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Burnout, motivation and job satisfaction among community health workers recruited for a depression training in Madhya Pradesh, India: a cross-sectional study

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ABSTRACT

Introduction Burnout, low motivation and poor job satisfaction among community health workers (CHWs) have negative impacts on health workers and on patients. This study aimed to characterise levels of burnout, motivation and job satisfaction in CHWs in Madhya Pradesh, India and to determine the relation between these levels and participant characteristics. This study can inform efforts to promote well-being and address stress in this population.

Methods In this cross-sectional study, we recruited participants via simple random sampling without replacement. We administered two validated questionnaires, the Copenhagen Burnout Inventory and a Motivation and Job Satisfaction Assessment, to CHWs who had enrolled in a training programme to deliver a brief psychological intervention for depression. We calculated mean scores for each questionnaire item, examined the reliability of the measures and analysed associations between participant demographic characteristics and questionnaire scores.

Results 339 CHWs completed the questionnaires. The personal burnout domain had the highest mean burnout score (41.08, 95% CI 39.52 to 42.64, scale 0–100) and 33% of participants reported moderate or greater levels of personal burnout. Items that reflected physical exhaustion had the highest item-test correlations. The organisation commitment domain had the highest mean motivation score (mean 3.34, 95% CI 3.28 to 3.40, scale 1–4). Items describing pride in CHWs' work had the highest item-test correlations. Several pairwise comparisons showed that higher education levels were associated with higher motivation levels (degree or higher vs eighth standard (p=0.0044) and 10th standard (p=0.048) and 12th standard versus eighth standard (p=0.012)). Cronbach's alpha was 0.82 for the burnout questionnaire and 0.86 for the motivation and job satisfaction questionnaire.

Conclusion CHWs report experiencing burnout and feeling physically tired and worn out. A sense of pride in their work appears to contribute to motivation. These findings can inform efforts to address burnout and implement effective task-sharing programmes in low-resource settings.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Burnout is a major problem among community health workers (CHWs), but context-specific information on burnout, motivations and job satisfaction are needed to create tailored interventions.

WHAT THIS STUDY ADDS

⇒ This group of CHWs are experiencing burnout mostly in the form of physical exhaustion and are motivated by a sense of pride and value in their work.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Interventions to reduce burnout in this group can focus on physical exhaustion and leverage feelings of pride. Future research can focus on the reasons for these findings to support policy change and intervention development.

INTRODUCTION

Burnout is prevalent among healthcare workers[1–4] and is associated with worse patient outcomes,[5 6] increased costs[7 8] and poor well-being of health workers.[9] While numerous studies have examined burnout in physicians and other allied healthcare professionals, historically there has been less research on burnout in community health workers (CHWs), especially in low- and middle-income countries (LMICs).[3] In recent years, however, evidence has been growing that burnout is also a problem for CHWs around the world.[10–17]

With the increasing reliance on moving healthcare from specialists to non-specialists (task-sharing) as an evidence-based strategy for delivering mental health services in low-resource settings,[18] CHWs may experience increased workloads and be exposed to a greater risk of burnout. CHWs are also uniquely predisposed to burnout, as they share a background with their patients and may be affected by the same structural and social challenges, and often share a stronger emotional connection with patients given their shared background.[19–21] CHWs also frequently visit patients at home and may face safety concerns in the socially vulnerable areas where their patients live.[22] The COVID-19 pandemic resulted in increased workloads for all healthcare providers as well, and studies have shown that pandemic-related stress is associated with burnout and mental health disorders in CHWs.[23–25] These factors have raised attention to the importance of understanding and preventing burnout among CHWs, who are providing an increasing amount of care.[26]

Closely linked to burnout is job satisfaction and the motivations that inspire CHWs to do their jobs. There is a strong consensus in the literature that a higher level of burnout is associated with lower job satisfaction in health workers in LMICs,[3 27–29] as well as mental healthcare workers worldwide.[30 31] Less is known about the relationship between burnout and motivation in health workers, but motivation may be an important aspect of understanding burnout and stress.[32–35]

This study explored burnout, motivations and job satisfaction in a group of Accredited Social Health Activists (ASHAs) in India. ASHAs are CHWs who are employed by the Ministry of Health and Family Welfare of state governments throughout most of India. They receive several weeks of training on basic health interventions and each ASHA serves a jurisdiction of approximately 1000 people.[36] Their primary role historically was to facilitate childhood immunisations and to accompany pregnant women to give birth in health centres.[37] However, they provide numerous other health-related services and are increasingly involved in the management of non-communicable diseases.[38] ASHAs are paid performance-based incentives for the services they provide in the community.[39 40] ASHAs are especially at risk of burnout due to caste-bias and gender-bias, hierarchy within the healthcare system, high workload, low access to resources and unstable remuneration.[11 14 37 39 41 42]

The purpose of this study was to characterise levels of burnout, motivation and job satisfaction in a group of ASHAs being trained to deliver a brief psychosocial intervention for depression in rural India. This training is the subject of randomised controlled trial (RCT) that contrasts several different levels of support for the training.[43] We also examined the association between ASHA characteristics (age, education level, designation and years of work experience) and their burnout and motivation. Understanding the burnout, motivation and job satisfaction of ASHAs and what characteristics influence these experiences is necessary to implement effective and ethical task-sharing programmes and properly support CHWs.[39 44 45] This study contributes to ongoing efforts to promote well-being and stress reduction in ASHAs in Madhya Pradesh,[46 47] and will provide setting-specific findings to inform development.

METHODS

Study site

This study was conducted in the Sehore district of Madhya Pradesh, one of India's largest and poorest states. Located in the centre of the country, it has a population of over 72 million, nearly three-quarters of whom live in rural areas.[48] The CHWs who participated in this trial work in the catchment areas of the Ashta, Budhani, Ichhawar and Nasarullaganj administrative blocks of Sehore. There are around 1250 ASHAs in the Sehore district based on the information our research team collected directly from the National Health Mission.

Study population

ASHAs and their supervisors (called ASHA facilitators) were included in this study. In addition to direct patient care, each ASHA facilitator provides supportive supervision to about 20 ASHAs and serves as the link between ASHAs at the community-level and facility-based care.[49] ASHAs can be promoted to ASHA facilitator after a certain number of years of work experience. ASHAs and ASHA facilitators are all women. Recruitment of the ASHA and ASHA facilitators in this study used simple random sampling methods. The inclusion criteria for the larger RCT[43] were: (1) status as an ASHA or ASHA facilitator; (2) aged ≥18 years; (3) minimum eighth grade education to ensure reading comprehension; and (4) willingness to complete the questionnaires.

Study design

This cross-sectional study was carried out between November 2019 and December 2020. This study reports baseline questionnaire results from the larger RCT that is described in detail elsewhere.[43] Questionnaires were obtained prior to randomisation in this cross-sectional study and thus all participant responses were included in the analyses presented in this study regardless of participants' group assignment. None of the participants had yet undergone the depression training of the RCT at the time of questionnaire administration.

Questionnaires

We conducted an informal literature search to identify questionnaires, with a focus on validated questionnaires that had been previously used in India and selected two that addressed our primary constructs of interest:

Copenhagen Burnout Inventory

This questionnaire consists of 19 items with 5-point Likert scales ranging from 'always' (100 points) to 'never' (0 points) in 25-point decrements.[50] One inversely coded

item used the opposite range of points. Lower means suggest lower levels of burnout. The questionnaire has three domains of personal, work-related and client-related burnout. We obtained a Hindi version of the questionnaire that had been used with ASHAs in Uttarakhand, India.[51] In this study, the Cronbach's alpha was 0.94.[51] The English and Hindi versions of the questionnaire are available in online supplemental materials 1; 2.

Motivation and Job Satisfaction Assessment

This questionnaire was originally developed in Kenya[52] and adapted by researchers for use with CHWs in Haryana, India.[53] It contains eight domains (general motivation, burnout, job satisfaction, intrinsic job satisfaction, organisational commitment, conscientiousness, timeliness and personal issues) distributed across 23 Likert-type items. Scores range from 1 (strongly disagree) to 4 (strongly agree), with several inversely coded statements. Higher scores indicate sources of motivation. We retained the same coding as the original study[53]; however, one statement 'I only do this job to get paid' was positively coded in the original study but could be interpreted as carrying a negative connotation. We retained the original positive coding for consistency. We obtained the English version of the questionnaire that had been used with ASHAs in India.[53] This study did not assess the validity of the questionnaire, but a prior study in a different setting found Cronbach's alpha to be 0.75 for the measure.[52] An experienced research assistant fluent in both English and Hindi translated the English questionnaire into Hindi. A team of bilingual researchers reviewed the translation for accuracy of translation and language difficulty, and the translated tool was tested in a pilot trial.[54] The English and Hindi versions of the questionnaires are available in online supplemental materials 3; 4.

Procedure

The sample selection, recruitment procedures and data collection for the larger RCT are described in more detail elsewhere.[43] Briefly, the research team compiled a list of all ASHAs from all community health centres in Sehore from the District Programme Manager, the National Health Mission and the Block Medical Officer. After screening by the eligibility criteria indicated above, this list became the sampling frame for the trial. ASHAs were selected from the sampling frame with simple random sampling without replacement, and research assistants called selected ASHAs to invite them to participate in the study. ASHAs were invited to attend an information session at their nearest community health centre, and a trained research assistant confirmed eligibility and consented ASHAs who were interested in participating. After consenting, a research assistant collected participants' socio-demographic information (including age, education and years of work experience) and then explained the instructions regarding self-administration of the remaining study questionnaires. The questionnaires were all paper-based. The research assistant remained present during the data collection to address any questions from the study participants. Completing the data collection required 30–40 min. After completion of the study questionnaires, the research assistant checked the questionnaires to ensure participants had responded to all items. All written and verbal communication with participants was in Hindi.

Data management and analysis

Data from the paper-based questionnaires were entered into REDCap (Research Electronic Data Capture) via the double-data entry method to avoid data entry errors and ensure the reliability of the study data. We checked missing data during data entry to assess for randomness. We next performed descriptive statistics to characterise the sample. We conducted exploratory analyses and computed the mean scores on each item of the questionnaires. To examine the reliability, Cronbach's alpha and item intercorrelations were calculated for each questionnaire. We also used non-parametric statistical tests to analyse the association between demographic characteristics (age, education level, designation and years of work experience) of the participants with their scores on the questionnaires, as normality assumptions did not hold. We used a Kruskal-Wallis H test and a post hoc test of Dunn with Bonferroni to adjust for multiple comparisons. The analyses were carried out using Stata V.14.[55] All statistics for which significance was relevant used a p value of 0.05.

Patient and public involvement

No patients or the public were involved in the design, conduct, choice of methods, recruitment or dissemination of this study.

RESULTS

Demographics

Table 1 details the participant demographics. There were 493 randomly selected potentially eligible ASHAs, of which 377 met eligibility criteria and were invited to participate. 340 participants elected to participate and were consented and enrolled. After consenting but

Table 1 Participant demographics (N=339)

Characteristic		
Designation N (%)	ASHA	304 (89.7)
	ASHA facilitator	35 (10.3)
Highest education completed N (%)	8th standard	100 (29.5)
	9th-10th standard	117 (34.5)
	12th standard	59 (17.4)
	Degree or higher	63 (18.6)
Age in years – mean (SD)		32.21 (5.32)
Years of work experience – mean (SD)		8.16 (3.8)

ASHA, Accredited Social Health Activists.

Table 2 Copenhagen Burnout Inventory mean scores

Domain	Question	Mean (95% CI)
Personal burnout	How often do you feel tired?	46.98 (45.05 to 48.90)
	How often are you physically exhausted?	46.53 (44.32 to 48.75)
	How often are you emotionally exhausted?	38.39 (35.75 to 41.03)
	How often do you think: 'I can't take it anymore'?	34.05 (31.17 to 36.94)
	How often do you feel worn out?	43.2 (40.87 to 45.52)
	How often do you feel weak and susceptible to illness?	37.17 (34.48 to 39.86)
	Overall domain score	**41.08 (39.52 to 42.64)**
Work-related burnout	Is your work emotionally exhausting?	26.77 (23.63 to 29.91)
	Do you feel burnt out because of your work?	24.56 (21.29 to 27.82)
	Does your work frustrate you?	23.45 (20.29 to 26.61)
	Do you feel worn out at the end of the working day?	34.37 (31.69 to 37.04)
	Are you exhausted in the morning at the thought of another day at work?	27.07 (23.79 to 30.35)
	Do you feel that every working hour is tiring for you?	25.22 (22.33 to 28.12)
	Do you have enough energy for family and friends during leisure time?*	27.88 (24.67 to 31.09)
	Overall domain score	**27.07 (25.19 to 28.94)**
Client-related burnout	Do you find it hard to work with clients?	26.47 (23.20 to 29.75)
	Do you find it frustrating to work with clients?	24.26 (21.12 to 27.40)
	Does it drain your energy to work with clients?	26.03 (22.86 to 29.21)
	Do you feel that you give more than you get back when you work with clients?	44.25 (40.40 to 48.09)
	Are you tired of working with clients?	25.59 (22.73 to 28.45)
	Do you sometimes wonder how long you will be able to continue working with clients?	45.35 (41.14 to 49.57)
	Overall domain score	**31.95 (29.83 to 34.08)**

*Inversely coded statement.

prior to data collection, one participant withdrew as they were no longer interested. All 339 of the remaining participants completed the questionnaires. As the questionnaires were paper-based, there were a few missing responses in some of the surveys. We checked these data during data entry and they were found to be random. There were so few missing responses that they had no impact on the results. As such, some survey questions had only 338 or 337 responses.

Out of the 339 ASHAs, 304 (90%) were ASHAs and 35 (10%) were ASHA facilitators. 100 participants (30%) had completed eighth standard education, 117 (34%) had completed up to 10th standard education, 59 (17%) had completed up to 12th standard education and 63 (19%) had completed a degree or higher. The age range of participants was 22–55 years with a mean age of 32.21 (SD=5.32) years, and the average amount of work experience was 8.16 years (SD=3.8).

Copenhagen Burnout Inventory

We calculated the means for all items and across the three domains of the measure in table 2. Higher means represent higher levels of burnout. The domain with the highest mean was personal burnout (41.08, 95% CI 39.52 to 42.64), suggesting that participants were physically tired and worn out. We also summarised participants' response frequency to the Copenhagen Burnout Inventory, as presented in online supplemental material 5. There were 112 ASHAs (33%) who had a mean score greater than 50 (corresponding to moderate burnout or worse) in the personal burnout domain, 32 (9.4%) who scored greater than 50 in the work-related burnout domain and 71 (20.9%) who scored greater than 50 in the client-related burnout domain.

Table 3 shows the reliability of the measure. The item-test correlation, item-rest correlation and average interitem correlations show that the items are correlated with one another. The Cronbach's alpha for individual items were not substantially different from one another, and the overall measure alpha was 0.82, indicating very good reliability.[56 57] The items 'Are you exhausted in the morning at the thought of another day at work?' and 'Do you feel that every working hour is tiring for you?' had the highest item-test correlation values, suggesting that these items are the most contributory to the construct.

Finally, we modelled the association between the score of the Copenhagen Burnout Inventory with participant characteristics (age, education, designation and years of work experience). There were no statistically significant associations.

Table 3 Baseline Copenhagen Burnout Inventory reliability table

Item	Frequency (n)	Sign	Item-test correlation	Item-rest correlation	Average interitem correlation	Cronbach's alpha
How often do you feel tired?	339	+	0.4549	0.3626	0.1955	0.8139
How often are you physically exhausted?	339	+	0.384	0.286	0.1998	0.818
How often are you emotionally exhausted?	338	+	0.5267	0.4412	0.1913	0.8098
How often do you think: 'I can't take it anymore'?	337	+	0.4844	0.3946	0.1937	0.8122
How often do you feel worn out?	338	+	0.5608	0.4797	0.189	0.8075
How often do you feel weak and susceptible to illness?	339	+	0.4397	0.3461	0.1964	0.8148
Is your work emotionally exhausting?	339	+	0.4769	0.3866	0.1942	0.8127
Do you feel burnt out because of your work?	338	+	0.4922	0.4037	0.1932	0.8117
Does your work frustrate you?	339	+	0.5494	0.4669	0.1898	0.8083
Do you feel worn out at the end of the working day?	339	+	0.5724	0.4924	0.1884	0.8069
Are you exhausted in the morning at the thought of another day at work?	338	+	0.6336	0.5617	0.1847	0.803
Do you feel that every working hour is tiring for you?	339	+	0.6018	0.5254	0.1866	0.8051
Do you have enough energy for family and friends during leisure time?	339	–	0.2983	0.1951	0.2049	0.8226
Do you find it hard to work with clients?	339	+	0.472	0.3814	0.1945	0.8129
Do you find it frustrating to work with clients?	338	+	0.507	0.4194	0.1924	0.8109
Does it drain your energy to work with clients?	339	+	0.4883	0.3992	0.1935	0.8119
Do you feel that you give more than you get back when you work with clients?	339	+	0.3696	0.2707	0.2006	0.8187
Are you tired of working with clients?	339	+	0.5505	0.468	0.1896	0.8081
Do you sometimes wonder how long you will be able to continue working with clients?	339	+	0.3722	0.2734	0.2005	0.8186
Test scale					**0.1936**	**0.8202**

Motivation and Job Satisfaction

Table 4 summarises the mean scores for the Motivations and Job Satisfaction Assessment across items and domains, and online supplemental material 6 displays the response frequency for the measure. Higher scores indicate stronger sources of motivation. The domain with the highest mean motivation score was organisation commitment (mean 3.34, 95% CI 3.28 to 3.40), and the lowest mean score was in the domain of personal issues (2.48, 95% CI 2.41 to 2.54).

The reliability of the measure is shown in table 5. Although there is some variability in the item-test correlations, item-rest correlations and average interitem correlations, the Cronbach's alpha for individual items were all quite similar. The overall measure alpha was 0.86 which indicates very good reliability.[56 57] The item-test correlations were highest for the items 'I am satisfied with the health services being provided by me' and 'I feel that the services being provided by me are essential'. The items 'This health facility really inspires me to do my very best on the job', 'I get ample opportunities for career and skill development' and 'I always complete my tasks efficiently and correctly' also had high item-test correlations. This suggests that these items contribute the most to the construct.

We analysed the association between the Motivation and Job Satisfaction Assessment and the demographic characteristics of the participants, and education was the only characteristic with a significant association. The mean motivation scores of the groups by education were: degree or higher was 24.54 (SD=0.27), 12th standard was 24.47 (SD=0.28), 10th standard was 23.66 (SD=0.26), ninth standard was 23.58 (SD=0.35) and eighth standard was 23.29 (SD=0.21). The Kruskal-Wallis H test showed that scores were statistically significantly different for the five educational groups ($\chi^2(4)=17.77$, p=0.0014) of eighth standard (n=96), ninth standard (n=45), 10th standard (n=71), 12th standard (n=59) and degree or higher (n=63). The post hoc test of Dunn test with Bonferroni correction found that the group with an education level of degree or higher had a higher mean motivation score than the eighth standard group (p=0.0044) and the 10th standard group (p=0.048), and the 12th standard group had higher mean motivation scores than the eighth standard group (p=0.012).

Table 4 Motivation and Job Satisfaction Assessment mean scores

Category	Description of item	Mean (95% CI)
General motivation	I feel motivated to work hard	3.36 (3.29 to 3.42)
	I only do this job to get paid	2.42 (2.33 to 2.51
	I do this job as it provides long-term security for me	3.14 (3.07 to 3.21)
	Overall domain score	**2.97 (2.92 to 3.02)**
Burnout	I feel emotionally drained at the end of the day*	2.33 (2.25 to 2.42)
	Sometimes when I get up in the morning, I dread having to face another day at work*	2.74 (2.64 to 2.84)
	Overall domain score	**2.54 (2.46 to 2.61)**
Job satisfaction	Overall, I am very satisfied with my job	3.28 (3.22 to 3.34)
	I am satisfied with my colleagues in my work	3.25 (3.19 to 3.31)
	I am satisfied with my supervisor	3.27 (3.21 to 3.34)
	Overall domain score	**3.27 (3.22 to 3.32)**
Intrinsic job satisfaction	I am satisfied with the health services being provided by me	3.27 (3.21 to 3.34)
	I feel that the services being provided by me are essential	3.33 (3.27 to 3.39)
	I get ample opportunities for career and skill development	3.28 (3.22 to 3.35)
	Overall domain score	**3.30 (3.24 to 3.35)**
Organisation commitment	I am proud to be working for this health facility	3.36 (3.30 to 3.42)
	I feel very committed to this health facility	3.31 (3.25 to 3.38)
	This health facility really inspires me to do my very best on the job	3.34 (3.27 to 3.41)
	Overall domain score	**3.34 (3.28 to 3.40)**
Conscientiousness and self-efficacy	I can rely on my colleagues at work	3.16 (3.09 to 3.23)
	I always complete my tasks efficiently and correctly	3.35 (3.29 to 3.41)
	I do things that need doing without being asked or told	3.03 (2.95 to 3.11)
	Overall domain score	**3.18 (3.13 to 3.23)**
Timeliness	I am punctual about coming to work	3.24 (3.17 to 3.31)
	I am often absent from work*	2.16 (2.08 to 2.24)
	It is not a problem if I sometimes come late for work/on leave	2.85 (2.77 to 2.93)
	Overall domain score	**2.75 (2.71 to 2.79)**
Personal issues	I suffer from health-related problems due to the work profile*	2.57 (2.47 to 2.66)
	I feel difficulty in doing field activities*	2.69 (2.59 to 2.78)
	My work affects my duties towards my family*	2.18 (2.09 to 2.27)
	Overall domain score	**2.48 (2.41 to 2.54)**

*Inversely coded statement.

DISCUSSION

This study measured burnout, motivation and job satisfaction among CHWs in Madhya Pradesh, India. We found that ASHAs are experiencing burnout and that pride in their work is a motivating factor. This study adds to the literature by describing these metrics and their association with demographic characteristics. These results pave the way for further research to understand the reasons for these metrics and to pilot policy and practice changes.

Our study shows that there are notable levels of burnout among this group of ASHAs, which is consistent with findings from prior studies of ASHA workers[10–13] and CHWs in LMICs.[3 15 16 58 59] Most participants in this study reported feeling burned out at least some of the time. The items describing feeling 'exhausted' and that working is 'tiring' had the highest item-test correlations. Although this cross-sectional survey cannot infer the reason for this physical fatigue, ASHAs in a recent qualitative study reported long working hours, a lack of resources and physically demanding tasks.[11] Several studies have noted that increasing workloads are a problem for CHWs[3 15 58 60] and that heavy workloads and long workdays are associated with burnout and poor job satisfaction.[13 58]

On the motivation assessment, the domain with the highest mean score was 'Organization Commitment'. The items that reflected pride and a sense of the importance of the ASHA's own work had the highest item-test correlations, and items reflecting pride in the ASHA's health centre also had high item-test correlations. This suggests that ASHAs feel proud of what they do and where they work. In a qualitative study with a similar group of ASHAs, participants described that their work

Table 5 Baseline Motivation and Job Satisfaction Assessment reliability table

Item	Frequency (n)	Sign	Item-test correlation	Item-rest correlation	Average interitem correlation	Cronbach's alpha
I feel motivated to work hard	339	+	0.553	0.4864	0.2045	0.8498
Only do this job to get paid	339	+	0.0559	−0.0323	0.2292	0.8674
I do this job as it provides long-term security for me	339	+	0.4031	0.3253	0.2121	0.8555
I feel emotionally drained at the end of the day	339	−	0.1322	0.0442	0.2253	0.8648
Sometimes when I get up in the morning, I dread having to face another day at work	338	−	0.0101	−0.0779	0.2313	0.8687
Overall, I am very satisfied with my job	339	+	0.6367	0.5793	0.2007	0.8467
I am satisfied with my colleagues in my work	338	+	0.5757	0.5117	0.2037	0.8492
I am satisfied with my supervisor	339	+	0.7277	0.6817	0.1962	0.843
I am satisfied with the health services being provided by me	339	+	0.7811	0.7426	0.1936	0.8408
I feel that the services being provided by me are essential	339	+	0.7907	0.7535	0.1931	0.8404
I get ample opportunities for career and skill development	338	+	0.7612	0.72	0.1945	0.8416
I am proud to be working for this health facility	339	+	0.7347	0.6899	0.1958	0.8427
I feel very committed to this health facility	339	+	0.7109	0.6629	0.1969	0.8436
This health facility really inspires me to do my very best on the job	339	+	0.7506	0.708	0.195	0.842
I can rely on my colleagues at work	338	+	0.5627	0.4976	0.2043	0.8496
I always complete my tasks efficiently and correctly	338	+	0.754	0.7117	0.1949	0.8419
I do things that need doing without being asked or told	338	+	0.4806	0.4082	0.2083	0.8527
I am punctual about coming to work	338	+	0.644	0.5875	0.2003	0.8464
I am often absent from work	337	−	0.2908	0.2069	0.2176	0.8595
It is not a problem if I sometimes come late for work/on leave	338	+	0.2522	0.1667	0.2195	0.8608
I suffer from health-related problems due to the work profile	338	−	0.2409	0.1551	0.22	0.8612
I feel difficulty in doing field activities	338	−	0.1594	0.0716	0.224	0.864
My work affects my duties towards my family	338	−	0.3095	0.2264	0.2167	0.8589
Test scale					**0.2077**	**0.8578**

gave them a sense of identity and pride.[11] Other studies with ASHAs[12 61] and CHWs in other LMICs[62–64] have found that many CHWs are motivated by pride and a desire to improve the lives of others. Some studies have found that increased compassion satisfaction in one's work, or a sense of value in the work, is associated with lower levels of burnout in CHWs.[19]

The results also suggest that participants feel a reasonable level of job security and career development opportunities. Poor payment, low job stability and a lack of routes for career advancement are common frustrations for CHWs around the world.[58 59 65–68] We are not able to infer from this study the reason that these ASHA workers report job security and opportunities for skill and career development. However, many CHWs around the world are employed by non-governmental organisations and funded by short-term grant funding, and so it is possible that ASHAs' position as government employees may offer more stability.

We found no associations between any demographic characteristics and levels of burnout, and a positive association between education level and motivations. The reasons for the positive association between education and motivation are unclear from this cross-sectional study and would require further investigation to elucidate. Interestingly, our study found no correlation between years of work experience and burnout or motivation/job satisfaction. Other literature has suggested that CHWs with more work experience tend to have higher levels of burnout.[13 25 69 70] Our study population was relatively young (with a mean age of 32 and a mean of 8 years of work experience) which could explain these findings.

An important strength of this study is that questionnaires had been previously validated and used in India with similar populations, and Cronbach's alpha scores in the present study were very good.[56 57] This study is limited in its cross-sectional design, and thus we cannot infer causality about reasons for burnout or motivation levels. The participants in this study may also not be a representative sample of ASHAs. Participants had volunteered to take a depression training course, so may be more motivated and less burnt out than other ASHAs. Alternatively, they may be particularly interested in mental health concerns from personal experiences.

The generalisability of these results thus may be limited. Finally, data collection occurred prior to and in the early days of the COVID-19 pandemic, and many studies, including several systematic reviews, have documented the increased levels of burnout in healthcare workers during the COVID-19 pandemic.[71–73] Burnout levels in our study population may be different now.

Future research can further explore the reasons behind ASHA burnout, motivations and job satisfaction and assess these levels in a broader group of ASHAs. Specifically, given ASHAs' position as a member of the communities that they are helping, further research can assess the effects of shared experiences and compassion satisfaction and compassion fatigue. It will also be important to continue studying burnout in post-pandemic ASHAs to understand how burnout has changed over time. Understanding the reasons for burnout, motivations and job satisfaction will be important for designing strategies to address them.

This study has important policy implications. CHWs are an essential part of the health workforce, and it is crucial to properly support them to address and prevent burnout to maintain a productive workforce. On an individual level, programmes can be created to improve CHW well-being. Digital self-help courses and mental health engagement platforms are scalable programmes with the potential to help alleviate psychological distress.[46 74] Targeted health promotion and wellness programmes designed for CHWs[47] can also be potentially impactful in addressing burnout and low motivation and low job satisfaction. Based on the importance of a sense of pride and value in their work, workplace programmes to support recognition of CHW work and knowledge could be helpful as well.[19 75] It is also vital to address upstream factors that impact CHW working conditions and well-being through policy changes, such as reducing individual workloads, implementing more supportive measures in the workplace and ensuring consistent and equitable compensation. This study is a building block for the next stage of research in the burnout field: piloting such practice changes and evaluating their impact on well-being, burnout, productivity and costs.

CONCLUSION

This study's description of burnout levels, motivation and job satisfaction among ASHAs shows that ASHAs are experiencing physical exhaustion and are motivated by pride and satisfaction in their work. These findings suggest that interventions in this group of ASHAs can focus on addressing physical exhaustion and strengthening feelings of pride. More broadly, these findings provide more specific targets for policy efforts to improve the workplace experiences of this vital, front-line workforce.

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