ISSN: P-2455-0515
E- 2394-8450

Educreator Research Journal

OPEN ACCESS

Volume–XIII, Issues–III

May – June 2026

Original Research Article

AN EMPIRICAL STUDY OF SOCIO-ECONOMIC DEVELOPMENT AMONG ASHA WORKERS: IMPLICATIONS FOR WOMEN-LED SUSTAINABLE DEVELOPMENT IN NORTH MAHARASHTRA

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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 — encompassing districts such as Nashik, Dhule, Nandurbar, and Jalgaon — ASHA workers act as essential intermediaries connecting rural and marginalized communities to the formal healthcare system. While these workers have played an integral role in advancing Sustainable Development Goals including Good Health and Well-being (SDG 3), Gender Equality (SDG 5), and Reduced Inequalities (SDG 10), they remain socioeconomically vulnerable due to low and uncertain earnings, inadequate social security, and poor career prospects. This empirical study examines the socioeconomic status of ASHA workers in North Maharashtra using both primary and secondary data sources across parameters including remuneration, educational qualification, household poverty, health coverage, occupational challenges, and community recognition. The study argues for policy reforms aimed at transforming ASHA workers into formally recognized employees, consistent with the objectives of Viksit Bharat @ 2047 and the UN 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.*

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 National Rural Health Mission (NRHM) — later integrated into the National Health Mission (NHM) — envisaging trained women community health workers, one per thousand rural residents, to ensure greater accessibility to preventive, promotive, and curative healthcare services.

North Maharashtra, a region characterized by tribal settlements, hilly terrain, agriculture, and pockets of severe poverty, constitutes a distinctive environment in which the effectiveness and welfare of ASHA workers may be rigorously analyzed. Districts such as Nandurbar — regarded among India's most backward areas — and tribal zones of Nashik and Dhule depend critically upon ASHA workers for maternal healthcare, immunization campaigns, TB monitoring, malnutrition programs, and epidemic management including COVID-19 activities.

ISSN: P-2455-0515
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Notwithstanding their importance, ASHA workers occupy a structurally ambiguous position: they are classified as 'volunteers' rather than full-time employees, thereby disqualifying them from fixed salaries, pensions, provident funds, and other statutory social benefits. As India simultaneously pursues the United Nations Sustainable Development Goals by 2030 and the vision of Viksit Bharat @ 2047, the socioeconomic marginalization of ASHA workers emerges as a fundamental contradiction that demands urgent policy attention. This study examines the socioeconomic development level of ASHA workers in North Maharashtra within this broader national and global context.

Review of Literature:

The contributions and structural challenges of ASHA workers have been extensively studied in the academic literature. Bajpai and Dholakia (2011) analyzed NRHM performance in Maharashtra, acknowledging that while ASHA workers had increased institutional deliveries and immunization coverage, deficiencies in training, supervision, and incentive distribution substantially reduced their efficacy and motivation.

Mishra and Bhatt (2014) articulated the 'feminization of unpaid labour', arguing that the state instrumentalized women's social capital by categorizing ASHA activity as community volunteerism rather than formal employment — a critique particularly salient in the tribal and semi-urban areas of North Maharashtra where gender-based economic marginalization already prevails.

Rao et al. (2016), in a multi-state study, reported average monthly ASHA remuneration of INR 2,000–4,000 — substantially below statutory minimum wages. ASHA workers in Maharashtra's tribal regions earned significantly less than their peri-urban counterparts due to a lower frequency of health events qualifying for incentive payments.

The Lancet India Group (2019) and post-COVID studies highlighted how ASHAs were deployed on pandemic frontlines without commensurate pay, protection, or insurance coverage. The nationwide ASHA strike of 2022, demanding employment regularization, marked a critical turning point in the political economy of community health practice in India.

Sharma (2020) argued, within the SDG framework, that SDG 3 (Health and Well-being for All) cannot be realized without addressing the social determinants affecting those who implement it. From this perspective, the ASHA model intersects with SDG 1 (No Poverty), SDG 5 (Gender Equality), SDG 8 (Decent Work), and SDG 10 (Reducing Inequalities) — placing ASHA worker welfare at the intersection of multiple global development commitments.

Objectives of the Study:

- To examine the socio-economic background — including income, educational attainment, caste, and family status — of ASHA workers in North Maharashtra.
- To identify and analyze the occupational challenges encountered by ASHA workers in the field.
- To assess whether existing ASHA welfare measures align with the targets of SDGs 3, 5, 8, and 10.
- To formulate evidence-based policy recommendations for integrating ASHA worker welfare into the Viksit Bharat @ 2047 agenda.

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Research Methodology:

1. Study Area

The research was conducted across five districts of North Maharashtra: Nashik, Dhule, Nandurbar, and Jalgaon. This region was selected for its diverse socio-economic composition, encompassing blocks predominantly inhabited by Scheduled Tribe (ST) communities, plains with OBC-majority populations, and semi-urban clusters — offering a representative cross-section for empirical investigation.

2. Data Collection

Both primary and secondary sources were employed. Primary data were gathered using structured questionnaires administered to 300 ASHA workers — 75 respondents per district — selected through stratified random sampling to ensure adequate representation of rural, tribal, and semi-urban areas. Semi-structured interviews were conducted with 20 ASHA Facilitators (AFs) and 10 District Health Officers (DHOs) to supplement quantitative findings.

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

3. Analytical Framework

Quantitative data were analyzed using descriptive statistics, frequency distributions, and cross-tabulations. Multidimensional Poverty Index (MPI) parameters were applied to measure deprivation among ASHA workers. Qualitative data from interviews were subjected to thematic coding aligned with the SDG framework, enabling a structured assessment of programmatic and policy gaps.

Data Analysis and Findings:

1. Socio-Economic Profile of ASHA Workers

The socio-demographic findings reveal that the overwhelming majority of ASHA workers in North Maharashtra originate from socially and economically disadvantaged groups. Table 1 presents the key socio-demographic indicators across all four study districts (N=300).

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

Districts: 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%

ISSN: P-2455-0515
E- 2394-8450

Educreator Research Journal

OPEN ACCESS

Volume–XIII, Issues–III

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Indicator	Category	No. of Respondents	Percentage (%)
	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%
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 belong to SC/ST communities. This finding underscores that the structural vulnerabilities of caste-based socioeconomic disadvantage are compounded by the precarious employment conditions inherent to the programme's design.

2. Income and Remuneration Analysis

Income distribution data expose a landscape of chronic financial instability. The incentive-based remuneration model produces highly inconsistent monthly earnings, as illustrated in Table 2.

Table 2: Monthly Income Distribution of ASHA Workers (N=300)

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 reported monthly incomes below INR 3,500 — substantially lower than the statutory minimum wage for unskilled labor in Maharashtra, set at INR 12,117/month in 2024. ASHA workers in the tribal regions of Nandurbar and Nashik reported the lowest income levels (INR 2,200–2,800/month), attributable to sparse population density and a reduced frequency of incentive-qualifying health events in these areas.

3. Occupational Challenges

Field interviews and questionnaire responses revealed a recurring set of occupational stressors among the 300 ASHA workers surveyed across Nashik, Dhule, Nandurbar, and Jalgaon:

ISSN: P-2455-0515
E- 2394-8450

Educreator Research Journal

OPEN ACCESS

Volume–XIII, Issues–III

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- Irregularity and delay in incentive release: 234 workers (78%) experienced significant delays in incentive payments, creating acute financial strain and compelling many to take up agricultural labor as supplementary income.
- Administrative overburden: ASHA workers reported spending six to eight hours daily on data entry and reporting tasks, substantially limiting their direct community health engagement.
- Absence of social security: 267 workers (89%) lacked any occupational health insurance, while 282 workers (94%) had no access to pension or provident fund schemes, leaving them structurally exposed to long-term socioeconomic insecurity.
- Safety concerns: 102 workers (34%) reported threats or intimidation during nighttime visits to assist pregnant women, particularly in tribal areas of Nandurbar and Nashik.
- Limited skill enhancement: Only 123 workers (41%) had attended a refresher course within the previous year, with attendance rates markedly lower in tribal blocks than in non-tribal areas.
- Inadequate grievance mechanisms: 67% of respondents (201 workers) were unaware of any formal process for addressing occupational grievances or non-payment of incentives.

4. Social Recognition and Community Status

Qualitative findings reveal a compelling paradox: ASHA workers enjoy high levels of trust and social recognition within their communities, with 82% of respondents reporting that community members sought their health guidance beyond official assignments. Yet this social capital remains institutionally unrecognized, financially unrewarded, and professionally unacknowledged. A significant majority of respondents articulated a sense of structural exploitation — their social embeddedness harnessed by the state without commensurate acknowledgment or compensation.

Asha Workers and the SDG Framework:

The activities undertaken by ASHA workers align directly with multiple SDG targets; however, their own socioeconomic marginalization constitutes a fundamental contradiction within the SDG mandate of 'leaving no one behind.' Table 3 maps ASHA contributions against corresponding socioeconomic gaps vis-à-vis relevant SDG goals.

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

ISSN: P-2455-0515
E- 2394-8450

Educreator Research Journal

OPEN ACCESS

Volume–XIII, Issues–III

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SDG Goal	ASHA Contribution	Socio-Economic Gap
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: Authors' compilation based on Primary Data & NHM Reports, 2024

This analysis reveals that ASHA workers simultaneously serve as instruments for SDG implementation and as populations that are themselves primary targets within these goals. This duality renders the current policy framework both internally contradictory and ethically untenable. A nation cannot credibly commit to SDG 5 (Gender Equality) while systematically underpaying its predominantly female community health workforce.

Linkage with Viksit Bharat @ 2047:

The 'Viksit Bharat @ 2047' vision articulates India's ambition to achieve developed-nation status by the centenary of independence, organized around four pillars: Yuva (Youth), Garib (Poor), Mahila (Women), and Annadata (Farmers). ASHA workers inhabit the intersection of the first three pillars — they are predominantly women, originate from economically impoverished households, and serve farming communities in rural India.

A credible vision of Viksit Bharat in health necessitates a committed, professional community health workforce. The current model — in which over ten lakh ASHAs nationally, including seven lakh in Maharashtra alone, operate as piece-rate volunteers — is structurally incompatible with this vision. Key imperatives include:

- Regularizing ASHA employment with fixed salaries indexed to the Consumer Price Index (CPI), supplemented rather than replaced by performance-linked incentives.
- Mandatory enrollment of all ASHA workers in PM Jan Arogya Yojana (Ayushman Bharat), PM Jeevan Jyoti Bima Yojana, and Atal Pension Yojana.
- Establishing structured career pathways enabling ASHAs to advance to ANM, Community Health Officer (CHO), or supervisory roles through bridge courses and Recognition of Prior Learning (RPL) programs.
- Digital empowerment through dedicated ASHA mobile applications for real-time incentive tracking, reducing dependence on physical registers and ensuring timely payment.
- Creation of ASHA Welfare Boards at the district level with mandates for grievance redressal, payment monitoring, and psychosocial support.

Policy Recommendations:

Drawing on the empirical findings of this study, the following evidence-based policy recommendations are proposed:

- Monthly Fixed Allowance: The Government of Maharashtra should introduce a state-sponsored monthly fixed allowance of at least INR 5,000 per ASHA worker, in addition to NHM incentives, subject to triennial revision in alignment with inflation indices.

ISSN: P-2455-0515
E- 2394-8450

Educreator Research Journal

OPEN ACCESS

Volume–XIII, Issues–III

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- Mandatory Social Security Entitlement: All ASHA workers should be compulsorily enrolled under government social protection schemes, including the Employees' State Insurance Corporation (ESIC), to provide health and accident coverage.
- Phased Regularization: A phased roadmap should be developed to transition ASHA workers from volunteer status to contractual employees, and ultimately to government positions with grade pay equivalent to Auxiliary Nurse Midwife (ANM) cadre.
- Tribal and Remote Area Allowances: Specific 'remoteness allowances' should be instituted for ASHAs operating in Fifth Schedule tribal areas, compensating for lower incentive-qualifying events and higher travel expenditures.
- Mandatory Annual Training: Residential refresher training of five days annually should be instituted for all ASHAs, with provision of untied funds covering childcare and transportation costs during training periods.
- Biometric Payment Mechanisms: Incentive disbursements should be linked to the Direct Benefit Transfer (DBT) ecosystem using Aadhaar-based biometric validation to eliminate payment delays and administrative leakages.
- Worker Safety Protocols: District-level fast-track complaint mechanisms for harassment and safety incidents should be established, complemented by mobile-based emergency SOS systems for ASHAs engaged in nighttime community work.

Conclusion:

The role of ASHA workers in North Maharashtra represents a remarkable convergence of social capital, community trust, and public health delivery. Their contributions to reducing maternal mortality, expanding immunization coverage, monitoring nutritional status, and managing epidemics have been empirically validated across multiple studies and government assessments. Yet their socioeconomic conditions remain marked by poverty, insecurity, and institutional neglect — a stark contradiction that this study has sought to document and analyze with empirical rigor.

The evidence presented in this paper demonstrates that the disparity between the work ASHA workers perform and the compensation and recognition they receive is not merely an administrative shortcoming. It constitutes a structural injustice — one that contradicts the foundational principles of both the Viksit Bharat mission and the SDG commitment to 'leave no one behind.' A nation aspiring to developed-country status by 2047 cannot sustain a public health model predicated on the economic marginalization of its poorest women.

The journey toward SDGs 2030 and Viksit Bharat 2047 passes inescapably through the well-being of ASHA workers themselves. Investment in their regularization, remuneration, social protection, and professional development is not charitable expenditure — it is a high-return investment in human capital, health system resilience, and social justice. Coordinated action by the state, civil society, and the research community is urgently required to construct a policy framework that transforms ASHA workers from instruments of development into its beneficiaries.

ISSN: P-2455-0515
E- 2394-8450

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OPEN ACCESS

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Cite This Article:

Gosavi N.B. & Dr. Magare S. (2026). *An Empirical Study of Socio-Economic Development Among Asha Workers: Implications for Women-Led Sustainable Development in North Maharashtra.* **In Educreator Research Journal: Vol. XIII (Issue III),** pp. 231-238