IPRR IMPACT AND POLICY RESEARCH REVIEW
Managed & Published by
IMPRI IMPACT AND POLICY RESEARCH INSTITUTE

Impact and Policy Research Review (IPRR)
Vol. 4, Issue 2, July - December 2025, pp. 35-47

Policy Perspective

IMPRI IMPACT AND POLICY RESEARCH INSTITUTE
•ETHICAL •NON-PARTISAN •INDEPENDENT

Community Health Workers in Health Care Paradigm: A Study of Scheduled Caste ASHAs from Punjab (India)

Gurinder Kaur[1] & Shaik Iftikhar Ahmed[2]

Abstract

For low and middle income countries (LMIC) like India large-scale inequalities are observed in terms of availability and affordability of quality medical care, particularly in rural India. In response to such inequalities impressive efforts have been made towards creating a cadre of Community Health Workers (CHW). The history of the CHW programme in India dates back to 1977, but faced difficulties from its inception and collapsed in a few years' time. The CHWs continued to work under the form of various titles as Anganwadi workers, health workers, etc. but their mandate and scope was limited. With the launch of National Rural Health Mission (NRHM, part of National Health Mission since 2013) in 2005, as commitment towards achieving targets set under MDGs, a specialised cadre of CHWs by the nomenclature of Accredited Social Health Activist (ASHA) was created. The present attempts to understand the labour, lives and roles of ASHA workers with the health system and the community they are located in. The study is based on primary data from SBS Nagar district in the north Indian state of Punjab. ASHAs have a complex relationship with their lives which comes to define their identity within social, political, and economic spheres and within which they further seek changes in their job conditions. The study shows that ASHAs demand for their right to salary as a right for the labour along with other issues of concern for them. A hierarchical set up goes parallel to their commitment for the work they undertake providing a strong base for government policies on health.

Keywords: *Community Health Workers, ASHA, Scheduled Caste, Punjab, gender, health care, women's empowerment, maternal health*

[1] Assistant Professor, Centre for Research in Rural and Industrial Development (CRRID), Chandigarh
[2] Research Investigator, Population Research Centre, CRRID, Chandigarh

1 Introduction

The concept of health for all targeted to be achieved by the year 2000 became the foundation of Millennium Development Goals (MDGs) 2015 and which later translated to Sustainable Development Goals (SDGs) 2030. Health for all was envisaged through the Universal Health Care (UHC) where Primary Health Care (PHC) would play the pivotal role with active participation and involvement of the community in matters of health. Prior to this the Alma Ata Declaration of 1978 attributed significant importance to "inter-relationship and inter-dependence" between health, social and economic development with the aim of involving individuals, families and community to bring health care as close to people as possible. As a part and continuity of this ideal, Community Health Workers (CHWs) were envisaged as cadres of the workforce who would act as the first point of contact between the state health care system and the community. the WHO (1978), thus, defined them as "community health workers should be members of the communities in where they work, should be selected by the communities for their activities, should be supported by the health system but not necessarily a part of its organisation, and have shorter training than professional workers" (WHO 1978: 6).

2 Community Health Workers in India

For low and middle income countries (LMIC) like India[3], large-scale inequalities are observed in terms of availability and affordability of quality medical care, particularly in rural India (Joe, Mishra and Navaneetham 2008). In response to such inequalities impressive efforts have been made towards creating a cadre of Community Health Workers (CHW). In India, the history of CHWs precedes the Alma Ata Declaration by a year. Under the Rural Health Scheme, launched in 1977, known by the name of Jan Swasthya Rakshak scheme, CHW were selected based on selected criteria. Though the history of the CHW programme in India dates back to 1977, but faced difficulties from its inception and collapsed in a few years' time (Lehmann and Sanders 2007, Leslie 1989, Nichter 1984). Leslie (1985) described the scheme as "an ambitious and controversial programme" and it was so because of the misgivings about it among the medical professionals, "particularly its use

[3] For the current 2024 fiscal year the World Bank (WB) identifies India as a LMIC.

and therefore its sanction of indigenous medicine, and its creation of a category of health care provider outside the occupational structure controlled by doctors" (Leslie 1985: 923). Nichter (1980) also made similar observations about the scheme. Apart from distrust of the larger medical community, the other issues with the scheme were related to the involvement of the local political leaders for selection candidate as CHWs which was considered problematic, there were uncertain perceptions about roles and responsibilities of the CHWs and the structure and medium of instructions to the CHWs about the same were also not commensurate with the local needs of the community. The CHWs continued to work under the form of various titles as Anganwadi workers, health workers, etc. but their mandate and scope was limited.

Some of these cadres have continued to exist, while others have been discontinued over the years. For example, the VHGs were discontinued by the states due to change in the funding of the scheme from 1st April 2002, from being fully centre sponsored to being state sponsored. Another peculiar feature of the CHW was that their cadre in India from 1970s to 1980s till date has changed from being more male concentrated to women concentrated. The focus of the state policy at the time was on male sterilisation and hence the cadre of CHWs was primarily male centric, whereas, the focus from 1990s onwards was more on maternal and child health and hence, the gendered form of CHWs changed from male to female. Lehman and Sanders (2007) reviewed research papers published across the world on CHWs and observed that the majority of research articles (numbers not mentioned by them), do not mention gender of the CHW, except for 17 articles, wherein 70 per cent of the CHW were women. The journey of CHWs in India has traversed from being viewed with scepticism, distrust and confusion to becoming the backbone of health care system in rural areas of India.

3 NRHM and ASHA

With the launch of National Rural Health Mission (NRHM, part of National Health Mission since 2013) in 2005, as commitment towards achieving targets set under MDGs, a specialised cadre of CHWs by the nomenclature of Accredited Social Health Activist (ASHA) was created. The major components of the ASHA programme focus on maternal and child health. Indeed since its inception and

implementation, there has been a significant decrease in the maternal and infant mortality rates in the country. NRHM is a highly structured programme with bureaucratic hierarchies with ASHAs at the lowest level. The focus of this programme, in consonance with the history of CHWs, was community involvement wherein the ASHAs are to be selected from within the community that they reside in. Their selection involves direct participation of the village Panchayati Raj Institutions.

According to Singh et al (2015) and Saprii et al (2015), three roles were formulated for the ASHA under the NRHM programme: to achieve government policies by acting as service extension workers; to act as bridge between the community and the state health apparatus; as an agent of change by engaging with the community. The context of this was to encourage direct local community participation. Even though their primary mandate relates to mother, child and adolescent health, they also look after tuberculosis medications, referral and follow up of communicable and non-communicable diseases, tobacco control and were also involved on the frontline during the covid 19 pandemic. Their work is not based on salaried remuneration but they receive incentive based payments. This gives the ASHA an imagery of an altruistic health volunteer. Also since ASHA is at the lowest rung of the bureaucratic hierarchy, she is under constant surveillance from multiple sections beginning from the Auxiliary Nurse and Mid-wife (ANM) to the Chief Medical officer (CMO) at the district level.

Since NRHM made community participation as its foundation through the cadre of ASHA and their selection from within the community with direct involvement of the village panchayats, this represents a typical example of state verticality and encompassment (Ferguson and Gupta 2002). Within the simultaneously moving processes of the state verticality and encompassment, the site of ASHA emerges as a location where the two meet. Within this paradigm, the ASHA worker is imagined as an activist, representing a pragmatic woman who has stepped out of her traditional role at home and who is responsible for the population that ‘falls under her purview’ (Gjostein 2014). Being at the lowest level she too is under constant surveillance of the state (especially through the check of official documents and registers that are maintained for this purpose) for her work and simultaneously is also under constant gaze of the community of which she is a part.

Yet, recent protests by ASHA workers across the country provide a different perspective, wherein, these workers are not passive receivers of discipline and surveillance. Rather, they are active agents of change for themselves as well. They have their own agency for resistance and assertion. They are viewed as empowered and as agents of the state at the level of the community.

This gaze at the same time intersects with the ascribed gender roles and at times with caste as well (Ved et al 2019). Previous studies that have followed the framework of power relations, agency, gender among the CHWs were located in countries of Africa (Kasteng et al 2015, Oliver et al 2015, Maes 2014) and in South Asian context in the countries of Pakistan (Colser 2015), Bangladesh and Nepal. In Indian context such studies have been limited to few other states (Saprii et al 2015, Roalkvam 2014). Studies pertaining to the state of Punjab were more focused on evaluation and appraisal of ASHA workers (Kaur 2018, Padda et al 2013, Mahajan and Kaur 2021). Moreover, as per the NITI Aayog health index, incremental performance for the state of Punjab from 2015-16 to 2017-18 did not show any improvement.

In this context the present study highlights the issues of ASHA workers and also gives insights to improve the work relations and capabilities thereby giving inputs for improving the overall quality of life. In this context the study attempts to understand the labour, lives and roles of ASHA workers with the health system and the community they are located in. The study is based on primary data collected through fieldwork using pre-tested questionnaires. For this purpose the north Indian state of Punjab has been selected as the site of study.

For the present study SBS Nagar district has been selected as specific focus of the study is on ASHA workers from Scheduled Castes (SC) and SBS Nagar has highest proportion of SCs in the state. Therefore, since ASHA workers are selected from within the districts, it can be safely assumed that a high proportion of ASHA workers from SBS Nagar would be SCs.

The study followed a random sampling technique. There are around 95 sub-centres in the district spread across five administrative blocks of Saroya, Balachaur, Mukandpur, Muzaffarpur and Sujjon. 43 sub-centres were randomly selected from all the blocks and 200 randomly selected ASHA workers from these 43 sub-centres were interviewed using questionnaire with open and close ended questions.

4 Results and Analysis

The maximum proportion, 71 per cent, of ASHA workers were in the age group of 40 to 49 years followed by those in the 35 to 40 years age category. The highest level education for maximum ASHA workers was up to secondary level at 48 per cent followed by upper primary at 26.5 per cent and higher secondary at 18.5 per cent. Most ASHA workers were homemakers, 71 per cent, followed by 15 per cent who were working in the private sector on menial wages, before joining the cadre of ASHA. 80 per cent ASHA workers have been working in this cadre for more than 10 years. Comparing the relation with age and years of work as ASHA, 63 per cent in the age group of 40 to 49 years have more than 10 years of work experience.

This age group is not only economically productive in general, but also is group most of whom have children pursuing higher education or the children are at marriageable age. Also, maximum ASHA workers had average monthly household income between 10 to 20 thousand rupees. 42.5 per cent of ASHA workers indicated that their husbands are casual labourers. This suggests that their household income is likely insufficient to maintain a comfortable and high-quality standard of living. In contrast, not having much in the form of a regular salary or incentives proves to be difficult to cope with the growing needs of not only daily survival but also the educational requirements of the children.

Since SBS Nagar has the highest population of SCs in the state, as an obvious extension of this, maximum ASHAs were from this category at 61 per cent. Religion-wise, maximum ASHAs, 82 per cent, were Hindu followed by 16 per cent Sikhs. Being a cadre of married women only, all ASHAs have been married at some point, with 87 per cent being currently married, 11 per cent widows and 1 per cent separated. This implies that for 12 per cent of them any earnings from ASHA work was or presently could be the only source of income. 62 per cent ASHA workers lived in nuclear families, primarily relying on their income and that of their husband. About two third ASHA workers are residing in Pucca house and 13.5 percent of ASHA workers are still residing in Kutcha house in SBS Nagar

General norm as per the NRHM guidelines is that one ASHA would serve a population of 1000. Though this may be changed as per the topographic and other work requirements of the state. Even though 50 per cent of ASHAs fulfilled this

norm of serving a population of less than 1000, 39 per cent served a population of up to 1500 and 11 per cent served population of more than 1500 as well. On an average maximum ASHAs, 56 per cent visited 10 to 29 households every week and 32 per cent visited more than 30 households per week.

The NRHM mandates at least 4 compulsory ANCs. Depending upon the registered pregnant women and duration of their pregnancy the visits varied from none to maximum of 7 and more. Maximum, 35 per cent ASHAs had completed two ANCs, whereas, 11 per cent had made 7 or more visits. The number of PNCs varies from immediate care for the mother and the new-born to visits for the newborn within 3 days, 7-14 days and 42 days. Depending upon the number of deliveries, maximum ASHAs, 22 per cent, had visited 3 new born within the first week of their birth, followed by 19.5 per cent who had visited 4 new born within the first week.

Also depending upon the pregnancies registered (718 pregnancies) in the given quarter, 64 per cent ASHA had referred pregnant women to the sub-centre/health care facility for regular check-ups and for these registered pregnant women, 88.5 per cent ASHA had accompanied them to the nearest health facility. All the ASHAs were aware of major causes of maternal death which ranged from anaemia, high BP, carelessness on part of the pregnant woman or her family like not taking precautions as advised, excessive bleeding, pre-existing health conditions, etc.

Apart from major duties related to maternal and child health care, ASHAs are also assigned a number of other tasks, like attending regular Village Health Sanitation and Nutrition Committee (VHSNC), creating awareness about health and hygiene, malaria and leprosy programmes. 97.5 per cent ASHAs had attended 3 meetings of VHSNC in the given quarter and 52.5 per cent disseminated awareness about general health and hygiene at least once a month through visits to homes or at Anganwadi centres during child immunisation days.

As for malaria programmes, maximum ASHAs work in the form of either creating awareness like keeping windows closed, not keeping stagnant water around the vicinity, etc. and remaining were involved in the regular surveys about the cases of malaria. Apart from these, the ASHAs were also assigned duties for constructing toilets during the Swachh Bharat Abhiyan and Covid for survey of individuals sowing flu like symptoms, those returning from some trip, Covid vaccinations, etc.

The all-female cadre of ASHA workers selected from within the community and by the community embedded in the conceptualisation and practice of voluntarism. These were considered to be essentials in order to ensure deeper outreach into the community to address overall maternal and child health. These factors, particularly that of voluntarism and incentive based work ethic, have been identified as having their own set of challenges faced by ASHAs. Based on their extensive review of policy documents and academic studies on ASHA, Ved et al (2019), observe that despite having been a source of empowerment for these women, it has also created high level of dissatisfaction among them related to limited remuneration, lack of stipulated salary, work load, limited scope for career progression.

71 per cent of ASHA workers were in the age group of 40 to 49 years and 63 per cent among them had work experience of more than 10 years. Many of them had started this work in 2005 when the NRHM programme was launched. Maximum ASHAs were approached by the ANM, 64 per cent, with the offer to work as ASHA. Since ANMs were the only cadre of CHWs who were in close contact with women of the villages, they were well aware of the demography of the village. Even though community participation is a major component in the ASHA selection, however, the encouragement to join the cadre was from family or ANM or a matter of self-motivation. Despite being new to the work back then and increasing work load over time, maximum ASHA workers, 69 per cent, came into this field for financial incentives, followed by 27.5 per cent who joined this workforce for it gave them a social prestige in their society.

The average working hours for maximum ASHAs were around 5 hours per day and beyond this, since they also accompanied pregnant women for their regular check-ups, particularly in case of high-risk pregnancies and for deliveries as well, for maximum of them, 36 per cent, this travel distance was between 6 to 10 kms. The mode of travel was usually by public transport, particularly buses. Many of them during discussion mentioned many times while taking women for deliveries or to main CHC for check-up in case of referrals, they did not get compensated for the money spent on travel. This added on to their personal expenditure particularly when maximum of them, 40 per cent, earned between Rs. 3000-4000 from their incentives, followed by 37.5 per cent who earned even less than Rs.

3000 from incentives. 93 per cent ASHAs mentioned that there expectation form the work they had joined was of financial incentives. Since the range of their incentives including monthly fixed allowance of Rs.2500 remains below Rs. 4000, almost all ASHAs were dissatisfied and disappointed with the amount they earned despite the amount of work load on them. They expect to be regularised like their counterparts in the Anganwadi centres and be given a monthly salary of at least Rs. 10000 to 15000 and all the ASHAs have only one demand from the state that they be given a regular salary as well. Another major problem that they face is from the hospital staff, 56.5 per cent of ASHAs mentioned that whenever they visited the government health facilities like PHC or CHC, the hospital staff did not cooperate with them.

The nature of work for ASHAs creates challenges particularly related to their position within the hierarchy of the health care system and the remuneration they receive. Issues related to job security and subtle forms of discrimination faced by them have emerged to be the prominent concerns for the ASHAs.

Even though 41 per cent ASHAs did not face any issues at the beginning of their career, 28 per cent reported that they faced problems in cooperation from local population they served, particularly in terms of convincing them for regular check-up of pregnant women and child immunisation. 14 per cent of them faced issues owing to not understanding their roles and responsibilities and 10 per cent of them faced problem in convincing their families to let them work. For the overwhelming majority of ASHAs, the villagers or families of pregnant women have become increasingly cooperative over the years. This is further supported by the observations where all ASHA reported that women seek and follow advice not only related to pregnancy but also related to birth control. Even adolescent girls from the village that they serve approach them for any help or clarifications, if any and they have reported 100 per cent immunisation of the children as well.

Even vis-à-vis their caste, since most of them were SCs, 97.5 per cent mentioned having never faced any caste-based discrimination. Only 2.5 per cent of them mentioned that some families had not allowed them to enter their house on some occasions.

On a personal front, the maximum proportion of ASHAs, 65 per cent, mentioned that their work hours or extent of their work did not affect their personal family

life. However, 35 per cent of them mentioned that on some specific occasions they have experienced disruptions in personal life on account of their work. This was especially the case at times of official inspections or surveys when a team from the headquarters would visit or when some specific information was sought at a short notice. On the other hand, 57 per cent ASHAs stated they were not satisfied with their jobs and some ASHAs mentioned that lack of proper incentives or salary is a matter of ridicule among the family members. Despite these issues and challenges that these women face, they are willing to continue their work as ASHAs. Even if lack of security in the work is a major concern, social prestige and a sense of independence is also felt by these women.

5 Conclusion

Apart from the formal medical cadre of doctors, paramedical staff and the associated state bureaucracy, community health workers form a broad base of this structure. Since the concept of local and community form the core of CHW cadre, they act as a source of integration between the community and the formal health apparatus. As such their contributions and role have significant importance for population health.

Nuanced understanding of the significant role that ASHAs play in the functioning of health care system requires thorough research related to their labour as workers in the hierarchical system; about their embeddedness in the social realities of their lives, of the community and the state; contextual understanding of their priorities, challenges and issues. The present study shows that ASHAs have a complex relationship with their professional lives which comes to define their identity within social, political, and economic spheres and within which they further seek and demand changes in their job conditions.

The study shows that ASHAs demand for their right to salary as a right for the labour along with other issues of concern for them vis-à-vis their lowest position a hierarchical set up goes parallel to their commitment for the work they undertake providing a strong base for government policies on health.

References

Closser, S., & Shekhawat, S. S. (2022). The family context of ASHA and Anganwadi work in rural Rajasthan: Gender and labour in CHW programmes. Global Public Health, 17(9), 1973-1985. https://anthrosource.onlinelibrary.wiley.com/doi/abs/10.1111/napa.12061

Colvin, C. J., & Swartz, A. (2015): Extension agents or agents of change? Community health workers and the politics of care work in post-apartheid South Africa. https://anthrosource.onlinelibrary.wiley.com/doi/abs/10.1111/napa.12062

Ferguson, J., & Gupta, A. (2002). Spatializing States: Toward an Ethnography of Neoliberal Governmentality. American Ethnologist, 29 (4), 981-1002. https://anthrosource.onlinelibrary.wiley.com/doi/10.1525/ae.2002.29.4.981

Gjostein, D. K. (2014): A veiled change agent: The 'Accredited Social Health Activist' in rural Rajasthan. In K.B. Nielsen, & A. Waldrop (Eds.), Women, gender and everyday social transformations in India (pp. 139–156). London: Anthem Press. https://www.cambridge.org/core/books/abs/women-gender-and-everyday-social-transformation-in-india/veiled-change-agent-the-accredited-social-health-activist-in-rural-rajasthan/7F40E75993725596F7B9F309B09A706B

Joe, W., Mishra, U. S., & Navaneetham, K. (2008). Health inequality in India: Evidence from NFHS 3. Economic & Political Weekly, 43 (31), 41-47.

https://www.epw.in/journal/2008/31/special-articles/health-inequality-india-evidence-nfhs-3.html

Kasteng, F., Settumba, S., Källander, K., Vassall, A., & inSCALE Study Group. (2016). Valuing the work of unpaid community health workers and exploring the incentives to volunteering in rural Africa. Health Policy & Planning, 31(2), 205-216.https://pubmed.ncbi.nlm.nih.gov/26001813/

Kaur, A. (2018). Awareness of ASHA workers about their role and responsibilities under National Health Mission: A study of Malwa region of Punjab. Indian Journal of Health & Wellbeing, 9(5), 707-713.

Lehmann, Uta, & Sanders, D. (2007). Community health workers: What do we know about them. Geneva: World Health Organisation. https://njcmindia.com/index.php/file/article/view/1463?articlesBySimilarityPage=6

Leslie, C. (1985). What caused India's massive community health workers scheme: A sociology of knowledge. Social Science & Medicine, 21(8), 923-930. https://pubmed.ncbi.nlm.nih.gov/4071126/

Leslie, C. (1989). India's Community Health Workers scheme: A sociological analysis. Ancient Science of Life, 9(2), 40-53. https://pubmed.ncbi.nlm.nih.gov/22557674/

Maes, K. (2015): Community health workers and social change: An introduction. Annals of Anthropological Practice, 39: 1–15. https://anthrosource.onlinelibrary.wiley.com/doi/abs/10.1111/napa.12060

Mahajan, N., & Kaur, B. (2021). Community health workers in rural Punjab, India: Analysing their role, expectations and challenges. Journal of Health Research, 36(2), 255-264. https://www.researchgate.net/publication/349989690_Community_health_workers_in_rural_Punjab_India_analyzing_their_role_expectations_and_challenges

Nichter, M. (1980). Community health worker scheme: A plan for democratisation. Economic & Political Weekly, 15(1), 37-43. https://www.jstor.org/stable/4368284

Nichter, M. (1984). Project community diagnosis: participatory research as a first step toward community involvement in primary health care. Social Science & Medicine, 19(3), 237-252. https://pubmed.ncbi.nlm.nih.gov/6484613/

Oliver, M., Geniets, A., Winters, N., Rega, I., & Mbae, S. M. (2015). What do community health workers have to say about their work, and how can this inform improved programme design? A case study with CHWs within Kenya. Global Health Action, 8(1), 27168. https://pubmed.ncbi.nlm.nih.gov/26004292/

Padda, P., Devgun, S., Gupta, V., Chaudhari, S., & Singh, G. (2013). Role of ASHA in improvement of maternal health status in northern India: An urban rural comparison. Indian Journal of Community Health, 25(4), 465-471. https://www.iapsmupuk.org/journal/index.php/IJCH/article/view/357

Roalkvam, S. (2014). Health governance in India: Citizenship as situated practice. Global Public Health, 9(8), 910-926. https://pubmed.ncbi.nlm.nih.gov/25132487/

Saprii, L., Richards, E., Kokho, P., & Theobald, S. (2015). Community health

workers in rural India: Analysing the opportunities and challenges Accredited Social Health Activists (ASHAs) face in realising their multiple roles. Human Resources for Health, 13, 95. https://doi.org/10.1186/s12960-015-0094-3.https://pubmed.ncbi.nlm.nih.gov/26646109/

Singh, D., Negin, J., Otim, M., Orach, C.G., & Cumming, R. (2015). The effect of payment and incentives on motivation and focus of community health workers: Five case studies from low- and middle-income countries. Human Resources for Health, 13, 58. https://doi.org/10.1186/s12960-015-0051-1.https://pubmed.ncbi.nlm.nih.gov/26169179/

Theobald, S., MacPherson, E., McCollum, R., Tolhurst, R., & REACHOUT. (2015). Close to community health providers post 2015: Realising their role in responsive health systems and addressing gendered social determinants of health. BMC Proceedings, 9, 1-11). https://pubmed.ncbi.nlm.nih.gov/28281706/

Ved, R., Scott, K., Gupta, G., Ummer, O., Singh, S., Srivastava, A., & George, A. S. (2019). 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. Human Resources for Health, 17, 1-15.https://pubmed.ncbi.nlm.nih.gov/30616656/

WHO. (1978). Primary health care: report of the International Conference on Primary Health Care, Alma-Ata, USSR. Geneva: World Health Organisation. https://www.who.int/publications/i/item/9241800011

WHO. (1989). Strengthening the performance of community health workers in primary health care. Geneva: World Health Organisation. https://books.google.co.in/books/about/Strengthening_the_Performance_of_Communi.html?id=cmkoAQAAMAAJ&redir_esc=y