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*Original Article*

# Voices From The Frontline: A Qualitative Study Of ASHA Workers' Experiences, Challenges, Expectations And Perceived Gaps In Healthcare Delivery System At Ayushman Arogya Mandir- Sub Health Centres Of Jalgaon District Of Northern Maharashtra

**Amrita Shastri[1], Mahesh Chavhan[1]*, Yogita Bavaskar[1], Girish Chavhan[2]**

[1]*Department of Community Medicine, Government Medical College, Jalgaon.*
[2]*Department of Pharmacology, Government Medical College, Akola.*

## ABSTRACT

**Background:** Accredited Social Health Activists (ASHAs) constitute the backbone of India's community-based primary healthcare system and serve as a critical link between rural communities and Ayushman Arogya Mandir- Sub-Health Centres (AAM-SHCs). Over time, their roles have expanded beyond maternal and child health to encompass non-communicable disease screening, national health programme implementation and digital reporting responsibilities. Despite their pivotal contribution, ASHAs frequently encounter operational, financial, infrastructural and supervisory challenges. Limited qualitative evidence exists from Jalgaon district of Northern Maharashtra, a region characterized by rural and tribal populations, necessitating context-specific exploration. **Aim and Objectives:** To explore the lived experiences, challenges, expectations and perceived healthcare delivery gaps among ASHA workers in Jalgaon district. The objectives were to explore work experiences, identify operational and systemic barriers, understand expectations from the health system, explore perceived service gaps at AAM-SHCs and generate recommendations for strengthening primary healthcare delivery system. **Methodology:** A qualitative study was conducted from June 2025 to July 2026 at selected AAM-SHCs in rural and tribal areas of Jalgaon district. Purposive sampling with maximum variation ensured representation across blocks and years of experience. ASHAs with at least one year of service were included. Data were collected through in-depth interviews (IDIs) and three focus group discussions (FGDs; 6–8 participants each) using a semi-structured guide. Interviews were conducted in the local language, audio-recorded with consent and supplemented by field notes. Data saturation determined the final sample of 47 participants. Transcripts were translated and analysed using manual thematic analysis. **Results:** Four major themes emerged: (1) Work experiences—highlighting expanding responsibilities, emotional burden and intrinsic commitment (2) Operational and systemic challenges—including delayed incentives, community resistance, infrastructural deficiencies, target-driven supervision and safety concerns (3) Expectations—seeking recognition, respect and (4) Perceived gaps—training inadequacies, digital literacy challenges, and a mismatch between policy expectations and ground realities. Participants described work-life imbalance, financial stress and limited authority despite high accountability. **Conclusion:** ASHAs in Jalgaon district demonstrate resilience and strong community commitment despite significant systemic constraints. Addressing incentive delays, strengthening infrastructure, ensuring supportive supervision, enhancing training, and recognizing ASHAs' contributions are critical to improving SHC functioning and primary healthcare delivery.

**Keywords**: ASHA workers, Qualitative research, AAM- Sub-Health Centres, Health system gaps.

## INTRODUCTION

Accredited Social Health Activists (ASHAs) are the backbone of community-level healthcare delivery system in India under the National Rural Health Mission (NRHM). They serve as a vital link between the community and the public health system, particularly at the level of Sub-Health Centres (SHCs), which represent the first point of contact in rural healthcare delivery system. ASHAs play a critical role in maternal and child health services, immunization, mobilization, family planning

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counselling, non-communicable disease screening, health education and implementation of various national health programmes.

Despite their pivotal contribution, ASHA workers often face operational, structural and systemic challenges at Sub-Health Centres. These challenges may influence their motivation, job satisfaction and overall effectiveness. Jalgaon district of Northern Maharashtra has diverse sociodemographic and geographic characteristics, including rural, tribal and underserved populations, which may uniquely influence ASHA workers' experiences. However, limited qualitative research has explored their lived realities in this regional context. A qualitative exploration is essential to capture in-depth insights into their experiences, perceived barriers, expectations and systemic gaps.

Understanding these perspectives can guide policymakers and administrators in improving workforce support mechanisms, strengthening Sub-Health Centre functioning and enhancing overall healthcare delivery effectiveness.

**AIM:** To explore the lived experiences, challenges, expectations and perceived healthcare delivery gaps among ASHA workers of Jalgaon district in Northern Maharashtra.

**OBJECTIVES:**

1. To explore the work experiences of ASHAs at Sub-Health Centres.
2. To identify operational and systemic challenges faced by ASHAs in delivering healthcare services.
3. To understand the expectations of ASHAs from the health system and supervisory mechanisms.
4. To explore ASHAs' perceptions regarding gaps in healthcare delivery at Sub-Health Centres.
5. To generate recommendations for strengthening primary healthcare services based on ASHAs perspectives.

**METHODOLOGY:**

This was a qualitative study designed to gain in-depth understanding of ASHA workers' experiences and perceptions. The study was conducted at selected Sub-Health Centres of Jalgaon district in Northern Maharashtra. Both rural and tribal areas were included to ensure contextual diversity. The study participants included were ASHA workers who have been actively working at Sub-Health Centres for at least one year. The study was conducted from July 2025 to August 2026.

**SAMPLING TECHNIQUE:** Purposive sampling was used to select participants to ensure representation from different blocks and service areas. Maximum variation was adopted by including ASHAs with varying years of experience.

**SAMPLE SIZE:** The number of participants were determined based on the principle of data saturation, that is, interviews were continue until no new themes emerge.

**DATA COLLECTION METHODS:**

1. In-depth interviews (IDIs)
2. Focus group discussions (FGDs)

A semi-structured, open-ended proforma was developed covering domains such as: Work roles and responsibilities, Daily challenges and barriers, Incentive and supervision issues, Community interactions, Expectations from the health system, Perceived gaps in Sub-Health Centre services.

Interviews were conducted in the local language, audio-recorded with consent. Field notes were maintained to capture non-verbal cues and contextual observations.

**ETHICAL CONSIDERATIONS:** Institutional Ethics Committee approval was obtained prior to data collection. Written informed consent was taken from all study participants. Confidentiality and anonymity were ensured by assigning codes instead of names. Participation was voluntary and participants may withdraw consent at any time.

**DATA ANALYSIS:** Data analysis was conducted using manual thematic analysis[19,24,25,26].

Audio recordings were translated into English where required. Transcripts were read multiple times to achieve familiarization. Open coding was performed to identify meaningful units of text and were grouped into broader themes.

An inductive approach was used to allow themes to emerge from the data rather than imposing predefined frameworks. Coding reliability was enhanced through peer review and cross-checking by research supervisors.

**RESULTS:**

A total of 47 ASHA workers participated in this study. 3 focus group discussions (FGDs) consisting of 6–8 participants each and In-depth interviews (IDIs) were conducted. Participants had work experience ranging from 2 to 15 years. Manual Thematic analysis was conducted. Coding was done to identify meaningful units of text. Similar codes were further organized into broader themes. 4 major themes and associated subthemes emerged.

**Themes:**

1. Work experiences of ASHAs

2. Operational and systemic challenges

3. Expectations of ASHAs

4. Perceptions regarding gaps of health care delivery system

| **Theme 1. Work experiences of ASHAs** | | |
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| **Subtheme** | **Code (No of Respondents)** | **Representative Quotes** |
| **1. Expanding Scope of Responsibilities** | Multiplicity of programme responsibilities **(32)** | Earlier our work was mostly related to mother and child health, like immunization and antenatal care, but now every new government programme is given to us, including NCD screening, TB follow-up and different surveys. All responsibilities at the village level come to ASHA, so our workload has increased a lot |
| | Lack of clearly defined work boundaries **(29)** | We are expected to be available 24 hours in the village, and people think ASHA is like a government doctor who can solve every health problem. Because of this expectation, we are always on call and under pressure |
| | Absence of fixed working hours **(27)** | We do not have any fixed duty hours like other jobs; if someone calls us at night for a delivery case or any emergency, we have to go immediately. Even during festivals or family functions, we cannot refuse because the community depends on us |
| **2. Emotional Burden and Occupational Stress** | Pressure from community and Health system **(19)** | Sometimes I feel very stressed. In our village, everyone comes to us with their problems, and the officers from the health department also keep asking for reports and targets. As an ASHA worker, it feels like both sides expect too much from me. |
| | Work-life imbalance **(30)** | After spending the whole day going door to door for surveys, immunization follow-ups, and counselling mothers, my work is still not over. When I return home, I have to cook, clean, and take care of my family. Balancing ASHA duties and household responsibilities becomes very tiring. |

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| | Mental exhaustion **(08)** | During the COVID-19 pandemic, our situation was very difficult. Many people in the village were scared and avoided us, and some even blamed us for bringing infection. That time was extremely stressful for me as an ASHA worker |
| **3. Commitment to Community and Sense of Responsibility** | Intrinsic motivation **(40)** | Sometimes the job is exhausting, but when I see families following health advice, children getting vaccinated, or mothers recovering well after childbirth, I feel that my efforts are meaningful. That satisfaction keeps me going, even on the toughest days. |
| | Community trust **(32)** | Villagers trust me, and they often call me first during an emergency. That trust makes all the hard work worthwhile, whether it is helping a sick child, assisting in a delivery, or counselling families. It feels rewarding to be someone the community can rely on at any time. |
| | Personal satisfaction **(33)** | Helping the community gives me satisfaction beyond money. Even if the incentives are small or delayed, the joy of seeing healthier families and happier children motivates me to continue my work as an ASHA worker every day |
| **Theme 2. Operational and systemic challenges** | | |
| **1. Financial Constraints and Incentive-Based Payment Structure** | Delay in payments **(12)** | Our incentive payment comes only after many months, and by that time we have already spent our own money for work-related expenses. It becomes difficult for us to manage because we do not get timely financial support. |
| | Inadequate incentives **(17)** | For the amount of work and responsibility we handle in the village, the payment we receive is very little. Sometimes we feel that our hard work and effort are not properly valued. |
| | Financial stress at household level **(13)** | Our family members often tell us that we work the whole day in the field but earn very less income. This creates pressure at home and makes us feel discouraged |
| **2. Community Resistance and Sociocultural Barriers** | Vaccine hesitancy **(24)** | Some families refuse vaccination because they are afraid the child will get fever or weakness, and sometimes they even hide the child when we come for immunization. We try to counsel them patiently, but due to myths and fear, it becomes very difficult to convince them |
| | Gender-related barriers in counselling **(31)** | During family planning counselling, many husbands do not allow their wives to speak openly or take their own decisions. Because of this, women cannot freely discuss their health concerns, and we face challenges in providing proper guidance. |
| | Influence of traditional beliefs **(23)** | In tribal villages, people first prefer to visit traditional healers and local faith practitioners, and they call us only when the condition becomes serious. By that time, the health problem is often complicated and harder to manage |

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| **3. Infrastructural Deficiencies at Sub-Health Centres** | Lack of medicines and supplies **(39)** | Many times, essential medicines are out of stock at the sub-centre, but villagers think it is our mistake and say we are not doing our duty properly. Even though supply is not in our control, we have to face their complaints and anger. |
| | Poor building condition **(12)** | We try our best to convince and motivate the community to use government health services, but the available facilities and resources are not sufficient. Without proper support and infrastructure, our efforts alone are not enough |
| | Inadequate counselling space **(25)** | There is no private space in home or at sub-centre to counsel women about sensitive issues like family planning or reproductive health. Because of lack of privacy, many women feel shy and hesitate to speak openly about their problems |
| **4. Support and Supervision Mechanisms** | Target-oriented supervision **(07)** | Supervisors mostly ask us about targets and numbers, but they rarely ask about the difficulties we face in the field. Our challenges and ground realities are often not understood. |
| | Lack of emotional support **(11)** | If we are not able to achieve the given target, we get scolded immediately, but nobody tries to understand the reasons behind it. Many times, the problem is due to community resistance or lack of facilities, not our lack of effort |
| | Infrequent review meetings **(06)** | We need proper guidance, support and encouragement from our seniors, not only checking of registers and records. Motivation and understanding will help us work better and feel respected |
| **5. Safety and Mobility Concerns** | Travel in remote areas & Night visits **(05)** | In some villages we have to walk long distances alone to reach the households. There is no proper path or street lighting, and during rains, it becomes even more difficult. Carrying medicines or supplies on foot makes the work exhausting, yet we cannot leave the families unattended |
| | Personal safety issues **(09)** | At night, when there is a delivery case, we often feel unsafe because roads are deserted and there are no streetlights. Despite our fears, we go because the mother needs help, and there is no one else available in the village. Sometimes, even wild animals or stray dogs on the way add to the worry, but duty comes first |
| **Theme 3. Expectations of ASHAs** | | |
| **Recognition and Respect** | Lack of formal recognition **(03)** | We are working at the grassroots level, visiting every household and helping people with health issues, yet our efforts hardly get recognized. People often take our work for granted, and it feels like our contribution goes unnoticed as ASHA workers. |

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| | Desire for social respect **(05)** | In official meetings with supervisors and health officials, our voice is not always heard. Even when we have important insights from field experience, decisions are made without considering our perspective, which can be frustrating. |
| | Feeling undervalued **(01)** | If the government acknowledges our efforts publicly, it really boosts our morale. Simple recognition, awards, or appreciation can make us feel that our hard work as ASHA workers is valued and motivates us to do even more |
| **Theme 4. Perceptions regarding gaps of health care delivery system** | | |
| **1. Training Gaps and Skill Development Needs** | Irregular refresher training **(23)** | We receive training only once in the beginning, but later many new updates and programmes are added to our work. For this new work, we are not always given proper training, so we feel confused and underprepared |
| | Lack of training for new programmes **(34)** | If regular refresher training and practical guidance are given, we can understand new responsibilities better and work with more confidence. Proper training will help us serve the community more effectively |
| | Need for digital literacy **(45)** | Now most of the reporting work has become online through mobile apps, but many of us are not fully comfortable using smartphones and digital platforms. Network problems in villages, app errors, phone storage issues, and lack of proper technical support make it even more difficult to upload data on time |
| **2. Expectation–Reality Mismatch** | Expectations from health administration & Gap between policy and ground reality **(03)** | Government schemes and health programs look good, but when we try to implement them at the field level, it becomes very difficult. Sometimes the supplies don't reach on time, or villagers do not understand the procedures. It feels like a gap between policy and reality, and we are the ones caught in between |
| | Mismatch between responsibilities and authority **(05)** | We are given targets to achieve, like immunizing all children or visiting every pregnant woman, but we are not provided with enough resources. Medicines, kits, or transport support are often missing, which makes it very hard to meet expectations. The pressure is there, but the tools to complete the work are not |

## DISCUSSION

This qualitative study explored the lived experiences of ASHA workers at Ayushman Arogya Mandir- Sub-Health Centres in Northern Maharashtra, highlighting an expanding workload beyond maternal and child health to include NCD screening, TB follow-up, surveys, and extensive documentation, often resulting in work overload and role strain[1,2]. Participants reported financial insecurity due to delayed and performance-based incentives, consistent with

findings from other Indian states[3,4]. Community resistance, vaccine hesitancy, and sociocultural barriers also affected service delivery, as documented in studies on ASHA–community dynamics and institutional delivery uptake[5]. Infrastructural deficiencies such as lack of medicines and counselling space further constrained effective service provision[6].

Supervision was largely target-oriented with limited supportive mentoring, echoing concerns raised in evaluations of ASHA support systems in India[7]. Participants emphasized the need for regular refresher training to cope with expanding responsibilities, aligning with evidence linking training to improved CHW performance and confidence[8]. Emotional strain and occupational stress were common due to heavy workload and community expectations[2,9]. Limited recognition, lack of career progression, and low institutional status were reported as demotivating factors in several Indian studies[3,10]. Safety concerns during field visits, particularly in remote areas, also emerged as an under-addressed issue.

Despite systemic constraints, ASHAs demonstrated strong intrinsic motivation, deriving pride and satisfaction from community service, consistent with findings on non-financial motivators among Indian CHWs[4,8]. However, a clear mismatch persists between policy expectations and field realities, particularly regarding incentives, supervision, and infrastructural support[6,7]. These findings underscore the resilience of ASHAs while highlighting the need for structural reforms to strengthen workforce support, recognition, and working conditions

## CONCLUSION

The study highlights while ASHA workers play a vital role in primary healthcare service delivery, they face multiple challenges including expanding workload, financial insecurity, infrastructural deficits, inadequate training, unsupportive supervision and safety concerns. These findings echo similar national research and underscore the need for policy interventions aimed at strengthening the ASHA programme through better incentives, structured support, training opportunities and infrastructural improvements.

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