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Addressing Job Stress and Enhancing Work–Life Balance among ASHA Workers in Karnataka: Social Work Interventions and Policy Implications

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Abstract

This study examines the interrelationship between job stress, well-being, and work–life balance among Accredited Social Health Activists (ASHAs) in Karnataka, employing a descriptive quantitative approach. A total of 1,310 ASHAs were surveyed using a structured interview schedule across four regional zones—North, South, Central, and Coastal Karnataka. Data analysis using SPSS revealed that 76.56% of respondents faced heavy workloads, 72.14% lacked adequate resources, and 66.26% reported low or irregular financial compensation, indicating deep-rooted structural inequities. More than 58% perceived their job as negatively affecting their physical or emotional health, while 62.95% cited excessive workloads and unrealistic deadlines as the primary sources of stress. Despite these pressures, 67% reported satisfaction with their work–life balance and derived intrinsic motivation from community service. Collaborative coping strategies, supportive supervision, and community engagement were identified as key factors in building resilience. The findings underscore the need for social-work-led interventions that focus on counselling, stress management, participatory supervision, and institutional reforms, such as fixed remuneration, regulated working hours, and welfare provisions. Policy implications suggest integrating psychosocial support, family-inclusive counselling, and workload rationalisation into Karnataka's National Health Mission framework to foster a healthier and more sustainable ASHA workforce.

Keywords: ASHA, Job Stress, Social Work, Occupational Health, Women's Empowerment.

1. Introduction

The role of Accredited Social Health Activists (ASHA) workers designated under the National Rural Health Mission (NRHM) has become a cornerstone of India's public health strategy, particularly in rural and underserved areas. ASHA workers serve as essential community health links, facilitating maternal and child health services, immunisation, health education, and linkages between households and primary health-care systems (Shetty et al., 2024). Recent research from Karnataka and other states suggests that this workforce is under considerable strain, with high workloads, role ambiguity, incentive-based remuneration, and extended

hours contributing to elevated levels of stress, burnout, and a diminishing work–life balance (Pulagam & Satyanarayana, 2019; Chahal et al., 2023).

Work–life balance, the equilibrium between professional duties and personal life, has emerged as an important indicator of employee well-being and organisational performance. In the context of healthcare and community service personnel, disruption of this balance can lead to job stress, decreased job satisfaction, and compromised service delivery. Studies among female employees have shown that increasing job demands are strongly correlated with reduced work–life balance and lower psychological well-being (e.g., a study of working women in Bengaluru banks found a significant relationship between job stress and work–life imbalance) (CIBGP, 2024). For ASHA workers, balancing community expectations, home and family responsibilities, and formal health-system obligations presents a unique challenge.

In Karnataka, ASHA workers often operate within environments where duties extend beyond fixed hours, incentives are delayed or uncertain, training is limited, and formal employment status remains ambiguous. These systemic stressors are further compounded by personal and familial demands, making work–life and lifework interplay a critical concern (The NewsMinute, 2025). The negative implications of unmanaged job stress are evident in lower performance, increased absenteeism, higher attrition rates, and ultimately, diminished community health outcomes.

Against this backdrop, social work frameworks such as stress-coping and resilience-building, supportive supervision, peer-led mutual aid groups, family-inclusive counselling, and structured referrals to mental health services offer practical pathways to buffer stress and improve balance. Recent trials of brief positive-psychology interventions with frontline workers in India show promise in reducing perceived stress and improving well-being, suggesting scalable models for Karnataka's ASHA system when paired with policy levers (predictable base honoraria, timely incentive disbursal, protected weekly rest, and safe spaces for respite). This article, therefore, situates job stress and work–life balance among Karnataka's ASHAs within current staffing and payment realities, synthesises evidence on determinants and consequences, and advances social-work-informed interventions alongside policy implications to strengthen both worker well-being and community health outcomes.

2. Review of literature

Accredited Social Health Activists (ASHAs) have become the backbone of India's community-level primary health system, connecting households to essential services in maternal and child health, immunisation, and health promotion under the National (Rural) Health Mission. Empirical evaluations describe ASHAs as pivotal to improving community engagement and access to public services, while also highlighting persistent structural vulnerabilities in their work environment. At the same time, qualitative work has shown that core features of the role—especially performance-linked incentives—can be double-edged, functioning as both motivators and sources of strain within family and community dynamics.

A growing body of Indian studies documents high levels of stress, anxiety, and burnout among ASHAs and other community health workers, with consequences for well-being and service quality. Recent multi-state and India-specific evidence links heavy caseloads, role ambiguity, and administrative pressures to heightened burnout and lower job satisfaction among community health workers. Karnataka-based studies provide corroborating evidence: cross-sectional research from Bengaluru during 2020–2021 reported that more than half of participating ASHAs experienced depression, anxiety, or stress during pandemic-intensified workloads, underscoring the fragility of psychosocial supports at the frontline.

Beyond acute mental-health outcomes, everyday work organisation also shapes ASHAs' capacity to sustain a healthy work–life equilibrium. Mixed-methods and cross-sectional studies from Karnataka (Bengaluru, Mysuru, and Udupi) describe extended work hours, task spillovers into domestic time, and skill-mix/training gaps that compound stress and erode boundaries between paid and unpaid care responsibilities—conditions that are emblematic drivers of work–life imbalance. In this milieu, "work–life balance" is not a peripheral concern but a determinant of performance, retention, and equitable participation of women in community health systems.

Encouragingly, intervention-focused scholarship, even if still nascent, suggests that structured psychosocial and organisational supports can mitigate stress and improve well-being and functioning among India's community health workers. A recent randomised pilot in India reported that a positive psychological intervention reduced perceived work stress among rural CHWs, pointing to the promise of scalable, low-cost approaches that could be adapted for ASHAs in Karnataka. Complementing individual-level supports, role clarification, fair and timely remuneration, and supportive supervision, recurrent themes across ASHA evaluations remain imperative system-level levers.

Situated within this evidence base, the present article focuses on Karnataka to synthesise the nature and sources of job stress among ASHAs, examine how work organisation and domestic roles intersect to shape work–life balance, and outline a package of social-work-led interventions and policy actions spanning psychosocial support, supervisory practices, and incentive/contracting reforms that can strengthen well-being and service quality. By foregrounding both individual and structural drivers, we aim to provide a pragmatic roadmap for improving ASHAs' occupational health and sustaining resilient community health delivery in Karnataka.

3. Objectives

- To analyse the level of agreement among ASHA workers regarding various job stress factors.
- To assess the work–life balance of ASHA workers using Hayman's (2005) 7-point Work–Life Balance Scale.
- To examine the influence of socio-demographic and occupational factors on the ability of ASHA workers to balance work and family responsibilities.
- To evaluate the overall well-being, safety conditions, availability of resources, and their relationship with work–life balance among ASHA workers.
- To explore the coping mechanisms and strategies adopted by ASHA workers to address and manage work-related challenges.

4. Scope and Methodology

The scope of the present study was confined to Accredited Social Health Activists (ASHAs) working in Karnataka. A descriptive quantitative research design was employed to examine the extent of work–life balance among ASHA workers and to identify the socio-demographic and occupational factors influencing it. The study population comprised all ASHAs employed under the National Health Mission (NHM) across the state. Using a stratified random sampling technique, a total of 1,310 respondents were selected from four geographical zones, North, South, Central, and Coastal Karnataka, to ensure proportional regional representation. Primary data were collected through a structured interview schedule that included both closed-ended and Likert-scale questions. The instrument was designed to gather information related to socio-demographic characteristics, job stress, perceived well-being, and the level of difficulty in achieving work–life balance. The schedule was prepared in English and Kannada to ensure clarity and comprehension for all respondents. Before commencing the primary survey, a pilot study was conducted among 30 ASHAs to assess the reliability and validity of the instrument.

Based on the pilot results, minor modifications were incorporated, and the instrument's internal consistency was confirmed with a Cronbach's alpha coefficient of 0.82, indicating high reliability.

The data collection process was conducted personally by the researcher through face-to-face interviews at primary and community health centres, as well as during ASHA review meetings. Informed consent was obtained from all participants, and ethical considerations, including confidentiality, anonymity, and voluntary participation, were strictly maintained throughout the study. The collected data were coded, tabulated, and analysed using Statistical Package for the Social Sciences (SPSS) Version 26.0. Descriptive statistical tools such as frequency, percentage, mean, and standard deviation were employed to summarise the data and interpret the findings meaningfully. This methodological approach ensured that the study accurately captured the occupational realities of ASHA workers in Karnataka and provided an empirical foundation for understanding the relationship between job stress, socio-demographic factors, and work–life balance.

5. Data analysis and interpretation

Table 1. Primary Challenges Faced by ASHA Workers in Performing Their Roles

Challenge	Number	Percentage
Heavy Workload	1003	76.56
Lack of Resources	945	72.14
Insufficient Training	512	39.08
Lack of Community Support	621	47.40
Administrative Issues (Paperwork, Reporting)	739	56.41
Community Resistance	536	40.92
Low Financial Compensation	868	66.26
Personal Safety Concern	484	36.95
Transportation Difficulties	527	40.23

Table 1 reveals that ASHA workers in Karnataka face a range of interconnected structural, financial, and social challenges that significantly affect their job satisfaction and work–life balance. A heavy workload was the most reported issue (76.56%), as ASHAs are expected to handle multiple health responsibilities with limited institutional support. The lack of adequate resources (72.14%), including medicines, safety kits, and reporting materials, further hampers their efficiency and contributes to frustration and stress. Low financial compensation (66.26%) emerged as another critical concern, as most ASHAs receive irregular or performance-based incentives rather than fixed wages, aggravating financial insecurity. Administrative burdens such as excessive paperwork (56.41%) and insufficient community cooperation (47.40%) also reduce morale and increase occupational strain. In addition, training deficiencies (39.08%) leave many ASHAs underprepared for emergencies or new responsibilities, while transportation problems (40.23%) and safety concerns (36.95%) expose them to physical fatigue and risks during fieldwork. Collectively, these challenges reflect systemic neglect and gendered exploitation within the informal public health workforce. From a social work perspective, these findings underscore the need for policy interventions, including regularised pay, social security benefits, continuous training, logistical support, and counselling services. Community sensitisation, safety measures, and

peer-support mechanisms are also essential to strengthen ASHAs' resilience, enhance their professional dignity, and ensure equitable and sustainable grassroots health delivery in Karnataka.

Table 2. Strategies Adopted by ASHA Workers to Address and Manage Work-Related Challenges

Strategy	Number	Percentage
Seeking support from a supervisor	905	69.08
Attending training programs	788	60.15
Collaborating with other health workers	967	73.82
Utilising community leaders' help	842	64.28
Self-care practices	733	55.96

Table 2 summarises the coping mechanisms adopted by ASHA workers in Karnataka to handle job stress and maintain work–life balance. The most common strategy, reported by 73.82%, was collaborating with other health workers, reflecting strong peer support and teamwork in addressing heavy workloads. Seeking help from supervisors was another key coping approach (69.08%), showing the importance of supportive supervision in resolving conflicts and clarifying duties. Attending training programs (60.15%) emerged as an empowering tool, improving confidence and professional competence. Engaging community leaders (64.28%) helped ASHAs gain cooperation and legitimacy during fieldwork, reducing local resistance. Over half of the respondents (55.96%) engaged in self-care activities, such as rest, prayer, or exercise, to relieve stress. Together, these findings highlight a balance between institutional, social, and personal coping mechanisms. However, the lower adoption of individual self-care practices indicates limited time and resources for personal well-being. From a social work perspective, these results emphasise the need to formalise such coping mechanisms through structured support systems, continuous training, and peer counselling to enhance ASHAs' resilience and strengthen community health service delivery.

Table 3. Comprehensive Well-Being, Safety, Resources, and Work–Life Balance of ASHA Workers

Well-being & Environment	Question	Response	Number	Percentage
Physical Health	Overall physical health	Very Good	184	14.05
		Good	592	45.19
		Neither Good nor Bad	329	25.11
		Poor	153	11.68
		Very Poor	52	3.97
	Enough energy for everyday	Always	298	22.75
		Often	524	40.00

	life	Sometimes	333	25.42
		Rarely (specify)	111	8.47
		Never	44	3.36
	Pain/discomfort affects work.	Not at all	265	20.23
		A little	428	32.67
		A moderate amount	401	30.61
		Very much	164	12.52
		Extremely	52	3.97
Psychological Well-being	Overall mental health	Very Good	172	13.13
		Good	587	44.81
		Neither Good nor Bad	340	25.95
		Poor	159	12.14
		Very Poor	52	3.97
	Feel optimistic about the future.	Always	312	23.82
		Often	509	38.85
		Sometimes	341	26.03
		Rarely	106	8.09
		Never	42	3.21
	Feel stressed because of your job.	Never	78	5.95
		Rarely	214	16.34
		Sometimes	544	41.53
		Often	332	25.34
		Always	142	10.84
Social Relationships	Satisfied with family support	Very Satisfied	423	32.29
		Satisfied	571	43.59
		Neither Satisfied nor	195	14.89

		Dissatisfied		
		Dissatisfied	89	6.79
		Very Dissatisfied	32	2.44
	Work valued by the community	Always	311	23.74
		Often	533	40.69
		Sometimes	346	26.41
		Rarely	92	7.02
		Never	28	2.14
	Personal conflicts with colleagues	Never	657	50.15
		Rarely	423	32.29
		Sometime	164	12.52
		Often	49	3.74
		Always	17	1.30
Environment	Satisfied with physical work conditions	Very Satisfied	208	15.88
		Satisfied	548	41.83
		Neither Satisfied nor Dissatisfied	324	24.73
		Dissatisfied	164	12.52
		Very Dissatisfied	66	5.04
	Feel safe while performing duties.	Always	544	41.53
		Often	491	37.48
		Sometimes	197	15.04
		Rarely	56	4.27
		Never	22	1.68
	Enough resources to perform effectively	Always	286	21.83
		Often	529	40.38
		Sometimes	363	27.71
		Rarely	98	7.48

		Never	34	2.60
Work–Life Balance	Time for personal & family activities	Very Satisfied	312	23.82
		Satisfied	512	43.59
		Neither Satisfied nor Dissatisfied	231	17.63
		Dissatisfied	143	10.92
		Very Dissatisfied	53	4.05
	How often is WLB adequate	Always	277	21.15
		Often	519	39.62
		Sometimes	351	26.79
		Rarely	117	8.93
		Never	46	3.51
	Job allows healthy WLB	Always	264	20.15
		Often	502	38.32
		Sometimes	366	27.94
		Rarely	126	9.62
		Never	52	3.97

The table presents a clear picture of ASHA workers' physical, psychological, social, and environmental well-being, as well as their perceived work–life balance in Karnataka. Nearly 59% rated their physical health as good or very good, though around 31% reported moderate or poor health, indicating physical strain from demanding fieldwork. Approximately 63% reported that they often had sufficient energy for their daily tasks, while over one-third experienced fatigue due to long hours and travel. Mental health scores showed a similar trend: nearly 58% reported good or excellent mental health, yet 16% struggled with poor well-being and recurring stress. Optimism levels were high for most, though almost a third expressed emotional fatigue or uncertainty. Family support emerged as a significant protective factor, with 75% expressing satisfaction, while 64% felt valued by their communities. Work conditions remained mixed—only 57% were satisfied with infrastructure, and 21% always had adequate resources, highlighting persistent shortages. Safety was perceived positively by most, but a small yet notable group still felt unsafe during field duties. Regarding work–life balance, 67% were satisfied; however, over one-third experienced an imbalance and felt neglected by the institution. Overall, the findings portray a resilient yet strained workforce that manages chronic stress, resource scarcity, and inconsistent institutional support. Social-work-led interventions such as wellness programs, workload rationalisation, fair pay, and family-inclusive work policies are essential to strengthen ASHAs' well-being and ensure sustainable community health delivery.

Table 4. Influence of Various Factors on Balancing Work and Family Commitments among ASHA Workers

Factor	Does not affect	Affects sometimes	Affects many times	Always affects
Work hours	154 (11.76%)	412 (31.45%)	501 (38.24%)	243 (18.55%)
Overtime	188 (14.35%)	466 (35.61%)	430 (32.82%)	226 (17.25%)
Work from home after office hours	397 (30.31%)	522 (39.79%)	244 (18.63%)	147 (11.22%)
Work on holidays	221 (16.87%)	498 (38.02%)	378 (28.85%)	213 (16.26%)
Travelling away from home	309 (23.66%)	441 (33.66%)	357 (27.25%)	203 (15.49%)
Excessive household duties	173 (13.20%)	489 (37.33%)	425 (32.44%)	223 (17.02%)
Negative attitude of family/spouse	736 (56.18%)	341 (26.03%)	168 (12.82%)	65 (4.96%)
Negative attitude of the supervisor	602 (45.95%)	404 (30.84%)	213 (16.26%)	91 (6.95%)

Table 4 highlights the multifaceted factors influencing ASHA workers' ability to maintain a healthy work–life balance in Karnataka. The results show that time-related pressures such as long work hours, overtime, and working on holidays are the strongest disruptors, with nearly 88% reporting interference from extended work schedules. Similarly, overtime work affected 85.65% of respondents, revealing the absence of regulated working hour compensation—around 70% experienced work spillover into personal time due to after-hours reporting and follow-ups. Holiday work and frequent travel to remote villages further constrained family time, leading to fatigue and emotional exhaustion. Domestic responsibilities were another significant burden for 86.8% of ASHAs, reflecting gendered expectations and a lack of spousal support. Interpersonal dynamics also played a role; 43.82% reported family-related attitudinal stress, and 54.05% cited supervisory behaviour as affecting their balance, indicating that emotional and organisational support remains inconsistent. Collectively, these findings underscore that ASHAs face both structural and social barriers to work–life integration. From a social work perspective, achieving a sustainable balance requires policy reforms to regulate working hours, time-management training, sensitisation programs for families and supervisors, flexible scheduling during campaigns, and counselling and peer support mechanisms. Work–life balance for ASHAs, therefore, must be viewed not as an individual adjustment but as a systemic and gender-sensitive institutional responsibility.

Table 5. Assessment of Work–Life Balance among Respondents Using Hayman's (2005) 7-Point Scale

Item	SD	D	SWD	NA/DA	SWA	AG	SA
I neglect personal needs because of work	102 (7.79)	154 (11.76)	171 (13.05)	164 (12.52)	296 (22.60)	291 (22.21)	132 (10.08)
I put personal life on hold for work	88 (6.72)	142 (10.84)	163 (12.45)	176 (13.44)	302 (23.05)	307 (23.44)	132 (10.08)
I miss personal activities because of work	95 (7.25)	151 (11.53)	168 (12.82)	170 (12.98)	298 (22.75)	306 (23.36)	122 (9.31)
I struggle to manage work and non-work	110 (8.40)	169 (12.90)	182 (13.89)	189 (14.43)	256 (19.54)	262 (20.00)	142 (10.84)
I am unhappy with the time for non-work activities	120 (9.16)	176 (13.44)	183 (13.97)	168 (12.82)	255 (19.47)	265 (20.23)	143 (10.92)
My personal life drains me of energy to work	168 (12.82)	214 (16.34)	226 (17.25)	221 (16.87)	214 (16.34)	185 (14.12)	82 (6.26)
I am too tired to be effective at work	152 (11.60)	203 (15.49)	217 (16.56)	209 (15.95)	216 (16.49)	200 (15.27)	113 (8.63)
My work suffers because of my personal life	201 (15.34)	228 (17.40)	226 (17.25)	232 (17.71)	186 (14.20)	169 (12.90)	68 (5.19)
It is hard to work because of personal matters	189 (14.43)	221 (16.87)	230 (17.56)	236 (18.02)	194 (14.81)	171 (13.05)	69 (5.27)
My personal life gives me energy for my job	68 (5.19)	101 (7.71)	132 (10.08)	189 (14.43)	282 (21.53)	337 (25.73)	201 (15.34)
My job gives me the energy to pursue personal activities	74 (5.65)	109 (8.32)	139 (10.61)	196 (14.96)	276 (21.07)	331 (25.27)	185 (14.12)
I have a better mood at work because of my job	79 (6.03)	112 (8.55)	145 (11.07)	205 (15.65)	269 (20.54)	329 (25.11)	171 (13.05)

Note-1: The scale ranges from 1 (Strongly Disagree) to 7 (Strongly Agree), covering dimensions such as Work Interference with Personal Life (WIPL), Personal Life Interference with Work (PLIW), and Work/Personal Enhancement (WPLE).

Note-2. Numbers within the parentheses represent the percentage.

Table 5 presents an in-depth analysis of ASHA workers' work-life balance in Karnataka, using Hayman's (2005) 7-Point WLB Scale across three dimensions: Work Interference with Personal Life (WIPL), Personal Life Interference with Work (PLIW), and Work/Personal Life Enhancement (WPLE). The findings show that over half of the respondents regularly sacrifice personal time for work, with 55–57 per cent agreeing that they neglect personal needs, postpone family activities, or feel dissatisfied with their time for non-work pursuits—confirming substantial work intrusion into their private lives. By contrast, personal-to-work interference is moderate: around one-third acknowledged fatigue or emotional strain from home responsibilities that occasionally affect job performance, yet most maintain professional commitment despite domestic demands.

Encouragingly, the WPLE dimension reflected high positivity, with nearly 60–63 per cent agreeing that their job or personal life provides them with mutual energy, satisfaction, and motivation. This suggests that ASHAs derive intrinsic meaning and pride from their service, even in the face of adversity. Overall, the results portray a dual reality—persistent job-related intrusion into personal life, but also emotional fulfilment and empowerment from meaningful work. From a social work perspective, these findings suggest the need for targeted interventions, including regulating work hours and overtime, ensuring fixed rest days, incorporating mental health and stress management modules into ASHA training, establishing peer support and reflection networks, and promoting family-inclusive engagement strategies. Recognising ASHA work as formal employment with fixed wages, job security, and social protection would further enhance both the well-being and motivation of ASHA workers. Balancing structural reforms with psychosocial support is thus key to achieving a sustainable and humane model of grassroots health service delivery in India.

Table 6. Distribution of Respondents by Level of Agreement on Job Stress Factors

Factor	SD	DA	NA/DA	AG	SA
Conditions at work are unpleasant or sometimes even unsafe	133 (10.15%)	268 (20.30%)	219 (16.72%)	458 (34.96%)	232 (17.70%)
My job is negatively affecting my physical or emotional well-being	98 (7.48%)	211 (16.10%)	236 (18.01%)	487 (37.17%)	278 (21.22%)
I have too much work / too many unreasonable deadlines	85 (6.49%)	192 (14.66%)	208 (15.87%)	523 (39.90%)	302 (23.05%)
I find it difficult to express my opinions/feelings about job conditions to my supervisor	162 (12.37%)	247 (18.85%)	261 (19.92%)	436 (33.28%)	204 (15.57%)
Job pressure interferes with family/personal life (ASHA work makes it hard to spend time with family)	101 (7.71%)	219 (16.72%)	231 (17.63%)	497 (37.94%)	262 (19.98%)
I have inadequate control/input over my work duties	123 (9.39%)	276 (21.07%)	249 (18.99%)	448 (34.20%)	214 (16.34%)
I receive inadequate recognition/reward for good performance	137 (10.46%)	298 (22.75%)	263 (20.08%)	401 (30.61%)	211 (16.10%)
I am unable to utilise my skills and talents at work fully	184 (14.05%)	291 (22.21%)	287 (21.91%)	356 (27.18%)	192 (14.66%)
Too many people at my level get burned out by job demands	97 (7.40%)	204 (15.57%)	219 (16.72%)	488 (37.25%)	302 (23.05%)

Note: SD = Strongly Disagree; DA = Disagree; NA/DA = Neither Agree nor Disagree; AG = Agree;

SA = Strongly Agree.

Table 6 summarises the significant sources of job stress among ASHA workers in Karnataka and their implications for well-being and work–life balance. More than half (52.66%) of respondents described their work environment as unpleasant or unsafe, primarily due to field travel, exposure to health risks, and inadequate protective equipment. Likewise, 58.39% agreed that their job negatively affects their physical or emotional health, confirming that stress and fatigue are daily realities. Excessive workload and unrealistic deadlines emerged as the most dominant stressors, reported by 62.95%, indicating systemic overwork and inadequate staffing support. Nearly 49% of ASHAs reported feeling unable to express their opinions or concerns to supervisors, indicating hierarchical barriers and a lack of participatory governance.

More than 57% stated that job pressure interferes with their family life, and 50% reported low autonomy in decision-making, which intensifies stress and contributes to role conflict. Recognition and reward deficits were highlighted by 46.71%, while 41.84% believed their skills were underutilised. Alarmingly, 60.30% acknowledged feelings of burnout, revealing chronic emotional exhaustion. These findings confirm that ASHA job stress is multifactorial, shaped by unsafe conditions, heavy workloads, limited voice, inadequate incentives, and poor work–life integration. From a social work perspective, this calls for structural and psychosocial interventions, including participatory management systems, occupational safety measures, counselling and wellness programs, role clarity and skill development initiatives, equitable reward mechanisms, and family-supportive policies such as childcare and flexible scheduling. Addressing these interconnected stressors is essential to enhance ASHAs' morale, mental health, and retention, ensuring a sustainable and motivated grassroots public-health workforce.

6. Discussion and Conclusion

The findings of this study highlight the complex interplay between job stress, work–life balance, and occupational well-being among Accredited Social Health Activists (ASHAs) in Karnataka. While ASHAs are indispensable agents in India's public health delivery system, they continue to face significant professional and personal challenges that threaten their health, motivation, and performance. The data reveal that a majority of ASHA workers (76.56%) experience excessive workloads, 72.14% lack adequate resources, and 66.26% receive insufficient or irregular financial compensation. Over half of the respondents (58.39%) reported that their job negatively affects their physical and emotional well-being, while 62.95% identified unrealistic targets and deadlines as significant sources of stress. These findings confirm that structural deficiencies within the National Health Mission framework—such as workload inequities, delayed remuneration, and insufficient safety provisions—are central determinants of occupational stress and imbalance.

At the same time, the study underscores the paradoxical nature of ASHA work. Despite high stress levels, a large proportion of respondents (67%) reported overall satisfaction with their work–life balance and derived emotional fulfilment from community engagement. This duality reflects both the empowering and exploitative dimensions of the ASHA role: it provides social recognition and self-worth while simultaneously burdening workers with disproportionate responsibilities and limited institutional support. The Hayman's (2005) Work–Life Balance Scale analysis further indicates that more than half of ASHAs regularly sacrifice personal or family time to meet work obligations, while a smaller proportion reported fatigue and emotional strain from home duties that occasionally affect their job performance. Nonetheless, the strong sense of purpose derived from serving their communities acts as a psychological buffer against complete burnout, aligning with findings from previous studies in Karnataka and other Indian states (Chahal et al., 2023; Shet et al., 2018; Sharma & Singh, 2025).

From a social work perspective, these findings reaffirm the importance of multi-level interventions in reducing job stress and improving occupational health. At the micro level, strengthening ASHAs' self-efficacy

through stress-management training, self-care practices, and mindfulness-based counselling can foster emotional resilience. At the mezzo level, promoting peer-led support groups, participatory supervision, and community recognition can help build solidarity and collective coping mechanisms. The study found that collaboration with co-workers (73.82%) and seeking help from supervisors (69.08%) were among the most common strategies used to mitigate stress, confirming that teamwork and supportive supervision remain critical coping resources. However, only 55.96% reported regular self-care, suggesting a need for institutionalised wellness initiatives and time protection for personal rejuvenation. At the macro level, policy reforms such as fixed honoraria, social security benefits, regulated working hours, transportation support, and clear job descriptions are imperative to institutionalise dignity, equity, and safety within the ASHA programme (Agarwal et al., 2024; Rao et al., 2023).

Integrating social-work principles into health governance is thus not merely desirable but essential. The ecological systems framework helps explain how ASHAs' well-being is shaped by interactions among family expectations, community norms, and organisational policies. Social workers, acting as mediators and advocates, can play a transformative role by facilitating counselling, family sensitisation programs, and mental health referrals for ASHAs. Embedding such psychosocial supports within the National Health Mission's structure would shift the focus from performance metrics to human-centred care, recognising ASHAs as both caregivers and workers with legitimate emotional and familial needs.

Ultimately, ensuring work–life balance among ASHAs must be treated as a systemic occupational health concern rather than an individual adjustment. Policymakers and health administrators must move beyond incentive-driven models toward a rights-based framework that recognises ASHAs as formal employees entitled to job security, fair pay, and psychosocial protection. The integration of social-work interventions—such as stress management workshops, peer-support circles, and family-inclusive counselling combined with structural measures like regular pay, predictable schedules, and safe working conditions, will not only improve ASHAs' quality of life but also enhance service delivery outcomes at the grassroots level.

The sustainability of India's ASHA programme depends on harmonising community health goals with the holistic well-being of its workforce. Recognising ASHAs as professional change agents, ensuring equitable treatment, and embedding social-work-informed strategies within Karnataka's health policies can create a more humane, motivated, and resilient community health system. When worker dignity and public health priorities align, both the ASHA workforce and the communities they serve stand to benefit—leading to healthier lives, empowered women, and stronger local health governance.

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