They are taught about the ASHA modules and an exam is conducted at the end of these training sessions. However, the ASHA who were recruited in the period of Covid-19 mentioned not receiving any formal induction training and learned everything while working in the field.

When questioned whether the training was residential, a predominant number of ASHA reported that the training were residential but they didn't stay as they had to return home everyday after the training to take care of their children. While others reasoned that they stayed nearby hence found it possible to travel every day for the training.

These trainings were majorly conducted in either the nearby Gram panchayat, Taluka Health office, District hospitals or any place belonging to government authorities.

***Subjects Taught in Training:***

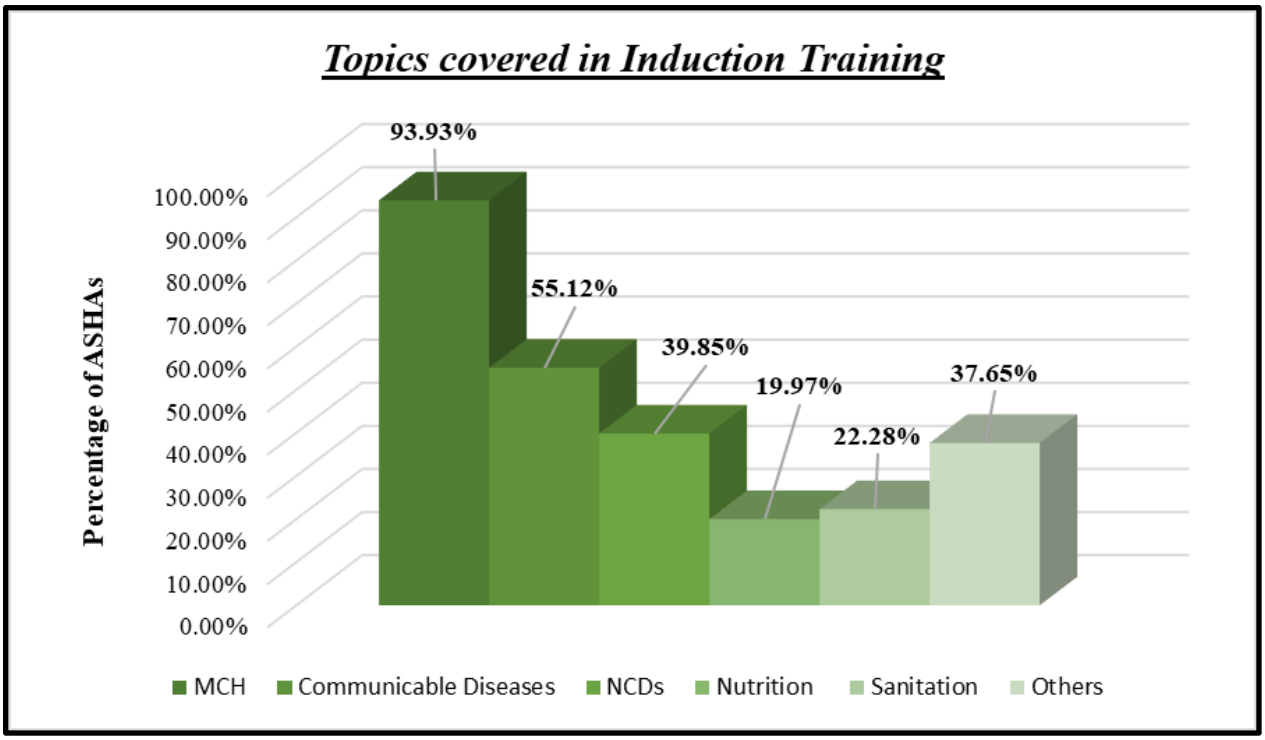


***Fig 14: Topics Covered in Induction Training (n=956)***

The Figure 14 shows the number of ASHA's and the training they received. After selection, ASHA will have to undergo a series of training episodes to acquire the necessary knowledge, skills and confidence for performing her spelled out roles. Considering the range of functions and tasks to be performed, induction training may be completed in 23 days spread over a period of 12 months. The first round may be of seven days, to be followed by another four rounds of training, each lasting for four days to complete induction training. The topics covered during the training includes

5 major topics as follows: Maternal and Child Health, Communicable diseases, Non-communicable diseases, Nutrition, Sanitation, Others.

**MATERNAL AND CHILD HEALTH**: 898 ASHAs i.e., 94% of ASHAs mentioned being taught the MCH in their training. In maternal and child health the subtopics included- ANC, PNC, HBNC, HBYC, institutional deliveries and care, pregnancy diagnosis, Danger signs during pregnancy, availing the public service schemes such as PMMVY, PMJY, JSY, JSSK.

**Antenatal care:** ANC specifically involves four scheduled visits throughout the pregnancy: within 12 weeks, between 14 and 26 weeks, between 28 and 34 weeks, and after 36 weeks. ASHAs are also trained on the importance of a nutritious diet and the necessary supplements and injections during this perinatal period.

**Post-natal care**: PNC training focuses on home visits, HBNC, exclusive breastfeeding practices, postnatal checkups, family planning methods, and recognizing danger signs and complications. ASHAs are equipped to identify these danger signs, such as vaginal bleeding, swelling, or severe anemia, and refer women to health facilities for proper care. However few ASHAs who have joined before 2015 mentioned about not receiving the HBNC training

**Danger Signs**: ASHAs are taught the danger signs during the ANC and PNC period, such as vaginal bleeding, swelling, severe anemia, and malpresentation. They then refer such women to a health facility for appropriate treatment.

Availing Government Health Schemes: ASHAs are also trained to inform women (labhartis) about government health schemes such as Janani Suraksha Yojana (JSY) and Janani Sishu Suraksha Karyakram (JSSY), helping them avail these benefits.

**COMMUNICABLE DISEASES**: Infectious diseases are a serious public health concern. Over half (55% or 527 ASHAs) reported learning about communicable diseases. They are trained in visually screening cases and referring them to the health system for diagnosis and medical intervention. ASHAs primarily focus on prevalent diseases like tuberculosis (TB), leprosy, and malaria. They learn about the modes of transmission of these diseases, common signs and symptoms, management, and prevention. Additionally, they are trained in collecting sputum and blood samples.

**NON-COMMUNICABLE DISEASES**: ASHAs are trained according to a training module that includes five common non-communicable diseases (NCDs): hypertension, diabetes, cervical cancer, breast cancer, and oral cancer. There are other NCDs like epilepsy, asthma, and other respiratory diseases. The NCD training builds ASHAs' knowledge of risk factors, prevention, and control of these common conditions. This equips them to mobilize the community on these issues, leading to increased screening, early detection, and referrals. ASHAs are also taught about the importance of health promotion and maintaining a healthy lifestyle. However, only 381 ASHAs (40% of the total) mentioned receiving training on NCDs.

**NUTRITION**: Around 19% (191 ASHAs) recalled receiving training related to nutrition. They learn about the importance of a balanced diet for pregnant women, including cereals, pulses (including beans and nuts), vegetables, milk, eggs, meat, fish, oils, jaggery, and fruits. ASHAs are trained to counsel mothers and families that no foods are forbidden during pregnancy and to emphasize meals with high protein intake. They are also trained on safe breastfeeding practices for newborns, recognizing signs of malnutrition, and referring them to appropriate channels. Additionally, they assist Auxiliary Nurse Midwives (ANMs) during village Health and Nutrition Days (VHNDs).

**SANITATION:** ASHAs are taught common measures to ensure good health, such as hand washing, maintaining hygiene of body parts, using clean toilets, safe handling of food and water, and sanitary disposal of solid and liquid waste. These simple hygiene practices help prevent diseases. However, only 23% (213 ASHAs) mentioned being taught about hygiene practices to prevent diseases.

**OTHER:** About 38% of ASHAs (360 ASHAs) recalled receiving training on other topics. These include their core roles within the community, maintaining five key registers (birth and death, ANC, PNC, newly-wed, and LMP), family planning methods like contraceptive use, and immunization for preventable diseases like tetanus, polio, as well as newborn vaccinations including BCG, Hepatitis-B, and OPV vaccines.

***Skills Taught in Training and Related Challenges:***

Skills taught during the training helps ASHA in mobilizing people and resources towards achieving the common goal of healthcare.

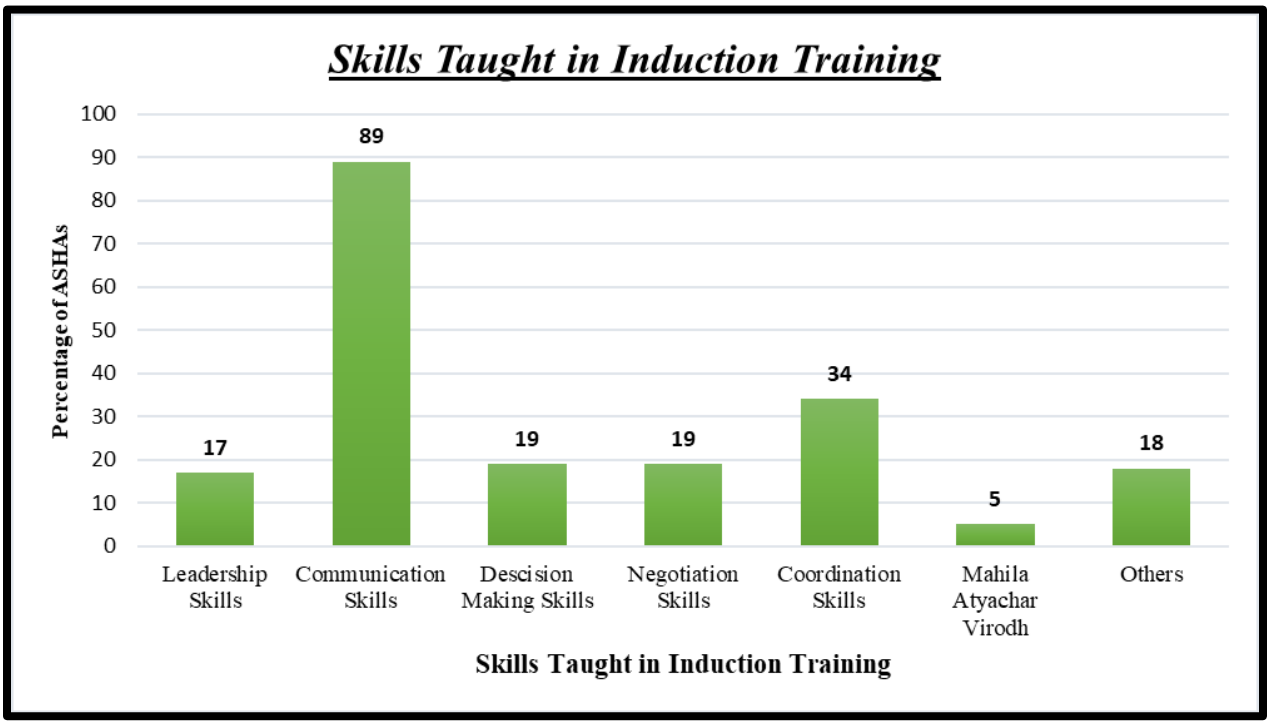


***Fig 15: Skills Taught in Induction Training (n=956)***

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**MAHILA ATYACHAR VIRODHI (Violence Against Women):** A disappointingly low number, only 5% of ASHAs, mentioned receiving training on handling cases of Mahila Atyachar (violence against women).

***Time Interval Between Trainings:***

According to the Guidelines of NHM program the ASHA are to have bi-monthly meetings. However, ASHAs mentioned having meetings once every month at the Primary Health Centre (PHC) where they are to submit their monthly reports and are being updated on the new government health schemes and national health programmes. In the meetings that happen predominantly once every month the ASHAs are taught and trained on the new topics and reoriented on emerging health trends. Despite the monthly frequency, the ASHAs themselves

reported that these monthly training and meetings are not sufficient to refresh their knowledge, as the training is not comprehensive and doesn't cover all the topics. The ASHAs mentioned that whenever there are trainers from the district and taluka level to train them on a specific topic such as online data entry, or diseases like cancer, or TB the training happens twice that month. Few ASHA also mentioned about not having received training in their monthly meetings.

***Last Held Trainings and Topics covered:***

ASHAs mentioned about having training in the meeting sessions held every month. This training varied by PHC and District. A wide variety of topics ranging from online data entry to the role of ASHAs were discussed in the training. The training is taken to orient ASHA with new and emerging health topics and making them aware about their responsibilities.

**HBNC/ HBYC training**: ASHAs underwent a major HBNC/HBYC training program in the previous year (2022-2023). This training covered practical aspects such as child handling techniques, newborn care, scheduled home visits and child weighing to detect wasting. Additionally, it addressed Mission Indradhanush and importance of essential immunizations, including 3 vaccines of BCG, Hepatitis B, OPV that are administered in the first 24 hrs of infants' birth.

> "Training happened in November 2023 on HBNC and HBYC. We were taught about the 7 visits of HBNC, breastfeeding, Post-delivery care, changing diets and starting complementary feeding alongside breastfeeding until 1.5 years and increasing the amount of food intake as the child grows the need to change.".
> ***(Urban ASHA, 40 years of age , 12 Years of education, 4 Years of experience.)***

**NCD training**: ASHAs were also trained in the NCD- screening, and promoting awareness about the risk factors like Blood pressure, Diabetes Mellitus, Cholesterol, smoking and preventive

measures such as health lifestyle, eating habits, quitting smoking, etc. Measuring blood pressure and conducting follow-up of patients.

> *"In training we were taught the causes of various types of cancers, their prevention and treatment, how to keep Bp under control, the signs and symptoms of diabetes and methods to control it, dietary changes to keep these in control, and exercise regularly, and maintaining timely meals"* ***(Rural ASHA, 43 years of age, 15 years of education, 3 years. of experience)***

**Communicable diseases**: Training about infectious diseases was also mentioned by ASHA. The training included the detection and screening of TB, Leprosy and malaria patients along with promoting awareness and treatment, advocating people about the importance of adherence to the DOTS treatment.

> *"Training was held in December-2023. It was about TB and leprosy, they taught us how to create awareness amongst people about these diseases and the necessary time duration for the patients to be cured."* ***(Rural ASHA, 43 Years of age, 10 Years of education, 7 years of experience)***

**Village Level Assemblies and Committees:** ASHA reported receiving training on managing and conducting the VHNSC (Village Health Nutrition and Sanitation Committee) and other village level assemblies (Sabha) These assemblies included Mahila Arogya samiti, Kishori Mulinchi Sabha (Adolescent girls meeting) for the women and teenage girls respectively to raise aware about good sanitary practices and the used of menstrual hygiene products(Sanitary pads), advocating them about the use of contraceptives and family planning methods.

**Online Data Entry**: ASHAs received training in Online data entry. This trainings primarily focused on making the Ayushman Bharat Health Account (ABHA) cards, Ayushmaan cards, and filling of online Pradhan Mantri Matru Vandana Yojana(PMKVY) forms- a maternity benefit scheme, Janani Suraksha Yojana(JSY) forms- a safe motherhood scheme, and CBAC(community based assessment checklist) forms for early detection of NCDs. ASHA also mentioned finding it difficult to learn online data entry unless practically done.

> *"Recently last month online training happened. We were taught about the online form filling of PMKVY forms, and Golden card. However, we couldn't understand without practically doing it"* ***(Rural ASHA, 47 years of age, 17 years of education, 14 years of experience)***

***Additional Training Required by ASHAs:***

ASHAs mentioned that the training they receive encompasses all the necessary topics and whatever is not covered they learn while working in the field.

> *"Everything is taught in the training, and then we're sent to work in the field. Whatever isn't covered there, we learn through practical experience"* ***(Urban ASHA, 34 years of age, 12 Years of education ,7 years of experience)***

**ONLINE DATA ENTRY:** ASHAs reported receiving training in online data entry. However, many complained about difficulty performing the tasks due to a lack of practical exercises. The training seemed to be primarily theoretical, making it challenging for ASHAs to fill out forms like PMKVY applications, ABHA cards, and Ayushman Bharat cards.

*"Whatever is taught in the training has proven important. But we are unable to do the online entry of the ABHA cards so they (Government health authorities) should properly train us so that we can work properly."* ***(Rural ASHA, 36 years of age, 11 Years of education, 14 years of experience)***

ASHA also reported receiving the video of online data entry and they are being told to do it hence, it's difficult for them to learn it.

*"We didn't receive online data entry training on the PMKVY form and Ayushman card, they sent us the video and told us to do the work"* ***(Rural ASHA, 45 years, 9 Years of education, 14 years of experience).***

**PRACTICAL KNOWLEDGE**: ASHA mentioned being taught theoretically but they lack practical knowledge hence they suggested more emphasis be given on practical training as after going into the field they encounter difficulties.

*"We are taught everything but there is a vast difference in being taught about something and applying the knowledge in the field. They tell us to communicate in a certain way but after going into the community, we have to face the community and tell them about the things in a language they can understand. We meet different kinds of people that we need to handle. So, we should be taught to face and deal with these people.* ***(Urban ASHA, 45 years of age, 15 years of education, 7 years of experience)***

**CONDUCTING DELIVERIES:** Few enthusiastic ASHAs reportedly mentioned that they wanted to learn about delivery as they encountered events where they had to handle such cases of emergency delivery. If they know how to conduct emergency deliveries and manage such cases of child birth it will increase the survival rate of the mother and the child.

*"The 108 ambulances didn't come on time. As a result of the delay the child died. We should be taught to do deliveries so the timely delivery will happen and no other child will have to die"* ***(Rural ASHA, 42 year of age, 12 years of education 13 years of experience)***

*"I know how to do the delivery but haven't received training for the same. I have helped in the 'delivery of a labharthi' (Beneficiary) I took to the hospital. I feel it necessary to know how to deliver."* ***(Rural ASHA, 48 years, 8 Years of education, 12 years of experience)***

**EXPANDING ASHAs SKILLSET:** ASHAs have expressed strong will of expanding their skillset. They have requested training on measuring vitals such as Blood Pressure, Hemoglobin, and Blood sugar levels and learning injection techniques alongside ANMs. This knowledge, they mentioned, is crucial as community members frequently ask them about these health markers.

*"We should also be taught to measure BP, sugar and injection technique. As nobody in my village knows how to do it, the patients have to travel long distances for the same"* ***(Rural ASHA, 27 years of age, 12 years of education, 7 years of experience)***

**REORIENTATION TRAINING:** ASHAs also suggested the necessity of reorientation training, as the training they receive every month are based on topic hence it becomes difficult for them to remember the remaining uncovered topics. Hence reorientation training once or twice a year will refresh their knowledge.

*"We should be given orientation training that can refresh our knowledge. It happens that we are taught everything in detail however as every time something new is taught we tend to forget the old topics"* ***(Rural ASHA, 40 years, 10 Years of education, 7 Years of experience)***

## ONLINE DATA ENTRY

### *Availability of Smartphone:*

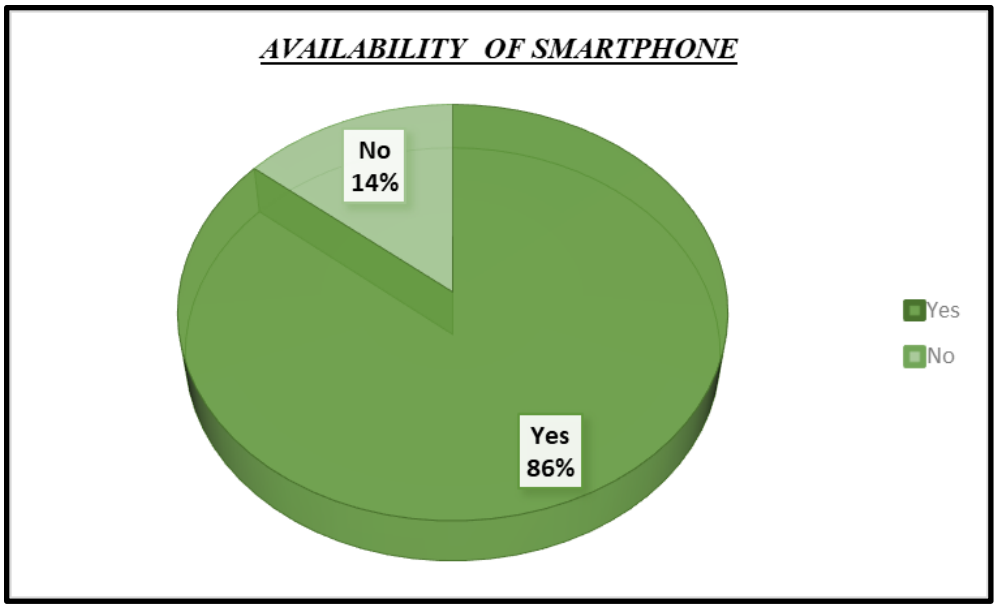


***Fig 16: Availability of Smartphone (n=956)***

Figure 16, elaborates the availability of smartphones among ASHAs. As seen, there are only 14% of ASHAs who have smartphones while 86% do not have smartphones. After Covid, this smartphone has become a very essential tool for ASHAs as India is progressing towards digitalization. In 2023, the government of India asked ASHA to make Ayushman card, ABHA card for every individual living in their village which is why the majority of ASHAs purchased smartphones last year. There are different apps too which ASHAs uses in their daily house visit such as Pradhan Mantri Janani Yojana, (PMJY) (Pradhan Janini Shishu Yojana,) National

communicable control programmed (NCCP), Nirogi AarogyaTarunaiche Vaibhav Maharashtrache (NATVM). In some districts the gram panchayat or NGOs have distributed TABS to ASHAs so they could do their online work, while some ASHAs use their husband or children's phone for their online work and performing their duties.

***Mobile Phone Recharge Contributions for ASHAs:***

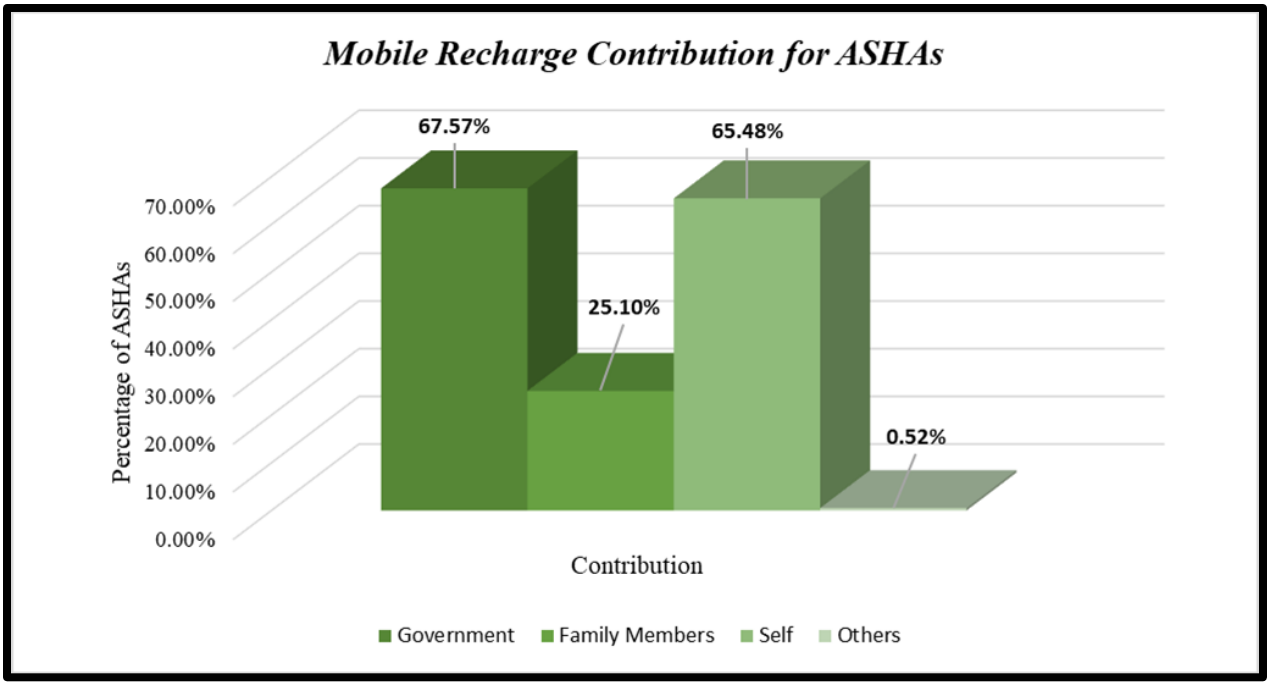


***Fig 17: Mobile Recharge Contribution For ASHAs (n=956)***

Figure 17 illustrates mobile recharge contributions for ASHAs. The three main sources of contribution for ASHAs in their mobile recharge are-

**Government of Maharashtra –** They are the biggest contributor (68%) in mobile recharge of ASHAs. They reimburse the amount ASHAs paid for their mobile recharge. Government support ASHA with Rs 100-150 for their monthly recharge to continue their online work. Although, ASHAs have mentioned their concerns of insufficient monetary help from government for their mobile pack recharge. ASHAs from all over 8 districts of Maharashtra mentioned their concerns about their mobile recharge.

**ASHAs themselves**- Almost two third of the ASHAs i.e. (65%) of ASHAs recharge their phone. They mentioned that every month they have to pay a huge amount from their monthly incentive to recharge their smartphone so they can continue with their online work. ASHAs spend around Rs 300-700 to recharge their phone every month which isn't feasible at all for them. In some districts we also have seen, ASHAs do not recharge their phones due to mobile packs being expensive which reduces their monthly incentive and overall performance.

**Family members**- Family members contribute a quarter (25%) of mobile recharge of ASHAs which is usually done by their husband or a family member.

Smartphones have become very important for ASHAs as they get different-different incentives based on their online data entry of the forms. For example by filling a pregnant woman details in forms in PMVVY ASHAs get Rs3000

> *"PMMVY/ Ayushman Bharat - Pregnant woman from filling, for the first time I get Rs3000 and after delivery Rs2000 I get"* ***(Rural ASHA, 36 year of age, 15 years of education, 13 Years of Experience)***

Thus, it's important for them to recharge their phone every month. As their monthly incentive work is also done online.

***Training Completed for online data entry using Smartphone:***

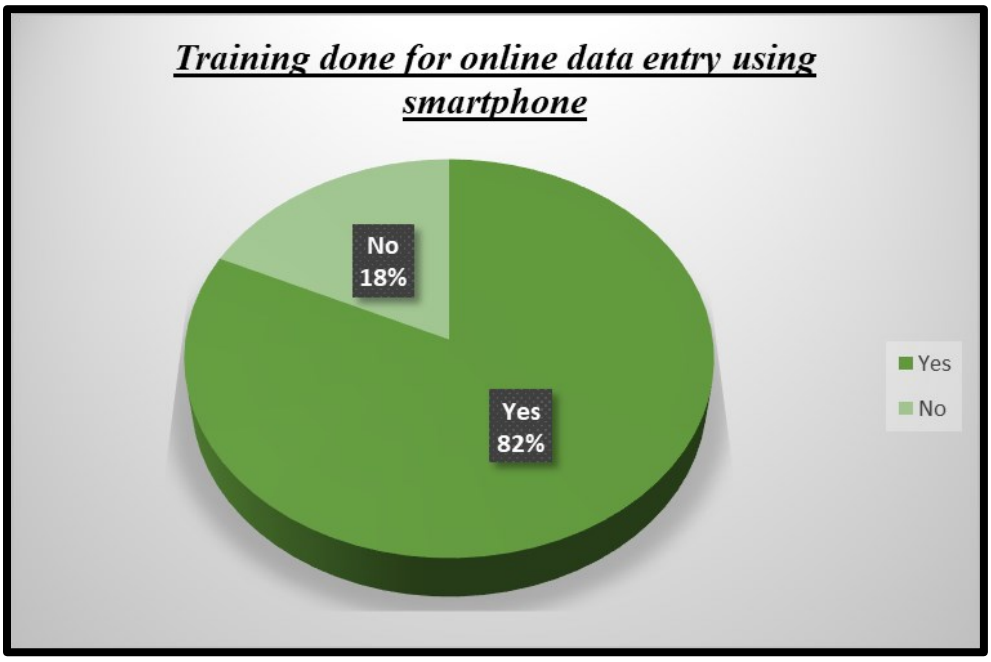


***Fig 18: Training Done For Online Data Entry Using SmartPhone (n=956)***

Figure 18 as shown above shows number of ASHAs who has gotten training for their online data entry using their smartphone. 82% of ASHAs mentioned they have gotten training to perform their online work using their own smartphone, while 18% of ASHAs mentioned they didn't get any training on their smartphone for their online work. The ASHAs mentioned receiving training for Ayushman Bharat, ABHA card, PMKVY. They felt the training was effective, enabling them to work as data operator.

**Mode of training-** ASHAs have mentioned that either ASHAs facilitator or medical officer from their respective districts PHC. take their online training on their phone. In a few cases, ASHAs have mentioned that for online training they are shown youtube videos through which they get to understand their online work. All the ASHAs have gotten training together in a group. There was no one on one training for any ASHAs which was quite difficult for those ASHAs with less education or one without the smartphone. The ASHAs who were absent during their online training said they didn't understand anything and neither higher authorities have taken any efforts to train them again.

Even if the majority of ASHAs have mentioned that their online training is done, they have faced many challenges with their online training and their efficiency to do their online work. Few of the reasons mentioned by them were,

1) **Irregular Training**- The ASHAs reported inconsistency in online training by their higher authority. Last online training was done after covid in the year 2021.

2) **Irrelevant Training Platform**-The training wasn't conducted on their phone, making it difficult for them to grasp the concepts and operate their smartphone for online work.

3) **Frequent Password Prompts**- Every time they opened the app to log in they were prompted for their password

4) **Ineffectiveness of YouTube Videos**- Training delivered through Youtube videos made it challenging for them to learn how to operate their smartphone independently

5) **Pressure to Perform**- They faced pressure from Higher authorities to expedite their online work and meet monthly targets

6) **Network Issue**- Network connectivity was a major hurdle for ASHAs in completing their online tasks. When they visited beneficiaries' homes to create Ayushman or ABHA cards, the slow generation of OTPs (one-time passwords) caused significant delays, discouraging them from online work

7) **Time consuming process**- Due to network issues, completing a single Ayushman form could take an entire day, leading ASHAs to avoid it as it hindered their household visits also mentioned that because of network issue in their phone a single Ayushman form takes their whole day, they tend to not do it as it affects their household visits.

8) **Limited digital Literacy**- Some ASHAs with lower education found it difficult to operate their smartphone for online work so they relied on their children or family members for help in completing their online work.

9) **Mobile data costs**- The cost of mobile pack recharge was a concern for some ASHAs. This sometimes led them to avoid recharging their phone and consequently neglecting their online work.

10) **Inadequate Training**- ASHAs felt the online training they received was insufficient.10) They are not given proper online training.

> *"In the year 2021 my online training was done, I do not recall what exactly it was, but after that only our ID was made. They had come from Mahanagar palika (Municipal Corporation) they taught us but at that time I didn't have my own mobile"* ***(Urban ASHA, 31 years of age, 15 years of education,7 years of experience)***

> *"They have shown us videos for online training and given all the details on it that is the process of our online training. First, they should give us proper training, they put a lot of pressure for online work on us"* ***(Rural ASHA, 40 years of age, ,11 years of education, 15 years of experience)***

> *"They make us first download the apps from the play store and then they teach us. I don't understand much and I am unable to use my mobile thus, I ask my daughter to help me with my online work"* ***(Rural ASHA, 38 years of age, 10 years of education, 5 years of experience)***

***Reduction in Data Entry Time using Mobile phones:***

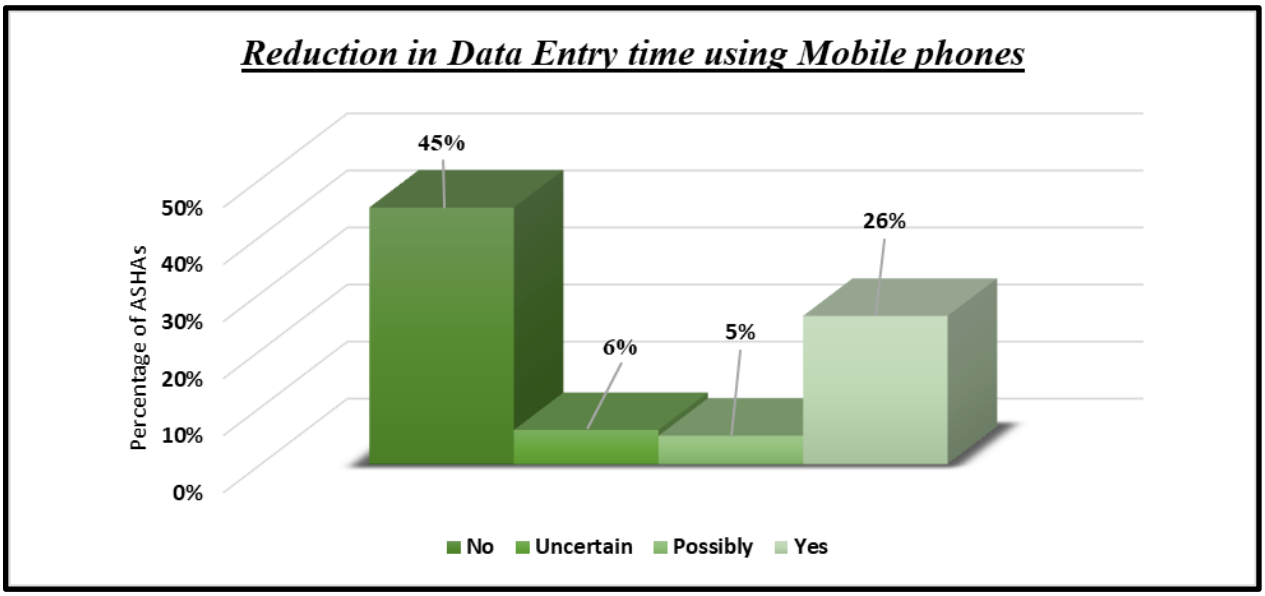


***Fig 19: Reduction in Data Entry Time Using Mobile Phone (n=956)***

Figure 19 represents reduction in data entry time after using a mobile phone . The main reason which ASHAs report no reduction in their online data entry workload is because they're still required to maintain offline records in separate registers for all 72 tasks they perform in their villages. This creates a double workload, as they struggle to complete both the online entries and handwritten registry which make them frustrated and wasted time.

Furthermore, server issues plague the app causing frustration and wasted time. Frequent crashes force them to repeat steps and upload can take hours, significantly impacting their ability to complete other crucial duties.

*"Yes, online training is done but even if we do online work we still need to keep our writing work which is a lot. If it's only Online data entry work maybe there will be reduction in our data entry time but we should get proper facility to work online. We on our mobile phone have our own personal data and when we fill an online phone our phone starts hanging due to insufficient storage so instead the government should provide a smartphone for our work which will make our online work easier. It's better than our handwritten register"* ***(Rural ASHA, 36 years of age, 12 years of education, 15 years of experience)***

*"There's a lot of server problems because of which again and again we have to sit and fill up the online form as it goes into pending because of which we have to do double work"* ***(Urban ASHA,29 years of age, 12 years of education, 2 years of experience)***

*"We don't get time at all after doing online work to write our handwritten register. Even after filling the online form of beneficiaries, we have to again write all the details of beneficiaries in our register. We have to keep records both online and offline because of this workload I don't get time to do my household work too"* ***(Rural ASHA, 48 years of age, 11 years of education, 12 years of experience)***

***Association between Reduction in working load due to Online data entry with ASHA Cohort (New and Old ASHAs).***

| Reduction in time using online data entry | ASHA Cohort | | *P* - Value |
|---|---|---|---|
| | New | Old | |
| No | 223 (28.5%) | 261 (33.4%) | 0.183 |
| Yes | 148 (18.9%) | 150 (19.2%) | |

There was no significant association between the Reduction in workload using online data entry and the ASHA Cohort i.e New and Old ASHAs which states that, ASHAs are not willing to do online data entry as they are not given the training for the same and the ASHAs who have received the training have to do double work i.e online data entry as well as manual data entry in registers.

**PAYMENT BASED INCENTIVES**

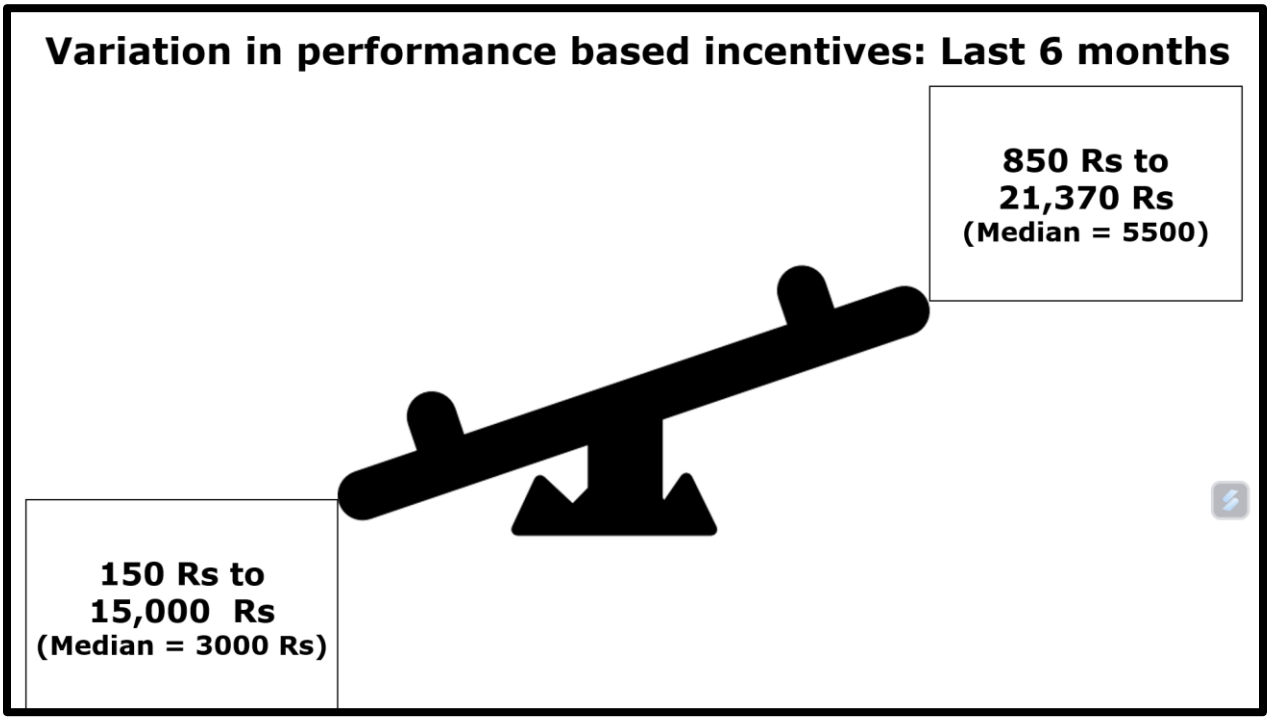


***Fig 20 - Variation in performance based incentives (n=956)***

According to Figure 20, ASHAs were surveyed regarding the range of their lowest and highest salaries over the past six months, revealing a considerable disparity. For the lowest earnings, ASHAs reported receiving anywhere from 150 Rs to 15,000 Rs, while for the highest earnings, the range was between 850 Rs to 21,370 Rs. Upon questioning about the reasons behind these varied amounts, ASHAs cited multiple factors influencing their pay. Firstly, the number of hours worked and the completion of various tasks played a significant role. ASHAs explained that their compensation was tied to the volume and complexity of the work they performed, indicating a direct correlation between effort expended and earnings received. Furthermore, performance-based incentives emerged as a crucial determinant of pay. ASHAs elaborated that achieving specific targets and meeting performance indicators allowed them to earn additional incentives, thereby augmenting their overall income. However, ASHAs also raised concerns about the impact of strikes on their earnings. Despite diligently carrying out their responsibilities and submitting required reports during strikes, they lamented not receiving any salary during these periods. This absence of payment during strikes underscores the vulnerability of ASHAs' income and highlights the need for mechanisms to ensure consistent compensation even in challenging circumstances.

ASHAs cited several reasons for the variability in their payments, with low payments primarily attributed to a strike that occurred throughout October and November. During this period, ASHAs participated in the strike, resulting in the non-acceptance of their pre-strike work and reports. Consequently, they did not receive payments for the work they had completed. Additionally, a decline in specific health indicators further impacted ASHAs' payments. These indicators included vaccination rates, ANC/PNC (Antenatal Care/Postnatal Care) visits, deliveries, the number of children under the age of 5, as well as various health programs such as HBNC (Home Based Newborn Care), HBYC (Home Based Young Child Care), JSY (Janani Suraksha Yojana), booster doses, Antara injections, among others. ASHAs earn incentives based on achieving targets related to these indicators. Therefore, a decrease in their performance in these areas directly affected their ability to earn incentives and subsequently impacted their payments. Moreover, ASHAs noted a decrease in the number of individuals diagnosed with tuberculosis (TB) and leprosy. Cases of TB and leprosy significantly contribute to ASHAs' incentive earnings. The decline in such cases negatively impacted the performance-based pay of ASHAs.

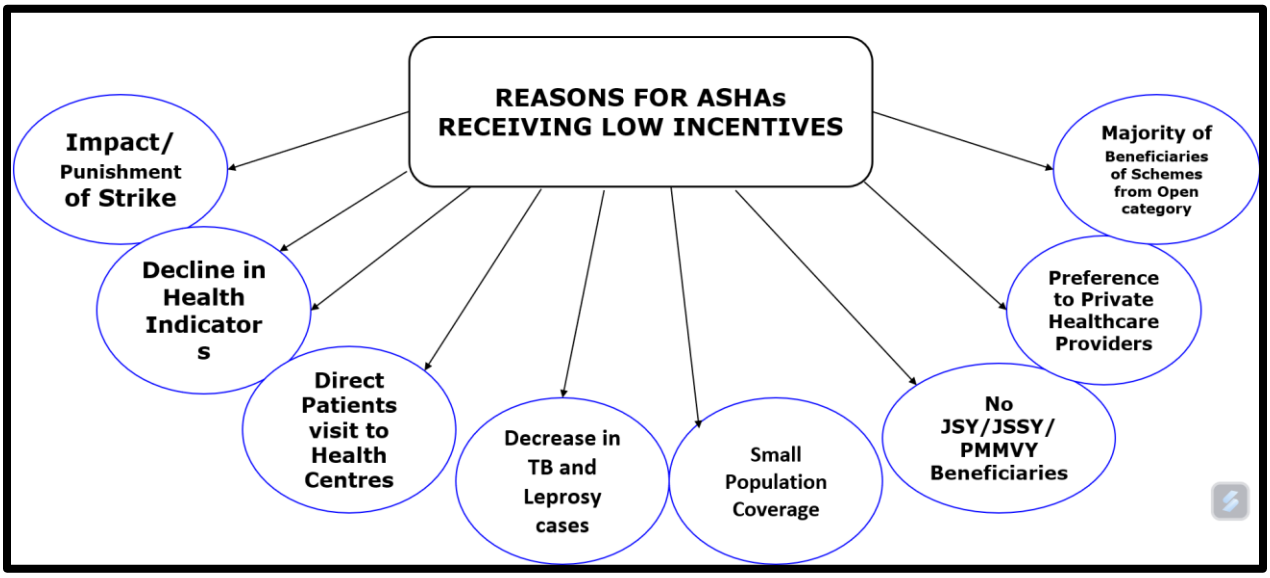


***Fig 21 - Reasons for Low incentives (n=956)***

As mentioned in Figure 21, The major reason reported by ASHAs was that the population that they are covering is very small, eventually resulting in fewer beneficiaries and a decrease in the incentives that can be earned depending on the indicators. ASHAs reported that the majority of the

population under them is in the open category, and due to the incentives that they receive from the Sc/ST categories, they don't get them here. Another reason was that the areas in which ASHAs work are the developed areas and there are no slum areas where the beneficiaries are more, but because they serve the population in developed areas, they don't get the beneficiaries.

Another main point highlighted by ASHAs was that the blood sample that ASHAs have to collect, if in any case the patient directly goes to the primary health center to submit his blood sample, and the incentives that they get for the same, they don't get. The majority of people in urban areas seek private healthcare facilities, eventually hampering the incentives of ASHAs. They also mentioned that if there are two ASHAs for one village, then the population gets divided, which leads to a decrease in beneficiaries and eventually performance-based payments.

*"I Received very less payment in the month of October because we all ASHAs from our area were on Strike, and whatever duties we did before the strike we prepared report for the same but we did not receive the payment for the same, I thought that ones the strike gets over we will get it but didn't receive it till date"* ***(ASHA: Rural, 42 Years of age, 14 years of education, 15 years of experience)***

The reasons reported by ASHAs for getting High incentives were many including TB Patients as they get Rs 5000 for completion of the TB DOTS Treatment, they also get 250 Rs per individual on completion of preventive TB Treatment. They receive a good amount of money for "Hathi Rog " i.e Elephantiasis where they receive Rs 200 per day for completing 50 Households. Then they Reported that they receive incentives for Immunization where if they complete full Immunization for a child under one year they receive Rs 100 and 50 Rs for the DPT Booster at 5 - 6 years of age of child. Another is the Maternal and child health domain where they Get huge amount of incentives for HBNC (Home Based Newborn care), ANC (Antenatal Care), PNC (Postnatal Care) and HBYC, here they receive 300 Rs in rural area and 200 Rs in urban area for ensuring antenatal care for the woman and for facilitating institutional delivery. Reporting the death of women (15 - 49 Years age group) to the PHC within 24 Hours gives them 200 Rs.

ASHAs reported additional reasons for receiving high incentives under maternal and child health initiatives, particularly related to home visits for newborns and postpartum mothers. These visits are crucial for monitoring the health and well-being of both the newborn and the mother during the critical postpartum period. For institutional deliveries, ASHAs reported that they conduct six visits on specific days following the birth: Days 3, 7, 14, 21, 28, and 42. These visits involve assessing the health of the newborn, providing guidance on breastfeeding and newborn care, and monitoring the mother's recovery from childbirth. In the case of home deliveries, ASHAs conduct seven visits on Days 1, 3, 7, 14, 21, 28, and 42. These visits are especially important for ensuring proper care and support for both the mother and the newborn in the absence of institutional healthcare services. Additionally, ASHAs undertake Home-Based Young Child (HBYC) visits to strengthen the health and nutrition of young children through home visits. These visits occur at regular intervals, typically at 3, 6, 9, 12, and 15 months of age. During these visits, ASHAs provide essential health education, monitor growth and development, and offer guidance on nutrition and immunizations.

ASHAs receive substantial incentives for their role in promoting family planning services within their communities. These incentives are tied to specific indicators aimed at encouraging behaviors that contribute to healthier reproductive practices. For instance, ASHAs are rewarded with 500 Rs if they ensure that couples maintain a spacing of two years after marriage or three years after the birth of their first child. Additionally, if ASHAs successfully advocate for a couple to opt for a permanent family planning method after two years, they receive a higher incentive of Rs 1000. Furthermore, ASHAs earn 200 Rs for their efforts in counseling, motivating, and following up with cases for tubectomy.

ASHAs Reported that they receive around 15000 Rs every 3 months i.e 5000 Rs per month, according to the NRHM Guidelines, ASHAs should get total 8000 Rs per month i.e 5000 Rs from state government and 3000 Rs from central government, but ASHAs mentioned that they don’t receive these 8000 Rs instead they get 5000 Rs per month that too, they get after 3 months together. In many of the areas of Maharashtra they also mentioned that they don’t receive any honorarium, they only get incentives on the duties they do on the daily basis i.e indicators.

## DELAY IN MESSAGES FROM HIGHER AUTHORITIES

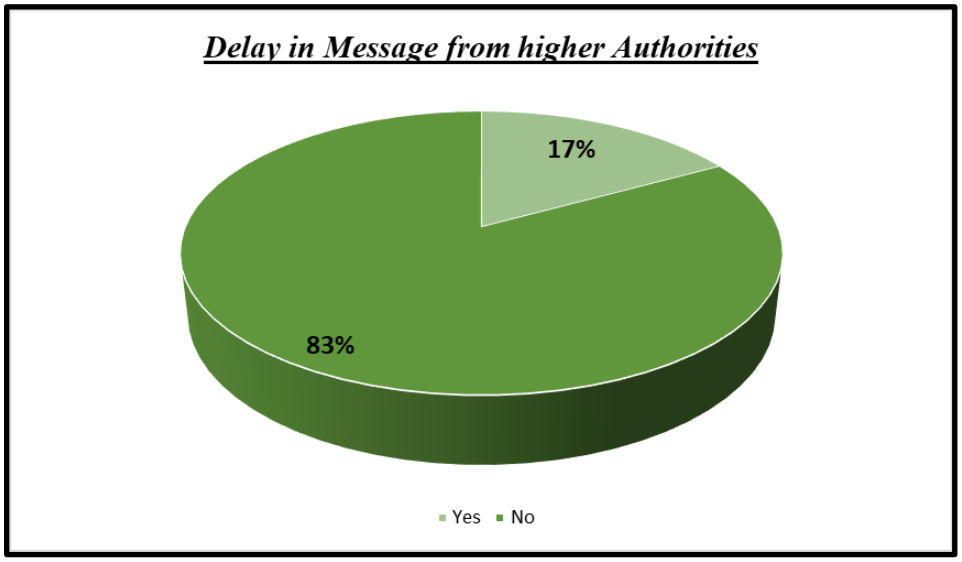


***Fig 22: Delay in Message From Higher Authorities (n=956)***

Figure 22 illustrates that 17% ASHA have faced delay in messages from higher authorities while 83% do not face any delays in their messages from higher authorities.

The reason for them receiving all the messages on time is a well-coordinated WhatsApp group that facilitates communication between them and various health officials in their district. This group includes the Primary Health Centre, Medical Officer, MPWs, ANMs, the ASHA facilitator, and all ASHAs from the district. They mentioned that rarely they have faced delay in messages from health officials and if they do they adjust sometime.

*"Yes, I have faced delay in messages from higher authorities. When there's a delay, they just keep pressuring us. If they give the message on time, we can do the same work neatly and properly. Delay in message made us work for 12-12 hours"* ***(Rural ASHA, 37 years of age,10 years of education,11 years of experience)***

*"Rarely it has happened, usually during immunization we have to be in the hospital till late evening, our phone gets switched off, we don't get time to check our phones on time that time we get messages delayed the OPD"* ***(Urban ASHA, 43 years of age, 13 years of education, 14 years of experience)***

***Association Between Challenges faced by ASHAs in the timely implementation of assigned tasks by higher authorities and ASHA Cohort.***

| Delay in message from higher authorities | ASHA Cohort | | *P* - Value |
|---|---|---|---|
| | New ASHAs | Old ASHAs | |
| Yes | 62 (6.5%) | 102 (10.7%) | 0.004 |
| No | 392 (41%) | 400 (41.8%) | |

The Above Table Talks about the association between Delay in message from higher authorities and ASHA cohort i.e New and Old ASHAs, it states that majority of the ASHAs get message on time which is highly significant.

***Association Between Challenges faced by ASHAs in the timely implementation of assigned tasks by higher authorities and Rural and Urban ASHAs.***

| Delay in message from higher authorities | Study Site | | *P* - Value |
|---|---|---|---|
| | Rural | Urban | |
| Yes | 128 (13.4%) | 36 (3.8%) | 0.020 |
| No | 553 (57.8%) | 239 (25%) | |

The above Table Talks about the association between Delay in message from higher authorities and Study site i.e ASHAs working in urban and rural regions, it states that Majority of the ASHAs working in Rural area don't face any delay in message from higher authorities, whereas there were 13.4% which is an highly significant number which faced delay in message from higher authorities in rural region.

**WORKLOAD FROM OTHER DEPARTMENTS**

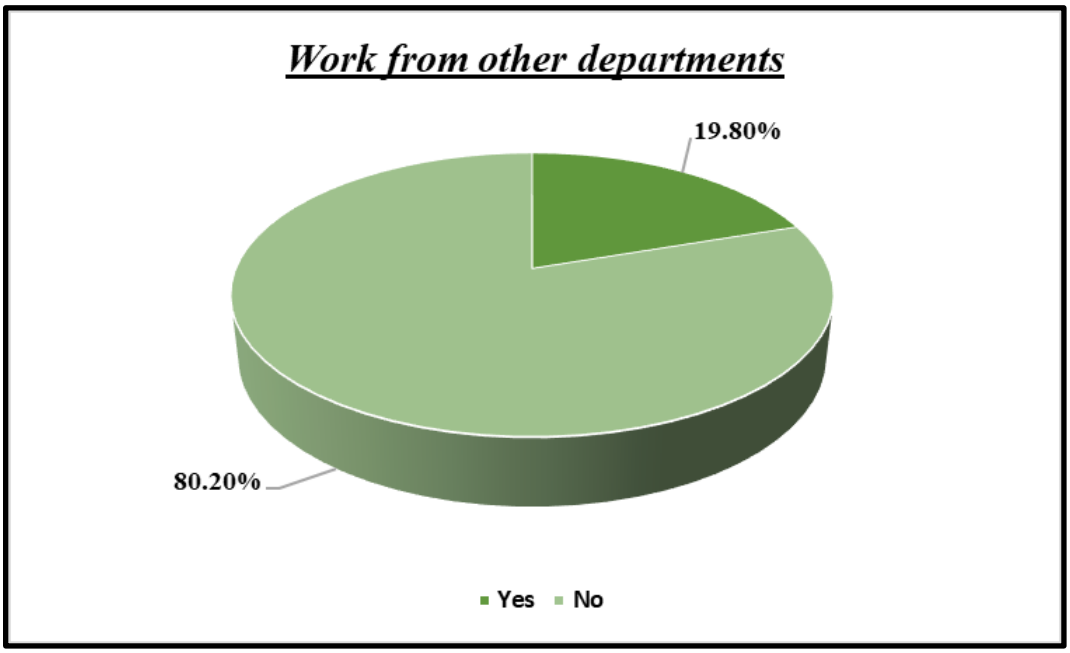


***Fig 23: Work From Other Departments (n=956)***

According to Figure 23 as shown above, ASHAs were asked questions focusing on their task burden and workload. Among the respondents, 19.80% of ASHAs acknowledged undertaking additional tasks beyond their regular health department duties, while the majority, constituting 80.20%, reported not engaging in such extra work from other departments.

When queried about the reasons for not undertaking additional tasks, ASHAs commonly cited a lack of sufficient time amidst their designated responsibilities. However, those who did engage in extra work explained that such tasks were assigned by the local gram panchayat or nagar

panchayat, and they felt obligated to fulfill them. While some ASHAs received compensation for these additional responsibilities, it was not consistent for all.

ASHAs expressed their willingness to undertake these extra tasks out of a sense of duty to serve humanity. This willingness to assist beyond their primary roles reflects a commitment to community service and highlights the multifaceted challenges faced by ASHAs in balancing their workload with societal expectations.

## WEEKLY WORKING HOURS

According to the National Health Mission guidelines ASHAs have a flexible work schedule and her work load would be limited to putting in only about two-three hours per day, on about four days per week, except during some mobilization events and training programmes. On an average they work for 14 hours per week.

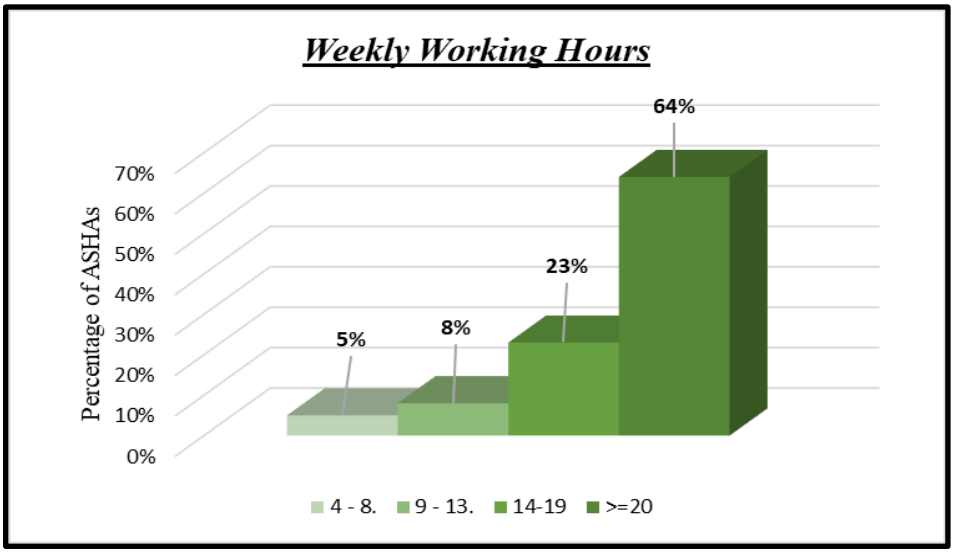


***Fig 24: Weekly Working Hours (n=956)***

**Extended working hours**: However, ASHAs mentioned having to work for more than 20 hours every week. About 64.20% ASHAs reported having to work more than 20 hours per week. This extended working hours were attributed to them having to do their daily duties of ASHAs as well as the making of ASHA cards and Ayushmaan cards. They also complained about having to

complete 25-30 home visits. During the Village Health and Nutrition Day, Vaccination campaign or the ANC camp, they are to work for the entire day from 9am to 5pm

> *"Visits for the work of making ABHA cards, Golden cards and HBNC visits, Due to Golden card we are regularly on field for 6 hours"* ***(Rural ASHA, 40 years of age, 15 years of education,7 years of experience)***

**Not having Fixed working hours:** ASHA complained about not having fixed working hours hence had to visit the patients as and when they are required.

> *"We work from 10 am to 5pm. We keep roaming from one house to another. As we are not allotted any fixed working time, we've to go to work whenever we receive a phone call from 'labharti' (Beneficiary) Our work isn't bound by time"* ***(Rural ASHA, 36 years of , 15 years of education, 13 years of experience)***

> *"We are working on making Golden cards and ABHA cards. We have to visit the people at night, as the majority of people are farmers and don't return home till evening".* ***(Rural ASHA, 40 years of age, 12$^{th}$ years of education, 14 years of experience)***

22.80% of ASHA reported working for 3-4 hours daily for 6 days i.e.14 hours to 19 hours per week.

> *"Visiting HBNC, escorting the mother for delivery to referral units, Measuring the weight of the baby and vaccination after the birth needs to be taken care of. Once we go, we require 3-4*

*hours for the same" (**Urban ASHA, 45 years of age,12 years of education, 13 years of experience)***

While the 7.9% ASHAs reportedly worked for 9-13 hours per week. The rest 5% ASHA were working for 4-8 hours weekly. Some ASHA were only delivering essential services while others were not working at all during the significant period after 11 January 2024 as they were on strike. Hence they didn't go into the community.

*"We have an ongoing strike for 1 month hence we didn't work for the entire month of January." **(Urban ASHA, 35 years of age, 10 years of education, 1 years of experience)***

*"There is an ongoing strike hence we didn't work, but I did refer a delivery patient for cesarean delivery to GMC hospital" (**Urban ASHA, 32 years of age.12 years of education, 1 year of experience)***

***Report Writing:***

The ASHAs are to maintain record of the events in the community and alongside daily diary entries which are then submitted in the monthly meeting. Time duration required for maintaining the records and reports varied from 1 hour to 4 hours daily. However, ASHA mentioned needing approximately 1-2 hours daily for 2 days i.e., 4-5 hours per week for the work of record keeping and report writing.

Predominantly they mentioned about having to maintain 5 main records. These include, ANC, PNC, newly married couple, LMP records, and birth and death. Other than these records the other records that are to be maintained are: Infectious diseases such Number of TB, leprosy patients in the community, records of BS and sputum tests, and their disease status.

Immunization records of the monthly vaccination campaigns and vaccinations given to the mother and the child. These include vaccination records for MMR booster, Govar booster, TT injection, Polio, etc

They have to maintain records of the medicines that are distributed in the community. For example, Paracetamol, contraceptive tablets, Nutritional supplementary tablets, etc. They are to maintain the report of the Village level Assemblies, Committees and campaigns conducted such as VHNSC, VHNC, immunization campaign, ANC camp.

> *"We approximately require 3-4 hours for report writing. This included reports on how many Ayushman cards were made, ANC, Vaccination status, any new child birth or death cases, were any one admitted to the hospital."* ***(Urban ASHA, 41 years of age,12 years of education, 7 years of experience)***

Filling all these reports takes approximately 4-5 hours per week. However, a minor number of ASHAs needed more time for report writing. Many ASHAs reportedly mentioned not doing any record keeping as they were on strike and hence didn't work.

> *"We didn't submit the reports as there is an ongoing strike"* ***(Urban ASHA, 41 years of age, 10 years of education 2 years. of experience)***

A few ASHA reported having to maintain the reports of any disease outbreak in the locality or the village such as dengue survey.

***Fixed Working Hours:***

ASHA reported about having to work long and extended hours in the community. Hence when asked about wanting to have fixed working hours so that they can maintain a work-life balance.

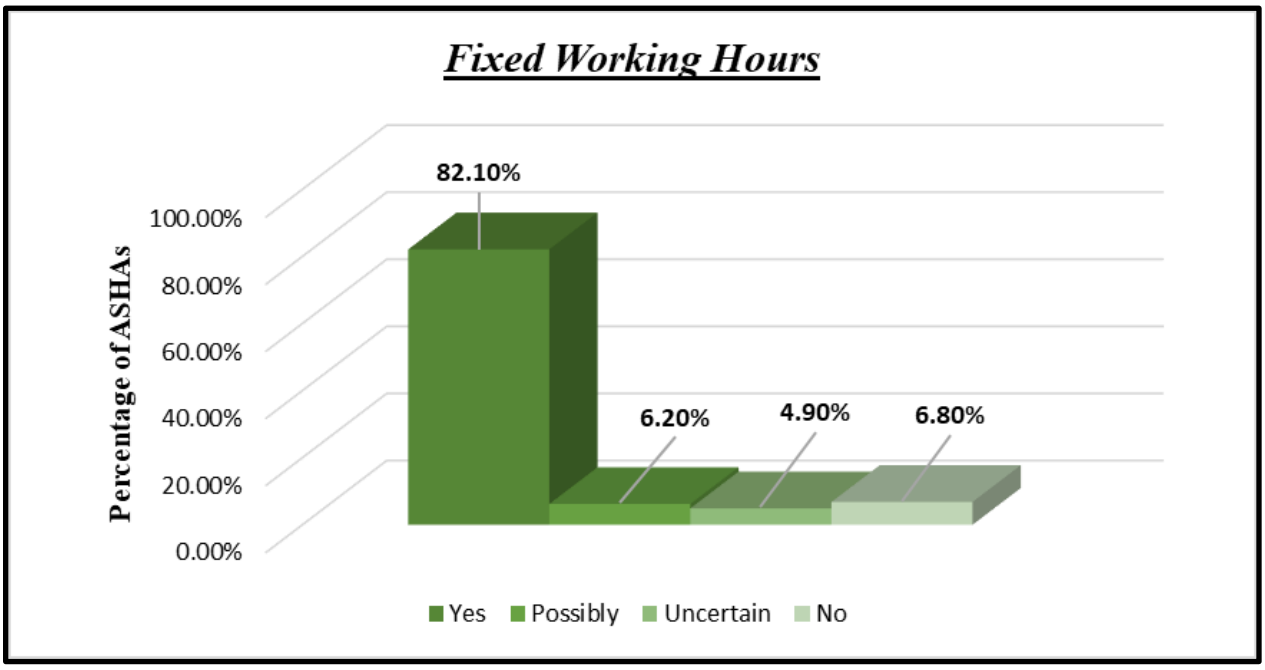


***Fig 25: Fixed Working Hours (n=956)***

According to Figure 25 as shown above, A significant majority of ASHA workers, with 82.10% reporting a willingness to adopt fixed working hours, as it can be a potential solution for solving the problem of extended working hours. By implementing this they mentioned having work-life balance.

*"Yes, it should be done, as we spend 2-3 hours in the field, after coming home we are to do the writing work. So, around 6-7 hrs are spent working. ANC, PNC visits, then escorting pregnant women for delivery. There is no limit for time as we are required to work whether its day or night"* ***(Urban ASHA, 35 years of age, 12 years of education, 8 years of experience)***

While 6.20% of ASHAs responded to the possibility of adopting the fixed working hours.

> *"I am fine with the fixed working hours; however, our payment is based on the incentives so we are more focused on working for incentive"* ***(Rural ASHA, 43 years of age, 15 Years of Experience, 5 years of experience)***

4.9% of ASHAs refrained from providing any clear stance indicating that they were uncertain as their payment was based on incentive they get for their work, and so found that it's not feasible as people are not available during the day hence, they have to conduct the visits in evening.

> *"Fixed working hours can make the work easy, but people go to work during the day as everyone is working class in my area, hence everything is dependent on the availability of people so I am not certain about it"* ***(Rural ASHA, 35 years, 12 Years of education, 8 years of experience)***

6.8% responded negatively as they are called for emergencies and deliveries hence its not practically possible to have fixed work hours.

> *"It isn't possible, we ASHAs can't have fixed hours because we are told to submit report anytime, patient or emergency occurs anytime" (****Rural ASHA, 33 years of age, 11 Years of experience, 14 years of experience***

**INFLUENCE OF UNIONS**

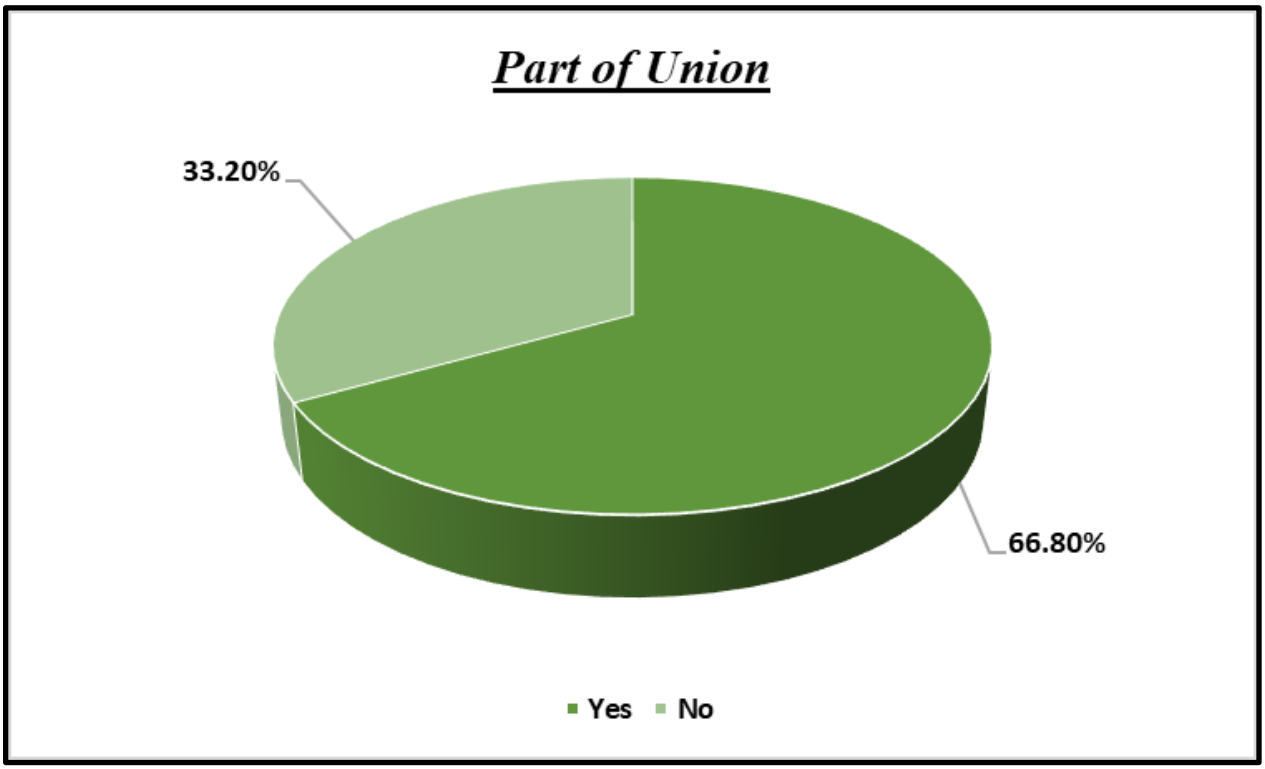


***Fig 26: Part of Union (n=956)***

Figure 26, explains ASHA (Accredited Social Health Activist) being part of union groups. Approximately 66.80% ASHA are part of the union group and 33.20% are not part of the union group. ASHA mentioned the names of many unions all over the 8 districts of Maharashtra. Asha defines union as a group of people who help them raise their voice in their rights and interest. There were many of the union which we found in 8 districts during our data collection mentioned by ASHA to name a few which we found in our study were,

1) CITU (Centre of Indian Trade Unions)
2) AIUTAC (All India United Trade Union Centre)
3) SHEKAP (Shetkari Kamgar Paksh)
4) Maharashtra Rajya ASHA va Gatpravartak Kruti Samiti
5) Maharashtra Rajya ASHA Swaysevika sangathan

The reasons for ASHAs to join this union were, they said that they helped them during their strike. They say whichever problem they have they convey it to their respective district union head and

further the union leader takes it up to their higher authorities. Some have been influenced by ASHA supervisors or ASHA to be part of this union.

> *"I'm part of CITU union, they have there central all over Maharashtra with their support we are going on strike tomorrow*" (***Rural ASHA, 42 years of age, 14 years of education, 13 years of experience)***

some ASHAs are also not part of these unions as they say we are willing to learn rather than going on a strike, some say they are of no use and in a district these union had also scammed the ASHAs and took their money in return promising them they will help in their salary increment.

**Safety and Security Issues of ASHAs**

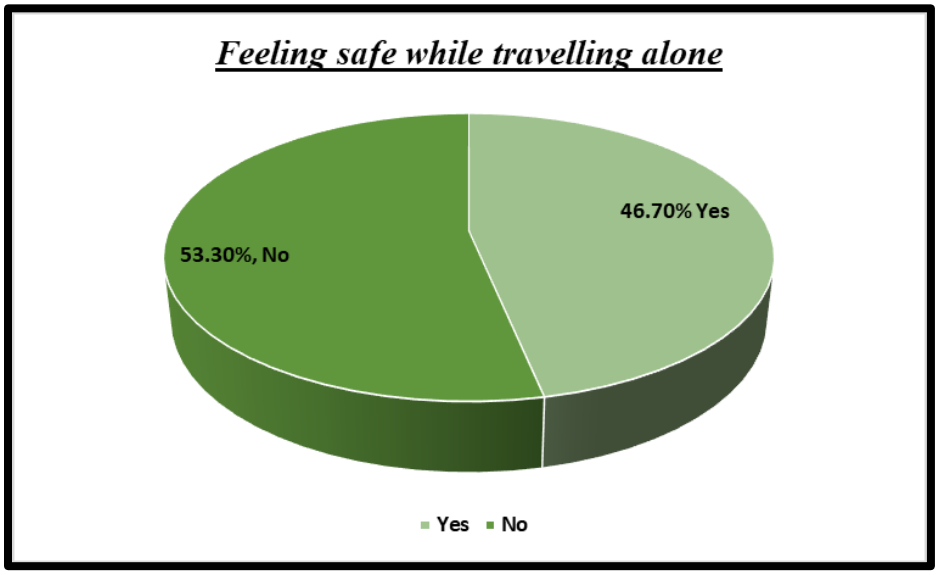


***Fig 27: Feeling Safe While Traveling Alone (n=956)***

Figure 27: reveals a concerning disparity in ASHA safety. While 46.70% feel secure traveling alone within their village and for training purposes, a significant majority 53.30% express discomfort traveling alone even within their villages.

The crux of the issue lies in transportation availability. ASHAs, who perform vital community work at the ground level, lack reliable transport options, forcing them to walk long distances to reach beneficiaries. This lack of mobility significantly compromises their safety particularly during night time hours when they feel more vulnerable. Majority of ASHAs do not have their own personal transportation which makes them feel unsafe while traveling alone.

ASHAs report a sense of security when traveling together in shared rickshaws. This practice is feasible for nearby ASHAs due to the shared out-of-pocket expense. However, it highlights a transportation gap. ASHAs describe situations where they must accompany pregnant women from villages to hospitals during deliveries. While ambulances might be available for the outward journey, returning home often proves challenging due to a lack of transportation options. Sometimes family members of pregnant women ill treat ASHAs making them more vulnerable to travel with them. In some cases, husbands can provide a drop-off and wait, but this isn't always a viable solution. ASHAs mentioned during rainy seasons finding transportation becomes considerably more challenging during these times. Interestingly, the data reveals a split in perception regarding safety during travel. Some ASHAs feel a sense of empowerment stemming from their position. They believe their ASHA uniform serves as a badge of authority, fostering a sense of security and encouraging assistance from those within their communities.

"*We never travel alone, we all travel together in a rickshaw or bus if we have to go anywhere"* ***(Urban ASHA,33 years of age,12 years of education,5 years of experience)***

*"We travel to really far places. Going to our local village I don't feel safe at all. I wear an apron or sun coat while visiting the household but you don't know how the people are looking at you, their intention might not be good. We do house to house visits where we sometimes just find*

*males in the house. That time I tried to cover my whole body with clothes".* ***(Rural ASHA 40 years of age, 15 years of education, 15 years of experience)***

**ANM/GNM COURSES**

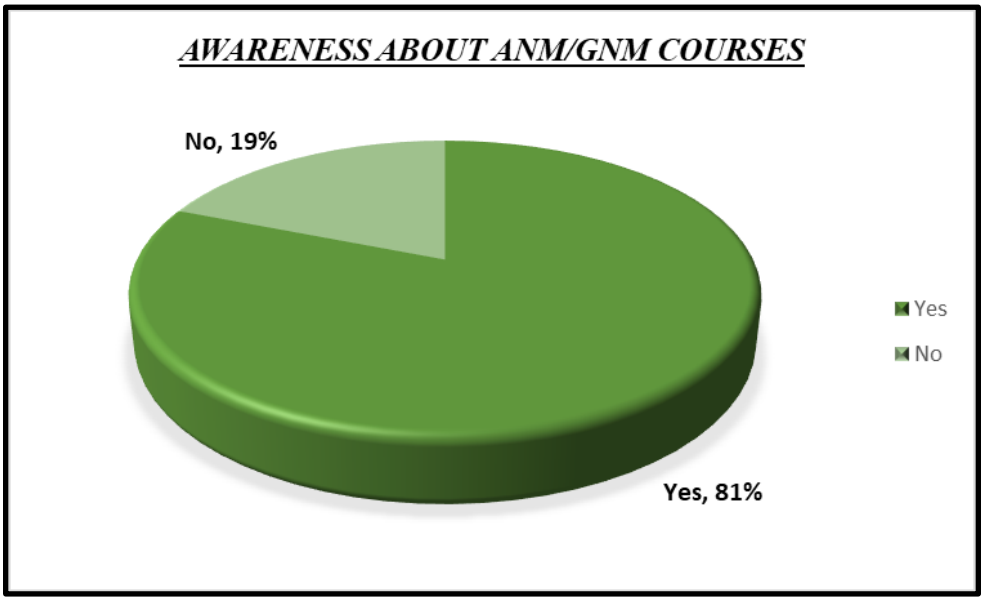


***Fig 28: Awareness About ANM/GNM Courses (n=956)***

According to Figure 28, ASHAs were queried about their awareness of ANM/GNM courses and the potential for career advancement through them. A significant majority, comprising 81% of respondents, affirmed their knowledge of these nursing-related programs. They indicated that their awareness stemmed from information provided by higher authorities such as Medical Officers (MOs) and Auxiliary Nurse Midwives (ANMs) during training sessions or monthly meetings. Despite this awareness, ASHAs reported a lack of knowledge regarding the NRHM funding supporting these courses. This underscores a potential communication gap between ASHAs and the authorities responsible for disseminating information about funding opportunities.

Moreover, ASHAs expressed a keen interest in pursuing these courses further, indicating a recognition of the potential benefits they could offer in terms of career progression and professional development. However, despite their enthusiasm, many ASHAs faced obstacles that

prevented them from enrolling in or completing the courses. These barriers included educational prerequisites, family responsibilities, age restrictions, and administrative challenges such as missing documents.

Out of the 81% of ASHAs who were aware of ANM/GNM courses, only 39% had actually enrolled or completed the courses. This indicates a notable gap between awareness and actual participation. The remaining 69% expressed interest in pursuing these courses but encountered significant barriers that prevented them from doing so.

One of the primary challenges reported by ASHAs was a lack of financial support. Many ASHAs were unaware of the NRHM funding available for these courses, which meant they were unable to access financial assistance to cover the costs of enrollment, tuition, and related expenses. Without this crucial funding knowledge, ASHAs faced difficulty in affording the courses, leading to their inability to enroll.

Additionally, another significant barrier was the lack of educational qualifications required for admission. Some ASHAs did not possess the necessary educational background or qualifications to meet the admission criteria for ANM/GNM courses. This educational barrier acted as a deterrent, preventing them from pursuing further education and professional development opportunities.

In addition to financial and educational barriers, ASHAs highlighted several familial and logistical challenges that hindered their ability to complete ANM/GNM courses. Family priorities, especially those related to childcare, emerged as significant factors preventing ASHAs from pursuing further education. Many ASHAs reported that their responsibilities towards their families, particularly caring for their small children, made it difficult for them to commit to the residential nature of these courses.

Residential requirements for ANM/GNM courses posed a particular challenge for ASHAs with young children. Being away from home for extended periods of time to attend classes or practical training sessions presented logistical difficulties, as ASHAs struggled to balance their family responsibilities with their educational aspirations. Furthermore, the age limit of 35 years for enrollment in these courses posed another barrier. Some ASHAs found themselves ineligible to

enroll due to age restrictions, especially if they got married or had children later in life, impacting their ability to pursue further education.

Moreover, ASHAs who embarked on their educational journey while already married or with children faced additional challenges. Juggling familial responsibilities alongside coursework proved to be demanding, often resulting in difficulties in managing both aspects effectively. The competing demands of family and education ultimately hindered many ASHAs from completing their ANM/GNM courses.

ASHAs also cited administrative hurdles, particularly related to documentation, as a significant barrier to enrolling in ANM/GNM courses. Many ASHAs reported lacking the necessary documents required for admission, most notably their caste certificates. Without these essential documents, they were unable to complete the enrollment process and secure a spot in the courses.

The absence of caste certificates presented a significant obstacle, as these documents are often required for admission into educational programs and institutions, including ANM/GNM courses. ASHAs who did not possess their caste certificates found themselves ineligible for admission, regardless of their qualifications or desire to pursue further education and training in healthcare.

The inability to provide the required documentation not only thwarted ASHAs' educational aspirations but also underscored broader systemic challenges related to administrative processes and documentation access. For some ASHAs, obtaining caste certificates may have been a complex or time-consuming process, further exacerbating the barriers to enrollment.

Many ASHAs conveyed that they did not wish to enroll in these courses voluntarily due to apprehensions regarding increased workload and additional responsibilities that would accompany higher qualifications. For ASHAs already engaged in demanding healthcare roles within their communities, the prospect of taking on more responsibilities and commitments posed a daunting challenge. They feared that pursuing ANM/GNM courses would intensify their workload and extend their professional obligations, potentially impacting their ability to manage their existing duties effectively.

Furthermore, ASHAs may have perceived pursuing further education as a disruption to their current roles and routines. They may have been hesitant to deviate from their established responsibilities and community roles, preferring to maintain continuity in their work rather than pursuing educational advancement.

## AWARDS AND RECOGNITION

### *Global Health Leaders Award:*

The World Health Organization (WHO) awarded the Global Health Leaders Award 2022 to the individuals who have contributed to improving healthcare as a frontline worker during Covid-19 pandemic. ASHA were recognized for their efforts and for providing the necessary care and support during that period.

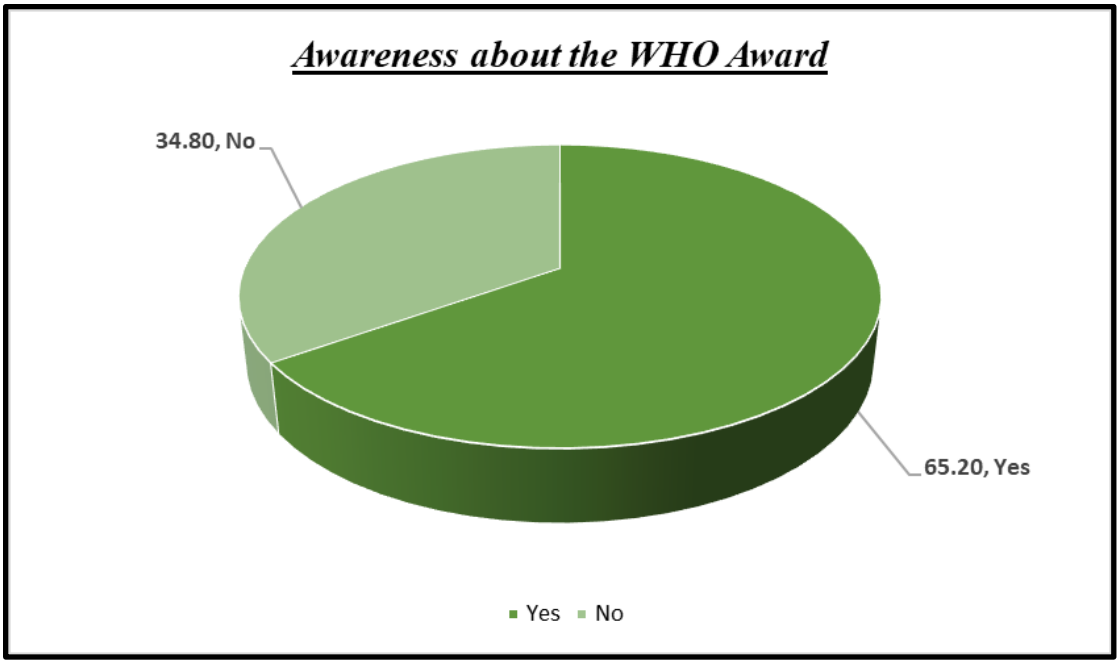


***Fig 29: Awareness about the WHO Award***

When questioned about ASHAs awareness of Global Health Leaders Award they received in 2022 for their contribution, 65.2% of ASHAs confirmed that they were informed by the authorities about this honor. However, 34.8% of ASHAs expresses unawareness of receiving any recognition according to Figure 29 above.

***Awards and Recognition Received by ASHA for their work:***

ASHAs receive Awards and recognition for their work in the health sector by Gram-panchayat, Panchayat samiti, Zilla-parishad, Municipal Corporation.

77.6% ASHA mentioned having received the honors in the form of trophy, cash price, felicitations on the occasion of Independence or Republic Day, verbal appreciations, or in th e form of gifts on festivals. Subsequently all these Recognitions and Awards were given for the work ASHA did during Covid-19. They were majorly felicitated on behalf of the gram panchayat or gram sevak.

| |
|---|
| *"We were awarded for the work we did during the Covid-19 by the Gram panchayat".* ***(Rural ASHA, 45yrs, 12 years of educations, 14 years of experience)*** |

| |
|---|
| *"We were awarded as Covid yodha (Covid warrior) by gram panchayat and we also received a cash price of 1000rs as honorarium".****(Rural ASHA, 42yrs, 12$^{th}$ pass, 7yrs of experience)*** |

22.4% ASHA reported not having received any form of recognition or award for their work.

## MOTIVATION AND SATISFACTION

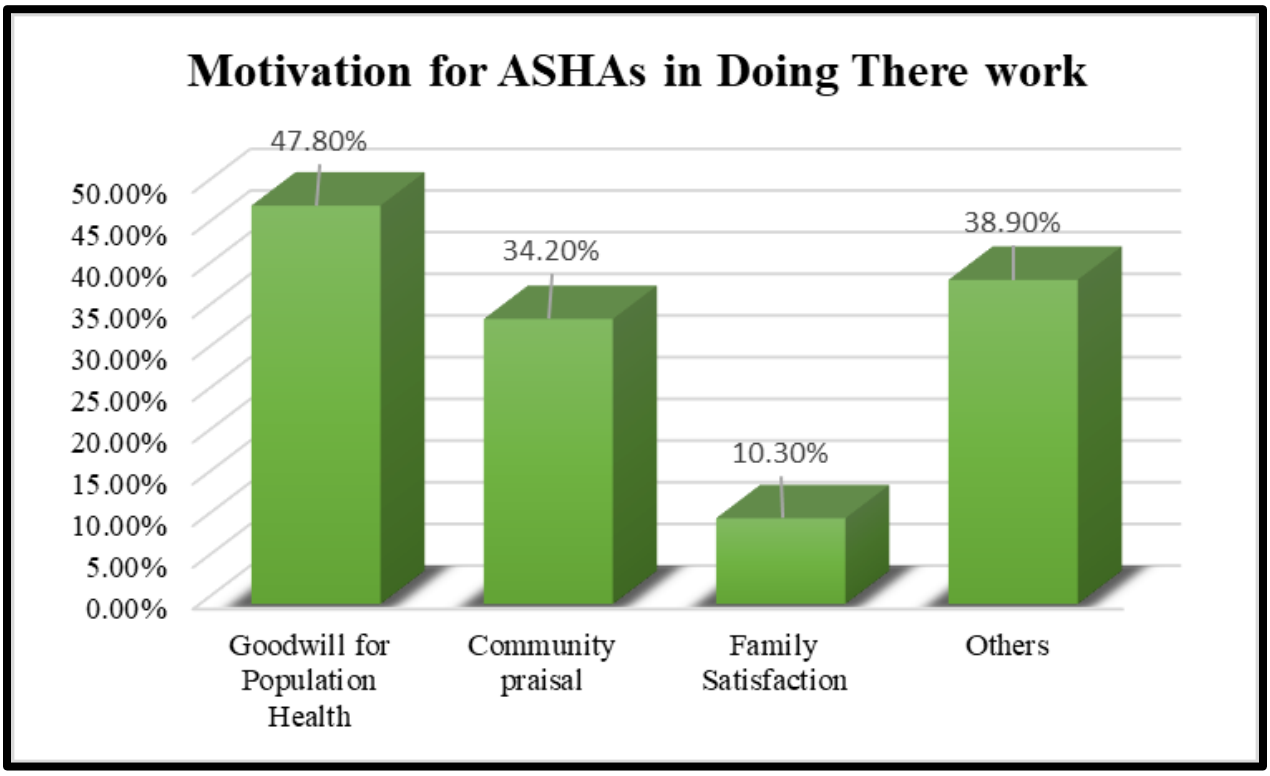


***Fig 30: Motivation for ASHA in Doing Their Work (n=956)***

Figure 30 above illustrates the motivational factors that drive ASHA workers in their daily work within the community. It reveals that the primary motivation for a significant portion of ASHAs, approximately 47.80%, is their goodwill towards population health. This suggests a deep-seated sense of altruism and commitment to improving the well-being of the community they serve. Furthermore, the chart indicates that 34.20% of ASHAs are motivated by the recognition and praise they receive from the community for their efforts. This acknowledgment serves as a source of validation and encouragement, reinforcing their dedication to their work. Additionally, a noteworthy finding is that 10.30% of ASHAs cited family satisfaction as a motivating factor. This implies that for some ASHAs, their commitment to their work is driven by the desire to provide for and support their families, highlighting the interconnectedness between personal and professional motivations.

In addition to the major motivational factors previously mentioned, a significant portion of ASHAs, comprising 38.90%, highlighted additional factors that drive their commitment to their work. Among these factors, ASHAs emphasized the importance of raising awareness about various diseases, especially among populations residing in slum areas who often lack knowledge about communicable and non-communicable diseases. By reaching out to these challenging areas and spreading awareness, ASHAs derive a sense of pride and motivation, knowing they are making a tangible difference in improving health outcomes.

*"Our motivation stems from the people we serve, particularly those residing in slum areas who often lack awareness about health. It's fulfilling for us when we educate them, especially about the importance of immunization. Witnessing their gratitude and appreciation fuels our passion for our work. Moreover, as many of them are parents, they are particularly pleased to learn that someone is looking out for the health of their children. Their happiness and reassurance inspire us to continue our efforts, knowing that we're making a positive impact on their lives and the well-being of their families"* ***(Rural ASHA, 45yrs, 12 years of educations, 14 years of experience)***

Moreover, ASHAs expressed that their daily fieldwork provides them with valuable opportunities for learning. Through their interactions with community members, they gain insights into the unique challenges faced by each household. This familiarity with the community allows them to better understand the population they serve, enhancing their ability to address individual needs effectively. This deep understanding of the community becomes a significant motivational factor for ASHAs, driving them to continue their efforts towards the betterment of households within their population.

Another significant motivational factor reported by ASHAs was the COVID-19 pandemic. In the face of this unprecedented health crisis, ASHAs found themselves compelled to work even more

diligently. The severity of the pandemic and the tragic loss of lives underscored the critical role ASHAs play at the grassroots level. During the pandemic, ASHAs came to realize the importance of their presence and efforts within their villages. The COVID-19 pandemic served as a catalyst for ASHAs to recognize their pivotal role in improving the health status of their communities. They understood that they were uniquely positioned to bring about positive change by addressing various health challenges at the village level. This newfound recognition of their significance and impact further motivated ASHAs to redouble their efforts and work tirelessly across all domains of health.

*"Every month, we gather for our regular meeting where our medical officers, ANMs, and other colleagues guide us on our fieldwork tasks and discuss the progress we've made in addressing community issues. With each meeting, we leave feeling motivated and focused on our mission—to serve the people. It's truly fulfilling to work together towards improving the lives of those we serve"* ***(ASHA: Urban, 42 Years, 12 Years of education, 11 Years of experience)***

Another thing which they reported was that they get motivation from the experience which they are getting day by day, they mentioned that early people would shut the door when they used to go to the households, but now with time they have become more familiar and comfortable with the population and in turn population has also started to accept them, now even if anytime ASHA misses to visit that particular household the people themselves approach the ASHAs for the services. Many also mentioned that the Gram panchayat also motivates them to do their work daily, as they have monthly sabha where ASHAs are also involved for the discussion due to which they get motivated to do better for the health of the population of their village.

Here is an example of the same:

*"Experience gives inspiration because as we work, we get inspiration to work, we get experience about people, first when we used to go for surveys, people used to close the door but now they ask if we need anything. They ask casually if someone needs a condom, if someone wants an interval injection, they ask. We feel very good because earlier people used to turn their backs on us but now everyone tells us problems"* ***(ASHA: Rural, 39 Years, 12 Years of education, 12 Years of experience).***

Another Cohort of ASHAs also mentioned that the kind of work they do also motivates them i.e if they are delivering any lady in the difficult times, they get praised from the health department and also from the family of the same, which increases there pride in the community leading to receiving more prestige and eventually a will to do the work more better. All these factors play a very pivotal role to the encouragement of ASHAs and push them to do better day by day.

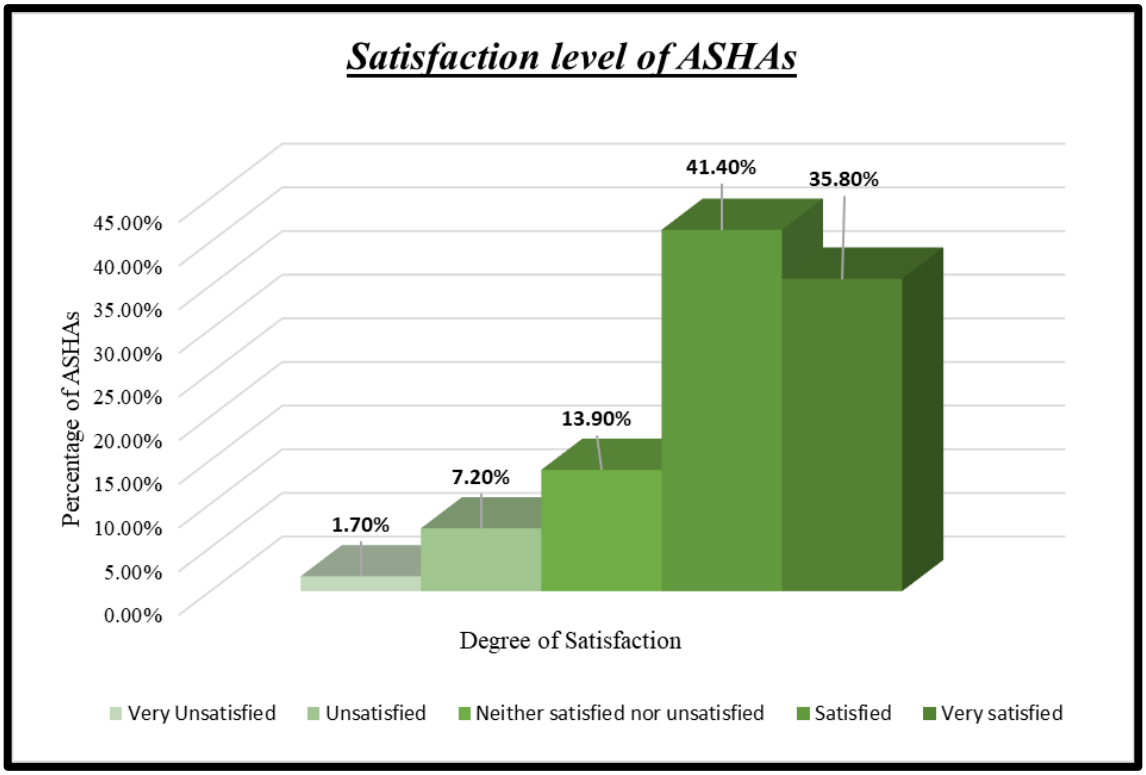


***Fig 31: Satisfaction Level of ASHAs (n=956)***

The Figure 31 above illustrates the satisfaction level of Accredited Social Health Activists (ASHAs) regarding their work. The majority, 41.40% of ASHAs, have expressed satisfaction in their work. The primary reason cited for this satisfaction is their contribution to population health. Specifically, ASHAs mentioned feeling fulfilled when maternal or neonatal deaths in their villages are reduced. They derive a sense of pride from the social work they engage in. Additionally, ASHAs find satisfaction in addressing challenges within their communities. For instance, they encounter individuals who hesitate to seek medical services due to stigma associated with diseases like TB. ASHAs play a crucial role in counseling these individuals and facilitating their access to hospitals or clinics. This aspect of their work satisfies them as they perceive it as saving lives and improving community health.

*"Those who suffer from diseases like TB are afraid to go to the hospital. So, we make an effort to explain to them, especially when their children are the ones who are prescribed medication they need to be focused more on. Seeing them start their treatment and feeling relieved, knowing that we might have saved someone's life, is incredibly satisfying. We try to understand their concerns and reassure them that they will be alright because they are hesitant, especially when it comes to undergoing tests or starting treatment. They tend to overlook everything until they come to us, and then, when we provide them with information about the disease and what could happen to their children, they feel much more at ease"* ***(ASHA: Rural. 45 Years, 12 Years of Education, 14 Years of Experience)***

ASHAs also mentioned additional factors contributing to their satisfaction in their work. One significant aspect is the financial support they receive through their ASHA duties. This income enables them to better provide for their families and contribute to household finances. Particularly noteworthy is the independence this financial stability affords ASHAs, especially those who are divorced, separated from their spouses, or widowed. For these individuals, the ASHA role not only offers financial autonomy but also a source of confidence and resilience. They express satisfaction in their ability to thrive independently under any circumstances.

*"I receive family support, my reputation is significant, and people show me respect; all these things truly bring me a lot of satisfaction. Even though my educational qualifications might be modest, people still show me a lot of respect. Seeing my children doing well at home also brings me immense joy. I am able to manage all household chores while staying at home while doing the ASHA Work"* ***(ASHA: Urban, 34 Years, 10 Years of Education, 12 Years of Experience)***

ASHAs feel satisfied in their work because they see the positive changes they bring to their communities. Whether it's reducing deaths during childbirth, helping children stay healthy, or simply being there for people when they need health advice, ASHAs know they're making a difference. They also feel good about being respected and recognized in their communities for the hard work they do. Plus, their work gives them a sense of purpose and helps them grow personally. They're proud to be independent and to be able to support themselves and their families.

Around 8.90% of ASHAs also mentioned that they are not satisfied in doing the work of ASHAs. The reasons reported by ASHAs for the same is that they are not getting enough incentives for the work which they are doing and they stated that they are working for more hours and doing all the duties which they are supposed to do, but the entitled incentives which is known as performance based incentive are very low and are not justified for the amount of work they do. They stated that the amount of money which they receive is very less and they are not able to do their daily chores, which needs money like, they stated that they are not able to put their children in good school due to lack of money and also ASHAs whose husbands were not working mentioned that it's very difficult to run the household with that little money. They also mentioned that even if they are getting payment they don't get it in a timely manner and due to which now they are thinking of leaving the Job.

*"I am not at all satisfied with the work I do as an ASHA, because the payment I receive monthly is not enough for the education of my son, we live in urban area where the fees of school is very high, my husband is also disabled due to which he is unemployed and not able to earn money,*

*so I only have to look after my household along with working in the field everyday, and that too for long hours of time. Even after working so much I don't receive the enough money due to which it affects my livelihood"* ***(ASHA: Urban, 32 Years, 12 years of education, 7 years of experience as an ASHA)***

ASHAs also mentioned that the population which they are serving is very small due to which the "Labharthi" (Beneficiary) are very less and due to which the HBNC Cases or the TB cases which they get annually are very less, many of the people are not married so the ANC/PNC Visists on which they get incentives are also not that much impacting there performance based incentives. They mentioned that they should leave the ASHA work and shift to farming as they mentioned that farmers on daily basis earn more as compared to ASHAs.

Urban ASHAs specifically mentioned that the work they are doing now is not enough for them as they are not getting promotion or enough money for the same, so because of this they are demanding that they should get additional training of ANMs so that they can shift to that work and earn from that instead of doing the ASHA work. They stated that they are living in the urban areas where the living cost is very high and the incentives like 5000 - 6000 Rs which they get after 3 months are not sufficient to raise their children and family.

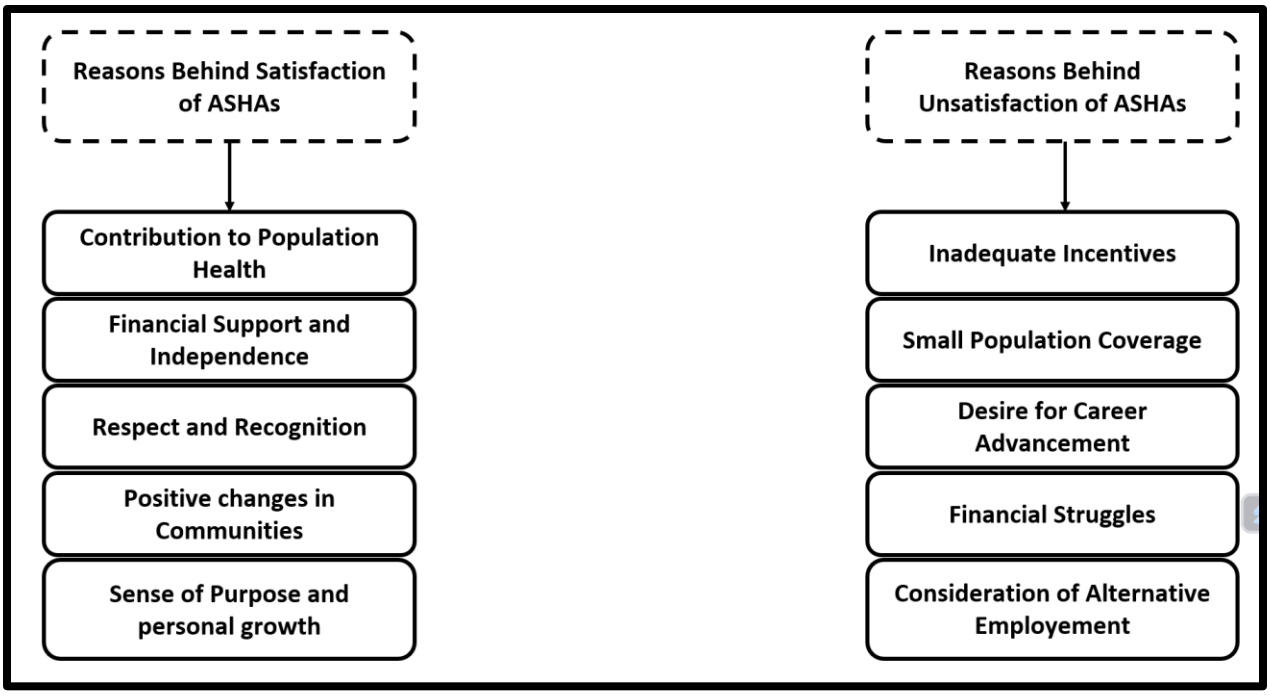


*Fig 32- Reasons for Satisfaction and Dissatisfaction of ASHAs*

***Association between Satisfaction level of ASHAs and ASHA Cohort (New and old ASHAs)***

| Satisfaction levels | ASHA Cohort | | *P* - Value |
|---|---|---|---|
| | Old | New | |
| Satisfied | 381 (39.9%) | 357 (37.3%) | 0.176 |
| Unsatisfied | 121 (12.7%) | 97 (10.1%) | |

There was no significant association found between Satisfaction level of ASHAs and the ASHA cohort i.e New and Old ASHAs, which states that the number of years they work don't influence their Motivational and Satisfaction levels.

*Association between Satisfaction level of ASHAs and Rural and Urban ASHAs.*

| Satisfaction levels | Study Site | | *P* - Value |
|---|---|---|---|
| | Rural | Urban | |
| Satisfied | 522 (54.6%) | 216 (22.6%) | 0.294 |
| Unsatisfied | 159 (16.6%) | 59 (6.2%) | |

There was no significant association between the satisfaction levels of ASHAs and the place which they work i.e rural and urban, which states that there are other parameters like the Payment based incentives and workload which Influences there satisfaction levels while working.

**RECOMMENDATIONS BY ASHAs**

***Grievance Redressal System for ASHAs***

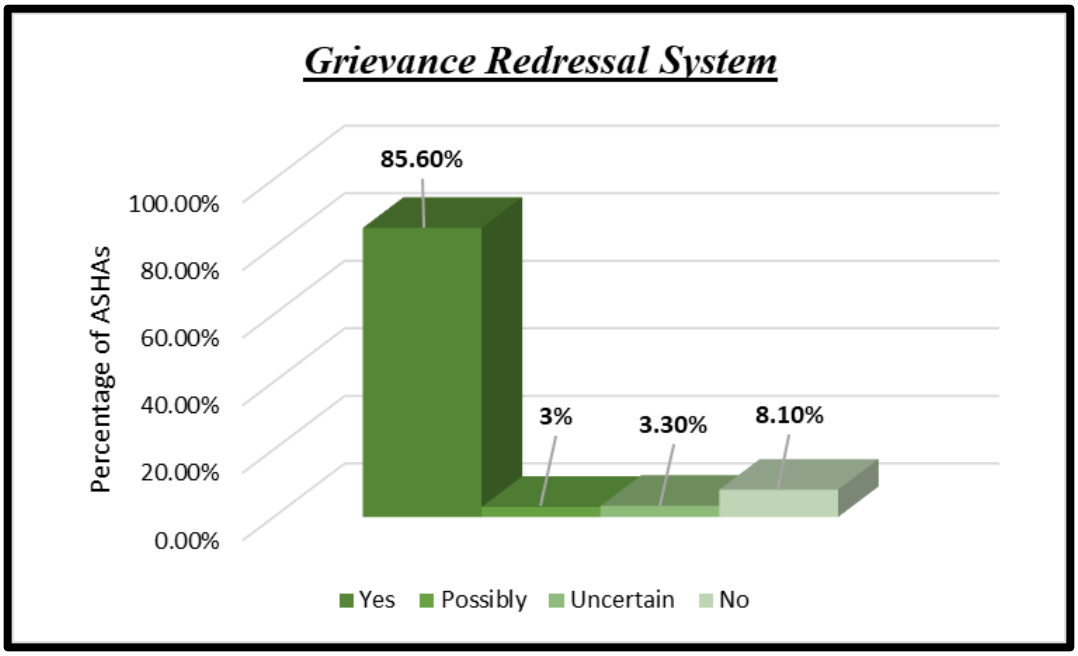


***Fig 33: Grievance Redressal System (n=956)***

In response to inquiries regarding the necessity of a grievance redressal system tailored specifically for Accredited Social Health Activists (ASHAs), a substantial majority of respondents as shown in figure 33 above, comprising 85.6% of ASHAs, expressed a definitive affirmation towards the establishment of such a mechanism. The rationale behind their advocacy for a dedicated grievance redressal system resides in the recognition of its potential to serve as a vital resource in addressing the myriad challenges and obstacles encountered by ASHAs during the course of their duties.

Conversely, a minority faction, constituting 8.1% of ASHAs, voiced dissenting views, firmly asserting that the existing channels for addressing grievances suffice for their needs. This subset of respondents emphasized that the hierarchical structure within the healthcare system facilitates effective communication and problem resolution, with higher authorities, Auxiliary Nurse Midwives (ANMs), and Block Facilitators (BFs) readily available to provide guidance and support in navigating workplace challenges.

Intriguingly, a smaller proportion of respondents, accounting for 6.3% of ASHAs, remained indecisive and equivocal in their stance regarding the necessity of a dedicated grievance redressal system. This contingent neither decisively advocated for its establishment nor explicitly opposed it, reflecting a degree of uncertainty or ambivalence towards the potential efficacy of such a mechanism in addressing their needs.

Following their affirmation for the establishment of a grievance redressal system, respondents who advocated for such a mechanism were further queried regarding their preferences for the composition of the committee overseeing this process. The suggested members included representatives from various stakeholder groups integral to the functioning of the healthcare system and community governance.

Among the proposed members were ASHA representatives, reflecting the desire for direct representation and advocacy from within the ASHA workforce. Additionally, Block Facilitators (BFs), Medical Officers (MOs), and Auxiliary Nurse Midwives (ANMs) were cited as potential committee members, highlighting the importance of incorporating key personnel involved in healthcare delivery and support.

Furthermore, respondents identified representatives from local governing bodies such as gram panchayats or nagar panchayats as essential members of the committee. Specifically, individuals such as sarpanches, gram sevaks, police patils, and nagar sevaks were mentioned, underscoring the significance of community leadership and administrative oversight in the grievance redressal process.

These suggestions reflect a holistic approach to committee composition, encompassing stakeholders from both within the healthcare system and the broader community governance framework. By incorporating representatives from diverse backgrounds and roles, the proposed committee aims to ensure comprehensive representation and effective resolution of grievances encountered by ASHAs in the course of their duties.

***Demands of ASHAs***

Towards the conclusion of the questionnaire interviews, ASHAs were provided with an open-ended opportunity to share their suggestions for improvements at the Primary Health Center (PHC) or village level that would facilitate their work. A range of responses was documented, with two prominent suggestions emerging as focal points for enhancing ASHAs' effectiveness and efficiency in community health service delivery.

Foremost among the suggestions was the expressed need for a designated space or room specifically allocated for ASHAs at the PHC level. ASHAs advocated for the establishment of a separate area where they could conduct meetings, organize educational sessions, and store essential records and documents pertinent to their duties. This proposed initiative aimed to afford ASHAs a dedicated workspace conducive to collaboration, planning, and administrative tasks, thereby streamlining their workflow and enhancing operational efficiency.

Another noteworthy suggestion voiced by ASHAs pertained to their desire for additional training opportunities to acquire new skills and competencies relevant to their role. Specifically, ASHAs expressed an interest in expanding their skill set to encompass advanced medical procedures such as administering injections, performing intravenous (IV) therapy, and conducting deliveries. By acquiring proficiency in these essential healthcare interventions, ASHAs aimed to enhance their

capacity to serve their communities effectively and address a broader spectrum of healthcare needs.

These suggestions underscore the proactive stance adopted by ASHAs towards optimizing their service delivery capabilities and overcoming existing challenges encountered in their work environment. The proposed initiatives, including the establishment of dedicated workspace and provision of specialized training, align with the overarching objective of empowering ASHAs to fulfill their roles as frontline healthcare providers and community advocates more effectively. As such, these suggestions hold significant implications for informing future policy decisions and interventions aimed at bolstering the effectiveness and resilience of the ASHA workforce within the broader healthcare landscape.

## STAKEHOLDER PERSPECTIVE ON ASHA PROGRAMME

The study explored the perspectives of various stakeholders, providing valuable insights into the ASHA program's strengths, weaknesses, and areas for improvement. The research employed interviews with a targeted group of stakeholders, including program administrators, healthcare professionals, authority personnels from PHC level, block level to district level.

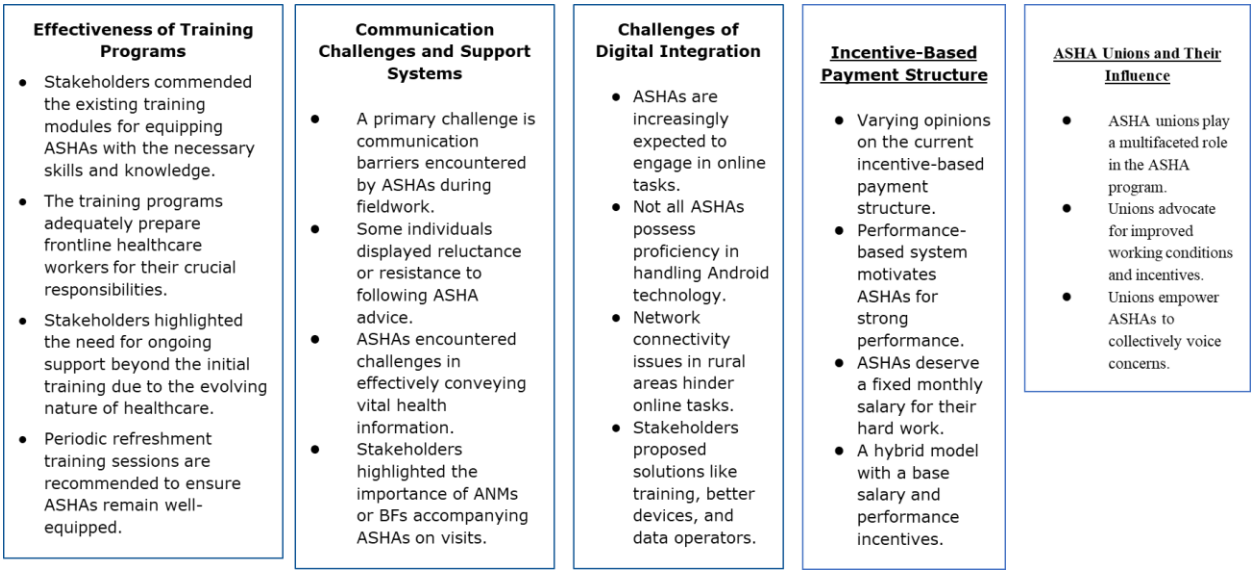


***Fig 34 - Stakeholders perspective on different Challenges***

***Effectiveness of Training Programs:***

The study revealed a strong consensus among stakeholders regarding the effectiveness of the current ASHA training regime. Stakeholders commended the existing training modules for equipping ASHAs with the necessary skills and knowledge to fulfill their roles effectively within their communities. This collective sentiment underscores the perceived value of the ASHA training programs in adequately preparing frontline healthcare workers for their crucial responsibilities.

However, stakeholders also highlighted the need for ongoing support beyond the initial training. They emphasized the dynamic nature of healthcare and the evolving needs of communities. To address this, stakeholders proposed integrating periodic refreshment training sessions into the ASHA training framework. These sessions would ensure ASHAs remain well-equipped to address emerging healthcare trends, adopt new techniques, and respond effectively to evolving community needs.

***Communication Challenges and Support Systems:***

Viewpoints on challenges faced by ASHAs revealed significant hurdles affecting their effectiveness in delivering primary healthcare services. A primary issue identified centred on communication barriers encountered by ASHAs during their fieldwork efforts.

Stakeholders observed instances where some individuals displayed reluctance or resistance to following the advice or instructions given by ASHAs. These individuals, hesitant to engage with ASHAs or disregard their guidance, posed unique obstacles to effective communication and healthcare service delivery. One specific example involved caregivers or parents declining vaccinations for their children despite recommendations from ASHAs. Despite efforts to educate caregivers about the importance of vaccination, some individuals expressed hesitancy or outright refusal due to concerns or misconceptions about vaccine safety.

In such instances, ASHAs encountered challenges in effectively conveying vital health-related information to these individuals. Acknowledging the complexity of these interactions, stakeholders highlighted the importance of Auxiliary Nurse Midwives (ANMs) or Block Facilitators (BFs) accompanying ASHAs during field visits in certain cases. The presence of ANMs or BFs was deemed crucial to offer additional explanation and support, particularly when

individuals showed resistance or lacked receptiveness to ASHAs' communication efforts. It is important to note that such cases were exceptions rather than the norm. ASHAs generally strived to provide accurate information and assistance to the communities they served, demonstrating their commitment and dedication as frontline healthcare workers.

***Challenges of Digital Integration:***

In addition to communication challenges, the research underscored emerging obstacles confronting ASHAs in adapting to evolving healthcare service requirements. Notably, ASHAs are increasingly expected to engage in online tasks, such as generating ABHA ID cards and creating new Ayushman Bharat cards. However, this transition to digital platforms poses significant hurdles for ASHAs, as not all possess proficiency in handling Android technology. Moreover, network connectivity issues in rural areas exacerbate the difficulty of performing online tasks effectively. ASHAs often encounter obstacles in accessing online resources and completing digital tasks due to these technological limitations.

*"There are lot of network connectivity issues in rural areas, ASHAs need to fill in forms again and again"* ***(Block Facilitator)***

*"Some ASHAs are just 7$^{th}$ or 8$^{th}$ pass then for them it is really difficult to adapt to this online thing".* ***(ASHA Coordinator)***

To address the challenges ASHAs face with online data entry, stakeholders have proposed a range of solutions. These include providing more comprehensive training in online data entry, equipping ASHAs with high-quality Android smartphones, and appointing data operators at the PHC level.

By implementing these solutions, stakeholders believe that ASHAs can overcome the challenges of digital integration and contribute more effectively to the overall success of the ASHA program.

***Incentive-Based Payment Structure***

Stakeholders revealed a range of opinions on the current incentive-based payment structure for ASHAs. Those positioned at the block level and above, generally administrators with a broader view of the program's goals, expressed strong support for maintaining a performance-based system. Their logic was clear: linking incentives directly to results would act as a powerful motivator for ASHAs. By performing their duties effectively, exceeding expectations in areas like immunization drives or prenatal care consultations, ASHAs would have the opportunity to significantly increase their earnings. This, they believed, would not only boost individual performance but also contribute to the overall success of the ASHA program in achieving its public health objectives.

> *"ASHA should get payment hike, until they get a hike in their payment they will not work passionately"* ***(ASHA Supervisor)***

However, a different perspective emerged from Block Facilitators (BFs), who provide crucial support and guidance to ASHAs, expressing strong reservations about the current system. They acknowledged the dedication and hard work put in by ASHAs, often under challenging circumstances. From their firsthand experience, they argued that the current incentive structure simply did not provide adequate compensation for the sheer volume and complexity of the tasks ASHAs are expected to handle. They passionately advocated for a fixed monthly salary, a guaranteed income that would offer ASHAs a sense of financial security and recognition for their tireless efforts.

*"Instead of choosing a fixed payment option one thing can be done as we can keep some basic amount fixed per month and then above that whatever tasks that ASHAs performs she will get incentives for that. This will also maintain quality work**." (Medical Officer)***

Interestingly, a third viewpoint emerged from another group of stakeholders. These individuals, perhaps recognizing the merits of both arguments, proposed a middle ground. They suggested a hybrid model that incorporated elements of both approaches. This model would establish a base fixed payment, providing ASHAs with a predictable and stable income stream. Importantly, it would also retain the performance-based incentive system. However, this group crucially emphasized the need to revisit and potentially increase the incentive amounts offered for specific tasks. By raising the financial rewards for achieving set goals, they believed they could create a win-win situation. ASHAs would be financially secure while still having the opportunity to earn more through strong performance, and the program would continue to benefit from a performance-driven approach.

***ASHA Unions and their Influence:***

The research also shed light on the multifaceted dynamics surrounding ASHA unions and their influence on the program's execution. Stakeholders acknowledged the crucial role ASHA unions play in advocating for improved working conditions and incentives for ASHAs. Unions empower ASHAs to collectively voice their concerns and negotiate for better support.

*"They (ASHAs) told us that they are on strike and we can not do anything with it. Even medical officers can't do anything about it. They said they won't work then they will not work." **(Block Community Mobilizer: BCM)***

Such instances revealed where the influence of ASHA unions posed challenges. As during a union-directed strike, no ASHAs reported to work despite appeals from medical officers at Primary

Health Centers (PHCs). This incident underscored the significant sway unions have over ASHAs' actions and decisions, potentially disrupting essential healthcare services within communities.

Furthermore, stakeholder responses highlighted the broader impact of ASHA unions on demands and working conditions. Unions played a central role in articulating ASHAs' grievances, negotiating with authorities, and advocating for policy changes to address systemic issues affecting ASHAs' welfare and effectiveness. Consequently, ASHA unions exerted substantial influence on the formulation of demands and the implementation of policies aimed at enhancing working conditions and incentivizing contributions to community healthcare.

***Suggestions for ASHA Program Enhancement***

Dedicated Space at PHCs: Stakeholders highlighted the need for a separate room for ASHAs at Primary Health Centers (PHCs). This dedicated space would allow ASHAs to conduct meetings with colleagues or community members in a private setting. Additionally, it would provide them with secure storage for their records, eliminating the need to carry them back and forth during each PHC visit. This dedicated space would offer a more professional work environment and improve overall efficiency.

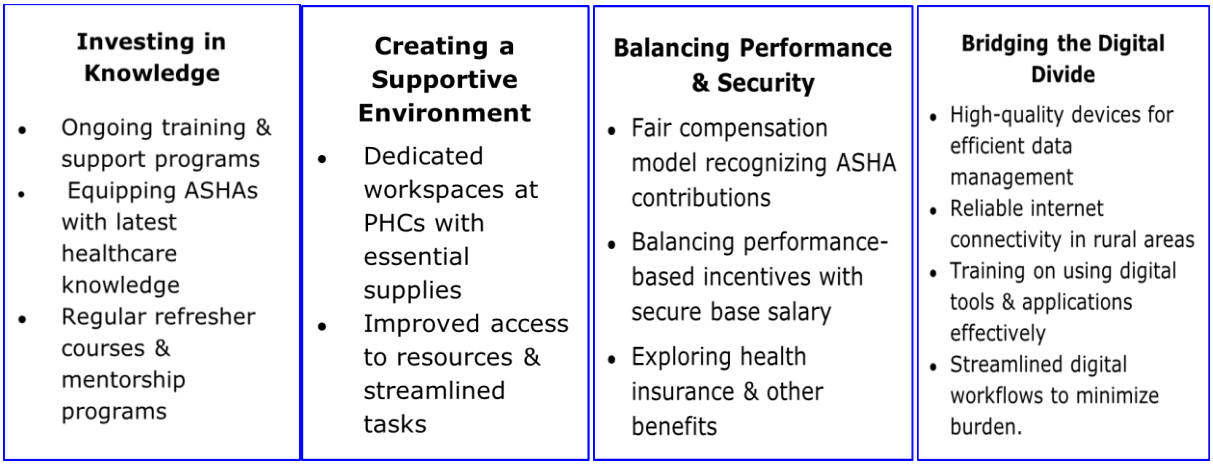


***Fig 35 - Stakeholders perspective on different challenges***

Adequate Office Supplies: Stakeholders also pointed out that the current supply of office stationery provided to ASHAs is often insufficient. They suggested providing additional essential office

supplies, such as pens, notebooks, and folders, to ensure ASHAs have the necessary materials to effectively complete their tasks.

Separate Photocopying Facilities: Another suggestion involved installing a dedicated photocopying machine at PHCs for ASHA use. Currently, ASHAs rely on external photocopying services, which can be time-consuming and add to their expenses. A dedicated machine would allow for quick and convenient copying of documents, reducing costs and streamlining workflows.

One notable recommendation was to continue with monthly tests to ensure continuous assessment of ASHAs' performance. Complementing this, stakeholders proposed organizing expert sessions on various topics each month, fostering ongoing professional development and knowledge enrichment among ASHAs.

> *"We conduct monthly exams for ASHAs, along with it if we can arrange an experts session every month from MO, or TB, Malaria Officer then it will be of great use. And as the Government has already provided ASHAs with dairies but along with it we should think of providing them with a booklet containing all the important information in pictorial form. This will help them in explaining the topic to the community effectively."* ***(District authority)***

Another noteworthy suggestion highlighted the importance of providing ASHAs with comprehensive educational resources tailored to their needs. Specifically, stakeholders advocated for the creation of a visually engaging booklet containing essential health information, complete with vivid pictures and informative tables. Such resources were perceived as invaluable tools to equip ASHAs with the necessary knowledge and communication skills to effectively engage with community members during fieldwork.

## DISCUSSION

**Key Findings:**

1. ASHAs mentioned that the induction training they receive after joining the cadre should be 23 days according to ASHA operational guidelines, but they get training only for 5 to 8 days and that too is distributed throughout the year and it's not in one go.

2. ASHAS reported that 94% of them throughout Maharashtra got trained in Maternal and child health services, 55% of them were trained in Communicable diseases, 40% of them in non-communicable diseases, 20% in Nutrition, and 22 % in sanitation, this shows that only MCH duties are given priority and other topics are neglected especially NCDs, Nutrition, and Sanitation.

3. ASHAs reported that 89% of them have been taught about Communication skills, 34 % of them have been taught about Coordination skills while many few reported about the skills like, Leadership skills, Decision-making skills, Negotiation skills, and Mahila Atyachar virodh been taught to them, i.e. only around 15% of ASHAs have been taught these skills.

4. A Significant number of ASHAs reported that they have got Online data entry training but it's only theoretical knowledge which is been provided due to which they face challenges in filling out the forms like ABHA cards, Ayushmann cards, etc due to which they are demanding for hands-on training.

5. ASHAs reported that they want to learn other skills like Delivery of the child, measuring vitals such as blood pressure, hemoglobin, and blood sugar levels, and learning injection techniques alongside ANMs.

6. ASHA suggested the necessity of reorientation training, as the training they receive every month mainly focuses on new programs and schemes, hence it becomes difficult for them to remember the remaining uncovered topics, hence reorientation training once or twice a month will refresh their knowledge.

7. Around 60% of ASHAs mentioned that online data entry in smartphones does not reduce their time off work, instead it doubles their work because even if they are filling out their records on smartphones then also, they have to prepare a hardcopy of reports and submit it to the PHC at the end of the month.

8. ASHAs reported that they don't get fixed 8000 Rs from the government (5000 from the state government and 3000 from the central government) which they should be getting according to NRHM guidelines, instead, they only get 5000 Rs per month from the state government and that too after every 3 months, where they receive 15000 Rs.

9. They also reported a lot of variation in their performance-based payments, ASHAs reported that due to the low population coverage, urban area, the population seeking private healthcare services, less beneficiaries of PMJY they don't get enough incentives, due to which their fixed payment should be increased.

10. Among all the ASHAs, 20% of them reported undertaking additional tasks beyond their regular health department tasks due to which they were overburdened with the work.

11. When asked about fixed working hours, 82% of ASHAs demanded fixed working hours so that they don't have to work at odd hours in the field.

12. Around 66% of ASHAs reported being part of unions like: the Centre for Trade Unions, All India united trade union center, Shetkari Kamgar Paksh, Maharashtra Rajya ASHA va Gatpravartak Kruti Samiti and Maharashtra Rajya ASHA Swaysevika Sangathan which played a major role in the strikes of ASHA.

13. Around 86% of ASHAs demanded for Grievance redressal system where they can put forth there problems and the members of that system according to them should be: Medical officers, Gram panchayat members, People from village and all ASHAs.

14. ASHAs also demanded for establishment of separate rooms where they could conduct meetings, organize educational sessions, and store essential records and documents pertinent to their duties.

15. According to the Knowledge questions asked, 86% of ASHAs were having knowledge about Diarrhea and 15 Days celebrated for diarrhea in July, 57% Of ASHAs knew the Nischay pregnancy kit, 80% of ASHAs knew the HBNC Visits (Home based newborn care), only 25% of ASHAs were knowing the Physical fitness domains. Surprisingly only 10% of ASHAs knew about the time range of tubectomy to be conducted after the delivery of the Child. Only 23% of ASHAs knew about Sickle cell Anemia; others mentioned that they were not given training on the Genetic disorders. 97% of ASHAs knew that compulsory breastfeeding should be done till the child gets 6 months old. 64% of ASHAs were knowledgeable about non-communicable diseases. 73% of ASHAs knew the immunization doses that should be given to the child within 24 Hours from birth.

**Comparison of Present Study Results with Past Research**

According to this Study ASHAs reported that they are given induction training but it is distributed throughout the year and ranges from 5 to 7 days, they mentioned that they don't get 23 days of Induction training, they even mentioned that the training they get like the online data entry is also theoretical and no practical knowledge or hands on training is given to them due to which they are not able to efficiently complete the reports and complete the target of ABHA and Ayushmann cards. Similar studies conducted in Vijayapura district of Karnataka assess the training details of the ASHAs working in Vijayapura District and to know problems faced by them in carrying out their roles and responsibilities, the results of the studies show that majority (86.1%) of ASHAs had 23 days of training with (5.2%) of ASHAs opinionated that the training session was over crowded. About 84.6% of ASHAs said that the teacher was able to explain clearly; 72.8% of ASHAs informed that content of training was appropriate and 18.5% replied that there was a need for refresher training. The main problem faced by ASHAs was delay in their payments (32%), followed by their Expenses incurred is more than the incentives (26%) that they get. Another Study conducted in Assam, aimed at assessing the situation of ASHAs working in the fragile and conflict settings and how conflict impacts them and their work. The study concluded that ASHAs reported facing challenges in ensuring access to health services during and

immediately after outbreaks of conflict. They experienced difficulty in arranging transport and breakdown of services at remote health facilities. Their physical safety and security were at risk during episodes of conflict. ASHAs reported hostile attitudes of the communities they served due to the breakdown of social relations, trauma due to displacement, and loss of family members, particularly their husbands.

The Satisfaction level of ASHAs according to the results showed that nearly 42% of ASHAs are satisfied in doing their work, while around 9% of ASHAs mentioned that they are not satisfied in doing their work, the study showing nearly same results was conducted in Maharashtra, The aim of the study was to assess the level of job satisfaction among ASHA workers in rural areas in the selected districts of Maharashtra and to find association between levels of job satisfaction with selected demographic variables, it stated that Majority (58.5%) of ASHA workers had high job satisfaction level. 26% of them had a moderate level of satisfaction and 15.5% of them had reported a low level of job satisfaction. Another study conducted in Taluka Waghodia, Gujarat aimed at assessing the level of job satisfaction among ASHA workers and to find association between level of job satisfaction with selected demographic variables. The results showed that According to this study, 25% of ASHA workers were dissatisfied with their job and 75% of ASHA workers were satisfied with their job. The association between level of job satisfaction with selected demographic variables with the use of chi square test, in that value of age and year of experience was found to be more than at the 0.05 level, so there will be significant association between these variables and job satisfaction. In the value of PHC, religion, marital status was found to be less than at the 0.05 level, so there will be no significant association between these variables and job satisfaction. level of job satisfaction.

According to the above results the performance based incentives varied hugely, and the reason being Low population under one ASHA, working in developed areas etc due to which they are demanding fixed payments from government so that the variation in there pay will not impact their livelihood, similar study conducted in Shahapur taluka of Maharashtra, a drought-prone adivasi-inhabited area, shows that the remuneration of ASHAs is a growing concern both for them, as well as their families. Recognising their contribution to public health services, the government should provide fixed payment to them, beyond which task-based incentives should continue to be given, though at a revised rate. The current system of remuneration is making it difficult for ASHAs to

meet their family's needs and the community's expectations. Further, payment and reimbursement procedures need to be simplified.

Out of the 81% of ASHAs who were aware of ANM/GNM courses, only 39% had actually enrolled or completed the courses. This indicates a notable gap between awareness and actual participation. The remaining 69% expressed interest in pursuing these courses but encountered significant barriers that prevented them from doing so. One of the primary challenges reported by ASHAs was a lack of financial support, huge family responsibilities, lack of education, problems with documents etc, Similar study conducted in Rajasthan stated that The ASHAs who shift to ANM/GNM Courses are very less i.e around 24% due to certain reasons like the burden of present work, rejection of the application and lots of responsibilities.

The study also found that 35 % of ASHAs have completed 12 years of education, whereas 10% of ASHAs have completed their graduation. Majority of ASHAs have studies below 12 years . About 44% of ASHAs have not reached 12th class, this also shows how low level of education affects their ability to grasp the things from training or any experience. Similar study conducted in Jaipur, Rajasthan aimed at assessing challenges and hurdles faced by ASHA during their field work in the rural area of district Jaipur, Rajasthan. The results of the study showed that Majorities ASHA were studied up to secondary (32%) and higher secondary (28%), around 20% were only eighth passed (i.e. minimum education criteria) and (few) seven percent graduated. Majorities (84%) of ASHA were satisfied with their work but experienced few challenges in eld work however 15% ASHA were totally satisfied with their job and found none challenges in eld work.

This Study also found that 86% of ASHAs are demanding for Grievance redressal system where they want medical officers, Gram panchayat members, People of the village and all ASHAs to be part of, The reason behind them asking for this system is that, they can put forth there problems faced in the field or in the primary health center, so that they can be solved. ASHAs also mentioned that they face pressure from higher authorities sometimes, where the Medical officers and ANMs pressurize them to complete the work which they have assigned to them first and then their duties.

In case of weekly working Hours, about 64% of ASHAs mentioned that they have to work for more than 20 hours per week, but based on ASHA operational guidelines they only have to work

for 16 hours per week but they are working currently more than 20 hours another thing was about the population served by ASHAs, according to the ASHA operational guidelines the population under one ASHA should be 1000, but what we found was that majority of the ASHAs i.e 55% of ASHAs were serving more than 1200 population. Similar study conducted in three districts of karnataka where they aimed at assessing the workload on ASHAs, impact of their responsibilities on their quality of life and the potential for structured task sharing/shifting among other healthcare workers. The results of the study showed that over 60% of ASHAs serve a population of more than 1,200. The average population served by ASHAs is 1,923 with a minimum of 500 and a maximum of 5,000. ASHAs covering more than 1,200 people said they had increased/extended working hours and nearly 83% of them work for more than 30 hours per week, and 17.3% work for 17–30 hours per week. Interestingly, none of the ASHAs said they work for only16 hours or less per week. Another study conducted in Madhya Pradesh aimed to gain perspectives into the experiences of work stress, the related health symptoms, and the responses to stress among ASHAs in India. The results of the study had following themes" Six FGDs with 59 ASHAs generated the following themes: (a) *Facility*: Workload, undue pressures, unstructured work; ASHAs' relationships with seniors (e.g., feelings of being disrespected, blamed, or targeted), and low access to physical and administrative resources; (b) *Home:* Feelings of guilt for putting less time for family/child care; disrespect by the elderly for a poorly incentivised job; (c) *Community:* Low acceptance by the villagers; caste- and gender-bias; difficult community-level relationships (emotional labor, fear/stigma towards her services); (d) *Somatic and psychological symptoms*: headache, exhaustion, depressive symptoms (to cite a few); and (e) *Responses to* stress: Motivation (support from peers, family, a sense of identity/pride, incentives), Individual strengths (e.g., social responsibility), and spiritual recourse mechanisms.

According to this study 86% of ASHAs were having knowledge about Diarrhea and 15 Days celebrated for diarrhea in the month of July, 57% Of ASHAs were having knowledge about the Nischay pregnancy kit, 80% of ASHAs had knowledge about the HBNC Visits (Home based newborn care), only 25% of ASHAs were having knowledge about the Physical fitness domains. Surprisingly only 10% of ASHAs knew about the time range of tubectomy to be conducted after the delivery of the Child. Only 23% of ASHAs knew about Sickle cell Anaemia; others mentioned that they were not given training on the Genetic disorders. 97% of ASHAs knew that compulsory

breastfeeding should be done till the child gets 6 months old. 64% of ASHAs were knowledgeable about Non-Communicable diseases. 73% ASHAs had knowledge about the immunization doses which should be given to the child in the period of 24 Hours from birth. Similar study was conducted in Bhadson City of Punjab on 196 ASHAs, which aimed at assessing knowledge of ASHA workers regarding maternal and child health (MCH) services and their provision by them to their beneficiaries (mothers with children aged 0–6 months). The results of this study showed that Very few, that is, 17 (23.6%), ASHA workers knew that breastfeeding should be started within the first hour after delivery of the baby. Counseling regarding nutrition, birth preparedness, institutional delivery, and birth registration was given by ASHA workers to 75%–85% of mothers. There was statistically significant improvement in the practices by mothers with the counseling given by ASHA workers regarding prelacteal feed, utilization of family planning methods, and delaying early bathing. Another similar study aimed at assessing the knowledge practice gap of Accredited Social Health Activist (ASHAs) about her work profile from northern India. The results from this study showed that 92 (97.87%) of ASHA workers completed training before working as ASHA. Almost all the study subjects had knowledge about immunization activities, accompanying delivery cases, and participation in family planning activities. Very few ASHAs knew that active participation in village health planning, providing counseling to the residents on various health issues and addressing adolescent health issues with residents of the village were part of her work profile. Drug kit stock register, format for individual birth preparedness plans, format for first examination of the newborn, and home visit form for high risk babies were relatively deficient with respect to their maintenance and completeness.

**Limitations of the Study**

This study has certain limitations that should be acknowledged. The primary limitation is the use of a cross-sectional design, which does not allow for a strong causal inference. Thus, future studies should employ a longitudinal design to establish causality.

**Challenges of the Study**

Multiple challenges were present while conducting the study, first was the message being not properly conveyed to Asha about our study from higher authorities, the higher authorities told

Asha that we were coming to take their exam which made them vulnerable and scared at the same time while giving us the answers. Second was the PHC Infrastructure, as our site of data collection in particular district war PHC, the lack of PHC infrastructure led to difficulty in conducting one-to-one interviews. Another thing was the lack of education of ASHAs in some districts led to them not understanding the questions properly due to which they needed to explain each and everything in detail which led to long hours of Interviews to get completed. The main challenge was Strike due to which our Data collection got prolonged. In Pune district it took us a huge amount of time to complete the data collection as the higher authorities were not responding back.

**Strengths/ of the Study**

The strength of the study lies in its methodological rigor and comprehensive approach. Firstly, the inclusion of a substantial sample size of 956 Accredited Social Health Activists (ASHAs) enhances the statistical power of the study, ensuring reliable and robust findings. Moreover, the deliberate selection of ASHAs from all 8 National Health Mission (NHM) Circles in Maharashtra ensures that the sample represents the diverse geographic and demographic characteristics of the state, thus enhancing the generalizability of the results. Additionally, by maintaining a consistent urban-rural ratio (20:80) throughout data collection, the study effectively captures the unique challenges faced by ASHAs in both urban and rural settings, further bolstering the representativeness of the findings. Importantly, the inclusion of perspectives from stakeholders such as Medical Officers, ANMs, ASHA Coordinators and District community Mobilizers adds depth and context to the study, enriching the understanding of ASHA-related challenges. Furthermore, the adoption of a mixed methods approach, combining qualitative and quantitative methodologies, allows for a comprehensive exploration of the issues at hand, ensuring a nuanced understanding of the complexities involved. Overall, these methodological strengths contribute to the credibility and applicability of the study findings, offering valuable insights to inform policies and interventions aimed at supporting ASHAs and improving community health outcomes in Maharashtra.

**Contributions of the Study:**

1. The study was carried out in all 8 NHM Circles of Maharashtra, this was the first study to be conducted all over Maharashtra for the ASHAs.

2. The study covered all the 3 aspects of the working of ASHAs i.e. Knowledge, skills, and Challenges, no other study before this has shown this holistic approach.

3. The study also gained the stakeholder's perspectives and what are their views on the challenges and knowledge of ASHAs, which again made it comprehensive.

4. The Data collection tool used was a Semi-structured Interview schedule which included both Qualitative and Quantitative parts.

5. For the triangulation of data, stakeholders' perspective was used.

**CONCLUSION**

ASHAs' training covers a wide range of topics, but there is a clear demand for practical knowledge. The topics covered in the training include maternal and child health (MCH), communicable and non-communicable diseases (NCD), nutrition, and sanitation, mainly focusing on MCH and communicable diseases such as TB and leprosy. 89% of ASHAs reported being taught communication skills, but other skills were not given more emphasis in the induction training. Reports and records of ASHAs were assessed every month in the monthly training, and simultaneously, they were also updated and trained on new health topics. However, they mentioned that these trainings weren't comprehensive, and there was a serious need for periodical reorientation training. ASHAs complained of having difficulty in online data entry due to the language barrier and lack of practical training. The work of issuing ABHA cards and Ayushman cards has led to overburden as they are needed to complete their daily targets of card making while simultaneously doing their ASHAs' duties at the village level. Around 65% of ASHAs worked for more than 20 hrs per week. 82% of ASHAs voiced their need for fixed working hours to have a work-life balance. Two-thirds of the total ASHAs were aware of the Global Health Leaders award which they received for their contribution during Covid-19. 77.6% of them mentioned having received recognition and awards from government institutions for their contribution during the pandemic.

This study and previous research highlight the difficulties ASHAs face in balancing their workload with community expectations. Solving these problems requires cooperation from policymakers, healthcare providers, and community members to give ASHAs the support they need to do their job well. Network issues and server problems were identified as major hurdles by ASHAs even after undergoing online training (which itself was often inadequate.) ASHA gets influenced by their other ASHA or supervisor to join these unions as they believe they help them to raise their voice in their rights and interest. The study also Highlights diverse motivational factors driving Accredited Social Health Activists (ASHAs) in India. These factors include altruism towards population health, recognition from the community, satisfaction derived from family support, and the sense of pride in their work. ASHAs find fulfillment in addressing health challenges, promoting awareness, and witnessing positive outcomes in their communities. However, challenges such as inadequate financial incentives and workload dissatisfaction impact their overall job satisfaction. Addressing these concerns is crucial to retaining ASHAs and ensuring the effectiveness of community health initiatives in India.

The satisfaction and motivation levels of Accredited Social Health Activists (ASHAs) are influenced by a variety of factors, ranging from intrinsic altruism to external recognition and financial stability. The majority of ASHAs find fulfillment in their work due to their dedication to improving population health, receiving recognition from the community, and experiencing personal and financial empowerment. However, challenges such as inadequate financial incentives, workload, and limited beneficiary populations can impact job satisfaction and motivation for some ASHAs. Addressing these challenges and providing adequate support, recognition, and incentives is crucial to maintaining the morale and commitment of ASHAs, ensuring their continued dedication to improving community health outcomes. Additionally, efforts should be made to empower ASHAs further by providing opportunities for skill development, career advancement, and meaningful engagement in decision-making processes. By addressing both the intrinsic and extrinsic factors influencing ASHA satisfaction and motivation, stakeholders can foster a more supportive and enabling environment for ASHAs, ultimately

enhancing the effectiveness of community health interventions and contributing to improved health outcomes.

## RECOMMENDATIONS

There is a clear need to shift the training sessions from theoretical to more practical. They should practically be trained in online data entry, handling emergency situations such as emergency deliveries. They should be trained in specific skills such as measuring vitals (Blood pressure, hemoglobin, blood sugar levels), and learning injection techniques. Regular Reorientation training should be conducted periodically every year to refresh Asha's knowledge and update them on new health programs and health trends. ASHAs need comprehensive and practical training rather than providing them with video-based training for online data entry. To fully leverage their potential in this digital landscape, a three-pronged approach is necessary: Smartphone accessibility, Proper training, and Reduced workload.

The majority of ASHAs expressed a willingness to adopt fixed working hours to maintain a work-life balance. Recognizing the contribution of ASHAs through awards and honors can prove crucial for motivating them. Reimbursement regulations should guarantee that ASHAs have enough money to keep their phones' internet connections active. This includes mobile recharge. Training modules must change from one-size-fits-all strategies. A focus on individual requirements, downloadable tools, and interactive sessions are crucial. To close the theory-practice gap, training should ideally be carried out directly on the personal smartphones of the ASHAs. Tailored online courses can be used. The current situation presents a complex challenge. Some ASHAs lack the necessary digital literacy skills, while training programs for online work are inconsistent. This, combined with the double burden of maintaining both paper and online records, creates inefficiencies in their work processes.

Strengthen rural areas' transportation systems to provide ASHAs dependable and safe ways to go to and from villages, particularly at night. Availability of an emergency transport for ASHA at village level to travel back to their home if they cannot find a public transport. Provide safety training for ASHAs to handle situations where they feel vulnerable, such as dealing with ill-treatment from family members of pregnant women. Provide ASHAs with personal protective

equipment, such as flashlights and whistles, to enhance their safety during nighttime travel. Advocate for policy changes that prioritize the safety and well-being of ASHAs, including better transportation options and social protection measures.

Ensure that unions operate transparently and are held accountable for their actions, particularly in handling ASHA funds and promises of support. Provide ASHAs with information about the benefits of joining unions and the potential risks, so they can make informed decisions.

It's crucial to allocate adequate resources and provide comprehensive training for ASHAs. This includes ongoing education on healthcare practices, communication skills, and community engagement strategies. By investing in their development, ASHAs can improve their effectiveness in delivering essential health services and information to their communities. Additionally, supporting ASHAs in managing their time more efficiently can significantly impact their productivity and effectiveness. This can be achieved through training in time management techniques, as well as providing tools and resources to streamline their tasks, such as digital health platforms for data collection and reporting.

Ensuring fair compensation and recognition for ASHAs is essential for motivating and retaining these frontline health workers. This includes providing competitive wages, as well as formal recognition of their contributions to healthcare delivery. Recognition can be in the form of awards, certificates, or opportunities for career advancement.

Collaboration with local authorities is key to addressing systemic challenges and ensuring that ASHAs have the necessary support structures in place. By working closely with government agencies, NGOs, and other stakeholders, efforts can be coordinated to address community health needs more effectively.

Creating a supportive work environment for ASHAs is essential for their well-being and job satisfaction. This involves providing access to essential resources, such as transportation, equipment, and supplies, as well as establishing mechanisms for peer support and supervision. Additionally, promoting a culture of respect and appreciation for ASHAs' contributions can foster a positive work environment.

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