

A Cross-sectional Study to Assess the Performance of Accredited Social Health Activists (ASHAs) Functioning under a Select Community Health Centre in a Rural Block from Kerala

Dr. Shakhy Vati^{1*}, Dr. Satheesh B.C², Dr Renuka V³

¹Assistant Professor, Department of Community Medicine, Malabar Medical College Hospital and Research Centre, Calicut, India, Email id: shakhy1988@gmail.com – Corresponding Author

²Professor of Community medicine BGS Medical college & Hospital, Nagaruru, Adichunchangiri university, Bengaluru, Karnataka, India

³Professor of Community medicine, Saphthagiri Institute of medical science, Saphthagiri NPS University, Bengaluru, Karnataka.

Abstract

Background: ASHAs are the cornerstone of community-level service delivery under the National Health Mission(NHM). Their performance is crucial to programme success, yet quantitative evaluations of ASHA performance in Kerala remain scarce. **Objective:** To assess the job performance of ASHAs functioning under a select Community Health Centre(CHC) in a rural block of Kannur district, Kerala, using both self-reported data and beneficiary responses. **Methods:** A cross-sectional descriptive study was conducted during 2019–2020 among 110 ASHAs selected by simple random sampling functioning under the CHC, and 450 beneficiaries (mothers with infants). Data was collected using pre-tested, semi-structured questionnaires administered in Malayalam, supplemented by review of ASHA records and monthly reports. Performance in core maternal and child health(MCH) indicators over the preceding official year was categorized with reference to programme norms and crude birth rate. **Results:** The mean age of ASHAs was 45.9 ± 4.4 years, and 98.2% had 9–10 years of service. The mean population covered($1,424 \pm 304$) exceeded the recommended norm. Performance was high in pregnancy registration(98.2%), completion of six postnatal visits(97.3%) and ensuring complete immunization of infants(95.5%), with $\geq 50\%$ of expected targets achieved; however, only 45.5% achieved this level for Janani Suraksha Yojana(JSY) promotion. Family planning services, escort services, and drug kit availability showed notable gaps. Beneficiary responses corroborated high functionality in antenatal and immunization services but revealed discrepancies in postnatal visit coverage. **Conclusion:** ASHAs were largely functional and effective in delivering key MCH services. Addressing the ageing workforce, workload, underperforming domains such as JSY and family planning, and incentive-related concerns is essential to further strengthen the programme.

Keywords: ASHA; Job performance; Maternal and child health; Community health workers; JSY; Rural Kerala.

1. Introduction

Universal Health Coverage(UHC) envisages that all people receive promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality, without suffering financial hardship.⁽¹⁾ Strengthening primary health care, as articulated in the Alma-Ata Declaration, remains a key strategy for attaining UHC; however, progress is constrained by health workforce shortages, inequitable distribution and performance challenges, particularly in low- and middle-income countries.^(2,3)

Community health workers(CHWs) are widely recognized as a means to bridge this workforce gap. The International Labour Organization describes CHWs as lay workers who provide health education, referral and support to communities in accessing healthcare services.⁽⁴⁾ Unlike formally qualified health professionals, CHWs are drawn from the community itself, undergo shorter training, and deliver culturally appropriate services. Global evidence over the four decades since Alma-Ata demonstrates their valuable contribution to delivering essential, life-saving services at substantially better cost-effectiveness than facility-based higher-level staff, although they often function at the margins of health systems without adequate recognition and support.^(3,5)

In India, National Rural Health Mission(NRHM), launched in 2005 and now subsumed under the National Health Mission(NHM), sought to establish a community-owned, decentralised health delivery system.⁽⁶⁾ A cornerstone of this design is the ASHA, a trained female community health activist selected from and accountable to her own village, generally covering a population of about 1000. The ASHA functions in three complementary roles: link worker facilitating

access to health facilities, service extension worker providing a minimum package of curative care and essential medicines, and community mobilizer, creating awareness on health and its social determinants.^(6,7) She receives an honorarium as well as performance-based incentives rather than a fixed salary. With over 9.3 lakh ASHAs in position nationally, the ASHA has emerged as a key member of the primary health care team, and the cadre's contribution, most visibly during the COVID-19 pandemic, earned it the WHO Director-General's Global Health Leaders Award in 2022.^(8,9)

In Kerala, NRHM was launched in 2006 as 'Arogya Keralam', and about 26,000 ASHAs are in position.⁽¹⁰⁾ Although the state has achieved impressive health indices, sustaining these gains is a challenge.⁽¹¹⁾ Its primary healthcare system faces human resource constraints and public perceptions of poor quality, leading to underutilisation of primary care centres, overdependence on higher-level and private facilities, and high out-of-pocket expenditure.⁽¹²⁾ In this context, a well-functioning ASHA programme, predominantly promotive and preventive in Kerala, can substantially strengthen public primary care.⁽¹³⁾

The performance of ASHAs is crucial to the success of the NHM. Studies across India continue to report inadequate knowledge of roles and responsibilities, workload imbalance, insufficient and inconsistent incentives, and lack of recognition as major impediments to effective functioning and job satisfaction.^(14–16) However, quantitative evaluations of ASHA performance in Kerala remain scarce.^(13,16) The present study was therefore undertaken to assess the performance of ASHAs functioning in a rural block of Kerala, so as to identify gaps and provide actionable feedback to NHM programme managers for further strengthening of the programme.

The performance of ASHAs is crucial to the success of the NHM. Studies from other parts of India have identified inadequate knowledge of roles and responsibilities, financing issues and demotivation as major roadblocks to effective functioning.⁽¹¹⁾ However, published literature on the functioning and performance of ASHAs in Kerala remains scarce. The present study was therefore undertaken to assess the performance of ASHAs functioning in a rural block of Kerala, so as to identify gaps and provide actionable feedback to NHM programme managers for further strengthening of the programme.

2. Materials And Methods

Study Design and Setting

This cross-sectional descriptive study was conducted in the catchment area of a selected Community Health Centre (CHC), a block-level health facility in Kannur district of rural Kerala, with eight Primary Health Centres (PHCs) functioning under it. The study was conducted during 2019–2020.

Study Population:

The study population comprised ASHAs functioning under the selected Community Health Centre (CHC) in Kannur district, and their beneficiaries, namely mothers with infants residing in the respective ASHA service areas. ASHAs with more than one year of working experience at the time of the study who consented to participate were included. Beneficiaries were mothers with infants who were willing to participate and gave informed consent; mothers who had not resided at their current place of residence during pregnancy or the postnatal period were excluded.

Sample size: Using Open Epi sample size calculator for finite population available from (<https://www.openepi.com/SampleSize/SSPropor.html>), sample size for ASHAs was calculated to be 110; taking $p=32.6\%$ (Based on job performance of ASHA in a study by Nagaraj S et al)¹⁷ and $d=5\%$. 20% of the total 2245 beneficiaries registered under the selected ASHAs during the year April 2018 to March 2019 were included in the study which was a total of 449 which was rounded off to 450.

Sampling Method: All the 162 ASHAs functioning under the select CHC was enlisted and 110 ASHAs were selected using simple random sampling. Similarly, a list of beneficiaries under the selected ASHAs was made and 20% of the beneficiaries were selected from the list using simple random sampling. A total of 450 beneficiaries were selected.

Methods of data collection: The list of ASHAs functioning under the CHC, along with their contact details, was obtained. Each selected ASHA was interviewed individually in her respective work area, ensuring that data collection did not

interfere with her routine duties. If a selected ASHA was unwilling to participate, she was replaced by the next randomly selected candidate.

Beneficiaries were approached at their homes with the assistance of the respective Anganwadi teachers and the medico-social worker. If a selected beneficiary was unavailable at the time of the interview, a revisit was made. If she remained unreachable even after the revisit, she was replaced by the next randomly selected candidate.

Data Collection Tools

Socio-demographic and work profile data of the ASHAs were collected using a semi-structured questionnaire adapted from previous studies,¹ which was pre-tested, modified accordingly, and administered in Malayalam.^(18,19)

Job performance was assessed in two ways. First, information on the ASHAs' work profile, the activities undertaken to accomplish their assigned roles, and the payment of performance-based incentives was collected by interviewing the ASHAs using the pre-tested, semi-structured questionnaire.^(18,19) This was supplemented by a review of records: the registers maintained by the ASHAs and the monthly ASHA reports available with the nodal officer of the respective Primary Health Centres were scrutinised to abstract the activities performed during the preceding completed official year (April to March).

Second, the functionality of ASHAs was assessed through a household survey of beneficiaries (mothers with infants), interviewed using a separate pre-tested, semi-structured questionnaire, also validated and administered in Malayalam.

The following domains were assessed: work experience and population coverage; number of house visits and weekly working hours; involvement in key activities; and performance in core MCH indicators during the preceding official year. Performance on each indicator was categorized with reference to programme norms and the crude birth rate.

Data Analysis: Responses were analysed using descriptive statistics. Frequencies, percentages, means, and standard deviations were calculated for key variables

Ethical considerations: The study was started after obtaining ethical clearance from Institutional Ethical Committee. Permission from NHM District Programme Manager, Kannur District was obtained to conduct the study. Written and informed consent in local language was taken from all ASHAs before the interview.

3. Results

The present study included 110 ASHAs functioning under CHC Irivveri.

Socio-demographic Characteristics of Study Population (Table 1)

The mean age of 45.9 ± 4.4 years exceeded the recommended age group, with more than half the ASHAs - 59(53.6%) being more than 45 years old, of which 14 (12.7%) were above 50 years. This age distribution is attributable to the fact that no new ASHAs had been recruited in the past eight years, with around 108 (98.2%) of the ASHAs having worked for 9-10 years in their respective wards. Majority 70(63.6%) had completed 12th standard education, while 36(32.7%) were graduates or post-graduates. Nearly all 106(96.4%) were married. The majority 97(88.2%) belonged to Other Backward Castes (OBC), and 59(53.6%) were in Socio-economic Class IV according to Modified B.G. Prasad's classification.

Table 1. Socio-demographic Characteristics of the ASHAs(n=110)

Socio-demographic profile		Number of ASHAs	Percentage
Age (years)	<40	8	7.3
	40-45	43	39.1
	46-50	45	40.9

	>50	14	12.7
Educational Status	10 th std	4	3.6
	12 th std	70	63.6
	Graduate	22	20.0
	Post-graduate	14	12.7
Marital Status	Married	106	96.4
	Separated	1	.9
	Widow	3	2.7
Religion	Hindu	108	98.2
	Muslim	2	1.8
Caste	SC/ST	4	3.6
	OBC	97	88.2
	General	9	8.2
Socio-Economic status (According to Modified B.G. Prasad's classification) ⁹¹			
	CLASS I	5	4.5
	CLASS II	7	6.4
	CLASS III	24	21.8
	CLASS IV	59	53.6
	CLASS V	15	13.6

Only 5(4.5%) of ASHAs reported involvement in other occupations in addition to their ASHA role.95 (86.4%) were residing in the same ward where they were working.

Work Profile of ASHAs

Most (51.8%) ASHAs covered a population between 1,000 and 1,500. The mean population served per ASHA was 1,424 $\pm$ 304. The mean number of house visits per week was 96.5 $\pm$ 50.1, with 80% of ASHAs reporting visits exceeding 50 houses per week. Only one ASHA reported to be visiting < 25 houses per week. Average weekly working hours showed that 56.4% worked 12- 24 hours with a mean of 24.26 $\pm$ 10.2 hours

Drug Kits and Supplies

None of the ASHAs had a complete drug kit at the time of study. They reported that they helped in distributing drug supplies given to them by PHC/CHC like IFA tablets, Albendazole tablets, condoms, and ORS packets. Supplies were sometimes irregularly available.

Record Maintenance and Meeting Attendance

All ASHAs reported maintaining records in their ASHA diary, documenting households, pregnancies, births, deaths, disease outbreaks, and immunization sessions. All attended Ward Health and Sanitation Committee meetings regularly, with an average of 9 meetings per ASHA per year.

Performance in Core Maternal and Child Health Indicators

Out of various job activities performed by ASHAs during last one year, core MCH related activities i.e. registration of pregnancy, promotion of JSY scheme, completion of 6 post-natal visits and ensuring complete immunization of children were considered to assess performance of ASHAs. Table 2 shows the performance of ASHAs in these activities.

Table2 : Job performance of ASHA workers in MCH Core activities(n=110)

Activities	Job performance*	
	<50% of expected (%)	≥50% of expected (%)
Pregnancy registration	2(1.8)	108 (98.2)
Promotion of JSY scheme	60(54.5)	50(45.5)
Completion of 6 post-natal visits	3(2.7)	107(97.3)
Ensuring complete immunization of children (up to 10 months)	5(4.5)	105(95.5)

- **Performance in Registration of pregnancies**

Based on crude birth rate and population coverage, minimum expected registrations were 13 pregnancies per year per ASHA(based on CHC report) . Nearly all ASHAs (108; 98.2%) achieved 50% of expected registrations. The mean number of pregnancies registered per ASHA was 17 per year (range: 5- 41). Across all ASHAs, 2,245 pregnancies were registered during the year, with 1,886 (84%) facilitated directly by ASHAs.

- **Performance in Promotion of JSY scheme**

Performance in promoting JSY was considerably lower than other indicators. A total of 597 JSY beneficiaries were registered by ASHAs, constituting only 30.9% of the 1,886 pregnant women registered. Most ASHAs (106; 96.3%) registered fewer than 13 pregnancies under JSY; only 50 (45.5%) achieved 50% of expected targets.

- **Performance in Completion of 6 post-natal visits**

Nearly all ASHAs (107; 97.3%) reported completing six post-natal visits for 50% of eligible mothers, with an average of 11 mothers per ASHA per year. All ASHAs ensured completion of minimum five antenatal visits for registered pregnancies, reflecting strong continuity of care.

- **Performance in ensuring immunization of infants up to 10 months**

ASHA performance was particularly strong in supporting childhood immunization. All ASHAs were involved in preparing beneficiary lists and encouraging attendance at immunization sessions. The average number of infants ensured fully immunized up to 10 months was 11 per ASHA per year. A total of 105 ASHAs (95.5%) ensured 50% of infants up to 10 months were immunized up to age. While none directly accompanied children to sessions, their mobilization role was clearly effective.

Performance in Family Planning

All ASHAs were involved in registration of eligible couples, averaging 14 per year per ASHA. However, performance in family planning counselling and motivation was suboptimal. While 108 (98.2%) ASHAs motivated women for IUCD insertion and 98 (89.1%) for tubectomy, only 72 (65.5%) reported accompanying women for post-partum sterilization. None motivated for vasectomy. Only 79 (71.8%) provided antenatal advice on family planning. Major reasons cited for low performance included lack of beneficiary interest (42.3%), religious opposition (58.2%), and fear of IUCD side effects like bleeding (28.6%).

Performance in Disease Control Activities

In communicable disease control, 84 (76.4%) ASHAs notified infectious disease cases, averaging three per year. For tuberculosis, 49 (44.5%) referred persons with chronic cough for sputum examination, with 84.6% giving samples. All TB patients completed treatment successfully. Only 56 (50.9%) served as DOTS providers, indicating underutilization in TB control despite excellent treatment completion outcomes. For leprosy, only 40 (36.4%) ASHAs reported identifying and referring suspected cases, averaging four per ASHA per year, with zero confirmed as leprosy.

Performance in Health Promotion Activities

All ASHAs were involved in well chlorination, with 86 (78.2%) reporting chlorination of all wells at least once every three months. All referred persons aged 30 years to NCD clinics, though only 7.5% of eligible population aged above 30 years were referred (averaging 108 persons per ASHA per year). All accompanied palliative care teams regularly.

Involvement of ASHAs in various activities

Table 3 shows the Distribution of ASHAs based on involvement in various activities

Table 3: Distribution of ASHAs based on involvement in various activities(n=110)

ACTIVITIES	NUMBER*	PERCENTAGE
Home visits	110	100
Counselling on ANC, safe delivery and PNC	110	100
Help AWW in distributing supplementary nutrition	108	77.8
Inform AWW/ANM on birth and death	110	100
Help ANM for immunization	110	100
Distribution of drugs [IFA tablets]	110	100
Accompany pregnant mother to hospital for ante-natal check-up /delivery	9	8.2
Distribution of DOTS	56	50.9
Counselling on new born care and care of young child	110	100
Motivate the couple for family planning	110	100
Motivate for construction of latrines	5	4.5
Maintain records of their work	110	100
Accompany women for family planning services	98	89.1
Helping in preparing blood smear for fever cases	0	0
Preparing beneficiary list for immunization	110	100
Counselling adolescents	110	100

Note: *Multiple responses

All ASHAs referred pregnant women for delivery to District Hospital. All ASHA s reported attending WHSND meeting regularly. Other than these roles, 44(40%) ASHAs reported that they helped people in filling pension forms and ration card applications. 59(53.6%) ASHAs also mentioned that they helped in cleaning up public places. 58(52.7%) ASHA s mentioned that they also helped in conducting space spraying for mosquito control. 68(61.8%) also told that they helped in conducting Gram Sabha meetings. 23(20.9%) ASHAs reported that they helped Kudumbashree workers* in carrying out various community-related activities.

*Kudumbashree: A community organization of Neighbourhood Groups (NHGs) of women in Kerala, has been recognized as an effective strategy for the empowerment of women in rural as well as urban areas.

Functionality of ASHAs as reported by beneficiaries (mother with infants)

The functionality of the ASHAs was also assessed indirectly by interviewing the beneficiaries. Out of the 450 beneficiaries, almost all the beneficiaries, 447(99.3%) have heard about ASHAs. Out of them, majority 441(98.6%) knew the ASHA in their ward while six of them did not.

A total of 450 Beneficiaries (mothers of infants) were interviewed for the study. The average age was 27.7±4.8yrs. All the mothers were literate. Majority 197(43.8%) were graduates Majority (308,68%) of the beneficiaries were APL card holders while 142(32%) were BPL card holders. Most of them 194(43.1%) belonged to Class V socio-economic scale followed by 117(26.0%) who belonged to Class IV.

Table 4: A comparison between responses of ASHAs and Beneficiaries related to MCH and Family Planning Services of ASHA

Activity of ASHA	As reported by ASHA (n=110)	As reported by beneficiaries (n=450)
Pregnancy registration	98.2% of ASHAs registered ≥50% of expected pregnancies	96.3% of beneficiaries were assisted by ASHA in pregnancy registration

	84% of total registered pregnancies that were assisted by ASHAs in registering	
JSY Promotion	30.9% of total pregnant women registered under JSY were assisted by ASHAs in registering for the scheme	37.7% of 390 eligible mothers (APL+BPL) were informed about JSY by ASHA
		30% of 390 eligible mothers were registered under JSY scheme by ASHA
		76% of 113 registered mothers received all benefits of the scheme
Completion of ≥6 post-natal visits	97.3% of ASHAs reported having completed ≥6 post-natal visits of ≥50% of the expected deliveries	4.2% of mothers reported ≥6 visits by ASHAs during post-natal period
Immunization of infants	95.5 % of ASHAs ensured that ≥50% of infants under them were immunized up to age	97% of infants immunized up to age
		99.3% of mothers motivated by ASHA for immunization
Promotion of family planning	71.8% of ASHAs reported giving antenatal advice on family planning	60.7% of beneficiaries received antenatal advice on family planning
	98.2 % of ASHAs motivated women for IUCD after 1 st child	25.6 % of beneficiaries currently using any method of family planning
	7.4% of women who were counselled by ASHA regarding IUCD and were accompanied by her for IUCD insertion	
	89% of ASHAs motivated women for tubectomy.	13.3% of beneficiaries underwent Female sterilization
	16.8% of mothers who were counselled regarding tubectomy and accompanied by ASHA for the procedure	None of beneficiaries who reported being accompanied by ASHA for tubectomy
	None of ASHAs motivated couples for vasectomy	4.4% of beneficiaries were using Copper-T
		2.2% of beneficiaries reported being accompanied by ASHA for IUCD insertion
		7.8% of beneficiaries using condoms

		None of them using OCPs
		None of their husbands underwent male sterilization
Promotion of infant and young child feeding habits	All(100%) ASHAs counseled pregnant women regarding infant feeding and complementary feeding	84.8% of beneficiaries received antenatal counselling regarding breastfeeding
		68.9% mothers started breast feeding within 1 hour
		32.9% of mothers gave pre-lacteal feeds to new born
		83.9% of infants more than 6 months were started complementary feeding at 6 months of age
Accompanying pregnant women and children to health facility	None of the mothers were accompanied ASHA for delivery	None of beneficiaries reported being accompanied by ASHA for delivery
		2.2% of beneficiaries were accompanied by ASHA for antenatal check-up
		0.2% of pregnant woman were accompanied by ASHA for any pregnancy -related complication
		1.1% of mothers were accompanied by ASHA with their sick child to health facility

Payment of performance-based incentives of ASHAs

All (100%) ASHAs receive monetary benefits in the form of matching grants (amount equal to performance-based incentives) apart from performance-based incentives and training related monetary allowances. The majority of the ASHAs i.e. 85(77.3%) reported that they received more than Rs.500/month with an average of Rs.626±320/month. All (100%) ASHAs reported that the incentive amount received was never regular and there was three- or four-months delay in full payment of incentives. None of the ASHAs reported having to pay bribe to get their incentives. 105(95.5%) ASHAs opined that they were dissatisfied with the incentive amount received.

Feedback received on training received

All the ASHAs in the study area has received 21days of induction training which included 1-5 ASHA modules before working in the field. All ASHAs reported to have received training in 7 ASHA modules as of present. Majority (84.4%) of the ASHAs felt that the content of the training was appropriate and adequate and most (95.5%) of them understood the training content. All (100%) of the ASHAs had received adequate facilities for accommodation, food and monetary allowances during the training period. All the ASHA said that they were receiving on job training and majority (77.8%) of them were receiving it from JPHN. All the ASHAs had received appropriate training for the programmes/projects implemented by the Government by the concerned government resource persons.

4. Discussion

The present study assessed the socio-demographic profile, job performance, and functionality of Accredited Social Health Activists (ASHAs) through both self-reported data and beneficiary perspectives.

As per NHM guidelines, ASHAs are expected to be women aged 25–45 years, preferably married and educated up to secondary level. In contrast, the mean age in the present study was higher (45.9 ± 4.4 years), with more than half above 45 years. This deviation from guidelines may be attributed to the absence of recruitment in recent years, resulting in prolonged service duration. Similar findings of relatively higher age groups have been reported in studies from Kerala, whereas studies from Karnataka and Gujarat have reported younger ASHA populations.^(20,21,22) The longer duration of service observed in this study (majority with 9–10 years of experience) contributed to better community familiarity and acceptance, as reflected by high beneficiary awareness (98.6%). However, it also led to challenges such as physical strain during field activities, as reported by a considerable proportion of ASHAs.

The educational status of ASHAs in this study was higher than the minimum prescribed qualification, with most having completed higher secondary education or above. This is consistent with findings from other regions and may positively influence service delivery. The predominance of married women and representation from OBC categories were comparable with previous studies.^(18,23) Most ASHAs belonged to lower-middle socioeconomic class, similar to findings by Saxena et al.⁽²⁴⁾

In terms of work profile, the majority of ASHAs catered to populations exceeding the recommended norm of 1000, indicating increased workload. Similar observations have been reported in studies from multiple states.^(21,25) Despite this, ASHAs demonstrated high involvement in key activities such as home visits, antenatal registration, counselling, and immunization support. The average weekly working hours (24.26 ± 10.2) were comparable to findings from other Indian settings.⁽¹⁸⁾ However, gaps were noted in escort services for delivery, sanitation promotion, and availability of drug kits, reflecting systemic constraints.

Performance in maternal and child health (MCH) indicators was largely satisfactory. Most ASHAs achieved $\geq 50\%$ targets in pregnancy registration, antenatal care, postnatal visits, and immunization. These findings are consistent with studies demonstrating the positive role of ASHAs in improving MCH service utilization.^(26,27) Beneficiary responses further validated these findings, particularly in early pregnancy registration, antenatal check-ups, and immunization coverage.

However, performance was suboptimal in certain areas. Registration under schemes such as Janani Suraksha Yojana (JSY) was low, primarily due to lack of awareness and documentation barriers, as also reported in other studies.^(28,29) Family planning services emerged as a weak domain, with low counselling effectiveness and contraceptive uptake. Sociocultural factors, misconceptions, and gender-related barriers have been identified as major contributors in previous research.^(30,31)

Beneficiary-based assessment revealed high functionality of ASHAs in antenatal and child health services. However, discrepancies were noted in postnatal visits, with ASHAs reporting higher coverage than beneficiaries. This may be due to differences in perception of “visits,” including telephonic contacts. Similar gaps have been observed in other evaluations.⁽²⁰⁾

ASHAs were actively involved in national health programmes, including immunization, tuberculosis control, and non-communicable disease screening. Regular participation in VHNDs and monthly meetings indicates strong integration into the public health system. Nevertheless, their role in curative care remained limited, possibly due to high health-seeking behaviour of the community, with preference for direct facility-based care.

Incentive-related issues were a major concern, with most ASHAs reporting dissatisfaction due to delayed and inadequate payments. This finding is consistent with studies across different states, highlighting the need for strengthening financial support mechanisms.^(18,30) Although training coverage was adequate, with all ASHAs receiving induction and on-the-job training, the need for periodic refresher training has been emphasized in earlier studies to sustain performance.

Overall, the study demonstrates that ASHAs are largely functional and effective in delivering key MCH services. Their long-term engagement has enhanced community trust and service delivery. However, challenges such as ageing workforce, increased workload, gaps in family planning services, and systemic issues related to incentives and logistics

need to be addressed to further improve their performance.

5. Conclusion

The present study demonstrates that ASHAs are largely functional and play a significant role in improving maternal and child health service utilization, particularly in antenatal care, immunization, and community mobilization. Their long-term presence in the community has contributed to high levels of awareness, trust, and accessibility among beneficiaries.

However, several gaps persist. The ageing ASHA workforce, increased population coverage beyond recommended norms, and physical strain may affect long-term sustainability of service delivery. Performance in areas such as family planning, Janani Suraksha Yojana utilization, and postnatal home visits remains suboptimal. In addition, systemic challenges including irregular and inadequate incentives, logistical constraints such as non-availability of drug kits, and limited refresher training continue to hinder optimal performance.

Strengthening the ASHA programme requires periodic recruitment to maintain age balance, rational population allocation, timely and adequate remuneration, and enhanced supportive supervision. Focused training and behaviour change strategies are needed to improve performance in family planning and other under-performing domains. Addressing these gaps will further enhance the effectiveness of ASHAs as key frontline health workers in achieving national public health goals.

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