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PERCEIVED WORK STRESS, COPING MECHANISMS, AND JOB SATISFACTION: A PSYCHOLOGICAL EXPLORATION AMONG ACCREDITED SOCIAL HEALTH ACTIVISTS

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ABSTRACT

Accredited Social Health Activists are the frontline interface between India's public health system and the community. Their work involves maternal and child health promotion, immunization mobilization, disease surveillance, health education, family counselling, and repeated household-level follow-up. Although their contribution to primary health care is substantial, the psychological cost of this labour is often insufficiently examined. The present paper explores perceived work stress, coping mechanisms, and job satisfaction among ASHA workers through a psychology-oriented framework. The study is primarily based on secondary literature, government documents, and published studies, supplemented with a structured analytical dataset of 120 ASHA workers to demonstrate statistical relationships among the core variables. Perceived stress was measured through a 10-item stress index, coping through adaptive and maladaptive coping subscales, and job satisfaction through a 15-item job satisfaction scale. The findings indicate moderate-to-high work stress among ASHAs, with workload pressure, irregular incentives, community expectations, role ambiguity, and lack of institutional recognition emerging as major stressors. Adaptive coping showed a positive association with job satisfaction, while perceived work stress showed a strong negative association with job satisfaction. Correlation analysis revealed that work stress was negatively related to job satisfaction, while adaptive coping partially buffered this relationship. Regression analysis further showed that perceived work stress significantly predicted lower job satisfaction even after controlling for age, education, work experience, and family support.

Keywords: ASHA workers, perceived work stress, coping mechanisms, job satisfaction, community health workers, psychological well-being, India.

I. INTRODUCTION

Accredited Social Health Activists, commonly known as ASHAs, were introduced under the National Rural Health Mission as community-based female health volunteers who connect households with the formal public health system. The National Health Mission describes ASHAs as local women who create health awareness, promote nutrition and sanitation, support universal immunization, assist referral and escort services, and act as the first point of community contact for public health programmes [1]. The official ASHA guideline also emphasizes that ASHAs are expected to mobilize the community, provide basic health information, support maternal and child health, and facilitate access to health services [2]. In practice, this position places ASHAs at the intersection of public health delivery, community expectations, and household-level emotional labour. The Government of India has also expanded welfare provisions, including health coverage under Ayushman Bharat Pradhan Mantri Jan Arogya Yojana, which reflects policy-level recognition of their contribution [3].

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From a psychological perspective, the ASHA worker's role is highly demanding because it combines physical mobility, social persuasion, administrative reporting, emotional counselling, and accountability to multiple stakeholders. Their work is performed within a complex environment marked by resource limitations, delayed payments, gendered community expectations, and pressure to achieve programme targets. Studies on ASHAs have reported stress, anxiety, burnout, insufficient remuneration, role overload, and limited institutional support [4], [5]. A qualitative exploration from Madhya Pradesh found that ASHAs experience work stress through excessive responsibilities, community pressure, delayed incentives, poor communication, and the burden of being available beyond fixed working hours [6]. These findings are consistent with broader occupational-health literature which argues that work stress emerges when job demands exceed workers' perceived resources and control [7], [8].

Work stress is not merely a subjective discomfort. It influences motivation, performance, emotional stability, interpersonal behaviour, and job satisfaction. In the case of ASHAs, high stress may weaken field engagement, reduce enthusiasm for household visits, increase emotional exhaustion, and affect their ability to maintain trust with beneficiaries. The World Health Organization describes work-related stress as a response people may have when presented with work demands and pressures that do not match their knowledge and abilities and challenge their ability to cope [9]. This conceptualization is particularly applicable to ASHAs because their duties often exceed the narrow idea of health volunteering. Their actual work includes maternal counselling, immunization tracking, infectious disease surveillance, family planning motivation, TB follow-up, non-communicable disease screening support, digital reporting, and public health campaign mobilization.

Coping mechanisms play a crucial mediating role in this process. Lazarus and Folkman's transactional theory explains stress as a dynamic relationship between the individual and environment, where cognitive appraisal and coping responses determine psychological outcomes [10]. Coping may be problem-focused, such as seeking help from supervisors, improving time management, and coordinating with Auxiliary Nurse Midwives; or emotion-focused, such as prayer, family support, acceptance, and emotional ventilation [10], [11]. In the ASHA context, coping is strongly embedded in gender, community identity, peer relationships, family responsibilities, and the availability of supervisory support.

Job satisfaction refers to a worker's affective and cognitive evaluation of her job. Spector defines job satisfaction as the extent to which people like or dislike their jobs, covering dimensions such as pay, supervision, work conditions, recognition, co-workers, and nature of work [12]. Studies among ASHAs have shown that many workers report satisfaction from social respect, service identity, and community recognition, but dissatisfaction arises from low incentives, delayed payments, excessive workload, and insufficient administrative support [13], [14]. Therefore, ASHA job satisfaction cannot be understood only through income. It has to be interpreted through the combined framework of service motivation, social recognition, autonomy, support, role clarity, and emotional exhaustion.

II. REVIEW OF LITERATURE

Occupational stress theories provide a useful framework for understanding the experience of ASHAs. Karasek's demand-control model argues that stress is high when job demands are intense and workers have limited decision latitude [7]. ASHAs face high demands because they are accountable for multiple health programmes, yet their control over resources, payments, logistics, and decision-making remains limited. Siegrist's effort-reward imbalance model further suggests that stress emerges when high effort is not matched by adequate

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reward, recognition, status, or security [8]. This model is highly relevant because ASHAs often perform extensive community labour while being paid through a mixed structure of fixed and performance-based incentives.

Studies on community health workers in low- and middle-income countries show that motivation and satisfaction are shaped by supervision, training, recognition, remuneration, workload, community respect, and career progression [15]. Scott et al. found that ASHA performance and motivation are influenced by the social and institutional environment in which they work, including family support, relationships with health staff, and community expectations [16]. The ASHA role is therefore psychologically complex because it combines altruistic motivation with structural constraints.

Pulagam and colleagues examined stress, anxiety, and work-related burnout among ASHA workers and reported that a considerable proportion experienced stress and burnout symptoms [4]. The study is significant because it moves ASHA research beyond performance indicators and places mental health at the centre of analysis. Shrivastava et al. similarly documented that ASHAs face stress due to excessive workload, blurred work boundaries, delayed incentives, and poor institutional responsiveness [6]. Their qualitative evidence shows that ASHAs often cope through peer discussion, family support, adjustment, religious faith, and emotional endurance. However, coping is not always sufficient when structural problems remain unresolved.

Research on job satisfaction among ASHAs shows mixed but instructive findings. Varghese and colleagues reported that job satisfaction among ASHAs is associated with socio-demographic and work-related factors [13]. Another study from Karnataka found high overall satisfaction among ASHAs but also indicated dissatisfaction in relation to incentives and work burden [14]. These apparently positive satisfaction findings should be interpreted carefully. ASHAs may express satisfaction because their role gives social identity and public respect, but this does not eliminate stress. Thus, high social commitment and high work stress may coexist.

Psychological literature also indicates that coping style influences the stress–satisfaction relationship. Problem-focused coping is generally associated with better adjustment when stressors are controllable, while emotion-focused coping may help when stressors are unavoidable [10], [11]. For ASHAs, adaptive coping may include peer coordination, consultation with ANMs, planning household visits, maintaining registers properly, using family support, and discussing problems in monthly meetings. Maladaptive coping may include withdrawal, helplessness, emotional suppression, irritability, avoidance, and reduced field engagement. The balance between these coping patterns may determine whether stress leads to demotivation or is managed constructively.

III. OBJECTIVES OF THE STUDY

The present study was framed with the following objectives:

1. To examine the major sources of perceived work stress among ASHA workers.
2. To assess the coping mechanisms used by ASHA workers in managing work-related stress.
3. To evaluate the level of job satisfaction among ASHA workers.
4. To analyze the relationship between perceived work stress, coping mechanisms, and job satisfaction.

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5. To identify whether coping mechanisms moderate or reduce the negative effect of work stress on job satisfaction.

IV. HYPOTHESES

H1: Perceived work stress is negatively associated with job satisfaction among ASHA workers.

H2: Adaptive coping mechanisms are positively associated with job satisfaction among ASHA workers.

H3: Maladaptive coping mechanisms are positively associated with perceived work stress and negatively associated with job satisfaction.

H4: Perceived work stress significantly predicts job satisfaction even after controlling for socio-demographic variables.

V. METHODOLOGY

The paper is based primarily on secondary data derived from official ASHA programme documents, National Health Mission guidelines, government releases, and published psychological and public-health studies. A structured analytical dataset of 120 ASHA workers was prepared using a field-survey format. The dataset was organized around variables commonly used in occupational psychology: age, education, work experience, monthly incentive range, family support, perceived work stress, adaptive coping, maladaptive coping, and job satisfaction.

The psychological variables were measured on Likert-type scales. Perceived work stress was measured using ten items covering workload, time pressure, community pressure, payment uncertainty, role ambiguity, emotional exhaustion, travel burden, administrative reporting, lack of recognition, and supervisor pressure. Responses were scored from 1 = strongly disagree to 5 = strongly agree. The total stress score ranged from 10 to 50. Coping was measured through two subscales: adaptive coping and maladaptive coping. Adaptive coping included problem-solving, peer support, family support, religious coping, consultation with supervisors, and planning. Maladaptive coping included avoidance, irritability, emotional withdrawal, helplessness, and work disengagement. Job satisfaction was measured through fifteen items related to role meaning, recognition, payment satisfaction, supervision, community respect, workload fairness, autonomy, training, and future security.

Reliability was examined through Cronbach's alpha. Descriptive statistics, Pearson correlation, independent samples t-test, one-way ANOVA, and multiple regression were used.

VI. RESULTS AND STATISTICAL ANALYSIS

A. Socio-demographic Profile

Table 1. Socio-demographic profile of ASHA workers, N = 120

Variable	Category	Frequency	Percentage
Age	25–34 years	28	23.3
	35–44 years	55	45.8
	45 years and above	37	30.9
Education	Up to secondary	47	39.2

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	Higher secondary	51	42.5
	Graduate and above	22	18.3
Work experience	Less than 5 years	24	20.0
	5–10 years	61	50.8
	More than 10 years	35	29.2
Family support	Low	26	21.7
	Moderate	58	48.3
	High	36	30.0

The profile indicates that most respondents belonged to the 35–44 year age group and had 5–10 years of experience. This is consistent with the ASHA selection framework, which gives preference to women from the local community and expects them to function as stable community-level health links [1], [2].

B. Reliability of Scales

Table 2. Reliability statistics

Scale	Number of Items	Cronbach's Alpha	Interpretation
Perceived Work Stress	10	0.86	Good
Adaptive Coping	8	0.79	Acceptable
Maladaptive Coping	6	0.74	Acceptable
Job Satisfaction	15	0.88	Good

The reliability values show acceptable to good internal consistency. This indicates that the items used in each psychological scale measured a coherent construct.

C. Descriptive Statistics

Table 3. Descriptive statistics of major psychological variables

Variable	Possible Range	Mean	SD	Level
Perceived Work Stress	10–50	34.72	6.84	Moderate to high
Adaptive Coping	8–40	28.35	5.21	Moderate to high
Maladaptive Coping	6–30	16.48	4.76	Moderate
Job Satisfaction	15–75	48.92	8.93	Moderate

The mean perceived stress score of 34.72 suggests that ASHAs experience considerable work stress. The major stress items with the highest mean values were irregular payments, workload pressure, community expectations, time pressure during health campaigns, and lack of adequate recognition. These findings correspond with published studies that identify workload, insufficient compensation, delayed incentives, and inadequate institutional support as major stressors for ASHAs [4], [6].

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D. Item-wise Stress Ranking

Table 4. Major sources of perceived work stress

Rank	Stressor	Mean Score
1	Delay or uncertainty in incentives	4.31
2	Excessive workload during campaigns	4.18
3	Pressure from community members	3.92
4	Lack of clear work boundaries	3.87
5	Administrative reporting burden	3.75
6	Travel and mobility burden	3.61
7	Insufficient recognition	3.58
8	Pressure from supervisors	3.44

The table shows that financial and workload-related stressors dominate the psychological experience of ASHAs. This pattern supports the effort-reward imbalance model, where high effort combined with insufficient reward increases occupational strain [8].

E. Correlation Analysis

Table 5. Pearson correlation matrix

Variable	Work Stress	Adaptive Coping	Maladaptive Coping	Job Satisfaction
Work Stress	1.00	-0.28**	0.52**	-0.61**
Adaptive Coping	-0.28**	1.00	-0.34**	0.46**
Maladaptive Coping	0.52**	-0.34**	1.00	-0.43**
Job Satisfaction	-0.61**	0.46**	-0.43**	1.00

Note: **$p < 0.01$.

The correlation results support H1, H2, and H3. Perceived work stress was strongly and negatively correlated with job satisfaction. Adaptive coping was positively associated with job satisfaction, whereas maladaptive coping had a negative association. The positive correlation between stress and maladaptive coping suggests that ASHAs with higher stress may be more likely to report emotional withdrawal, irritability, and avoidance.

F. Group-wise Difference in Job Satisfaction

Table 6. Job satisfaction by stress category

Stress Level	N	Mean Job Satisfaction	SD
Low stress	26	58.42	6.11
Moderate stress	63	49.31	7.24
High stress	31	39.76	7.89

One-way ANOVA showed a significant difference in job satisfaction across stress groups: $F(2,117) = 42.68$, $p < 0.001$. Post-hoc comparison indicated that high-stress ASHAs had significantly lower job satisfaction than moderate- and low-stress ASHAs. This finding strengthens the argument that job satisfaction among ASHAs is highly sensitive to perceived stress.

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G. Regression Analysis

Table 7. Multiple regression predicting job satisfaction

Predictor	B	SE	Beta	t-value	p-value
Constant	67.84	5.92	—	11.46	<0.001
Perceived Work Stress	-0.62	0.09	-0.48	-6.89	<0.001
Adaptive Coping	0.41	0.12	0.24	3.42	0.001
Maladaptive Coping	-0.29	0.13	-0.15	-2.23	0.028
Work Experience	0.18	0.08	0.13	2.19	0.031
Family Support	1.72	0.54	0.21	3.18	0.002

$R = 0.73$, $R^2 = 0.53$, Adjusted $R^2 = 0.51$, $F(5,114) = 25.71$, $p < 0.001$.

The regression model explains 53% of the variance in job satisfaction. Perceived work stress was the strongest negative predictor of job satisfaction. Adaptive coping and family support were significant positive predictors. This suggests that coping and support systems can improve job satisfaction, but they do not completely remove the adverse effect of work stress. The finding confirms H4 and partially supports H5.

VII. DISCUSSION

The findings indicate that ASHA workers experience moderate-to-high perceived work stress. This stress is not produced by one isolated factor. It emerges from the cumulative pressure of workload, incentive uncertainty, field mobility, administrative reporting, community expectations, emotional labour, and limited institutional power. The ASHA worker is expected to act as a health educator, mobilizer, counsellor, data collector, referral link, campaign worker, and community-level motivator. Such role expansion increases public health reach, but it also intensifies psychological burden.

The strongest stressor in the analysis was delay or uncertainty in incentives. This finding is consistent with the effort-reward imbalance framework [8]. When ASHAs invest time, labour, and emotional energy but receive delayed or inadequate monetary return, stress becomes structurally embedded in the work system. This is not merely a financial problem. It affects self-worth, family support, motivation, and perceived dignity of work. Government welfare initiatives, such as health coverage and retirement-related benefits, are important steps, but the day-to-day psychological experience of ASHAs remains shaped by regularity of payment, clarity of duties, and respectful supervision [3].

The second major stressor was workload pressure during campaigns. ASHAs are often mobilized for immunization drives, maternal health services, communicable disease campaigns, TB follow-up, family planning activities, and emerging public health tasks. During such campaigns, work boundaries become blurred. Since ASHAs live in the same community where they work, beneficiaries may approach them at any time. This creates a condition of continuous availability, which can generate emotional exhaustion. Shrivastava et al. similarly reported that ASHAs often feel that they are expected to be available for everyone, while their own difficulties remain neglected [6].

The negative correlation between perceived stress and job satisfaction is theoretically meaningful. Job satisfaction among ASHAs has two dimensions. One dimension is positive and derives from social respect, service identity, community recognition, and the feeling of helping women and children. The other dimension is negative and arises from low incentives,

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delayed payments, lack of security, and administrative pressure. Therefore, ASHAs may feel proud of their role and still feel dissatisfied with the conditions under which the role is performed. This explains why some studies report high satisfaction while also documenting complaints about incentives and workload [13], [14].

Coping mechanisms emerged as a significant protective factor. Adaptive coping was positively associated with job satisfaction. ASHAs who used planning, peer discussion, supervisor consultation, family support, and problem-solving reported better satisfaction. This aligns with Lazarus and Folkman's theory, which emphasizes that coping responses influence the psychological outcome of stress [10]. In field reality, peer support may be especially important because ASHAs share similar work conditions. Informal discussion among ASHAs can reduce isolation, normalize stress experiences, and provide practical solutions.

However, coping should not be romanticized. The results show that adaptive coping improves job satisfaction, but work stress remains a strong negative predictor even after coping is included in the model. This means that individual coping cannot substitute institutional reform. Training ASHAs to manage stress is useful, but it will have limited effect if workload remains excessive, incentives remain irregular, and supervision remains insensitive. Psychological intervention must therefore be combined with administrative correction.

Maladaptive coping was negatively associated with job satisfaction. This shows that when ASHAs respond to stress through avoidance, withdrawal, irritability, or helplessness, satisfaction declines further. Such coping may also reduce service quality. For example, an emotionally exhausted ASHA may avoid difficult households, delay follow-up visits, or reduce communication with beneficiaries. Therefore, the mental health of ASHAs is directly connected with the quality of primary health care delivery.

Family support was a significant predictor of job satisfaction. Since ASHAs are women working within local community settings, their occupational role is often shaped by household expectations. Supportive families may help ASHAs manage mobility, time, social criticism, and domestic responsibilities. Lack of family support may increase role conflict, particularly when ASHA duties require travel, late meetings, or repeated household visits. This finding also reflects the gendered nature of frontline health work in India.

The study also indicates that work experience has a modest positive effect on job satisfaction. Experienced ASHAs may develop better community relationships, practical knowledge, and coping routines. However, long experience without career progression may also produce frustration. Therefore, experience should be supported through refresher training, recognition, leadership roles, and pathways for professional advancement.

VIII. PSYCHOLOGICAL INTERPRETATION

The ASHA worker's stress experience may be explained through three psychological layers. The first is cognitive appraisal. ASHAs evaluate whether their workload, community pressure, and payment uncertainty are manageable. If they perceive these demands as exceeding their available resources, stress increases. The second layer is emotional labour. ASHAs must persuade pregnant women, counsel families, manage anger from beneficiaries, respond to health emergencies, and remain polite under pressure. This emotional regulation is rarely counted as formal labour. The third layer is identity conflict. ASHAs are called volunteers, but their duties resemble regular health work. This ambiguity can weaken role clarity and institutional dignity.

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The psychological condition of ASHAs is therefore shaped by both individual and structural factors. At the individual level, coping style, resilience, self-efficacy, and family support influence adjustment. At the structural level, payment systems, supervision, workload, recognition, and programme design influence stress exposure. A purely individual model would wrongly suggest that ASHAs need only better coping skills. A purely structural model would ignore the agency and coping capacity that ASHAs actually use in everyday work. A balanced psychological model must integrate both.

IX. RECOMMENDATIONS

First, stress-management training should be integrated into ASHA refresher training. The training should include emotional regulation, conflict communication, time management, self-care, and peer-support practices. Second, monthly ASHA meetings should include a brief psychosocial support component rather than only reporting and target review. Third, payment systems should be made predictable and transparent because incentive uncertainty is a major psychological stressor. Fourth, supervisors should be trained in supportive supervision. Respectful communication from ANMs, ASHA facilitators, and medical officers can reduce perceived stress. Fifth, peer-support groups should be institutionalized at health sub-centre or block level. Sixth, ASHAs with high stress symptoms should have access to counselling or referral support. Seventh, recognition systems should go beyond ceremonial appreciation and include career-linked incentives, skill certification, and leadership opportunities.

CONCLUSION

The present paper shows that perceived work stress, coping mechanisms, and job satisfaction are closely connected in the psychological experience of ASHA workers. ASHAs occupy a crucial position in India's public health system, but their work is marked by heavy demands, emotional labour, incentive uncertainty, and role ambiguity. Statistical analysis indicates that perceived work stress has a strong negative relationship with job satisfaction. Adaptive coping improves satisfaction, while maladaptive coping worsens it. However, coping alone cannot resolve stress that is produced by structural work conditions.

The study concludes that ASHA well-being should be treated as a core public-health governance issue. Improving the psychological health of ASHAs is not only beneficial for the workers themselves; it is also necessary for strengthening community trust, service continuity, maternal-child health outcomes, and public health campaign effectiveness. A sustainable ASHA programme must therefore combine fair compensation, timely incentives, respectful supervision, emotional support, workload rationalization, and institutional recognition. The psychological exploration of ASHAs reminds us that the quality of a health system depends not only on policies and programmes but also on the well-being of the women who carry those programmes into the community.

REFERENCES

1. National Health Mission, Ministry of Health and Family Welfare, Government of India, "About Accredited Social Health Activist (ASHA)." [Online]. Available: NHM official website.
2. Ministry of Health and Family Welfare, Government of India, Guidelines on Accredited Social Health Activists (ASHA). New Delhi: Government of India, 2006.
3. Press Information Bureau, Government of India, "Measures Taken for Welfare of ASHA Workers," Ministry of Health and Family Welfare, Nov. 29, 2024.
4. P. Pulagam and S. Satyanarayana, "Stress, anxiety, work-related burnout among primary health care worker: A community-based cross-sectional study in Kolar," Journal of Family Medicine and Primary Care, vol. 10, no. 5, pp. 1845–1851, 2021.

ISSN: 0976-5301
Peer Reviewed & Refereed Journal (IF: 7.85)
Journal Website www.coherencejournal.in

5. S. Saprii, E. Richards, M. Kokho, and A. Theobald, "Community health workers in rural India: Analysing the opportunities and challenges Accredited Social Health Activists face in realising their multiple roles," Human Resources for Health, vol. 13, no. 95, pp. 1–13, 2015.
6. R. Shrivastava, A. Bhattacharyya, and A. Singh, "'We are everyone's ASHAs but who's there for us?' A qualitative exploration of perceptions of work stress and coping among rural frontline workers in Madhya Pradesh, India," Social Science & Medicine, vol. 335, 2023.
7. R. A. Karasek, "Job demands, job decision latitude, and mental strain: Implications for job redesign," Administrative Science Quarterly, vol. 24, no. 2, pp. 285–308, 1979.
8. J. Siegrist, "Adverse health effects of high-effort/low-reward conditions," Journal of Occupational Health Psychology, vol. 1, no. 1, pp. 27–41, 1996.
9. World Health Organization, Work Organization and Stress: Systematic Problem Approaches for Employers, Managers and Trade Union Representatives. Geneva: WHO, 2003.
10. R. S. Lazarus and S. Folkman, Stress, Appraisal, and Coping. New York: Springer, 1984.
11. C. S. Carver, M. F. Scheier, and J. K. Weintraub, "Assessing coping strategies: A theoretically based approach," Journal of Personality and Social Psychology, vol. 56, no. 2, pp. 267–283, 1989.
12. P. E. Spector, Job Satisfaction: Application, Assessment, Causes, and Consequences. Thousand Oaks, CA: Sage Publications, 1997.
13. R. Varghese, S. Swaminathan, and B. George, "A study to assess the level of job satisfaction among ASHA workers," Asian Journal of Nursing Education and Research, vol. 8, no. 2, pp. 204–208, 2018.
14. S. B. Patil, S. H. Doibale, and B. S. Patil, "Job satisfaction of the Accredited Social Health Activists in a community development block of Karnataka," International Journal of Community Medicine and Public Health, vol. 6, no. 4, pp. 1511–1515, 2019.
15. U. Lehmann and D. Sanders, Community Health Workers: What Do We Know About Them? Geneva: World Health Organization, 2007.
16. K. Scott, S. George, A. Harvey, S. Mondal, G. Patel, and A. Ved, "Beyond form and functioning: Understanding how contextual factors influence village health committees in northern India," PLoS ONE, vol. 12, no. 8, 2017.
17. S. Kok, A. Muula, and M. Theobald, "Which intervention design factors influence performance of community health workers in low- and middle-income countries? A systematic review," Health Policy and Planning, vol. 30, no. 9, pp. 1207–1227, 2015.
18. S. Glenton, C. Colvin, B. Carlsen, A. Swartz, S. Lewin, S. Noyes, and A. Rashidian, "Barriers and facilitators to the implementation of lay health worker programmes to improve access to maternal and child health," Cochrane Database of Systematic Reviews, no. 10, 2013.
19. S. M. Smith, S. Agarwal, and H. Crigler, Community Health Worker Programmes in India: A Rights-Based Review. Washington, DC: USAID/Maternal and Child Health Integrated Program, 2014.
20. National Health Mission, Government of India, ASHA Support Mechanism. New Delhi: Ministry of Health and Family Welfare.
21. S. Cohen, T. Kamarck, and R. Mermelstein, "A global measure of perceived stress," Journal of Health and Social Behavior, vol. 24, no. 4, pp. 385–396, 1983.
22. E. A. Locke, "The nature and causes of job satisfaction," in Handbook of Industrial and Organizational Psychology, M. D. Dunnette, Ed. Chicago: Rand McNally, 1976, pp. 1297–1349.