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AN ANALYSIS OF INCOME OF HOUSEHOLDS OF RURAL FEMALE HEALTH WORKERS IN PUNJAB

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Abstract

Health is a fundamental human right, so therefore, health care should be widely accessible. According to WHO, women account for 70 per cent of health sector workers globally in 2019. The NRHM launched by the GOI in April 2005, appointed ASHAs at the village level, along with one MPW and two ANMs at the sub-health facility. The social status and financial rewards of these workers were much inferior than those of other health professionals. The paper analyses the levels and pattern of income of rural female health workers in Punjab. This paper is based on primary data collected from 504 female health workers in rural Punjab. the average annual income of a family with a rural female health worker in Punjab is Rs. 324,633.13. The household income of ANM families is 2.52 times more than that of ASHA worker households. The households of ASHA workers derive the highest income (25.29 per cent) from incentive payments. ANM households derive 42.81 per cent of their total income from government services. The distribution of income is slightly worse among ASHA households.

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1.0 INTRODUCTION

Health is a fundamental human right; hence, healthcare ought to be universally accessible (Thomas, 2021). In 2019, women constituted 70 per cent of healthcare workers globally, as reported by WHO (Thomas, 2021). The attainment of universal health requires the ultimate worldwide deployment of two million community health workers. The establishment of the CHWs aligned with the Alma-Ata Declaration. Community Health Workers function at the grassroots level in specified sites, including primary health care facilities (WHO 1978). Initially, they were assigned a limited number of responsibilities, but their training progressively broadened. The intensive training procedure broadened their activity range and, over time, improved the quality of services provided (Frankel, 1992).

The Millennium Development Goals (MDGs), emphasizing health, ultimately supplanted the Alma Ata statement of 2000 advocating for "health for all" (Ashtekar, 2008). Healthcare service accessibility remains an issue in rural India, home to 700 million individuals (Sreerame et al., 2015). The objective of the NRHM, initiated by the GOI in April 2005, is to improve the health of the disadvantaged in rural regions. (NHM, 2024). The public health infrastructure has been enhanced within the NRHM framework. Sub-health centres serve 5,000 individuals, primary health centres accommodate 30,000 people, and community health centres cater to 120,000 individuals, representing various segments of the health infrastructure. The NRHM appointed ASHAs (Accredited Social Health Activists) at the village level, along with one MPW (funded by the states) and two ANMs (supported by the Government of India) at the sub-health facility. Secondly, Auxiliary Nurse Midwives (ANMs) are appointed in sub-centers according to certain criteria, including receiving up to Rs. 7000 in monthly remuneration, residing in the village under the sub-center's oversight, and not being relocated before to the completion of their ten-year tenure. In its absence, each sub-center would be allocated two TBAs/RMPs or trained ASHA workers without incurring any expenses (MOFHW, 2005). A primary objective of NRHM is to enlist women as Accredited Social Health Activists (ASHAs), who facilitate community access to health services by serving as health educators and promoters (Sharma et al., 2014). Upon finishing a fundamental course in community health, ASHAs—female community health workers—are assigned to their respective villages, with one given every 1,000 residents. Auxiliary Nurse Midwives (ANMs) are allocated to sub-health centers and must live within the community governed by the respective sub-health center (MOFHW, 2005). Auxiliary Nurse Midwives (ANMs) received monthly remuneration from their respective departments, while ASHA workers, as rural health advocates, earned incentives based on their performance. The social status and financial rewards of these workers were much inferior than those of other health professionals, and they face discrimination from more senior health personnel. Moreover, their work performance deteriorated due to the insufficient, inconsistent, and installment-based incentives and payments (Sharma et al., 2014).

1.1 Objectives

The objective of the present paper is to analyse the income levels and patterns of female health workers in rural punjab. The specific aims of this study are:

1. To ascertain the per family and per capita income of rural female health workers families in punjab.
2. To analyze the share of different components of income of rural female health worker families in punjab.
3. To examine the extent of income disparities among rural female health worker families in rural punjab.

1.2 Methodology

The study is based on primary data. For analysis of income of rural female health workers, specifically ASHAs and ANMs, in Punjab. A random sampling technique is used to gather primary data from selected rural female health workers. Data has been collected from 504 rural female health workers, comprising 429 ASHAs and 75 ANMs, for the purpose of the study. The gathered data will undergo analysis utilizing a range of statistical tools and techniques, including mean values, percentages, and the Gini coefficient. During the data analysis phase, statistical tools including Excel and SPSS will be utilized.

2.0 RESULT & DISCUSSION

2.1 Income Per Household for Rural Female Health Workers Household

Table 1 presents the average income derived from different sources by the household of rural female health workers in the Punjab. The data indicates that the average annual income of a family with a rural female health worker in Punjab is Rs. 324,633.13.

TABLE 1 :

LEVEL OF INCOME OF RURAL FEMALE HEALTH WORKERS (MEAN VALUES, IN RS., PER ANNUM)

Source of Income	ASHA	ANM	All
Farm business	21398.60	31200	22857.14
Hiring-out contractual labour	2016.32	0	1716.27
Livestock	6783.68	3386.67	6278.17
Rent on land	13018.65	66800	21021.82
Government Services			

a	Regular	20508.16	286165.33	60040.48
b	Contractual	0	161333.33	24007.94
	Private Services	42424.24	64720	45742.06
	Incentive	66909.09	0	56952.38
	Income from wages	58778.55	0	50031.75
	Pensions	19344.99	37413.33	22033.73
	Central/state govt. scheme	517.48	1200	619.05
	Other sources	12831	16200	13332.33
	Total	264530.77	668418.67	324633.13

Source: Field Survey, 2022-23.

The differences can be seen in the fact that the average income for ASHA and ANM households in rural Punjab is Rs. 264530.77 and Rs. 668418.67, respectively. By looking at the different ways that rural female health worker households earn money, we can see that government regular services are the major source from which an average rural female health worker household earns money. An average household of female health workers earns Rs. 60040.48 from government regular services. The households of ANM workers in rural Punjab generate income of Rs. 286,165.33 from government services. The second important source of income is income from incentives. An average household earns Rs. 56952.38 from incentives. The ASHA worker households get the maximum income from incentives, totalling Rs. 66909.09. Income from hiring out labour in non-agricultural sector and private services come at the third and fourth rank. An average household earn Rs. 50031.75 and Rs. 45742.06 from hiring out labour in non-agricultural sector and private services, respectively. An average family of ASHA workers earns Rs. 58,778.55 from hiring out labour in non- agricultural sector. Income from private services is Rs. 64720 and Rs. 42424.24, respectively for the ANM and ASHA worker households. The contractual services contributed Rs. 24007.94 to the total income of an average sampled household. The households of ANM workers in rural Punjab generate income of Rs. 161,333.33 from contractual services. Income from pensions contributed Rs. 22033.73 to the total income of an average sampled female health worker household. This amount is Rs. 37413.33 and Rs.19344.99 respectively for the ANM and ASHA worker households. An average sampled female health worker household earns Rs. 21021.82 from rent of land. This amount is the highest for the ANM households followed by the ASHA worker households.

From the above analysis, it is clear that ANMs earn more than ASHAs in whole Punjab. The primary income sources for rural female health worker families in Punjab are government, services, ASHA incentives, private services, pensions, and other sources.

2.2 Income Patterns of Households of Rural Female Health Workers

Table 2 shows the information about how much of a household's income comes from different sources for the households of rural female health workers. The table shows that 18.49 per cent of the total income of rural female health worker households comes from government services. The ANM households derive 42.81 per cent of their total income from government service. The households of ASHA workers earn about 8 per cent of the total income from government services. In rural Punjab, payment from incentives is the second most important source of income for female worker households contributing 17.54 per cent to total income. The households of ASHA workers derive the highest income (25.29 per cent) from incentive payments The next important source of income is hiring out labour in non-agricultural sector contributing 15.41 per cent to total income of rural female health worker households. The households of ASHA workers earn 22.22 per cent of total income from hiring out labour in non-agricultural sector. The income from private services contributes 14.09 per cent to the total income. This proportion is 16.04 and 9.68 respectively for the households of ASHA workers and ANM workers. An average female health worker household earned 7.49 per cent of the total income from contractual services. The ANM worker households earned 24.14 per cent as transfer income.

TABLE 2

INCOME PATTERN OF RURAL FEMALE HEALTH WORKERS (PERCENTAGE OF TOTAL INCOME)

Source of Income		ASHA	ANM	All
	Farm business	8.09	4.67	7.04
	Hiring-out contractual labour	0.76	0.00	0.53
	Livestock	2.56	0.51	1.93
	Rent on land	4.92	9.99	6.48
Government Services				
a	Regular	7.75	42.81	18.49
b	Contractual	0.00	24.14	7.40
	Private Services	16.04	9.68	14.09
	Incentive	25.29	0.00	17.54

Income from wages	22.22	0.00	15.41
Pensions	7.31	5.60	6.79
Central/state govt. scheme	0.20	0.18	0.19
Other sources	4.85	2.42	4.11
Total	100.00	100.00	100.00

Source: Computed from table 1

Slightly more than 7 per cent of total income comes from farm business. This proportion is 8.09 and 4.67 per cent respectively for the households of ASHA workers and ANM workers. The next important source of income is pensions contributing 6.79 per cent to total income. This proportional share is the highest for the ASHA worker households followed by the ANM households. Income earned from rent of land contributes 6.48 per cent to the total income of an average sampled female health worker household. The ANM and ASHA worker households earn 9.99 and 4.92 per cent, respectively of their total income from rent of land. Slightly more than 4 per cent of the total income of an average female health worker household comes from other sources such as working at grain market, religious work, commercial vehicles, white washing etc. This proportional share is the highest for the ASHA worker followed by the ANM worker households

From the above analysis it can be concluded that the household of ANM workers earns major part of their income from government services and the household of ASHA workers earns major part of their income from incentive payments and hiring out labour in non-agricultural sectors.

2.3 Per Capita Income of Households of Rural Female Health Workers

The preceding discussion has examined the income patterns of rural female health worker families in both absolute and relative terms. The family size of sampled rural female health worker households in Punjab is 4.69. Nonetheless, variances in family size exist across the different categories of rural female worker families. The family size is 5.07 for ASHA families and 4.32 for ANM households. It is important to examine the per capita income levels of the different categories of rural female health worker families since the family size differs among them. Table 3 presents the per capita income of different categories of rural female health worker families. The average yearly per capita income of a rural female health worker family is Rs. 69,218.15. The per capita income for ASHA households is Rs. 52,175.69, whereas for ANM households it is Rs. 154,726.54 in rural Punjab.

The per capita income from incentive payments is the highest for ASHA workers at Rs. 13,197.06. The per capita income from government services is greatest for ANMs at Rs. 66,241.97 and the lowest for ASHA families at Rs. 4,045.00. Regarding per capita income derived from agricultural businesses, land rental, contractual services, private services, pensions, central/state government programs, and other sources, it is the highest for Auxiliary Nurse Midwives (ANMs) and the lowest for Accredited Social Health Activists (ASHA) workers. The per capita income derived from hiring out labour, livestock, and pensions is the highest among ASHA families and the lowest among ANM households.

TABLE 3:

PER CAPITA INCOME OF RURAL FEMALE HEALTH WORKERS (IN RS., PER ANNUM)

Source of Income		ASHA	ANM	All
Farm business		4220.63	7222.22	4873.59
Hiring-out contractual labour		397.70	0.00	365.94
Livestock		1338.00	783.95	1338.63
Rent on land		2567.78	15462.96	4482.26
Government Services				
a	Regular	4045.00	66241.97	12801.81
b	Contractual	0.00	37345.68	5118.96
Private Services		8367.70	14981.48	9753.10
Incentive		13197.06	0.00	12143.36
Income from wages		11593.40	0.00	10667.75
Pensions		3815.58	8660.49	4698.02
Central/state govt. scheme		102.07	277.78	131.99
Other sources		2530.77	3750.00	2842.71
Total		52175.69	154726.54	69218.15

Source: Computed from table 1

The preceding discussion indicates significant differences in per capita and family income across different

categories of rural female health worker families. The household income of ANM families is 2.52 times more than that of ASHA worker households. The per capita income of ANM households is 2.96 times more than that of ASHA worker households. As family size grows from ANM to ASHA households, ANM households' per capita income stays comparatively high.

2.4 Income Distribution Among Households of Rural Female Health Workers

Table 4 illustrates the distribution of total family income across different categories of rural female worker families. The data indicates that the bottom 10 per cent of rural female health worker families get just 5.14 per cent of the total income generated by all the households in Punjab. The top 10 per cent of families get 21.61 per cent of the total income of all rural female health worker households. The table clearly indicates that the lowest 50 per cent of households comprise only 33.02 per cent of the total income of rural female health worker households, while the top 20 per cent of households represent approximately 35.92 per cent of the total income for all female health worker households in rural Punjab. The Gini coefficient for all rural female health

TABLE 4:

DISTRIBUTION OF HOUSEHOLD INCOME OF RURAL FEMALE HEALTH WORKER HOUSEHOLDS

Description		Cumulative Percentage of Worker Income of Rural Female Health Workers		
Sr. No.	Cumulative Percentage of Workers	ASHA	ANM	ALL
1	10	4.96	6.14	5.14
2	20	11.25	13.59	11.50
3	30	17.99	20.78	18.08
4	40	25.19	28.44	25.13
5	50	33.22	36.85	33.02
6	60	42.55	46.28	42.10
7	70	53.05	56.17	52.48
8	80	64.75	66.97	64.08
9	90	79.16	80.77	78.39
10	100	100.00	100.00	100.00
Gini Coefficient		0.24	0.19	0.24

Source: Field Survey, 2022-23

worker households in Punjab is 0.24, indicating a very equitable distribution of family income among them.

A comparable scenario arises from the various groups of rural female health worker homes throughout Punjab. The bottom 10 per cent of ASHA and ANM families account for 4.96 and 6.14 per cent of the total income, respectively. Conversely, the highest 10 per cent of families from the ASHA and ANM categories allocate 20.84 and 19.23 per cent of their total income, respectively. The Gini coefficients for ASHA and ANM households in rural Punjab are 0.24 and 0.19, respectively. The above study indicates that both health worker families have a somewhat worse distribution pattern.

2.5 Distribution of Per Capita Income Among Households of Female Health Workers

Table 5 illustrates the distribution of per capita income among the households of rural female health workers. The data indicates that the bottom 10 per cent of rural female health worker households get just 4.61 per cent of the overall per capita income. The top 10 per cent of households get 26.29 per cent of the per capita income of all rural female worker families. The Gini coefficient for all rural female health worker families is 0.28, indicating a skewed distribution of per capita income among them. The table further indicates that the lowest 10 per cent of ASHA and ANM get just 4.60 and 4.72 per cent of the total per capita income, respectively. The highest 10 per cent of workers from ASHA and ANM families account for 25.95 and 22.95 per cent of the total per capita income, respectively. The Gini coefficients for ASHA and ANM households are 0.28 and 0.25, respectively, indicating a worse distribution of total per capita income among the ASHA households in Punjab.

TABLE 5 :

DISTRIBUTION OF PER CAPITA INCOME OF RURAL FEMALE HEALTH WORKER HOUSEHOLDS

Description		Cumulative Percentage of Worker Income of Rural Female Health Workers		
Sr. No.	Cumulative Percentage of Workers	ASHA	ANM	ALL
1	10	4.60	4.72	4.61
2	20	10.33	11.03	10.47
3	30	16.67	17.28	16.73

4	40	23.65	24.64	23.64
5	50	31.26	32.89	31.20
6	60	39.52	41.75	39.39
7	70	48.88	51.60	48.71
8	80	59.83	61.86	59.64
9	90	74.05	77.05	73.71
10	100	100.00	100.00	100.00
Gini Coefficient		0.28	0.25	0.28

Source: Field Survey, 2022-23.

Consequently, the above analysis indicates that the per capita income distribution is more equitable for ANM homes, but it is worse for ASHAs and average rural female health worker households.

3.0 CONCLUSION AND POLICY IMPLICATION

This study concludes that access to healthcare services remains an issue in rural India. Initially, female healthcare workers were assigned limited responsibilities; however, their training progressively broadened. The training process, characterized by its rigor, broadened the scope of activities they could undertake and subsequently improved the quality of services provided. The social status and financial rewards of these workers were significantly inferior to those of other health professionals, and they faced discrimination from senior health workers. Households of average rural female health workers and Auxiliary Nurse Midwives (ANMs) receive the highest financial support from government services, whereas Accredited Social Health Activists (ASHAs) generate the most income through incentives.

It is found that ANMs get more income than ASHAs across Punjab, where rural female health workers are employed. The annual per capita income of a rural female health worker's household is Rs. 69,218.15. The per capita income for ASHA homes in rural Punjab is Rs. 52,175.69, whereas for ANM households it is Rs. 154,726.54. The per capita revenue from incentive payments is highest for ASHA workers, whereas it is biggest for ANMs in government services. The analysis revealed that the lowest 50 percent of families account for about one-third of a percent of the overall income of rural female health worker homes, but the top 20 percent of households constitute nearly 36 percent of the total income for all female health worker households in rural Punjab. The Gini coefficient for all rural female health worker homes in Punjab is 0.24, indicating a very equal distribution of family income among these households. The distribution of per capita income is more equal among ANM families, but it is less favorable for ASHA and ordinary rural female health worker households.

The policy ramifications of raising the wages of rural female health workers extend far into the spheres of economics, health, government, and society. More public health budget reallocation and stronger fiscal commitment are necessary economic consequences of greater compensation. This will increase government spending in the short term, but it will pay off in the long run by making workers more invested, decreasing turnover, and making services more efficient. Higher family incomes, less rural poverty, and more expenditure on education, nutrition, and communal amenities all contribute to women's economic empowerment. Better pay reduces gender pay discrepancies and increases women's labor force participation, promoting gender equality and inclusion. Health policy-wise, better remuneration impacts service quality and health outcomes. Governance and institutional consequences include formalizing community health worker employment frameworks and setting salary standards. To avoid delays and corruption, payment methods must be transparent and timely, ideally digital. To avoid economic increases at the price of workload or stress, policy must address gender-sensitive issues including work-life balance, safe working conditions, and childcare help.

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