

# Role of Asha Workers as Grassroots Leaders in Strengthening Rural Healthcare in Karnataka, India

Dr. Salma Begum<sup>1</sup>, Dr. Uma C Swadimath<sup>2</sup>, Dr. Shalu Singh<sup>3</sup>

<sup>1</sup>Associate Professor, <sup>2</sup>Professor, <sup>3</sup>Assistant Professor  
Faculty of Management Studies, CMS Business School, JAIN (Deemed-to-be University)  
Bangalore, Karnataka, India

**Abstract:** The Accredited Social Health Activists (ASHAs) are an integral part of the health system, bridging the gap between the formal healthcare services and communities. This study examines the role of the grassroots leaders in enhancing the rural healthcare services in Karnataka. The study is based on secondary data analysis and an extensive literature review that highlights the distribution of the frontline health workforce and its beneficiaries. Further, a correlation analysis is conducted to assess the strong positive relationship between health workers and beneficiaries, underscoring the importance of workforce allocation for health service equity in rural areas. Further, despite the challenges they face, they have emerged as leaders, with 100 percent of ASHAs being women, efficiently strengthening community health engagement. The paper identifies limitations in research on highlighting ASHA workers' roles as grassroots leaders, especially in Karnataka.

**Keywords:** Grassroots Leader, ASHA, ANMs, Health, Community Engagement

## 1. Introduction

Public health being one of the Sustainable Development Goals, it is the responsibility of the Government to provide better health services to its people, particularly the underprivileged groups. Promoting better health care services has always been one of the primary objectives of the Government, both at the state and central levels. In this context, there is a separate portfolio known as the Ministry of Health and Family Welfare (MoHFW), which works towards providing better health care services, undertakes public health programmes such as the creation of health awareness, the establishment of primary health and community health centres, and health education, all of which contributes to a better health care system. The National Rural Health Mission (NRHM) was established by the Government of India in 2005 with the objectives of improving the health care delivery, increasing health expenditure, and providing quality health care services. It has been found that, over a period of time, there is a rise in the feminisation of the health workforce. Their occupations are influenced by socio-economic factors. ASHA workers, ANMs, are significant in sustaining health care functions and services in villages and remote areas.

Globally, women account for around 67% of employment in the health and care sector, making it a highly feminized sector (63.8% in low- and middle-income countries (LMICs) and 75.3% in high-income countries (HICs)) (World Health Organization (WHO) & International Labour Organization (ILO), 2022). Health activists work outside the conventional system to improve accessibility of health services, raise awareness on quality health care and address health-related issues.

### 1.1 Background of the Study

The National Rural Health Mission (NRHM) introduced Accredited Social Health Activists (ASHA) workers to provide health care facilities in the villages and remote areas. The focus

was to make health care services accessible in the villages. The ASHA program is thought to be the NRHM's most visible and important mechanism for community outreach. It is likely the world's largest CHW program with about 1 ASHA per 1000 individuals in India (Santhosh et al, 2021) . ASHA workers are trained female health workers who act as a link between the community and the public health system. They are considered frontline health care providers to improve maternal and child health services and to attain universal health coverage. ASHA workers are chosen from their own villages, must be literate, and are selected by various community groups, self-help groups, Anganwadi centres, and the village health committees. ASHA workers are expected to play a responsible role in performing health functions, such as maternal and child health, disease control, and providing essential medical care, including first aid. ASHA workers are given appropriate training to deliver first contact health care, participate in public health programmes in their villages, provide referral and support services for child health and they will be first point of contact to provide health services to those people who find it difficult to access health services. They also promote good health practices to the rural people. They will provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, information on existing health services, and the need for timely utilisation of health & family welfare services. They are also a part of health and wellness centres. J & Angadi (2015) elaborate on the role of ASHA workers. They conducted a cross-sectional study of ASHA workers who worked in primary health centres in the Bijapur district of Karnataka. Every ASHA worker was to provide basic health care services, and they were aware of the incentives that would be given to them based on their performance. They were also trained before reaching out to the people in rural villages. Sharma et al. (2014) note that since 2005, ASHA workers have played a crucial role in strengthening community health services in India. Although ASHAs primarily work under the health department, they supported the Government in Rajasthan. They analysed how factors such as motivation, training, and incentives improve the performance of ASHA workers, thereby improving the overall health outcomes. They work under the Integrated Child Development Scheme (ICDS), providing nutrition, health, and early childhood services. The functions of ASHA workers include population enumeration, assessment of health risks, and awareness of chronic illness.

## **2. Review of Literature**

The NRHM report (2014) Government of Karnataka, examines the National Rural Health Mission (NRHM) programme launched in 2005 to support and improve India's public health system. This report provides insights about the assessment undertaken in Karnataka which focuses on fund allocation, health expenditure and health infrastructure. The report states that health funding has been mainly in Reproductive and Child Health allocation whereas there was a small share for routine immunization. There exist regional disparities in the districts of Karnataka. The role of frontline health workers, particularly Auxiliary Nurse Midwives (ANMs) and Accredited Social Health Activists (ASHAs), is widely recognized in the report as a key strength of NRHM implementation. The report also reveals the challenges such as workload, job security, inadequate remuneration and support, there is a lack of administrative staff in primary health centres. The report states that though Karnataka is ranked high among other northern states in terms of rural health care but there remain district gaps in the health care provided by the state. Gulbarga, Raichur, Bellary, Bidar, Koppal and Chamarajanagar districts have inadequate health care facilities as there exists malnutrition in under-five children and anaemia in women, poor hospital infrastructure and shortage of ANMs and doctors in primary and community health centres.

S Karpagam, et.al (2016) examine the problems faced by women from marginalized communities in accessing health care facilities through Government funded health insurance schemes such as the Rashtriya Swasthya Bima Yojana (RSBY) and the Vajpayee Arogyasri Scheme (VAS). The authors analyse the implementation of these schemes and observe that most vulnerable groups, elderly women, were excluded, and argue that health resources are diverted from Governmental health facilities and preventive, non-profitable health interventions towards profitable tertiary care services delivered by the private sector. Empirical evidence indicates that poorer households in districts covered by state and centrally sponsored health insurance schemes experienced an increase in real per capita health care expenditure. In Karnataka, households incurred substantial out-of-pocket expenses under all government-sponsored health insurance schemes (GSHIS). Notably, beneficiaries of the Vajpayee Arogyasri Scheme spent an average of ₹32,256 to access services under this programme.

R. Vijayalakshmi (2016) evaluates the role of self-help groups (SHGs) in empowering rural women in Gubbi taluk of Tumkur district at the individual, household and institutional levels. The author emphasized women's participation in economic affairs to help not only develop a nation but also attain gender equality, which could be achieved through SHGs. SHGs are microcredit institutions that serve as a mechanism for empowering women economically and socially and also help reduce rural poverty. Through her study, it was strongly felt that education was essential for ensuring women's participation, along with awareness and motivation. Although there were improvements at the individual and household levels, institutional support was required.

Asha, B. et al. (2018) highlight the importance of community participation for identifying local health problems and needs among women and children. According to the authors, women are bound by socio-cultural norms where customs and beliefs influence their health status. An effective use of the public health system is essential for proper maternal and child care. Their study has used a participatory rural appraisal (PRA) method to analyse health conditions through tools such as village mapping, transect walks and focus group discussions and demonstrated that through this method they could collectively identify health problems and prioritise health needs such as maternal health services and child health needs in rural areas of Giriyapura and Lokikere villages of Davangere district in Karnataka.

A report by the Directorate of Economics & Statistics (2020) provides an overview of the status of women in Karnataka. The report states that the nutritional status of women and children in the state is not satisfactory and requires interventions to bring improvements. Rural health infrastructure in Karnataka is faced with inadequate resources of trained manpower, medicines, and equipment, and there is a high maternal mortality rate in rural districts. This requires improving rural health infrastructure.

Gupta, N. (2021) elaborates on the health issues faced by rural women in India and examines the role of women in maintaining household and agricultural activities. Women shoulder responsibilities since their childhood marked by limited autonomy, illiteracy and financial dependence. Though education is a fundamental right, rural girls have limited access to schooling and high dropout rates. Reports by the United Nations and UNICEF highlight persistent gender inequalities in access to education, health care, and nutrition, with households frequently prioritising the schooling of male children. High levels of female illiteracy in rural areas are closely associated with early marriages and pregnancies, increased maternal and

infant mortality, and adverse health outcomes. Poverty, child marriage, gender-based violence, and deep-rooted gender norms remain key obstacles to girls' education. Although some progress has been made, Rajasthan continues to have one of the lowest female literacy rates in the country, with many women dropping out before completing upper primary education.

Meenakshi, M., & Kulkarni, S. (2022) have described the importance of women empowerment and discussed the challenges faced by women. Despite legal policies, women continue to face harassment, discrimination and humiliation, with a limited role in decision making and family support. The paper suggested that it's only through empowering them that women can uphold their rights, realize their potential, and become financially independent. The study was conducted in Rural Bangalore district and discussed the issues and challenges of women empowerment.

### **Research Gap**

Though the Government at the central and state levels have introduced various health care schemes, rural people are not aware of these schemes. The National Rural Health Mission report, Government of Karnataka indicates lack of health care facilities in rural areas. The health system focuses on the provision of health care services, but there are limited studies on the role of ASHA workers as grassroots leaders and to help and empower rural women. There are fewer studies on how empowerment indicators such as mobility, participation in household decision-making, education and access to information that relates to women's ability to utilise health services. In this context, these gaps need to be addressed to improve the status of the frontline health workers and the health status of rural women.

### **3. Data Analysis and Findings**

The study is based on secondary data analysis to examine the role of women health workers in strengthening rural healthcare service delivery.

#### **3.1 Distribution of ASHA workers**

Figure 1 demonstrates the state-wise database of ASHA workers in India (as per the report of the Ministry of Health and Family Welfare, Department of Health and Family Welfare, 2024). The top three states across India are Uttar Pradesh, Bihar, and Chhattisgarh. Karnataka, as a state, represents 41,013 ASHA workers, which is 4% of the total distribution.

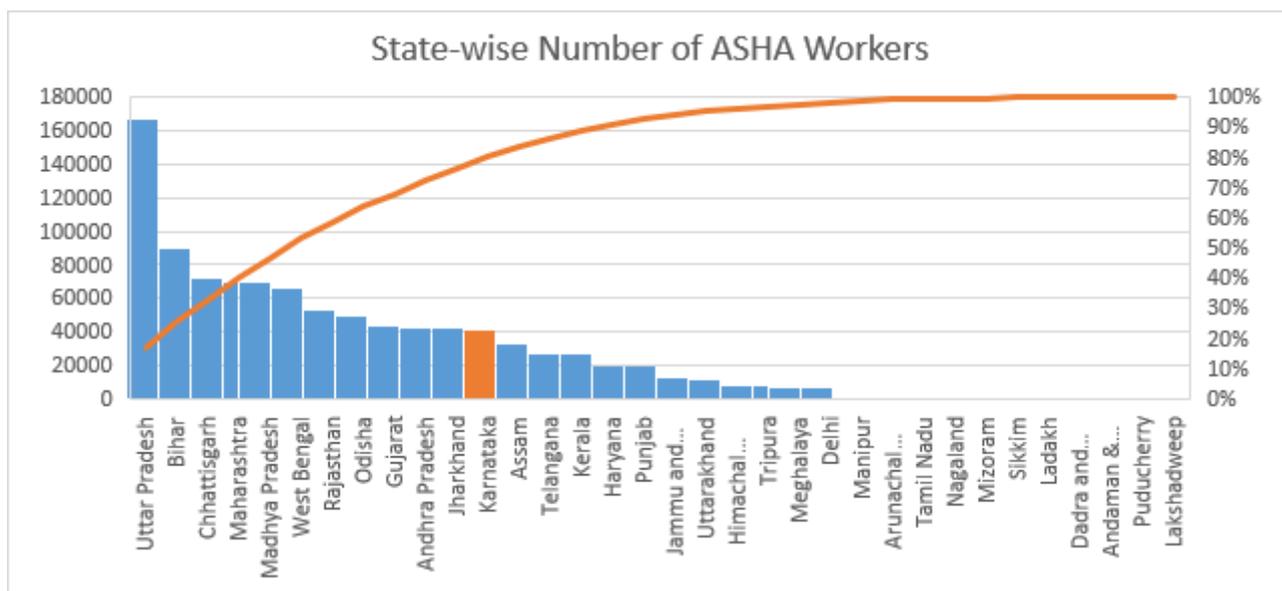


Figure 1: State-wise number of ASHA workers

Source: [Ministry of Health and Family Welfare, Department of Health and Family Welfare, 2024](#)

District-Wise (Karnataka) Details of Eligible ASHA’s, Aww and AWHs in The State of Karnataka

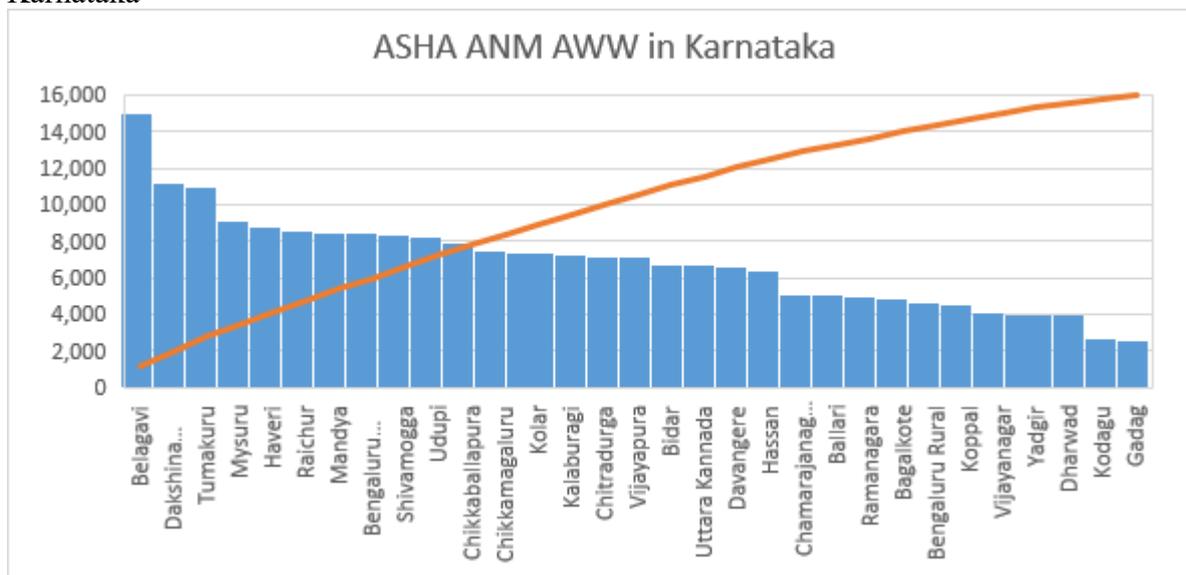


Figure 2: District-wise number of ASHA workers in Karnataka

Figure 2 presents the data for 31 districts in Karnataka, which represent the eligible and active numbers of ASHA, AWW, and AWH. The Total number represents 215,105 of the active members. The table highlights significant variation across districts in Karnataka. Belagavi district has the highest number, 15,061, while Gadag has the lowest, 2,631. The above data provide a clear understanding of the ASHA and AWW distribution and demonstrate a comparative analysis of policy-level interventions in order to improve the ASHA involvement and the outreach activity.

### 3.2 Eligible Beneficiaries

#### District-Wise Details of Eligible Beneficiaries in The State of Karnataka

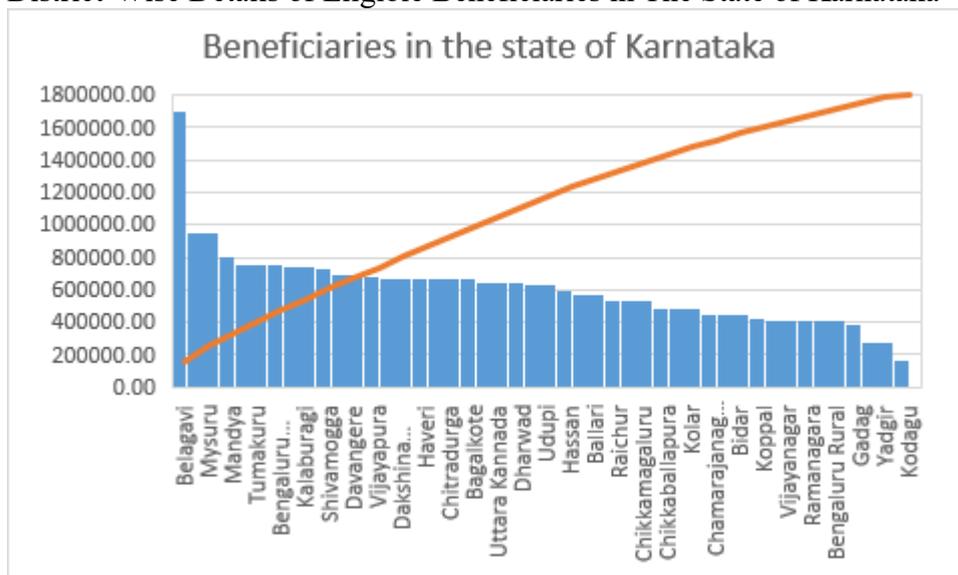


Figure 3: District-Wise Details of Eligible Beneficiaries in The State of Karnataka

Source: [https://sansad.in/getFile/annex/268/AU1075\\_5KZP4Y.pdf?source=pqars&utm](https://sansad.in/getFile/annex/268/AU1075_5KZP4Y.pdf?source=pqars&utm)

Figure 3 represents district-wise data of eligible beneficiaries in Karnataka, with moderate variation across all 31 districts. All the given districts have a relatively moderate range of beneficiaries, which shows a balanced distribution of the beneficiaries across Karnataka. The Mysuru districts and Kodagu districts indicate the highest and lowest counts of beneficiaries, respectively. This also suggests that policymakers can bridge this gap by implementing the Health Program Initiative in such districts.

### 3.3 Correlation between Workforce and Beneficiaries

To examine the relationship between the health workforce and beneficiaries, a correlation test is conducted.

Table 1: Correlation Test

	<i>Eligible ASHA, AWW &amp; AWH Workers and Family Members</i>	<i>Eligible Beneficiaries</i>
Eligible ASHA, AWW & AWH Workers and Family Members	1	
Eligible Beneficiaries	0.814498	1

Source: Author's Calculation

The correlation coefficient of 0.814 indicates a strong positive correlation between the ASHA workers and women beneficiaries. Districts with more ASHA/ANM workers tend to serve more beneficiaries. This underscores the importance of workforce allocation in achieving equitable healthcare delivery.

### State-wise Number of ANM Trained

State/UT-Wise Number of Trained Nurses as on 31.12.2022

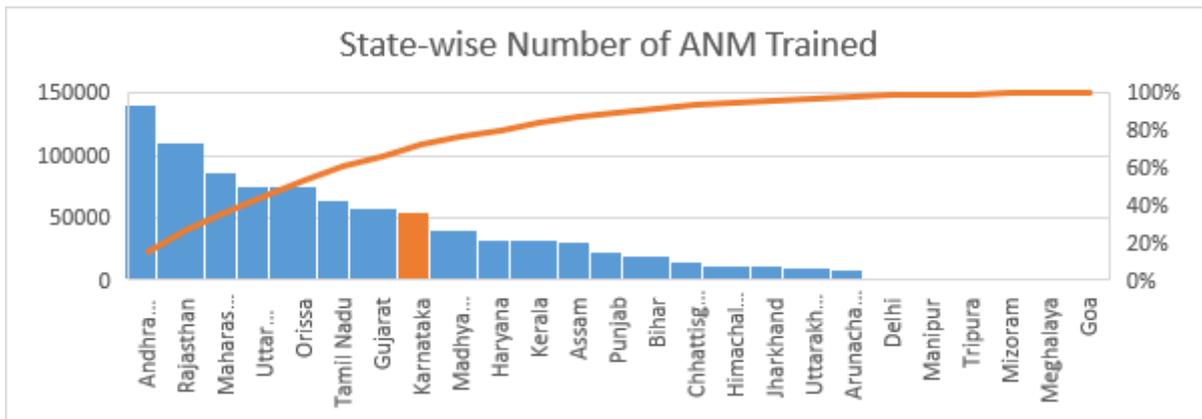


Figure 4: State/UT-Wise Number of Trained Nurses

Source: [https://rsdebate.nic.in/bitstream/123456789/744673/1/PO\\_262\\_12122023\\_U1089\\_p446\\_p449.pdf?utm](https://rsdebate.nic.in/bitstream/123456789/744673/1/PO_262_12122023_U1089_p446_p449.pdf?utm)

Figure 4 represents the State/UT-wise number of Auxiliary Nurse Midwives (ANMs) across India as on 31 December 2022. The data shows significant variation across Rajasthan, Andhra Pradesh, Uttar Pradesh, and Maharashtra, with the highest numbers of trained ANMs in these states. In a few states and Union Territories, such as Goa, Meghalaya, and Mizoram, there are relatively fewer trained ANM personnel.

#### ANM Training Centre in Karnataka

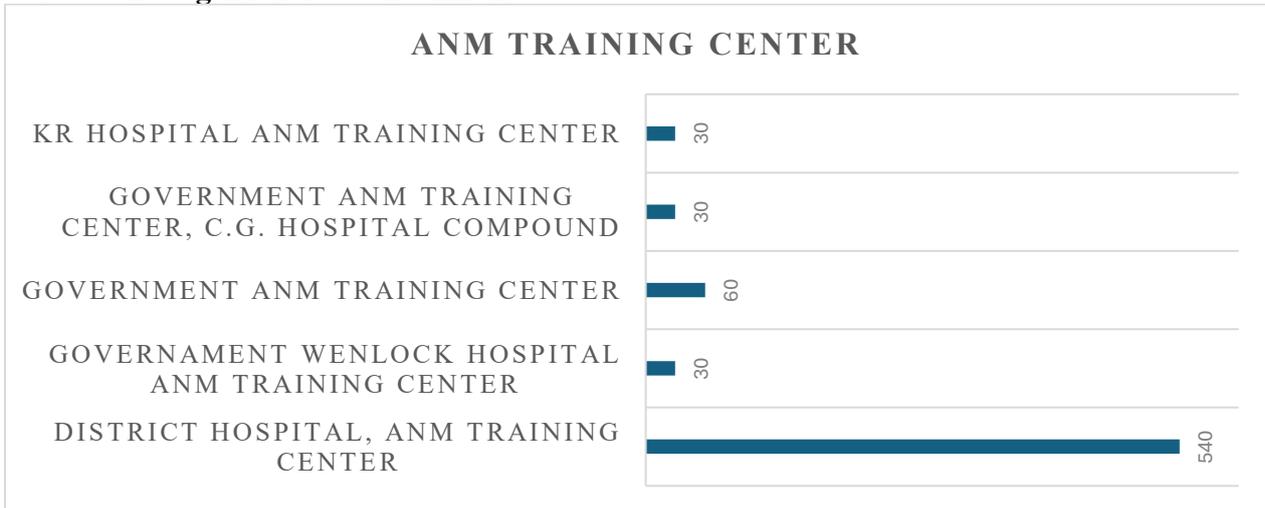


Figure 5: ANM Training Center

Source:

[https://www.ksnc.karnataka.gov.in/userfiles/file/ANM%20Recognised%20List\\_FINY9.pdf](https://www.ksnc.karnataka.gov.in/userfiles/file/ANM%20Recognised%20List_FINY9.pdf)

Figure 5 presents the district-wise Auxiliary Nurse Midwife (ANM) training centers in Karnataka, as well as highlight annual intake capacity. There are total of 23 ANM training hubs have been listed; each hub indicates the uniformity in intake of 30 trainees, reflecting standardized training capacity process across all districts in Karnataka. These centers are primarily located in district hospitals and government hospital campuses, ensuring wide geographic coverage across the state.

#### 4. Challenges

ASHA workers have to travel long distances, so they do not have access to toilets or clean drinking water. It has been found that there is a delay in receiving their incentives and

remuneration, there is no job security, and they are underpaid. Rao et al (2021) highlighted the fact that ASHA workers are prone to emotional and physical violence in the regions of North Karnataka. Despite these challenges, a recent study by Mishra et al. (2024) emphasizes the need for improved institutional and maternal service delivery by ASHA workers to improve rural healthcare. However, limited research on Karnataka limits understanding of the challenges and their contributions as grassroots leaders in rural healthcare.

## 5. Conclusion

ASHA is the backbone of India's rural health system. In Karnataka, they significantly improve access to care, promote preventive practices, and facilitate women's empowerment. However, structural and institutional challenges persist. Strengthening training, incentives, and recognition mechanisms is critical to sustain their contributions and ensure equitable healthcare delivery across rural districts.

***Acknowledgments:** The authors gratefully acknowledge the financial support provided by the Indian Council of Social Science Research (ICSSR) under the Punyashloka Devi Ahilyabai Holkar Special Call for Women-Led Research on Women-Led Development for the project titled "Women's Leadership in Rural Healthcare: Evaluating Gender-Sensitive Health Systems and Community Well-being in Karnataka". The support of the funding agency in facilitating this research is sincerely appreciated.*

## References

1. Asha, B., Kumar, A., & Kengnal, P. (2018). Assessment of Health Problems, Needs and Cultural Beliefs of Women in a Rural Area of Karnataka, India: A Participatory Rural Appraisal Method. *Journal of Integrated Community Health*, 7(1), 14–19.
2. Directorate of Economics & Statistics, Government of Karnataka (2020). Men and women in Karnataka 2019–20. [https://des.karnataka.gov.in/storage/pdf-files/PTC/Men%20and%20Women%20in%20Karnataka\\_%202019-20.pdf](https://des.karnataka.gov.in/storage/pdf-files/PTC/Men%20and%20Women%20in%20Karnataka_%202019-20.pdf)
3. J. S. K., & Angadi, M. M. (2015). Assessment of roles and responsibilities of ASHA workers in Bijapur taluk of Karnataka. *Indian Journal of Pharmaceutical and Biological Research*, 3(2), 78–80. <https://doi.org/10.30750/ijpbr.3.2.9>
4. Gopalan, S. S., Mohanty, S., & Das, A. (2012). Assessing community health workers' performance motivation: A mixed-methods approach on India's Accredited Social Health Activists (ASHA) programme. *BMJ Open*, 2(5), e001557. <https://doi.org/10.1136/bmjopen-2012-001557>
5. Government of India. (2011), Report of the working group on National Rural Health Mission (NRHM) for the Twelfth Five Year Plan (2012–2017).
6. Gupta, Neeta. (2021). Health Issues of Uneducated Working Women in Rural Areas of India. *International Journal of All Research Education & Scientific Methods*, Volume 9(12), 43-50. <https://www.ijaresm.com/health-issues-of-uneducated-working-women-in-rural-areas-of-india>
7. Karpagam, S., Vasan, A., & Seethappa, V. (2016). Falling Through the Gaps: Women Accessing Care under Health Insurance Schemes in Karnataka. *Indian Journal of Gender Studies*, 23(1), 69-86. <https://doi.org/10.1177/0971521515612864>
8. Meenakshi, M., & Kulkarni, S. (2022). Issues and challenges of women's empowerment in Bangalore Rural District. *International Journal of Food and Nutritional Sciences (IJFANS)*. 11(10). 5424-5430

9. Rao, L., Prakash, R., Rai, P., *et al.* (2021). Investigating violence against Accredited Social Health Activists (ASHAs): A mixed methods study from rural North Karnataka, India. *Journal of Global Health Reports*, 5, e2021054. <https://doi.org/10.29392/001c.24351>
10. Shanthosh, J., Durbach, A., & Joshi, R. (2021). Charting the Rights of Community Health Workers in India: The Next Frontier of Universal Health Coverage. *Health and human rights*, 23(2), 225–238.
11. Vijayalakshmi, R. (2016). Empowerment of rural women through self-help groups in Tumkur and Gubbi talukas of Karnataka. *International Journal of Applied Research*, 10(9). 642-649 <https://www.allresearchjournal.com>
12. World Health Organization. (2022a). Community health officers: A promising resource in delivering comprehensive primary health care in Assam. <https://apps.who.int/iris/handle/10665/352600>
13. World Health Organization, & International Labour Organization. (2022), The gender pay gap in the health and care sector. <https://www.who.int/publications/i/item/9789240052895>