ASHAs: How the 'Volunteerism' of Poor Women Subsidizes the Indian State

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Introduction

As care needs of populations around the world grow, the number and significance of care workers in society is also rising. Public social services in many countries, including India, have come to rely heavily on these workers (Razavi and Staab 2010). Frontline health workers are a type of care workers, who provide or connect communities with health services. However, despite the centrality of their work to public health—spotlighted by COVID-19 prevention and management efforts—they are not always classified as workers. India's Accredited Social Health Activists or ASHAs, are a case in point. Appointed since 2005 as part of the National Health Mission (NHM), ASHAs are classified as community health 'volunteers'. This almost one-million-strong, all-women workforce is paid incentives per-case and not salaries, and does not have the entitlements available to other public employees, like leave. How does the status of 'incentivized volunteer' impact women who are ASHAs? Feminist scholars have noted a worldwide trend of the feminization of obligation in which women are being made to work for development, rather than development enabling women to secure decent employment (Chant 2008; Swaminathan 2015). Here, I explore what this trend means in the everyday for women who are ASHAs in India.

Methods

I conducted a total of 14 months of ethnographic fieldwork in North India between 2017 and 2019. This included field observations with ASHAs across a rural and an urban block of Muktsar district, Punjab, as well as 60 interviews with ASHAs and 20 with ASHA program experts. Because ASHAs are positioned as links between their communities and the health system, I followed ASHAs as they interacted on both these ends. I observed home visits, community-level campaigns and meetings, weekly immunization drives, as well as ASHA trainings, health department meetings, patient-servicing in hospitals, and protests by the ASHA union. From a list of all ASHAs in the rural and urban block, I sampled equal numbers of Dalit and dominant caste ASHAs for my interviews. The interviews used a semi-structured questionnaire, and lasted from 30 to 90 minutes.

Context

ASHAs are community women with at least 8 years of education, who receive 23 days of initial training and perform five key activities: home visits, community meetings, monthly meetings at primary health centers, outreach services in their communities, and maintaining records. The earliest recruitments of ASHAs in my field site happened in 2007 (rural) and 2014 (urban). Most women found out about the post through social networks, that is, through a state functionary who was related or otherwise close to them, like the sarpanch, ANM, AWW, or other ASHAs. The ASHA coordinator for Muktsar told me that turnover was high in the early years of the program: upper caste women had cornered these posts thinking they were regular government jobs, but began to drop out once they realized what the role involved.

ASHAs are appointed across rural India at the ratio of one ASHA per 1000 population, and increasingly also in marginalized urban settlements (Ved et al. 2019). In my sample, the population serviced by rural ASHAs was 1275 on average, and a much higher 2860 on average by urban ASHAs. As per the requirement, all urban ASHAs in my sample had completed 10th standard, but not all rural ASHAs had completed 8th. Even the ones who met these requirements had to teach themselves how to read and write so they could maintain registers; this is a component of their work that has grown over time, and ASHAs often complained to me that they were doing 3 jobs: in the home, outside the home, and becoming literate.

ASHAs receive a fixed monthly honorarium from the central government (increased from INR 1000 to INR 2000 in 2018), which is paid against the completion of basic tasks like maintaining a register. Apart from this, ASHAs are paid through task-based incentives. The list of tasks for which ASHAs receive incentives began with 5 in 2005 and grew to 38 in 2017 (Ved et al. 2019). Some of these tasks are recurring monthly activities, while others are one-time campaigns. ASHA payments vary across states as different state governments contribute differently to the fixed or incentive component of their earnings. When I began my fieldwork in Muktsar, the average ASHA earned INR 2700 per month, which is roughly a quarter of the monthly minimum wage for a skilled worker in Punjab.

Findings

ASHAs are the only cadre of workers in the Indian state's health department to have the unique occupational status of remunerated volunteers. I find that this status creates a systemic mismatch between the work and the pay of ASHAs. This occurs through three pathways that I identify below:

1. The incentive payment system conceals the unpaid and underpaid labor of ASHAs

Incentives exist for formal tasks that ASHAs perform, which are only the tip of the iceberg of labor that ASHAs do. ASHAs have to do vast amounts of informal labor to build up to their formal tasks. However, this informal labor is rendered invisible because it is not recognized/compensated as work. Here is an example from my fieldnotes:

On a humid September day, I was observing DPT and TT immunization at a village school in Muktsar district. It took one ASHA (Jaspreet), and two ANMs (Auxiliary Nurse Supervisors) from 10 AM to 2 PM to cover all the first, fifth, and tenth graders. Jaspreet, the ASHA, did most of the work of cajoling, grabbing, even lifting the younger kids, in addition to clearing up the room each time the ANMs were done administering the injections. When we were leaving the school compound,

Jaspreet joked with me that her duty is never over. She has been a rural ASHA for over 10 years now. She was at the school the day before, dropping off new registers in which the ANMs would make their entries, and she would have to be at the school the next day too, with a new supply of iron tablets. Jaspreet said of the schoolchildren, "*Some parents will bring them to me this evening. It is hard to move your leg after DPT, and there can be a rash after tetanus. So, they usually come home, asking why it hurts, and I will explain and I will give them paracetamol*". This makes sense because the ASHA lives in the village, whereas the ANMs are in charge of several villages but live in the city. Jaspreet has spent at least three half days on the school immunization, but none of this is incentivized so she will not be paid for it.

For the formal tasks that are incentivized, payments are low and inconsistent. By being low, these payments reproduce a devaluation of care work. Moreover, ASHAs do not always receive the payments that are due to them. For instance, ensuring that women receive antenatal care is a routine ASHA activity. ASHAs are to bring pregnant women from their areas to the civil hospital for tests—ultrasound and hemoglobin—thrice in the course of a pregnancy. A lot of these patients are poor and non-upper caste, and oftentimes they are engaged in daily wage labor. As a result, ASHAs end up making many rounds of their homes before they can persuade these women to visit the hospital. Even when persuaded, women might not have anyone who can accompany them or pay for their passage, so ASHAs may offer to do both. Once in the hospital, the ASHA will walk the woman through every step, from cutting a slip to standing in line. After the patient has given blood, for instance, she will likely leave to do her day's work. The ASHA will stay back to collect the reports at the end of the day, or return another day if the reports take longer, which they often do. The ASHA will then deliver the reports to the patient's doorstep. At the end of the patient's pregnancy, the ASHA will receive a sum total of INR 200 as the antenatal checkup incentive.

Even paltry payments such as this are not always forthcoming. One ASHA, for instance, was not paid her antenatal checkup incentive because the baby was stillborn. Another did not receive a postnatal checkup incentive because the baby was delivered in a private hospital instead of a public one. These are not legitimate reasons to refuse payments, but as the district ASHA coordinator pointed out to me, ANMs are sometimes genuinely confused about payment details. The list of tasks for which incentives exist is a shifting one; activities may be added or removed depending on the priorities of the health department.

These anecdotes demonstrate that the incentive payment system, by way of both design and implementation, disregards a vast portion of labor that ASHAs perform, compensating them only for a fraction of their work.

2. The incentive payment system gives the health department leverage over ASHAs.

ASHAs are paid on the basis of a monthly report that is filed together with ANMs, who are their supervisors. ANMs sign off on the tasks completed by an ASHA for any given month, and how much the ASHA will be paid for that month is calculated by totaling the incentive for each of these tasks. The ability to validate these tasks and determine her monthly pay gives ANMs power over the ASHAs under her. This power is leverage for the health department, and can be used to make ASHAs do work that is outside of the tasks assigned to them.

During my time, I saw this leverage play out several times, in big and small ways. ASHAs find it difficult to refuse their ANMs. This can mean that ASHAs will make or procure tea for their ANMs every time they are conducting immunization, or that an ASHA with a two-wheeler will end up driving her ANM around at the latter's whim. It can also mean that incentives that ASHAs have rightfully earned are withheld from them, so as to arm-twist them into doing work that is outside their purview. When the civil hospital in Muktsar held a vasectomy camp, ASHAs were told by their ANMs and senior staff (including the district family planning officer) that any ASHA who did not bring one or two men from her area for the operation would have her incentive for maintaining registers cut for the next six months. In some cases, this threat was carried out, till the ASHA union protested. When I had a conversation with the Lady Health Visitor (who supervises ANMs), she told me, "the pressure is all verbal, nothing is in writing, but this is how things get done".

3. As volunteers ASHAs occupy a liminal position in the state

As volunteers, ASHAs are not treated by staff as one of them. If they complain about payment delays, they are reminded that they are doing "service". The offhanded attitude to ASHA payments is not per chance. Because they are volunteers, many staff members imagine these payments are not a living or household wage for ASHAs, but rather, a form of petty, extra cash. However, most ASHAs in Muktsar are poor, SC or OBC women, with low educational attainments. On account of their husbands' unemployment or addiction, they are struggling to provide for their families. But this 'neediness' only serves to make them more exploitable by the state.

ASHAs' liminal status in the state is evident in other ways as well. When ASHAs accompany women for a hospital birth, for instance, there is no room in the hospital assigned to ASHAs to rest/sleep in. As a result, they must lie alongside the patient, or on the floor by the patient's bed. An urban ASHA, Kamla, told me that when a group of them asked for a room in the hospital, the in-charge told them, "we might not have place for you in the rooms, but there is always place for you in our hearts". ASHAs' liminality of status is justified using a gendered discourse of service. ASHAs are often told in meetings that they are the "backbone" of the health department. Not only does this claim not bear out in the practices of the health department, 'volunteerism' makes it difficult for ASHAs to claim their rights as workers.

Conclusion

The occupational status of "incentivized volunteer" is a defining feature of ASHAs' vulnerability. It both naturalizes care as a gendered practice and institutionalizes its devaluation. If we care about gender equity, worker rights, and the quality of care that our masses receive, we must care for these workers whose identities as workers is systematically denied.

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