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ASHA Workers in India: A Quest for Socio Legal Identity

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Abstract: ASHA workers play a key role in the healthcare apparatus as links between public healthcare delivery systems and the community they serve. Their principal tasks involve creating awareness and providing information to communities on matters of nutrition, sanitation, hygiene, family planning and existing public health services. They are involved in counselling women and their families on birth preparedness, breastfeeding, immunisation of infants, health and contraception. Given the declining female labour force participation, the government's recognition of front-line workers and their contribution to human development is an urgent requirement. ASHAs deliver services crucial to the health and well-being of the population. The advancement of ASHA workers translates to grassroot recognition, revival of rural economies, and women's empowerment. Therefore, recognizing ASHA workers is a legal, social, and moral duty, the consequent encouragement of which will go on to advantage rural communities at large.

Keywords: ASHA workers, Public health services, Female labour force participation, Rural communities

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Introduction

ASHA will be a health activist in the community who will create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services. She would be a promoter of good health practices. She will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals. ASHA will be the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services (NRHM, 2005). On the health front, ASHA workers play a key role in the

healthcare apparatus as links between public healthcare delivery systems and the community they serve. According to the National Health Mission guidelines, their principal tasks involve creating awareness and providing information to communities on matters of nutrition, sanitation, hygiene, family planning and existing public health services. They are involved in counselling women and their families on birth preparedness, breastfeeding, immunisation of infants, health and contraception. ASHAs also accompany pregnant women and children requiring treatment to the nearest health facility (such as a primary health centre [PHC], community health centre or first referral unit). None of them perceived it as "voluntary" work that could be done based on how much time they had, rather as duties that any regular employee has to perform (Sinha *et al*, 2021). The burden of work on these women is not something that would qualify as being part time or voluntary (Jain *et al* 2020).

Given the declining female labour force participation, the government's recognition of front-line workers and their contribution to human development is an urgent requirement. ASHAs deliver services crucial to the health and well-being of the population. The chronic lack of attention to their working conditions only serves to weaken policy outcomes, women's empowerment and community development over all (Sinha *et al*, 2021). This has also prompted the National Human Rights Commission to ask the Centre and States to file reports on the poor working conditions of ASHAs. The existing policy framework for ASHAs, based on regressive classifications of women's labour, does not support adequate compensation, and is in need of a complete overhaul.

Objective

Keeping the above perspective in mind the basic objective of this study is to examine the socio legal identity of ASHA workers in India

Methodology

Descriptive research design and secondary sources will be used in the research study.

Discussion

ASHA as a women health worker

Gender analysis in human resources for health highlights the overrepresentation of women as unpaid and often unrecognized carers for sick or elderly family

members (George, 2008). A gender analysis of the health labour force also reveals significant levels of violence experienced by health workers in the health sector. Women health workers are disproportionately victimised by such violence due to gendered ideologies that subjectively sanction such violence or due to their structurally disadvantaged position within the health labour force. As female health workers contravene conservative gender norms in their homes, in public spaces and through their health work, they risk attacks on their intimate selves, endangering their sexuality and personal safety, despite being educated and economically viable. Interventions must address both the normative values that naturalise and sanction such violence, as well as the structural biases that place female health workers at greater risk through poor working conditions and gender blind management practices (George, 2007). With regard to CHWs in particular, studies have found that women generally prefer that CHWs who deliver reproductive, maternal, and child health interventions be female, because norms limit interaction between women and men who are not members of the same family. However, female CHWs are themselves limited by social norms constraining movement beyond the home and are vulnerable to critique and censure if they are seen to violate norms, such as by travelling outside the home at night or speaking to men (Kok, 2015). Apart from the cross-cutting influence of social norms, gender dynamics influence CHWs at individual (family and intra-household relationships), community (safety and mobility), and health systems (remuneration and career progression) levels (Steege, 2018).

This analysis identified the gender trade-offs and complexities inherent to developing and sustaining a CHW programme at scale within a challenging context of patriarchal norms, health system hierarchies, federal governance structures, and rapidly evolving aspirations, capacities, and demands from female CHWs and the communities in which they reside. While the ASHA programme has consciously tried to move past its instrumentalist origins, continual adaptations are required to address ongoing gender challenges, both anticipated and unanticipated. These reforms, while imperfect due to the complexities faced, do chart progress and highlight the investments and responsive planning required to support gender transformation in CHW programmes (Ved *et al*, 2019).

ASHA: Volunteer or Worker?

The stereotype that persists of women's ability and their inbuilt consciousness to understand other fellow beings' feelings, especially other women, makes them

perfectly suitable to be recruited as community workers. This explains the presence of a large number of women in community-based programmes across the world. But, in India, there is a refusal to recognise this "all women workforce" as workers providing labour. They are classified as "honorary workers", denied minimum wages, leave and other conditions that work entails. Sugar-coated in the superior value-domain of women as the embodiment of care service providers, the state prefers to call them "volunteers". The assumption that women's care and emotional labour is outside the mundane world of markets is often evoked to pay these overworked workers just an honorarium. But, even in the best paid states, this honorarium is not even close to the government-mandated minimum wages offered to workers doing comparable jobs. Many petitions have been submitted by community workers and their unions demanding recognition as workers. During the pandemic, Anganwadi, ASHA and National Health Mission workers had a two-day nationwide strike demanding safety, insurance, risk allowance and fixed wages. The Parliamentary Standing Committee on Labour also recommended formalising the work of community workers. But the government has not relented (Neetha, 2021).

Performance based Incentive of ASHA

In India under National Rural Health Mission, it was decided that CHWs i.e. ASHAs would be financially remunerated through activity or task based incentive was considered as one of the motivational factors. By-design even though the ASHAs are defined as volunteers but PBP introduced incentive regime into this programme. Incentive regime establishes a contractual relationship with the ASHA and in principle negates the voluntary nature of ASHAs work. The decision of the government to keep ASHAs as volunteers, not sanction them as full time employees and earn based on task specific incentives was premised on a number of reasons. It was believed that all-women cadre of CHWs will not get into malpractices and focus more on the care and co-ordination aspect of clinical care; secondly, this position was made voluntary in nature because the Ministry of Finance was not in favour of creating a large new government cadre with a long term commitment for salaries, related benefits and pension. It was felt that respective states should develop their capacity to manage such positions later (Ved et. al, 2019). The experience of PBP to ASHAs in India shows that it does not help to cease the continuous demand for future fixed monthly salary and government employment. The state governments are yet not agreeing to provide income guarantee at a minimum level. It overall prevents them from integrating

with the economy through their occupational roles and function in full capacity (Langer *et al.,* 2015).

The Need for Social Protection and Opportunities for Growth

Not being classified as 'employees', ASHAs do not have access to formal frameworks of social protection. They instead have to rely on ad hoc, temporary welfare measures. In 2018, the Union Government made ASHAs eligible for life insurance, accident insurance and pension under the following schemes: *Pradhan Mantri Jeevan Jyoti Beema Yojana*, *Pradhan Mantri Suraksha Beema Yojana*, *Pradhan Mantri Shram Yogi Maan Dhan*. However, the free cover under these schemes appears to only have been provided for a period of one year. Several States have enrolled ASHAs under their own social security schemes. Following the pandemic, an additional monthly incentive of Rs. 1000 was provisioned for ASHAs undertaking COVID-related activities, and they were also included for insurance cover under *Pradhan Mantri Garib Kalyan Yojana*. However, over 30 per cent of ASHAs claim they have not received the incentive amount, as reported in a study by Behan Box and Azim Premji University. Further, there was high variability among States in the number of months for which this additional incentive was provisioned.

In sum, these are temporary measures and do not guarantee social protection in the long term. Frontline workers, including ASHAs, have not been included in the new Code on Social Security, 2020, contrary to the recommendations of the Parliamentary Standing Committee on Labour. In 2013, states were asked to identify ASHA workers who wanted to obtain class X or class XII qualifications, which would enable them to enrol in ANM or Nurses Training Schools, and fund their registration with NIOS. However, a 2018 review of the NHM shows limited progress. The number of ASHAs enrolled in career advancement avenues was very low across States: 1800 in Jharkhand, 120 in Maharashtra and 119 in Assam (Ambast, 2021).

Conclusion

ASHAs as CHWs are core to the availability of health services and their quality improvement. Thus, it is realised that the burden of underpaid community health work in India falls on the ASHAs. In this process there is a need to engage with the ASHA workers organization and collectives to develop better pay regimes with right to decent work and recognize them as workers with right. At the same time the state in healthcare has to develop better systems of measuring and

understanding programme management, sustainability and accountability and value. All this is critical in order to realize the four targets of United Nations' Sustainable Developments Goals (SDGs) by 2030: SDG 3 (health care for all), SDG 4 (education for all), SDG 5 (gender equality) and SDG 8 (decent work and economic growth) (Roy, 2019). The advancement of ASHA workers translates to grassroot recognition, revival of rural economies, and women's empowerment. It is imperative that their working conditions and task-based incentives be standardised, upholding the principle of equal pay for equal work. There is a need for employment rights of ASHA workers. Therefore, recognizing ASHA workers is a legal, social, and moral duty, the consequent encouragement of which will go on to advantage rural communities at large.

References

Ambast S, Why do ASHA workers in India earn so little?, 2021.

George A. Nurses, community health workers, and home carers: gendered human resources compensating for skewed health systems. *Glob Public Health.* 2008; 3(Suppl 1):75–89.

George AS. Human resources for health: a gender analysis. Review Paper prepared for the Women and Gender Equity, and Health Systems, Knowledge Networks Networks (KNs) of the WHO Commission on the Social Determinants of Health. 2007. Available from: https://www.who.int/social_determinants/resources/human_resources_for_health_wgkn_2007.pdf.

Government of India. National Rural Health Mission-ASHA. Module Guidelines. New Delhi, India: Ministry of Health and Family Welfare; 2005.

Jain, Anoop, Dilys M Walker, Rasmi Avula, Nadia Diamond-Smith, Lakshmi Gopalakrishnan, Purnima Menon, Sneha Nimmagadda, Sumeet R Patil and Lia C H Fernald (2020): "Anganwadi Worker Time Use in Madhya Pradesh, India: A Cross-sectional Study," BMC Health Service Research, Vol 20, No 1130, https://doi.org/10.1186/s12913-020-05857-4.

Kok MC, Kane S, Tulloch O, Ormel H, Theobald S, Dieleman M, *et al*. How does context influence performance of community health workers in low- and middle-income countries? Evidence from the literature. Heal Res Policy Syst. 2015;13(1):13.

Langer A, Meleis A, Knaul F M, Atun R, Aran M, Arreola-Ornelas H, Bhutta Z A, Binagwaho A, Bonita R, Caglia J M, Claeson M, Davies J, Donnay F A, Gausman J M, Glickman C, Kearns A D, Kendall T, Lozano R, Seboni N, Sen G, Sindhu S, Temin M, Frenk J (2015) Women and Health: the key for sustainable development, Lancet, Vol 386 September 19, http://dx.doi.org/10.1016/ S0140-6736(15)60497-4

Neetha N., Govt must give ASHAs, Anganwadi volunteers rights, benefits due as workersIndian express Updated: January 12, 2021.

Roy B. 4th International Conference on Public Policy (ICPP4) June 26-28, 2019, ASHAs in India: Gender, Voluntarism and Performance Based Payment. Centre for Women's Development Studies, Indian Council for Social Science Research Institute, New Delhi

Sinha, Dipa, Mohini Gupta and Diksha Shriyan (2021): "High Risk without Recognition: Challenges Faced by Female Front-line Workers," Economic and Political Weekly, www.epw.in/engage/article/high-risk-without-recognition-challenges-faced.

Steege R, Taegtmeyer M, McCollum R, Hawkins K, Ormel H, Kok M, *et al*. How do gender relations affect the working lives of close to community health service providers? Empirical research, a review and conceptual framework. Soc Sci Med. 2018;209(April):1–13.

Ved, R *et al*., How are gender inequalities facing India's one million ASHAs being addressed? Policy origins and adaptations for the world's largest all-female community health worker programme, 17 Human Resources for Health 3 (2019).