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COMMENTARY

Working at the frontlines, trailing behind in fair remuneration: ethics of the ASHA workers' socio-economic position

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Abstract

Apart from medical and public health interventions, human resources for health are a critical component of any effective public health system. In this context, the role and significance of caregiving within societies are of critical importance. Women are often designated to undertake these caregiving responsibilities, which are frequently seen as an extension of traditional household care. The exploitation of human resources in the guise of caregiving in India, particularly in the case of Community Health Workers or Accredited Social Health Activists (ASHAs), represents a fundamental ethical issue within our health systems. The contradiction of labelling their structured and compulsory labour as "voluntary" must be addressed with utmost urgency and seriousness. Categorised as "voluntary workers", the ASHAs in India have remained underpaid and under-valued, despite the frequent expansion of their responsibilities and the significant hardships they endure in fulfilling them. It is essential to provide them with adequate remuneration and security, recognising the nature and extent of their work which generates immense social value.

Keywords: *ASHA, volunteer, community health worker, fair renumeration, NHM*

Introduction

For the majority of people in the country, particularly in rural areas, Accredited Social Health Activists (ASHAs) play a vital role as the first point of contact with the healthcare system. Yet, in Kerala, the ASHAs had to protest for 266 days in front of the Kerala Secretariat, demanding increased honoraria from the Government of Kerala.

We are students of public health, working closely with grassroots-level healthcare workers, especially ASHAs. During our field visits as part of our Masters in Public Health training, we collaborated with ASHAs to identify individuals with specific characteristics for our studies. We have observed that elderly or bedridden patients and their families often regard ASHAs as members of their family. The ASHAs' presence fosters trust in the community, ensuring that help is readily accessible when needed. ASHA workers in Kerala began their statewide protest on February 10, 2025, and continued it at district level, demanding a fair wage and regularisation of their work [1]. Given their semi-skilled tasks and crucial role in the health system, ASHA workers are entitled to wages equivalent to Class 4 government employees, or at the very least, to the minimum wage fixed for unskilled workers as a transitional measure. As public health students, we believe their demands are just and reasonable, given the significant impact of their contributions on communities. The intrinsically exploitative nature of the health system's engagement with them, and the specific social and gendered vulnerabilities of ASHA workers present an ethical challenge to public healthcare.

What is their role and why were they obliged to go on strike?

The duties of ASHAs include providing essential care for and mobilising pregnant women and children for immunisations, offering breast feeding counselling, distributing medicines, screening for non-communicable diseases (NCDs), conducting health surveys, and supporting palliative care patients and the elderly. They mobilise the community and help people access health services and related resources. Every week, they report on fever patients, check up on pregnant women, and visit those living alone, particularly the elderly. They participate in all panchayat meetings and training programmes [2, 3]. ASHAs receive comprehensive training in various modules, ranging from maternal and child health to disease prevention [2,3].

Kerala state has a total of 26,125 ASHA workers with 21,529 working in rural areas, 4104 in urban areas, and 492 hamlet ASHAs in tribal areas. Initially, the ratio was one ASHA worker for every 1000 people, but this was revised in 2018 to one ASHA per ward, for better coordination. In urban areas, the ratio was revised to one ASHA worker for every 2,500 people, due to the higher population density. Depending on the workload, the standard in tribal areas was relaxed to one ASHA per habitation [2,3].

The ASHAs' demand is for the state to recognise their contribution as "work" and their position as "workers" within the public healthcare system. Their work should not be seen as an extension of feminised domestic care work, but as legitimate public health employment.

On what basis are ASHAs paid?

The Government of India has classified the work of ASHAs as "voluntary". As a result, they receive payments merely as "incentives" disbursed through the National Health Mission (NHM) for the relevant financial year. A fixed incentive of Rs 3000 per month for routine and recurrent activities, and other performance-based incentives are given for various

activities under different national health programmes [1,4]. In Kerala, ASHA workers receive a monthly honorarium of Rs 7000, which is the fourth highest in the country, following Puducherry — paying Rs 18,000, and Andhra Pradesh and Sikkim — each paying Rs 10,000 per month [5]. The incentive was hiked in these states due to strong pressure from the local ASHAs.

The criteria for receiving the rest of the monthly honorarium of Rs 7000 include ten specific requirements, ranging from ward-level health report documentation, to conducting ward-level meetings, attending meetings at health and wellness centres, participating in panchayat and hospital meetings, mobilising people and attending four monthly clinical or homecare duties in the concerned ward, engaging in ward-level health activities and discussions, besides 10 home visits to people who need special care. For ASHAs to meet the requirements for the monthly honorarium [2], they are required to provide documentation to prove that they have completed these tasks.

The previous Kerala state government had waived the requirement of completion of the ten tasks to receive the honorarium of Rs 7000 per month. However, it also increased the routine and recurrent activities for ASHAs to receive at least Rs 2000 as a fixed incentive and Rs 500 as a performance-based incentive, to qualify for the monthly honorarium. Hamlet ASHAs are obliged to earn at least Rs 2000 to receive the monthly honorarium of Rs 7000. For ASHAs who are unable to complete the assigned tasks and receive below Rs 2,500 (Rs 2000 for hamlet ASHAs) as a fixed incentive, half of the monthly honorarium is deducted as per the revised norms, further worsening their economic hardships [4].

The figures above are based on the data available as of October 2025. They have been updated and remains subject to change as new information becomes available. Currently, the newly elected state government in Kerala has raised the monthly honorarium from about Rs 9000 to Rs 12000, still far short of the Rs 21,000 the ASHAs had demanded [6]. Besides, this small hike in honorarium has not addressed their basic grievances regarding service conditions.

Financial insecurity and systemic challenges undermine the ASHAs' role

Despite playing a crucial role in health initiatives ranging from maternal care to disease prevention, ASHAs often struggle to make ends meet. The low and irregular remuneration for services rendered pushes them into severe financial hardship, frequently resulting in indebtedness [7]. They have to wait three to four months to receive this payment after completing their tasks. While the state advocates for women's empowerment, it denies ASHA workers their basic right to live with dignity, in spite of the admittedly valuable services they provide to the community. Their work often extends into personal time due to the extensive documentation required to demonstrate completed tasks and to claim the "incentives" owed to them [8], while the demands on their time continue to increase. This is also because of the spillover effect of their pre-eminent position within the community. For instance, they receive inquiries from the police and local self-government agencies about deceased individuals and have to respond to these. This additional work is not compensated for; but emerges from their close ties with the communities they serve.

Reporting requirements demand that the ASHAs upload large volumes of data as part of their NCD reporting. They are not compensated for the recharging of their mobile phones, which are essential to complete their tasks. Transportation charges, sometimes to distant wards or in difficult terrain, are not covered by the government. If there are no regular bus services, they have to rely on costly autorickshaws. They often stay late in their assigned wards, or work on Sundays, to connect with working men and women. Returning home at night due to the unreliable public transport services, makes them vulnerable to attack. After all this, the incentives or honoraria, when finally received, are insufficient to manage their basic financial needs.

Alongside their designated responsibilities, ASHA workers are required to conduct preventive programmes for seasonal diseases, which include the mosquito source reduction initiative [9,10]. The women are even compelled to attend political events, a task entirely unrelated to their assigned work and adding to their exploitation.

What are the striking ASHAs in Kerala demanding?

The ASHA workers of Kerala are demanding a monthly honorarium of Rs 21,000 and want this to be credited into their bank accounts during the first week of every month, as with other government health workers. Currently, their daily wage of Rs 232 is significantly below the government's prescribed minimum daily wage of Rs 675 for unskilled workers [11]. They are demanding Rs 700 per day, which would align their wage with the Minimum Wage Requirement for unskilled workers in Kerala [1]. They are also demanding retirement benefits of Rs 5 lakhs at the age of 62 [12]. Considering their responsibilities and the semi-skilled nature of their work, they are entitled, as an integral part of the healthcare system, to at least an equivalent wage to Class 4 government employees. Till then, as an interim step, they are fully eligible to receive the minimum wage set by the government for unskilled workers. As contradictions between the government and workers sharpened, and the ASHA movement in Kerala grew more organised, thousands of women health workers were drawn into strikes, demanding justice, fair wages, and regularisation of their work.

The most recent strike garnered widespread attention in the media [13], which strengthened the ASHA workers' struggle

for fair and timely wages. In response to the ongoing strike, some local self-government departments in Kerala have decided to offer additional financial incentives to support them [12].

How is the ASHAs' categorisation a source of exploitation?

ASHAs are categorised as "voluntary" workers, requiring an average of no more than three hours work per day, supposedly not interfering with their regular livelihood [1]. In reality, the varied demands on their time are relentless and their social and structural positions within the community compel them to fulfil these demands, often going beyond the call of duty. The work requirements spill over into several hours of fieldwork (if travel is included), social interaction to achieve targeted health system needs, and fulfilling the documentation requirements to obtain their incentives. This makes it difficult for them to seek alternative employment to augment the incentives for their "voluntary" ASHA work. The labelling of their work as "voluntary" prevents them from being entitled to any retirement benefits and health insurance, leaving them vulnerable as they age and face health issues.

Gender-related challenges

The criteria for the selecting of an ASHA worker stipulate that she must be a woman who is married, divorced or widowed. In many households, ASHA workers are the sole breadwinners; most come from poor socio-economic backgrounds, often balancing work and household duties.

The job exposes them to safety risks, especially when arriving home late at night. This timing subjects them to scrutiny from family, reflecting the gendered cultural norms of accountability. As women, ASHAs also bear caregiving responsibilities in their homes which cannot be shirked in a patriarchal society, since unwritten gender norms view women as designated caregivers for families. The history of the community health worker (CHW) programme reveals that, in 1977, it was launched at the national level to serve rural populations, initially comprising only male CHWs. Due to increasing concerns about maternal and child health, the government started recruiting women while phasing out male employees in the late 1970s [14]. The male CHWs formed unions and pursued legal action against their removal. A lack of negotiation was evident as the scheme concluded within two years of its introduction, in 1977 [14]. It is important to note that the political leadership and bureaucracy of that time showed resistance to the CHWs' protests for their rights [15]. In 2006, the National Rural Health Mission (NRHM) launched the ASHA scheme, aimed at enhancing access to basic healthcare services in rural areas [14]. The scheme for recruiting female CHWs was introduced after the successful implementation of the *Mitanin* programme (2002) in Chhattisgarh, and based on the belief that women volunteer workers are best suited to provide maternal and childcare services [15].

Informal activities or "voluntary" activities, when performed by women, are often not recognised as legitimate employment, but viewed as an extension of their unpaid domestic responsibilities within the community [16]. In this context, ASHA workers, though initially appointed as volunteers, shoulder numerous demanding tasks that extend far beyond the scope of honorary service. Many continue this work with the hope that their efforts will eventually be recognised through a permanent position — a hope that reflects not only their personal aspiration for job security but also a broader claim to fairness and justice [17].

In Kerala, the demand of ASHAs for permanent positions is rooted in the state's history of labour rights movements, where collective action has often led to the recognition of rights and better working conditions. Kerala's social and political history has always emphasised labour rights and the dignity of workers. ASHAs may have gained inspiration from earlier women-led strikes, such as the *Pombilai Orimai* movement of women workers in the Munnar plantations for an increase in their basic pay [18].

Discussion

Globally, the role of voluntary work in the public health sector has expanded but exists in the grey area between paid and unpaid labour [16]. The International Labour Organisation describes this as "disguised employment", where workers lack protection under labour laws. It is essential to recognise that when these activities take place within formal organisations, they are regarded as formal work, differentiating them from volunteerism [16]. It is both unjust and unethical for ASHAs to have to shoulder these responsibilities while being denied their labour rights [16]. ASHAs play an essential role in delivering healthcare services; however, their unwavering dedication often goes unrecognised by the system and is seen by the Government as work done merely for payment. The basic issue is one of dignity of labour and the ASHAs demand that their contributions be recognised as legitimate work and accorded remuneration that is reasonable, for delivering myriad and ever-increasing services to the community [19]. It is important to acknowledge their significant contribution and provide the necessary support and solidarity that they are entitled to as labour rights. While it is recognised that ASHAs play a vital role in healthcare across India, they are still obliged to struggle for proper recognition and government support.

Since ASHA workers have specific mandatory targets to meet [2], referring to their work as "voluntary" is irrational, and denies them a fixed and decent salary. Their financial condition forces them to remain in this role despite the demanding nature of the work and insufficient

compensation. The most recent strike and the hostile response to it by various institutions impacts their mental, physical, and social well-being. This reveals the exploitative process that labels them "voluntary workers" and yet expects them to respond to most of the community's health needs at the grassroots level. This scenario also highlights the State government's capacity to distance itself from its own labour regulations under the Minimum Wages Act of 1948, on the pretext of "voluntary service", leading to exploitative working conditions for ASHA workers [15].

Recommendations

ASHA workers ought to be recognised as "workers" rather than "volunteers". Studies on working hours demonstrate the actual work undertaken by ASHA workers, and this should form the basis for allocating any additional work to them, along with due remuneration [20]. Otherwise, they should not be expected to carry workloads far in excess of what is prescribed. Additionally, we observed that studies addressing the socio-economic challenges of ASHAs remain limited, creating a gap in relevance for understanding their current struggles. We also call on the Kerala government to initiate discussions with the striking ASHA workers and take all necessary actions to address their concerns promptly, as these women are the unsung heroes of primary healthcare.

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