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Review Article

Work, job satisfaction and role performance among ASHA workers in Karnataka: an overview of existing evidence

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ABSTRACT

Accredited social health activists (ASHAs) are an important component of community-based health service delivery in India. Their responsibilities have expanded considerably and include maternal and child health, health education, community mobilisation, referral services, disease prevention and support for national health programmes. The conditions under which ASHAs work may influence their job satisfaction and role performance. Evidence from Karnataka is available, but it is dispersed across studies examining workload, incentives, training, motivation, stress, digital reporting and performance. An overview was undertaken of published evidence concerning work environment, job satisfaction, motivation, workload and role performance among ASHA workers in Karnataka. Relevant studies published predominantly from 2020 onwards were identified from electronic databases, journal websites and other academic sources. Studies were examined according to geographical setting, population, study design, major variables and findings. The evidence was narratively synthesised under the themes of work environment, training, job satisfaction and motivation, role performance, and emerging challenges. Studies from Karnataka indicate that ASHAs perform a wide range of community health activities but face challenges related to workload, extended working hours, additional responsibilities, transportation, incentives, resources, training and organisational support. Digital systems have created opportunities for improved documentation and monitoring but may also add reporting responsibilities. Recent studies have increasingly examined job motivation, occupational stress, quality of life and job satisfaction. Performance studies indicate generally active participation in several maternal, child and community health activities, although gaps remain in selected areas of knowledge and service delivery. Existing evidence suggests that work environment is an important context for understanding job satisfaction and role performance among ASHAs in Karnataka. However, evidence integrating all three constructs remains limited. Future studies using standardised measures should examine their interrelationships and determine whether work environment modifies the relationship between job satisfaction and role performance.

Keywords: Accredited social health activists, ASHA, Community health workers, Job satisfaction, Role performance, Work environment

INTRODUCTION

The accredited social health activist (ASHA) programme was introduced as an important component of the National health mission to strengthen community participation and improve access to health services. ASHAs function as a link between communities and the public health system and are involved in health promotion, community mobilisation, maternal and child

health activities, referral services and implementation of national health programmes.[1,2]

Over time, the responsibilities of ASHAs have expanded beyond the initial focus on maternal and child health. Their activities increasingly include communicable disease prevention, non-communicable disease-related activities, mental health, health education, digital reporting and other community-level health interventions.[2-4] This expansion has increased the importance of understanding not only what ASHAs do, but also the conditions in which they perform their work.

The work environment of a community health worker differs. ASHAs work predominantly within communities and households and may have to travel between dispersed populations. Their work environment therefore includes workload, population coverage, transportation, availability of resources, supervision, training, communication with health personnel, relationships with co-workers, incentives, recognition and digital reporting requirements.[3]

Work environment can influence the way workers perceive their jobs. Job satisfaction among ASHAs may be influenced by financial incentives, recognition, relationships with health personnel, supervision, training, opportunities for development and the perceived value of community service. At the same time, workload, inadequate resources, delayed incentives and occupational stress may adversely affect satisfaction and motivation.[3,5]

Role performance refers to the extent to which ASHAs carry out activities expected of them. These include antenatal and postnatal care support, institutional delivery mobilisation, newborn care, immunisation mobilisation, health education, family planning, referral, home visits and participation in national health programmes.[1,2,6]

Evidence from Karnataka has examined several of these aspects. An early statewide assessment involving three districts found that ASHAs were predominantly involved in home visits, antenatal counselling, delivery escort, breastfeeding advice and immunisation advice, although performance varied across different tasks.[6] More recent studies have examined workload, quality of life, performance, digital systems, training, motivation and stress.[3,4,5,7]

However, the literature remains dispersed. Some studies focus mainly on performance, whereas others examine workload, motivation, job stress, digital work or quality of life.[3,4,5,7] There is limited synthesis examining work environment, job satisfaction and role performance together within the Karnataka context.

The present overview therefore brings together available evidence to identify common work-environment characteristics, factors influencing job satisfaction and motivation, patterns of role performance, and areas requiring further research.

The objective of this article was to provide an overview of existing evidence concerning work environment, job satisfaction and role performance among ASHA workers in Karnataka and to identify research and practice gaps relevant to strengthening the ASHA workforce.

METHODS

Review approach

An overview of published evidence was undertaken. The review focused on studies conducted among ASHA workers in Karnataka that addressed at least one of the following areas: work environment, workload, working conditions, organisational support, supervision, incentives, training, job satisfaction, motivation, occupational stress, quality of life or role performance.

The purpose was to synthesize the available evidence rather than statistically pool study findings. Therefore, the findings were analysed narratively.

Search strategy

Literature was searched using combinations of the following terms: “ASHA”, “Accredited Social Health Activist”, “community health worker”, “Karnataka”, “Bengaluru”, “Mysuru”, “Vijayapura”, “Raichur”, “Koppala”, “Hubballi”, “work environment”, “workload”, “job satisfaction”, “motivation”, “job stress”, “performance”, “role performance”, “training”, “supervision”, “incentives”, “quality of life” and “digital health”.

Search

Electronic databases and publicly accessible academic sources were considered, including PubMed/MEDLINE, Google Scholar, web of science, Scopus where accessible, journal websites and relevant Government of India/NHM Karnataka websites

Search period

January 2020 to September 2026.

Eligibility criteria

Inclusion criteria

Studies were considered for inclusion were conducted in Karnataka. Included ASHA workers as the primary study population or included ASHAs as a clearly identifiable subgroup. Examined work-related conditions, workload, job satisfaction, motivation, stress, training and quality of life or performance. The study Were published in peer-reviewed journals or credible academic sources. The

study was published predominantly from 2020 onwards for the contemporary evidence synthesis. Selected Karnataka studies were retained as they provided important baseline evidence concerning ASHA role performance or working conditions. Studies conducted outside Karnataka were excluded from the state-specific evidence synthesis, although national or international evidence were referred for contextual comparison.

Exclusion criteria

Studies excluded are editorials, news reports or non-academic commentaries without original or review evidence.

Data synthesis

Information was extracted according to study location, sample size, design, principal variables and major findings. Findings were grouped into five themes: work environment and workload; training and capacity building; job satisfaction, motivation and occupational stress; role performance; and emerging issues including digitalisation and role expansion.

Because the studies differed in design, instruments, sample characteristics and outcomes, a narrative synthesis was considered appropriate.

Table 1: Selected studies concerning ASHA workers in Karnataka.

Author	Location	Sample	Main focus	Major findings
Rohith et al[12]	Vijayapura	617 ASHAs	Knowledge and practice	Identified gaps in child-health knowledge and practice.
Antao et al[8]	Central Karnataka	20 ASHAs	ASHA-soft	Digital system generally accepted; technical difficulties reported.
Manjunath et al[3]	Mysuru, Raichur, Koppala	538 ASHAs	Workload/QoL	Workload, extended hours, transport, support and delayed incentives were important concerns.
Lonimath et al[13]	Bengaluru	130 ASHAs	Performance	53.8% scored >75%; refresher training was inadequate.
Manjunath et al[7]	Koppal, Raichur, Mysuru	739 CHWs	Quality of life	Environmental domain was lowest; working environment, transportation, income and job satisfaction were highlighted.
Siddareddy et al[17]	Hubballi	134 CHWs	Motivation/stress	Rural-urban differences in motivation and occupational stress.
Patley et al[4]	Ramanagara	ASHAs	Mental-health service delivery	ASHAs functioned as a bridge between patients and the District Mental Health Programme during COVID-19, demonstrating expansion of their role.
Srinidhi et al[11]	Karnataka	14 ASHAs	Digital technology and maternal assessment	Digital technology-supported task sharing was implemented with training and regular support; ASHAs were involved in identifying maternal risks during home visits.
Kapanee et al[14]	Bengaluru	91 ASHAs	Mental-health orientation/training needs	Unfavourable orientation toward several dimensions of mental illness was identified, indicating the need for targeted capacity building.
Nirisha et al[15]	Karnataka/ Bengaluru-linked programme	ASHAs	Technology-supported mental-health training	Technology-supported training was evaluated as a method for task shifting among ASHAs.

RESULTS

The literature identified from Karnataka demonstrates that ASHA work has evolved considerably over time. Earlier studies primarily assessed recruitment, role performance and maternal and child health activities, whereas more recent studies have increasingly examined workload, incentives, digital systems, training, stress and expansion of ASHA responsibilities.

Work environment

Workload was one of the most consistently reported work-environment concerns. A multi-stakeholder study

conducted in Mysuru, Raichur and Koppala reported that ASHAs experienced workload related to population coverage, extended working hours and additional tasks. Lack of transportation, inadequate support from other health personnel and delayed incentive payments were also reported as factors contributing to feelings of being overworked and underpaid.[3] These findings highlight that ASHA workload is not determined solely by the number of assigned beneficiaries. Travel requirements, additional programme activities, documentation and interaction with multiple components of the health system also contribute to the overall work burden.

The same study suggested that selected tasks could potentially be shared or shifted among frontline health workers according to complexity and capability.[3] Such approaches may help to reduce unnecessary duplication and allow ASHAs to concentrate on activities that require community-level engagement.

Financial incentives and recognition

Financial incentives are an important component of the ASHA programme. The incentive-based system links several payments to specific activities and programme outputs. Evidence from Karnataka indicates that financial incentives can act both as a source of motivation and as a source of dissatisfaction when payments are delayed or when workers perceive that the amount received does not correspond with the workload involved.

A study examining ASHA-soft in central Karnataka reported that the digital system was generally accepted by ASHAs and was associated with increases in recorded activities and incentives.[8] However, technical difficulties were also reported. The Karnataka health system has subsequently introduced a fixed monthly honorarium in addition to performance-based incentives.[9] Such changes are relevant to the work environment and may influence the financial security and motivation of ASHAs.

Supervision and organisational support

Support from the health system is an important part of the ASHA work environment. Supervision may provide guidance, problem-solving support, monitoring and reinforcement of skills. However, the literature indicates variation in the nature of support received by ASHAs. Inadequate support from other health personnel has been identified as a workload-related concern. Supportive supervision may therefore be more useful than supervision that focuses predominantly on administrative reporting.[10]

Organisational communication, recognition of work, availability of assistance and opportunities to discuss field-level difficulties are also likely to influence job satisfaction and performance.

Quality of life and working conditions

Quality of life provides another perspective on the work environment. A cross-sectional study conducted among 739 community health workers from Koppal, Raichur and Mysuru found an overall quality-of-life score indicating neither clearly good nor poor quality of life. The environmental domain had the lowest mean score, 48.6±16.6. The authors identified job satisfaction, income, physical safety, working environment and transportation as areas requiring attention.[7]

These findings are relevant because many factors affecting environmental quality of life are directly related to the conditions under which ASHAs perform their duties. Transportation, physical safety, financial circumstances and working conditions can affect both the experience of work and the ability to perform field activities.

Digitalisation and changing work responsibilities

Digitalisation has introduced another dimension to the ASHA work environment. The implementation of ASHA-soft in Karnataka was associated with increased recording of activities and incentives, and the system was generally accepted by ASHAs; however, technical difficulties were reported.[8] Similarly, the ASHA Kirana initiative used a digital maternal clinical assessment tool and provided ASHAs with training and ongoing support during implementation.[11]

These findings suggest that technology may support ASHA performance when adequate training and technical support are provided, but digital systems may also add responsibilities when documentation requirements are not integrated into routine field activities.

Training and role expansion

Training emerged as an important factor associated with ASHA functioning. A study in Vijayapura identified gaps in knowledge and practice related to child health services.[12] In Bengaluru, a performance assessment found that although induction training was provided, refresher training was inadequate.[13] The responsibilities of ASHAs have also expanded beyond maternal and child health activities. During the COVID-19 pandemic, ASHAs in Ramanagara were utilised as a link between patients and the District Mental Health Programme.[4] Other Karnataka-based initiatives have explored mental-health orientation, digital training and task shifting among ASHAs.[14,15]

The expansion of ASHA responsibilities makes continuous training particularly important. ASHAs are increasingly expected to participate in areas extending beyond their original maternal and child health responsibilities. Thus, the expanding scope of ASHA responsibilities creates a continuing need for competency-based and periodic refresher training.

Role performance

Evidence from Karnataka indicates that ASHAs perform a broad range of community-based activities. In Bengaluru, 53.8% of 130 ASHAs achieved a performance score above 75% and were classified in the highest performance category. Financial incentives and opportunities to participate in health-service activities were among the reported reasons for joining the programme.[13] The findings from Vijayapura and earlier Karnataka studies also indicate that performance is not uniform across all components of the ASHA role. Activities such as home visits, antenatal counselling, breastfeeding advice and immunisation mobilisation have generally been performed more consistently than some technically demanding or less frequently performed activities.[12,6]

The findings indicate that ASHA performance is multidimensional and should not be represented by a single activity or programme indicator. An ASHA may perform well in maternal and child health mobilisation while experiencing difficulties with documentation, technical services or newer programme responsibilities

Job satisfaction, motivation and stress

The available Karnataka literature suggests that job satisfaction and motivation are influenced by multiple factors rather than remuneration alone. Financial incentives, recognition, supportive relationships, training, supervision and perceived value of community service may contribute to motivation, whereas workload, inadequate resources, payment-related concerns and occupational stress may reduce satisfaction. Recent work-stress research among community health workers has further highlighted the importance of addressing intrinsic wellbeing in addition to conventional extrinsic factors such as incentives and supervision.[16]

The Bengaluru performance study reported that financial incentives and opportunities for greater exposure to health services were important reasons for joining the ASHA programme.[13] At the same time, problems related to incentive documentation and payment were identified.

Recent evidence from Hubballi provides additional information concerning motivation and occupational stress. A comparative study involving 134 community health workers, of whom the majority were ASHAs, found differences between urban and rural workers in motivation and occupational stress.[17] These findings indicate that motivation should not be considered solely a financial issue. The geographical and organisational context in which ASHAs work may also influence motivation and stress.

Occupational stress and work-life balance

Workload, additional responsibilities and inadequate resources may contribute to occupational stress. The Karnataka literature indicates that ASHAs can experience difficulties balancing multiple programme requirements with household and community responsibilities.

The workload study from Mysuru, Raichur and Koppala specifically identified extended working hours, additional tasks, transportation difficulties, inadequate support and delayed incentives.[3] These conditions may collectively influence wellbeing and job satisfaction.

Recent studies have also increasingly examined the broader wellbeing of community health workers rather than focusing only on service-delivery indicators. This shift is important because a sustainable community health workforce requires attention to workers' wellbeing as well as programme outputs.

Emerging challenges

The studies reviewed indicate that the role of ASHA workers in Karnataka is gradually expanding beyond their traditional maternal and child health responsibilities. ASHAs are increasingly involved in multiple national health programmes and additional community-based activities, resulting in an increased workload and extended working hours.[3,13.] A multi-stakeholder study conducted in Karnataka reported that ASHAs experienced work burden due to population coverage, additional tasks and extended working hours. Lack of transportation, inadequate support from other health personnel and delays in incentive payments were also identified as important challenges.[3]

Table 2: Major work-environment factors identified.

Work-environment domain	Factors identified
Workload	Population coverage, extended hours, additional tasks
Financial	Incentives, payment delays, adequacy of remuneration
Organisational	Supervision, support, communication, recognition
Training	Induction training, refresher training, competency gaps
Physical	Transportation, safety, field conditions
Digital	Data entry, digital reporting, technical difficulties
Social	Community support, co-worker relationships
Role-related	Role clarity, role stress, expanding responsibilities

The reviewed studies also indicate the need for regular refresher training to maintain and improve ASHAs' knowledge and performance.[12,13] With the increasing use of digital reporting and technology-supported health

services, digital literacy, network connectivity and access to appropriate technical support have also emerged as areas requiring attention.[11]

These challenges may influence the work environment and job satisfaction of ASHAs and may have implications for their role performance (Table 2).

Relationship among work environment, job satisfaction and role performance

Although the available studies provide evidence concerning individual components of work environment, satisfaction, motivation, stress and performance, relatively few studies have examined these constructs simultaneously among ASHAs in Karnataka.

The evidence therefore supports a conceptual relationship in which working conditions may influence job satisfaction and motivation, which may subsequently influence role performance. However, the available literature does not provide sufficient evidence to establish that work environment statistically moderates the relationship between job satisfaction and role performance. This represents an important area for future research. Studies using standardised measures and moderation analysis could determine whether the effect of job satisfaction on role performance varies according to the quality of the work environment.

DISCUSSION

The present review brings together evidence concerning the work environment, job satisfaction, motivation and role performance of accredited social health activists (ASHAs) in Karnataka. The findings indicate that ASHAs continue to play an important role in community-based health service delivery, but their ability to fulfil their responsibilities is influenced by workload, financial incentives, training, supervision, transportation, organisational support and changing programme requirements. An important observation is that these factors are interconnected, although most available studies have examined them separately. This is consistent with the review by Scott et al which highlighted the need to understand the ASHA programme within the wider health system rather than viewing worker performance in isolation.[18]

Work environment and workload

Workload was one of the most consistently reported concerns in the Karnataka evidence. The study by Manjunath et al conducted among 538 ASHAs in Mysuru, Raichur and Koppala districts, identified extended working hours, additional responsibilities, transportation difficulties, inadequate support from other health personnel and delayed incentive payments as important challenges.[3] These findings suggest that workload is influenced not only by the number of assigned activities but also by the geographical area covered, travel requirements, documentation and coordination with other health personnel.

The findings are consistent with the mixed-methods study by Dutta et al which examined the workload of ASHAs in India and described the difficulties of balancing community health responsibilities with household and family commitments.[19] Similarly, a multi-stakeholder study by Naimoli et al identified unclear roles, gaps in training, inadequate resources and difficulties in coordination as factors that may affect community health worker performance.[20] Together, these studies indicate that workload should be understood as both a quantitative and an organisational issue.

The findings have particular relevance for Karnataka, where ASHAs may work across geographically dispersed communities and face different travel and service-delivery demands. Increasing the number of assigned activities without considering the time and resources needed to complete them may create competing priorities. Workload assessment should therefore include population coverage, travel time, additional programme responsibilities and documentation requirements. Better coordination among health programmes and appropriate task-sharing may help reduce duplication and enable ASHAs to focus on activities requiring community engagement.[3,20]

Financial incentives and recognition

Financial incentives emerged as another important dimension of the work environment. The Karnataka workload study reported delayed payments and concerns about compensation in relation to the work undertaken.[3] The ASHA-soft study by Antao et al. found that the digital system was generally accepted and was associated with changes in the recording of activities and incentives, although technical difficulties were also reported.[8] These findings indicate that financial motivation depends not only on the incentive structure but also on the efficiency of the systems through which activities are documented and payments are processed.

Evidence from outside Karnataka supports this interpretation. Sarin et al found that incentives could provide ASHAs with financial independence and self-confidence, while low rates and irregular or incomplete payments could create dissatisfaction and pressure within their families.[21] In another study, Abdel-All et al found that ASHAs expressed preferences for employment conditions that included fixed remuneration, training linked to promotion opportunities and family health benefits.[22] These findings suggest that financial security and professional development may be important alongside activity-based payments.

The introduction of a fixed monthly honorarium in Karnataka, in addition to performance-based incentives,

represents an important change in the financial context of ASHA work.[9] However, the policy change itself does not establish that job satisfaction or performance has improved. Its effects require systematic evaluation using information on payment regularity, total remuneration, workload and workers' perceptions before and after implementation. Financial recognition should also be accompanied by supportive supervision, adequate resources and opportunities for professional development.

Quality of life and working conditions

The quality-of-life evidence provides an additional perspective on the conditions under which ASHAs work. The study conducted among 739 community health workers in Koppal, Raichur and Mysuru reported an overall quality-of-life score that did not indicate clearly good or poor quality of life. The environmental domain had the lowest mean score, at 48.6±16.6, and the authors highlighted income, transportation, physical safety, working environment and job satisfaction as areas requiring attention.[7] These findings are important because environmental quality of life reflects circumstances that may affect the daily experience of fieldwork. Difficulties with transport, personal safety and access to resources can make household visits and other community activities more demanding. Although the study assessed quality of life rather than directly measuring the relationship between work environment and role performance, its findings identify practical conditions that warrant consideration when planning support for ASHAs.[7]

The findings also suggest that workforce support should extend beyond monitoring service-delivery targets. Attention to safety, travel requirements, available facilities and financial circumstances may help create more sustainable working conditions. Further studies should examine whether improvements in these areas are associated with changes in job satisfaction, wellbeing and performance.

Digitalisation and changing responsibilities

Digital systems have introduced both opportunities and challenges for ASHA work. In Karnataka, Antao et al reported that ASHA-soft was generally accepted, while technical difficulties remained a concern.[8] The ASHA Kirana initiative demonstrated the use of digital technology to support maternal assessment by frontline workers, with training and ongoing support provided during implementation.[11] These studies illustrate how technology can support documentation and task-sharing when appropriate implementation support is available.

However, the introduction of digital tools may also increase workload if electronic reporting duplicates existing paperwork or if technical assistance is limited. The benefits of digitalisation should therefore be assessed in relation to usability, training, time requirements and the reliability of reporting systems. Technology should simplify routine work and support decision-making rather than add avoidable administrative demands.

The expanding responsibilities of ASHAs also require attention. Patley et al. described the role of ASHAs in connecting patients with the District Mental Health Programme during the COVID-19 pandemic in Ramanagara.[4] Other Karnataka-based studies have examined mental-health orientation and technology-supported training for task-sharing.[14,15] These initiatives demonstrate the potential for ASHAs to contribute to emerging health priorities. However, expansion of responsibilities should be accompanied by appropriate training, clearly defined roles and continued support from the health system.

Training and capacity-building

The Karnataka evidence indicates that training needs continue beyond the initial induction period. Rohith and Angadi identified gaps in ASHAs' knowledge and practice concerning child health services in Vijayapura district.[12] Similarly, Lonimath et al reported that 53.8% of the 130 ASHAs assessed in Bengaluru achieved a performance score above 75%, while inadequate refresher training was identified as a concern.[13] These findings indicate that performance may be satisfactory overall while specific knowledge and practice gaps remain.

The need for continued training is also consistent with the wider evidence on ASHA performance. Naimoli et al highlighted limitations in training, role clarity and coordination as factors affecting community health worker functioning.[20] Training should therefore be designed around identified needs rather than delivered only as a routine administrative activity.

Refresher programmes could focus on gaps in child health, counselling, referral procedures, documentation and newly assigned responsibilities. Practical demonstrations, mentoring and opportunities to discuss difficult cases may help workers apply knowledge during fieldwork. Where performance is affected by insufficient equipment, unclear instructions or limited supervisory support, training alone will not resolve the problem. Capacity-building should therefore be integrated with organisational improvements.

Role performance and service delivery

The Karnataka studies show that ASHAs participate in a broad range of maternal, child and community health activities, but performance is not uniform across all areas. The assessment by Lonimath et al. found that 53.8% of participants achieved a performance score above 75%.[13] In Vijayapura, Rohith and Angadi identified gaps in knowledge and practice related to child health services.[12] The earlier statewide assessment by Fathima et al also

described variation in the performance of ASHAs across different activities, including home visits, antenatal counselling, delivery-related support, breastfeeding advice and immunisation counselling.[6]

These findings suggest that an overall performance classification may conceal differences between service domains. An ASHA may perform well in community mobilisation and maternal health activities while requiring further support in child health, documentation or newer programme responsibilities. This variation reinforces the importance of assessing performance through clearly defined indicators that reflect the different components of the ASHA role.

Performance assessment should also distinguish the completion of activities from the quality-of-service delivery. Registers and activity records provide useful information, but they may not fully capture the quality of counselling, the appropriateness of referrals, communication with families or continuity of follow-up. Combining activity-based indicators with relevant assessments of service quality may provide a more comprehensive understanding of ASHA performance.

Job satisfaction, motivation and occupational stress

The available evidence suggests that job satisfaction and motivation are influenced by financial, interpersonal and organisational factors. The Karnataka workload study identified concerns related to additional responsibilities, delayed incentives and inadequate support.[3] The quality-of-life study further highlighted income, working conditions, transport and job satisfaction as areas requiring attention.[7] In Hubballi, Siddareddy et al reported differences in motivation and occupational stress between urban and rural community health workers, most of whom were ASHAs.[17] These findings suggest that the geographical and organisational context may influence workers' experiences and should be considered when developing workforce-support measures.

Evidence from other Indian settings provides additional context. In their study of ASHA motivation, Singh et al. found that workload, healthcare infrastructure, incentives and supportive supervision were relevant dimensions of motivation, although motivation varied across individual and health-system domains.[23] Sarin et al similarly demonstrated that incentives could be empowering while also becoming a source of dissatisfaction when payment was inadequate or irregular.[21] These findings support the interpretation that job satisfaction cannot be understood through financial remuneration alone.

Intrinsic motivation, including the value placed on serving the community, may coexist with dissatisfaction about workload, payment, resources or career opportunities. Consequently, continued participation in community health activities should not automatically be interpreted as evidence of satisfaction with all aspects of work. Measures of job satisfaction should separately examine remuneration, supervision, working conditions, relationships with colleagues, recognition and opportunities for development.

Occupational stress also warrants greater attention. Rashmi and Thippesh discussed job stress and work-life balance among ASHA workers in Karnataka, while Bondre et al evaluated a positive psychological intervention intended to reduce work stress among rural community health workers in India.[5,16] Although these studies differ in purpose and design, they highlight the importance of considering worker wellbeing alongside service-delivery outcomes. Interventions addressing stress may be useful, but they should complement efforts to address structural sources of pressure, including excessive workload, inadequate support and financial uncertainty.

Relationship between work environment, job satisfaction and role performance

A central finding of this review is that the available evidence provides useful information about individual aspects of ASHA work but remains limited in explaining the relationships between work environment, job satisfaction and role performance. Karnataka studies have examined workload, quality of life, digital reporting, training, motivation and performance, but these variables have generally been assessed separately or using different instruments.[3,7,8,12,13,17]

The wider ASHA literature similarly identifies performance, motivation, incentives, training and organisational support as important themes, while highlighting the need for a broader health-system perspective.[18,20] These findings support the view that work environment is an important context for understanding ASHA functioning. However, they do not establish that work environment directly causes higher job satisfaction or better performance, nor do they demonstrate that job satisfaction mediates or moderates performance.

The relationship may operate in more than one direction. Supportive working conditions may help ASHAs perform their duties and feel more satisfied, while positive experiences of completing tasks and receiving community recognition may strengthen motivation. These possibilities require direct empirical investigation. In particular, moderation analysis could determine whether the relationship between job satisfaction and role performance varies according to the quality of the work environment. Such an analysis would require data on all three constructs and an explicit statistical test of the interaction between work environment and job satisfaction.

Research gaps and implications for practice

The evidence reviewed indicates several priorities for future research. First, studies should use standardised measures of work environment, job satisfaction and role performance to improve comparability across districts. Second, more research should examine these constructs together rather than treating them as unrelated outcomes. Third, studies should compare rural and urban settings and consider differences in geographical accessibility, workload, training exposure and organisational support.

Longitudinal research could help determine whether changes in remuneration, supervision, training or digital systems are followed by changes in satisfaction and performance. Qualitative studies could complement quantitative findings by exploring how ASHAs experience competing responsibilities and navigate

difficulties in the field. Further research should also assess the quality-of-service delivery rather than relying solely on counts of completed activities.

For practice, the evidence supports a coordinated approach to strengthening the ASHA work environment. Priorities include timely and transparent incentives, regular competency-based refresher training, supportive supervision, manageable workloads, appropriate transport and safety arrangements, and digital systems that reduce rather than duplicate documentation. The effects of policy changes, including fixed honoraria, should be monitored systematically instead of being assumed to improve outcomes.

Overall, the available evidence indicates that the contribution of ASHAs should be understood in relation to the conditions under which they work. Strengthening their role requires attention not only to individual knowledge and commitment but also to the financial, organisational, interpersonal and practical support provided by the health system. Addressing these dimensions may help promote worker wellbeing and strengthen community-based primary health care in Karnataka (Table 3).

Table 3: Evidence gap and future research.

Existing evidence	Remaining gap
Workload is documented	Need to determine its effect on satisfaction and performance
Performance has been assessed	Need standardised performance measures
Motivation and stress have been studied	Need integration with work environment
Job satisfaction has been examined in some studies	Need consistent measurement across Karnataka
Digital systems have been studied	Need assessment of digital workload
Rural/urban differences have been reported	Need broader Karnataka comparisons
Work environment factors are documented	Moderating effect has not been adequately tested

The review identified the following important gaps:

Most Karnataka studies have examined individual components such as workload, incentives, stress, motivation or performance rather than integrating all three major constructs. There is limited evidence using a standardised measure of work environment among ASHAs. Job satisfaction has not been consistently assessed using the same domains across studies, making comparison difficult.

Studies assessing role performance have used different indicators and scoring systems. Evidence directly examining the relationship between work environment, job satisfaction and role performance is limited. There is insufficient evidence regarding whether work environment modifies the relationship between job satisfaction and role performance.

Rural and urban ASHA work environments may differ, but comparative evidence remains limited. Digital reporting and documentation have become increasingly important, but their relationship with workload, satisfaction and performance requires further investigation.

There is limited longitudinal evidence examining how changes in incentives, supervision, training or digital systems influence ASHA outcomes over time. More district-level evidence is required from different geographical regions of Karnataka, particularly coastal, northern, central and rural areas.

CONCLUSION

ASHA workers constitute an important community-level workforce within the Indian health system. Evidence from Karnataka shows that ASHAs undertake a broad range of maternal, child, reproductive, preventive and community health activities. At the same time, their work is influenced by workload, transportation, incentives, training, supervision, resources, digital reporting and other organisational conditions. The available literature indicates that these work-environment factors are relevant to motivation, job satisfaction, wellbeing and role performance. However, existing studies have generally examined these dimensions separately. There remains a

need for integrated research examining work environment, job satisfaction and role performance within a common framework.

Future research using standardised measures and appropriate multivariable methods should determine how these factors interact. In particular, moderation analysis may help determine whether the quality of the work environment changes the relationship between job satisfaction and role performance. Strengthening the work environment of ASHAs is therefore relevant not only to worker wellbeing but also to the sustainability and effectiveness of community-based health service delivery in Karnataka.

Recommendations

Future research on ASHAs in Karnataka should address several priorities. Studies should use standardised instruments to measure work environment and job satisfaction, and consistent indicators should be developed for ASHA role performance so that findings can be compared across settings. Comparative studies should include both rural and urban ASHAs, and geographical differences across Karnataka should be examined. Further work should study how workload and digital reporting affect job satisfaction, and should evaluate the effectiveness of supportive supervision. Longitudinal designs are needed to assess changes over time, and the relationship between training and performance deserves closer examination. Qualitative research would complement these quantitative approaches by capturing ASHAs' own experiences of their working environment. Finally, moderation analysis should be used to determine whether the work environment modifies the relationship between job satisfaction and role performance.

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