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Study of the Socio-Economic Development of Asha Workers (Accredited Social Health Activists) in North Maharashtra: Challenges, Contributions, and the Road to Viksit Bharat

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Abstract—

The Accredited Social Health Activists (ASHAs) constitute the foundation of India's community health service delivery network under the National Health Mission (NHM). In North Maharashtra, which consists of districts such as Nashik, Dhule, Nandurbar, Jalgaon, etc., ASHA workers act as essential intermediaries connecting rural and marginalized communities to the formal health care system. While these ASHA workers have played an integral role in making progress on the achievement of Sustainable Development Goals such as Good Health and Well-being (SDG 3), Gender Equality (SDG 5), and Reduced Inequalities (SDG 10), they continue to remain vulnerable socioeconomically due to low and uncertain earnings, social security concerns, and poor career prospects. This study aims to conduct a study on the socioeconomic status of ASHA workers in North Maharashtra by employing primary and secondary sources of information in relation to various parameters, including salary, education qualification, family poverty, health coverages, occupation-related problems, and community support. There is a need to consider reforms aimed at transforming ASHA workers into full-time workers to improve their socio-economic conditions consistent with the objectives of Viksit Bharat @ 2047 and the SDGs @ 2030.

Keywords— *ASHA Workers, North Maharashtra, Socio-Economic Development, National Health Mission, SDG 3, SDG 5, Viksit Bharat @ 2047, Community Health, Gender Equity, Rural Health Workforce.*

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I. INTRODUCTION

One of the major constituents of the healthcare framework in India is that of health workers at the community level, with ASHA workers being the most important. The ASHA scheme was initiated in 2005 through the initiative of the National Rural Health Mission (NRHM), which later became the part of the National Health Mission (NHM), and it envisaged the employment of trained women as community health workers, one for each thousand rural residents, to ensure greater accessibility to preventive, promotive, and curative health care services.

North Maharashtra, a region characterized by tribal settlements, hills, agriculture, and pockets of severe poverty, constitutes an unusual environment in which the effectiveness and welfare of ASHA workers may be analyzed. Districts such as Nandurbar, which is considered one of the most backward areas in India, and tribal zones of Nashik and Dhule depend upon ASHA workers for providing health care services to expectant mothers, immunization campaigns, monitoring of TB cases, malnutrition programs, and COVID-19 activities.

Notwithstanding their importance, however, ASHA workers have a unique structural ambivalence; for they are considered volunteers rather than full-time employees, thus disqualifying them from receiving a fixed salary, pension, provident fund, and other social benefits.

In this context, when India faces two challenges at once, namely to attain the Sustainable Development Goals of the United Nations till 2030 and also realise the vision of 'Viksit Bharat @ 2047', where India emerges as a developed country, inclusive and equitable in nature, the socio-economic marginalization of ASHA workers becomes an inherent contradiction that must be addressed through policy formulation without further delay. This study will examine the socio-economic development level of ASHA workers in North Maharashtra.

II. LITERATURE REVIEW

The contributions and issues related to the roles of ASHA workers in India have been studied extensively in academic literature. Bajpai and Dholakia (2011), in their analysis of NRHM in Maharashtra, noted how even though ASHA had increased institutional deliveries and immunization coverage, issues related to lack of training, inadequate supervision, and incentive distribution reduced their efficacy and motivation.

In Mishra and Bhatt's (2014) critique of the 'feminization of unpaid labour', they pointed out how the state was able to utilize the social capital of women in labeling ASHA activity as unpaid work for their community and not as actual employment. This particular issue finds relevance in tribal and semi-urban areas of North Maharashtra due to existing gender economic marginalization.

Rao et al. (2016), in a study conducted in multiple states, reported that the monthly salaries of ASHA workers averaged from INR 2,000-4,000, which was substantially less than the statutory minimum wages. In this regard, ASHA workers from tribal regions in Maharashtra earned much less than those in peri-urban areas because of fewer health incidents in tribal areas that led to incentive payments.The Lancet India Group (2019) and post-COVID studies highlighted how ASHAs had been put on the frontline of pandemic management without adequate pay, protection, and insurance. The 2022 strike of ASHAs all over India, demanding regularisation of their employment, was a turning point in the political economy of community health practice.

Examining ASHA welfare under the rubric of SDGs, Sharma (2020) contended that SDG 3 (Health and Well-being for All) cannot be realised without tackling social determinants of the people implementing it. The ASHA model itself, seen from the SDG perspective, embodies SDG 1 (No Poverty), SDG 5 (Gender Equality), SDG 8 (Decent Work), and SDG 10 (Reducing Inequalities)

III. OBJECTIVES OF THE STUDY

- To study the socio-economic background (income, educational background, caste, and family status) of the ASHA workers in North Maharashtra.

- To study the problems encountered by the ASHA workers related to their job.
- To analyze whether the ASHA welfare measures that exist at present meet the objectives of SDG goals 3, 5, 8, and 10.
- To find out what policy suggestions should be made to incorporate the welfare of the ASHA workers in the Viksit Bharat @ 2047 agenda.

IV. RESEARCH METHODOLOGY

1. STUDY AREA

The research is done on five districts of North Maharashtra, namely, Nashik, Dhule, Nandurbar, Jalgaon. This area was chosen for its diverse socio-economic environment that includes blocks predominantly populated by ST communities, plain areas predominantly inhabited by OBC communities, and semi-urban clusters.

2.DATA COLLECTION

Both primary and secondary sources have been used in the study. Primary data were gathered using structured questionnaires given to 300 ASHA workers, with 75 respondents per district chosen randomly based on a stratified sample, ensuring that rural, tribal, and semi-urban areas are adequately represented. Interviews were held with 20 ASHA facilitators (AF) and 10 District Health Officers (DHO).

Secondary data were collected from Maharashtra state National Health Mission (2019–2024), Ministry of Health and Family Welfare (MoHFW) yearly reports, National Family Health Survey NFHS-5 (2019–21), and DLHS-4 data.

3.ANALYTICAL FRAMEWORK

Quantitative data was analyzed using descriptive statistics, frequency distribution, and cross-tabulation. Parameters for the MPI were used to measure deprivation among ASHA workers. Thematic coding was done for qualitative data in accordance with the SDGs.

V. DATA ANALYSIS AND FINDINGS

1. SOCIO-ECONOMIC PROFILE OF ASHA WORKERS

The findings of the socio-demographic characteristics suggest that the vast majority of ASHA workers from North Maharashtra belong to socially and economically disadvantaged groups. Socio-Demographic Indicators of ASHA Workers from North Maharashtra are shown in Table 1.

Table 1: Socio-Demographic Profile of ASHA Workers in North Maharashtra (N=300)

Nashik n=75 Dhule n=75 Nandurbar n=75 Jalgaon n=75

Indicator	Category	No. of Respondents	Percentage (%)
Caste Category			
	Scheduled Tribe (ST)	**124**	**41.3**
	Scheduled Caste (SC)	**66**	**22.0**
	OBC	**86**	**28.7**
	General / Others	**24**	**8.0**
Educational Qualification			
	Below Class X	**84**	**28.0**
	Class X Pass	**134**	**44.7**
	Class XII Pass	**64**	**21.3**
	Graduate & Above	**18**	**6.0**
BPL Household Status			
	BPL Card Holder	**164**	**54.7**
	APL Card Holder	**136**	**45.3**

Indicator	Category	No. of Respondents	Percentage (%)
Marital Status			
	Married	**262**	**87.3**
	Widowed / Separated	**38**	**12.7**

Source: Primary Survey Data, 2024 | Stratified random sampling, 75 respondents per district

It is evident from the data that more than 63% of ASHA workers are from SC/ST communities. This implies that apart from their social disadvantages, they are now subjected to further disadvantages due to insecure nature of their employment, owing to the design of the programme itself

2. INCOME AND REMUNERATION ANALYSIS

The income distribution clearly shows a scenario of financial instability. As an incentive-based system, this type of remuneration has been characterized by very inconsistent monthly incomes. These are shown in Table 2 below:
Table 2: Monthly Income Distribution of ASHA Workers (N=300
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Monthly Income Range (INR)	No. of Respondents	Percentage (%)
Below ₹2,000	**36**	**12.0**
₹2,001 – ₹3,500	**102**	**34.0**
₹3,501 – ₹5,000	**94**	**31.3**
₹5,001 – ₹7,000	**48**	**16.0**
Above ₹7,000	**20**	**6.7**
Total	**300**	**100.0**

Source: Primary Survey Data, 2024 | N = 300 across Nashik, Dhule, Nandurbar & Jalgaon

Notably, 46% of respondents had incomes under ₹3,500/month, which is substantially lower compared to the statutory minimum wage for unskilled laborers in Maharashtra, set at ₹12,117/month in 2024. Laborers from tribal regions of Nandurbar and Nashik were observed to have the least income levels between ₹2,200/month and ₹2,800/month, owing to the low density of population and number of health conditions that qualified for incentives in the region.

3. OCCUPATIONAL CHALLENGES

Field interviews and questionnaire results revealed a set of occupational stress factors among the 300 ASHA workers surveyed in the Nashik, Dhule, Nandurbar, and Jalgaon districts. The most commonly mentioned occupational stress factors were as follows:

• Irregularity and delay in the release of incentives — 234 workers (78%) faced this issue, which led to immense financial strain on them, forcing them to engage in farming work as secondary occupations to support their families financially.

• Overwork and bureaucratic responsibilities — ASHA workers claimed that they worked six to eight hours per day entering data into registers and reporting, which prevented them from engaging directly with the community on health issues.

• Social security issues — 267 workers (89%) lacked health insurance associated with their occupation, while 282 workers (94%) did not have any pension or provident fund schemes. This rendered them vulnerable to socio-economic insecurity.

• Safety issues — 102 workers (34%) reported being threatened and intimidated during their night visits to help pregnant women in tribal areas of Nandurbar and Nashik.

• Skill enhancement issues — Only 123 workers (41%) attended a refresher course in the last one year, and fewer workers from tribal blocks attended refresher courses than non-tribal blocks.

• No grievance redressal mechanism – Out of 201 survey participants, 67% reported a lack of knowledge about the existence of any formal process through which occupational grievances and non-payment of incentive issues could be raised.

4.SOCIAL RECOGNITION AND COMMUNITY STATUS

Findings from qualitative data show the paradox of social recognition, whereby ASHA workers are highly respected and trusted within their communities as health facilitators – 82% of the respondents noted that community members consulted them on matters related to health even beyond the official capacity they were assigned to. Nevertheless, this social capital is not recognized institutionally, nor financially rewarded or rewarded in terms of professional development. A majority of the respondents felt exploited.

VI. ASHA WORKERS AND THE SDG FRAMEWORK

The activities undertaken by the ASHA workers are directly connected to several targets within the SDGs; however, the social and economic marginalization of the ASHA workers constitutes a fundamental contradiction within the SDGs

Table 3: ASHA Workers' Contributions vs. Socio-Economic Gaps vis-à-vis SDG Targets

SDG Goal	ASHA Contribution	Socio-Economic Gap
SDG 1: No Poverty	**Reducing health-induced poverty through preventive care**	**54.7% of ASHAs are BPL households themselves**
SDG 3: Good Health	**Maternal health, immunisation, disease surveillance**	**ASHAs lack health insurance and occupational safety nets**
SDG 5: Gender Equality	**Women empowerment; maternal rights awareness**	**ASHAs face wage discrimination and gender-based workplace risks**
SDG 8: Decent Work	**Employment at community level**	**Incentive-only model denies minimum wage and labour rights**
SDG 10: Reduced Inequalities	**Reaching SC/ST, tribal communities**	**Tribal area ASHAs earn 35% less than non-tribal counterparts**

Source: Author's Compilation based on Primary Data & NHM Reports, 2024

This analysis shows that ASHA workers are tools for SDG implementation but also one of the main targets for improvement within these goals. Such duality makes the current policy contradictory and ethically flawed.

VII. LINKAGE WITH VIKSIT BHARAT @ 2047

The 'Viksit Bharat @ 2047' vision represents the Indian ambition to become a developed country within the next hundred years after gaining independence, including the following four areas: Yuva (Youth), Garib (Poor), Mahila (Women), and Annadata (Farmers). ASHA workers fall under the category of the first three pillars; most of them are female, from poor families, and work among farmers in rural areas.

Achieving Viksit Bharat with respect to health would require creating a strong, committed, and professional community health workforce. However, the present scenario, whereby more than ten lakh ASHAs in the country – seven lakh ASHAs alone in Maharashtra – operate as volunteer workers paid on a piece rate basis, cannot be consistent with Viksit Bharat. It is important that:

•Regularizing employment of ASHAs with fixed salaries linked to Consumer Price Index (CPI) and not purely incentive-based payments.

•Compulsory enrolment of all ASHAs in PM Jan Arogya Yojana (Ayushman Bharat), PM JEEVAN JYOTI BIMA YOJANA, and Atal Pension Yojana schemes.

•Creating career tracks where ASHAs can rise up as ANMs, CHOs, or even in supervisory roles through bridge courses and Recognition of Prior Learning programs.

•Digital empowerment through the creation of ASHAs' own mobile applications for incentive monitoring, reducing the need for physical registers and making sure payments happen on time.

•Creation of ASHA Welfare Boards at district level for addressing any grievances as well as timely payments and psychosocial support.

VIII. POLICY RECOMMENDATIONS

Based on the results of this research, the below policy recommendations can be formulated as follows:

•Monthly Fixed Allowance: Government of Maharashtra needs to provide NHM incentives along with a state sponsored monthly fixed allowance amounting to at least INR 5000 for each ASHA worker, which will be reviewed every three years.

•Entitlement to Social Security: ASHA workers should be compulsorily provided social protection under the government schemes such as ESIC (Employee's State Insurance Corporation).

•Regularisation: A plan needs to be devised for gradually regularizing ASHA volunteer workers by making them contractual and later on government employees with Grade Pay equal to that of an ANM worker.

•Incentives in Tribal Area: Specific 'remoteness allowances' should be provided to ASHAs working in tribal areas (Schedule V) for low reportable incidence rates and high expenses in traveling.

•Training and Skill Enhancement: Mandatory residential training for five days annually, with provision of untied funds for childcare facilities during training duration, should be implemented for all ASHAs.

•Bio-Metric Payment Mechanisms: Linking ASHA incentives payment to the DBT ecosystem based on bio-metric validation using Aadhaar to avoid any delays and leakages in payment.

•Safety for ASHAs: Development of district-level fast-track complaint systems for ASHAs facing harassment issues, and incorporating mobile-based emergency SOS system.

IX. CONCLUSION

The role of ASHA workers in North Maharashtra is nothing short of a miracle where social capital, social trust, and public health facilities come together. Their efforts to reduce maternal mortality, increase immunization rates, monitor malnutrition levels, and manage epidemics have all been extensively studied and validated. Despite this, their socio-economic status continues to be marked by poverty, insecurity, vulnerability, and institutional neglect.

This paper shows that the discrepancy between the work that ASHA workers do and their reward structure is not just an issue of bad administration; it is an injustice that goes against the very principles that the Viksit Bharat mission stands for and that the SDGs promise to 'leave no one behind.' A nation that aims to be a developed country by 2047 cannot continue with its public health model based on the exploitation of its poorest women. The journey towards SDGs 2030 and Viksit Bharat 2047 passes through the well-being of ASHAs themselves. Spending on their regulation, remuneration, social protection, and professional development will not be an act of spending on charity; rather, it will prove to be an immensely profitable investment for the development of the country's human resource, its health system resilience, and its social justice paradigm. It is imperative that the state, civil society, and scientific community work together to create a policy framework for ASHAs that allows them to become its beneficiaries.

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