Wages of Liminality: How an in-between status lowers the earned wages of women health workers

Vrinda Marwah
Dedicated to interdisciplinary and critical dialogue on international human rights law and discourse, the Rapoport Center’s Working Paper Series (WPS) publishes innovative papers by established and early-career researchers as well as practitioners. The goal is to provide a productive environment for debate about human rights among academics, policymakers, activists, practitioners, and the wider public.

ISSN 2158-3161

Published in the United States of America
The Bernard and Audre Rapoport Center for Human Rights and Justice at The University of Texas School of Law
727 E. Dean Keeton St.
Austin, TX 78705
https://law.utexas.edu/humanrights/

https://law.utexas.edu/humanrights/project-type/working-paper-series/
ABSTRACT

In this paper, I analyze the experiences of the world’s largest, all-women community health workforce through the lens of liminality. Originally used to describe transition from one state to the other, the concept of liminality in the study of work and organizations can frame workers’ experiences of being in-between established structures and roles in varying degrees, times, and/or places. India’s ASHAs, or Accredited Social Health Activists, are community women at the frontlines of the state’s health care provisioning. But the state does not categorize them as workers or employees. ASHAs are considered volunteers. Instead of salaries, they are paid task-based incentives. Based on 14 months of ethnographic fieldwork, including 80 interviews, I find that ASHAs’ liminal occupational status as ‘paid volunteers’ produces conditions of chronic underpayment and control for them, further lowering their already low wages. This has implications for how we understand the gender wage gap. I argue we need to consider not just how much women are paid, but how the amount is structured, and how that places women workers in relation to others in the workplace. Moving beyond whether liminality is a negative or positive experience, future research should delineate the conditions under which liminality is negative or positive, and for whom.

KEYWORDS:
care work, liminality, gender wage gap, state, volunteer, community health workers
Introduction

Liminality, introduced in anthropology to describe the process of transition from one state to the other (Gennep, 1960; Turner, 1967), has been applied to the study of work and organizations to much scholarly effect. Liminality captures workers’ experiences of being in-between established structures, roles, and occupational categories in varying degrees, times, and/or places (Daly et al., 2015; Simpson et al., 2018; Thomassen, 2009; Willis et al., 2020; Zadoroznyj, 2009). It especially captures the increasingly common experience of nonstandard work, that is, new employment relations that in various ways diverge from permanent full-time status (Kalleberg, 2011). In its original formulation, liminality is supposed to reference a temporary state, associated with marginality but also creativity. However, liminality at work is becoming a more permanent experience today (Garsten, 1999; Johnsen & Sørensen, 2015; Szakolczai, 2014), feeding into an important debate in the literature about whether the experience of liminality is positive or negative for workers.

In this article, I present a case of “permanent liminality” from India: women community health workers—called Accredited Social Health Activists or ASHAs—who have not been designated workers at all. ASHAs are an important workforce for several reasons: appointed since 2005 and numbering one million today, this relatively new and all-women workforce is the largest of its kind in the world (Scott et al., 2019; Ved et al., 2019). Although the scope of ASHAs’ responsibilities has grown, they are tasked chiefly with connecting marginalized communities to state health services in a bid to improve India’s maternal and child health outcomes. This is a significant role in a country home to a staggering 45,000 maternal deaths a year, 17% of the global maternal mortality burden (Rao, 2017). However, ASHAs are also a liminal workforce. The Indian
state has ascribed them the unique and in-between status of “paid volunteers”. Although ASHAs work for the government’s health department, they are not recognized as workers, and despite their collective struggle for employment, they have not been made employees—not even contractual employees. ASHAs remain volunteers, but they do receive remuneration, in the form of per-case incentives. These incentives exist for tasks performed from an official, and shifting, list of tasks.

ASHAs are part of a larger trend in India and around the world, wherein women are appointed to public social services in developing countries in “voluntary” and “community” roles (Razavi & Staab, 2010). This “feminization of obligation” has a negative impact on their rights as workers to decent work (Aye et al., 2018; Chant, 2008; Swaminathan, 2015). The Indian state’s reliance on women workers paid well below minimum wage to implement health, education, and nutrition policies intensifies occupational segregation and increases the gender wage gap (Mondal et al., 2018). However, while we know these women workers are grossly underpaid, we know relatively little about how they experience their liminality in the everyday (Razavi & Staab, 2010).

I conducted 14 months (June-July 2017, and July 2018 to June 2019) of ethnographic fieldwork in North India, including 60 interviews with ASHAs and 20 interviews with ASHA program experts. I find that ASHAs’ liminal occupational status creates conditions for their chronic underpayment and control by the health department. This further lowers ASHAs’ already low wages. I show the quotidian ways, intentional and unintentional, in which liminality erodes ASHAs’ legitimacy as workers, and makes them highly dependent on supervisors. My findings illuminate new ways in which the devaluation of care is being institutionalized. Rather than answering whether liminality is a positive or negative experience, these findings raise questions about for whom, and under what conditions, liminality is positive or negative.
Liminality, work, and organization

The concept of liminality, introduced by anthropologist Arnold Van Gennep (1960) and developed by Victor Turner (1967), refers to the transitional state in which individuals are “neither here nor there… betwixt and between the positions assigned and arrayed by law, custom, convention…” (Turner, 1969, p. 95). Its usage describes rites of passage in different cultures. Liminality is the middle, transitionary step of a three-step process. Through rituals, an individual is moved from a familiar world, through a liminal space characterized by precarity and separation, to an eventual re-incorporation back into the group. The transition is understood to be physically and psychologically painful, and success is measured by enduring and overcoming this pain. It is made bearable, however, by the acquiescence and support of the individual’s family and community, as also by the knowledge that the pain of liminality is temporary and will lead the individual to arrive on the other side anew, from child to adult. For Turner, liminality is associated with marginality and inferiority—because the transition lacks status, power, rank, insignia, etc.—but also with creativity, for it offers a space of ambivalence from which growth, transformation and re-formulation can occur.

Liminality has been used to describe many situations in which human beings are transitioning from one state to another. Although studied mostly in temporal and spatial terms, liminality can also be analyzed in relation to type of subjects, scale or intensity, and whether liminality is produced artificially or happens organically (Thomassen, 2009). While the nature of these distinctions is somewhat artificial, they nevertheless help analyze liminality along its many dimensions (Ibid). Liminality has referenced, for instance, the experiences of indigenous groups in post/colonial regimes (Baker & Verrelli, 2017), diasporic communities in cosmopolitan centers.
(Delphine Fongang, 2017), and migrants and refugees in a nation-state system (Barry & Yilmaz, 2019).

Within the study of work and organizations, liminality describes a position of “ambiguity and uncertainty” (Beech, 2011, p. 287) that arises from being “in-between institutionalized arrangements, taken-for-granted socio-cultural structures, and established social positions” (Winkler & Mahmood, 2015, p. 53). It best captures the transitional time-space of precarious and mobile employment such as temporary, project, and consulting work. These types of work are likely to be experienced as both unsettling and creative. The use of liminality in the study of work and organizations has proliferated over the last couple of decades to grasp nonstandard work and new employment relations that have taken hold in this time (Beech, 2011; Czarniawska & Mazza, 2003; Daly & Armstrong, 2016; Garsten, 1999; Johnsen & Sørensen, 2015). Mapping the experiences under new employment relations allows scholars to update analytical categories and make sense of the increasing, and increasingly, multifarious ways in which people experience liminality (Winkler & Mahmood, 2015). Studies describe, for instance, how management consulting is liminal for both consultants and client organizations (Czarniawska & Mazza, 2003), how workers make liminal work spaces meaningful to their lived experience in contrast to the dominant work spaces that surround them (Shortt, 2015), and how business dinners mark a highly structured and strategic use of a zone of liminality (Sturdy et al., 2006). For the future, Thomassen (2009) suggests research investigate the various dimensions of liminality in workers’ experiences, the relationship between these dimensions, and the similarity and differences between various liminal experiences.

Liminality at work: premium or penalty
What determines whether liminality is experienced positively or negatively? Liminality can create confusion in employees’ sense of affiliation and belongingness: temporary agency workers do not benefit from the structural bonds created by permanent employment, but they are expected to demonstrate loyalty and commitment to their employer (Garsten, 1999). In the same vein, liminality can create identity work and require identity reconstruction, such as for employees experiencing organizational change (Beech, 2011). Sometimes a transient identity becomes part of an individual’s self-concept, enabling them to embody multiple, even conflicting, roles to their advantage. This is the case with “professional hybrids”—individuals with a professional background who take on managerial roles—who use their liminal position to move between different groups and organizational contexts, growing both their creativity and their influence as an elite (Kippist & Fitzgerald, 2009; O’Reilly & Reed, 2010). Most of the literature on professional hybrids in healthcare focuses on doctors. This research finds doctors are able to align their professional identity with a hybrid role, mediating between general managers and professional peers (Llewellyn, 2001; Pratt et al., 2006). However, to this generally positive review of professional hybrids, Croft, Currie and Lockett (2015) add a study of nurse hybrids who experience “perverse liminality” (Fischer, 2012), that is, a stable, negative space that is turbulent, destructive, and prevents identity transition. Nurse hybrids are unable to move successfully between groups, and experience intense identity conflict. The authors conclude that the liminal nature of hybridity is positive for more powerful professions, like doctors, who can accommodate the competing demands of hybridity, and negative for subordinate professionals like nurses, who feel undermined by it.
Another dimension along which the distinction between the negative and positive effects of liminality are stark is time. Traditionally, liminality refers to a temporary state. But in occupational terms today, this temporal dimension of liminality has changed significantly, leading to negative consequences for workers who find themselves in a permanent state of liminality. In permanent liminality, the suspension of structure is not limited to a certain time or space, in contrast to a “normal”, non-liminal, work environment. Rather, there is an “institutionalization of liminality” as the norm (Szakolczai, 1999). For instance, Czarniawska and Mazza (2003) find that consulting has become a lifestyle for management consultants, blurring the distinction between work and life, creating constant indeterminacy in one’s everyday experience of work, and carrying the dangers of stress and breakdown. Additionally, consultants experience an external locus of action control (Ibid, p. 275). They are supposed to internalize their clients’ interests—they are expected to be more than just flexible, they have to be pliable. In the case of organizations undergoing restructuring as part of new public management strategies, professionals in these organizations report a loss of identity and of familiar symbols, which may occur so often over the course of their careers that it ceases to be a phase and becomes a norm (Cunha et al., 2019). In a comparable case but in a low-wage setting, companions hired privately by families to care for residents in publicly funded long-term care facilities find themselves a permanently liminal and invisible labor force (Daly & Armstrong, 2016). While they may enjoy high autonomy in their work and high demand for their work, the use of companions’ labor limits the state’s responsibilities, individualizes care, removes the incentive to improve working conditions for paid staff, and promotes inequality between residents (Ibid). Taken together, research suggests that when rendered permanent, liminality can become the antithesis of the creativity it is supposed to
generate (Willis et al., 2020). It can impede learning at the individual and organizational level, by increasing stress and inequalities, and decreasing access and organizational memory (Tempest & Starkey, 2004). As a result, some suggest the introduction of greater formality and structure into liminal occupational roles (Simpson et al., 2018). In this article, I weigh in on the debate about whether liminality is experienced positively or negatively, using the example of a paid care workforce in India that has been assigned a status that falls into the gaps, rather than being perceived as members of an occupational group (Turner 1969).

Liminality in care work

Care work is a social expectation of all women (Baines & Armstrong, 2019; England et al., 2002). Considered something women do naturally and without boundaries in their homes and communities, care work is not regarded as high skill work worthy of decent wages and working conditions. Because of the many “blended and messy ways in which care work is at once formal and informal, paid and unpaid” (Daly & Armstrong, 2016, p. 4), the concept of liminality can shed light on the interstices in care¹, and how they impact theory, practice, and policy (Daly et al., 2015).

Research shows that the rhetoric of home and family provides a “common-sense ideological backdrop” (Baines & Armstrong, 2019, p. 941) for mostly-women workers to provide “elastic” unpaid care, and for management and families to expect it. Elastic caring is the notion of women’s endlessly stretchable capacity to provide care in any context, to the detriment of their health and wellbeing (Baines, 2006). For instance, Baines and Armstrong (2019) find that the

---

¹ Care work refers to the work of meeting the emotional and physical needs of children and adults. The bulk of this work is done by women, and not counted as part of the Gross Domestic Product despite its obvious contributions to well-being (Duffy et al., 2013; England, 2005; Glenn, 2000). While care work can be both paid and unpaid, in the past decades paid care workers have become a large and growing segment of the labor force in developed and developing countries alike, making paid care work an important arena for research and policy (Razavi & Staab, 2010).
predominantly women workers in Canadian nursing homes routinely take on unpaid work outside the workplace. This unpaid work is tightly woven into their paid work, and is even monitored and evaluated to the point that it becomes an institutionally accepted and normal part of work. Baines and Armstrong (2019, p. 944) develop the concept of non-job care work to describe this work “that is similar or identical to paid work and yet remains outside of organizational boundaries and is not counted or rewarded as paid work”. Non-job care work operates in the liminal spaces between work that is formally recognized and paid for, and work that is informally recognized and unpaid. It demonstrates how liminality can increase the burden of work for women.

Liminality is also implicated in the rebranding, indeed mislabeling, of women’s work. In a trend scholars of gender and development identify as the “feminization of obligation”, public social services in developing countries have come to rely heavily on women’s ‘voluntary’ or ‘community’ work (Razavi & Staab, 2010). ‘Volunteers’ are appointed by the state but not classified as workers, they receive stipends and not wages, and lack leave and other entitlements available to regular public employees (Palriwala & Neetha, 2011). Here, the state sidesteps its own labor regulations by appointing women to care work without counting them as part of the labor force (Swaminathan, 2015). These women workers are ascribed a liminal occupational status as neither insiders nor outsiders to the workforce. This has serious consequences, demonstrably in particular on women’s wages.

Between 1993-94 and 2011-12, the gender wage gap in India’s public sector increased as a result of the government’s extreme reliance on the underpaid labor of contractual women workers rather than permanent employees for the implementation of policies in health, nutrition, and education (Mondal et al., 2018). These women workers, who are the focus of this paper, are paid
well below minimum wage. In this nearly twenty-year period, job discrimination dominated wage discrimination in India. This means that while differential earnings within the same job (wage discrimination) declined, differential access to certain occupations (job discrimination) increased in both urban and rural areas (Ibid). While the trend of feminization of obligation has been noted, as has its effects on women’s wages in India, we know relatively little about the lived experiences of liminal workforces in paid social services in developing countries. My research attempts to fill this gap through a granular look at the everyday life of India’s community health workers in the health department. I ask, how does a low-wage workforce experience its liminal occupational status?

The answer to this question is relevant beyond India, indeed beyond the global south. The rise and spread in recent years of nonstandard work—employment relations that in various ways diverge from permanent full-time status—is a defining feature of work around the world (Kalleberg, 2011). There is evidence that nonstandard work increases the gender wage gap (McCall, 2000). Female workers are more likely than males to hold contingent, part-time, low wage jobs (Bernhardt et al., 2008). In the US for instance, female workers continue to be disadvantaged by wage dispersion and most of the remaining wage gap arises within occupations (Moore, 2018). Women’s over-representation in care occupations means that the expansion and feminization of market-based care impacts the wage gap depending on the magnitude of these shifts, as well as the extent to which the occupational wage differs from the workforce average (Ibid, p. 86). However, we know relatively little about how the wage gap works at different points in the earnings distribution (Petrescu-Prahova & Spiller, 2016). Most of the evidence we do have is quantitative. While this can show significant patterns—such as the higher employment
violations and wage theft experienced by immigrant female workers compared to their male counterparts in the US (Ibid)—it may miss other non-quantifiable experiences of workers who claim contingent wages. I focus not on the amount but the experience of a liminal wage. How smooth or not are workers’ experiences claiming payments? How does a liminal wage impact workers’ relationships with others in the organizational setting? And finally, is liminality a positive or negative experience for this workforce?

**Context: The “paid volunteerism” of India’s ASHAs**

The Indian government has sought to expand public services in health and education without the required increases in public spending. This has intensified occupational segregation and increased the clustering of women into low-paid occupations (Mondal et al., 2018). In 2005, as part of a flagship program expanding health services, called the National Rural Health Mission (later National Health Mission or NHM), the government of India appointed Accredited Social Health Activists, or ASHAs. ASHAs are community women with at least 8 years of education, who receive 23 days of initial training and perform five key activities: home visits, community meetings, monthly meetings at primary health centers, outreach services in their communities, and maintaining records. India now has almost a million ASHAs, appointed across rural India at the ratio of one ASHA per 1000 population, and increasingly also in marginalized urban settlements (Ved et al., 2019). Chiefly, ASHAs connect women from their communities to the government-run health system. Their primary responsibility is to track pregnant women, and ensure they get check-ups, medication, and when they are due, deliver in a hospital instead of at home (for which mothers receive a cash transfer). Because the NHM is temporary but renewable, all personnel hired under the NHM are contractual and not tenured employees. However, ASHAs are the only cadre
of workers in the NHM to not be given the status of employees at all, not even contractual employees. Oxymoronically, ASHAs are categorized as “paid volunteers”.

In December 2013, following agitations by ASHA unions, a fixed monthly honorarium of INR 1000 (approximately USD 14) was notified by the central government for all ASHAs. Some states announced honorariums above this level. In 2018, the central government raised this amount to INR 2000 (approx. USD 29), to be paid for the completion of basic tasks like maintaining a register. Apart from this fixed honorarium, ASHAs are paid through task-based incentives. The list of tasks for which ASHAs receive incentives began with 5 in 2005, and has grown to 38 in 2017 (Ved et al., 2019). Some of these tasks are recurring monthly activities, others are one-time campaigns, so payments come from different budget streams, and payouts can be choppy or sporadic.

ASHAs experience liminality along several of Thomassen’s classifications, namely, type of subject, time, and space. At a collective level, the unique occupational category of “volunteer” makes ASHAs a liminal type of subject—insiders to the state’s health department without being members, or employees, of it. In terms of time, their experience of liminality covers both extended periods and sudden events. In extended terms, since their appointment in 2005, ASHAs have been hopeful that they will be upgraded to the status of employees, but now almost two decades later, their liminality appears more permanent than temporary. At the same time, their daily work responsibilities make it difficult to plan even a few days away; ASHAs in my field complained they struggled to attend weddings and funeral in their natal villages. ASHAs also experience spatial liminality because their work requires them to be of service in public spaces like hospitals, and private spaces like homes, including their own homes by always being on call for their
communities. ASHAs in my field would often say with a tired smile, there is no timetable for birth, signaling how they accompany pregnant women to public hospitals for their deliveries round-the-clock.

**Study and methods**

My research is based on fieldwork in the north Indian state of Punjab. On account of its overall prosperity, caste mobility, and low fertility (Jodhka, 2004), Punjab represents a privileged case in the Indian context. Perhaps for this reason, the state of Punjab is underrepresented even in the mostly evaluative public health studies on the ASHA program (Scott et al., 2019). In sociological terms, the study of privileged or extreme cases is important because it shows processes and problems in particularly clear relief (Zussman, 2004). My choice of Punjab was based on this logic, as well as on my previous experience conducting qualitative research in Punjab, and my familiarity with Punjabi and Hindi, both languages spoken in my field site.

The district of Shri Muktsar Sahib, where I conducted my fieldwork, is one of Punjab’s 22 districts, predominantly rural. Muktsar’s workforce participation rate for women is 14.7 percent, which is lower than the national rate of 27.4, already one of the lowest in the world (Census 2011). Despite rising incomes and structural transformation, women’s labor force participation rate (LFPR) in India is declining. However, jobs in social services like health and education are one sub-sector where female employment is either growing or constant (Sarkar et al., 2019). The average monthly payment to an ASHA in Muktsar when I began my fieldwork was INR 2700 (approx. USD 39). In March 2019, Punjab declared that the monthly minimum wage for a skilled

---

2 This amount has increased after the state government added a monthly COVID incentive of INR 2500, on account of the frontline work ASHAs do to control the spread of COVID, such as tracing, referrals, and vaccinations in their communities.
worker is INR 10129 (approx. USD 145) (Department of Labour Punjab, n.d.). ‘Skilled worker’ is the statist category under which ASHAs might fall if they were to be recognized as workers instead of volunteers.

I secured permission from the Ministry of Health and Family Welfare in Punjab’s capital, Chandigarh, for my study. I conducted 14 months of ethnographic fieldwork (June-July 2017, and then July 2018 to June 2019) on the ASHA program. I did field observations and interviews (n=60) with ASHAs across an urban and a rural block of Muktsar district in Punjab. In order to map the conflicts and consonances between the views of those who run the ASHA program, and the ASHA themselves, I conducted interviews (n=20) with officials and experts on the ASHA program at the district, state, and national level.

Because ASHAs are positioned as links between their communities and the health system, I followed ASHAs as they interacted on both these ends. I observed home visits, community-level campaigns and meetings, weekly immunization drives, etc. as well as ASHA trainings, monthly health department meetings, patient-servicing in hospitals, protests by the ASHA union, etc.

I sampled ASHAs to interview from an official list of all ASHAs in my fieldsite, ensuring equal representation along the lines of rural/urban location, and Dalit and dominant castes. In my interviews with ASHAs (lasting from 30 to 90 minutes) I asked questions about their work history and selection into the ASHA role; knowledge of public life and networks in public and private hospitals; the details of their work, barriers to their work, and how they overcome these barriers; experiences with women from within and outside their castes; reflections on the impact of the ASHA role on their lives, and recommendations for the program. I compensated ASHA interviewees a standardized amount for time/wages lost and travel costs incurred. I coded my
interviews and fieldnotes in ATLAS.ti to inductively identify recurrent patterns and exceptions of interest. The codes used both, the logic of the question, such as the code “challenges of role” and the theme of the answer, such as “credibility crisis”. The most common codes were about the burden of work and payment problems. To preserve anonymity, I use pseudonyms.

For the purposes of this article, I focus on my observations and interviews in Muktsar district. As a young, urban, unmarried, upper-middle-class woman of mixed ethnicity, I was an outsider to my field in most senses. This generated curiosity, and required me to field questions of a personal nature with some openness. However, my father is Punjabi (he grew up in an adjacent district), I have a recognizable Punjabi surname, and I was living with extended family who also ran a local eye hospital of some repute; I leveraged this information to make myself socially legible to my participants. When I first arrived in the district, I was routinely taken for a journalist or a government official from Delhi who was conducting a “check”. My participants were reticent, and I spent many initial days waiting to hear back from people. In the second month, something shifted rather fortuitously. The local ASHA union that had been dormant for some time was revived, and I began to tag along for their meetings and protests. This seemed to reassure some of the ASHAs that I was not part of, or answering to, the state machinery, and we became friendly. These friendships were later instrumental in helping me make sense of and access the social lives of ASHAs during the remainder of my time in the field.

**Findings**

I find that ASHAs’ liminal occupational status adversely impacts their wages. We know ASHAs’ wages are low. However, liminality further lowers these already low wages. Here, I show the mechanism through which this happens. ASHAs receive payments every month not in the form
of a fixed salary, but as incentives totaled from a pre-determined list of tasks performed by them and approved by their nurse supervisors. I find the metric of incentive payments is prone to confusion, causing delays, and even denial of earnings. Incentives are also easy to manipulate; they are withheld to get ASHAs to do more work than their brief. When ASHAs attempt redress, their claims are dismissed using the discourse of service: volunteers should not “run after” payments, they are told. The incentive format gives nurse supervisors disproportionate control over ASHAs: this can turn them into friends or foes for ASHAs’ claims. However, as I show, even in seemingly positive uses of liminality, that is, when nurse supervisors support ASHAs’ claims, the dynamic only serves to strengthen their position of influence over ASHAs. I argue, therefore, that liminality manifests negatively for ASHAs, lowering their already low earnings.

*Denial of incentives*

During my time in the field, there were several instances in which ASHAs were denied incentives despite earning them. On a winter morning in 2018 I run into Sheenu, an urban ASHA, at the tea stall at the entrance of the district hospital. Sheenu is a 30-year-old, Hindu upper-caste woman. After a string of foggy days, it is sunny and clear. I remark to Sheenu that it is such a good day. Immediately Sheenu begins to complain, “What good day? My supervisor has ruined my mood.” I inquire why. “She struck off one antenatal checkup incentive from my monthly report. The woman had delivered a stillborn child. So the nurse said to me, what care are we paying you for, if the child didn’t make it?”

ASHAs receive their monthly payment based on a monthly report that is filed together with their nurse supervisor. The nurse must sign off on the tasks completed by the ASHA for any given month, and how much the ASHA will be paid for that month is calculated by totaling the incentive
for each of these tasks. Only the tasks that are validated by the nurse make it to this monthly report. In this instance, Sheenu is upset because her nurse supervisor has struck off a payment Sheenu was expecting will go through. The nurse supervisor pegs the incentive for a patient’s antenatal checkup to the birth of a live baby. The nurse argues that because the baby did not live, Sheenu’s care was pointless and so will not be remunerated. Technically, this is incorrect. The rule is that Sheenu should still be paid for the visits she made. But as the ASHA coordinator at the district level, Sunil, explained to me later, nurses are often confused about the conditions that have to be met in order for an incentive to be paid. According to Sunil, nurses do not always have clarity on incentives. In department meetings, I commonly witnessed nurses asking Sunil to go over the list of ASHA incentives with them. This happens also because incentives frequently change—amounts can increase or decrease, and tasks can be added or removed—depending on what the state’s health department decides is the new public health priority.

Confusion about how tasks are to be performed for ASHAs to secure incentives is not limited to nurse supervisors alone. ASHA incentives can be confusing for other staff members of the health department too, with consequences for ASHAs, as this excerpt from a focus group discussion with nurse supervisors illustrates:

*Whatever ASHAs earn is because of their hard work. They should get that money. But a lot of the staff does not understand what ASHAs do, how much they work. Sometimes a pregnant patient reaches the hospital for delivery, but the patient’s ASHA does not reach with her. The ASHA may be ten minutes behind, twenty minutes behind. The staff on duty will ask, is your ASHA here? The patient will say, no. The patient gets nervous right? The staff will write in the file, “no ASHA”. That’s it! The ASHA will not get her hospital delivery incentive. But the ASHA has run after that patient for nine months, she has motivated the patient to deliver in the government hospital. But no! If the file says “no ASHA”, then the ASHA gets no incentive.*
Problems with payments have been documented in other studies on the ASHA program as well (Bhatia, 2014; Gjostein, 2014). Without a fixed and steady monthly salary, ASHAs are at the mercy of other health department staff to validate their tasks and secure their incentives. Because incentives can be confusing, ASHAs are often denied payments for tasks they have completed.

**Incentives as leverage over ASHAs**

The denial of earned incentives to ASHAs is not always unintentional, resulting from confusion. It can also be intentional, a strategy to exert control over ASHAs. Early in my fieldwork, I attended a monthly meeting in the community health center of the rural block. There were about fifty people in attendance: the nurse supervisors, and their supervisors. ASHAs were not present, because the ASHA monthly meeting is held separately. Here is the fieldnote from that day:

The gap in JSY payments is a key issue in today’s meeting. JSY or Janani Suraksha Yojana (Mother Protection Scheme) is the government’s cash transfer program for mothers, instituted in 2005 as part of the same effort to combat maternal mortality under which ASHAs were appointed. The health center staff is concerned that while the district has seen a rise in mothers delivering in hospitals, all these mothers are not receiving the JSY cash transfer that is due to them when they deliver in hospitals. This gap is a problem: why should the number of JSY payments to mothers be low when the number of hospital births is high. It turns out that mothers must have bank accounts and *aadhaar* cards in order to receive the JSY payment. There is some discussion around how easy or difficult it is for women to get *aadhaar* cards. It seems that a lot of women who are eligible for JSY have the address of their natal homes on their *aadhaar* cards, which they must change to the address of their marital homes before they can be paid.

The accountant, Santosh, is speaking. She has ideas about how the JSY gap can be fixed, “You have to make sure that you take down all patient details. If you leave any of the columns on the form empty, it becomes very difficult for us to make the payments. And take things in writing from patients. If the patient says, I don’t have an aadhaar card, or I don’t want the payment, then take it in writing. That way, at least we will be able to explain the gap. Also, you tell the ASHAs, we will stop your JSY incentive if you don’t close this gap. You tell them this for one month and then see the difference. Look, you are the department. You have to make it run. You have to get strict.”

---

3 Aadhaar is a new form of national biometric identification introduced by the government, and controversial for data protection concerns and for significant gaps in population coverage.
She swiftly moves onto the next agenda item. One of the ASHA incentives is to be discontinued; this is the incentive ASHAs receive for bringing in anemic pregnant women to be administered iron intravenously. This announcement is met with a loud murmur from the room. Immediately Santosh holds up one hand, gesturing for them to stop, “Please! Listen, I cannot do anything about this, I am just letting you know so when the payment doesn’t come, your ASHAs don’t form long lines outside my office to ask about it. The work still has to happen the same way, but the incentive will be stopped.” She starts announcing the names of sub-centers that have filed incorrect paperwork in the last month. This signals the end of the meeting, and the room starts to break up.

This meeting epitomizes the problematic character of the incentive payment system. Incentives function as a lever through which the health department can exert control over ASHAs. By withholding or threatening to withhold incentives, the department can arm-twist ASHAs into doing work that is outside of their purview. This is evident from the accountant’s solution to the problem of the JSY payment gap. The accountant advises the supervisors to withhold the incentive ASHAs receive under JSY for a hospital birth if the mother does not receive her JSY incentive. The ASHA’s JSY incentive is separate from the mother’s. The former is paid to ASHAs for persuading women, usually after nine months of engagement and care, to deliver in government hospitals. Effectively, here the accountant suggests that it does not matter that the work for which the JSY incentive is given to ASHAs has been done by the ASHA; the accountant wants the room to use their ability to withhold this incentive to get ASHAs to do the additional and uncompensated work of ensuring JSY payments to mothers. Never mind that the reason for the JSY gap could be unrelated to ASHAs, or outside their influence. During my time in the field, I saw other instances of this arm-twisting: for instance, the ASHA incentive for maintaining registers was withheld to put pressure on urban ASHAs to bring patients to the district hospital’s vasectomy camp.

Significantly, the accountant follows up her advice with telling a roomful of nurses, “look, you are the department, you have to make it run, you have to get strict”. She is implying here that
ASHAs are not the department. They are, rather, the object of the room’s action, the ones with whom the room should get strict. This attests to the liminality of ASHAs’ status.

When the accountant informs the room that the ASHA incentive for iron has been stopped, she does not have an explanation for it. But she states that incentive or not, the work of bringing in anemic pregnant women to be administered iron must happen as before. During my time in the field, I realized that the list of tasks for which ASHAs receive incentives is a shifting one, based on health campaigns being prioritized or de-prioritized by the government. Routinely, some incentives increase, and some decrease or are removed altogether. The burden of work for ASHAs, however, shifts only to grow. By being expected to work with as much dedication, irrespective of payment, ASHAs are expected by the health department to live up to an idealized standard of volunteerism that is purely altruistic. For an all-women workforce, this reinforces the naturalization of care as a gendered practice. It also serves to undercut their rights, as workers, to timely payments. I explore this dynamic in the next section.

Volunteerism as an alibi

Community health workers are poor people from poor communities (Aye et al., 2018), and the women in my field rely on their income as ASHAs to run or support their households. However, the title of ‘volunteer’ suggests otherwise, and this impacts how ASHAs’ claims about payments are received in the health department.

Its 10 am, and I have come to the civil hospital this morning looking for Kamla. Kamla is a 48-year-old Dalit woman, who has been working as an urban ASHA for 3 years. She is wiry looking, with eyes that dart about when she talks. Today she will be filing her monthly report, and I want to see how this is done. I find Kamla standing in the corridor outside the postpartum unit, together with Japneet (48 years, Nai Sikh) and Roop (34, Mazhabi Sikh), also ASHAs. Kamla, Japneet, and Roop share a nurse supervisor, and their areas are adjacent neighborhoods in the city. We greet each other, and I ask what’s going on. Immediately they all start complaining. It is the 27th of August, but their payments for
July have still not come through. Japneet says, “How are we supposed to run our homes, pay our bills? I am widowed, she (points at Kamla) is fighting a court case against her husband for abandonment (Kamla looks at the ground blankly), her husband (nods her head at Roop) is jobless. They should at least give us some money for transport. We are paying out of pocket to work!” Japneet drops her voice dramatically and leans in. She adds, “When they want work from us they say ‘you are staff, you are part of this hospital, if you work well, you will earn all of us a good name’. And when it comes to paying us? When we ask about the delays they say, ‘It’s not like you are staff.’ Our work is so hard. We have to run around so much. In the heat! It is not easy! But this is how it works here: the highest person has the easiest job. The SMO (Senior Medical Officer, head of the district hospital) sits in an airconditioned room, he just summons people when he needs them, and he gets the highest salary."

Now it is Kamla and Roop’s turn to chime in. ‘Look, there is no room for us to sit in even. Sometimes when we come with delivery patients and we have to stay the night, we sleep on the floor, next to the patient’s bed. The SMO says, we might not have place for you in the rooms but there is always place for you in our hearts. Is this correct?!’ she asks with incredulity. Roop and Japneet shake their heads, lips pursed.

Japneet, Kamla and Roop call out what they experience as double standards: words of high praise for ASHAs that find no reflection in the daily practices of the department. ASHAs do not even get a room of their own. The lack of space signifies their lack of status in the state. Spaces are “doubly constructed” (Gieryn 2000), that is, they are physically built structures, but they are also interpreted, felt, and imagined subjectively, in what Lefebvre (1991) identifies as a materialization of power relations. A space that workers can mark as their own allows for respite, privacy, solidarity, and even inspiration (Shortt 2015). ASHAs see the denial of space in the hospital as a reminder that they are not part of the hospital, that the people in charge do not see ASHAs as belonging with other staff. The SMO’s refusal to assign ASHAs a room in the hospital attests to their liminal occupational status for the health department. Moreover, it corresponds to the imagination of care work as being altruistic in nature, and carrying intrinsic rewards such that other rewards—like wages or a room of one’s own—do not or should not matter (Morgan et al., 2013; Nelson, 1999). When the SMO tells Kamla that there is space for ASHAs in their hearts, he
is saying that there may not be physical space to accommodate their physical selves, but there is emotional appreciation of their labor, and that *that should be enough*. I found this was a recurrent theme. For instance, in another interaction when a group of 6-7 urban ASHAs brought up their payment delays with the Lady Health Visitor (the boss of ASHAs’ nurse supervisors), she told them that they were here to do service (*sewa*). She said, quoting a common Hindi idiom, that they should focus on their work and not its fruits, and that god would repay them.

The next time I meet with the district ASHA coordinator, Sunil, I ask him why the incentives are paid unevenly. He explains that ASHA incentives are made up of activities that are routine (antenatal checkups, hospital deliveries etc.), activities that fall under other verticals in the same department (tracking patients with TB, leprosy etc.), and activities that are one-time campaigns (de-worming, diarrhea fortnight etc.). Routine payments are not usually delayed, but the others can be because of systemic reasons. He pauses to reconsider, “*Even if there are delays* (he raises his eyebrows and says this emphatically, as though to indicate how rare this is) *at the most the delay is a few months here and there, if the funds have not been coming. There is no issue really.*”

Here, Sunil admits that incentives can sometimes be delayed by a couple of months. But the way he frames this admission shows that he does not think this is a real issue. Most women who work as ASHAs cannot hold down another job because of the hours and burden of their work. But the title of community health *volunteer* suggests that the work of an ASHA is something women can do by the by, on their own time and on top of whatever else they do. The income from this work, therefore, is not imagined to be a household or even a living wage, but a form of petty
cash, like an honorarium. This is likely why, unlike Japneet who is agitated about how she will pay her bills, Sunil is unperturbed.

I ask Sunil about ASHAs’ JSY payments being withheld. He explains in his usual patient manner: “We give the payment eventually, but yes we sometimes put it on hold to put pressure on the ASHA, like for JSY uptake. Everyone from the SMOs to the civil surgeon is under pressure from above. They have to answer for discrepancies. So, they pass on the pressure. But this is not a big deal. It happens to us too. Sometimes the civil surgeon will say to me, I will withhold your salary till you turn in such-and-such report.” Another staff member standing over a filing cabinet chimes in to educate me: “Madam, there is a sword hanging over everybody’s neck. The only difference is that the sword is closer to some necks than others!”

Sunil, like the rest of the staff employed under the National Health Mission⁴, is a contractual and not tenured employee of the state. The NHM has been created as a parallel line within the Ministry of Health and Family Welfare. As a result, the health department now has two types of employees: a) regular with tenure, benefits, and significantly higher pay scales, like the civil surgeon Sunil reports to, and b) contractual with no tenure, fewer benefits, and lower pay scales, like the NHM staff. The pressure Sunil describes as coming “from above” and being passed down all the way to the ASHA has been normalized. Sunil does not think it is a big deal to coerce work from employees by withholding payments because this happens to him too.

_Nurses as the key locus of control_

---

⁴Only the mission directors of the NHM (the highest authority in each state) are tenured. They are officers of the elite Indian civil services.
Nurse supervisors—officially titled Auxiliary Nurse Midwives or ANMs—are closest to ASHAs in rank and their immediate supervisors. Before the National Health Mission, there were fewer nurses and no ASHAs. Now, there are more nurses and ASHAs form a whole cadre of workers under them, so while the workload of the department has increased after the NHM, and nurses are no exception to this, nurses have also most benefitted from the appointment of ASHAs, who take a chunk of work off their hands.

Jaspreet, a rural Dalit ASHA who has been in the role since 2007, sheds light on the nurse-ASHA relationship during our interview:

Me: Do ASHAs face problems with ANMs?

J: ANM… well yes, there are problems, but I will never tell the ANM that I am facing a problem with her! (we both laugh) Even when I am very upset with her, I will say, I am so happy with you. I simply cannot. Because she files my monthly report. If I say anything, she will strike off my incentives. She will come up with something- ‘there is a problem here’, ‘the date is different there.’ The 2000 I am getting now will not even come to 1500.

Me: But some ASHAs do fight with their ANMs…

J: There are many ASHAs who have fights with their ANMs. When the ANM gets after you over and over again, some like me will say, never mind her, I have to raise my kids. Some others say, I have to raise my kids yes, but not like this! I don’t want to take this crap. If I have done my work, why should I listen to her crap?

Me: So what happens when they fight? What comes of it?

J: Every time an ASHA fights with an ANM, ultimately it is the ASHA who has to give in. Never the ANM. I have made up my mind about this. I will never fight with my ANM. Because if I do, I will first get told off by her. Then I will get told off by the SMO, the civil surgeon, by everyone. All the ASHAs who fight, they have to finally eat crow. Even if the ANM is at fault, it is the ASHA who will lose.

Me: Why does that happen you think?

J: This happens because… See, if the ASHA were salaried like the ANM, if we marked attendance like the ANM, then maybe the department would respect us, the civil surgeon
would respect us. They don’t consider us their equals, they don’t consider us a part of health department, like them. They think we are the lowest… the smallest of small fry. You know? No one says to us, ‘come, come, have a seat.’ We do our work standing up. We greet them with namastes. We ask, ‘what can we do for you.’ They think if someone is salaried, that means they are superior. If someone is not salaried, they are nothing. *They don’t respect us because we are not paid* (emphasis mine). They think ASHAs have a duty, a free duty. Every time we bring up our payment we are told, your work is service, only service. Yes, we are here to do service, but what about our service towards our children? With 2000 a month, I can’t give them two square meals. Then they say, you focus on the work, the money will follow! I have been doing this work for ten years now, I don’t see any money following! The money never follows me! (Laughs).

Jaspreet brings to the surface the imbalance in the ASHA-ANM relationship. Jaspreet is unusually frank about this dynamic. Most ASHAs I interview, in response to this question (‘do ASHAs face problems with ANMs’) will deny there are any problems and launch into high praise for their ANMs. If pressed, they will say they have seen other ASHAs have problems with other ANMs, usually to do with being paid less than their due. Jaspreet suggests ANMs always win against ASHAs because staff close ranks, and ASHAs, as volunteers, are on the outside of this occupational solidarity.

Notably, Jaspreet believes ASHAs are not respected because they are not paid a salary. In her experience, the status of ASHAs as incentivized volunteers *legitimizes* their mistreatment by staff. In creating their post as it did, the state has marked ASHAs as less-than-equal, as liminal. Staff simply follows this brief in treating ASHAs as inferior in status.

Jaspreet also shores up the moral force of motherhood, the most salient of women’s claims to public life. She calls attention to her struggle to provide for her children that brought her to this role in the first place. She intentionally describes her responsibility to her children as service, as a
counter to how the discourse of service is commonly used with ASHAs to deny them fair and timely pay. No, she insists, the money does not simply follow.

Jaspreet articulates how ASHAs’ liminal position allows the department to mistreat them and disregard their claims. Her answers implicate all the health department staff but focus most on nurses. Nevertheless, it is not the case that nurses only give ASHAs a hard time. An ASHA’s nurse supervisor can also be her biggest advocate. Simran is a 50-year-old ASHA from the city. Everyone speaks highly of her work. Simran has the aspect of a kind matriarch, with a broad, easy smile that shows a few missing teeth. The ASHA on record for Simran’s area is actually her daughter-in-law, but Simran works in her place. This arrangement is unusual, but it has her nurse’s blessing.

Simran lives with her husband, two sons, two daughters-in-law, and five grandchildren. She tells me her husband and sons spend all their earnings on drugs. Simran taught Punjabi in a local school for 24 years. This is where she became friendly with her nurse. The nurse would come to the school to administer vaccines, and Simran would help out. When urban ASHAs began to be appointed in 2015, the nurse suggested that Simran apply. Simran got her daughter-in-law to apply. But the daughter-in-law was studying for her BA then, and has a newborn now, so Simran works in place of her. This arrangement is able to sustain even though the doctor in charge of urban ASHAs, Dr. Suraj, is not happy about it. Simran tells me about this during her interview:

Dr. Suraj says ‘your daughter-in-law should come for work.’ He kicked me out you know. I sat at home for two months. I was under so much stress. My daughter-in-law, in the seventh month of her pregnancy, started to come for work. My nurse was on maternity leave at the time. As soon as she got back, she went and fought with Dr. Suraj. She took me with her. She said, ‘doctor sahib, this aunty WILL work with me’. I had lost my
certificates you see, that is why I couldn’t be appointed under my own name. But I know the work, I have done it from the very beginning.

Simran’s daughter-in-law now tutors schoolchildren from their home. These are children who used to be taught by Simran. “She has taken over my work, I have taken over hers, and our family manages well now.” Simran has crafted something delicate. With her nurse firmly behind her, she has worked the informality of the ASHA role to her advantage. I suspect, though, that this takes constant and considerable people management. Her ‘appointment’ is precarious. It must drive her to work doubly hard. Perhaps it explains why her work is considered so exemplary by the rest of the staff.

**Discussion and conclusion**

Research on gender and labor finds many contradictions in women’s employment vis-à-vis the state (Kingfisher, 2002; Lister, 2009; Orloff, 1996). State-created employment can be “an engine and a break” for women, facilitating their entry into the labor force but also creating strongly gender-segregated labor markets (Evertsson, 2000). Most of this research is on welfare states. However, the growing trend of feminization of obligation—where women work for development but development does not provide women with decent work—also demands scholarly attention (Chant, 2008). Here, developing countries hire women in public services like health and education in euphemistically titled “community” and “voluntary” roles. These are liminal occupational categories, neither inside nor outside the state. They allow women to be hired by the state but not as employees, so states can withhold the entitlements of employees, especially minimum wage. This has consequences: in India it intensifies occupational gender segregation and
increases the gender wage gap. It violates women’s rights as workers with impunity by simply not recognizing these women as workers.

Here, I present evidence from an ethnographic study of one such liminal workforce, India’s women community health workers, called Accredited Social Health Activists or ASHAs. I find that liminality further lowers their already low wage. Through observations and interviews, I show how this happens. As “paid volunteers”, ASHAs are subject to a unique payment metric: incentives. This metric is flexible by design. ASHAs are paid more or less each month based on whether the number of tasks performed or patients serviced for that month is higher or lower. However, I do not find that this flexibility works to ASHAs’ advantage. On the contrary, ASHAs are taken advantage of because of the flexibility of the incentive payment metric. Flexibility makes the incentive payment metric a shifting and contingent one, causing confusion among health department staff who determine ASHAs’ wages. As a result, ASHAs are often denied incentives they have earned. Flexibility is also leverage. The health department staff uses their ability to withhold or deny ASHAs’ incentives to coerce more work out of them. These findings are significant but not surprising. Flexibility that meets the needs of an organization is not necessarily the same flexibility that suits workers. Research from Sweden (Jonsson, 2011) shows, for example, that part-time employment for care workers has been a problematic way to organize care more “efficiently” in the public sector. Indeed, the same research argues that when it is not implemented equally for all employees, flexibility serves to reinforce the gender division of labor. With ASHAs, flexibility serves gender discrimination in labor practices. ASHAs are the only workforce in the health department that is remunerated with incentives instead of a salary because of its “volunteer” classification. ASHAs are also an all-women workforce, appointed primarily for women’s health.
issues. Effectively here, a liminal occupational status—and an exclusive, narrow, and exclusionary payment metric deemed appropriate to it—has been assigned for a role only women can fill.

How does a liminal occupational status shape ASHAs’ experiences? I find it erodes their legitimacy. This is most evident when ASHAs make claims as workers—when they demand timely payment or a room of their own. In these instances, they are reminded that they are volunteers, here to serve others and not to advance themselves. Liminality becomes the perfect alibi to deny ASHAs the rights of workers. Like nurse hybrids, ASHAs, too, find themselves in a position where their labor far exceeds quantified, measurable outcomes, they are stereotyped as altruistic and passive, and their status creates conflicts for them. Like nurse hybrids then, ASHAs experience perverse liminality. My findings support the assertion that liminality works positively only for powerful professions (Croft et al., 2015; Fischer, 2012). This is not to say liminality always works for powerful professions. Consultants, for example, can find themselves burnt out by the extent to which liminality allows work to take over their life (Johnsen & Sørensen, 2015). However, it does indicate that a powerful profession—high wage and high legitimacy—is a necessary if not sufficient condition for positive liminality. The question for future research on liminality and work to consider, then, is not so much whether liminality is positive or negative for workers, but for whom, and the conditions under which liminality is positive or negative.

As the nature of caregiving work in the health care sector becomes more varied and challenging (Vogus et al., 2020), it behooves scholars of care to pay attention to the interstices in care. Usually care is performed privately or in informal settings, and this feeds into the invisibilization of care. For this reason, some scholars have argued that care work is best kept in non-profit or governmental sectors rather than the private sector, where bottom lines prevail (Held,
Others reject the idea that the wellbeing of workers is so readily determined by whether they are in the market or non-market sectors (Nelson, 2006; Zelizer, 2002) and argue for more empirical research on the mechanisms of specific problems rather than arguments about oppositional spheres. As the state itself informalizes, liminality is a useful analytic with which to capture new dynamics, or new versions of old dynamics, at the interstices of care.

One dynamic is the new ways by which the rewards in care—or rather their lack—are being institutionalized today. Gender is inextricably woven into this dynamic. As women, ASHAs are expected to provide “elastic caring” (Baines, 2006)—to care beyond the call of duty because it comes “naturally” to them. As community health workers, ASHAs live in the communities they serve, which leads to a blurring of boundaries between work and leisure. While women experience the burden of elastic caring in many jobs, and indeed in the home, the role of an ASHA seems practically designed for elastic caring. Indeed, elastic caring is institutionalized through the role of a woman community health “volunteer”. Just as Baines & Armstrong (2019) note with home and family, the notion of community too provides a “common-sense ideological backdrop” for elastic caring. Women “naturally” build community. Therefore, community work need not be compensated as real work. ASHAs experience a constant disciplining into altruism: they are told service is its own reward, and to not worry about other rewards. This is an idealization of the emotional rewards of care, and neglects the structural factors that organize and stratify caring labor (Pande, 2010; Uttal & Tuominen, 1999). For the Indian state to recruit and retain a million-strong all-women workforce, the largest community health workforce in the world, in such a position is to institutionalize, naturalize, and legitimize gender inequality.
Two, ASHAs’ experiences with health department staff are a window into the relational aspects of liminality. A study of strategic management consultancy finds liminality is multi-layered and highly structured, allowing it to become an organizational tool or tactic (Sturdy et al., 2006). By examining the tactical and productive uses to which business dinners are put, Sturdy et al emphasize that liminality is not isolated from organizational or social norms and structures, rather it must be analyzed in relation to those. ASHAs’ liminality is embedded within an informalizing health department, where staff increasingly comprise contractual rather than tenured employees. This organizational context both creates a locus of external control for ASHAs and normalizes this control. By this I mean, ASHAs’ liminality subjects them to exceptional control by health department staff, but because a lot of that health department staff too experiences some version of liminality, albeit a qualitatively different one, they do not see ASHAs as being uniquely vulnerable to control. Contractual staff are subjected to pressure tactics at work—the sword hanging over everybody’s neck as one staff member put it to me—so the “passing on” of pressure is normalized in their eyes. At most, they see ASHAs as under more pressure—the sword is closer to their necks—but that is all. However, the difference is not one of degree but of kind. Contractual health department staff may not have the same privileges as tenured employees, but they are salaried and they are employees. ASHAs are neither. Indeed, the ability to control ASHAs seems to have been an important factor in ascribing them liminal status. In a policy review of the ASHA program, Ved et al. (2019) interviewed Indian health system actors who were extensively involved with designing, implementing, and adapting the ASHA program. These policymakers cite a number of reasons why a salaried position was not considered feasible for ASHAs; in addition to
concerns around flexibility, finances, India’s federal structure, etc. is also the concern that ASHAs would be difficult to monitor if salaried.

Understanding liminality in relational terms can help examine nonstandard work more comprehensively and critically. The key locus of control over ASHAs is nurse supervisors. Nurses are responsible for validating each task an ASHA performs in a month, making the nurse’s approval key to what an ASHA’s total payment for that month will be. This power to determine monthly payments makes this supervisor-supervisee relationship more than just unequal; it infuses it with a sense of fealty. ASHAs feel beholden to their nurse supervisors. As Jaspreet so articulately explains, ASHAs feel the need to demonstrate loyalty and satisfaction lest they invite the fury of their nurses in the form of slashed payments. But this relation of fealty can also be worked to ASHAs’ advantage, as we see with Simran. Simran’s nurse successfully advocates for the rules of appointment to be relaxed for Simran. However, even this seemingly positive iteration of liminality only serves to shore up the nurse’s authority over Simran. It does not give Simran real autonomy or security, rather it strengthens and consolidates her fealty to her nurse. It confirms that Simran can enjoy her position only at the pleasure of her nurse. I argue this is a caution against a short-sighted celebration of the “victories” of liminality.

Scholars have long studied the gender wage gap as an important indicator of gender equality (England, 2005). Improving women’s occupational status is still key to closing the gender wage gap (Budig et al., 2019; Moore, 2018). Evidence from India supports the argument that globally the concentration of women workers in low paying jobs is the main reason for the persistent gender wage gap (Mondal et al., 2018). In care work occupations in particular, scholars have studied the wage penalty compared to non-care occupations, its disproportionate impacts on
women from marginalized race and class backgrounds, and the need for improved measures of care to raise the wages in care (Budig et al., 2019; Duffy et al., 2013; England et al., 2002). By bringing the lens of liminality to bear on ASHAs’ experiences, I draw attention to an understudied aspect of the wage for care: not how much is paid, but how the wage is structured, that is, as incentives rather than salaries. I show that to structure the wage for care as an incentive rather than a salary is much more than form, i.e. a mode of compensation. It is also content. I demonstrate that a liminality lowers wages for ASHAs. The liminal occupational status of “paid volunteers”, neither insiders nor outsiders to the state health department, creates conditions for the chronic underpayment and control of ASHAs. This illuminates how the standard of both wages and working conditions in care is being lowered today.

And finally, given the significant role of community health workers in the provision of health services, their wages have important practical implications. National community health worker (CHW) programs have generated much excitement in recent years for their ability to create uptake of public health services, meet development goals, and be a panacea to health workforce shortages (Schneider et al., 2016; Ved et al., 2019). As a result, there is ongoing discussion about how best to design, scale up, and sustain such programs, including how best to remunerate workers (Kasteng et al., 2016). These discussions have become even more urgent with the COVID-19 pandemic spotlighting the life-threatening difficulties faced by frontline workers. The World Health Organization recommends that CHW programs be appropriately financed to ensure services are sustainable, and that CHWs receive adequate wages (Kasteng et al., 2016). A commensurable salary is the first step towards increasing the motivation of health workers (Chandler et al., 2009). Every ASHA in my study sought tenured, salaried employment from the government. In the
absence of this, we will continue to rely on individuals, especially women, from low-income communities to contribute their time, knowledge, and skills freely to help address health inequalities (Kasteng et al., 2016, p. 212).

References


