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Occupational Stress and Burnout Among Anganwadi Workers in India: A Narrative Review Through the Job Demands – Resources Lens

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Anganwadi workers (AWWs) are the frontline functionaries of India's Integrated Child Development Services (ICDS) scheme, delivering supplementary nutrition, immunisation support, preschool education, growth monitoring, and maternal and child health services at the village level. Despite their centrality to public health and early childhood development, AWWs work under conditions widely associated with chronic occupational stress: heavy and expanding task loads, growing administrative and digital documentation demands, low honoraria paid under an "honorary worker" classification rather than formal employment, weak infrastructure, and limited recognition. This narrative review synthesises peer-reviewed and grey literature on the occupational and psychosocial burdens faced by AWWs and evaluates the findings using the Job Demands-Resources (JD-R) model, which is augmented by role strain theory. Across studies, the majority of AWWs experience moderate-to-severe occupational stress, and similar burnout has been found in the larger community health worker (CHW) profession. According to the review, AWW stress is largely caused by a structural imbalance between increasing job demands and consistently inadequate resources, which is exacerbated by the gendered devaluation of care labor. The recommendations revolve around decreasing demands, improving resources, and altering the work status of AWWs. The review is conceptual; it does not include primary data and is constrained by the heterogeneity and primarily cross-sectional nature of the underlying research.

Keywords: Anganwadi workers; ICDS; occupational stress; burnout; job demands–resources model; community health workers; women's work

1. INTRODUCTION

The Integrated Child Development Services (ICDS) scheme, launched in 1975, is among the world's largest community-based programmes for early childhood development, maternal nutrition, and child health. Its delivery is based on a massive network of village-level centers known as anganwadis, each staffed by an Anganwadi worker (AWW) and a helper. The AWW is in charge of supplemental nutrition, growth monitoring, pre-school (non-formal) education, immunization mobilization, referral, and health and nutrition counselling, and serves as the primary link between the state and the community in rural and neglected regions.

AWWs are overwhelmingly women, are engaged as "honorary workers" rather than regular government employees, and are paid a monthly honorarium rather than a salary. This classification has far-reaching consequences for their pay, job security, and access to benefits, and it frames much of the occupational stress discussed in this review. Over successive policy cycles, the responsibilities of AWWs have expanded—most recently into smartphone-based data entry and a widening portfolio of surveys and campaign duties—without a commensurate increase in resources or institutional support.

A growing amount of Indian research reveals significant levels of occupational stress and psychological discomfort among AWWs and the closely associated Accredited Social Health Activist (ASHA) workforce. However, most of this literature is descriptive and dispersed among nations, instruments, and disciplines, and it is rarely organized under a clear theoretical framework. This narrative review compiles that information and explains it using the Job Demands-Resources (JD-R) model, concluding that AWW stress is best understood as a foreseeable result of a structural imbalance between job demands and job resources, rather than an individual failure.

2. OBJECTIVES

The objectives of this review are:

1. To describe the occupational and psychosocial demands placed on Anganwadi workers within the ICDS system.
2. To synthesise the available evidence on the prevalence and correlates of occupational stress and burnout among AWWs.
3. To interpret these findings through the Job Demands–Resources model and role strain theory.
4. To make evidence-based suggestions to improve the working conditions and wellness of AWWs.

3. METHODS

This is a narrative (conceptual) review rather than a systematic review. Relevant literature was identified through searches of PubMed and general academic search engines using combinations of the terms "Anganwadi worker," "ICDS," "occupational stress," "burnout," "job satisfaction," "mental health," and "community health worker," together with the names of the major theoretical frameworks. Peer-reviewed empirical studies conducted in India, relevant policy literature, and foundational theoretical sources were prioritised. Studies were selected purposively for their relevance to the occupational and psychosocial experience of AWWs and the wider community health worker (CHW) workforce; the synthesis is thematic rather than meta-analytic.

Because the search was not extensive and study selection did not follow a pre-registered process, the findings should be interpreted as an interpretative synthesis rather than a full list of all available data. Authors who plan to publish a systematic review should replace this section with a written procedure

(databases, specific search strings, date restrictions, inclusion and exclusion criteria, screening counts, and a PRISMA flow diagram) and undertake formal screening and quality assessment.

4. THE ANGANWADI WORKER WITHIN THE ICDS SYSTEM

The anganwadi is the operational unit of the ICDS scheme, and the AWW is its primary functionary. A single worker is typically expected to maintain enrolment and beneficiary registers, prepare and distribute supplementary nutrition, weigh and monitor the growth of young children, run pre-school activities, mobilise families for immunisation and antenatal care, conduct home visits, and deliver nutrition and health education. Studies of how AWWs actually spend their time show that a substantial share is absorbed by administrative work—particularly the maintenance of paper and, increasingly, digital registers—reducing the time available for direct care (Jain et al., 2020). Studies on service utilisation and performance indicate the system's reach as well as strain. A substantial number of pregnant women use anganwadi services for supplemental nutrition, immunisation, and health check-ups, with physical distance to the facility playing a major role in uptake (Harikrishna et al., 2020).

At the same time, evaluations of AWW performance reveal coexisting knowledge and quality gaps alongside heavy task expectations (Debata & Ranganath, 2023), and infrastructural instability—such as the frequent relocation of rented centres—can disrupt service continuity (Somani et al., 2023). These conditions form the backdrop against which occupational stress accumulates.

5. THEORETICAL FRAMEWORK

This review adopts the Job Demands–Resources (JD–R) model as its primary interpretive lens, with role strain theory as a complementary perspective. A brief note explains why need-hierarchy approaches are treated as secondary.

5.1 *The Job Demands–Resources Model*

The JD–R model proposes that every occupation contains two broad categories of working conditions: job demands, which require sustained physical, cognitive, or emotional effort and carry physiological and psychological costs, and job resources, which help achieve goals, reduce demands, and stimulate growth (Demerouti et al., 2001). The model predicts a health-impairment pathway, in which chronically high demands deplete energy and lead to exhaustion and burnout, and a motivational pathway, in which adequate resources foster engagement (Bakker & Demerouti, 2007). Crucially, resources can buffer the impact of demands; strain arises when high demands coincide with insufficient resources. This framing is well suited to the AWW context, where demands have expanded while resources—pay, infrastructure, training, technical support, and recognition—have lagged.

5.2 *Role Strain Theory*

Role strain theory highlights the difficulty individuals have in fulfilling various, sometimes competing, social roles (Goode, 1960). AWWs serve many responsibilities at once, including educator, nutrition worker, health mobilizer, record-keeper, and, for the most part, primary caregiver in their own families. The buildup and occasional clash of various responsibilities results in role overload and conflict, which add to the JD–R explanation by identifying one crucial process via which demands generate strain.

5.3 *A Note on Need-Hierarchy Approaches*

Earlier assessments of AWW discontent have used Maslow's (1943) hierarchy of needs to argue that unfulfilled basic and security requirements—low and insecure honoraria, delayed payments—degrade motivation. While intuitively attractive, the need-hierarchy model has minimal empirical support as a theory of workplace motivation and is used here as an example rather than an explanation. The JD–R

model provides a more testable explanation of the same data by defining compensation and job security as (insufficient) work resources.

6. SYNTHESIS OF THE EVIDENCE

6.1 Prevalence of Stress and Burnout

Indian studies consistently report that a majority of AWWs experience clinically meaningful occupational stress. A cross-sectional study in Rajkot, Gujarat, found that roughly four in five AWWs reported moderate stress and a further one in five reported severe stress, with less-experienced workers reporting higher levels (Dhanani, 2020). Earlier work in Mangalore using the General Health Questionnaire documented appreciable psychological distress among AWWs and linked worker wellbeing to the quality of services they provide (Mohanani et al., 2012). Although direct burnout data for AWWs is limited, community-based research on the closely related ASHA and primary health care workforce found moderate stress in roughly half of respondents, along with measurable personal and work-related burnout and a near-universal perception of low pay (Pulagam & Satyanarayana, 2021). Taken together, the data suggests that high stress is the rule rather than the exception in this workforce, however specific estimates differ depending on environment and tool.

6.2 Job Demands

The demand side of the JD–R equation is heavily loaded for AWWs. Quantitative workload is high: a single worker juggles nutrition, education, growth monitoring, home visits, and community mobilisation. Administrative and documentation demands are particularly burdensome; time-use evidence shows that register maintenance consumes a large share of the working day and competes directly with care activities (Jain et al., 2020). The progressive digitalisation of reporting—via smartphone applications—adds a further layer of demand that is especially taxing where digital literacy, connectivity, and technical support are limited. AWWs are also commonly employed for tasks unrelated to child development, such as surveys, census work, and election and campaign activities, which increase working hours and divert attention. Emotional challenges are inherent to the profession, since AWWs interact with starving children, nervous moms, and often reluctant communities.

6.3 Resource Deficits

Against these demands, job resources are conspicuously thin. The defining structural feature is the “honorary worker” status of AWWs: they are not classified as regular government employees, are paid a monthly honorarium rather than a salary, and have historically lacked the pension, provident fund, and job security associated with formal employment. Honoraria, while frequently reviewed and augmented in certain jurisdictions, are usually seen as insufficient in relation to the extent of the job [writers should include current, state-specific honorarium values here, accompanied by citation]. According to ethnographic study, many women continue to work in these low-paying jobs in the belief that they would one day be regularized, a dynamic that both exploits and promotes gendered labor-market inequities (Closer & Shekhawat, 2021). Infrastructural resources are similarly constrained: many centres lack adequate buildings, sanitation, safe drinking water, and teaching materials, and reliance on rented premises can disrupt continuity of service (Somani et al., 2023). Training, technical support, supportive supervision, and formal recognition—each a potential buffer against demands—are frequently inadequate.

6.4 Gendered Labour and Work–Family Conflict

Because the AWW workforce is almost entirely female, the occupational burden is inseparable from the gendered organisation of care. AWWs typically carry substantial domestic and caregiving responsibilities in addition to their official duties, and the boundaries between the two are porous. Family structures shape recruitment, working hours, and mobility, and the caregiving content of the job is often normalised and undervalued precisely because it is performed by women (Closer & Shekhawat, 2021). Work-family

conflict, according to the JD-R paradigm, serves as an extra demand and a drain on the personal resources (time, energy, recuperation) that workers require to meet workplace obligations.

6.5 Consequences for Wellbeing and Service Delivery

The convergence of high demands and low resources has consequences on both pathways of the JD–R model. On the health-impairment pathway, chronic strain manifests as fatigue, anxiety, emotional exhaustion, and reduced wellbeing. On the motivational pathway, scarce resources and limited recognition erode engagement and job satisfaction. These outcomes are not only matters of worker welfare: Because the well-being of AWWs is connected to the quality and continuity of the services they provide (Mohanani et al., 2012), worker strain may undermine the same child-development and public-health goals that the ICDS system is designed to accomplish.

7. DISCUSSION

Read through the JD–R lens, the literature points to a coherent conclusion: occupational stress among AWWs is a structural outcome of a sustained imbalance between expanding job demands and persistently inadequate job resources, rather than a problem of individual resilience. The same studies that document heavy workload, administrative and digital burden, and additional non-ICDS duties also document the resource deficits—low and insecure honoraria, weak infrastructure, limited training and recognition—that, in JD–R terms, remove the buffers that would otherwise protect workers from those demands.

Much of this strain may be traced back to the honorary worker designation. By classifying AWWs as volunteers rather than workers, the system legitimizes sub-employment compensation and the denial of conventional safeguards while maintaining a full and expanding workload. Role strain theory clarifies one mechanism—the simultaneous management of multiple professional and domestic roles—while the gendered devaluation of care work explains why this arrangement has persisted with limited political challenge. Interpreting pay and security as deficient resources, rather than as unmet needs in a motivational hierarchy, also yields clearer, more testable policy implications.

A word of caution is necessary. The direct data foundation for AWW burnout is lower than for stress, and some often mentioned findings derive from the larger CHW workforce. Estimates vary by state and instrument. These caveats temper the precision of any prevalence claim but do not undermine the central, well-supported argument about the demand–resource imbalance.

7.1 Summary of Key Studies

Table 1 summarises representative studies informing this review.

Table 1

Representative studies on the occupational and psychosocial burden of Anganwadi and community health workers in India

Study	Setting / sample	Design & measure	Key finding relevant to this review
Dhanani (2020)	Rajkot, Gujarat; AWWs	Cross-sectional; occupational stress scale	About 81% reported moderate and 19% severe occupational stress; less-experienced workers reported higher stress.

Mohanan et al. (2012)	Mangalore; AWWs	Cross-sectional; GHQ-12	Documented psychological distress among AWWs and linked worker wellbeing to service quality.
Pulagam & Satyanarayana (2021)	Kolar, Karnataka; ASHA / PHC workers	Cross-sectional; PSS, Zung, Copenhagen Burnout Inventory	Around 54% moderate stress and notable personal/work-related burnout; low perceived pay near-universal. Used here as a comparator for the wider CHW workforce.
Jain et al. (2020)	Madhya Pradesh; AWWs	Cross-sectional time-use study	Substantial work time absorbed by register and administrative tasks, displacing direct care.
Closser & Shekhawat (2021)	Rural Rajasthan; ASHAs & AWWs	Ethnographic interviews & observation	Low-paid 'honorary' roles sustained by hope of regularisation; workload and mobility shaped by family; gendered exploitation.
Somani et al. (2023)	Ahmedabad, Gujarat; AWCs	Cross-sectional	Frequent relocation of rented centres and infrastructure constraints affected service delivery and participation.
Debata & Ranganath (2023)	Rural Karnataka; AWWs	Cross-sectional; performance scoring	Knowledge and performance gaps coexisted with heavy task expectations across 21 centres.

Note. AWW = Anganwadi worker; ASHA = Accredited Social Health Activist; AWC = Anganwadi centre; PHC = primary health centre; GHQ-12 = 12-item General Health Questionnaire; PSS = Perceived Stress Scale.

8. RECOMMENDATIONS

Consistent with the JD–R framework, recommendations are grouped into reducing demands, strengthening resources, and addressing the underlying employment structure.

8.1 Reduce Job Demands

- Rationalize the AWW portfolio and safeguard it against non-ICDS deployments (surveys, campaigns, election obligations) that disrupt core operations.
- Simplify and simplify reporting; eliminate duplicate paper-plus-digital record-keeping, which consumes care time.
- Before implementing app-based reporting, ensure that there are effective digital tools, connection, and on-call technical assistance.

8.2 Strengthen Job Resources

- Improve centre infrastructure—buildings, sanitation, safe water, and teaching–learning materials—and reduce dependence on unstable rented premises.

- Provide regular, supportive supervision and accessible psychosocial support, including stress-management and counselling services.
- Deliver ongoing training (including digital-literacy training) and visible professional recognition of AWWs as essential frontline workers.

8.3 Reform Employment Status and Pay

- Review the honorary-worker classification and move toward fair, timely, and secure remuneration with appropriate social-security benefits.
- Ensure that honoraria and incentives are paid on schedule and predictably, as payment delays are a proven source of stress.

8.4 Support Work–Life Balance

- Adopt scheduling and workload norms that acknowledge the dual burden carried by a predominantly female workforce, and embed gender-sensitive policy design.

8.5 Strengthen the Evidence Base

- Commission longitudinal and multi-state studies using validated instruments (e.g., PSS-10, Maslach or Copenhagen Burnout Inventory, GHQ-12) to move beyond cross-sectional snapshots and establish causal pathways.

9. LIMITATIONS

This review has a few restrictions. Because this is a story rather than a systematic review, study selection was deliberate, and the search was not complete; pertinent research may have been overlooked. The underlying evidence is predominantly cross-sectional, limiting causal inference, and is heterogeneous in setting, sampling, and measurement, which constrains comparability and precludes pooled estimates. Direct burnout data specific to AWWs are limited, and some cited findings derive from the wider community health worker workforce. Finally, as a conceptual paper, the review reports no primary data of its own.

10. CONCLUSION

Anganwadi workers are indispensable to India's child-development and public-health architecture, yet they work under conditions strongly associated with chronic occupational stress and burnout. Interpreted through the Job Demands–Resources model, the evidence indicates that this strain is a structural product of escalating job demands set against inadequate job resources, anchored in an honorary-worker classification that withholds fair pay and protection while extracting a growing workload, and compounded by the gendered devaluation of care. Addressing AWW wellbeing therefore requires more than individual coping support; it requires reducing demands, strengthening resources, and reforming employment status. This is not just a commitment to the workers, but also a prerequisite for the proper delivery of services that millions of women and children rely upon.

CONFLICT OF INTEREST

The author(s) declare no conflict of interest.

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