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Role of Asha Workers in Combating Covid- 19 in Kerala

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Accredited Social Health Activists (ASHAs) constitute the backbone of the National Rural Health Mission (NRHM). They act as an interface between the local public health support system and the community on nutrition, basic sanitation and hygienic practices, healthy living and working conditions, information on existing health services, and the need for timely utilization of health and family welfare services. The meticulous work carried out by the ASHA workers was widely acknowledged during the outbreak the COVID-19. The 'trace-test-isolate-support' strategy by the Health Department during the pandemic proved to be successful, thanks to the tireless work carried out by these 'foot-soldiers' in the state of Kerala. The role of ASHAs during the COVID includes community awareness through inter-personal communication, support ANM/Supervisor in house-to-house surveillance including identification of High-Risk Groups and probable cases, ensuring uptake of medical services in urban and rural areas, psychosocial care, removal of stigma and discrimination, reporting and feedback and dissemination of information about personal safety and precautions. Despite their yeoman service, the ASHA workers were treated shabbily by the state and society. Their woes include heavy workloads, lack of safety gear and training, low pay, stigmatization, caste discrimination, domestic abuse, etc. The present paper deals with the rights issues faced by the ASHA workers in the state.

***Keywords**: ASHA workers, Community Health Workers, COVID-19, Frontline forces*

Accredited Social Health Activists (ASHAs) are one of the key components of the National Rural Health Mission (NRHM) to provide every village in the country with a trained female community health activist to create awareness among the local community on health and its social determinants. An ASHA worker will provide information to the community on determinants of health such as nutrition, basic sanitation and hygienic practices, healthy living, and working conditions, information on existing health services, and the need for timely utilization of health and family welfare services. They are the grass-root functionaries who drive the state's health policy. During the outbreak of COVID-19, the meticulous work carried out by the ASHA workers was widely acknowledged as they constituted the most essential 'foot-soldiers of Kerala's COVID-19 battle'. ASHAs' pre-COVID-19 comprehensive household database on those who moved out of Kerala for work enabled the state to

develop a rapid 'trace-test-isolate-support' strategy when the pandemic made its entry into the state. ASHAs are supposed to perform a variety of tasks so crucial to contain the disease from surreptitiously spreading in society. During the early phase, the Health Department made all efforts to identify symptomatic persons, removing them from homes and admitting them to hospitals, tracing the contacts, testing them, and quarantining the secondary contacts as well as those coming from outside of Kerala. The ASHA workers acted as an effective link between the Health Department and the community. Their networking in the community helped locate not only the Covid positive cases but also those who violated the State's COVID-19 protocol. The paper tries to analyze the role of ASHAs in the strategic measures to contain COVID-19, challenges faced during their work, and policies taken by the Government of Kerala to protect and safeguard them. The article is structured into three parts: a theoretical analysis, a main body consisting of the primary data interpretation, and a concluding part with observations and suggestions.

Literature Review

Research studies about ASHA workers are very few. *Community Health Workers in Rural India: Analysing the Opportunities and Challenges Accredited Social Health Activists (ASHAs) Face in Realising Their Multiple Roles* by Lipekho Saprii1, Esther Richards, Puni Kokho and Sally (2015) Theobald analyses the role played by ASHAs in rural Manipur and the risks and challenges they face while discharging their duties. The article viewed ASHAs role as CHWs in the backdrop of the social activism they are doing.

Awareness of Family Planning Services among ASHA Workers in A Municipality of Northern Kerala by Arya Lokesan Ratnam, Jayasree Anandabhavan Kumaran (2018) studied the role of the knowledge and skill of ASHAs in the success of the National Rural Health Mission (NRHM). The work explained the multifaceted role of ASHAs and how they effectively work in implementing national health programs on family planning(Ratnam & Kumaran, 2018).

COVID-19 in Rural India, ICT India Working Paper #40 by Nirupam Bajpai and Manisha Wadhwa (2020) focused on the impact of COVID-19 in various rural states of India along with the strategies adopted by those states to contain the pandemic. The role of ASHAs in pandemic management, comprehensive training given to them, effective control and oversight, and timely and adequate payments for the ASHAs were also analyzed in the paper (Bajpai, 2020).

Kerala's Strategies for COVID-19 Response: Guidelines and Learnings for Replication by Other Indian States authored by Mehul Das, Isalyne Gennaro, Sneha Menon, Anahita Shah, Kadambari Shah, Tvesha Sippy and Priya Vedavalli (2020) gives a comprehensive picture about the COVID-19 management in Kerala. The paper found the role of ASHA workers as one of the state functionaries who helped to fight the battle against COVID-19(Das et al., 2020).

Role of Asha Workers in Rural Development with Reference to Kottayam District by Tissy Eruthickal (2016) reveals that the health of rural people has clearly improved as a result of the implementation of ASHA. ASHAs have been successful in tasks including ensuring that new-borns receive their recommended immunisation regimen, sanitation systems and a range of healthcare initiatives(Eruthickal, 2016).

ASHA Workers Rights' Violations in the time of COVID-19: A Critical Reflection a

critical analysis by Deepika Jain (2021) on the human rights violations experienced by the ASHA workers during the COVID times(Jain, 2021). She further emphasized that ASHAs are a crucial component of India's institutional healthcare system, yet the government and other healthcare professionals still view them as inferior.

Research Gap

The majority of the research and literature available in the public domain on ASHA (Accredited Social Health Activist) workers primarily focuses on their role in rural development. These studies highlight how ASHA workers contribute significantly to improving health outcomes in rural areas by facilitating access to healthcare services, promoting health awareness, and acting as a bridge between the community and the formal health system. However, the current work is distinctive as it shifts the focus to explore the pivotal role that ASHA workers played as frontline forces during the COVID-19 pandemic, specifically in the context of the state of Kerala from 2020 through 2021.

During the COVID-19 pandemic, ASHA workers emerged as crucial agents in the battle against the virus. Their responsibilities extended beyond the traditional scope of their duties to encompass a wide array of tasks crucial for pandemic management. These included conducting door-to-door surveys to identify potential COVID-19 cases, ensuring adherence to quarantine protocols, disseminating vital information about the virus and prevention measures, assisting in contact tracing, and facilitating access to medical services for those affected by the pandemic. The dedication and tireless efforts of ASHA workers in these roles underscored their importance as an integral part of the public health system, particularly in times of crisis.

This study places a strong emphasis on examining the human rights and labour rights of ASHA workers. It delves into the challenging conditions under which these workers operate, highlighting issues such as inadequate remuneration, lack of job security, and insufficient access to personal protective equipment (PPE) during the pandemic. Despite their essential role, ASHA workers often face significant challenges in terms of recognition and compensation for their work. The study argues that their labour rights are frequently overlooked, leading to exploitation and lack of adequate support from the health system they serve.

Furthermore, the study exposes the double standards that prevail in Kerala society regarding ASHA workers. On one hand, society relies heavily on the services of these health workers, especially during health crises like the COVID-19 pandemic. ASHA workers were called upon to perform critical tasks that were instrumental in controlling the spread of the virus and providing care to affected individuals. Their contributions were celebrated in rhetoric and media, recognizing their bravery and dedication.

On the other hand, when it comes to addressing their genuine career-related demands, the same society that praises their efforts often falls short. ASHA workers' demands for fair wages, job security, and better working conditions are frequently met with reluctance or outright refusal. This discrepancy highlights a societal tendency to exploit the willingness of ASHA workers to serve their communities while ignoring their legitimate needs and rights as workers. The study underscores this hypocrisy, advocating for a more equitable approach that acknowledges the invaluable contributions of ASHA workers and addresses their demands for fair

treatment and adequate compensation.

In conclusion, this work contributes to the existing body of knowledge by shedding light on the crucial role of ASHA workers during the COVID-19 pandemic in Kerala and the broader implications for their human and labour rights. It calls for a re-evaluation of how society values and supports these essential workers, emphasizing the need for systemic changes to ensure that their rights are protected and their contributions are justly compensated. By focusing on these issues, the study aims to foster a more inclusive and fair healthcare system that recognizes and respects the pivotal role of ASHA workers.

The study made use of both primary and secondary data. In-depth interviews with ASHAs, local body members, Health Department officials, and former COVID patients were carried out to gather primary data. Qualitative data is mostly used. Ten ASHA workers were chosen for the in-depth interview out of the 100 ASHA workers who were first surveyed. During the COVID-19 pandemic, these ten ASHAs were actively performing their jobs in their respective wards. They shared some unusual and difficult situations they experienced while serving as front-line combatants for COVID-19. Twelve former COVID patients, five health department officials, and five local body representatives were interviewed over the phone. The method of purposeful sampling is applied. The responders' requested anonymity is guaranteed.

ASHAs as Community Health Workers (CHWs)

Community health workers (CHWs) are lay members of the community who work either for pay or as volunteers in association with the local healthcare system in both urban and rural environments. CHWs usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve (U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions., 2007). Community health workers (CHWs) became prominent with the Alma Ata Declaration in 1978 which recognized primary health care as the key element for improving community health. (World Health Organisation, 1978) The World Health Organization characterizes CHWs as members of the community, selected by and answerable to the community they work for, and supported by the health system but with shorter training than professional health workers(World Health Organisation, 2007). CHWs are commonly trained in the context of health interventions to carry out defined functions related to healthcare delivery but rarely have formal professional or paraprofessional certifications or tertiary education(Lewin et al., 2005).

Different literatures identified the major roles of CHWs as twofold: as service extension workers and activists for social change.(Saprii et al., 2015) As service extension workers CHWs aid physicians and nurses in tasks like immunisation and health promotion(Scott & Shanker, 2010). They are viewed as "another pair of hands" in providing services to marginalized communities and they boost the health system's ability to overcome financial and human resource constraints in a setting with limited resources(WHO et al., 2007). As activists, CHWs have been envisioned as bolstering the interface between the community and the current healthcare system by acting as both social and cultural intermediates(Lehmann et al., 2004) In this way, their job should be to encourage community involvement and take the necessary steps to

remove the social and cultural obstacles that contribute to ill health(Witmer et al., 1995).

ASHA workers are women volunteers/health activists from within the community who are trained to provide information, mobilize the community towards local health planning, and increase utilization and accountability of the existing health services. The 10.4 lakh ASHA (Accredited Social Health Activist) workers in India have been recognized by the World Health Organization as "Global Health Leaders" for their work in bringing the public's attention to the government's health initiatives(Dutt, 2022).

According to NHM, the following are identified as the key components of ASHA(National Health Mission, 2022):

- ASHA must primarily be a woman resident of the village married/ widowed/ divorced, preferably in the age group of 25 to 45 years.
- She should be a literate woman with due preference in selection to those who are qualified up to class 10 wherever they are interested and available in good numbers. This may be relaxed only if no suitable person with this qualification is available.
- ASHA will be chosen through a rigorous process of selection involving various community groups, self-help groups, Anganwadi Institutions, the Block Nodal officer, the District Nodal officer, the Village Health Committee, and the Gram Sabha.
- Capacity building of ASHA is being seen as a continuous process. ASHA will have to undergo a series of training episodes to acquire the necessary knowledge, skills, and confidence for performing her spelled-out roles.
- The ASHAs will receive performance-based incentives for promoting universal immunization, referral and escort services for Reproductive & Child Health (RCH) and other healthcare programmes, and the construction of household toilets.
- Empowered with knowledge and a drug kit to deliver first-contact healthcare, every ASHA is expected to be a fountainhead of community participation in public health programmes in her village.
- ASHA will be the first port of call for any health-related demands of deprived sections of the population, especially women and children, who find it difficult to access health services.
- ASHA will be a health activist in the community who will create awareness of health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services.
- She would be a promoter of good health practices and would also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals.
- ASHA will provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, healthy living, and working conditions, information on existing health services and the need for timely utilization of health & family welfare services.

- She will counsel women on birth preparedness, the importance of safe delivery, breast-feeding, and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infections (RTIs/STIs), and care of the young child.
- ASHA will mobilise the community and facilitate them in accessing health and health-related services available at the Anganwadi/sub-centre/primary health centres, such as immunisation, Ante Natal Check-up (ANC), Post Natal Check-up supplementary nutrition, sanitation, and other services being provided by the government.
- She will act as a depot holder for essential provisions being made available to all habitations like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc.
- At the village level, it is recognized that ASHA cannot function without adequate institutional support. Women's committees (like self-help groups or women's health committees), village Health & Sanitation Committee of the Gram Panchayat, peripheral health workers especially ANMs and Anganwadi workers, and the trainers of ASHA and in-service periodic training would be a major source of support to ASHA.

The different roles to be performed by ASHAs can be summarised: The first role that ASHAs are expected to play is that of a "link worker" to bridge the gap between the health care centres and the rural and vulnerable population(Chandramouli, 2011) Second, ASHAs are to function as a 'service extension worker', whereby they are trained and provided with a kit that includes commodities such as condoms, oral contraceptive pills, delivery kits and simple life-saving drugs including cotrimoxazole and chloroquine(Chandramouli, 2011). Thirdly, they are envisioned as "community health advocates who will raise knowledge of health and its socioeconomic determinants and push the community toward local health planning and enhanced usage and accountability of the current health services."(Chandramouli, 2011)

ASHAs during COVID-19

During COVID-19, the basic purpose of ASHAs was to serve as a conduit between the community and healthcare services, ensuring that the rural population has access to primary healthcare services. Typically, the ASHA performs ten key duties for the community in which she works[1] as follows:

- Create awareness and provide information to the community
- Counsel mothers on birth preparedness, safe delivery, feeding practices, immunization, family planning, RTI, etc
- Facilitate community access to health care and health facilities
- Accompany pregnant women and children to a health facility
- Provide care for minor ailments
- Act as depot holder for Oral Rehydration Solution ORS, Daily oral iron and folic acid (IFA), DDK, Oral pills, condoms, etc.
- Provider of Directly Observed Treatment (DOTS)

- New-born care and treatment of childhood illness (IMNCI)
- Inform birth and deaths, disease outbreaks
- Construction of Toilets for TSC (Total Sanitation Campaign) -Not included in UP state policy for ASHAs

Owing to the peculiar health situation in Kerala, the function of ASHAs has been expanded to include areas such as communicable disease prevention and control, NCD identification and control, palliative care, and community-based mental health programmes(Government of Kerala, 2021). Apart from their conventional duties, the ASHAs responsibilities have been widened after the COVID outbreak. The Economic Survey of India 2020-22 acknowledges the efforts of ASHA workers, who play a critical role in the country's response to COVID-19 prevention and management(Reji et al., 2021). They continued to support community members in obtaining vital health services such as anti-natal care, vaccination, safe birth, and adherence to treatment for chronic diseases during the pandemic, in addition to doing COVID-19-related responsibilities.(PLOS, 2021)

In Kerala, the second phase (First wave)(National Health Mission, 2022) of COVID-19 cases was from Pathanamthitta District in March 2020 when a trio from Italy skipped the voluntary screening at the airport, traveled to their hometown at Ranni and socialized with many, before developing symptoms. The entire state became alert and planned strategies to contain the virus's possible spread. Suddenly the ASHA workers and their services came into the forefront and they became the eyes and ears of the health system. They already have a database of the residents of the jurisdictional areas allotted to them. Besides, they have constant communication with the local people which was very crucial for the successful implementation of the containment strategy. When the first wave of COVID came, the ASHAs were deputed to act as detectives, to find people with symptoms and to monitor those in quarantines. If someone coughs or sneezes, she would be the person who gets altered first. If someone entered the ward after traveling from another district, she would be the first to know (Primary Data; Interview with ASHA worker, 2021). ASHA workers played a vital role in dealing with COVID-19 in the rural areas. ASHAs are involved in conducting house-to-house visits, reporting symptomatic cases, carrying out contact tracing, maintaining documentation, monitoring the situation, and creating awareness about COVID-19 in the community (Primary Data; Interview with Asha Worker, 2021).

The role of ASHAs related to COVID duties can be summed up as community awareness through interpersonal communication, support ANM/Supervisor in house-to-house surveillance including identification of High-Risk Groups (HRG) and probable cases, ensuring uptake of medical services in urban and rural areas and psychosocial care, stigma and discrimination; Reporting and feedback across different phases of COVID-19 pandemic (no cases, imported/ sporadic cases, clusters and community-wide transmission); Personal Safety and Precautions(Bajpai & Wadhwa, 2020). ASHAs became crucial during this time since they only have the complete health profile of the community assigned to them. They were entrusted to collect quantifiable data about the foreign returnees too. Whenever a case is reported, they are called first to get the details of the infected person (Primary Data; Interview with Asha Worker, 2021). Every day, ASHAs called up their superiors to report on the residents of their various wards before Chief Minister Shri. Pinarayi Vijayan spoke to the media in Thiruvananthapuram(Chandramouli, 2011). Further, they were assigned

to communicate with the primary and secondary contacts; and sometimes they would have to act as a family member too. An ASHA worker recollected that the daughter of an infected mother in her ward panicked and tightly held her for a long time (Primary Data; Interview with Asha Worker, 2021). They were not performing a time-bound duty then.

The communities have benefited greatly from ASHA workers since they were actively involved in campaigns to educate the public about the need to take preventive measures, like regularly washing their hands with soap and water, wearing a mask while they're out in public, and keeping a sufficient physical distance. The public also felt free to communicate with ASHAs as they are also a part of the community (Primary Data; Interview with Asha Worker, 2021). Some innovative techniques were also introduced by some of the ASHAs to make the process more effective. Many of them have formed WhatsApp groups in their community, where relevant communications about the pandemic from the authorities were posted timely (Primary Data; Interview with Asha Worker, 2021). Besides, it was their duty to create awareness about and to ensure the successful installation of the 'Arogya Setu App'. It was their duty to assist the local government units and *Kudumbashree* in preparing and distributing food rations and medicines for people in containment zones, home and community quarantine, and migrant relief camps across the state.

ASHAs did a commendable job regarding the COVID-19 vaccination drive. Their duties and responsibilities range from preparing the lists of eligible people for vaccination and informing them of the dates of vaccination to coordinating the vaccination drive at the grassroots level (Primary Data; Interview with Asha Worker, 2021). ASHAs are entrusted to ensure nobody has been left unvaccinated in their allotted area. During the initial days, many people were reluctant to take the vaccine and it's the ASHAs who undertake the strenuous task of convincing them. (Primary Data; Interview with Asha Worker, 2021). Health officials were frequently in touch with ASHAs during the vaccination days to get information about those who had already taken the jab and those who were yet to receive their first dose of vaccine (Primary Data; Interview with Asha Worker, 2021).

Challenges faced

However, ASHA employees face several difficulties, including a heavier workload, a lack of safety gear and training, low pay, stigmatisation, caste discrimination, domestic abuse, etc. During the first phase of the outbreak, the state prepared and published the route map of the infected individual. An ASHA worker mentioned the unwelcoming behaviour she faced from some of the infected. According to them " they were irritated while asking for details about their travel and behaved arrogantly to her". She hopes that if ASHAs are a little more acknowledged and supported by the government with adequate policy measures, the attitude of the community will also change (Primary Data; Interview with Asha Worker, 2021). She added, the chauvinistic attitude of the men also made things harder while discharging duties. Mostly, discordance comes from men more than women (Primary Data; Interview with Asha Worker, 2021).

During the initial days of the outbreak, ASHAs were working in unsafe conditions without adequate masking, sanitizers, gloves, etc. ASHAs and junior health inspectors patrolled the neighbourhoods while the general people stayed in their houses and

bureaucrats were comfortably in their offices(Chandramouli, 2011). They had to use towels to cover their faces to protect themselves from the virus. After a long struggle and protests, they were able to get N95 masks. In the distribution of PPE (Personal Protective Equipment) kits also, ASHAs were never counted but they were entrusted to find out the number of PPE kits needed. After months of repeated requests, they were finally given N-95 masks, even those were paid from the MLA funds as well as police and other charitable organisation donations(Chandramouli, 2011).

Human Rights Issues

ASHA workers in Kerala, as well as many other places in India, encountered several difficulties and human rights breaches during the COVID-19 outbreak. These were some of the problems they faced:

- Absence of Personal Protective Equipment (PPE): ASHA employees frequently lacked appropriate PPE, which increased the likelihood of contracting the virus while performing their jobs. This infringed upon their right to a safe working environment.
- Minimal Salary and Insufficient Recompense: Despite playing a vital role in the pandemic response, ASHA workers often received minimal compensation. A substantial percentage of individuals did not receive adequate compensation for the heightened dangers they faced throughout the pandemic.
- Long Work Hours and Overwork: ASHA workers had to do a lot of work, sometimes without breaks, like finding contacts, providing supplies, and disseminating information about how to avoid contracting COVID-19. As a result, the individuals experienced burnout and fatigue, which infringed against their entitlement to adequate working hours and rest. People who worked for ASHA were stigmatized and treated badly by communities because they were involved with COVID-19 response attempts. This encompassed experiences of social exclusion or deprivation of essential services, so infringing against their entitlement to dignity and non-discrimination.
- Inadequate Training and Assistance: Certain ASHA employees have reported insufficient training and assistance from the government when managing COVID-19 cases. This hindered their capacity to carry out their responsibilities with efficiency and security.
- Physical and Verbal Abuse: Sometimes, people in the community who didn't want to follow COVID-19 rules would hit and swear at ASHA workers. This action infringed upon their entitlement to a job environment that ensures their physical and emotional well-being.
- Administrative obstacles and delayed payments: ASHA employees frequently experienced delays in getting their bonuses or salary, which made their already difficult situations even more stressful monetarily. The obstacles in obtaining benefits also impacted their means of subsistence.

In this situation, it was very important to protect the rights of ASHA workers, not only for their health but also for the success of public health efforts during situations like the COVID-19 pandemic.

Labour Rights Issues

One of the ASHA workers mentioned that "they were treated as employees when the system needed them, however, they became mere volunteers when it came to payment". (Primary Data; Interview with Asha Worker, 2021). The efforts of the Government of Kerala to substantially hike the honorarium of ASHAs from Rs.1000/- to Rs. 5000/- during the COVID-19 times were commendable. Besides, the Chief Minister announced an extra allowance of Rs.1000/- for the pandemic management duties they were performing. Many of the ASHA workers also acknowledge this (Primary Data; Interview with Asha Worker, 2021). However, this alone couldn't suffice to address their rights-based issues. They were overburdened with work and were underpaid to meet their livelihood at the same time. They had to walk long distances to reach every household, some of them used their two-wheelers while others used various means of transport, but no travel incentives were paid to them. (Primary Data; Interview with Asha Worker, 2021).

Many women found themselves politically, economically, and socially empowered after joining as ASHA workers. Several ASHAs got a chance to contest and win in local government elections since they created a good rapport with the voters in their wards(P.M, 2020) In 2011, the then-ruling government of Kerala, the Congress-led United Democratic Front (UDF), issued an order prohibiting ASHAs in panchayat positions, from accepting payment for their healthcare activities(P.M, 2020). Public school teachers, Anganwadi workers, and government bank employees who also held elected posts in local self-government were not subject to this provision that prohibits dual earnings from multiple jobs. These employees are compensated for both positions. The Left Democratic Front (LDF) administration changed the laws and agreed to pay ASHAs for both tasks only in April 2019 in response to persistent requests and demonstrations by the ASHA Workers' Union(P.M., 2020).

ASHAs in India work as honorary volunteers for the National Health Mission rather than being formally employed by the health department. As a result, they received no regular income, no fixed pay, and no paid time off or other essential benefits. Rather, they were rewarded for specific tasks like administering oral rehydration sachets, escorting expectant mothers to government facilities for delivery, and administering vaccinations (Primary Data; Interview with Asha Worker, 2021). All ASHAs who were interviewed expressed that their participation in COVID-19 management efforts gave them a sense of respect and recognition from their community and other health professionals. However their long-standing demand for treating them as a workforce remains unaddressed (Primary Data; Interview with Asha Worker, 2021).

ASHA Workers: A Triple Responsibility and the Need for Formal Recognition

Accredited Social Health Activists (ASHAs) in India have triple responsibility as community health workers, homemakers, and caregivers. In most countries around the world, community health workers are mostly women and their role is multifaceted. The traditional roles of women as nurturers and caregivers are broadly socially sanctioned. This makes ASHAs nature of work legally and socially acceptable for women. In addition, as the number of job opportunities for women is limited, these jobs tend to be cheaper for female labour; leading to a major part of the workforce

being women. As the ASHA does not receive any salary and typically belongs to an underprivileged or marginalized community, she is motivated by the expectation that the government will regularize their services at some point in the future (Primary Data; Interview with ASHA Worker, 2021).

How community health workers like ASHAs reside within the Kerala welfare regime is incredibly problematic in terms of the frameworks of gender rights and labour rights. Existing responsibilities in combination with additional ones during COVID-19 and their household duties further add to the burden of ASHAs. A fair number of them are subjected to interpersonal abuse, and gender-based violence and are underpaid and jobless (Primary Data; Interview with ASHA Worker, 2021). It is an illustration of a neoliberal ploy to offset a deficit in public coffers by extracting unpaid labour - in this, everyone was roped in, women predominantly.

Amid the COVID-19 pandemic, ASHAs tasks were more indispensable. They were on the frontlines of the public health response - conducting house-to-house surveys, implementation of quarantine protocols, information dissemination on the virus, and contact tracing, among others. However, beyond these remarkable achievements, ASHAs faced many logistical challenges such as poor or no provision of proper personal protective equipment (PPE), inadequate or irregular pay, and lack of job security. The rights of their labour were violated routinely.

In a state that prides itself on its development model, ASHAs have become the most integral cog in the machine that is Kerala's public health maintenance programme. ASHAs from become a cornerstone of the Kerala Model of Development that strongly emphasizes health and education. But, the credit and support for the efforts made by them are missing. Policy measures have to be taken to formally regularize ASHAs as an intrinsic part of the model of public health in Kerala. This means their labour rights should be safeguarded and they should be receiving at least the minimum wage.

To be able to support ASHAs fully and make them work better, they need to be trained well. For instance, they can be trained in using medical devices like oximeters and blood pressure monitors to work more efficiently. ASHAs can also be crucial in bridging the digital divide across much of rural and tribal India, where telemedicine faces myriad challenges. With the right training and resources, ASHAs could arrange telemedicine consultations thereby providing an opportunity for people from remote areas to get access to basic healthcare.

Here we could see that two distinct principles run parallel: on the one hand, the state is resourceful enough to produce this large workforce in the healthcare industry, and on the other, recruiters brazenly break national law to maximize their profit margins by taking advantage of the desperation of the workforce once created. ASHAs were used as an adjunct for unprepared health systems during public health disasters like the COVID-19 pandemic. While they enroll and serve their country, their demands for more pay, safer working conditions, and better working circumstances are ignored. This mismatch reflects a larger social tendency in which ASHAs' goodwill is exploited to gain significant influence in her communities, but her legitimate requests and rights are not respected.

The fate of ASHAs is a reflection of a larger trend, of women's labour being underpaid, and undervalued. This exploitation is not simply a case of economic injustice but also targeted under gender justice. Recognizing and resolving ASHA

workers' issues is essential to any chance of gender-just outcomes as well as worker well-being that challenges persistent patriarchal beliefs.

Conclusion

In summary, ASHAs are essential in the Public Health system, especially in times of crises such as the COVID-19 pandemic. Their role in accomplishing the Kerala Model of Development proves that they play a crucial part in ensuring public health standards. Nevertheless, even while they are providing this life-enhancing service, ASHAs work under precarious labor rights conditions and in infirm working conditions.

Without it, these existing issues need to be addressed and this can only be done when they are professionally accepted in the public health system. A measure would be to formalize ASHAs as front-line workers and provide them with the pay and job security that is warranted by their contributions. They need to receive timely and appropriate training. The training would have enabled the ASHAs to more effectively employ telemedicine and medical technology, enabling them to approach patients in even the most remote and underdeveloped locations. Acknowledging and bolstering ASHAs suitably would mirror the actual worth of their labor and services to the community. Additionally, it would guarantee that ASHAs are driven and well-prepared to carry out their responsibilities, which would improve the general efficacy of public health programs.

In short, ASHAs are the backbone of the public health infrastructure in Kerala and have greatly contributed to the development model shaping up in the state. In conclusion, it is impossible to overestimate the importance of ASHAs to Kerala's development model and their crucial role in public health. We can effectively support ASHAs by taking the appropriate measures to legalize their status, guarantee just compensation, and give the required training. More significantly, by addressing the undervaluation and exploitation of female labor in the health industry, such reforms would advance gender equality and social justice.

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