



Rights on the Periphery: ASHA Workers and the Quest for Gender Justice in India

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An Abstract

Accredited Social Health Activists (ASHAs) form the foundation of India's community health system by delivering vital maternal, child health, and preventative services at the grassroots level (Nandan, 2010). ASHA workers, despite their vital contribution to public health initiatives, often endure precarious working conditions characterised by insufficient remuneration, absence of social security, and lack of basic labour rights, reflecting the broader structural inequalities faced by women in the informal sector (Nandi et al., 2016). The situation of ASHA workers highlighted the wider systemic inequalities faced by women in the informal sector, due to gendered expectations that lead to the devaluation and marginalisation of women's work. In this context, this article proposes to examine the rights of ASHA workers within the broader framework of women's rights in India. The study also aims to examine the difficulties faced by ASHA workers, considering their labour rights, gender justice, and relevant public policies. In addition, the research will explore the theoretical aspects of ASHA workers' marginalisation.

Keywords: ASHA Workers, Labour Rights, Women's Rights, Gender Justice.

1. INTRODUCTION

In the Global South, the region characterised by insufficient infrastructure and a shortage of trained health care professionals, the delivery of health care services depends solely on Community Health Workers. In India, Accredited Social Health Activists (ASHAs) constitute a significant cohort of community health workers. They are crucial in enhancing local health governance and advancing mother and child health. The ASHA initiative, initiated in 2005 under the National Rural Health Mission (NRHM), sought to promote community engagement, enhance health awareness, and facilitate access to institutional healthcare services (Ministry of Health and Family Welfare, 2005).

Accredited Social Health Activists (ASHAs) have emerged as an integral component of India's public health infrastructure. ASHAs provide a range of services, including promoting community participation in immunisation programs, supporting institutional deliveries, advocating for adequate nutrition and sanitation, and participating in disease surveillance and public health campaigns. Scott and Shanker (2010) have shown that their work has been widely recognised for improving health outcomes, such as higher rates of institutional births and better immunisation coverage. Conversely, despite their important role, ASHA workers often face marginalisation within labour governance structures, mainly because they are classified as volunteers instead of formal employees. This situation highlights the broader structural dynamics associated with the feminisation of informal labour and the persistent devaluation of care-work.

Feminist theorists have consistently posited that the labour inherent in social reproduction, encompassing caregiving, health assistance, and domestic management, is often undervalued in formal economic assessments, despite its crucial contribution to societal and economic advancement (Waring, 1988; Folbre, 2006). The implementation of incentive-based payment structures for ASHA workers illustrates how welfare initiatives can leverage gendered labour norms to facilitate public service provision while simultaneously addressing financial limitations.

The sidelining of ASHA workers has sparked significant scrutiny of labour rights and gender equity. Though India's labour laws offer protections for employees in both formal and informal sectors, the voluntary basis of ASHAs' employment limits their access to benefits like minimum wages, social security, maternity leave, and workplace safety measures.

Studies have shown that these exclusions foster precarious working conditions, characterised by economic vulnerability, reduced bargaining power, and a lack of professional identity (Standing, 2011). The experiences of ASHA workers necessitate analysis through an intersectional lens, recognising the interplay of gender, caste, class, and rural marginalisation. A significant number of Accredited Social Health Activists (ASHAs) come from socio-economically disadvantaged backgrounds and work in areas with poor infrastructure and established social hierarchies. These conditions hinder their ability to negotiate employment terms and secure institutional support, which in turn reinforces cycles of compounded marginalisation (Crenshaw, 1989). In the contemporary period, significant changes have been observed in Community health programs alongside the management of welfare activities. These changes include decentralisation, using performance-based incentives, and participatory development methods. While improvements in efficiency and accountability have given the programme greater importance, low-paid frontline workers are assigned the task of providing services to the community at a marginal cost. Bhattacharyya et al.(2001) argue that the success of community health worker initiatives hinges on community involvement, coupled with sufficient incentives, training, and institutional acknowledgement.

1.1 Objectives of the Study

This study has three main goals. First, it will examine the theoretical ideas that explain the marginalisation of care work, which is often associated with women. Following this, the research will analyse the legal and policy frameworks governing women's labour rights in India, with a focus on ASHAs. Moreover, it will explore the daily experiences and collective actions of ASHA workers, ultimately leading to policy suggestions aimed at promoting gender justice in public health governance.

1.2 Significance of the Study

This research contributes to the existing conversation surrounding informal labour, the responsibilities of welfare states, and the value of care work. Classifying ASHA workers as employees represents more than a simple administrative adjustment; it constitutes a crucial step toward establishing fair labour practices and strengthening the foundations of inclusive public health systems.

1.3 Research Methodology

The study was analytical and descriptive in nature. Data for the study are collected from secondary sources. These sources include Government reports, various national and international journals, articles, newspaper etc. The suggestions recommended by the researcher are solely based on the opinion of the researcher.

2. THEORITICAL FRAMEWORK: GENDER, LABOUR, AND THE POLITICS OF CARE

Understanding the marginalisation of Accredited Social Health Activists (ASHAs) requires situating their experiences within broader theoretical frameworks of gendered labour, welfare government, and the political economy of care. Feminist theorists assert that the organisation of labour in modern economies reflects significant gender hierarchies, where women's labour, particularly in care work, is continually undervalued and inadequately recognised (Elson, 1999; Fraser, 2016). The absence of ASHA workers from formal labour protections indicates not only policy shortcomings but also systemic disparities embedded in the social framework of both productive and reproductive labour.

2.1 Feminist Political Economy and Devaluation of Care-Work

The treatment of care work within the framework of capitalism and welfarism can be best analysed from a feminist political economy perspective. Marilyn Waring (1988) demonstrated that national economic accounting frameworks have historically omitted women's unpaid labour, hence sustaining their invisibility and absence of financial remuneration. Diane Elson (1999) similarly emphasises that macroeconomic policies often rely on women's unpaid or undercompensated labour to facilitate social reproduction and the delivery of public services. ASHA workers, who are the primary providers of maternal health counselling and community organisation, are classified as volunteers, not employees. This classification allows the government to expand public health programs while also reducing its financial responsibilities related to formal employment. These dynamics illustrate Fraser's (2016) concept of the "crisis of care," where welfare systems increasingly depend on female labour without providing adequate institutional support or recognition.

2.2 Social Reproduction Theory and Community Health Labour

Social reproduction theory provides a holistic framework that underscores the essential role of labour in guaranteeing human existence and maintaining societal structures. Vogel (1983) argues that reproductive labour encompasses activities crucial for the maintenance and regeneration of the workforce, such as childcare, educational endeavours, and healthcare services. Furthermore, contemporary scholars, including Bhattacharya (2017), argue that understanding social reproduction is crucial for analysing current labour disputes, especially in sectors with a high percentage of women workers. ASHAs play a vital role in reproductive health by promoting preventive healthcare, helping with births in healthcare facilities, and ensuring access to nutrition and sanitation programs. These activities contribute to enhanced public health outcomes and heightened economic productivity. The placement of this labour outside conventional employment structures mirrors wider patterns of marginalisation linked to reproductive labour.

2.3 Labour Citizenship and the Politics of Recognition

Labour citizenship offers a valuable lens through which to examine the marginalisation of ASHA workers within existing frameworks. Marshall's (1950) concept of social citizenship highlighted the significance of economic entitlements and social safeguards in fostering comprehensive societal engagement. Later research has refined this framework, clarifying the connection between employment conditions and the realisation of rights (Standing, 2011). Classifying Accredited Social Health Activists (ASHAs) as volunteers significantly undermines their standing as workers. This designation diminishes their ability to claim minimum wage, social security provisions, and workplace safeguards. Moreover, this exclusion limits their involvement in health governance, which then reinforces the inequalities between formally recognised workers and those employed in the community.

2.4 Intersectionality and Layered Marginalisation

Intersectionality offers a vital lens through which to comprehend the marginalisation experienced by ASHA workers. This approach highlights the interrelation of diverse forms of disadvantage, including gender, caste, class, and rural residence (Crenshaw, 1989). Most ASHAs hail from socio-economically disadvantaged backgrounds and operate in contexts where limitations on mobility, educational disparities, and established social hierarchies substantially impact their employment opportunities.

Intersectional perspectives reveal that the obstacles faced by ASHA workers extend beyond the confines of gender-based discrimination. These impediments stem from a confluence of interconnected structural inequities. Therefore, this analysis clarifies the reasons for assigning community-based care responsibilities to marginalised women, while also highlighting the ongoing issue of inadequate pay for their work.

2.5 Critical Theory and the Ideology of Voluntary Labour

Critical theory offers a more sophisticated understanding of how ideological structures shape views on work and the notion of consent. Marcuse (1964) posits that modern governments often utilise narratives that portray existing institutions as logical and beneficial, thus integrating individuals into systems of control. The

narratives concerning ASHA workers, which highlight empowerment, community involvement, and national progress, could, in reality, conceal the exploitative aspects intrinsic to incentive-driven labour models. However, the increasing mobilisation of ASHA workers across India demonstrates the limitations of ideological integration. The current policy discussions were challenged by the growing need for recognition and rights, which highlighted the potential for disagreement within the welfare governance.

3. WOMEN'S LABOUR RIGHTS IN INDIA: A COMPARATIVE ANALYSIS

3.1 Women in the Formal Work Force: An Analysis

A mix of constitutional safeguards, current regulations, and other social programs determines women's rights at work in India. There are many important regulations in place to make sure that men and women are treated equally and that everyone has a fair place to work. However, these rules are not always followed in all areas. The fact that Accredited Social Health Activists (ASHAs) are included in this situation shows that they don't have access to the same labour safeguards as other workers. This predicament prompts us to consider gender equality and the effectiveness of welfare programs.

The Indian Constitution is the main law that protects women's rights at work.

Article 14 sets the standard for legal equality, while Article 15 makes clear that discrimination based on sex is prohibited. Also, Article 16 says that everyone should have the same chances to work in the public sector.

Article 42 of the Directive Principles of State Policy further says that the government should make sure that everyone has good working conditions and maternity benefits. Article 39(d) says that the government should also make sure that everyone gets compensated equitably for the same amount of work. When you put these elements of the constitution together, they show that the constitution is in favour of labour governance that takes gender into account (Deva, 2012). But in order to employ these constitutional protections correctly, you usually need to create significantly more legal and administrative structures. Also, women's capacity to gain positions and protections at work is greatly affected by structural differences based on caste, class, and geography.

The situation of Accredited Social Health Activists (ASHA) highlights the limitations of constitutional protections when specific professional groups lack legal recognition.

Laws are in place to protect women in the formal workforce, with the goal of improving their economic stability and creating a professional environment based on mutual respect.

The Minimum Wages Act of 1948 provides the framework for wage-setting, mandating that each state establish minimum wage rates.

The Equal Remuneration Act of 1976, now incorporated into the 2019 Code on Wages, was designed to eliminate wage imbalances based on gender. Furthermore, the Maternity Benefit Act of 1961 guarantees paid maternity leave and offers protection against job loss during pregnancy.

The Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013, provides additional protections by establishing procedures for handling workplace harassment.

The Code on Social Security, 2020, aims to expand access to social security services, including health insurance, pensions, and maternity benefits (Ministry of Labour and Employment, 2020). Despite existing legal structures, women's engagement in formal employment remains restricted. Women's progress in the workforce is consistently hindered by elements such as occupational segregation, unpaid domestic responsibilities, and dominant socio-cultural norms (Kabeer, 2012). Formal sector employment provides a structured framework for the assertion of rights, negotiation of working conditions, and utilization of grievance redress mechanisms.

3.2 Women in the Informal Work Sector: An Analysis

A large number of women in India work in informal jobs, which pay poorly, don't have written contracts, have irregular hours, and don't have easy access to institutional social security. Women who work informally include agricultural labourers, domestic workers, home-based workers, construction workers, street vendors, and self-employed producers. In the past, this category of workers has not been protected by labour laws. But recent amendments to the law have tried to incorporate them in certain rights and assistance programs. The Unorganised Workers' Social Security Act of 2008 is a very important piece of law. It recognises the instability of the lives of people who work outside conventional jobs and lays out a framework for social security programs.

Life and disability insurance, healthcare and maternity benefits, old-age pensions, and other social programs are all part of these programs (Government of India, 2008). Even though there are still problems with putting this law into effect, it is a big step forward in officially recognising informal work.

The Street Vendors (Protection of Livelihood and Regulation of Street Vending) Act, 2014, recognises street vendors as workers and gives them the right to sell goods in certain places, protects them from eviction without cause, and allows them to file complaints. This law shows that the government is beginning to recognise the rights of people working in informal urban economies (Bhowmik, 2014). The Building and Other Construction Workers (Regulation of Employment and Conditions of Service) Act, 1996 protects women who work in construction by making welfare boards give them benefits like help with maternity leave, accident compensation, pensions, and help with learning new skills. These steps recognise how dangerous construction work may be and try to make workers' lives more stable (Srivastava, 2012).

Even though there is no national law, domestic workers have been included in more state-level support programs and minimum wage announcements. Some places have set up welfare boards and ways for workers to file complaints about exploitation, wage fraud, and workplace maltreatment (International Labour Organisation, 2015).

The 2020 Code on Social Security marks a substantial change in labour law, with the goal of broadening protections. It achieves this by including gig and platform workers, as well as other types of unregulated labour. The Code's main aim is to make it easier for people to access social protection programs like health

insurance, maternity benefits, and retirement plans. However, its actual impact is still being discussed (Ministry of Labour and Employment, 2020). It's essential to incorporate informal female workers into labour statistics, social programs, and collective organisations. This inclusion allows them to claim their rights and participate in negotiations.

Rather than solely seeking acknowledgement as labourers, their advocacy often prioritises the enhancement of existing policies, the expansion of their reach, and the maintenance of economic stability. This distinction is crucial for comprehending the increasing marginalisation of ASHA workers. They are frequently excluded from the essential safeguards afforded to other informal workers, primarily due to their prevalent classification as volunteers.

4. DISCUSSIONS ON FINDINGS

4.1 Employment Conditions and Daily Experiences of ASHA Workers

The daily experiences of Accredited Social Health Activists (ASHAs) highlight the primary structural deficiencies of India's community-based public health system.

Accredited Social Health Activists (ASHAs) are widely acknowledged as crucial healthcare providers that link healthcare facilities with rural populations; nonetheless, they encounter irregular compensation, occupational hazards, and administrative challenges.

To understand how gendered labour hierarchies continue in welfare systems, we need to look at these lived experiences. What the job is like and what it entails. ASHAs do a lot of different things that go beyond what most people think of as volunteer work. These duties include encouraging people in the neighbourhood to get vaccinated, assisting with institutional deliveries, conducting home surveys, supporting disease control efforts, and participating in various health campaigns. National guidelines usually assign one ASHA worker to about 1,000 people, indicating the number of people they are responsible for in the public health system.

4.2 Compensation and Financial Instability

The way ASHA personnel are paid is a big problem for them. Their remuneration is mostly performance-based, not a set amount. The National Health Mission manages the program monies that pay for these incentives. They are related to certain tasks. Because of this, the payment mechanism often breaks down, and payments can arrive at unexpected times.

Empirical research indicates that delays in incentive disbursements are common; many ASHAs encounter difficulties in obtaining payments, frequently enduring prolonged waits for remuneration after completing their designated responsibilities. A poll showed that about one-third of ASHAs had received their most recent payment in the last month. The rest had to wait a long time or didn't get all their money back. Field studies also show that the value of incentive payments can vary significantly depending on the task at hand. For example, ordinary tasks receive smaller payouts, whereas specific program achievements receive larger incentives. This fluctuation makes finances less stable and leads people to view ASHA employment as extra revenue rather than a necessity for their household.

Recent national reviews have shown that, even though many states have set up fixed honorariums and other incentives, payment delays are still a big problem in many places. This hurts worker enthusiasm and the overall effectiveness of the programs.

4.3 Occupational Risk and Safety Concerns

Occupational safety and the associated dangers are of utmost importance. ASHA's fieldwork presents several occupational hazards, including the need for extended travel in remote areas, inadequate transportation infrastructure, and the potential for harassment or violence during community outreach efforts.

The absence of stringent workplace safety regulations often compels workers to depend on informal support networks. During public health crises, ASHAs are particularly susceptible to infectious diseases while performing their standard duties. Reports from diverse sources indicate that these workers have conducted extensive screening and awareness campaigns, often without sufficient protective equipment and with delays in wage disbursement. Furthermore, the absence of structured health insurance or compensation for work-related illnesses in certain states exacerbates these risks, prompting concerns about the viability of relying on volunteer labour for essential health interventions.

4.4 Administrative Pressures and Accountability Mechanisms

Administrative requirements and accountability frameworks have a significant influence on the operations of Accredited Social Health Activists (ASHAs). These healthcare workers are required to perform within a complex administrative system that demands detailed record-keeping, participation in training programs, and attainment of specified performance targets.

ASHAs must undergo stringent verification protocols involving multiple stakeholders, such as supervisors and data entry personnel, to receive their incentives. Delays in payment are commonly attributed to issues such as slow data entry or delayed beneficiary registration across various states. Additionally, manual or semi-digital monitoring systems have historically obscured payment status, resulting in uncertainty for ASHAs regarding the timing and amount of their remuneration. To address the issues, digital applications and tracking systems have been introduced in India, yet their implementation remains inconsistent across different states.

4.5 Gendered Double Burden and Social Expectations

Gendered expectations and the way things are done in society have a big effect on the working circumstances of ASHA personnel. Most ASHAs still do most of the unpaid work around the house, take care of children, and care for the elderly. Because of this, they often have to do their public health work at the same time as these other tasks, which means longer hours and fewer chances to rest or move on in their careers

People think of ASHA labour as community service, which makes it more likely that women will do these jobs because they feel morally obligated to, not because they want to make money. This way of thinking makes it easier to accept low or inconsistent pay, which makes it harder to negotiate successfully with people in charge.

4.6 Developing Alliances and Communal Assistance

These mechanisms of mutual aid have also helped bigger efforts to mobilise grow.

These efforts need to be classified as labour and have access to social protection measures. So, the daily experiences of instability and uncertainty are vital things that make community health workers better aware of their rights and work together to safeguard them. The marginalisation of Accredited Social Health Activists (ASHAs) has sparked collective action, resistance, and a demand for recognition. Consequently, ASHA workers have staged rallies, strikes, and discussions in various Indian states, pushing back against the government's claim that their work is voluntary. They are united in their demands: equitable pay, social security, and formal recognition of their employment.

These activities show how new labour politics are growing in welfare state systems, which makes gender justice even more important in current labour battles.

The increasing collective action of ASHA workers mirrors wider changes in India's informal labour sector. Studies show that women in unstable jobs are increasingly banding together to demand respect, job security, and government accountability (Agarwala, 2013). Unlike traditional industrial labour movements, these actions often occur within fragmented employment structures and rely on local networks of associations, unions, and civil society groups.

The involvement of ASHAs in these collaborative efforts illustrates the development of "precarious consciousness," a term Standing (2011) used to describe how precarious workers, facing instability and a lack of professional recognition, begin to express common grievances and demand their rights. The shared experience of fluctuating incentives, heavy workloads, and bureaucratic limitations has fostered inter-regional solidarity. As a result, labour strikes and protests have surged across the country. ASHA workers, especially, have staged major strikes in states like Kerala, Karnataka, Maharashtra, and Delhi, pushing for minimum wages, pension benefits, and hazard pay. The prolonged protests in Kerala, for instance, garnered national focus on the systemic challenges encountered by community health workers, especially around inadequate compensation and deferred payments (George, 2020). In a similar vein, the demonstrations that occurred during and following public health crises highlighted the heightened vulnerabilities experienced by ASHAs, particularly stemming from insufficient protective gear and the lack of insurance coverage. These actions challenged dominant policy viewpoints that portrayed ASHA work as a voluntary social contribution, repositioning their demands within the contexts of labour rights and gender equality (Sen & Kar, 2021). Consequently, collective action has required partnerships with trade unions and women's organisations, which have played a crucial role in advocating for policy reforms at both state and national scales.

As a result, these partnerships have strengthened the negotiating power of ASHA workers, which has led to gradual improvements in their pay and benefits. The experiences of ASHA workers provide a clear example of how recognition is achieved within welfare governance. Their situation highlights the complex challenges of securing labour rights within community-based welfare programs. Unlike jobs with formal contracts or factory settings, ASHA work is structured within decentralised administrative systems. These systems include

local health officials, elected representatives, and program coordinators. This division often makes it harder to negotiate as a group and can undermine accountability in how policies are carried out.

Conversely, the mobilisation efforts have engendered specific policy alterations. These include the establishment of standardised monthly disbursements across numerous states and the provision of supplementary incentives during public health emergencies. These developments illustrate the capacity of collective action to reshape welfare governance, particularly in environments characterised by ongoing debates regarding the formal recognition of workers (Nandi & Schneider, 2020).

4.7 Gendered Aspects of Resistance

The introduction of ASHA workers serves as a notable instance of gendered political involvement. Women, who were once primarily responsible for household tasks, have become active participants in public spheres through protests, negotiations, and advocacy campaigns. This transformation directly challenges patriarchal structures that have historically limited women's participation in collective political activities, thereby broadening the scope of feminist labour movements. Feminist theorists argue that discussions concerning compensation for caregiving work are essential for re-evaluating citizenship and social justice within contemporary economic frameworks (Fraser, 2016). By claiming their identity as workers rather than volunteers, ASHAs challenge the conceptual distinction between productive and reproductive labour, thereby contributing to broader discussions about the valuation of care.

4.8 Constraints and Obstacles to Mobilisation

Despite the growing activism, ASHA groups face significant challenges. Their lack of formal employment prevents them from using institutional mechanisms to resolve disputes or negotiate collectively. Moreover, differences in how policies are implemented across different areas lead to unfair results. Certain states provide superior compensation and enhanced perks compared to others. Thus, socio-economic disadvantages can hinder regular participation in protests, as employees may risk losing benefits or facing administrative consequences. These challenges highlight the need for strong legal protections and improved union activities to ensure lasting progress in working conditions.

5. POLICY RECOMMENDATIONS AND THE PATH TOWARDS GENDER-JUST PUBLIC HEALTH GOVERNANCE

The marginalisation of Accredited Social Health Activists (ASHAs) underscores profound structural impediments inherent in India's labour governance, gender dynamics, and the formulation of welfare policies. Although community health worker initiatives have demonstrably improved public health outreach and service provision, their enduring viability hinges on addressing the economic precarity and institutional neglect experienced by these frontline workers. Consequently, a gender-sensitive approach to public health administration necessitates comprehensive legislative measures that acknowledge ASHAs as workers and incorporate them into established labour protection frameworks. The formal classification of ASHA personnel as employees, rather than volunteers, constitutes the most consequential policy shift. When workers are

classified as something other than employees, they lose important legal protections related to work. This also reduces organisations' responsibility for their working conditions.

International labour standards emphasise the recognition of all types of work that contribute to economic and social progress. The International Labour Organisation (ILO) has consistently stressed the importance of extending labour rights to workers in informal and community-based sectors to promote decent work and social justice (International Labour Organisation, 2018).

5.1 Formal Recognition as Workers

If ASHAs were officially recognised, they would have a minimum wage, set work hours, and a way to file complaints. Such a shift would enhance their negotiating power with health authorities, thereby reducing their dependence on manager-controlled incentive programs. Changing from incentive-based pay to a guaranteed income system presents a significant challenge. A major challenge stems from the current system's reliance on separate incentive payments, which are tied to how well different programs perform. While performance-based incentives hold the promise of enhancing efficiency, an overreliance on them can lead to revenue instability and administrative difficulties. Consequently, policy adjustments should prioritise the establishment of fixed monthly salaries compliant with state minimum wage regulations, while judiciously incorporating performance-based bonuses.

5.2 Augmentation of Social Security Coverage

Reducing the vulnerabilities linked to informal employment requires strong social protection. Including ASHA workers in national social security systems is crucial. This would provide them with health insurance, maternity benefits, pensions, and accident compensation.

This enhancement of protective measures is consistent with wider policy objectives concerning universal social security, as articulated in labour reforms such as the Code on Social Security (2020). Given the gendered dimensions of community health work, the provision of maternity benefits and occupational health provisions assumes special significance. Therefore, these efforts would reduce the financial burden associated with health issues, childbirth, and ageing, thereby promoting long-term financial stability.

5.3 Enhancing Occupational Safety and Support Frameworks

ASHAs, those committed community health workers, face a daily gauntlet of hazards.

They grapple with physical fatigue, the ever-present threat of infectious diseases, and the unsettling potential for harassment. Consequently, policy frameworks must incorporate safety protocols. Protective gear, transportation stipends, risk insurance, and a system for reporting workplace violence are all essential components of these protocols. Furthermore, training programs should address mental health and emotional well-being, recognising the psychological demands inherent in community engagement and crisis management.

The WHO guidelines highlight the significance of supportive supervision, ongoing skill enhancement, and secure working conditions in enhancing the performance of community health workers (World Health Organisation, 2018). Augmenting participation in health governance is essential for incorporating ASHA workers' viewpoints in the formulation and implementation of policies. Participatory decision-making can be improved through institutional mechanisms such as worker involvement in district health committees, consultative forums, and grievance redressal bodies. Integrating ASHAs into these structures would not only increase the program's effectiveness but also cultivate a sense of labour citizenship. This approach necessitates recognizing ASHAs as crucial actors in public health management, rather than simply as individuals tasked with program implementation.

5.4 Confronting Gendered Norms and the Valuation of Care Labour

Prolonged policy reform requires addressing the socio-cultural norms that frame care employment as either a voluntary undertaking or a moral obligation. Public awareness campaigns, gender-sensitive fiscal policies, and the integration of care-economy perspectives into developmental strategies could shift attitudes toward the economic value of reproductive labour. Feminist policy scholars argue that recognising care work as essential labour is vital for achieving genuine gender equality and sustainable economic expansion (Fraser, 2016). Consequently, incorporating this perspective into public health policy would strengthen efforts to reduce gender wage gaps and improve women's access to high-quality employment opportunities.

5.5 Promoting Collective Organisation and Unionisation

The experiences of ASHA workers highlight how important it is to work together to bring about gradual changes in policy. Governments and organisations in civil society should help create labour associations and encourage discussions between unions and health authorities. Strengthening collective bargaining systems can create formal ways to resolve conflicts and promote fair labour practices.

CONCLUSION

To improve the working conditions of ASHA personnel, a shift is essential from welfare-focused, incentive-based strategies to a rights-based model for public employment. This shift demands formal recognition, guaranteed pay, improved social security provisions, occupational safety measures, inclusive governance structures, and gender-sensitive policy adjustments. These actions would not only benefit ASHA workers but also strengthen the resilience and inclusivity of India's public health infrastructure. Recognising ASHA workers as employees constitutes both a necessary policy adjustment and a commitment to gender equity. The challenges they encounter underscore the necessity of amending existing labour legislation. Such revisions should more accurately reflect the significance of care work, mitigate employment precarity, and foster equitable advancement.

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