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Original Research Article

A cross sectional study on the influence of stress and burnout on the quality of life of accredited social health activists (ASHA) in Telangana

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Abstract

Background: Accredited Social Health Activists (ASHA) workers, as the linchpins of India's public healthcare system, play a pivotal role in addressing the healthcare needs of under-served communities. However, their responsibilities are accompanied by substantial stressors, potentially leading to burnout—a phenomenon that remains under-explored in the context of ASHA workers. This article examines the intricate relationship between stress, burnout, and the quality of life of ASHA workers.

Objectives of the Study: This study aims to assess the quality of life of ASHA workers, exploring the influence of stress and burnout on the quality of life of ASHA workers and to investigate the socioeconomic factors contributing to stress and burnout among ASHA workers.

Methodology: The study sample included 80 ASHA workers from Ankoli PHC, Adilabad District, Telangana. Multistage cluster sampling method was applied. Mixed-methods approach was utilised, using structured surveys and interviews. Required permissions and informed consent were taken for the study. After obtaining all the scores data is analysed using SAS Version 9.4.

Findings: Stress has a negative correlation with quality of life in all four domains, with the correlation coefficients, ranging from -0.04893 to -0.267. Burnout has a negative correlation with quality of life in all four domains with the correlation coefficients ranging from -0.327 to -0.547. The mean stress score for ASHA workers is 70.5, which indicates a moderate level of stress. The mean values of Burnout for client related burnout is 19, work related burnout is 33 and personal burnout is 38. The mean values for Quality of life for physical health is 82.7, for Psychological health is 77.2, for Social relationships is 77.7 and for environment is 60.9.

Conclusion: Correlation between burnout and quality of life in the four domains is negative, which means that as the level of burnout increases, the quality of life of ASHA workers decreases in terms of Physical health, Psychological health, Social relationships, and Environment. There is a negative correlation between the stress and quality of life of ASHA workers, but the strength of the relationship is not very strong.

Keywords: Stress, Burnout, Quality of life, ASHA workers.

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1. Introduction

Accredited social health activists are crucial for providing healthcare in rural areas. They have been recognized by the World Health Organisation and received the Director-General's Health Leaders Award at the 75th World Health Assembly in 2022 for their exceptional contributions to promoting and improving health. The ASHA program, now part of the National Health Mission, plays a significant role in managing chronic diseases, facilitating data collection at village/ward level, and responding effectively to public health crises.[1,2] ASHA workers now play a crucial role at Ayushman Bharat - Health and Wellness Centers, with expanded responsibilities covering various healthcare services including oral care, eye care, emergency care, ENT care, mental health support for expecting and new mothers, elderly healthcare services, and palliative care (Annual ASHA update 2020-21).[3]

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However, alongside their valuable contributions, ASHA workers face challenges and pressure due to workload, limited incentives, and job security concerns, leading to stress and burnout.[4] Currently, ASHA workers often work more than 8 hours a day, frequently leads to feelings of fatigue and exhaustion.[5] The combination of training, meetings, travel to remote areas, and extra responsibilities has led to feeling overworked.[6] The addition of extra tasks like screening for oral cancers, efforts to combat open defecation, data gathering for surveys, and voter registration drives can lead to stress.[9] ASHA workers face challenges in collecting uncompensated sputum samples, as there are no specific incentives for this task. Incentives are only given upon successful completion of the treatment program protocol.[8] Certain ASHA workers expressed a higher susceptibility to illness and shared concerns about the impact it has had on their overall health.[10] ASHA workers face challenges with commuting during emergencies due to the need to pay out of pocket for autorickshaw rentals and uneven population distribution, which increases travel time. Access to Android mobile phones and lack of necessary technical skills also pose difficulties for them.[11]

Workplace stress is defined as a change in physical or mental state due to a challenging environment, influenced by factors like heavy workload and difficult relationships. Burnout, resulting from long-term exposure to chronic stressors, can lead to increased absenteeism and employee turnover. Employee stress significantly affects the quality of work and individual productivity. WHO defines Quality of Life as "individuals' understanding of their position in life in relation to the value systems and culture in which they live and in relation to their goals, expectations, standards and concerns." Quality of life is a key indicator of health, encompassing physical and mental well-being, independence, social connections, living environment, and acceptance of the illness. Employment can positively impact mental health, but a negative work environment can lead to well-being concerns.

Research on stress and burnout in healthcare professions is well-documented, but there is a lack of exploration into how these factors impact the quality of life for ASHA workers. Our study aims to fill this gap by examining the complex connections between stress, burnout, and the quality of life of ASHA workers. The study assesses the quality of life among ASHA workers, exploring the influence of stress and burnout. It also aims to uncover socioeconomic factors contributing to work-related stress and burnout in this group. Findings will enhance understanding of challenges faced by Accredited Social Health Activists, informing potential interventions for addressing their well-being.

2. Materials and Methods

The study aims to explore the relationship between stress, burnout, and quality of life among Accredited Social Health Activists. The current study is a community-based cross-sectional investigation conducted over 3 months from April 2023 to June 2023 in Adilabad, Telangana, India. It is a mixed-method study utilizing both quantitative and qualitative data collection methods to explore stress levels, burnout rates, and quality of life among ASHA workers. Quantitative data was gathered through self-administered questionnaires including the measurement of the Quality of life of ASHA workers using the WHO QoL-BREF Scale, the measurement of Stress using Cohen's Perceived Stress Scale and Burnout using Copenhagan's Burnout inventory.[12,14] Qualitative study was done by in depth interviews with a subset of participants to obtain deeper insights into their experiences and perceptions regarding these factors. A Multi-stage cluster sampling techniques is used involving all the 80 ASHA workers in Ankoli PHC of Adilabad district in Telangana state.

The perceived stress scale is a self-reported questionnaire that was designed to measure "the degree to which individuals appraise situations in their lives as stressful".[13] The revised version known as PSS-10 was used for the study which is a 5-point Likert scale and measures the degree to which situations in one's life are appraised to be stressful. Many studies have shown that the PSS-10 demonstrates adequate internal consistency with Cronbach's alpha coefficients ranging from 0.67 to 0.91 in various samples. The Copenhagan's Burnout Inventory differentiates between three types of exhaustion: personal burnout, client-related burnout, and work-related burnout.

The content validity index (CVI) values ranged from 0.83 to 1.00, indicating good content validity. The internal consistency of the questionnaire was assessed using Cronbach's alpha coefficients, which ranged from 0.79 to 0.90, indicating good reliability for the three CBI scales. The intraclass correlation coefficients (ICC) were high, ranging from 0.80 to 0.91, indicating good test-retest reliability. The WHOQOL-BREF is a 26-item questionnaire developed from the original 100-item questionnaire, the WHOQOL-100. The Cronbach's alpha values for the WHOQOL-BREF domains were Physical health: 0.82, Psychological health: 0.81, Social relationships: 0.68, and Environment: 0.80 with higher values indicating good reliability.[15]

In the first stage, ASHA workers from Adilabad District in Telangana were chosen from a list provided by the District Health Office. Adilabad was selected as one of the Aspirational districts in Telangana, included in a program initiated by the Prime Minister of India in January 2018. For the second stage of the study, Adilabad Mandal was selected from the 18 Mandals and serves as an important urban centre within the district. A primary healthcare centre within the Adilabad District was randomly chosen and Ankoli Primary Healthcare Centre was selected as the study site. The study included ASHA workers from Ankoli PHC who met specific eligibility criteria, including being registered for at least six

months and providing informed consent. Participants with pre-existing mental health abnormalities were excluded from the study. All the ASHA workers under Ankoli PHC were included in the sample according to the criteria and the sample size was 80 (n=80). Before conducting the study, necessary permissions were obtained from the District Medical and Health Officer and the respective authorities. Informed consent was taken from all participants with an assurance of confidentiality and anonymity. Purposive sampling was used to select ASHA workers for a qualitative study, with participants chosen to represent diverse geographic regions, demographic backgrounds, and levels of experience. For an in-depth interview phase at PHC of Ankoli, five ASHA workers were ultimately chosen as study participants.

For quantitative study collected data is entered into an Excel sheet. Mean score of the attribute was used to fill the missing values. Scores were calculated according to the procedures indicated in the respective tools. After obtaining all the scores Data is analysed using SAS Version 9. The frequency count was obtained using the FREQ function. To obtain these statistical values (P value, F value), the T TEST and ANOVA procedures were used. Pearson correlation coefficient is used to obtain correlation between Quality of life with stress and quality of life with burnout. To visually depict the relationship between quality of life, stress, and burnout in an online plot, the SGPLOT procedure was used. Telephonic interviews were done for qualitative study with the selected ASHAs and their responses were recorded. They were assured of confidentiality and anonymity of their responses.

3. Results

Table 1 projects the distribution of study participants according to their socio-economic profile and work-related status. The **Table 1** shows a majority of participants fall under the age range of 35-50 years, that is up to 73.75% of the total participants, while 20% of the participants fall into <35 age group and only 1.25% of the participants are above 50 years old.

1. 67.5% of the participants belong to a nuclear family, while 32.5% belong to a joint family.
2. 80% of the participants have a family income between 5000-10000/-, while only 20% have a family income between 10000-20000/-.
3. 72.5% of the participants were allotted only one village, while 27.5% were allotted two or more villages.
4. 77.5% of the participants are married, while only 1.25% are unmarried. 17.5% of the participants are widows, and 3.75% are separated from their husband.
5. 43.75% of the participants have completed secondary education, while 38.75% have completed primary education. Only 17.5% have completed higher education.
6. 82.5% of the participants are not suffering from any sickness at present, while 17.5% are suffering from sickness.

Table 2 provides the distribution of study participants according to variables and stress. The variables included in the table are marital status, economic status, number of villages allotted, suffering with sickness at present, and education. The **Table 2** shows the mean stress scores for each category of each variable, as well as the F value and p value for each variable. For marital status, the mean stress score was highest for participants who were widowed or separated from their husband (22.06), followed by unmarried participants (20.00) and married participants (20.15). However, the difference in mean stress scores between these groups was not statistically significant ($p > 0.05$).

While study by Celmece et al., found that married healthcare professionals exhibited significantly higher mean scores of stress, anxiety, and burnout compared to their single counterparts.[17] For economic status, has slightly higher stress higher for participants with an income of 10,000-20,000 rupees per month (22.00) compared to those with an income of 5,000-10,000 rupees per month (20.19). However, this difference was not statistically significant ($p > 0.05$). For the number of villages allotted, participants who were allotted two or more villages had a slightly higher mean stress score (21.27) compared to those allotted only one village (20.28). This difference was statistically significant ($p < 0.05$). This findings align with the previous study[4] that increased workload leads to higher stress levels. For suffering with sickness at present, participants who reported currently suffering from sickness had a slightly higher mean stress score (20.64) compared to those who did not report any sickness (20.53). However, this difference was not statistically significant ($p > 0.05$). For education, there was no significant difference in mean stress scores between participants with higher education, primary education, or secondary education ($p > 0.05$).

Table 3 provides the distribution of participants according to their variables and burnout. The burnout domains included in the table are personal burnout, work-related burnout, and client-related burnout. The independent variables included in the table are marital status, economic status, number of villages allotted, and education. The table shows mean burnout scores for each category of variables, as well as the F value and p value for each variable. These findings align with the previous study by P Pulagam et al[5] that about one-fourth of the participants experienced personal burnout, while a similar proportion reported work-related burnout. Moreover, a small percentage experienced client-related burnout at moderate levels. The study found that workplace stress is a significant problem among primary healthcare workers, and it can have negative effects on their mental health and job performance. For marital status, married participants had the highest mean scores for personal

burnout (40.99) and work-related burnout (34.74), followed by participants who were widowed or separated from their husband. However, the difference in mean scores between these groups was only statistically significant for personal burnout ($p< 0.05$). Unmarried participants had the highest mean score for client-related burnout (16.67), but this group has only one participant, so the result cannot be interpreted. For economic status, there was no significant difference in mean burnout scores between participants with an income of 5,000-10,000 rupees per month and those with an income of 10,000-20,000 rupees per month ($p > 0.05$).

For the number of villages allotted, there was no significant difference in mean burnout scores between participants allotted one village and those allotted two or more villages ($p > 0.05$). For education, there was no significant difference in mean burnout scores between participants with higher education, primary education, or secondary education ($p > 0.05$).

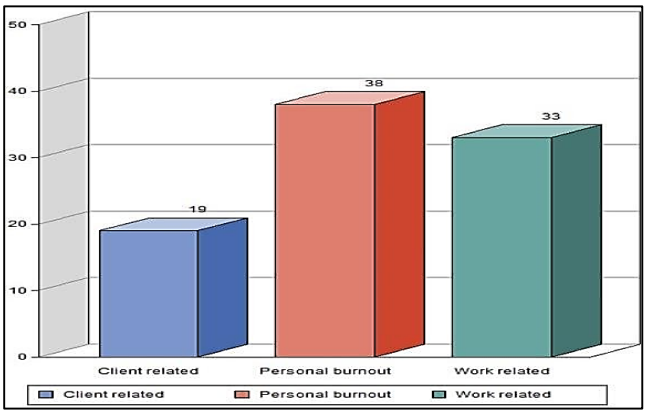

Figure 1: Brunouts individual means

Figure 1 represents the mean values of burnout. The mean value of client related burnout is 19, The mean value of personal burnout is 38 and the mean value of work related burnout is 33.

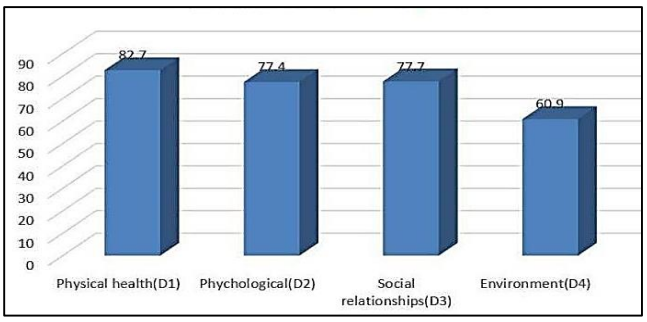

Figure 2: Mean values for quality of life

Results from the WHOQOL-BREF (**Figure 2**) conducted among 80 ASHAs domain-wise analysis revealed that higher scores were seen in 'Physical health' followed by 'Social relationships' and 'Psychological' domain among all the respondents, and the lowest score was seen in the 'Environmental' domain. There is very little difference between the three domains. These findings align with the previous study by Manjunath et al.,[4] in which Socialrelationships domain had the highest score followed by Psychological and Physical. Another study by Bullappa et al., showed that among the various domains of quality of life, the ASHA workers had higher mean scores in the social domain, followed by the physical, environmental and psychological domains.[20]

The mean overall Quality of life is 3.2625 suggesting an average to slightly above average quality of life overall. **Figure 3** shows 26% of the study sample had very good quality of life, 15% with good Quality of life, 47% with little better Quality of life, 11% with average Quality of life, and only 1% with very poor Quality of life. This indicates that more than 88%of the study population had above average quality of life.

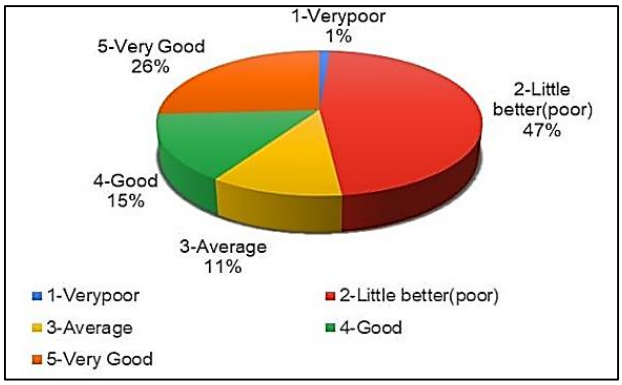

Figure 3: Quality of life

Table 4 shows the correlation between stress, burnout, and quality of life of ASHA workers in four domains: Physical health, Psychological health, Social relationships, and Environment. The Pearson correlation coefficients indicate the strength and direction of the correlation between each variable and quality of life.

The table shows that stress has a negative correlation with quality of life in all three domains, but the correlation coefficients are weak, ranging from -0.04893 to -0.267. This suggests that there is a negative relationship between stress and quality of life of ASHA workers, but the strength of the relationship is not very strong. Burnout also has a negative correlation with quality of life in all four domains, and the correlation coefficients are stronger than those for stress, ranging from -0.327 to -0.547.

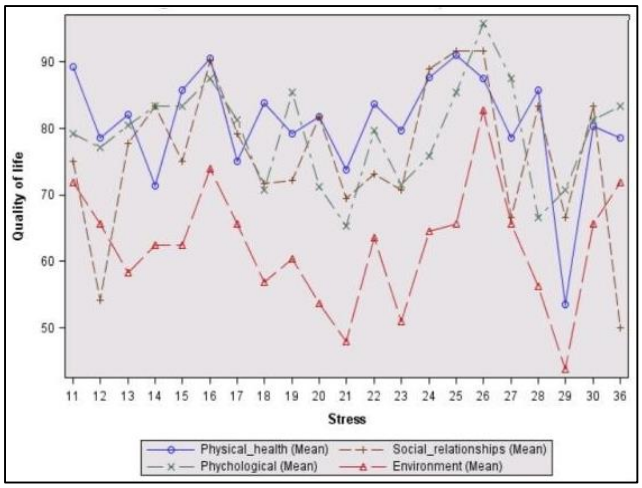

Figure 4: Influence of stress on the quality of life of ASHA

Figure 4 shows the influence of stress on the quality of life of ASHA workers. The table presents the mean scores for stress and quality of life, as well as the standard deviation for stress. The mean stress score for ASHA workers is 70.5, which indicates a moderate level of stress. The mean quality of life score is 26.5, which is relatively low. The table also shows that there is a negative correlation between stress and quality of life, as indicated by the negative coefficient (-0.56) in the correlation column (**Table 4**). This suggests that as stress levels increase, quality of life decreases. The p-value for this correlation is less than 0.05, which indicates that this correlation is statistically significant. Therefore, we can conclude that stress has a significant negative influence on the quality of life of ASHA workers.

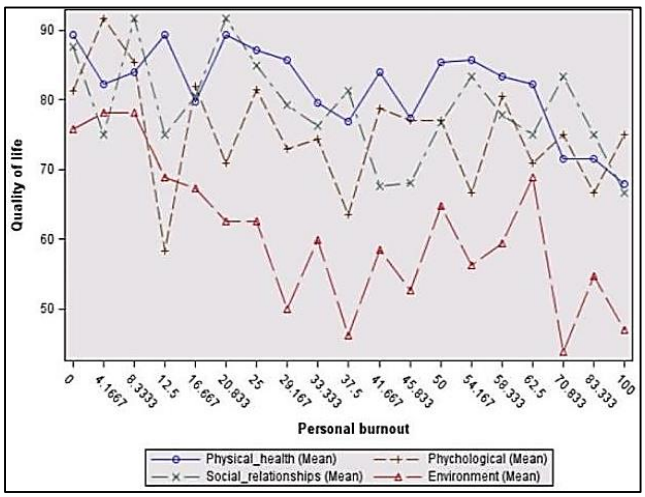

Figure 5: Influence of personal burnout on the quality of life of ASHA

Figure 5 projects the influence of personal burnout on the quality of life of ASHA workers in four domains: Physical health, psychological health, social relationships, and environment. The mean scores for each domain decrease as the level of personal burnout increases. For example, when personal burnout is at 90, the mean score for physical health is 62.57, which is lower than the mean score of 83.33 when personal burnout is at 50. This indicates a negative correlation between personal burnout and the quality of life of ASHA workers in all four domains.

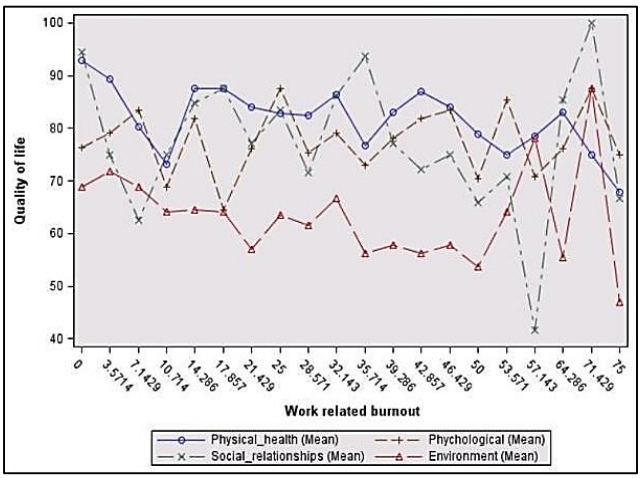

Figure 6: Influence of work related Burnout on the quality of life of ASHA

Figure 6 projects the work-related burnout that has a negative influence on the quality of life of ASHA workers in all four domains. The mean scores for physical health, psychological health, social relationships, and environment decrease as the level of work-related burnout increases. For example, when work-related burnout is at 100, the mean score for Physical health is 46.429, which is lower than the mean score of 75 when work-related burnout is at 40.

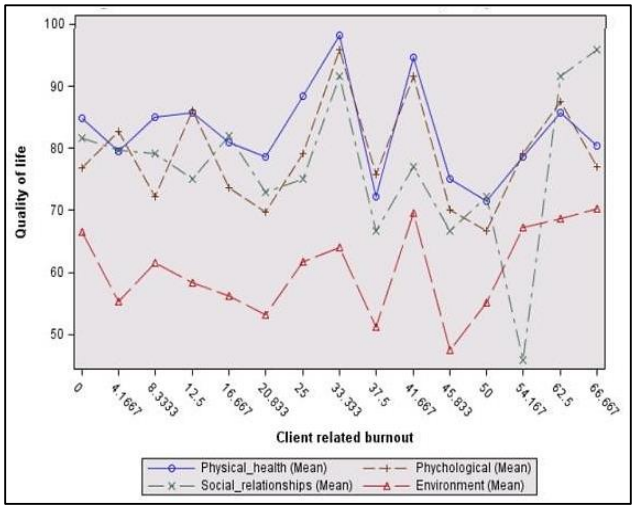

Figure 7: Influence of client related Burnout on the quality of life of ASHA

Similarly, **Figure 7** shows that client-related burnout also has a negative influence on the quality of life of ASHA workers in all four domains. The mean scores for Physical health, Psychological health, Social relationships, and Environment decrease as the level of client-related burnout increases. For example, when client-related burnout is at 100, the mean score for Physical health is 45.833, which is lower than the mean score of 83.333 when client-related burnout is at 40.

Overall, the results suggest that burnout has a stronger negative correlation with quality of life than stress does. These results suggest that there is a significant negative correlation between burnout and quality of life of ASHA workers in all four domains.

Table 1: Distribution of study participants according to socioeconomic profile and work related status

Economic demographic profile and work related status, n= frequency						
Age in years	**<25**	**30-35**	**35-40**	**40-45**	**45-50**	**>=50**
n,%	4 (5%)	12 (15%)	13 (16.25%)	2 3(28.75%)	23 (28.75%)	5 (6.25%)
Type of Family	Nuclear	Joint family	--	--	--	--
n,%	54 (67.5%)	26 (32.5%)	--	--	--	--
Family income	5000-10000/-	10000-20000/-	--	--	--	--
n,%	64 (80%)	16 (20%)	--	--	--	--
Villages allotted	1 Village	2 or more villages	--	--	--	--
n,%	58 (72.5%)	22 (27.5%)	--	--	--	--
Marital status	Married	Unmarried	Widow	Separated from husband	--	--
n,%	62 (77.5%)	1(1.25%)	14 (17.5%)	3 (3.75%)	--	--
Education status	Primary	Secondary	Higher	--	--	--
n,%	31 (38.75%)	35 (43.75%)	14 (17.5%)	--	--	--
Sickness present	Yes	No		--	--	--
n,%	14 (17.5%)	66 (82.5%)		--	--	--
Stress levels	Low	Moderate	High	--	--	--
n,%	6 (7.5%)	68 (85%)	6 (7.5%)	--	--	--

Table 2: Distribution of study paricipants according to variables and stress

Variables	**Stress**	**Stress**	**Stress**	**Stress**	**Stress**
Marital status	**Married**	**Unmarried**	**Widowed/ Separated from Husband**	**F value**	**P value**
Mean±SD	20.15±4.31	20.00+	22.06±4.88	1.251	0.292
			Widowed-14, Separated from husband-3		
Economic Status	**5000-10000/-**	**10000-20000/-**	--	**F value**	**P value**
Mean±SD	20.19±4.07	22.00±5.62	--	1.904	0.079
			--		
Number of Villages alloted	**1 Village**	**2 or more villages**	--	**F value**	**P value**
Mean±SD	20.28±4.88	21.27±3.01	--	2.624	0.017
Suffering with sickness at present	**Yes**	**No**	--	**F value**	**P value**
Mean±SD	20.64±3.30	20.53±4.67	--	2.012	0.163
Education status	**Higher**	**Primary**	**Secondary**	**F value**	**P value**
Mean±SD	19.79±4.64	21.39±4.49	20.11±4.34	0.922	0.402

Table 3: Distribution of study participants according to variables and domains

Variables	Personal burnout	Work related burnout	Client related burnout
Marital Status			
Married	40.99±19.21	34.74±16.41	21.10±21.06
Unmarried	25	0	16.67
Widow/Separated from Husband*	27.94±17.91	28.78±18.28	10.54±13.59
p value	0.038	0.068	0.154
Economic Status			
5000-10000/-	39.39±19.70	33.48±17.63	19.73±20.06
10000-20000/-	32.55±18.33	31.25±15.73	15.10±19.77
p value	0.794	0.646	1
Number of Villages allotted			
1 Village	38.15±19.83	32.08±17.50	19.97±20.45
2 or more villages	37.69±19.09	35.55±16.48	15.72±18.72
p value	0.879	0.785	0.671
Suffering with sickness at present			
Yes	44.94±17.77	36.22±14.14	27.08±16.32
No	36.55±19.68	32.36±17.80	17.05±20.33
p value	0.715	0.362	0.385
Education			
Higher	38.10±14.42	23.72±10.72	12.20±16.30
Primary	43.01±16.04	39.29±16.83	25.27±20.83
Secondary	33.57±23.13	31.22±17.84	15.71±19.39
p value	0.146	0.012	0.058
*Widow-14, *Separated from Husband-3			

Table 4: Correlation between stress, burnout and quality of life

Pearson correlation coefficient, N=80				
Prob > (r) under H0: Rho=0				
	Physical health	**Psychological**	**Social relationships**	**Environment**
Stress_score	-0.04893	-0.01846	0.03941	-0.00189
	0.6664	0.8709	0.7285	0.9867
Personal_burnout	-0.20759	-0.14964	-0.2037	-0.33537
	0.0646	0.1852	0.0699	0.0024
Work_related_burnout	-0.21585	-0.04462	-0.1579	-0.17976
	0.0545	0.6943	0.1619	0.1106
Client_related_burnout	-0.15684	0.00925	-0.18262	-0.13279
	0.1647	0.9351	0.1049	0.2403

4. Discussion

4.1. Theme 1: Job-Related Stress

The first prominent theme, "Job-Related Stress," highlights the significant stressors experienced by ASHA workers, including the absence of fixed leaves leading to personal sacrifices and burnout. Additionally, struggles with Auxiliary Nurse Midwives and bureaucratic issues add to their stress, reflecting systemic challenges in their work environment. The fear of infections and contamination among ASHA workers is worsened by the stress of dealing with infectious diseases especially like tuberculosis. They also face disrespect from hospital staff and doctors, which adds to their challenges when interacting with healthcare professionals. Family resistance adds stress for ASHA workers during nighttime duties, creating internal conflicts as they balance familial responsibilities with their demanding roles.

"This week my daughter was sick and I had to go to duty leaving her at home". - ASHA1 (IDI)

"ANMs are not always supportive, If they don't like us they will not upload our work properly" - ASHA 2 (IDI)

"We are worried about the fear of getting infections and contamination as we take patients with TB and other infectious diseases to hospitals". -ASHA2(IDI)

."Once I was asked not to enter the labor room, my patient trusted me and came with me to hospital and she wanted me to be with her, but hospital staff treated me very badly" -ASHA 5 (IDI).

"Sometimes family members oppose when we go on duty, especially during night times." -ASHA3(IDI)

4.2. Theme 2: Coping mchanisms

Despite the formidable stressors, ASHA workers displayed remarkable resilience and coping mechanisms. They demonstrated adaptability by adjusting to challenging situations, recognising that they often had no alternatives. These findings align with Folkman and Lazarus's theory of stress and coping, where individuals are driven to find adaptive solutions when facing stressors.[17] These findings also align with the previous study on challenges and opportunities for Accredited Social Health Activists.[20] ASHA workers highlighted the importance of building rapport with patients to improve compliance and sought support from colleagues and friends as a coping strategy. Their motivation to continue their work underscores their dedication to their communities.

"I try to explain myself to cope with the stress, get adjusted to the situations and manage myself. Job satisfaction and the love and respect I get from the public help me to go forward with my work" ASHA 1 (IDI).

4.3. Theme 3: Job satisfaction

The interviews consistently showed that ASHA workers find fulfillment in their roles despite challenges, due to the love, respect, and dependence they receive from the community. This recognition gives them a sense of purpose and fulfillment, even though financial difficulties persist. This finding is consistent with studies highlighting the relationship between job satisfaction and community health worker motivation, "After considering other factors, the multivariate analyses revealed that variables such as pride, self-efficacy, satisfaction with financial rewards, and satisfaction with facility resources had a significant association with motivational outcomes".[30]

"My social relationships are very good and people respect, listen, share their problems and have a good bonding with me when I visit their homes" ASHA 4 (IDI).

4.4. Theme 4: Quality of life

The "Quality of Life" theme revealed varying perceptions of overall well-being among ASHA workers. Financial constraints, stemming from insufficient salaries, were a common concern. Additionally, health issues, including the fear of infections, were a source of worry. However, their positive social relationships within the community, characterised by respect and recognition, contributed positively to their quality of life. These findings resonate with the multifaceted nature of quality of life (WHOQOL Group) and underscore the need for a holistic approach to assessing well-being.[31]

"As I'm the only person earning and managing finances is very difficult to manage family finances" ASHA 5 (IDI).

"Though life is stressful I have to manage it and get adjusted. I try to share with my friends to get some relief" ASHA 4(IDI).

4.5. Theme 5: Suggestions for Improvement

In the final theme, "Suggestions for Improvement," ASHA workers provided valuable recommendations for enhancing their working conditions. Some of the suggestions were

1. Advocating for fixed salaries
2. Addressing heavy workloads
3. Implementing proper leave policies
4. Proper implementation of job chart

These practical recommendations offer potential solutions to alleviate the challenges faced by ASHA workers, which can ultimately lead to improved job satisfaction and quality of life.

4.6. Cross-theme analysis

A cross-theme analysis highlights the inter-connectedness of these themes. Job satisfaction appears to act as a buffer against job-related stress while coping mechanisms serve as adaptive responses to stressors. The financial constraints discussed in the quality of life theme are intricately linked to job-related stress, emphasizing the need for systemic improvements.

5. Conclusion

In conclusion, the mean overall Quality of life is 3.2625, suggesting an average to slightly above average quality of life. And this study on the influence of stress levels and burnout on the quality of life of ASHA workers highlights the significant impact to their work. Overall, correlation between burnout and quality of life in the four domains is negative, which means that as the level of burnout increases, the quality of life of ASHA workers decreases in terms of physical health, psychological health, social relationships, and environment. There is a negative correlation between the stress and quality of life of ASHA workers, but the strength of the relationship is not very strong.

The thematic analysis of the interviews with ASHA workers concludes that they face significant job-related stress due to various factors such as lack of respect, absence of fixed leaves, fear of infections, resistance from family members, and bureaucratic issues. This study suggests that ASHA

workers experience significant job-related stress and burnout due to various factors that can have a negative impact on the quality of life for ASHA workers. Therefore, there appears to be a correlation between stress and burnout and the quality of life among ASHA workers as these experiences can contribute to a lower overall well-being. However- coping mechanisms plus resilience along with motivating factors such as community respect do aid in moving forward as an ASHA worker. Further research is needed to establish more concrete evidence regarding this correlation.

6. Declaration of Patient Consent

The authors certify that they have obtained all appropriate participant consent forms. In the form the participants has/ have given his/her/their consent for his/her/their IMAGES and other clinical information to be reported in the journal. The participants understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

7. Source of Funding

Nil.

8. Conflicts of Interest

There are no conflicts of interest.

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