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Original Research Article

Knowledge of Accredited Social Health Activists (ASHAs) Regarding Their Job Responsibilities: A Cross-Sectional Study from Rural Kerala

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Abstract:

Background: ASHAs serve as critical links between communities and health systems in India. Their awareness of job responsibilities directly impacts service delivery quality.

Objective: To assess the awareness of ASHAs working under Community Health Centre (CHC) Iriveri regarding their diverse job responsibilities across Maternal-child health, communicable disease control, and health promotion domains.

Methods: This cross-sectional study included 110 ASHAs functioning under CHC Iriveri. Data was collected through structured interviews. Awareness of 41 distinct job responsibilities across three domains (link-worker/facilitator, service provider, and activist roles) was evaluated.

Results: All 110 ASHAs (100%) demonstrated complete awareness of core maternal-child health responsibilities including pregnancy counselling, institutional delivery promotion, newborn care, and childhood immunization. Awareness of facilitator roles was universally high (93.6-100%), particularly for pregnancy registration (100%), ANC monitoring (100%), and child immunization (100%). However, awareness of voluntary escort services was limited: only 22(20%) knew about accompanying pregnant women and sick children to health facilities, and 20(18.2%) were aware of accompanying under-5 children for routine immunization. Service provider roles showed awareness levels of 75.5-90% for minor ailments management and DOTS provision 93(84.5%). All ASHAs demonstrated complete awareness of activist roles including community mobilization, health awareness creation, and sanitation promotion.

Conclusion: While ASHAs possess comprehensive awareness of core MCH responsibilities and health promotion activities, significant knowledge gaps exist regarding voluntary escort services. Targeted training on these optional but important roles could enhance community health outcomes. This study provides evidence for capacity-building interventions and role clarification initiatives.

Keywords: Awareness, Job responsibilities, Maternal-child health, Communicable disease control, Rural health systems.

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Introduction

Accredited Social Health Activists (ASHAs) form the backbone of the National Health Mission in India.[1] They act as critical interface between communities and the public health system, serving as essential components of primary healthcare delivery. For an ASHA to perform her work effectively and be a useful contributor to the health of her community, she must possess comprehensive awareness of her job responsibilities and work within a supportive environment. [2,3]

The ASHA programme recognizes three distinct role categories: link-worker/facilitator roles (establishing connections between community and health system), service provider roles (direct provision of basic preventive and promotive services), and activist roles (community mobilization and advocacy).[4,5,6] Despite their importance, evidence regarding ASHA's awareness and understanding of these diverse responsibilities remains limited, particularly from Kerala, a state with advanced health infrastructure and strong community engagement.

Comprehensive awareness of job responsibilities is foundational to effective performance. ASHAs with clear understanding of expectations are more likely to implement services correctly, maintain accurate records, and report systematically to health facilities. Conversely, awareness gaps can lead to missed opportunities for health promotion, incomplete service delivery, and compromised data quality for disease surveillance systems.

The present study was designed to assess awareness of ASHAs regarding their job responsibilities across all three domains, identify knowledge gaps, and provide evidence to guide training and capacity-building interventions.

Material and Methods

Study Design and Setting: This was a cross-sectional descriptive study conducted in the area covered by Community Health Centre (CHC) Iriveri, a block-level health facility in Kannur district of rural Kerala. This CHC has eight Primary Health Centres functioning under it. The study was conducted during 2019-2020.

Study population: All the ASHAs functioning under CHC Iriveri.

Inclusion criteria: Those who have working experience of more than 1 year at the time of study and who give consent to participate in the study.

Exclusion criteria: No exclusion criteria were applied, and all available ASHAs were recruited for the study

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) and d=5%.[7]

Sampling Method: A total of 162 ASHA functioned under CHC Iriveri and all of them had working experience of more than 8 years. All the 162 ASHAs were enlisted and 110 ASHAs were selected using simple random sampling.

Methods of data collection: The list of ASHAs under CHC Iriveri was obtained along with their contact details. Each of the selected ASHAs were interviewed individually in their respective work area [It was ensured that no hindrance to their duty was created during the data collection]. If one ASHA was not willing to participate in the study, they were removed from the sample and the next random candidate was included.

Data Collection: Data was collected through structured interviews with each ASHA using a validated questionnaire that covered 41 distinct job responsibilities.[1] These responsibilities were categorized into three domains:

1. **Link-worker/Facilitator Roles (20 items):** Pregnancy counselling, ANC monitoring, TT vaccination monitoring, IFA tablet distribution, STD screening, institutional delivery promotion, Newborn care, immunization monitoring, disease surveillance, and leadership in community health planning.
2. **Service Provider Roles (6 items):** Distribution of ORS, condoms, sanitary napkins, IFA tablets, contraceptive pills, minor ailment management, DOTS provision, and medication depot functions.
3. **Activist Roles (15 items):** Community meetings, Adolescent health counselling, awareness generation on health schemes and sanitation, toilet construction promotion, vector control, chlorination activities, and referral to specialized services.

For each responsibility, ASHAs were asked whether they were aware it was part of their job and, if applicable, to specify implementation details.

Data Analysis: Responses were analysed using descriptive statistics. Awareness was presented as number and percentage of ASHAs aware of each responsibility. Comparisons were made across the three role domains. Data was analysed using SPSS version 20.

Ethical considerations: The study was started after obtaining ethical clearance from Institutional Ethical Committee. Permission from National Health Mission 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.

Results

ASHA workers form the backbone of the National Health Mission. She acts as an interface between the community and the public health system. For an ASHA to perform her work well and be a useful contributor to the health of her community, she has to be aware of her job responsibilities as well as be in a good work environment to carry out these responsibilities. [9,10,11]

In this regard, the present study was done to determine if the ASHAs were aware of their job responsibilities.

Socio-demographic Characteristics of Study Population: The mean age of the ASHAs was 45.9 ± 4.4 years, with 88(80%) between 40-50 years of age. 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, with family support for their ASHA work universally reported. 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, reflecting the community-embedded nature of the role. Only 5(4.5%) of ASHAs reported involvement in other occupations in addition to their ASHA role.

As per National Health Mission guidelines, an ASHA should be primarily a woman resident of the village, preferably in the age group of 25 to 45 years, should be a married, literate woman with formal education up to the tenth class. [12,13]

In the present study, 95 (86.4%) were residing in the same ward as they were working in. 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.

Link-Worker/Facilitator Role Awareness: All 110 ASHAs (100%) demonstrated awareness of core link-worker responsibilities. Universal awareness was reported for:

- Pregnancy counselling on birth preparedness, safe delivery, feeding practices, and family planning
- Ensuring minimum 5 ANC check-ups
- Monitoring tetanus toxoid (Td) vaccination
- Iron folic acid (IFA) tablet consumption monitoring
- Screening for sexually transmitted diseases in first trimester
- Ensuring institutional delivery
- Identifying pregnancy complications and referral
- Newborn care provision
- Reporting infant deaths to Junior Public Health Nurse (JPHN)/Auxiliary Nurse Midwife (ANM) within 48 hours
- Ensuring child immunization up to age
- Monthly newborn follow-up
- Pregnancy registration with MCTS (Mother and Child Tracking System)

Slightly lower awareness was noted for several facilitator roles. [Table 1]

Table 1: Distribution of ASHAs based on their awareness of their role as as facilitator

Particulars	N=110
Accompanying pregnant women and sick children to health facilities	22 (20%)
Accompanying under-5 children for routine immunization	20 (18.2%)
Promoting and accompanying for terminal sterilization	106 (96.4%)
Promoting and accompanying for IUCD insertion	103 (93.6%)
Facilitating community access to health care	104(94.5%)
Informing about AFP cases in less than 15 years old within 48hrs to health centre and help obtain 2 stool samples from each case	107 (97.3%)
Ensuring a patient on treatment of TB and leprosy completed their treatment.	106(96.4%)

Regarding escort service which is a voluntary role of ASHA, the low awareness regarding escort services 22(20%) for pregnant women and 20(18.2%) for children) represents a significant gap.

All of them were aware of informing JPHN(ANM) about pregnant mothers within 3 months of pregnancy so as to register them in MCTS.

All (100%) the ASHAs were aware of their role in

- helping to conduct monthly meetings of mothers of under-five children and pregnant women and also help organize adolescent meeting for counselling and promoting adolescent health.
- that they had to participate in the monthly meeting at PHC/CHC and that that they were supposed to inform birth and deaths, disease outbreaks to sub-centre/primary health centre.
- that they had to ensure deworming medications are taken by all 1-19 yr olds once every 6 months and that it was their responsibility to identify new cases of leprosy and refer to government facility for diagnosis and treatment.
- that it was their role to accompany palliative care team at least once a month in their activities and follow-up patients weekly.
- that it was one of their responsibilities to refer 30 year old individuals to life-style clinics held in health centres for check-up.
- that she was to identify individuals who need mental health services and refer them to CMHP camps and do regular follow-up as well as refer patients to government health facilities for cataract surgery.
- that they were to provide salt samples for iodine estimation and also help authorities in distribution of bleaching powder for well chlorination and source reduction activities.

Service Provider Role Awareness: Awareness of service provider roles ranged from 75.5% to 100%. [Table 2]

Table 2: Distribution of ASHAs based on their awareness of their role as as service provider

Particulars	N=110
Depot holding for ORS, IFA, condoms, sanitary napkins	110 (100%)
Depot holding for paracetamol, OCPs, and other drugs	99 (90%)
Providing care for minor ailments	83 (75.5%)
DOTS provision for TB patients	93 (84.5%)

Activist Role Awareness

All ASHAs (100%) were aware of activist responsibilities including:

- Community health planning with WHSC
- Conducting health and sanitation sessions
- Awareness on government health schemes
- Health education on nutrition, sanitation, and hygiene
- Toilet construction promotion
- Vector control and source reduction
- Well chlorination
- Referrals to specialized services (mental health, cataract surgery, NCD screening)

Discussion

The demographic variables from the present study were comparable to studies conducted in Kerala. In a study by M. Gopi et al. in Kannur district (2015), 64% of ASHAs were found to belong to the age group of 35-44 years, and in a study by Ratnam AL et al. in Kannur (2018), the mean age was 41.11 ± 4.19 years with majority (42.1%) belonging to the age group of 42-45 years.[14,15] A national evaluation by the National Health Systems Resource Centre (NHSRC, 2011) covering eight states found that all ASHAs were married, but Kerala was unique in that only one-third belonged to the younger 24-35 year age group, with the majority of the remaining above 36 years of age.[16]

This study reveals that ASHAs in rural Kerala possess comprehensive awareness of their job responsibilities across all three domains. The universal awareness of core maternal-child health responsibilities reflects the intensive focus of national MCH programmes on these priority areas. Similarly, complete awareness of health promotion and advocacy functions demonstrates that community mobilization responsibilities are well understood by this cadre.

The uniformly high awareness of facilitator roles, particularly for pregnancy-related activities (registration, ANC monitoring, IFA supplementation, STD screening, institutional delivery), reflects successful implementation of the ASHA programme's core objectives. The 98.2% awareness that all ASHAs should promote institutional delivery and the 100% awareness regarding identification and referral of pregnancy complications are particularly noteworthy, as these directly impact maternal mortality reduction.

However, notable gaps emerge in awareness of voluntary escort/accompaniment services. Only 20% of ASHAs were aware of accompanying pregnant women and sick children to health facilities, and merely 18.2% knew about accompanying children for immunization. While these are optional roles, their underutilization represents a missed opportunity for reducing barriers to health service utilization, particularly among vulnerable populations with limited transportation or health literacy. The awareness gap likely reflects these roles' variable emphasis in training programmes and the perception that they are non-essential in Kerala's context where health-seeking behaviour is generally good. In contrast, studies from other regions show different patterns. In Uttar Pradesh, Kumar et al. found that 97.8% of ASHAs were aware they should accompany pregnant women to health facilities, but only 38% knew about creating community awareness as part of their responsibility.[17] This variation likely reflects regional differences in health-seeking behaviour and the perceived importance of different ASHA roles.

The lower awareness regarding minor ailment management (75.5%) and DOTS provision (84.5%) suggests that these service provider roles are less emphasized in training or perceived as secondary compared to facilitator roles. The 90% awareness for depot holding of common drugs is relatively high but indicates that 10% of ASHAs lack awareness of this responsibility. In Kerala, dependence on the ASHA's curative role is minimal due to good health-seeking behavior and easy accessibility to healthcare facilities, which may partially explain the somewhat lower awareness levels compared to other states.[18]

Minor ailment management awareness (75.5%) could be enhanced through training on common childhood illnesses and basic first aid. DOTS provision awareness (84.5%) indicates that most ASHAs understand this critical TB control function, but refresher training for the 15% unaware would strengthen TB programme outcomes.

The complete awareness of activist roles across all 15 items is a significant programmatic achievement. Qualitative studies from other states have often revealed limited understanding of these broader health promotion functions, but Kerala's ASHAs demonstrate comprehensive awareness of community mobilization, health advocacy, and participation in national programme initiatives.

This universal awareness across activist roles is a significant strength of the programme in this setting. Guha et al., in a qualitative study among ASHAs in Maharashtra, found that while ASHAs had good awareness of their role as link worker, they had somewhat compromised clarity regarding roles as facilitator, social activist, and service provider.[19] Similarly, Saprii et al., in Manipur, revealed that ASHAs mostly understood their role as link worker and service provider but had limited knowledge on their role as 'health activist'.[20] The present study shows better awareness of activist roles, possibly due to intensive training and community engagement programmes in Kerala.

In a study by P. K. Garg et al. in Haryana, while majority were aware of helping in immunization (100%), accompanying delivery cases (98%), and family planning (96.4%), very few ASHAs mentioned assisting ANM in village health planning (21%), creating awareness on basic sanitation and personal hygiene (26%), or registration of births and deaths (17%) as their responsibilities.[21] The study suggested this may be because ASHAs receive very little or no incentives for these activities. In the present study, universal awareness of activist roles despite variable incentive structures suggests that Kerala's training and supervision systems have been more effective in communicating these responsibilities.

The relatively high educational status of the study population with (32.7% graduates/post-graduates) likely contributes to their overall awareness levels. However, awareness does not necessarily translate to correct implementation as crucial distinction that should be explored through performance evaluation studies.

The study demonstrates the effectiveness of the ASHA training programme in conveying comprehensive information about responsibilities. However, structured training on optional but high-impact roles (escort services, minor ailment management) and periodic refresher training on technical aspects would strengthen service delivery.

Conclusion

ASHAs in rural Kerala demonstrate near-universal awareness of core maternal-child health responsibilities and health promotion activities, representing a significant strength of the ASHA programme. However, awareness gaps exist regarding voluntary accompaniment services, which could potentially enhance health-seeking behaviour and reduce barriers to institutional care. These findings suggest the need for targeted training programs emphasizing the importance and implementation of escort services and minor ailment management, as these roles could substantially enhance health outcomes by improving service accessibility.

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