Original Research

WORK PROFILE OF ACCREDIATED SOCIAL HEALTH ACTIVISTS (ASHAS) IN A TALUK OF RAICHUR DISTRICT, KARNATAKA: A CROSS – SECTIONAL STUDY

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ABSTRACT

Background: Accrediated Social Health Activists (ASHAs) are the link between the community and health system in India. One of the primary component of NRHM is to provide every village in the country with a trained female community health activists called as ASHA. ASHAs are healthy volunteers, promoters of health services who are the key force of action at the grass root level. She is responsible for improved utilization and accountability of existing health services and also expected to bridge the gap between the health system and the community.

Objectives:

- To study the work profile of ASHA's
- To study the work satisfaction and difficulties faced by ASHA's

Methods: A cross sectional study conducted among ASHA workers, a pretested questionnaire was used to collect data on socio-demographic profile, morbidity status, nutritional status and mental health. Data were analyzed using SPSS version 22 IBM. Analyzed data is presented as descriptive statistics with suitable graphical and tabular form. Categorical data is presented as proportions and continuous data is presented as mean and SD. **Results:** A total of 301 ASHA workers were participated. 292(97.1%) covered a minimum population of 500 to 2000 population. 231(76.6%) have experience between 5 – 15 years. All 301 ASHA workers accompanied at least 1 pregnant women for ANC and visited at least 1 PNC case. **Conclusion:** The majority of ASHAs covered population as per the guidelines. Almost all ASHA workers were involved in maternal care, Child care and family planning activities but they were lagging behind in promotion of male sterilisation.

INTRODUCTION

The National Rural Health Mission (NRHM) was launched on April 12, 2005, with the goal of providing adequate health care to the rural health population, with a focus on disadvantaged women and children. One of the primary components of the NRHM is to provide every village in the country with a trained female community health activist called as Accredited Social Health Activist (ASHA)[1]. ASHAs play a crucial role in bridging the gap between the community and the healthcare system, facilitating access to essential health services, and promoting health education. Their presence is vital in enhancing the reach and effectiveness of health interventions, particularly in rural and underserved areas[2].

More than one million ASHA workers have been trained and working across the country.

www.ajmrhs.com
eISSN: 2583-7761

Date of Received: 01-02-2026
Date Acceptance: 09-02-2026
Date of Publication: 10-03-2026

ASHA won the global health leaders award and have been recognised for their outstanding contribution towards protecting and promoting health[3]. It is necessary to keep the ASHA workers motivated so that they can effectively and efficiently carry out their responsibilities.[4] ASHA employees face numerous challenges in executing their healthcare responsibilities, encountering issues such as a lack of cooperation from various individuals, notably family members – particularly husbands – due to their demanding work hours, unpredictable schedules, and limited financial incentives.[5]

MATERIAL AND METHODOLOGY

This cross sectional study was undertaken in Raichur taluku and all ASHAs were included. Among the 5 talukas of Raichur district, one taluku i.e. Raichur taluku was selected randomly and all ASHAs working in the selected taluku were included in the study. The study was conducted between September 2023 to May 2024.

We have done the universal sampling hence we have included all the ASHAs (301) working in the selected taluku. The inclusion criteria encompassed

All ASHAs working in the taluk of a Raichur, while ASHAs not giving consent were excluded from the study. A pre-structured questionnaire was developed based on the study objective, the tool was validated through expert review and pilot testing.

The study was initiated after obtaining the necessary permission from Institutional Ethics Committee of RIMS, Raichur and also permission was obtained from District Health Officer, Raichur District. After explaining the purpose of the study in their own understandable language, written consent was obtained from the participants. The confidentiality of the information provided by study subjects was maintained throughout the study. The detailed information regarding socio-demographic characteristics was such as age, religion, family type, income and socioeconomic status recorded using a pre-tested, semi-structured questionnaire by interviewing all the ASHAs

Work profile was studied by questionnaire regarding their involvement in various health related works as per the program guidelines ex – involvement in contraceptive distribution, accompanying pregnant women for delivery, DOTS agent, attending VHSNC meeting, nutritional counselling etc.

Data were analyzed using SPSS version 22 IBM. Analyzed data is presented as descriptive statistics with suitable graphical and tabular form. Categorical data is presented as proportions and continuous data is presented as mean and SD.

RESULTS

Table 1: Demographic Characteristics of Participants (N=301)

Characteristics	Category	N	%
Age Groups (yrs)	18-30	42	13.9
	31-40	168	55.8
	41-50	76	25.2
	51-60	15	4.9
Marital Status	Married	278	92.4
	Widowed	23	7.6
Number of living Children	0	16	5.3
	1-2	188	62.4
	3-4	92	30.5
	>4	5	1.6
Type of Family	Nuclear	191	64
	Joint	110	36
Religion	Hindu	265	88
	Muslim	31	10
	Christian	5	2

A total of 301 ASHAs participated in the study. Majority of participants (55.8%, n=168) were aged 31-40 years, with 25.2% (n=76) in the 41-50 age range. Most respondents were married (92.4%, n=278) and had two living children (62.4%, n=188). The predominant family type was nuclear (64%, n=191), and the majority participants were Hindu (88%, n=265).

Table 2: Distribution of ASHA workers according to Population covered by (N=301)

Population covered	Frequency	Percentage
500 – 1000	31	10.2
1001 – 1500	141	46.8
1501 – 2000	120	39.8
> 2000	9	2.9
Total	301	100

In our study, 292 ASHAs covered a minimum population of 500 to 2000, while 9 ASHAs covered more than 2000 population.

In our study 201(66.7%) ASHAs spent 4 hours daily at work, 97(32.2%) ASHAs spent 5 hours daily at work, 3(1%) ASHAs spent hours daily at work, 3(1%) ASHAs spent 6 hours daily at work.

Among 301 ASHA workers 8(2.6%) have job experience of less than 5, 101(33.5%) have experience between 5-10 years, 130(43.1%) have experience between 11-15 years, 62 (20.5%)

Table 3: Distribution of ASHA workers according to provision of maternal and child care

Maternal care	Yes Frequency	No Frequency

ASHA workers accompanied at least 1 pregnant women for ANC visits in the last month	301 (100)	0
ASHA workers accompanied at least 1 pregnant women for PNC visits in the last month	301 (100)	0
ASHA workers distributed at least 1 UPT kit in last 1 month	241(80.3)	59 (5.10)
Child care	**Yes Frequency**	**No Frequency**
ASHA workers mobilized at least 1 child for vaccination in the last month	301(100)	0
ASHA workers distributed at least 1 ORS packet to child in the last month	233(77.4)	68(28.5)
Family Planning	**Yes Frequency**	**No Frequency**
ASHA worker promoted at least 1 Female case successfully for sterilisation in last 1 year	227(75.4)	74(24.5)
ASHA worker promoted at least 1 Male case successfully for sterilisation in last 1 year	15(4.9)	286(95)
ASHA workers distributed at least 1 Condoms in the last month	212(70.4)	89(29.4)
ASHA workers distributed at least 1 Combined pills in the last month	157(52.1)	144(47.80

All 301 ASHA workers accompanied at least 1 pregnant women for ANC and visited at least 1 PNC case. 242(80.3%) ASHAs distributed at least 1 UPT kit, among that 59 (20.7%) have not distributed because they were not having sufficient kits.

All ASHA workers mobilized at least 1 child for vaccination, 233(77.4%) ASHAs distributed at least 1 ORS packet and remaining 22.5% not distributed because they were not having ORS packets and there were no cases 0f Diarrhoea

227(75.4%) ASHAs promoted at least 1 female case for successfully sterilisation, 34(11.2%) said there is denial from females and 30(9.6%) said there were no cases. 15(4.9%) promoted at least 1 male case for sterilisation, 286(95%) said there is denial from male individuals. 212(70.4%) distributed at least 1 condom, 50(16.6%) were not distributed because of not having condoms and 39(12.9%) denied to take condoms. 157(52.1%) distributed at least 1 OCP and 82(27.2%) were distributed emergency pills.

Table 4: Distribution of ASHA workers according to provision of other work

Other work	**Yes Frequency**	**No Frequency**
ASHA workers involved in Birth Registration for the last 1 year	301 (100)	0
ASHA workers involved in Death Registration for the last 1 year	301 (100)	0
ASHA workers involved in sending at least 1 smear suspected malarial fever patients to PHC in last one month	212(70.4)	89(29.5)
ASHA workers referred at least 1 Dengue symptom patient to Government hospital	240(79.7)	61(20.2)
ASHA worker surveyed at least 1 House for mosquito larva in last year	301 (100)	0
ASHA worker surveyed at least 1 House for TB in last month	301 (100)	0
ASHA workers taken at least 1 TB sputum for AFB collected in last one month	267(88.7)	34(11.2)
ASHA currently working as DOT provider	33(10.9)	268(89)
ASHA worker surveyed at least 1 House for Leprosy in last month	301 (100)	0
Other than routine health work	**Frequency**	**Percentage**
Election duty	119	39.5
Sports event duty	51	16.9
Both	6	2

All 301 ASHA worker involved in Birth, Death Registration, surveyed houses for mosquito larva, Leprosy and TB (ACF), 33(10.9%) ASHA currently working as DOT provider, 267(88.7%) ASHA workers taken at least 1 TB Sputum for AFB collected in last month.

Among 301 ASHAs 119(39.5%) said they had Election duty, 51(16.9%) said they had sports event duty and 6(2%) said they had both these work other than routine health work.

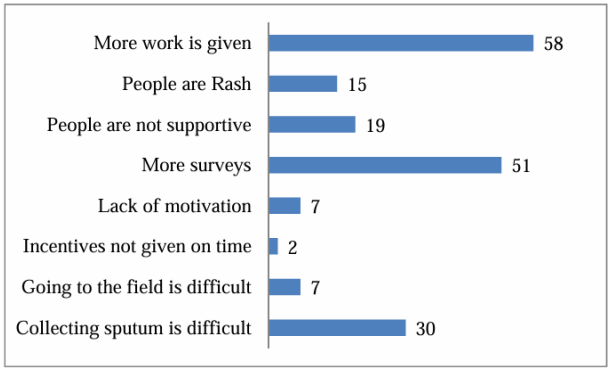

Fig 1: Distribution of ASHA workers according to difficulties faced by them

ASHA workers mentioned difficulties faced by them among that 30(9.9%) said collecting sputum is difficult, 7(2.3%) going to the field is difficult, 2(0.6%) said incentives are not given on time, 7(0.3%) said there is lack of motivation, 51(18.9%) said more surveys, 19(6.3%) people are not supportive, 15(4.9%) said people are rash, 58(19.2%) said more work is given.

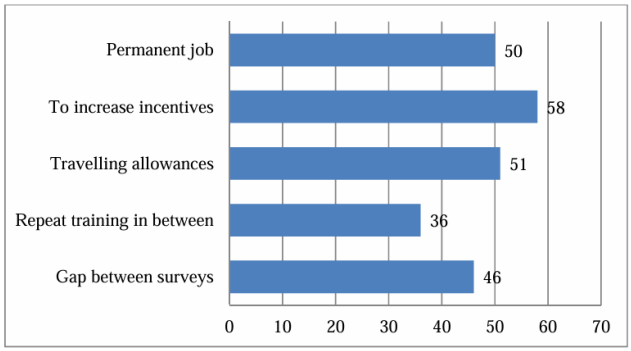

Fig 2: Distribution of ASHA workers according to their expectations

ASHAs mentioned about expectations among that 46(15.2%) said there should be gap between surveys, 36(11.9%) said repeated training is required, 51(16.9%) said travelling allowance is needed, 58(24%) said to increase incentives, 50(20.7%) said they need permanent job.

DISCUSSION

In the current study, 141 (46.8%) served a population of 1000–1500, 120 (29.8%) served a population of 1500–2000, and 9 (2.9%) covered a population of more than 2000. Of these, 31 (10.2%) served a population of < 500. ASHA workers served an average of 1165 people in Bihar and 1431 people in Uttar Pradesh, according to a study by Nirupam Bajpai et al.[6]

In the current study, 222 (88.4%) of ASHAs had the correct drug kit. 91% in Madhya Pradesh had drug kits available, according to NRHM's ASHA program evaluation in 7 states. According to the current study, 100% in Orissa, 83% in Uttar Pradesh, 100% in Assam, 38% in Jharkhand, 100% in Jammu and Kashmir, and 83% in Assam, which is comparable to this.[7]

In the present study, based on number of pregnancy registration, All 301 ASHA workers have registered at least 1 ANC and PNC cases in last 1 month. In the study by Nirupam Bajpai et al., more than 90% of ASHAs were involved in pregnancy registration; in Bihar, Rajasthan, Uttar Pradesh, and Chhattisgarh, the average number of pregnant women registered per ASHA was 21, 25 and 10 respectively.23 ASHA registered 74.15% antenatal women in Dehradun's Parul Sharma study, which examined urban and rural slums.41 Shobha Malini et al., in South Orissa, found that the performance of ASHA workers was 65.0% in delivering ANC and in 62.0% cases, they accompanied for institutional delivery.[8]

According to the current study, every ASHA participated in house visits and registered pregnancies at their place of employment. Based on their job performance in different areas related to population stability and mother and child health care, All ASHAs provided advice on safe delivery methods and prenatal care. All ASHA workers involved in registration of Birth and Death for the last one year, 222(73.7) were having sufficient medicines (kit), 33(10.9%) involved as a DOTS providers, majority 245 (81.3%) gave awareness to the household for construction of latrines, and 237(78.7%) treated minor ailments. Comparably, in a study conducted in three districts of Karnataka, a significant majority (>50%) attended VHSC meetings, organized VHNDs, provided nutritional

counselling, visited households to see newborns, sufficient medicines(drug kit) and served as DOTS providers for tuberculosis patients. ASHAs reported engaging in critical activities such as home visits, ANC counselling, escort services for delivery, and coordination for immunization. However, it indicates that participation in other activities—such as organizing village meetings for health action, handling minor diseases —is less than 50%. This demonstrated that the bulk of her work-related activities were determined to be functional for the ASHAs in our study.[9]

In the present study, 227(75.4%) ASHAs motivated for Tubectomy, 15(4.9%) had motivated vasectomy, 212(70.4%) had given condoms, 157(52.1%) had distributed OCP's and 82(27.2%) had distributed emergency pills. This demonstrates ASHA workers' active participation in mobilizing for family planning. In a similar 73 study by Nandan D et al., approximately 40% were advised by the ASHAs to accept any family planning method; of these, 6% accepted tubectomy. Less than 2% got IUDs inserted, and 3% began to use oral pills or other traditional methods, 26% are condom users.[10]

In our study some difficulties are faced by ASHAs, 19.2% ASHA said that more work is given, 18.9% mentioned that more surveys are conducted frequently, 9.9% mentioned collecting sputum is difficult,6.3% said that people are not supportive and less than 1% ASHAs mentioned there is lack of motivation, Incentives not given on time. In a similar study done by Ancy Joseph done on problems faced by ASHA workers in the delivery of Primary health care services, In some areas, the ASHAs position has remained vacant and no additional recruitments have taken place. Some of them have a population ranging between 2000-3000. The entire compensation received by ASHAs per month is quite inadequate for their sustenance. Majority of the ASHAs are not getting incentives in time. And lot of communication 74 is needed with the people in the community, ASHAs demand some monthly payment towards telephone charges.[11]

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How to cite this article: Dr. Pramod, Dr. Shashidhar S. Basagoudar, Dr. Akshata Warad, Dr. Rahul C. Kirte, WORK PROFILE OF ACCREDIATED SOCIAL HEALTH ACTIVISTS (ASHAS) IN A TALUK OF RAICHUR DISTRICT, KARNATAKA: A CROSS – SECTIONAL STUDY, Asian J. Med. Res. Health Sci., 2026; 4 (1):-573-577.

Source of Support: Nil, Conflicts of Interest: None declared.