Protecting the Protectors: A Critical Analysis of the Labor Rights, Health, and Life Security of ASHA Workers in India

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ABSTRACT

The systemic weaknesses of Accredited Social Health Activists (ASHAs) in India are critically examined in this paper. Even though the ASHA program has received praise from all around the world for its effectiveness in enhancing public health outcomes, our research shows that its foundation is based on a risky and exploitative labour model. The main contention is that the government's designation of ASHAs as "honorary volunteers" is a purposeful legal and policy framework intended to deprive them of statutory protections, formal labour rights, and just compensation. This tactic exposes them to a triple burden of structural violence, occupational health hazards, and economic precarity, all of which are exacerbated by deeply ingrained caste-based and patriarchal societal norms. These weaknesses were not created by the COVID-19 outbreak; rather, it brought them to light and made them worse, emphasizing the fundamental contradiction between the state's reliance on ASHAs and its failure to behave as a conscientious and moral employer. Based on a comparative analysis of formalized community health worker programs in nations like Brazil and Rwanda, this article argues that formalizing ASHAs as permanent government employees is essential for a respectable and long-lasting public health system. The suggestions made provide a road map for immediate institutional, social, and legislative changes to protect the rights, dignity, and welfare of this vital workforce.

Keywords: ASHA workers, India, Labor rights, public health, community health workers (CHWs), Devaluation of labor, Volunteerism, Gendered labor, Economic precarity, Occupational health and safety, Social security, Protest movements, Health policy

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INTRODUCTION

The Paradox of India's Health Warriors

With their name meaning "hope" in Hindi, Accredited Social Health Activists, or ASHAs, are the cornerstone of India's public health system, especially in underserved and rural areas.[2] The ASHA program has worked to place a trained female community health activist in every village since the National Rural Health Mission (NRHM) was introduced in 2005. This individual will act as the "first port of call" for any health-related issues. From organizing institutional births, delivering vaccinations, and acting as a crucial conduit between impoverished communities and the official healthcare system, their roles are critical and varied. They provide a minimal package of curative care for minor illnesses, give women advice on breastfeeding and birth preparation, and distribute necessities like condoms and Oral Rehydration Therapy (ORS).[3] Their work is not a traditional nine-to-five job; rather, they are expected to be on call almost 24 hours a day to respond to community health needs, a responsibility that often requires them to travel across villages in challenging climates without protective gear.[4] During the COVID-19 pandemic, they were recognized globally for their heroic efforts, earning the World Health Organization's World Health Leaders Award in 2022 for their contributions as frontline workers.[5]

ASHAs are at a crossroads of great responsibility and vulnerability despite their vital contributions. They work in a setting of ongoing uncertainty and instability and are among the most underpaid and overworked employees in India's public health system. By proving that ASHAs' precarious status is not an accidental result of their explicit legal classification as "volunteers" rather than official "workers," this study seeks to resolve this paradox. By shifting the costs and risks of providing public health services to a marginalized, mostly female workforce, this legal deception perpetuates a cycle of economic and social devaluation, as this paper will establish. Because healthcare work is framed as a "natural extension" of women's

[2] Ameya P. Bondre et al., *Evaluation of a Positive Psychological Intervention to Reduce Work Stress among Rural Community Health Workers in India: Results from a Randomized Pilot Study*, 21 Soc. Indic. Res. (forthcoming 2025), https://pmc.ncbi.nlm.nih.gov/articles/PMC11832669/

[3] Nat'l Health Mission, *Accredited Social Health Activist (ASHA)*, Ministry of Health & Fam. Welfare, Gov't of India, https://nhm.gov.in/index1.php?lang=1&level=1&lid=49&sublinkid=969.

[4] Nat'l Health Mission, *Guidelines on ASHA* (2012), https://nhm.gov.in/images/pdf/communitisation/task-group-reports/guidelines-on-asha.pdf.

[5] Hari Sankar D. et al., *The role(s) of community health workers in primary health care reform in Kerala, before and during the COVID-19 pandemic: a qualitative study*, 3 Front. Reprod. Health (2024), https://pmc.ncbi.nlm.nih.gov/articles/PMC10937443/.

domestic responsibilities rather than as skilled labour deserving of just compensation and legal protection, the paradox of ASHAs is a profoundly gendered and labour-centric issue.

This report's fundamental argument is that, despite meeting all of the de facto requirements for employees, ASHAs are routinely excluded from the rights and protections that accompany that status. Regardless of the existence of a written contract, Indian labour law uses the "control and supervision" test to determine whether an employer-employee relationship exists, as established by significant Supreme Court rulings. Since they must report to local health committees, attend frequent meetings at Primary Health Centres, and have their work evaluated by Auxiliary Nurse Midwives (ANMs) and other health officials, ASHAs are actually subject to a structured system of control.[6] The legal designation as "volunteers" is a purposeful administrative decision that permits the state to circumvent basic labour laws, preventing ASHAs from receiving a minimum wage and from being included in important laws like the Payment of Gratuity Act of 1972 and the Code on Social Security of 2020.[7] The concrete and human repercussions of this institutional denial of labour rights include placing ASHAs in a state of continuous financial instability, exposing them to workplace dangers, and maintaining a sense of powerlessness and emotional exhaustion. By combining legal analysis with an empathetic perspective on ASHAs' daily experiences, this document aims to serve as a fundamental resource for understanding the intricate problems they face and the urgent need for systemic reform.

LITERATURE REVIEW

The Genesis and Evolution of the ASHA Program

In order to close the gap between communities and the official health system, the ASHA program was created in 2005 as a key component of the National Rural Health Mission. The original idea was to develop a group of health activists who would educate and raise awareness of health issues in communities, encouraging them to use the services that are already available.[8] With an initial focus on three main objectives are immunization, encouraging hospital deliveries, and reducing infant and mother mortality. These roles were created as part-

[6] Anu Maria E. et al., *A Conceptual Paper on ASHA Worker: The Need to be Recognized as Employees*, Indian Inst. of Mgmt. Ahmedabad (2023), https://www.iima.ac.in/sites/default/files/2023-04/WP%202023-04-02.pdf.

[7] Nat'l Human Rts. Comm'n, *Manual DM* (2010), https://nhrc.nic.in/sites/default/files/MANUAL_DM.pdf.

[8] Nat'l Health Mission, *Accredited Social Health Activist (ASHA)*, Ministry of Health & Fam. Welfare, Gov't of India, https://nhm.gov.in/index1.php?lang=1&level=1&lid=49&sublinkid=969.

time, voluntary work with a modest honorarium of Rs. 500. But as time went on, the range of their duties grew considerably, putting a tremendous strain on the workforce without a corresponding adjustment to their pay or legal status. In addition to serving as depot holders for necessary medications like Iron Folic Acid (IFA) tablets and Oral Rehydration Therapy (ORS), ASHAs are now expected to offer a minimal package of curative care for minor illnesses and be integral to disease-specific programs like Directly Observed Treatment Short-course (DOTS) for tuberculosis. In villages and sub-centres, they are also in charge of facilitating access to health-related services, educating women about health determinants, and counselling them on how to prepare for childbirth. Although they are still regarded as volunteers, their role has changed from that of a "link worker" or "activist" to that of a central, essential source of services.

Devaluation of Labor: A Global and National Perspective

The systematic undervaluation of ASHAs' work is a reflection of a larger, worldwide public health trend in which overburdened public health systems are supplemented by unpaid or inadequately compensated labour. These workers, who are frequently women, are denied official employment rights and benefits because they are labelled "volunteers" or "honorary workers." This strategy justifies a lack of equitable compensation by framing their crucial contributions as a logical progression of gendered caregiving roles.[9] The "casualization of female labour" in the public sector is best illustrated by the ASHA program, which is widely acknowledged as the largest cohort of informal health workers in the world. This devaluation results from India's caste system and patriarchy, which are intertwined problems that diminish the social and economic worth of women's labour, especially that of marginalized groups. The state can legally avoid paying them a living wage, providing social security, and providing safe working conditions by classifying their work as "voluntary." This effectively shifts the costs and risks of providing public health services onto a workforce that is already at risk.[10]

The Legal-Economic Conundrum

The classification of ASHAs as "volunteers" and the performance-based incentive system are directly related to their financial precarity, as research continuously shows. A modest fixed honorarium from the central government and a long list of performance-based incentives

[9] S. Mahajan, *ASHA-A Social Audit*, SSRN (2025), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=5361040.
[10] Citizens for Just. & Peace, *India's ASHA Workers: Overworked, Underpaid, and Exploited* (June 28, 2025), https://cjp.org.in/indias-asha-workers-overworked-underpaid-and-exploited/.

(PBIs) for accomplishing particular, quantifiable tasks, like encouraging institutional deliveries, family planning, and vaccination drives, make up their compensation model.[11] Although this model theoretically aims at motivating and incentivizing performance, in reality, it has caused extreme financial instability of ASHAs. They have very unstable monthly earnings and the ones who receive them are sometimes below the minimum wage in their states.[12] This precarity is further compounded by frequent delays in payment, which can extend for months, forcing ASHAs into a cycle of debt and financial distress, a phenomenon that has been described as a form of "economic violence." The approach also generates a skewed incentive structure, in which ASHAs may prioritize high-incentive duties over less financially rewarding community education and preventative care. For instance, while they are compensated for specific tasks like assisting in a delivery, they are not paid for the time spent counselling a community member on basic hygiene, which is a critical part of their job.[13] This model thus undermines the very goals of the program by creating a fundamental conflict between a worker's livelihood and the holistic needs of their community. Furthermore, ASHAs have reported that their income is often eroded by fines for missing meetings or delayed data submissions, transforming their "benefit" into a system of "financial extraction" that deepens their economic vulnerability.[14]

RESEARCH METHODOLOGY

This paper is built on a comprehensive, qualitative, and comparative research design. It combines a variety of scholarly, legal, and journalistic sources to create a complex and evidence-based case. The analysis of ASHA workers' conditions is underpinned by the examination of qualitative data points, such as income levels, work hours, and the prevalence of specific health issues like malnutrition, as reported in various studies. These numerical

[11] Adity Singh, *Frontline, Forgotten: The ASHA Workers' Fight for Fairness*, Int'l Health Pol'y (July 26, 2025), https://www.internationalhealthpolicies.org/featured-article/frontline-forgotten-the-asha-workers-fight-for-fairness/.

[12] Nat'l Health Mission, *ASHA Incentives* (2024), https://nhm.gov.in/New-Update-2023-24/ASHA/Orders_and_guidelines/ASHA-Incentives.pdf.

[13] Lakshmi Gopalakrishnan et al., *Association between coordinated counseling from both ASHA and Anganwadi Workers and maternal health outcomes: A cross-sectional study from Madhya Pradesh and Bihar, India*, 4 PLOS Glob. Pub. Health 1 (2024), https://pmc.ncbi.nlm.nih.gov/articles/PMC11560015/.

[14] Priyanka Raj, Devaki Nambiar & A. Sivaram, *Community health workers: challenges and vulnerabilities of Accredited Social Health Activists working in conflict-affected settings in the state of Assam, India*, 16 BMC Health Serv. Res. 1 (2021), https://pmc.ncbi.nlm.nih.gov/articles/PMC8369326/.

findings are used to quantify the impact of their "volunteer" status on their health and economic security.[15]

This study's comparative section includes a detailed review of policies and outcomes in several Indian states as well as a worldwide perspective. This strategy entails meticulously comparing labor laws, remuneration patterns, and social security measures across jurisdictions to discover best practices and demonstrate that ASHAs' precarious condition is not an unavoidable conclusion.By contrasting India's model with those of countries like Brazil and Cuba, this report employs a cross-national, comparative framework to highlight the link between a formalized, well-supported Community Health Worker (CHW) cadre and improved public health outcomes.[16] The synthesis of these qualitative and comparative analyses allows for a deeper understanding of the causal relationships between the legal classification of ASHAs and their lived experiences.[17]

RESEARCH QUESTIONS

1. What is the de jure and de facto legal status of ASHA workers within the framework of Indian labor jurisprudence?
2. How does this classification impact their right to minimum wages, social security benefits, and occupational safety protections under Indian labor laws?
3. What are the specific health and life security vulnerabilities faced by ASHAs, and how are these exacerbated by their employment status?
4. How do legislative and judicial actions, both proposed and historical, reflect and influence the ongoing struggle for ASHA workers' rights?
5. What lessons can be drawn from the varying state-level policies in India and formalized CHW models in other countries to inform a more equitable framework for ASHAs?

[15] Varsha Singh & Sanjay Dahiya, *Rural Health Management: A Diagnostic Analysis of the ASHA's Challenges vis-à-vis Work Performance*, 18 HSB Research Rev. 42 (2023), https://gjust.ac.in/portal/upload/5.%20RURAL%20HEALTH%20MANAGEMENT%20A%20DIAGNOSTIC%20ANALYSIS%20OF%20THE%20ASHA%E2%80%99S%20CHALLENGESVIS-%C3%80-VIS%20WORK%20PERFORMANCE_24April2024_10-59-36-48.pdf.

[16] S. Mahajan, *ASHA-A Social Audit*, SSRN (2025), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=5361040.

[17] Ritu Shrivastava et al., *"We are everyone's ASHAs but who's there for us?" a qualitative exploration of perceptions of work stress and coping among rural frontline workers in Madhya Pradesh, India*, 344 Soc. Sci. & Med. 116234 (2023), https://chwcentral.org/wp-content/uploads/We-are-everyones-ASHAs-but-whos-there-for-us-a-qualitative-exploration-of-perceptions-of-work-stress-and-coping-among-rural-frontline-workers-in-Madhya-Pradesh-India.pdf.

RESEARCH OBJECTIVES

The central paradox of the ASHA program is its reliance on an indispensable, yet profoundly vulnerable, workforce. It is a direct outcome of a deliberate legal classification that places them outside the formal protections of labor law. This section will delve into the legal, economic, and social dimensions of this issue, drawing on empirical and comparative analysis to answer the core research questions posed by this study.[18]

THE LEGAL AND DE FACTO STATUS OF ASHAS

The legal classification of Accredited Social Health Activists (ASHAs) as "volunteers" has been one of the most enduring contradictions in India's public health governance. De jure, ASHAs are not considered employees of the state but rather honorary volunteers who receive honoraria and incentives for certain tasks.[19] This classification strategically exempts the government from obligations under the Minimum Wages Act, 1948, the Payment of Gratuity Act, 1972, and the Code on Social Security, 2020, which would otherwise mandate a comprehensive suite of rights, benefits, and entitlements. However, when looking at their job through the prism of labor law, ASHAs plainly meet all of the criteria for an employment relationship. They are formally recruited through government channels, trained in public health procedures, overseen by Auxiliary Nurse Midwives (ANMs) and medical officers, and must attend mandatory meetings at Primary Health Centres (PHCs).[20] Their daily routines are not independent acts of charity but organized labor subject to the control and supervision of state health machinery.[21]

Indian labor law has historically relied on the "control and supervision" test to determine whether an employment relationship exists. The Supreme Court in ***Mackinnon Mackenzie & Co. Ltd. v. Audrey D'Costa*** underscored that what matters is not the nomenclature of a worker's

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[18] Varsha Singh, *ASHA Workers in India: A Quest for Socio Legal Identity*, 3 Soc'y & Culture Dev. in India 301 (2023), https://www.arfjournals.com/image/catalog/Journals%20Papers/SCDI/2023/No%202%20(2023)/10_Varsha%20Singh.pdf.

19 Nat'l Health Sys. Res. Ctr., *9th Common Review Mission Report* (2015), https://nhsrcindia.org/sites/default/files/2021-03/9th%20CRM%20Report.pdf

20 Ministry of Ayush, Gov't of India, *Annual Report 2016-17* (2017), https://ayush.gov.in/resources/pdf/annualReport/ANNUAL-REPORT-2016-17-ENGLISH.pdf

21 The Code on Social Security, 2020, No. 36, Acts of Parliament, 2020 (India), https://vvgnli.gov.in/en/code-social-security-2020

designation but the substance of their working relationship, particularly whether the employer exercises effective control over their duties.[22] Using this test, ASHAs are subject to rigorous control mechanisms: their targets are defined by the state, their performance is measured using structured metrics, and their incentives are linked to compliance with state directives. In other words, they are not autonomous actors, but rather essential components of the state's health-care infrastructure.

Yet the Supreme Court's judgment in ***State of Karnataka v. Uma Devi*** presents a formidable legal hurdle. In Uma Devi, the Court held that contractual or temporary employees cannot claim regularization unless specific statutory authorization exists. The government has now used this precedent to oppose calls for ASHA formalization, claiming that without a legal mandate, they cannot be recognized as permanent employees. This judicial doctrine has been challenged for allowing the state to profit from workers' labor while avoiding employer-related obligations.For ASHAs, it translates into a legal limbo: they are "workers" in practice but "volunteers" in law.[23]

The implications of this legal deception are substantial. By designating ASHAs as outside the jurisdiction of labor law, the government denies them the same safeguards that Indian courts have traditionally provided to other marginalized workers, such as beedi workers and domestic workers.Their exclusion reflects not only administrative convenience but also the political economy of gendered labor. In interviews, ASHAs repeatedly articulate the contradiction of being treated as employees in every practical sense—being given orders, monitored, and disciplined, yet being denied the dignity, stability, and rights that come with formal recognition. This denial of status is thus not accidental; it is an intentional design to sustain systemic exploitation under the cloak of volunteerism.

WAGES, BENEFITS, AND ECONOMIC VIOLENCE

The financial condition of ASHAs exposes the structural inequities built into their employment model. ASHAs typically receive between ₹2,000 and ₹4,000 per month, depending on state-specific honoraria and performance-based incentives (PBIs). Most states' statutory minimum

22 Mackinnon Mackenzie & Co. v. Audrey D'Costa, (1987) 2 S.C.C. 469 (India), https://clpr.org.in/wp-content/uploads/2024/12/1.Mackinnon_Mackenzie_and_Co_Ltd_vs_Audrey_Dcosta_ans870446COM891108.pdf

23 Sec'y, State of Karnataka v. Umadevi, (2006) 4 S.C.C. 1 (India).

salary for unskilled labor is between ₹9,000 and ₹12,000 per month.The inadequacy of these wages is compounded by frequent delays: government audits reveal that in several states, payments are withheld for periods extending from three to six months. Such unpredictability pushes ASHAs into chronic debt cycles, forcing them to borrow from informal lenders at exploitative interest rates just to manage household expenses.[24]

The PBI system's design inherently reinforces disparities. ASHAs are reimbursed for services that may be quantified and easily measured, such as escorting a lady to an institutional delivery or guaranteeing sterilization following childbirth. However, they are paid little or nothing for equally important but less quantifiable responsibilities like counseling women on hygiene, nutrition, and nursing practices.This creates a perverse incentive structure in which ASHAs are compelled to prioritize tasks that provide financial reward, even if the community's broader health needs lie elsewhere. The model thus undermines the holistic objectives of public health by reducing care work to a checklist of incentivized activities.

The punitive part of the incentive system exacerbates this precarious situation. Reports show that ASHAs have suffered deductions or fines for missing meetings, submitting data late, or failing to reach arbitrary benchmarks. This turns what was already modest pay into a vehicle for wealth exploitation.Instead of empowering ASHAs, the remuneration system actively penalizes them, deepening their vulnerability and stripping the agency.[25]

Scholars have correctly described this system as a type of "economic violence." Economic violence, unlike physical violence, operates insidiously: it deprives workers of critical resources, denies them stable income, and forces them to cycles of deprivation that diminish dignity and autonomy. For ASHAs, economic violence manifests in the state's deliberate decision to externalize the costs of public health delivery onto women's unpaid or underpaid labor. This model allows the government to boast of improved health indicators while hiding the fact that such gains are achieved at the expense of a precarious workforce whose basic needs are systematically neglected.

24 Kavita Bhatia, *Performance-Based Incentives of the ASHA Scheme: Stakeholders' Perspectives*, 50 Econ. & Pol. Wkly. 71 (2015), Performance-Based Incentives of the ASHA Scheme: Stakeholders' Perspectives on JSTOR

25 Kavita Bhatia, *Performance-Based Incentives of the ASHA Scheme: Stakeholders' Perspectives*, 50 Econ. & Pol. Wkly. 71 (2015, Performance-Based Incentives of the ASHA Scheme: Stakeholders' Perspectives on JSTOR

In contrast, global examples reveal the transformative impact of recognizing community health workers as employees. In Brazil, community health workers are salaried municipal employees who are entitled to pensions, protective equipment, and set working hours. Their compensation is not based on particular performance criteria, but rather on the overall worth of their public health contributions. The Brazilian experience demonstrates that public health outcomes improve when workers are financially secure, underscoring that India's reliance on volunteerism is not an economic necessity but a political choice.

HEALTH AND LIFE SECURITY VULNERABILITIES

ASHAs' precarious condition manifests not just in economic hardship, but also in severe health and life security concerns. Their job demands them to go large distances on foot or by bicycle, often in harsh weather conditions and without proper protection gear.Exposure to dust, heat, and rain is routine, yet occupational health protections—such as footwear, umbrellas, or even clean drinking water—are rarely provided. This absence of basic safety provisions underscores the structural disregard for their wellbeing.

The COVID-19 pandemic starkly magnified these vulnerabilities. ASHAs were deployed as the frontline agents of pandemic control, tasked with contact tracing, household surveys, awareness campaigns, and facilitating vaccinations. Yet they were sent into high-risk environments without adequate personal protective equipment, regular testing, or insurance coverage. Thousands caught COVID-19, and many died in the line of duty. Families of deceased ASHAs frequently had their compensation claims dismissed on the basis that they were "volunteers" rather than workers. The government's refusal to acknowledge their sacrifice through institutional compensation illustrates a callous exploitation of women's labor in the guise of patriotic sevices.[26]

Beyond the pandemic, ASHAs face routine social risks. Reports highlight widespread instances of sexual harassment when ASHAs accompany pregnant women to hospitals at night or conduct home visits in isolated areas. Many people are forced to endure such abuse in silence because there is no institutional support or grievance processes. Their designation as

26 Swetha Sridharan et al., *Frontline Health Workers' Experiences of a Digital Health Information System in India: A Qualitative Study*, 14 BMJ Open e082348 (2024), https://pubmed.ncbi.nlm.nih.gov/39398660/

"volunteers" limits their capacity to request protection measures including transportation allowances, escorts, and complaint redressal mechanisms.

Scholars have described this phenomenon as "structural carelessness." The word describes how systemic negligence, rather than isolated instances, results in a predictable pattern of harm. For ASHAs, the lack of occupational safety is intrinsically rooted in their precarious situation. The interplay of gender, class, and caste exacerbates this vulnerability. Many ASHAs come from marginalized neighborhoods, where their social status predisposes them to exploitation.The state's abdication of responsibility thus compounds existing hierarchies, producing layered vulnerabilities that undermine not just the workers but also the communities they serve.[27]

Humanizing these risks are the stories of ASHAs who balanced unpaid domestic labor with unpaid pandemic response. Many recount leaving their own children unattended to conduct COVID-19 surveys, only to face public hostility from neighbors who feared infection. Such narratives illustrate the emotional and psychological toll of structural carelessness, reminding us that behind every "volunteer" statistic is a woman whose dignity and safety are routinely sacrificed in the name of public health.[28]

PROTEST, MOBILIZATION, AND STATE RESPONSES

Despite their precarious situation, ASHAs have evolved as one of India's most vocal and organized informal worker groups. More than 600,000 ASHAs went on strike in different states in July 2020, demanding more compensation, on-time payments, and safety equipment.Their mobilization during a global health crisis reflected not only the depth of their grievances but also their growing recognition that collective bargaining is essential to challenge systemic exploitation.[29]

The history of ASHA protests reveals a trajectory of transformation. Initially introduced as passive volunteers expected to serve without question, ASHAs gradually built networks of solidarity across states. Trade unions and civil society organizations were instrumental in

27 Christa Wichterich, *Protection and Protest by "Voluntary" Community Health Workers: COVID-19 Authoritarianism in India*, 46 Hist. Soc. Rsch. 163 (2021), Protection and Protest by "Voluntary" Community Health Workers on JSTOR

28 Hitha V. Nair et al., *Role and Function of Frontline Health Workers During the COVID-19 Pandemic in a Rural Health Center in Kerala: A Qualitative Study*, 16 Cureus e69128 (2024), https://pmc.ncbi.nlm.nih.gov/articles/PMC11469169/

29 Dep't of Admin. Reforms & Pub. Grievances, Gov't of India, *Viksit Bharat @2047: Governance Transformed* (2025), https://darpg.gov.in/sites/default/files/Viksit_Bharat_2047_Governance_Transformed.pdf

amplifying their demands, portraying them as claims of workers' rights rather than petitions for kindness. Strikes, sit-ins, and petitions have become common characteristics of their activity, shattering the myth that they are altruistic caregivers outside the scope of labor law.

The state's response, however, has been piecemeal and evasive. At times, governments have announced token increases in honoraria or temporary insurance schemes, often in response to public pressure rather than structural reform. In March 2025, for example, the Minister of State for Health and Family Welfare responded to a Lok Sabha question by stating that state governments, rather than the Union government, bear primary responsibility for funding ASHAs. The deferral of responsibility splits accountability and prevents any single authority from recognizing ASHAs as employees.

The continuation of such evasive responses exposes an underlying political logic. The government benefits from the present paradigm, which achieves considerable public health outcomes at a low cost. Formalizing ASHAs would entail economic duties while also providing negotiating power to a huge cadre of female workers. Resistance to reform stems from a desire to keep control over a necessary but subordinate workforce, rather than economic feasibility.

However, the trajectory of ASHA mobilization indicates that the present quo may be unsustainable. Their strikes are increasingly disrupting public health services, compelling governments to recognize their importance. More crucially, ASHAs have begun to describe their position as labor deserving of praise, rather than charity. This change from passive compliance to active resistance is a huge step forward for India's labor movement, with the potential to reshape public health governance.

COMPARATIVE MODELS: BRAZIL, RWANDA, SOUTH AFRICA

International experience demonstrates that the precarious status of ASHAs is neither inevitable nor necessary. Countries such as Brazil, Rwanda, and South Africa provide compelling counter examples, showing that community health workers (CHWs) can be formalized, salaried and protected while strengthening public health outcomes.

In Brazil, CHWs are integral to the *Sistema Único de Saúde*, the country's universal health

system. They are municipal employees who receive fixed salaries, pensions, and occupational benefits. Their occupation is classified as professional labor, and they are given with protective equipment and ongoing training. By institutionalizing CHWs, Brazil has achieved remarkable improvements in maternal and child health outcomes, demonstrating that public health systems flourish when frontline workers are treated with dignity.

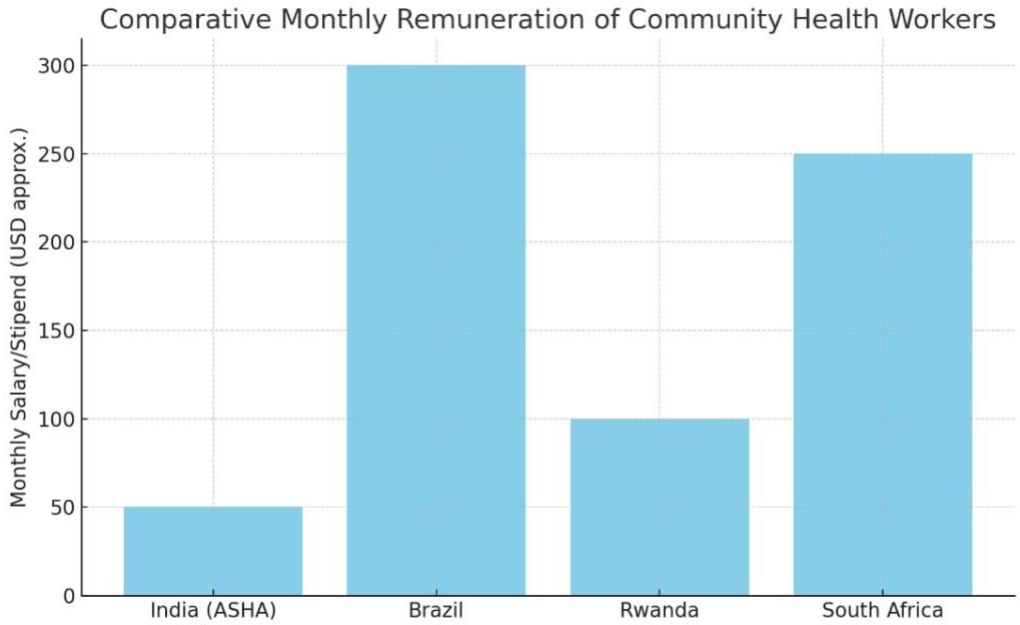
Rwanda offers another instructive example. Its CHWs receive stipends from the government, along with formal training and integration into health planning structures. Unlike India's fragmented incentive-based model, Rwanda's strategy ensures that CHWs are motivated not only by financial incentives, but also by a sense of belonging and institutional support. This has resulted in more stable and resilient health personnel who can effectively respond to disasters.

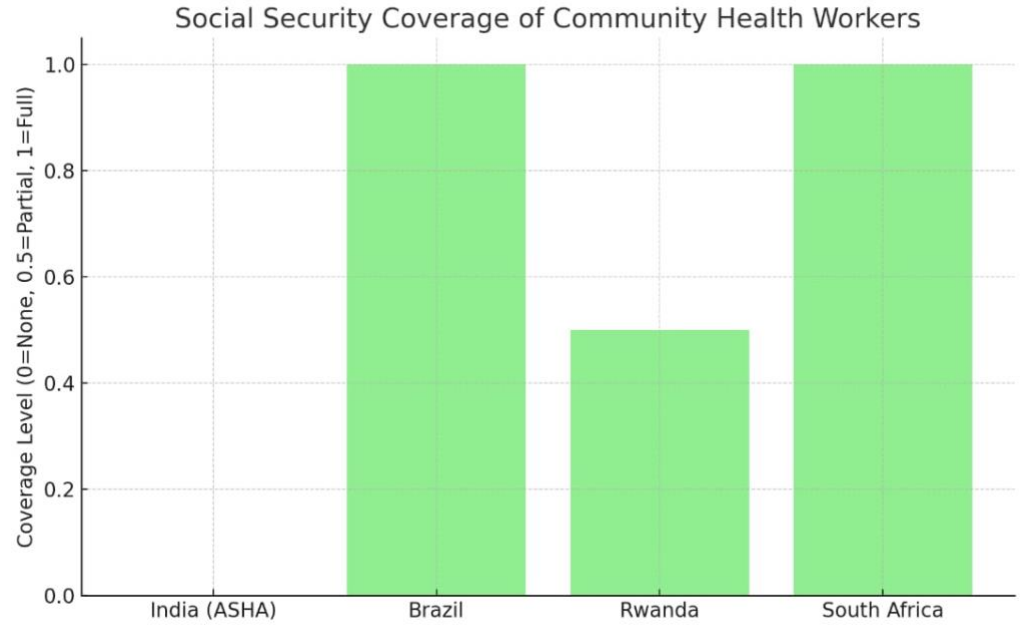
South Africa's history demonstrates the need of collective action in gaining recognition. CHWs there have fought long legal and political fights for formalization, eventually gaining pay and union representation.Their unionization has ensured that CHWs have a voice in policy-making, creating a feedback loop that strengthens both worker rights and health governance.[30]

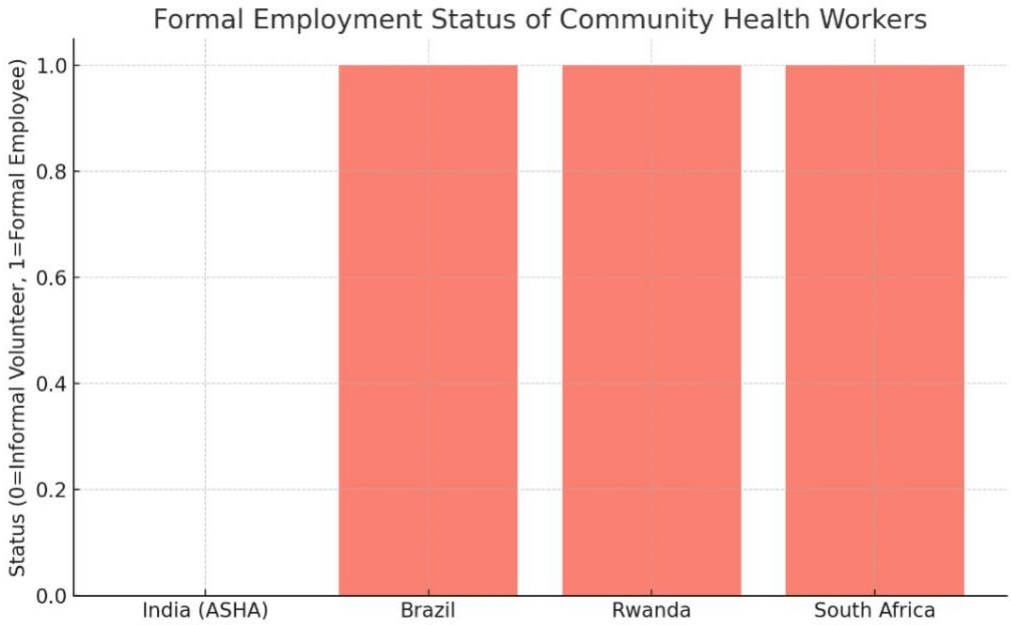
The contrast with India is striking. Despite being the world's largest democracy and one of the fastest-growing economies, India continues to cling to a model that frames ASHAs as volunteers. The difference is not in resources, but in political will. By favoring volunteerism over formalization, India demonstrates its unwillingness to invest in women's labor and its preference for a low-wage, feminized workforce.The international models prove that alternatives exist and that the Indian state's resistance to reform is a matter of political choice, not fiscal inevitability.[31]

30 Kavita Bhatia, *Community Health Worker Programs in India: A Rights-Based Review*, 134 Persp. Pub. Health 276 (2014), https://pubmed.ncbi.nlm.nih.gov/25169614/

31 Priyanka Rohra et al., *Community Health Workers: Challenges and Vulnerabilities of Accredited Social Health Activists Working in Conflict-Affected Settings in the State of Assam, India*, 19 Hum. Res. for Health 89 (2021), https://pmc.ncbi.nlm.nih.gov/articles/PMC8369326/


Comparative Monthly Remuneration of Community Health Workers
Monthly Salary/Stipend (USD approx.)
0
50
100
150
200
250
300
India (ASHA)
Brazil
Rwanda
South Africa


Social Security Coverage of Community Health Workers
Coverage Level (0=None, 0.5=Partial, 1=Full)
0.0
0.2
0.4
0.6
0.8
1.0
India (ASHA)
Brazil
Rwanda
South Africa



STATEMENT OF THE PROBLEM

The core problem is the fundamental **paradoxical classification of Accredited Social Health Activists (ASHAs)** in India. While they are de facto indispensable frontline workers performing essential, skilled, and 24/7 labor, they are de jure classified as "volunteers" or "honorary workers." This purposeful legal illusion enables the state to consistently deny people basic labor rights, fair compensation, and social security benefits, effectively shifting the costs and dangers of public health delivery to a vulnerable, mostly female workforce. This precarious situation creates major and quantifiable vulnerabilities, including chronic financial insecurity caused by an unpredictable, sub-minimum wage, performance-based incentive system.It also exposes them to severe health and life security risks, such as occupational hazards and a lack of protective gear, as starkly highlighted by the COVID-19 pandemic. The state's continued reliance on judicial precedents like *State of Karnataka v. Uma Devi* to avoid regularization, combined with its policy of deferring responsibility to state governments, perpetuates a cycle of economic violence and structural carelessness. This systemic issue is more than just an administrative mistake; it is a highly gendered and caste-based problem that devalues care work and lays the burden of public health on people with the least power, eventually weakening the whole core of India's healthcare system.

CONCLUSION

The analysis indicates that ASHAs' precarious status is not an accidental blunder, but rather a direct result of their deliberate legal designation as "volunteers," a legal fiction that allows the state to dodge its commitments to an essential workforce. This de jure status, while legally ambiguous, has de facto human and economic ramifications, putting ASHAs in a position of chronic financial insecurity and severe vulnerability to health and social dangers.The COVID-19 pandemic served as a global wake-up call, starkly highlighting the recklessness with which these frontline workers were deployed without adequate protection, a form of "care extractivism" where the state externalizes the costs of public health onto its most marginalized workers.

The campaign for ASHA workers' rights, as seen by their increasing mobilization and rallies, is more than just a call for increased pay; it is a fundamental challenge to the systemic undervaluation of crucial care work. The government's ongoing reliance on legal precedents and delegation of duty to states reveals a deeply ingrained opposition to formalizing this workforce.However, as international examples in Brazil and Rwanda have demonstrated, a formalized, well-compensated, and protected cadre of Community Health Workers (CHWs) is not only an issue of social justice, but also a critical component of a strong and resilient public health system.

Finally, the paradox of ASHAs represents a larger dilemma in India's public health policy, in which short-term fiscal prudence has taken precedence over long-term human and systemic welfare. A forward-thinking solution must include a radical reassessment of ASHAs' status, transforming them from a fragile "volunteer" army to fully recognized, salaried employees with full access to social security benefits and labor rights.This reform is not only a moral imperative but also a strategic necessity to ensure the health and dignity of ASHAs and, by extension, the millions of rural Indians who depend on them.