

**EXPLORING GENDERED CHALLENGES AND
VULNERABILITIES:
A QUALITATIVE STUDY OF ASHA WORKERS
IN UTTARAKHAND**

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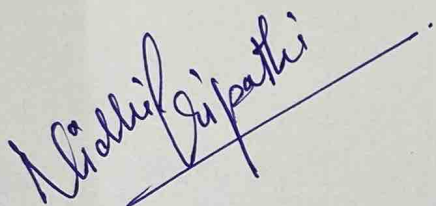
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DECLARATION

I hereby declare that this dissertation titled “**Exploring Gendered Challenges and Vulnerabilities: A Qualitative Study of ASHA workers in Uttarakhand**” is the bonafide record of my original research. It has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.



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CERTIFICATE

Certified that the dissertation titled **“Exploring Gendered Challenges and Vulnerabilities: A Qualitative Study of ASHA workers in Uttarakhand”** is a record of the research work undertaken by Dr Nidhi Tripathi in partial fulfilment of the requirements for the award of the degree of **“Master of Public Health”** under my guidance and supervision.



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GLOSSARY OF ABBREVIATION

Abbreviation	Full form
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
ANM	Auxiliary Nurse Mid-wife
BA	Bachelor of Arts
CHW	Community Health Worker
DWCD	Department of Women and Child Development
GEN	General
GoI	Government of India
HPS	High Performing State
IDI	In-depth Interview
IMR	Infant Mortality Rate
ID	Institutional Deliveries
ICDS	Integrated Child Development Services
ILO	International Labour Organization
JSY	Janani Suraksha Yojana
LMICs	Low- and Middle-Income Countries
LPS	Low Performing State
MSW	Master of Social Work
MMR	Maternal Mortality Rate
MO	Medical Officer
MDG	Millennium Development Goals
MoHFW	Ministry of Health and Family Welfare
NHM	National Health Mission
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
NCD	Non- Communicable Diseases
OBC	Other Backward Caste
PMGKP	Pradhan Mantri Garib Kalyan Yojana Package
PI	Principal Investigator
RBSK	Rashtriya Bal Swasthya Karyakram
SC	Scheduled Caste
ST	Scheduled Tribe
SHGs	Self-Help Groups
U5MR	Under-5 Mortality Rate
WCDC	Women and Child Development Centre
WHA	World Health Assembly
WHO	World Health Organization

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ABSTRACT

This study aims to understand the lives and lived experiences of ASHA workers, who navigate the dual care taker roles of home maker within the home and frontline worker within the community. It explores the challenges faced by them in an environment shaped by traditional beliefs, socio-cultural norms and taboos against working women along with structural inequalities and injustice in a selected district* of Uttarakhand.

Methodology: The study employed a qualitative approach and data was collected using in-depth interviews and photovoice methods among ASHA workers from hilly and plain regions of the selected district. Data was analyzed using QualCoder version 3.5 and thematic analysis was done for the in-depth interviews and photovoice. Gender analysis was completed using the framework by WHO.

Results: ASHAs face chronic financial instability due to irregular and inadequate compensation. Additionally, they incur personal expenses for fulfilling their professional duties. They navigate steep terrains, dense forests and remote settlements, under hazardous weather conditions, with limited or no transportation and concerns about their personal safety. Gendered norms such as ‘good women stay in the domestic sphere’, exposes them to moral policing, stigma, harassment and extremes of violence, particularly when working at night, in public spaces or while engaging with male members of the community. Institutional barriers such as disrespectful behavior by health staff and lack of facilities for their stay at health centers where they bring women for institutional delivery, further exacerbate their vulnerabilities.

Conclusion: ASHAs’ work is seen as low status work, not work that respectable women do, as they step out to work in the community spaces meant only for men. Women’s labor is normalized, they are expected to work without rest, caring for their families and communities for meagre incentives and no concern for their safety. While ASHAs try to

uplift their communities and aim for professional recognition as a Government servants, their work is belittled by their families, communities and the health system. Pressure from the community and health system causes them to neglect their health, safety and self-esteem. Yet they toil for the sense of self-worth and limited autonomy that the work brings.

*The district cannot be named as permission for undertaking the study from the Uttarakhand Govt was obtained with the condition that the district should not be identified.

CHAPTER 1

INTRODUCTION

1.1 Background

In 2005, the National Rural Health Mission (NRHM), under Ministry of Health and Family Welfare (MoHFW) introduced the ASHA (Accredited Social Health Activist) programme as part of health sector reforms. The ASHA programme was a strategic initiative aimed at enabling access to health for rural India. The programme was designed to strengthen rural health systems and to improve health outcomes by focusing on maternal and child health (*National Health Mission*, 2024). These key health indicators aligned with the success of the Millennium Development Goals for health (Millennium Development Goals (MDGs), 2018) following the commitment to Minimum Needs Programme introduced by NRHM.

The ASHA programme was introduced in 2005, after the success of the “Mitanin programme in Chhattisgarh” which served as the programme model for resource-limited settings. Chhattisgarh, after state formation in 2000, faced issues related to poor maternal mortality and infant mortality health indicators due to lack of health infrastructure and human resources (Vir et al., 2014). The state focused on introducing a local health system where people from the community were appointed to tackle the health problems. Mitanin are “female friend” called in Chhattisgarhi language, where women are selected from each hamlet and trained to assist in the community mobilization (State Health Resource Centre, 2024). Since 2002, Mitanins have served as the cornerstone of Chhattisgarh's healthcare system, actively working to address social determinants of health, including malnutrition and gender-based violence (Vir et al., 2014). Similarly in Rajasthan, before the inception of ASHA programme Sahyogini programme was running, where a woman was chosen from community for outreach services. Later, it was modified to ASHA-

Sahyogini programme (Gjøstein, 2012). ASHA supports the Anganwadi Worker (AWW) to implement Integrated Child Development Services(ICDS) programme focused on nutrition, education and child health under Department of Women and Child Development (DWCD) (Sharma et al., 2014).

ASHA workers are primarily voluntary, performance-based individuals who act as crucial link between the community and the health system (Gogoi, 2020). They are selected by local village councils based on effective communication skills, leadership qualities, and the ability to engage with the community to improve health outcomes (*National Health Mission*, 2024). Their responsibilities include conducting home visits, organizing community meetings, maintaining records, facilitating outreach services, distributing essential medicines, treating minor illnesses and promoting health awareness. ASHA workers are to be deployed at a rate of one per 1,000 persons in rural areas, and their role is to serve marginalized rural populations. Due to the immense success of ASHA programme, it has been expanded to Urban (USHA) and slum area in 2012 under NUHM (MoHFW, GoI, 2014). Typically, ASHAs have at least eight years of formal education and undergo an initial 23-day training program (Bajpai and Dholakia, 2011). They are generally married, widowed, or divorced women aged 25 to 45, chosen primarily because married women in India traditionally reside in their husband's community, making them well-placed to serve their local population (Mane and Khandekar, 2014). Utilizing the nurturing quality of women as ASHA workers has helped in the attainment of good-quality services at a very low-cost investment (Gogoi, 2020; Wahid et al., 2020).

The program was initially envisioned with ASHA workers as activists, but their role extends beyond as link worker/ facilitators for the health system. They not only help overcome socio-cultural barriers between the community and the health system, but also act as service providers, assisting ANMs, AWWs, and Medical Officers in immunization

and disease burden reduction. Today, the ASHA programme operates in a majority of Indian villages and includes nearly 10,00,000 (about a million) ASHAs serving the community (Ved et al., 2019). It is the world's largest female-based cadre, making them one of the core elements of the Indian health system.

WHO has recognized the ASHA programme design as “Community Healthcare Workers” like other countries Pakistan, Brazil, Bangladesh, China, Iran., as a fundamental element in low- and middle-income countries (LMICs) (Shakir, 2015). They are often called the "another pair of hands" for the health system (Saprii et al., 2015). In India, nearly two million female community health workers (CHWs) which includes ASHAs, who work within communities, and Anganwadi workers, who serve in childcare centers (Closser and Shekhawat, 2022). In 2022, the WHO awarded ASHA workers as “Global Health Leader” as the biggest women-based frontline workers, but the challenges faced by ASHA workers are relatively less known and often remain unaddressed. ASHA workers were envisaged as part-time “voluntary- incentive-based workers” who receive an honorarium but not a salary and were responsible for mobilizing the community for health services. But over a period, they are on standby 24*7 for the community to deliver services under many programmes of the state or center, implemented by them at a grass-roots level. They are not provided employee benefits in comparison with other government organizations’ workforce, since they are not regularized and considered as informal sector.

Despite their commendable effort for the community, the ASHA workers face numerous risk factors and barriers in performing routine tasks, as well as during emergencies. These challenges are well documented in various literature and need to be addressed. Letting these challenges unattended may disrupt a very strong workforce within the Indian Health system.

1.2 Rationale of the study

According to the WHO, 8 to 38% of healthcare workers face physical violence, verbal abuse, and threats, resulting in over 1.6 million deaths annually and numerous injuries (World Health Organization (WHO), 2022). ILO Convention, defined “workplace violence includes unexpected and unplanned acts resulting in injury, illness, or death related to work”. In a global emergency impacting healthcare systems and workers, health and welfare workers are at the highest risk (ILO, 2019). The World Health Assembly resolution WHA 60.26, “Workers’ Health: Global Plan of Action”, urged Member States “to work towards full universal coverage of all workers, particularly those in the informal sector, agriculture and industrial along with essential interventions and basic occupational health services for primary prevention of occupational and work-related diseases and injuries (WHO, 2007).

In India, a study found a high prevalence (34.5%) of workplace violence (Garg et al., 2019). ASHA workers, who face widespread violence and harassment, experience significant challenges, including gender-based violence and social harassment, with 63% of global health workers reporting similar issues (Hindustan Times, 2020; Dasgupta et al., 2017; Closser et al., 2023).

ASHA workers, despite international recognition by WHO, face significant safety risks as incentive-based health workers. Their marginalization and lack of social protection were further exposed during COVID-19. The Pradhan Mantri Garib Kalyan Yojana Package (PMGKP) Insurance scheme for health workers, provided some insurance benefits, that covers personal accidents and deaths due to risk of direct contact with COVID patients (MoFHW, 2021). Many reports suggested that 30% of ASHA workers did not receive their incentives, increasing their vulnerability to violence (Behan Box, 2021).

They encounter numerous challenges, including physical health risks due to exposure to health risks, safety insecurity, and emotional strain due to gender issues, environmental hazards, commuting difficulties, and heavy workloads. The combination of these factors, alongside inadequate safety measures, undermines their ability to effectively deliver services. To understand the issues related to their safety, efficiency, and well-being, it is essential to investigate the factors contributing to their vulnerability to physical, socio-economic, and emotional violence.

The study site, Uttarakhand, is a northern state in India with an area 53,483 square kilometers and a total population 10,086,292 with 7.46 million in rural and 4.18 million in urban areas (Census of India, 2011). It has 13 districts with varied geo-spatial diversities, the topography of state mainly hilly area (86%) and Plains (Bhabhar 14%). The state has a unique social class and caste system, predominantly Brahmins (Shah and Joshi., 2016), and this makes the state unique for the study. The state receives high inflow tourist for religious and adventurous activities, almost 300% of the state's population every year. The Socio-demographic profile of Population in districts of Uttarakhand is given in detail in Annexure 1. Table – 'Socio-demographic profile of population in districts of Uttarakhand, 2011'.

Over 80% of Uttarakhand state is prone to slope instability as well as environmental hazards (floods, soil erosion, forest fires, landslides) making it vulnerable to deleterious impact on livelihood and health of people. Details regarding distribution of district-wise ASHA workers in Uttarakhand and the risk of natural hazards are provided in Annexure 2. Thus, Uttarakhand is a state where environmental hazards exacerbate the health issues among the residents and demands that the health system be resilient to disasters, particularly of an environmental kind. Considering the Uttarakhand geography where

86% is designated as hilly area, the ASHA's vulnerability increases due to the physical risks posed by the terrain and due to limited provisioning for their safety and security. Uttarakhand has a Maternal Mortality Ratio (MMR) that is high, 101 (CI-51-152) which is comparatively similar to the overall MMR for India which was 103 (CI 94-113) for the period 2017-2019 (SRS, 2022). This could be indicative of the work load of ASHAs whose primary responsibility is maternal and child health. Indeed, the state's performance with respect to institutional delivery has improved from 68.6% for the 2016-17 period to 83.2% for the 2019-21 period (NFHS-5, 2021)

The Infant Mortality Rate (IMR) was 39.1 and the Under-5 Mortality Rate (U5MR) stands at 45.6, for year 2019-21 (SRS, 2022). The Total Fertility Rate in Uttarakhand was 1.9 for 2019-21 period, which is lower than the national average (NFHS-5, 2021), this could be indicative of the improvements in health sector across the state. District A in Uttarakhand is geographically challenging as it is divided into Hilly and Plains (bhabhar) areas thus providing a diverse geographical terrain related challenges for ASHAs. Although the population count of those whom ASHA workers have to serve is with the Guidelines, considering the difficult terrain and scattered nature of settlements in rural areas, it makes the healthcare facilities inaccessible and increases the dependency of residents on community health workers (ASHAs). District A is also prone to environmental hazards due to its terrain and monsoon season adds to the difficulties in transportation and carrying out assigned duties. This contributes to the workload of ASHAs who have to negotiate this terrain as part of their work.

In district A, about one fifth of the total population belongs to the Scheduled Castes and it has a negligible percentage (less than one percent) of Scheduled Tribe (Population Census of India, 2011). With regards to Public Health infrastructure, there are 2 District Hospitals, 4 Sub-District Hospitals, 3 First Referral units (FRUs), 8 Community Health

Centres (CHCs), 15 Primary Health Centres (PHCs), and 136 Sub Centres (SCs). In addition, 9 adolescent friendly health clinics, 1 Medical College, 1 district early intervention centre are functioning in the district. District-wise distribution of health facilities in Uttarakhand is provided in Table 3 Annexure 3.

District A, which is both difficult in terms of terrain and includes both hilly and plain lands and has forest cover and a shortfall in ASHAs for hilly terrain has been selected for this study because the work of the ASHAs is challenged by the terrain. In addition to the work load, this district poses additional risks for ASHA workers in terms of distances to cover, work load and nature of terrain which is prone to landslides and floods. This district has not been named and its specific features have not been mentioned as it would breach the confidentiality of workers within the district. Secondly, permission to undertake the study was conditional upon not mentioning the specific district in the thesis.

1.3 Research Question

How does the difficult environment and gendered contexts of women's lives shape the working of ASHA workers?

1.4 Objectives

1. To identify the economic, socio-cultural and environmental challenges experienced by ASHAs in their work in a selected district of Uttarakhand
2. To identify the vulnerabilities to physical and emotional violence due to these challenges
3. To describe the consequences of these challenges on the ASHAs work process, and
4. To describe the gendered nature of these challenges

1.5 Chapterisation plan

This thesis consists of 5 chapters, of which this constitutes the first. The first chapter, the Introduction, introduces the broad topic of interest, the site of research, the rationale for undertaking the study and specific objectives of the study. The second chapter outlines the relevant literature reviewed for the study. The third chapter described the methodology employed to achieve the objectives, including the research design, sampling strategies, the methods of analysis and expected outcomes. It also describes the ethical challenges in undertaking the study. The fourth chapter provides the findings of the study under the title 'Results'. The last and fifth chapter provides the discussion and conclusions drawn from the results.

CHAPTER 2

REVIEW OF LITERATURE

2.1 Type of Review

The review of literature was done as scoping review following the framework outlined by Arksey and O'Malley(2005) and guided by PRISMA-ScR. The review consisted of the following stages-

1. Identifying the Research Question: The Review explored the intersection of challenging physical environments and gendered experiences of ASHA workers, specifically examining the risks, safety and well-being.
2. Identifying the Relevant Studies: Three databases searched included PubMed, Google scholar, and Google along with the grey literature, newspaper and blogs. The key search terms were –“ASHA workers” AND “Challenges”, “Risk and Safety”, “Violence”, “Roles and Responsibilities”, “Gendered experience” OR “Norms”, “Covid-19”. The search was done as “Title/Abstract” with duration from 2005-2024 and filtered as full text articles.
3. Study Selection: The articles were screened based on relevance to the research question. Studies focusing solely on ASHA Programme assessments or risk related to the themes were excluded.
4. Charting the Data: Data was extracted and re-grouped into thematic categories such as Occupational barriers; Gendered risk and societal barriers; Challenges during Pandemic; and Empowerment and exploitation: Duality of ASHAs Programme.
5. Collating, Summarizing and Reporting results: The findings were synthesized to highlight the intersection of gendered experiences and occupational challenges

faced by ASHA workers while performing their task, as well as the gaps in the literature to be further addressed.

The search yielded total of 97, 1370 journal articles through PubMed and Google scholar, respectively. Through In-text citations, 10 additional journal articles were reviewed.

Apart from these, newspaper websites like The Hindu, Deccan chronicle, The Hindustan and 2 Individual blogs were also considered. In total, 54 journal articles and others were included in literature review. After initial screening, the focus shifted to ASHA workers risk to physical environment and gendered challenges. This shift allowed specific aspect of their challenges including concerns related to safety of ASHA workers and factors which impact their work and leading to vulnerability to be considered.

Fig.1 Flowchart of literature review process from PubMed

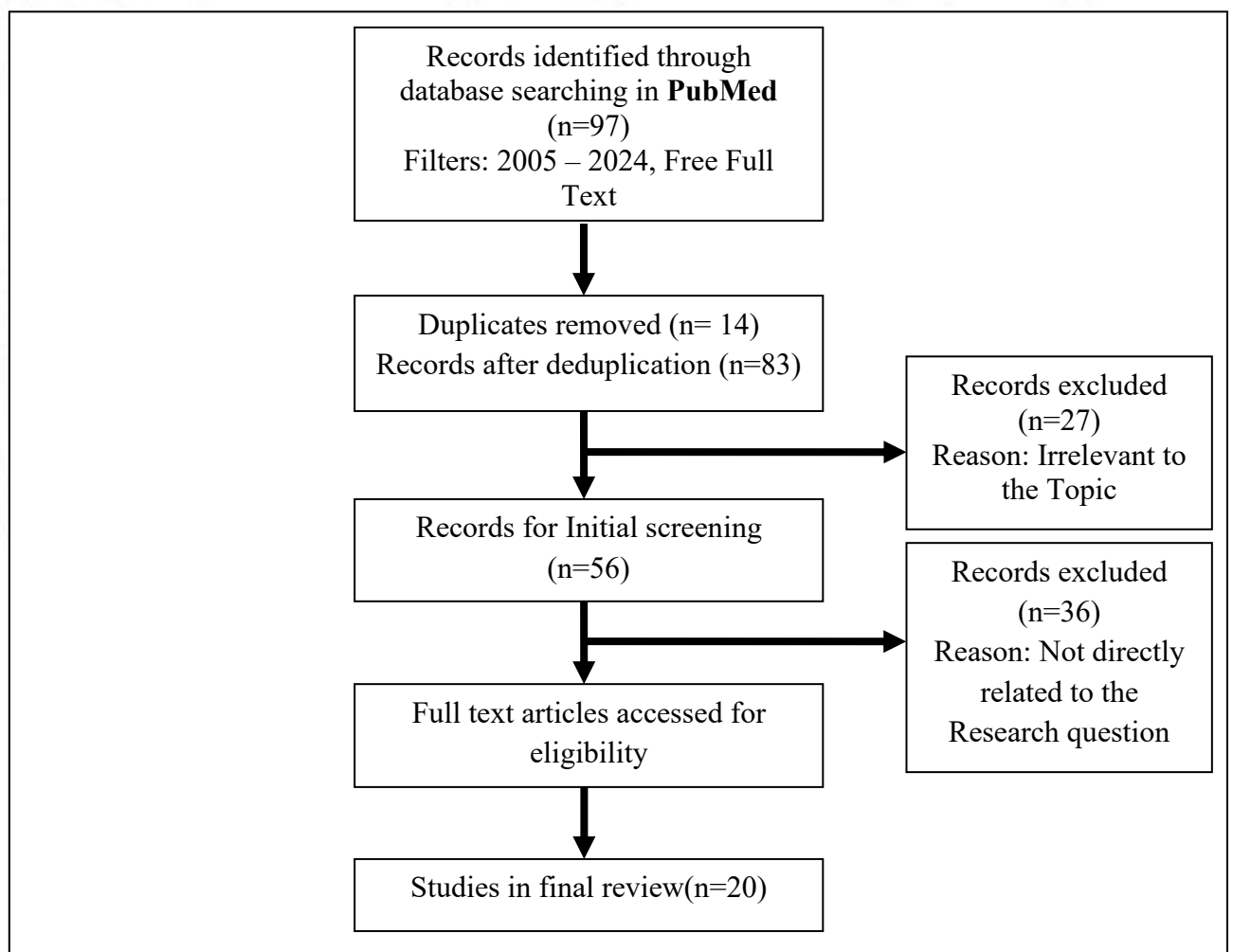
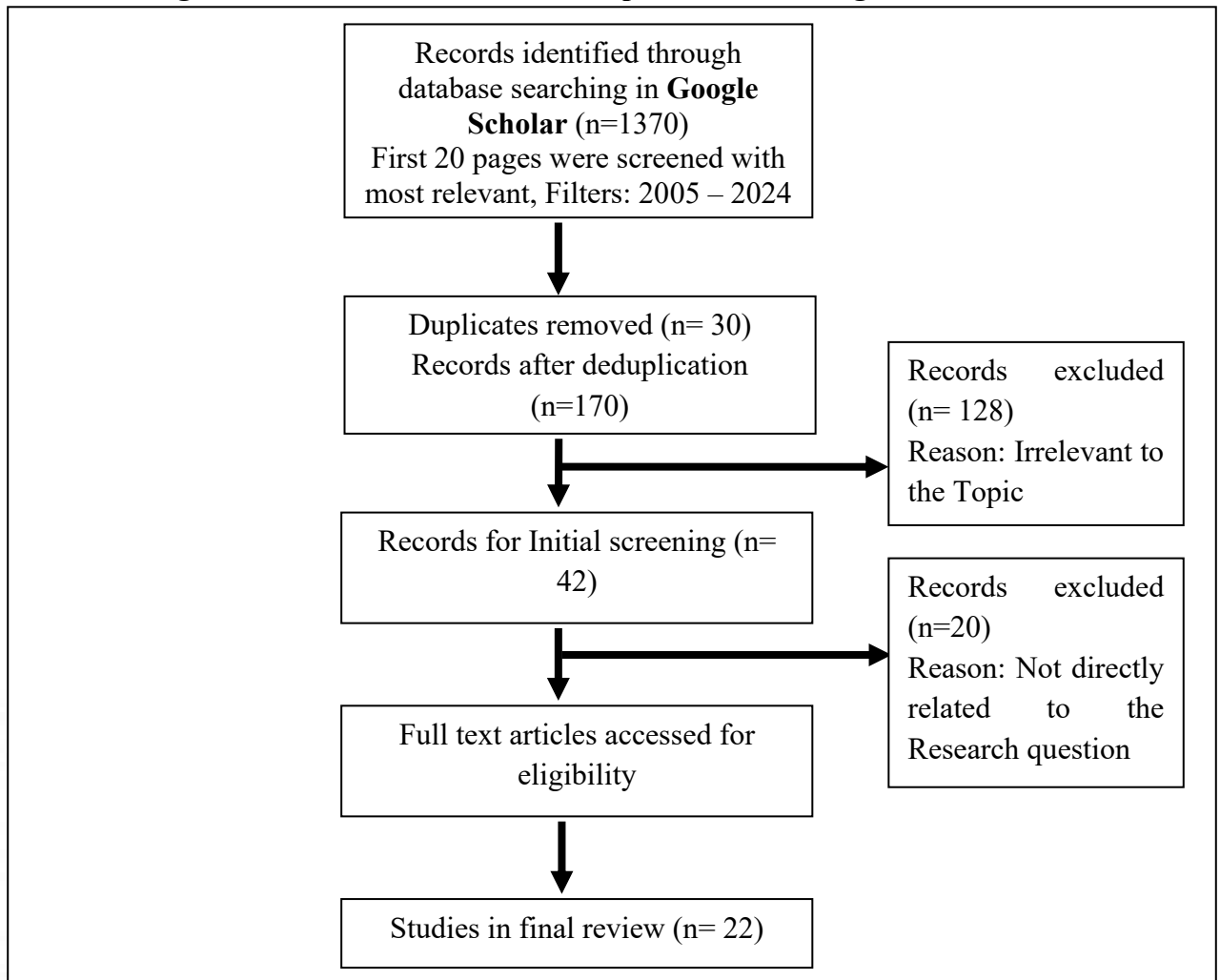


Fig.2 Flowchart of literature review process from Google Scholar



The studies were grouped under different sections such as economic, sociocultural, and environmental and gendered risk faced by ASHA workers while performing their task. There was overlapping of sections in papers where the workload was also discussed, community expectations and support system, along with those that highlighted the gaps in the policies regarding safety of ASHA workers. There were notable gaps with respect to physical and emotional violence against ASHA workers. Some studies used the terms like abuse, threat but further explorations were not addressed which may have directly contributed to building an understanding of the violence against ASHA workers. This research gap is the focal point for study objective, specifically examining the intersection of gendered and other risk factors affecting the ASHA workers in terms of safety

concerns and their well-being and how they are physically and emotionally abused due to various risk factors. Finally the literature review is done thematically and grouped under subheading as Occupational barriers; Gendered risk and societal barriers; Challenges during Pandemic; and Empowerment and exploitation: Duality of ASHAs Programme.

2.2 Occupational Barriers

ASHA workers are grass root level workers engaged in diverse programmes such as Non-Communicable Diseases(NCD), oral health and mental health. Their primary focus, however remains on Maternal and Child Health. From the period when ASHA workers were initially envisioned, their roles have evolved as link workers and service facilitators (Fathima et al., 2015). ASHAs work in community has shown dividends in terms of successful utilization of maternal services, aligning to the programme's objectives (Agarwal et al., 2019) and with success, additional responsibilities were thrust upon ASHAs. They are now engaged in multiple government programmes, which has led to increased workload, unclear job role, multiple training and meetings and excessive documentation, consuming considerable time and effort (Abdel-All et al., 2019; Khandre et al., 2022; Sharma et al., 2014). Across India, ASHA workers reported excessive workloads, remote population coverage, extended working hours, and underpayment (Bajpai and Dholakia, 2011; Manjunath et al., 2022; Saprii et al., 2015).

ASHAs' primary source of income is through the Janani Suraksha Yojana (JSY) programme, where they escort pregnant women for Institutional deliveries(ID), as outlined by Government of India (GoI) guidelines and incentivized (Saprii et al., 2015). ASHAs assist in enrolling women for JSY benefits and handle related documentation. For each institutional delivery in rural area of Low Performing State(LPS), ASHA workers receive an honorarium of ₹600 after verification and the mother will receive ₹1400 (Janani Suraksha Yojana: National Health Mission, 2024).

The programme classifies states into high performing states (HPS) and low performing states (LPS) based on Maternal Mortality Rate(MMR) and Infant Mortality Rate(IMR). Each beneficiary should be registered under this yojana, with JSY card and MCH card. ASHA/AWW/Other link workers should identify the beneficiary under supervision of (ANM) and Medical Officer (MO). ASHAs are supposed to collect proper documents from the beneficiaries such as AADHAR CARD (identity card issued by the Govt of India), ration card, bank details and MCH card. The hesitance to share information, suspicion to share bank details and encouragement for hospital delivery adds to major obstacles for ASHA workers (Gore et al., 2022; Saprii et al., 2015). ASHAs face significant pressure from the health system to secure organizational goals and their being the primary contact to community leads to expectations of them (Kandpal et al., 2024). The resistance from the served community results in emotional, economical and reputational harm, adding to the anxiety and stress (Bhatia, 2017).

Operational Challenges, such as non-availability of staff, shortage of medicines, lack of diagnostic test and ASHA kit, and difficulties related to travelling leads to aversion of government facilities (Saprii et al., 2015; Sarin and Lunsford, 2017; Saxena et al., 2012). These issues not only undermine their efforts but also erode community trust in health system. ASHAs often incur personal expenses for the institutional deliveries and transport, leading to financial burdens and indebtedness. These factors collectively impacts ASHAs performance, motivation and effectiveness in fulfilling the community expectations and programme objectives (Neogi et al., 2016; Shah and Velhal, 2020; Sharma et al., 2014).

ASHA workers reported that geographical barriers exacerbate challenges in rural India (Pandey et al., 2018; Saprii et al., 2015). They travel long hours to scattered villages, often on foot, to visit households for counseling, surveys, and provision of basic

healthcare services (Saxena et al., 2012; Sharma et al., 2024; Shukla and Bhatnagar, 2012). Remoteness of villages, odd hours for escorting of women for deliveries, management of the transport, restriction in mobility due to improper roads connectivity, and risk of attacks from animals in hilly forested areas heightens their risk and discomfort to perform their role in the community (Bhatia, 2017; Meena et al., 2020; Shah and Velhal, 2020). They face significant threats to their physical safety due to geographical and environmental barriers (Kandpal et al., 2024).

Financial instability remains a significant challenge and disappointment for ASHA workers. Despite their workload, ASHAs are paid inadequately and often delayed payments add to their financial stress and emotional strain (Parmar et al., 2024; Saprii et al., 2015). ASHAs are also often humiliated and questioned by families and communities for delayed and inadequate payments (Gogoi, 2020; Pavithra A.V. and Lokesh M.U., 2023; Rizvi et al., 2023). It is reported, Front Line Workers (FLWs) under India's social development schemes receive meager honorariums, often far below the statutory minimum wage (Remesh, 2017). Although some states have fixed basic amount for ASHA workers, it is not sufficient for the amount of work they perform and the additional financial burden involved in completing their designated tasks pushes them to financial indebtedness (Mutha, 2020). Despite facing substantial risks in the performance of their duties, ASHA workers maintain a steadfast commitment and motivation to serving their community, driven by a sense of duty, even in the face of potential threats, economic crisis, emotional strain and physical vulnerabilities to their well-being and life (Gopalan et al., 2012; Wahid et al., 2020).

These challenges not only expose ASHA workers to physical and emotional risk in their day-to-day work but also highlights the vulnerability of ASHA workers as women.

ASHAs are first caregivers, often bound to face emotional distress and physical risks

while performing their duties within their communities. Addressing these concerns is crucial, where safety of ASHA workers should be at the center of health care policy, along with provision for fair compensation, recognition and understanding the intersection of gendered risk and occupational hazards.

2.3 Gendered Risk and Societal Barriers

The societal structures and ideologies associated with ASHA workers role add another layer of complexity to their work and further marginalization (Das and Das, 2021). In many Indian communities, women are restricted from travel alone and must seek permission from their family members. Traveling at night and working along with menfolk is particularly frowned upon, as it is seen as a breach of social norms (Babu and Babu, 2021; Dasgupta et al., 2017; Ved et al., 2019). ASHA workers often encounter disrespectful behavior from family members, the broader community, and even higher officials in the form of verbal abuse, lewd comments, and even rape as reported in some case studies (Census of India, 2011).

Behan Box (2021) reported that ASHA workers are often exploited under the guise of being voluntary workers, resulting in a violation of their human rights. A study done in Uttar Pradesh showed that ASHA workers are often referred to as "bahu," or daughter-in-law, a term that reflects their traditional roles within family and community structures. While this designation symbolizes their deep integration into local societal norms, it also highlights the inherent conflict they face as female health workers. Along with their work as an activist they are supposed to do household chores. ASHAs are tasked with addressing sensitive issues like reproductive health, menstrual hygiene, contraceptives, support to abused woman and family planning—topics often deemed inappropriate for women, especially those traditionally seen as obedient daughters-in-law (Dasgupta et al., 2017).

During 1990s there was Sahyogini programme in Rajasthan, where a woman is appointed from community called “Saathin” under WCDC (Women and Child Development Centre) for outreach services. The woman worker belonged to lower caste, was sexually abused by affluent and dominant caste group of village because she campaigned against child marriage as part of her job; her actions were considered as a challenge to patriarchy and feudal mindset that supports such cultural practices. She was victim of sexual assault, accused of lying when she openly talked about it (BBC, 2017). This incident and the legal fight to bring justice to the health worker led to formulation of Vishakha guidelines, 1997 by the Supreme Court of India. ASHA workers often feel unsupported by the department, perceiving a lack of meaningful backing in their roles. Their limited awareness of legal protections adds to this sense of isolation (Garg et al., 2019). The stigma and shame surrounding their challenges, coupled with the lengthy and arduous process of seeking justice, leave many feeling abandoned, even when laws are in place to safeguard their rights (BBC, 2017; Closser et al., 2023).

ASHA workers, as a women-based workforce, and positioned at the lowest level of the healthcare hierarchy, encounter patriarchal barriers and discrimination influenced by village power structure, gender and class dynamics (Ved et al., 2019). ASHAs are expected to bridge socio-cultural barriers and advance public health initiatives. However, they constantly navigate between the traditional expectations of their roles within the community and the government’s broader health agendas, which often clash with local norms. ASHAs find themselves in a continuous negotiation between these conflicting demands: advocating for change as mandated by the government while respecting the conservative values of the very communities they serve (Sarin and Lunsford, 2017). This dual pressure forces them to balance the expectations of their superiors with the cultural constraints of their communities, challenging deeply rooted patriarchal norms while

striving to implement health programs effectively (Gjøstein, 2012). However, these roles often conflict, particularly in sensitive areas like reproductive health, where state agendas may clash with local social values, ideals of kinship, gender norms, and societal maintenance (Kalia, 2024; S and N S, 2022; The Hindustan Times, 2020).

Globally, Community Health Workers (CHWs) play a vital role in fragile and conflict-affected areas, effectively delivering services under challenging conditions (Gilmore et al., 2016). In India, conflict zones such as Kashmir, Assam, Manipur, and Chhattisgarh rely heavily on CHWs, including ASHA workers, to provide essential healthcare services (Armstrong et al., 2014; Malla et al., 2019). However, their contributions often go unrecognized, and they face numerous challenges in these volatile settings. Conflict zones lead to the displacement of communities, creating insecurity and complicating healthcare delivery. ASHAs have frequently expressed fears about working in unfamiliar and hostile environments (Sinha and Liang, 2021). They struggle with access to healthcare facilities, as many district hospitals are located far from conflict zones. The ongoing internal ethnic conflicts that occur foster distrust, leading to hostile attitudes towards ASHA workers, who face non-acceptance, threats, and a breakdown in community rapport built over time. Research from Assam highlighted that ASHA workers often hesitate to serve in other ethnic communities due to personal safety concerns (Rajbangshi et al., 2021). They face both practical and social barriers, such as arranging transportation for pregnant women in conflict zones, where even private and government ambulance drivers are reluctant to enter. The heightened risk of collateral damage puts ASHAs in danger, adding to the burden on their families. ASHAs often become scapegoats for community dissatisfaction in the absence of support from other healthcare providers, due to their positioning in community as caregivers. During emergencies, they continue to work despite personal safety risks, frequently feeling undervalued and under-

compensated by senior officials. The expectation that they would work tirelessly without adequate recognition or financial remuneration leads to burnout and emotional exhaustion. Subsequent studies across India have consistently found similar issues and have led to calls for reforming the ASHA program to enhance their motivation and capability to contribute to PHC system's performance (Gopalan et al., 2012; Saprii et al., 2015).

There is need to understand the barriers ASHA workers face in conservative setup and their perspectives related to safety. Due to lack of legal awareness and support system, ASHAs are further exposed to violence, exploitation and emotional harm (Closser et al., 2023; Garg et al., 2019).

2.4 Challenges faced during Pandemic

During the COVID-19 pandemic, ASHA workers played a crucial role in India, demonstrating remarkable resilience and unwavering commitment (Nichols et al., 2022; The Hindustan Times, 2020). ASHA workers had to navigate flood-affected areas by boat in Assam, trek steep slopes in hilly terrains during the pandemic for ANC visits during pandemic further risking their lives (Gore et al., 2022). During quarantine, ASHA workers had to monitor individuals, check health status, and record data. While everyone was advised to stay home to avoid the virus, ASHA workers educated and informed about the control of disease and stigma attached to the virus by house-to-house visits and their supervision (Sankar D et al., 2024). ASHA workers, as the face of the healthcare system within their communities became targets of verbal abuse and threats, also bore the brunt of community anger, humiliation and distrust particularly when there was widespread fear of forced isolation in hospitals or quarantine centers (*Hindustan Times*, 2020; Kalia, 2024; Rizvi et al., 2023). ASHAs significantly helped the health system in achieving the goals in multiple outreach programmes. There is ambiguity within health system about

the ASHA's role and this leads resistance in acceptance by the community. They were not only subjected to physical risk to virus due to improper protection measures such as lack of good-quality masks, sanitizers, and PPE kits (Gogoi, 2020; Schaaf et al., 2020), but faced humiliation and insult from families and communities who blamed them for the virus's spread. Despite their previous work and rapport with locals, ASHA workers' efforts went unrecognized, and their safety was repeatedly compromised by the community and the government (Nair et al., 2024; Nichols et al., 2022). This not only damaged their morale but also exacerbated the social stigma surrounding disease, heightening both emotional violence and physical threats (Parmar et al., 2024). In states like Bihar, Madhya Pradesh, Delhi, Assam, and Jharkhand, several ASHA workers have died due to COVID-19 infection, road accidents, and exhaustion while performing their duties (Bist et al., 2023; Singaraju and Mandela, 2020; The Wire, 2021).

During COVID-19, Government announced, that the ASHA worker will be paid Rupees 1000 extra for their work in addition to their other incentives but 30% of them didn't receive the amount (Ambast, 2021; Behan Box, 2021). Many of frontline workers were unaware of the government schemes and benefits during pandemic. In rural areas, the remoteness of village housing, inadequate road conditions, lack of lighting, and long commutes to health facilities, coupled with the unavailability of ambulances and transportation, exacerbate their vulnerability. In addition as women they had menstrual difficulties, non-availability of water and food during visits (Brahmachari, 2021) during the pandemic. The studies reported that ASHA workers feel undervalued and unsupported due to less payment for the amount of work they performed. They were emotionally abused not just in public but private space when they had to work without receiving incentives during COVID-19 (Gogoi, 2020). They often faced pressure from families to

discontinue work due to low payment and risk they would bring to the families (Gogoi, 2020; Parmar et al., 2024).

2.5 Empowerment and Exploitation: Duality of ASHA programme

ASHA workers hold positions in Self-Help Groups (SHGs) and Village Health and Nutrition Committees (VHNC), which have empowered many women, enhancing their leadership skills, boosting self-confidence and personal growth (Gopalan et al., 2012).

ASHAs have become role models in rural areas, experiencing increased autonomy, self-empowerment, and a heightened sense of community standing. Their work has enhanced their interpersonal skills and leadership qualities, enabling them to navigate public health challenges boldly, such as reproductive health, family planning, and menstrual hygiene—topics often considered taboo in rural settings. Their work has allowed them to gain an identity beyond traditional roles, such as wife or daughter, challenging societal norms that restrict women's roles (Dasgupta et al., 2017).

Despite the positive aspects, many ASHAs feel unappreciated by the health system and supervisors, with frequent reprimands and blame, particularly when targets are not met or when community expectations clash with official duties (Wahid et al., 2020). The lack of clear role definitions in SHGs and VHNCs, combined with top-down pressure to meet unrealistic targets, contributes to their de-motivation. ASHAs also experience heavy workloads due to expanding public health priorities and changing trends, including additional tasks like data collection for surveys, voter registration drives, and open defecation campaigns, often starting early in the morning and extending late into the evening. ASHA workers are often subjected to gendered challenges such as balancing the traditional familial roles within their homes along with the duties, enduring the financial and emotional pressure (Bishnoi et al., 2025; Meena et al., 2020).

ASHAs also face power imbalances with their supervisors, who have control over their incentive payments, often using this power to withhold funds if performance criteria are not met. The rigid, command-and-control supervisory approach often overlooks the individual needs of ASHAs, leading to dissatisfaction, de-motivation, and burnout (Bhattarai et al., 2023; Pulagam and Satyanarayana, 2021; Richa and Narula, 2021).

Along with the organization, ASHA selection is influenced by bias and favoritism to position and power in the community (Closser and Shekhawat, 2022). While the ASHA program has created opportunities for women's empowerment and community leadership, it has also exposed ASHA workers to exploitation, financial insecurity, and increased workload without adequate support (Behan Box, 2021).

Despite the extensive research on ASHA workers, few studies specifically address the gendered challenges women face while performing the assigned tasks in their community. All of these factors increase the risks and vulnerabilities of ASHA workers in their daily life along with societal expectations, organizational pressure and lack of recognition. The study aims to examine the intersection of challenging physical environments and gendered experiences of ASHA workers, who are the women selected from the community, for the community. As women, they face restrictive norms domestically limiting their public roles. Therefore their work is seen with same societal expectations that govern their lives in the communities. The physically demanding terrains and unprecedented environmental conditions, amplify challenges and responsibilities of ASHA workers. This study seeks to examine as to how these intersecting factors impact their work and well-being.

CHAPTER 3

METHODOLOGY

3.1 Study Type/Design

This is a Qualitative study using in-depth interviews (IDI) guidelines and photo narrative technique (photovoice) among ASHA workers in a selected district of Uttarakhand. The qualitative approach was chosen to explore how gender intersects with the challenges faced by ASHA workers in their setting. The study also examined how these challenges impact their work process using the in-depth interviews. The photovoice was used to supplement the information about the context of work and the difficulties experienced by ASHAs.

3.2 Study Setting

The study was conducted in the rural areas of District A, Uttarakhand, India. Uttarakhand is a northern state of India, spanning an area 53,483 square kilometers, with a total population 10.1 million. Of this, 69.8% resides in rural areas and 30.2% constitutes the urban population (Census of India, 2011). It has unique social class and caste system, predominantly Brahmins (Shah and Joshi., 2016). The geography of the selected district reveals that 71.6% of the area is forested, making ASHA workers' jobs more challenging and increasing the vulnerability to the physical risks posed by the terrain and scattered nature of population in rural areas.

3.3 Sample Size

I proposed to interview 15-16 ASHA workers across various settings, considering the participants' characteristics such as area of work (hills or plains), age, experience and social classification (Hindu/Muslim, SC/ST category). A total of 16 interviews were completed until information saturation was achieved.

3.4 Sample Selection

The ASHA workers were selected in 'A' district of Uttarakhand. The name of the district remains undisclosed to maintain the anonymity of ASHA workers. Initially, ASHA workers were selected based on convenience and later purposively, incorporating the diversity in participants selection. The samples selection included variation in age, years of experience, education, marital status, family structure, geographical location, socio-economic background and social classification to ensure a comprehensive understanding of their challenges.

Demographic details of ASHA workers

- **Age Range:** The participants' age ranged from 28 years to 56 years, with most ASHA workers in their 40s.
- **Experience:** The years of experience varied from 4 years to 18 years, reflecting veterans and new-comer ASHA workers.
- **Education Level:** Twelve of the ASHAs had an education upto 12th standard, other progressed to BA and MSW.
- **Marital Status:** 15 out of 16 ASHA workers were married during the study, while one was widowed.
- **Family Type:** The sample included ASHA workers from nuclear, stem and joint family, influencing their responsibilities at the household level.
- **Geographical Diversity:** The ASHA workers operated in hilly regions, remote forested areas and plains (bhabhar), exposing them to geographical challenges with other environmental challenges. Uttarakhand has proneness to landslides and flooding.
- **Work Environment:** Mostly ASHAs had to cover the forest areas or region with difficult terrains (Nalla), which poses physical risk and limited accessibility.

- **Socio-Economic Background:** Mostly ASHAs came from financially unstable background, necessitating them to work other than household related activities to supplement their income.
- **Social Classification:** The sample primarily consisted of ASHA workers from General category, as the selected district has high percentage of General category (GEN). To maintain the diversity other categories like Scheduled Caste (SC) and Other Backward Classes (OBC) were identified.

This diverse selection allowed to capture a broad spectrum of challenges, showcasing impact of location, financial instability and social background affecting their personal and work lives.

3.5 Data Collection Techniques

For data collection, In-depth Interviews (IDI) and photovoice were employed. In-depth interview is a well-established qualitative research tool, particularly for exploration of personal experiences and perception. In this study, In-depth interview guide was used to explore the challenges faced by ASHA workers and how they perceive gendered challenges and vulnerabilities in their work. These interviews allowed participants to provide detailed, personal insights into experiences, which was crucial in this study. The interview guide contained semi-structured, open-ended question to elicit in-depth responses. The question was grouped as per the study objectives – economic challenges, sociocultural barriers, environmental challenges, perceived risk of physical and emotional violence and impact on their work and concerns related to their safety and well-being. The indirect and probing questions approach helped in deeper understanding of specific experiences related to safety concerns, gendered challenges and vulnerabilities faced by ASHA workers. Photovoice was also employed for further understanding of the study

objectives related to gendered challenges, risk and experiences related to safety and well-being.

Photovoice is a participatory method. It empowers the participants to voice their strengths and concern, in socially stigmatized condition and status through photographs (Wang and Burris, 1997) . According to C.C.Wang , the goals of photovoice is to record and reflect, promote critical dialogue and knowledge about community issues through discussion on photographs and to reach the policymakers regarding the concerns emerging after the discussion from the photographs. Photovoice helps in understanding the viewpoint and the needs of the people who living under that condition. It is a powerful tool for communication and highlights different perspectives (Budowski and Beutow, 2010; Tsang, 2020). As per the SHOWED technique by Wang and Burris, (What do you See? What is Happening? How does this relate to Our lives? Why does this Exist? What we can Do about it?), these questions were asked. This provided deeper insights and clarification of photographs meaning along with verbal narrative.

Photovoice enabled ASHA workers to document visuals related to gendered challenges they face along with other risk factors during their work and field visit. They captured the moments which amplified their concerns related to their vulnerabilities. This supplemented the verbal narratives from the in-depth interviews held with ASHA workers.

3.6 Data Collection and Analysis

3.6.1 Preparations for Data Collection

Data was collected from 16 ASHA workers in District A, with all the interviews conducted by Principal Investigator (PI). The list of participants was provided by the district's National Health Mission (NHM) office and included ASHA workers from various blocks within the district. Based on PI's convenience and feasibility, four blocks

were selected to reach out to ASHA workers through ASHA coordinators assigned to each block.

Initially, 20-30 ASHA workers were contacted, but only four agreed to participate in interviews. Subsequently, additional ASHA workers were approached with the assistance of relatives and existing participants, using characteristics based on emerging themes during the initial data collection process. The availability and familiarity in using camera phones were considered for the selection of ASHA workers. The selected ASHA workers were requested to click at least 5-6 photographs over a period of 7 days till the interview. They were asked to record photographs and caption the photographs. Flexibility was given to ASHA workers to work with camera phones and no restriction on number of photographs clicked. They were informed about the photographs they were expected to click to elicit further information. Specifically, they were asked to photograph sites, symbols and situations that made them feel unsafe or threatened while performing their work. The basics of capturing photos and captioning them were conveyed to the ASHAs through phone calls. ASHA workers were informed about the ethical aspects of photography including refraining from photographing individuals without their consent, and refraining from photographing children below 18 years of age. The photographs were sent by ASHA workers through WhatsApp with captions to be documented further. A total of 15-20 Photographs and 2-3 videos were received from the participants who agreed for the Photovoice component. The date and time for the interviews were fixed as per the convenience of PI and specific ASHA worker.

3.6.2 Interview Procedure

The participants' interviews were conducted at various locations including ASHA's homes, villagers' residences, common meeting points and restaurants (travel to this meeting point was reimbursed). Each interview lasted between one to two hours.

Throughout the process, ASHA workers were reassured regarding their anonymity, and sensitivity was exercised when addressing the study questions. In case of participants who didn't have camera phones, PI accompanied them on field, captured photographs and maintained field notes.

The interviews were audio-recorded in PI's phone with prior consent, both oral and written on the day of interview. The audio- recordings and photos are securely saved in PI's phone and laptop, with PI bearing the sole responsibility for ensuring their security and handling any breach of confidentiality. There were moments where the ASHA workers got emotional and interviews were stopped, and continued later only after ASHA workers' comfort.

3.6.3 Data analysis

The interviews were translated into English in MS word, from the original language Hindi and local language terms were retained in instances where translation proved challenging. Finally, the interviews were coded using QualCoder version 3.5. The translated transcripts were iteratively analyzed to identify emerging themes and to further plan the interviews. An inductive approach was employed throughout the study, allowing the emerging themes to be identified and recorded. All the 16 interviews were coded and primary codes were established after completion of data collection. The codes were regularly peer-briefed to ensure alignment with the transcripts' coding done by the PI and further validated by guide.

A total of 82 primary codes were identified after thoroughly reading through the interviews. A codebook containing the primary codes and excerpts from the interviews were maintained in an Excel spreadsheet. This code-book has been attached to the thesis as Annexure 4. Through continuous reading of interviews and discussions with the guide, 15 axial codes were generated. Finally themes were identified from linking the axial

codes resulting in seven themes. These seven themes were analysed using a gender analysis framework to holistically address all the study objectives (World Health Organization, 2003). The photos shared by the participants has been attached in Annexure 5 as part of study.

3.7 Ethical Considerations

The study was conducted only after obtaining approval from the Ethics Committee of Sree Chitra Tirunal Institute for Medical Science and Technology (SCTIMST) (SCT/IEC/2324/DECEMBER/2024). Written consent was obtained from the participants for both Interviews and Photovoice, and they were informed about the potential risks involved in the study. Ethical guidelines regarding the use of images were adhered to, and participants were made aware of these rules. No photographs were taken as part of study will be part of the dissemination without written consent of both ASHA workers and the individual photographed.

The interviews were conducted in environment where participants feel safe and comfortable. The information collected was shared solely during the interview and later with the guide. Considering the sensitive nature of study, the confidentiality of ASHA worker was safeguarded by assigning each participant a unique ID. Measures were taken into consideration to ensure that no participants face any risk or repercussions as a result of their involvement in the study.

3.8 Expected Outcomes

The study aimed to examine the gendered context of ASHAs' life, affecting the way they work in the community. The study also provided insights into how gendered challenges, along with socio-cultural, economic and environmental factors, affect ASHA workers and increases their vulnerability. The findings of the study would help to document the

suggestions for improvement in terms of safety measures which will enhance the working contexts of ASHA workers and their well-being in Uttarakhand.

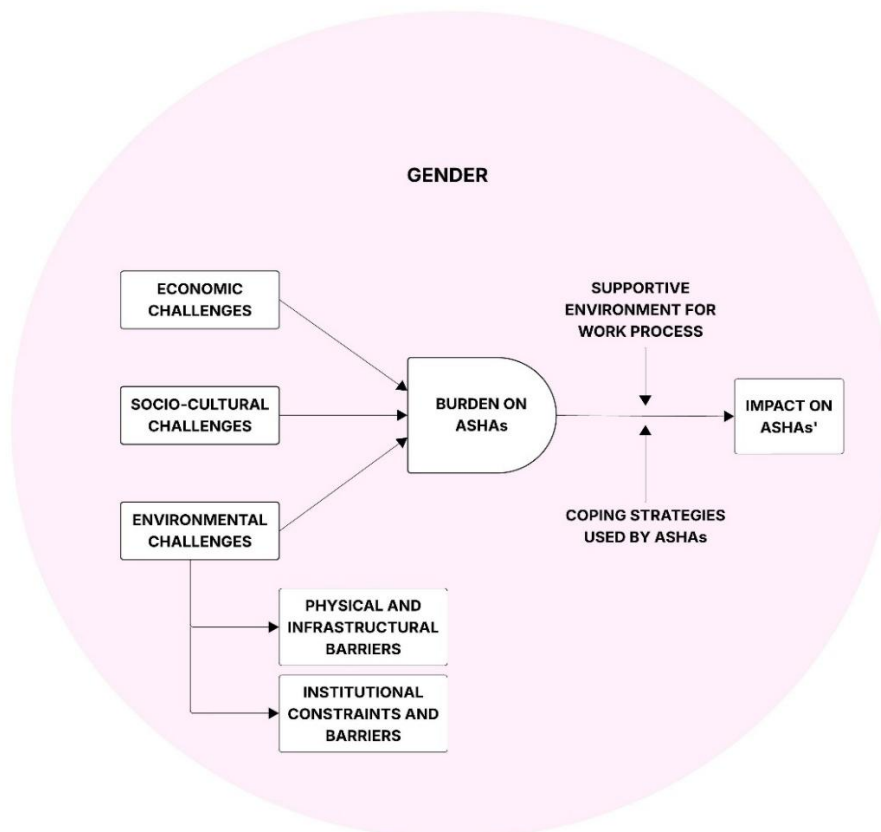


CHAPTER 4

RESULTS

This chapter presents the finding of the study conducted to explore how gender intersects with the challenges faced by ASHA workers in their everyday work environment, and how these challenges influence their work processes. The narratives derived from in-depth interviews and photovoice method were carefully analysed. Through Thematic analysis, seven themes emerged aligning with the core objectives of the study and these are carefully described in the first section of the study. Using gender analysis, these themes were further reviewed to determine how gendered norms, values, roles, and responsibilities shape the ASHA's work in district "A" of Uttarakhand state.

Fig. 3 Schematic diagram of multi-dimensional challenges faced during ASHAs' work



4.1 Thematic Analysis

4.1.1 Economic Challenges

ASHA workers face profound economic insecurity and financial difficulties due to informal nature of their work and inconsistent payments. Despite their critical role in bridging healthcare access in rural and marginalized communities, they are deprived of fair compensation and financial stability. This systemic negligence not only undermines their economic well-being but also enhances the inequities, ultimately pushing them further into poverty. This section describes the multifaceted challenges encountered by frontline workers, who are predominantly women from socio-economically disadvantaged background.

Income-related issues

ASHA workers are the female-dominated volunteer cadre, primarily employed to deliver maternal and child health services at the community level. They are compensated through service-based incentives and minimal honorarium. However, there have been consistent sense of inadequate compensation for ASHA workers throughout the narratives. The financial remunerations does not reflect labour-intensive nature of their work and is often undervalued in comparison to other professions.

“The daily wage labourer also earns Rupees 700/day.. for a month they also get 19,000-20,000Rs, but we are not even that.. neither weekly we get.. in one week there is Wednesday, on that day whatever we earn it is that, 2,000-3,000Rs government gives us as incentive money.. that too, it comes in 2-3 months...”

-ASHA worker, highly educated(MSW) and town area

The lack of fixed salary, combined with their informal status as volunteers, contributes to the absence of monitoring and accountability for timely payments. Instances of irregularities in payments, along with substantially lower amounts claimed leaves ASHA workers financially strained and unable to meet basic needs.

“PI- As an ASHA worker how much do you get at the end of the month for all the work you do as you told me?”

IDII- Money we get for reports that we provide, Rs 600 for delivery, for immunization, we get in 6 months.. all this money you can calculate... Rs 2,000 we get, it comes after 5-6 months... this time we were paid after 7-8 months, got Rs 10,000...

PI- You are not being paid every month?

IDII- No, no, no... They don't give us every month... since august it has come now in our account, every month they don't give..."

-ASHA worker, economically unstable

The financial struggles are intertwined with identity and social values. Inadequacy and unpredictability often lead to emotional and financial stress. They require fair compensation, recognition and support from authorities to empower ASHAs in the work and domestic environment. The demand is not just for higher income but also validation for their contribution to the programme.

"We think—well, we've done what we had to do, whatever little the government is giving us, we've accepted that. We serve selflessly. We also console ourselves thinking at least our children might have a better future someday... Yes, we do want to request the government—please, think about us too... Whatever you're giving us in bits and pieces, at least make it fixed, make it a monthly salary. We want to request the government for that."

-ASHA worker, veteran (18 years' experience)

A significant portion of the community continues to distrust ASHAs and other healthcare providers, the challenges arise from the informal status of ASHAs. Community members suspect hidden agendas when ASHAs are tasked with collecting information related to AADHAR card, bank accounts and other documents. The erosion of trust leads to misunderstanding the ASHAs' roles and thus disrupting the relations build over the years from hard work. This distrust often leads to lack of empathy towards ASHAs and their commitment. Socio-cultural challenges significantly obstruct the effective functioning of these frontline workers within the community, affecting outreach and acceptance due to assumptions that they are they pull money by pushing the community into the health-related interventions. This causes the resistance within community and suspicion, ultimately affecting ASHA's income.

"Recently what happened was, the Ayushman card were made, in that we faced so much issue, people didn't share their id and questions us why we want these details and for

what purpose...we want one thing from government is don't ask us to bring AADHAR card from anyone... we don't want that government ask us to do other work, we were hired to reduce the maternal and infant mortality rate... now so much work is given to us, one who sits at the office does not do this much work, we are daily questioned about our motives and work ... what is the benefit for working over 20 years... ”

-ASHA worker, veteran

Work-related expenses and financial burden

ASHA workers routinely incur additional expenses while fulfilling their duties, despite their own financial struggles and underpayment. The informal and incentive-based nature of their work often compels them to meet societal expectations, demanding them to use their personal funds- for transportation, food, or even emergency needs. They do this to maintain stature in the community's eyes and meet their performance expectations professionally.

“We do a lot of work, but the payment is very meagre. We have to spend our own money on transportation, food, and sometimes even on medical emergencies for patients. Many times, we don't receive payments for months. We end up using our own savings to manage everything. we spend on transportation when going to hospitals with the patients for ultrasound, we have to pay there, so many times we have to pay for food when they are poor, they can't afford.. and now for deliveries we have to keep separate amount, like this is for delivery and food for us...”

-ASHA worker, distant, remote and hilly areas

Financial burden is further compounded by informal payments and petty corruption

within the health system, but this is not visible. They are expected to 'grease palms' to foster relationships with hospital staff. This is intended to secure immediate attention and prompt treatment for the patients they bring.

“IDI12- In X hospital nurses openly ask for money to the patients... if patients give 500 Rupees, they ask for 1000 Rupees... we all ASHA used to be scared to go to women's hospital because at the end pressure used to come on us ..they used to say to us that tell your patients to give “Meethai” ... now how we would say...

PI- What was the reason to be scared while going to the hospital?

IDI12- It is because if we don't do according to them and do the argument then next time when we take another patient then they would create an issue, ignore us and in a way take the revenge... ASHAs are struck both ways from the system and the community... (laughs). So many times I have seen and heard that ASHA gives money from their own pocket so that their mouth is shut and they attend to our patients and don't create fuss for our next patient... there are many problems... ASHAs don't take bribes and work hard and even then they are criticised (referring to news reports about ASHAs demanding money to take patients to hospitals) but others in the health system openly take money

and doing this then nothing happens... although now it has stopped in women's hospital but in X hospital it is openly happening..."

-ASHA worker, hilly areas

4.1.2 Environmental Challenges

Another critical dimension which emerged is environmental challenges, which influence the work experience and effectiveness of ASHA workers. This spanned both physical and institutional working conditions. One highlights the geographical and infrastructural barriers such as difficult terrain and adverse weather. On the other hand, the institutional environment emphasizes- lack of basic facilities, adequate working space, insufficient logistical and institutional support, all posing substantial challenges to ASHA's functioning. The following section details these constraints and barriers in depth.

Physical and Infrastructural Barriers

One of the critical challenges faced by ASHA workers is navigating through geographical dispersion and complex physical landscapes. The challenging terrain, forested areas and other geographical complexities significantly impact their work efficiency and hinders their ability to deliver essential services. ASHA workers are tasked to perform immunization, coverage surveys, follow-ups, escort services for institutional delivery and health education to the population under their jurisdiction.

In addition to topographical constraints, the scattered nature of households in the rural and remote areas adds to their physical strain, making it difficult to reach their designated population.

"In this photo, as you can see, there are far away houses and forest area, we have to walk through these steep areas, through all the forest we have to go, it is all forest. Our usual route for work, we have to through steep terrain, walk back and forth up the hills to reach the houses, the paths are usually irregular; terrain will be high and low, like this the houses are scattered one house is here and another will be very far away, there are dense forest area in between. There is fear of wild animals and we have to go for the survey in this.

We are going alone through this area, if we encounter wild animal, then there is nothing related to our safety, but anyway we have to go and provide services. The main road

from my house is 3KM away and have to walk till there, at night there are no light, through phone's torch I walk in these irregular paths to reach the pregnant women..."
-ASHA worker, remote hilly areas

Fig. 4 Widespread distribution of house and terrain of mountainous regions



A core responsibility of ASHA workers under RBSK programme, is to facilitate the timely admission of pregnant women for institutional deliveries. However, lack of accessible and timely transport, especially in rural and geographically remote areas, poses a significant barrier to achieving this. The absence of ambulance services for private hospital and delays in reaching to destination during medical emergencies adds to further delay timely care. Many families and ASHA workers seek private vehicles, at personal expenses requiring mutual negotiation between families and ASHA workers for the cost. These delays are a cause for added risk to maternal and neonatal complications. In areas with distant hospital, difficult terrain, and poor road infrastructures, logistical constraints are amplified.

"we go through "Khushiyon Ki Sawari." Government ambulance, it is... 102, then we used to take them there to hospital... but it won't go to a private hospital... that is not for private, and for that it does not come..."

-ASHA worker, hilly areas

The lack of proper transport facilities directly contributes to delays in care, and responsibility of ASHA workers for timely admission in health facilities. These issues are further intensified when ASHA workers are required to accompany patients to distant

referral hospitals due to non-availability of medical personnel, medical equipment and other essentials at the local health center.

Fig. 5 Private vehicle for transportation



“There is an ultrasound machine in “A” place. Machine is there, the problem has been going on here for the last six months due to absence of doctor... nobody is coming... those who have money get it done in private and those who are poor get it done in government. There are no doctors there at Block hospital...otherwise have to go to other place in women's government hospital, which is 55km away from here.”

-ASHA worker, remote hilly area

ASHA worker lacks basic infrastructural support, there are no provisions for overnight stay or food for ASHA workers from distant villages at healthcare institutions. There are no provisions for safety equipment (mask, sanitizer and gloves), medical kits, and emergency medicine during the crisis and other emergencies.

“Now it is like there we go for delivery... at night... there should be one room for us... ASHA Ghar... like we have brought the patient there from very far away... so we can rest... and there should be some food facilities...”

-ASHA worker, distant remote area

ASHA workers face different challenges depending on their location, with clear variation for hilly and plains ASHA worker. ASHA workers operating in hilly areas have significantly higher levels of logistical problems to carry out their tasks in comparison to ASHA from plains. Scattered settlements across mountains and forested areas lead to longer travel

time, greater area coverage, increases their workload and emotional burden. The standard of 1000 individuals per ASHA is unrealistic target in hilly areas, where workload and accessibility are often shaped by terrain rather than population density. The physical dispersion of population in the difficult terrain significantly extends their time and effort required to complete the task given by the system. Therefore ASHA workers in remote areas carry a greater burden with hardly any difference in compensation or work expectation.

“In villages house are far away, there is forest and roads are tough but in plains hospitals are near... house is near for ASHA to reach hospital and can come back home at night. But ASHAs here have to leave everything when gone with the delivery case to hospital.”

-ASHA worker, hilly area

In addition to it, the workload among ASHA workers is also influenced by the temporary population or migrants. These individuals are not formally registered under the state health system yet ASHA workers are expected to provide services to them, including antenatal care. This adds to their workload without additional reimbursement or benefits for the service provision.

“IDI15- There are many people from Nepal, yesterday the delivery happened is also Nepali, for them we do all the work, vaccination, check-ups, ultrasound, so for them we don't get any kind of benefit.

PI- for them you don't get any payment, but you are asked to do the work for them?

IDI15- Yes, as they are in my area, they are also living in India. Here, for Nepali people vaccination is subsidised at the cost of Rs. 80... they have come under my name and area, so have to look after them, in case they have delivery this year, if the miscarriage happened or the infant dies, that will be counted in my area, my record becomes bad. We have to do all the work... but for deliveries we should get the money... because we are giving our services... for 9 months we are looking after them and then child is born, the PNC happens at 45 days that money we don't get, for Nepalese...”

-ASHA worker, hilly area (Temporary population)

The geographical burden is compounded by harsh and unpredictable weather conditions where ASHAs are expected to carry out duties as the primary contact between community and health system. Their major role in maternal and child health exposes them to

unpredictable weather conditions for which they are often unprepared. They work regardless of the heavy rains, floods, snowfall, cloudburst or landslides, often risking to their personal safety as their incentives are dependent on the services they provide.

“It snows here so I have to see how I will reach from here... there is constant fear of slipping of the vehicle... mother and child also... sometimes landslides happen due to excessive rain... the roads are narrow trails... now we have to go for vaccination, with difficulty we cross debris of stone and water, but there is constant fear of stone falling from the mountains...”

-ASHA worker, hilly area

Despite the honorary volunteer status, they are expected to continue service delivery in these unpredictable and high-risk situations often without adequate compensation and safety equipment. Due to widespread terrain and dispersed population in rural settings, ASHA workers often required to traverse hazardous environments, including crossing dry rivers, distant hamlets (khatta) and navigating through dense forested areas, in order to complete their task within limited timeframes.

“It affects, if it rains and call comes for meeting at PHC/CHC, even if it rains, we have to go anyway, once when my younger son was about to be born, in the month of January, too much snow fell and I had to go for polio duty, still went there I had to go... I wore shoes, wrapped polythene around feet, so cold water doesn't seep in...”

-ASHA worker, hilly area

Fig. 6 Traversing through dangerous terrains



Institutional Constraints: Systemic Limitations Undermining ASHA Workers' Roles and Wellbeing

Another significant constraint is institutional challenge embedded within the health system that diminishes their morale, future goals and the perception of institutional value. ASHA workers strongly articulated the concern for their career stagnation and no future aspirations, consistently regret their choices to join as ASHAs. The frustration was due to the absence of formal recognition, promotions, and opportunity for transitioning to permanent posts in government service for their years of dedication. This was articulated by ASHAs, especially the active and educated, despising the career choices they made years ago.

“We just wonder why we wasted so many years like this. We could have worked somewhere else—by now, we would have even gotten a permanent job, even if we had worked in a factory, we would have gotten something for these years—at least 3-4 years' worth of benefits, and we would have received a bonus too, even if we didn't get anything extra, and our salary was just ₹8,000-9,000, we would still be able to eat comfortably...”
-ASHA worker, sole breadwinner

ASHAs emphasized the need to upgrade outdated methods and training modules, and demanded practical skills to manage complicated situations, especially when accompanying pregnant women. A major concern was regarding the exploitation through systemic neglect and lack of institutional support. ASHA described themselves as underpaid, overlooked and overworked by the health system. ASHA workers struggle with lack of transparency in the payment process, reports confusion and lacking clarity for the vouchers claims and incentives.

The absence of fixed working hours was mentioned, and this lead to disruption in the personal and professional space. ASHA workers are expected to be work task as the priority and be attentive for the work-related commands from the higher authorities, despite their personal engagements.

“One thing is people have this wrong assumption, every it comes for all work ASHA will do, everybody thinks ASHA is hired so she is our servant, like servant who has to do all the work, likewise these people think, ASHA is there so she will do all the work... at least understand ASHA's work...”

-ASHA worker, remote areas of plains

ASHAs also reported the lack of institutional support for grievances and logistical assistance during COVID-19 pandemic. During pandemic, digital reports and communication through mobile phone, posed additional challenges to ASHA workers due to lack of training and digital literacy. Many ASHA workers struggled with reports submission and understanding the functioning of mobile apps, became a necessity during the pandemic.

ASHAs also suffer the hierarchical disparities and power imbalance that exist within the bureaucratic system. ASHAs find themselves at the bottom of organizational pyramid, lacking decision making power or authority to advocate for the community's needs, in fact mocked and rudely behaved by the other professions with the hospitals.

“it happens like we give report to ANM, CHO report we only give the report we made, in that ANM also signs, then only that report will further proceed... format is there in that sign required.. Sometimes ANM thinks of herself as equal to even the doctor(laughs).. they might think themselves as our head.. don't know why they have issues with signing...”

-ASHA worker

In all, these institutional constraints and barriers encountered by ASHA workers reflect the broader gap between expectation by the health system and support structures provided to them to fulfil their roles and responsibilities.

Institutional Barriers- Systemic challenges that create problems for ASHA's work and make their role more difficult

This presents the challenges that reflect the deep-rooted structural inefficiencies that complicate the ASHAs' role and sustainability. A major issue identified was the role expansion from the activities related to maternal and child to incorporation into every

government led programmes-especially during public health emergencies like COVID-19. ASHAs face the role ambiguity and burnout due to excessive workload and unrealistic demands made by the authorities, without adequate manpower or timely notice. There is constant state of urgency for the work, leading to physical exhaustion. The fieldwork is intensive and time-consuming, leading to ASHAs working round-the-clock for field-visits, community mobilization and emergency situations.

“It is like we will receive a call in the morning, they ask for it by evening. If they call in the evening, they expect it by morning. That pressure is there, but after that... I mean, we always have the reports with us. All the information about our entire area is with us. But still, it takes some time; it's not like everything can be done instantly. Like, we have to travel here and there.”

-ASHA worker, veteran

ASHAs face verbal abuse and disrespectful behaviour from the hospital staff for not getting timely ultrasounds and delayed in admission to hospitals. When the ASHA is not respected within the Health system, trust in her within the community is impaired. This form of abuse of ASHAs by the Health system staff impacts the ASHAs self-worth and job satisfaction, making them feel invisible with the healthcare system they actively work for.

Fig. 7 Poor Institutional conditions



These challenges are further coupled with the financial instability faced due to repeated and time-consuming visits to acquire the vouchers to claim for completed services. These multiple difficulties discourage ASHA workers.

“We don't get the cash, we have to get the signature from the doctor on the vouchers, seal them and then have to go B place to submit then we get 600 Rs ... for that we have to run here and there so many times then we get...so there we don't get...here also when delivery happens we don't get immediately but when we bring another patient then we get the voucher signed from here...”

-ASHA worker, hilly areas

4.1.3 Socio-cultural Challenges

The ASHA workers perform their roles and responsibilities in a complex environment where society shapes the nature of their work, limiting it due to resistance and the deeply-embedded societal norm and expectations.

Constraints due to community's way of thinking/acting/treating ASHA workers

The study shows that ASHA workers face challenges not just the logistical but also the constraints produced by the society. This shapes the way ASHA's work is perceived and treated. As women, ASHAs are not trained to dealing with men who do not belong to their families or kinship network. Therefore there is hesitance in engaging with the male member of the community, particularly respect to sexual reproductive health and family planning programs. The ASHA workers face backlash from the community when they discuss these issues with women who are social relations of daughters in law and sisters because one is not supposed to discuss these matters with nominal daughters in law or sisters. The stigma around women who work results in limited engagement by ASHA and eventually affects the government-led health program.

“...a lot of impolite behaviour has been done with ASHA workers and when gents related work is given, here people comment condom de do, openly boys/man ask for condoms, they shout from behind give us condoms... like this kind of rude behaviours is done, that is why I am saying that gents related work please don't give to ASHA workers...”

-ASHA worker, widowed

Additionally, the resistance shown by community in accessing the health care services further compounds their challenges. The community's reluctance to accept for delivery at hospital, vaccination during pregnancy and infants are all associated with the taboos and seen as challenging the traditional beliefs of the community. There is tendency to blame ASHA workers for bring changes within the community. In addition they are blamed for any shortcomings during delivery, even when the issues are beyond their control.

“When we first became ASHAs... we faced so many difficulties, so many, you know... Nobody agreed... no one was ready to take the polio drops, and they used to taunt us. They'd say, 'Oh look, this ASHA has come to our house, doing this, doing that.' (pauses) They used to say we were spoiling their daughters-in-law... that we were misleading them. They'd accuse us of all sorts of things. (softly) They even refused to let us give vaccines... they were totally against polio drops, saying things like, 'This has been spread in the village,' and since women lived throughout their life in villages, didn't know, they'd say that if we gave polio drops, then their children wouldn't be able to have kids in the future.”

-ASHA worker, veteran

Another layer of social-cultural resistance is stigma related to menstruation and women's health. Taboos around menstruation often inhibit an ASHA from entering and interacting with community. This is because there is refusal to have vaccination from menstruating women and if it is done, they purify the ASHAs by sprinkling cow's urine “Go mutra”. These practices are not just in the community per se but also practiced in hospital by the staff fearing bad omen if had physical contact. This reinforces and perpetuates these traditional practices which may not be hygienic.

“in my area it was not much but village people would say, you went there so chuth-chath, like there is delivery, although for hospital we don't consider, but now in hospitals they consider it a lot, like cow's urine (Gounth/Go mutra)...as they go home, any people have avatar of god and goddess, many sister and people say it, I put cow's urine/Gounth on myself, take bath and then have food..”

-ASHA worker, plains

ASHA workers also burdened with gendered expectations, both at work and at home. They are expected to fulfil their role as mother, wife and daughter at home, and simultaneously also required to fulfil professional responsibilities with dedication and

competence. ASHA workers often juggle to balance family responsibilities and assigned duties, as they have household obligations and caregiving responsibilities within family, coupled with the extension of their nurturing nature to the community. The unequal distribution of work at home, and resistance produced by the society towards their acceptance as the health care worker burdens the ASHA workers.

“in others family it happens, they say why are you here for that work, you would know how it works in villages, you have to maintain the relations otherwise they will get offended saying these women think their work is more important, they just leave their family behind for it, there are many such problem in the family and community, every ASHA worker has to face this... it is not like that every ASHA's family has motivation... there are many problems.”

-ASHA worker, joint family

In some severe cases, ASHA workers face gender-based defamation and character assassination, especially when their work needs late-night travel, interaction with men and engagement outside the home and village. The nature of ASHA's work renders them vulnerable to moral policing as this is not socially acceptable behaviour.

“When village people go for work, they are told that they don't do any real work, they just wander around. These are the challenges.”

-ASHA worker, hilly area

The ASHA workers work under such complexities of gender, cultural norms, social expectation and identity. These constraints not only hinder their ability to deliver the health services effectively but also affect their dignity, safety and sense of self- worth.

Community-level barriers

The community level barriers faced by ASHA workers are the deep-rooted social hierarchies, cultural misconception, and unrealistic community expectations, all of which negatively impact ASHA's functioning and acceptance within the community.

A commonly reported barrier is the misconception regarding ASHA workers' work and their remuneration. There is no clarity regarding the ASHA's social and professional standing, often community members assume it to be similar to that of highly paid

government employees and assigned to work for the community. This leads to unrealistic expectations regarding the scope and nature of work, at odd hours and irrelevant work, at times resentment builds among both community and other stakeholders. They put undue pressure and blame ASHAs for systemic shortcomings, and this compromises their work ability and motivation.

“They think that because we work for the government, that's why... She even said, 'You get such a high salary, it's your responsibility to show us, take it away... How many people sit idle like this...’”

-ASHA worker, town area

Another challenge faced by ASHA workers is the discrimination on the basis of caste and economic status. ASHAs belonging to marginalized communities often experience exclusion, disrespect and limited cooperation with the society.

“caste wise also, higher caste people will say who will listen to them, they just come like that, what to do, do you work, when we used to go to polio program, they won't come outside their house ma'am to get polio dose for their children, they come just like that, some even come like that, they wouldn't even bother to carry their child from inside the house to the courtyard.”

-ASHA worker, marginalized community

There is also difference in the attitude of community with younger and experienced ASHAs. This generational bias among younger and experienced ASHAs, challenges the younger ASHA as they are perceived less knowledgeable and authoritative, irrespective of their capabilities.

“sometimes people don't take me seriously because they think I am new, don't know much and they also see me as Bahu, just... before ASHA Didi was aged woman, so she had good connections with people, in fact they would call her many times.. if I am not able to tell them or they understand.. older men don't talk to me directly, I also hesitate..”

-ASHA worker, young and less experience

4.1.4 Burden on ASHAs

Physical and emotional burden caused by challenges imposed due to work conditions, society and institutional structures

The study showed the multifaceted challenges faced by ASHA workers within their community, workplaces and institutional structures that shape their experience. The remoteness of villages and the geographically scattered households, particularly affects ASHA workers in hilly areas. The long hours to walk to distant location for surveys, immunization and follow-ups of pregnant women, affects them physically and mentally. The pressure of immediate reports drafting, collection of information in community and door-to door survey documentation, significantly contributes to physical and emotional fatigue.

“sometimes I feel very bad, for whom I am doing this when I am not present in important events, people forgot your work.. with whom I go they forget about us, when child is born... I see my children then feel bad more that I could be there with them.. At that time I feel like leaving but then I think my children will have good future... I have missed many family marriages due to ASHA work...”

-ASHA worker, hilly area

Reports of ASHAs experiencing verbal threats or emotional intimidation by community members or superiors, heightens the fear of replaceability in their job, undermining their safety and dignity. ASHA workers endure the humiliation, taunts and emotional blackmail by the community during their work, as they try to balance the community expectation and the health system goals.

““Since 2007, there have been so many problems... very rude behaviour by the nurse.. they would shout on us saying don't you know how many tests are to be done, how many ultrasounds are to be done, we were new to this didn't know.. they would say she came for the money, badi agayi ASHA ban gyi (after becoming an ASHA, Have you become a very wise person that you will advise us what to do), how we would go there for money?”

-ASHA worker, veteran

There has been feeling of exclusion and being demeaned in clinical and the institutional environment, particularly accompanying the pregnant women to far off healthcare facilities. Such experiences reflect the structural hierarchies in the system, ASHA workers

despite being crucial part of system still disrespected and not acknowledged for their efforts and commitment.

“they say it directly leave it, but mam you did this much hard work, you go here and there but at the last moment someone else gets the benefit, how you will feel... (trembling voice with tears in eyes), you will feel bad, it is wrong, we have made the field and done everything, now saying you can leave...”

-ASHA worker, plains

The consistent concern of being paid less and having no formal recognition causes them to feel undervalued and long-term dissatisfaction with their role. As a result, ASHA workers have been on strike and protest to showcase their demand for fair wages, recognition and better work conditions. There is collective frustration among ASHAs showcasing the work condition and negligence by the health system to the plight of ASHA workers.

“don't know why they do this... we do protest so many times to tell them we have all these issues but at the end they say we are thinking, doing something... so many years have passed... When other do protest somethings are done for them but us we never get any solution... we demand only...”

-ASHA worker, veteran

Physical and emotional burden arising due to ASHA workers' own experience, perception or personal sacrifices during their work

The study found out that ASHA workers bear an invisible cost and engage in unpaid labour, due to their commitment towards community often at expense of their own-wellbeing. Their family life, emotional stability and financial security are compromised due to their role. This reflects critical gap within community health services, where the frontline workers are heavily relied upon for programme implementation but not supported proportionately for their contribution.

ASHA workers neglect their personal well-being and health while maintaining the needs of family and the needful. The unpredictable work demands keeps them on their toe with

limited time for themselves. This self-neglect is not the consequence of personal choice but rather pressure they received from the system and undervaluation of their health.

“I have health issues.. I don't get time to show myself to the doctor.. especially don't come.. when came with patient then after getting check-up of patients then for yourself don't get time.. keep aside my problem and just see the patient first.. they also come with us by trusting us..”

-ASHA worker, remote area

Many participants reported missing of family events and festivals due to work obligation even when on holiday. There is no time-off and their work calls for them to overlook holidays due to emergency health care and government health-related initiatives. The demands to provide care 24*7 contributes to burnout and negatively affects family relation and mental peace.

“during my Brother-in-law's (BIL) marriage, there was one delivery, now what to do, I feared asking them, because if I go they will say it is family function and you want to go, so at that time if you don't go then have to listen from them that for what you are elected, you are not coming and refusing to accompany us to the hospital... this no one understands that we also have problems in our house... at that time family also get upset, in this situation have to leave, what else we can do.”

-ASHA worker, middle-aged woman

There is consistent pressure from both community and the institution to perform well, maintain positive image and avoid offending anyone. Role confusion and keeping up to community's expectations leads to emotional exhaustion and burnout. There is dual burden of physical and mental strain on ASHA workers linked to their fatigue, body pain and stress they have as a consequence of their job role. The lack of support from the institution and no external help intensifies their vulnerabilities to the emotional and physical violence.

“physically we are tired on daily basis... mentally when there is too much pressure of work, like they are asking report Friday like tomorrow... for fever... sometimes ask this and that.. we have families, we are stuck with familial responsibilities... when we were not ASHA worker at that time also we were so busy with household chores... whole day at home, used to not get time at all, now at least by duty excuse we are coming out of house, meeting people.. so we get new learning also, money is not everything...”

-ASHA worker, 56 years old

4.1.5 Supportive Environment for Work Process

Another important factors that define the sustainability of ASHA workers in the community outreach programmes is the support and recognition they gained due to their contribution. These factors balance the negative emotion of ASHA workers due to their role and controls the attrition of ASHA workers.

Recognition and Social respect

In community health outreach programmes, the pillars of strong social relations and respect are foundation. The supportive environment fosters the individual who is valued and acknowledged. This has particularly reflected in the ASHA workers programme, whose tireless dedication and unwavering commitment to their roles have earned them deep sense of belonging and recognition.

Not to mention the husband, children and extended family members of ASHA workers, providing the unwavering support to conduct their duties. The emotional encouragement and practical help by sharing household responsibilities allows ASHA workers to focus on their work.

“I have joint family, my sister-in-law (SIL), mother-in-law (MIL) sees them when I am gone... I am youngest daughter-in-law (DIL) in the family... so I have less house related responsibility... we all do work together but they see the kids when I am not at home... Yes, they help me but I feel sometimes I should stay back and help them.. but many times we I am needed then I have to go for work.”

-ASHA worker, young and new ASHA

Community support for ASHA workers forms a critical bridge between the health system and the population they serve. By appreciation and solidarity, the community can nurture their work efficiency and further commitments to their role. Praise and recognition from peers and the community serve as powerful motivators for ASHA workers, not only boost their morale but also sense of pride and ownership.

“but now they have got knowledge, that ASHA is there, working between us, giving immunization to our children, again and again came to our house, as we go for so many

times for polio drops, motivated them for it, motivated for immunization... told them the benefits of immunization and like before there used to be death of women and infant, now it is not at all happening, 1 in 100 or not even that.. out of 10, 1 may happen otherwise it won't... now people learning are seeing each other and understand when other's daughter-in-law went and it was good, did hospital delivery and did get cleaned, after that came and took our daughter-in-law... so people are awakened, now they don't say anything."

-ASHA worker, veteran

ASHA workers' tireless advocacy and proactive engagement with the community are reflected in the many programme goals they worked for. The commitment and responsibility are now beyond the scope of compensation and benefits. These build the strong foundation within the health system for future goals.

Social respect and Recognition from stakeholders

Through the study, it was found that the significant enablers in the effective functioning of ASHA workers is extensive cross-community support they receive, which highlights the inclusivity and collective spirit within the public health. ASHA workers functioning heavily rely on emotional and practical support from immediate environment- the fellow ASHA. This has built the strong sense of sisterhood among ASHA workers for any constraints and barriers.

The external support of stakeholders plays a crucial part in facilitation of ASHA workers' day-to day responsibilities by ensuring the essential supplies such as gloves, medicine and sanitizers in the difficult situation for example COVID-19.

4.1.6 Coping strategies used by ASHAs

ASHA workers cope with collective challenges in their work process due to financial struggles, community barriers and environmental challenges. ASHA workers employ coping and risk prevention strategies for their safety from animal attack, difficult terrain and working in harsh weather conditions. They pretend to talk on the mobile to someone or avoid going alone to deserted places or do not react to verbal abuse to avoid risks.

“fear is for everything..(laughs)..there are animals here in forest at night, we go alone so their fear is there.. there is no light and have to walk till main road, so I used to ask my husband to accompany me and sometimes the family members of pregnant woman till her home...”

-ASHA worker, hilly area

They emphasized the importance of familiarity with the community, that gives them a sense of safety. This helps in better communication and understanding of community needs. ASHA workers face significant challenges when the institution demands them going against the community beliefs and deeply embedded societal norms. They negotiate the resistance produced by the community and try to maintain the harmony by manipulation, education and consistent persuasion within the community.

“People respect us. But sometimes, family members of patients' don't cooperate for example, some husbands refuse to take their wives to the hospital for delivery. The MIL would say that they will insult our DIL, they will be ashamed... they used to fear that they will beat them... so they prefer home births and sometimes even threaten us when we try to convince them. We say no, no, it is not like that, and try to explain.”

-ASHA worker, veteran

ASHAs have supportive network among themselves, to provide assistance for work related tasks and personal struggles. ASHAs reported that talking to each other, help from family and colleagues in difficulties has strengthened their resilience and ability to overcome challenges collectively.

4.1.7 Impact on ASHAs

There is negative as well as positive implications for ASHAs work from all of these issues that have been highlighted earlier.

Concerns regarding safety and working with constant fear

ASHA workers consistently demonstrated an amplified sense of fear and safety concern, particularly while operating in distant, remote and unfamiliar areas. The perceived threat from drunk individuals in villages and potential encounter or attack from wild animals (Tiger, elephants, snakes and dogs). These problems are intensified by the challenging

terrain and forested area that ASHAs navigate, often in late nights hours. Travelling from the villages to delivery centres through poorly lit areas that lack structured paths serve as barrier and produces detrimental impacts on their safety and well-being.

“We, have to go whenever we get a call whether it's at 2 AM, 2:30 AM, or midnight. We have to go to the hospital... even if I don't fear night but there is fear of animals, humans.. My family supports me, but there are risks at night... there is always the fear of encountering wild animals, especially leopards. Dogs also become aggressive at night, which is another concern...”

-ASHA worker, hilly area

ASHAs fear of verbal abuse, physical assault, and harm, after hearing the real-life encounters by individuals from both people and animal. These instances significantly affect their willingness and confidence to engage in field activities.

“it happened with me, I was kidnapped... I was coming back from polio duty at noon, this was year XXXX ...We had to go house to house for polio duty, my daughter was about a year old, and I had to breastfeed her, there is “O” place and my area is till K place.. I was coming back with another ASHA worker, she went home, and I continued, the route was busy and cemented path, nearby had construction site for buildings...Then out of nowhere suddenly someone came from behind on bike, he threw a cement sack over my head and dragged me from there... Nearby there was a cottage, I knew if he would take me inside I won't be alive... Would society let me live? He dragged me for 1 kilometre and after that there was grill, pointed one, scratched the sack inside that my face was.. it was good that it was slippery, it opened by chance... I don't know whether it was my power or god was with me or his power reduced... I pulled it so it came out.. then he dragged me pulling my hair... that grill came in front of me like a god, he couldn't cross that...I thought what else I can do so I just pushed my head over it... because I won't be able to live, then suddenly he left me after hearing some sounds... and I jumped onto the road, grabbed my bag, left my slippers behind and ran off (crying).”

-ASHA worker, town area

In addition, the families' concern over their safety, when required to accompany patient's at late hours, they travel to distant places in ambulance or private vehicle. These responsibilities often lead to restriction on their mobility and conflicts within the household, especially spouses and elders. The constant reports of crime and fraud against women surfacing in news and internet, worries the families of ASHA workers and they are often questioned about nature of their work.

As a results of safety concerns and emotional distress, when ASHA workers are unwilling to perform certain tasks – they are threatened and intimidated by health system staff who invoke guilt and replaceability. These coercive behaviours are aimed to silence their concerns in the hazardous conditions, often shamed and discredited, undermining their credibility and judgement.

“threat is given for everything, for everything, if you won’t do this, this will happen, there won’t be signature, your payment will be stopped.. complaint will reach further, means without threat our no work happens...(toned down).. all the ASHA are tortured this much.. from my place all are frightened, except me.. (laughs), I don’t fear.. it is not government job, I won’t fear.. I will openly say..”

-ASHA worker, Awardee

Financial instability and family income

The financial precarity impacts not only their ongoing inability to meet basic needs but also affects the ASHA’s emotional health. The overwhelming financial insecurity causes tension within household as they are criticized and pressurized by their spouses and families. The weight of financial responsibility often worsened for ASHA workers who are the sole breadwinner or have limited support from family. This has led to them falling into debt traps.

“I take from my husband.. sometimes he jokes or say it in serious way (laughs), just for namesake you have become an ASHA worker, at the end you have to come to me for money... what is the benefit of you becoming the one... I say I will give back, all together don’t worry... he would say yeah, as if you get a lot... he says such things in witty manner but he is right, it is matter of concern... although I don’t get affected, but some may get... recently one ASHA did suicide because of family’s debts(tangi), she did suicide.. we were talking in group... her husband could not earn and pay the debts, at the end she did suicide.. isn’t this the problem.. if government would have given her enough to look after family her needs, why she would do that...why she would have that helplessness...”

-ASHA worker, economically stable

In response to low and delayed incentives, ASHA workers take up additional forms of employment to support their family. Despite their efforts towards community health, their work does not provide them sufficient and fulfilling income, rather it compels them to take up other forms of labour.

“I do farming as well, through that I am able to meet the needs of family, just from ASHA work I don't make much, because of ASHA work demand I am not able to do farming also, if they would have given us enough honorarium then I would have left the farming , and would have focused only in this work... but I am not able to balance both and earn enough from both... that's why there are fights at home (sad).. ASHA workers are living in this plight.. she has to bear the brunt of family and within community... from system also she has to endure the scolding...”

-ASHA worker, hilly areas

The emotional toll on ASHA workers is especially high on those who are solely dependent on their incentives and belong to economically weak families. There is increased stress and self-doubt regarding their status as a result of protracted delays in payments.

“everyone is in stress, the ones who have service people in their house, okay, they are fine. But for those whose family depends only on one woman, that poor one is very troubled.. and if man has a job, the woman is not working, okay, and if that woman is earning she is doing for herself, because the family is run by the man, right? But those where both are unemployed, what about those ASHAs, it is a big trouble..”

-ASHA worker, wife of daily wager

Motivation for Work

ASHA workers have heightened sense of altruism and perceive their role as sacred duty “Punya” towards community and themselves. ASHA workers take the pride being chosen as to work for the community and along with the health system, serving with dedication and passion. Their role drives deep sense of purpose and desire to make positive impact in society and in their lives.

“We think, let's do what we had to do. Whatever the government gives us, it's a little bit, but we do selfless service, so we also think about our children's future tomorrow.”

-ASHA worker, veteran

The ASHA role has empowered them through bridging the gaps between health system and community, as a result enhancing their new found independence and social status.

The confidence has strengthened their commitment to sustain in this role, despite

persistent challenges. The praise and recognition by the peers and community has boosted the ASHA workers, additionally the need to get validated at national level is still a desire.

“first thing is the feeling of being a social worker, and secondly for woman belonging to hilly areas, we only go out to visit our maternal house.. now I have to come out in society, if there is work in block like meeting they call us, then we come otherwise the situation of woman in rural areas is that we only go out of house when visiting relatives or maternal house, our only work is to go forest and come back, from there go to farms and come back.. for us this is only.. it has given strength in the society and also like we can go out of house, like I can talk to you, I studied and got married after 12th, after marriage for 8-10 years I stayed at home, during that I could not talk to outside people, there used to be anxiety, if I say something nonsense while talking, but now when I am going out, can talk openly, this is the motivation for us..”

-ASHA worker, joint family

4.2 Gender Analysis

4.2.1 Gendered Construction of ASHAs' Work and Societal Invisibility of Women's

Labour

ASHA workers are a large, exclusively female workforce, classified as volunteers and compensated through incentive-based mechanism. This gendered construction of their role, both within the health system and community, reflects broader societal undervaluation of women's labour, often labelled as caregivers rather than skilled workers. Deeply embedded gender norms that associate women with nurturing and reproductive roles contributes to the perception of their work as inherently unskilled and, therefore, undeserving of equal and adequate compensation.

The belief that women's work is not about finances but rather about selfless care and the provision of 'unpaid' services is rooted within gendered understanding of care work.

ASHA workers, being the lowest in the power hierarchies of the health system imbibe this belief and see their care work as altruistic bringing “punya” rather than earnings

Their belief of being the caregiver and responsibility of given task takes toll on their own needs and leads them to negligent their safety. The lack of proper facilities at hospitals and protective kits, even during crisis, indicates that women's life is not valued. Although,

in books there is presence of such system for personal spaces like ASHA Ghar, they remain largely aspirational. This further undervalues women's work.

4.2.2 Patriarchal norms, Power imbalances, and Financial dependency

Gendered expectations dictate women's roles, restricting them within the domestic sphere, sometimes extending it to only caring roles within the community as ASHAs.. If they are permitted to work outside, then they are expected to contribute financially. As remuneration is limited, ASHAs are financially dependent on their spouses and family. This dependency adds emotional and social stress.

Persistent income instability, out of pocket work-related expenses and the burden of additional work leaves them with minimal wherewithal to fight for their rights. Women belonging to lower socio-economic background and being only earning member of family, the experience emotional toll due to financial uncertainty.

This power imbalance normalizes the exploitation of ASHA workers and socially positions them to provide care even in harsh weather conditions without adequate support and safety. The absence of gender sensitivity in the formulation of the programme and distribution of task showcases the patriarchy and power imbalance in the program planning and its implementation.

4.2.3 Intersectional Vulnerabilities and Gender-Blind Policies in the Health System

ASHA workers are recruited to serve a total population of 1000 individuals in rural areas (and 500-800 in urban areas). Often this compels them to traverse riverbeds, forests, and wildlife areas, exposing themselves to precarious situations without adequate training or safety equipment. Despite being largest women workforce, the biological realities of women, including menstrual cycles and reproductive health, are often overlooked during work allocation and responsibilities.

Societal norms restrict mobility and reinforce them to limit themselves and fulfil family and domestic responsibilities. Stigma related to women's work such as interacting with men, talking about sexual reproductive health to men and women brings them under societal scrutiny, for the type of work and disrespect it may bring to family.

The absence of gender-sensitive spaces such as ASHA private rooms in hospitals for stay during deliveries and support systems during travel compound this problem. The call for their presence at night, walking through the steep terrain and forested areas exacerbates their vulnerability to violence, harassment, and physical threats. When ASHA workers accompany pregnant women to distant hospitals, they often arrange their own transportation after delivery. The urgency to be at home and fulfil her role as mother, daughter and wife leads to urgent by expensive choices for themselves. ASHA workers have double burden of the household responsibilities and activist role under the programme, further compromising their well-being and health due to expectations and pressure. No travel allowances, no proper shelter and unpaid labour highlight structural devaluation of women's labour and blindness towards ASHA's work.

The conscious negligence by the system highlights the lack of vision, from the time when the programme was envisioned to provide care to pregnant women to now where ASHAs (the women) are pushed towards complex vulnerabilities. This neglect also reflects a broader societal attitude that expects women to prioritize unpaid care work. The volunteer nature of ASHAs' work, coupled with incentive-based compensation, subtly coerces workers to prioritize their duties over their own well-being.

These are intersection of caste, religion, disability and region along with gender, shapes the ASHA's challenges and experience within the health system and the community.

ASHA's role expansion even during the COVID-19 crisis highlights the condition of

women, who were deprived of training and safety kits, commanded to work in those stressful environments, ultimately showcasing women's position in the society.

A detailed matrix of the Gender Analysis is included as Annexure 5 “Gender Analysis of ASHAs work processes in a district of Uttarakhand”.

CHAPTER 5

DISCUSSION

5.1 Objectives of the study-reiterated

This study aimed to explore the intersection of the gendered context of ASHAs work environments in a selected district of Uttarakhand with the economic, socio-cultural, and environmental challenges experienced by them. It also expected to build an understanding of their lives and lived experiences, as they navigate dual roles of caretaker within their households and as frontline workers in their community. It explores the challenges faced by the women selected from within their communities to bridge the gaps between the public health system and marginalized population. However, they often work in an environment which is shaped by traditional beliefs, socio-cultural norms and the taboos around women. Their work is influenced not only by the expectation of health system but also by traditional roles, patriarchal norms and the cultural practices of their own communities. They face the challenges from both structural inequalities as well the societal barriers.

In this chapter, each of the themes identified in the results are discussed. This is followed by a description of the limitations and strengths of the study. The conclusions drawn from the discussion are elaborated and lastly the potential policy implications of the study are listed.

5.2 Economic challenges

ASHA workers are compensated for their work through an incentive scheme combined with a minimal honorarium. In Uttarakhand, this minimal honorarium is fixed at Rs.5000, of which Rs.3000 is from the state Government and Rs.2000 is from the Central

Government (Press Information Bureau, 2024). The amount they earn is way below that earned by daily wage earners in that region. Yet, their work extends beyond normal work hours and they are on call, 24x7 for the pregnant women and for the health system. These findings echo those of another study in Gujarat which found a very high work load of maternal and child care services borne by ASHA workers (Abrar and Malik, 2025; Gadhavi et al., 2024). In addition, because families of pregnant women do not prefer institutional delivery, it falls to the ASHA to facilitate institutional delivery. Similar findings of reluctance of families to allow institutional deliveries burdening the ASHA workers to cajole families of pregnant women to facilitate institutional deliveries was reported from districts of Punjab and Haryana (Sarin et al., 2016; Sarin and Lunsford, 2017). This includes transportation to the hospital if the family is unwilling to foot the bill and also paying for the ASHA worker's return journey from the hospital after the delivery or even food costs while staying at the hospital for herself. These are not reimbursed by the health system and the ASHA worker often meets these expenses from her meagre earnings (Bajpai and Dholakia, 2011; Lavanya and Bhargava, 2015). They also incur additional informal payments by way of bribes in order to collect their genuine compensations. These forms of informal payments have also been reported in earlier studies among ASHA workers in Rajasthan (Sharma et al., 2014).

5.3 Environmental Challenges

Physical environment: Uttarakhand state is located within the Himalaya ranges with steep mountain terrain, dense forest and scattered, sparsely populated villages. Given this terrain, the health system relies on the front-line workers, the ASHAs for the outreach programmes to rural settlements. ASHAs are usually selected from the community in which they work, have to be between ages 25-45 years, and should have been married or currently married and living within the serving community. Therefore, they are subject to

the same value systems that operate in parts of India, which is patriarchal and looks at working women as having lower status and social value when compared to the ‘good family women’ who stay within the courtyards of homesteads (Dyson and Moore, 1983; Gogoi, 2020; Saprii et al., 2015).

As ASHA workers, these women have to traverse the difficult and diverse terrains in rural Uttarakhand, reaching out to the population they serve. The lack of public transport or personal transport (because they are women) hinders their work. In addition, when families prefer private health facilities for delivery, ASHA workers are unable to utilise the government ambulance services that are available for pregnant women. Even when they do reach a designated hospital for delivery, it is possible that the facility does not have staff present or equipment needed to undertake the delivery for the pregnant women, leading to further delays due to refers to further hospitals (something which the women’s families may not approve of) (Scott and Shanker, 2010). Similar findings have been reported from rural Maharashtra or even rural Assam where ASHA workers found that after getting families to go with pregnant women to the nearest government health facility, they were further referred to distant centres (Bhatia, 2017; Rajbangshi et al., 2021). These infrastructural and staffing issues are further compounded if the women are from very distant or remote villages because the distances to be covered and the nature of the terrain make them all the more difficult (Kawade et al., 2021). The unpredictability of weather conditions adds to their difficulties in this terrain (Bist et al., 2023).

In addition to these concerns, ASHAs are also expected to cater to the needs of migrants and unevenly distributed population who might be available in their area of operations (Bishnoi et al., 2025). While these are not registered residents for whom provision of care gives the ASHA incentives, ignoring them will result in ill-will within the communities where they work as the migrants could be relatives of local residents.

Institutional challenges: When the ASHAs do manage to get the pregnant women to centres where delivery occurs, they are abused for delayed arrival at the facility or for not being able to produce the required medical documents such as ultrasound reports and the like. Such abusive behaviour has also been reported in another study from Madhya Pradesh (Shrivastava et al., 2023).

In addition to maternal and child care, the Health System requires ASHA workers to report about ongoing outbreaks, number of specific events in their area of operations and so on. They are almost never given sufficient time to collect such information and report to the health system. They have to comply with these demands from the health system as they fear non-payment or withholding of payments for genuine work done, should they decline. In addition, their payments when they do receive them have no statement with an itemised payment scheme indicating which of their claims were accepted or rejected. ASHA workers are treated as voluntary workers and therefore have no career advancing opportunities for themselves within the system (Sharma et al., 2014b). This can be frustrating when they continue to remain at the beck and call of the health system with no fixed hours of work. They have also reported a need for upskilling their work as often they are the only somewhat trained person accompanying the pregnant woman to the health facility. This is all the more necessary in remote and difficult terrains like Uttarakhand's mountainous districts. If anything goes wrong with the pregnant women in the ASHA workers' care, they face the community's ire in terms of reprimands and social ostracism and this has also been reported in other studies from Madhya Pradesh (Scott and Shanker, 2010; Shrivastava et al., 2023).

5.4 Socio-cultural challenges

Within the community, gendered norms that women should not engage in conversations with men who are not their family or kin holds strong. As ASHA workers are also from

within the same community and are governed by the same norms, they hesitate to engage with men who are not from their kinship group, particularly for sexual and reproductive health matters (Moller, 1993). Older ASHAs who may have a nominal relationship of sister or mother-in-law with younger women in the community also face a similar block. They are not supposed to refer to sexual and reproductive health matters to such women. In addition to these norms, there are menstrual restrictions requiring women to not socialise and confine themselves to their households if they are menstruating. Because of this understanding, ASHA workers find it difficult to enter households and interact with women when they menstruate as they consider themselves impure (Chawla, 1994; Shalini et al., 2022). These ideas persist to this day according to my study, rendering it difficult for ASHAs to fulfil their professional responsibilities. These findings have been reported in other states like Bihar where there was resistance to Institutional delivery and distrust of ASHA workers who asked them to go to public sector institutions for delivery because of the abusive behaviour by health system staff (Abrar and Malik, 2025; Wahid et al., 2020).

Within the home, ASHA workers have to complete both their domestic work and also their families' farm work. As wives and daughters-in-law of the household, they are held to their responsibilities and these they have to fulfil to be able to step out to undertake their professional requirements. This has also been reported as an expectation of women in other districts of Uttarakhand as well (Moller, 1993). Only if they have a supportive environment at home, conflict between these two roles is limited.

While they work within these norms governing their behaviour, communities view them as wage earners in the employment of the Government Health System with high salaries. They are also seen as collectors of data for the Government. Therefore, communities ignore their persuasions and view them as trying to earn their salaries and therefore, not

requiring their support. Given that there are caste-based hierarchies, lower caste ASHAs do find it difficult to work with upper caste households. This has been noticed in many other studies of ASHA workers in north India (Rattu et al., 2022). In addition to caste, the age of ASHAs also is a barrier to their work, as communities are geared to respect older women and therefore older ASHAs. Even educated but younger ASHAs are not likely to be respected as much as noted in this study also.

5.5. Burden on ASHAs

ASHAs are required to undertake surveys, send reports about pregnant women and children and other illnesses are required by the health system. As the terrain is hilly or requires ASHAs to cross forest land, conducting surveys is strenuous and physically taxing. In addition to this, they are not absolved of their domestic or farm related work and earlier studies have noted that married women in Uttarakhand have very high domestic burdens in part due to absentee menfolk (Lavanya and Bhargava, 2015; Moller, 1993).

In addition to the physical burden of the work, ASHAs faced emotional abuse and intimidation from their supervisors within the Health System with threats of being removed from their ASHA position if they did not respond to the myriad requirements from the health system staff and this also has been reported from studies among ASHA workers in Udaipur, Rajasthan (Sharma et al., 2014) and in rural parts of northern Karnataka (Rao et al., 2021). Such threats and the undermining of their contributions in the presence of community members was found to be demoralising for the ASHA workers as their contributions to improving institutional delivery rates remains unacknowledged. Over time, the work burden of ASHAs has increased as has the pressure on them from the health system (Gopalan et al., 2012; Lavanya and Bhargava, 2015). But their remuneration has not increased commensurately, in fact, in Uttarakhand, on an average

around 2015, the average income from ASHA work for ASHAs was Rs.1355.50 and for close to 60 percent of the women, it contributed less than 25 percent of their household income (Lavanya and Bhargava, 2015). Recognising the low payments for the work they accomplished, they have reported resorting to strikes demanding fair wages and better work conditions. Such strikes by ASHA workers have been reported in other states of India as well (India Today, 2025; Kailash Pandey, 2025)

As an ASHA workers' income is limited both due to the low levels of compensation and the lack of timeliness in receiving these compensations, they are not seen as salaried women, worthy of respect by families. On the other hand, communities view them as salaried from the Government and therefore to be distrusted. In this environment, ASHA workers toil, often ignoring their own health and socio-cultural expectations from their families. In addition to the ASHA work, they undertake paid work in other places to fulfil their financial obligations to their family, particularly if they are the sole bread winners for their families. Non-fulfilment of socio-cultural roles within family such as not attending family occasions or helping during family events leads to discouragement and pressure from family members to quit ASHA work. This has also been reported in other studies in Jaipur among ASHA workers (Meena et al., 2020) and in Bhubaneswar (Bishnoi et al., 2025) and in Maharashtra (Bhatia, 2017). They continue to work because they think that Government associated work will bring prestige to them and their families within the community. Such an expectation has also been reported in other studies as reasons for taking on ASHA work and persisting even when the burdens are far too much (Lavanya and Bhargava, 2015; Scott and Shanker, 2010).

5.6. Supportive Environment for ASHA work

Support from other women in their joint families such as mothers-in-law and co-sisters-in-law enabled them to gain courage to negotiate domestic responsibilities members and

therefore continue to work as ASHAs. This is a common feature of managing domestic workload by ASHAs and has been reported in Uttarakhand earlier (Kandpal et al., 2024). Sometimes community outreach programmes of ASHA workers have a demonstration effect in terms of successful and safe delivery in a government hospital for one household serves as an example of the ASHA's contribution to community's well-being. There were stories of home deliveries by Dais (Traditional Birth Attendants) causing infections and maternal deaths in the past and this was common knowledge among women in the communities. So, gradually, ASHAs have gained strong social recognition for their role in achieving safe deliveries. In Uttarakhand, other studies have also reported gaining prestige in the community as a reason for continuing to work as ASHAs in spite of the difficulties experienced (Lavanya and Bhargava, 2015).

In addition to this community support, ASHAs felt a solidarity with other ASHA workers, who provided information on managing the health system requirements for submitting reports and standing in for each other during deliveries in order to ensure that their fellow ASHA workers toil does not go unremunerated. Such solidarity has also been reported in other settings (Gopalan et al., 2012; Pandey, 2023; Sankar D et al., 2024).

5.7 Coping strategies used by ASHAs

ASHA workers report avoiding dangerous places where they were likely to be attacked by wild animals or travelling with other women while negotiating spaces where they felt that sexual harassment was possible. This has been a strategy reported by lone female travellers in places of tourism (Rajkhowa and Qaim, 2022; Wilson and Little, 2008).

While having to travel with strangers to places to visit pregnant women ASHA workers have reported that they pretend to talk to someone on the mobile. This gives the other person a sense that someone else is aware of the whereabouts of the ASHA worker and that offers a semblance of protection. This is a protective strategy recommended by

Wander Womaniya a travel blog for Indian women who may travel alone (Bhalla, 2023; Rajkhowa and Qaim, 2022). The communities' resistance to the ASHA workers' persuasions is managed through negotiating the culture using their knowledge of it to manipulate and educate families to meet the health systems desired goals. This they do by persisting with explanations and offering examples of successes and also failures when their words were not heeded. In addition, they talk to other ASHA workers who have faced similar situations and succeeded and learn of strategies to employ in the difficult contexts. Such coping strategies have been reported by ASHAs in UP (Kumar et al., 2012) and Kerala (Nair et al., 2024).

5.8 Impact of various challenges on ASHAs' work

Concerns regarding safety and working with constant fear: ASHA workers traverse difficult mountainous and forested terrains to reach the household within their area of operations and there are no roads or lights that facilitate navigation, particularly at night. Nevertheless, they need to cross these paths to reach homes from where women need to be taken to hospitals for delivery or for undertaking surveys or perform other tasks entrusted to them by the Health System. These pathways, particularly through forests are not seen as safe as they are also the areas where wild animals belong, such as tigers, elephants, snakes and dogs. Women are familiar with these spaces in day time when they go to forests to collect fodder and firewood with other women as part of their domestic chores (Moller, 1993). But during nights, these familiar spaces become hazardous because they are alone or with strangers and also because there is not light to facilitate visibility. Such fears have been reported by ASHA workers from Uttarakhand in another study among ASHAs (Lavanya and Bhargava, 2015).

Apart from wild animals, women also fear encounters with drunk men and one ASHA worker reported an attempted abduction and rape while she returned from work. Other

studies have also reported violence against women health workers in the field (Dasgupta et al., 2017; Rao et al., 2021). When one ASHA worker reports such a hazardous encounter, it affects the morale of all other women, particularly ASHAs working in that area. Moreover, such risks that include physical harm causes ASHA's families to worry about their well-being and restrict them from working at night. ASHA workers do not heed these well-intentioned familial concerns because of the likely abuse and threats about loss of position from the health system staff. Such intimidation and abuse of ASHA workers by health system staff has been reported from various states including Uttarakhand and Karnataka (Lavanya and Bhargava, 2015; Rao et al., 2021).

Financial insecurity and family income: The earnings of an ASHA are limited due to delays in its disbursement. As they cannot predict or depend on income from this source, they do take up other work to ensure that they earn to contribute to their family income. As this income has been reported to be less than 25 percent of the household income for 58 percent of ASHAs in Uttarakhand in 2015 (Lavanya and Bhargava, 2015), the meagre amounts earned, combined with the need to spend from their pocket to avoid being abused by the health system for not meeting the requirements, pushes them into debt as well. They therefore live in a state of financial precarity, particularly if they are the sole breadwinners for their families.

Continuing and sustaining as ASHAs: ASHA workers care roles, brings them closer to the community and earns them respect. This generates social capital that serves the ASHAs and their families as has been noted elsewhere (Marwah, 2023). The fact that they do not get adequate remuneration for the work they do causes them to see their work as beyond paid work, as being worthy of religious merit 'punya'. The work also brings them independence and a degree of autonomy as they know things that benefit the community, earning them respect and praise. This enables them to continue to work, in

spite of the fears regarding personal safety, financial precarity and resistance from family and community and abuse and neglect by the health administration.

5.9 Gender Analysis of ASHAs' work within the health system

Gender analysis indicates that the existing construction of women's roles within the society as that of carers extends into the social and health sphere and classifies ASHAs as volunteers only compensated through an incentive mechanism. This systemic undervaluation of ASHAs work viewing it as an extension of their domestic roles is shaped by the entrenched patriarchal norms that shaped the ASHA program for enhancing institutional delivery and its role expansion into a general dogsbody at the grassroots level for the Health System. As ASHA workers are lower in the socio-economic hierarchies to the health systems' workers like the Auxiliary Nurse Mid-wife or other health supervisors, they are forced to heed the demands of the various health system workers who find in the ASHAs, a community resource to exploit to meet the targeted requirements.

ASHA workers are recruited to serve a population of 1000 in rural settings and about 500-800 in urban settings. But this policy is blind to varying and difficult geographies which include low density of population, mountainous and forested terrains and the absence of road network to traverse this terrain. The lack of recognition of the build-up of community expectations of ASHAs without empowering them with resources (transport and authority) by the health system is indicative of the gender-blind nature of the program. It leads the system to ignore the ASHAs legitimate demands while continuing to exploit their myriad vulnerabilities including physical threats and sexual assault within community settings to achieve its goals.

5.10 Limitations and strengths of the study

Limitations: The study has certain limitation due to time constraints during the data collection. The research was conducted in the district “A” which has a very limited population of Scheduled Tribes (ST) category. As a result, the data lacks the diverse social backgrounds of ASHA workers especially from the ST category. Additionally, the study couldn’t include the ASHA workers with minor disabilities, limiting the understanding of their unique experiences in the community and within the health system. ASHA workers from very distant and remote areas were not included due to limitation of PI during conduction of study, which excludes important perspective of those ASHA workers.

Another potential limitation of the study is PI’s own position. The PI hold doctor’s title and also obtained permission from the National Health Mission (NHM) office of District “A”, which could have created a sense of inhibition in information sharing related to health system and communities during the interaction with ASHA workers. Due to audio recording, even after the consent may have affected the interviews between the ASHA workers and the PI.

Strengths: Despite the above stated limitation of the study, the study holds several strengths. The study incorporated variation in participants characteristics, including diverse social categorization and geographical variation. The methodology was robust, utilizing the in-depth interviews, supplementing with the photovoice and peer briefing. The analysis was conducted through inductive coding approach, thematically and gender lens were incorporated.

5.11 Positionality and Reflexivity

I as a PI, belonging to upper caste, middle-class, educated woman from Uttarakhand, a doctor by profession, although directly not operating under health system, definitely had

privilege in conduction of the study without facing much constraints. I also understand the privilege, I had in comparison to ASHA workers whose lives and labour I had to study. My social and educational positioning let me afford an education that led to the conduct of study, interpret the data and access to all kind of resources. I also understand there will be certain gaps in understanding the everyday struggles of ASHA workers- shaped by caste, class and recognition, of whom mostly belonged to marginalized, less-educated and lower economic backgrounds.

Throughout the study process, I remained aware of my identity which could produce the unintentional hierarchical disparity- during framing of question, contacting ASHA workers for study, while interviewing and during interpretation of narratives. I constantly reminded myself about my own biases and my worldview.

To reduce the risk of a patronizing gaze, I acknowledged and empowered them to provide the unique insights and perspectives they bring, shaped by their real-life experiences and interaction between community and health system using the photovoice option. It provided an entry point to conversations that drew away from my identity. It was more of a collaboration of understanding their worldview through interviews and photovoice. There emotions during the study were respected and only after assurance between PI and the participants was carried forward.

This study is work of pure commitment to listen, understand and bring out the realities of ASHA workers challenges and impact in their functioning. I also acknowledge that being “from Uttarakhand” has offered me ease in interaction with ASHA workers due to shared culture, language and emotional connect (as a woman)- while I have been to rural parts of Uttarakhand. This reinforces my position as an outsider due to education, caste and

profession but a half insider because of close association with the rural Uttarakhand. This had some time benefited me for study and also produced as barriers.

Approaching ASHA workers as Dr. Nidhi Tripathi would have hesitated them to express openly about their difficulties during the study. I understand that my position with ASHA workers did not resolves the inherited power asymmetries, but it is an attempt to remain grounded, self-critical and accountable to the women whose stories this work seek to hold major space and can openly voice their experiences.

5.12 Trustworthiness

To enhance the trustworthiness of the study, the study adopted following strategies based on the established criteria (Lincoln and Guba, 1985).

Table 1. Measures to ensure trustworthiness

Sl. No.	Criteria	Strategies
1.	Credibility	1. Engagement: Started talking to ASHA workers a year ago; Religiously following updates related to ASHA workers in newspaper and articles 2. Triangulation: Used two methods IDI and Photovoice 3. Peer Debriefing: Discussed codes, themes and interpretation with guide for similar understanding and reducing the biasness during interpretation.
2.	Transferability	1. Thick description: Details related to study context, participants and the study process 2. Transparent Methods: Documented every step in terms of tool design, sampling, field challenges, analysis and use of software.
3.	Dependability	1. Code-recoding: Iterative coding and recoding, pre-analysis for participants' selected, maintenance of excel codebook for categories and these generation 2. Detailed records of data collection, transcription process, field and working diary and reflexive comments and notes for traceability.

5.13 Conclusions

ASHA workers in District A, Uttarakhand travel to far-off places, alone and sometimes depend on another person, usually male whom there are not necessarily familiar with. They go to these places with anxiety and fear, because they work under incentive-based model which will reward them only if they are present during the delivery of woman, otherwise they do not get paid even if they did 9 months of follow-ups and motivation. The work of ASHAs is seen as “cheap work”, they are labelled as not having good character within the community as they break the norms for ‘good’ women within the community. Their dignity is challenged both within the family and within the community meagre amounts which are not regular. The deep-seated patriarchal and caste-based attitudes characterises the ASHA workers as “loose woman” as they move late nights or interact with males, violating the societal norms for modesty and “femininity”. Though some are supported by their families, but this does not help to overcome the stigma even when they work in the community for their own people and are associated with the health system.

ASHAs have strong bond among themselves and gather strength from their families and peers that accommodated them, but they feel they are abandoned by the health system as it does not support them within the community to improve their status or prestige and neither does it provide any facilities they demand and need. Their work is unrecognized and efforts are undervalued, they feel abandoned and lonely within a system which started with an idea of rural woman upliftment.

They deserve the support for their determination and changes they have brought within the community in terms of utilisation of health care services. The recognition and social standing can only be provided by the health system when given a public recognition. Ironically, the ASHA workers programme was started under NRHM for the woman, for

their health and well-being and with time they are called as “Backbone of Health system” but simultaneously intentionally or unintentionally exploited, remain invisible and ignored, just as women’s work in the domestic sphere is rendered invisible and their contributions ignored and not valued.

I would like to conclude the study with the statement said by an ASHA worker during the interview:

“Hum ASHA ko toh ek pairo ke chappal ki tarah samjha ja raha hai. Jaise jab kisi ke paas chappal nahi hoti, toh keh dete hain — Arey bhaiya, isko dal lo, abhi kaam chala lo, baad mein koi aur aa gaya toh use de dena... Vahi hisaab humara ho raha hai”.

5.14 Policy Implications

1. Institutional recognition and fair compensation: The ASHA Programme can introduce the minimum fixed salary structure in addition to the performance-based incentives, ensuring financial stability and sustainability as per the current economy. Introduction of monitored and transparent payments processing system to avoid delays and confusion regarding the payments to the services provided will benefit the ASHAs for the continuum of care without wasting time for the process. They should be incorporated into government employee scheme by providing the employee benefits like classified leave, sick leave and social security benefits. The ASHA Soft program of Rajasthan is a good benchmark to learn from, incorporation of technology and internet to make the payment related process easy ASHA workers and other difficulties. This is quite acceptable and effective among ASHA workers. This will reduce the difficulties faced during the payment process and increase the effectiveness to focus on core mission (Joshi et al., 2020).

2. Gender sensitive infrastructure and safety measures: The ASHAs should be provided with safe transport (especially at night) and designated resting spaces which are sanctioned already in the government documents but not yet implemented, particularly for the ASHA workers from distant remote places. The provisioning of these facilities should also be monitored routinely to ensure adequacy.

The ASHA should be provided the training for personal safety while travelling between the community and hospital in collaboration with the local self-help groups. For example, pepper sprays can be supplied to them and they could be trained on how to use them.

3. Community sensitization and gender sensitization within the health system to understand ASHAs' role and responsibilities. Uplifting women workers in the professional space by acknowledging their effort by the senior officials within the health system and in community Would go a long way to develop and maintain their dignity and status.

4. Geographical sensitivity: The ASHA programme cannot be a “one size fit all model” when the country has such diversity in terms of geography. The consideration of workload as per 1000/ ASHA wouldn't fit well for hilly area population which is scattered and terrain marks the difficulty. The travel remuneration should be provided during institutional deliver whether it's private or government hospital. The area specific remuneration accordingly to remoteness and difficulty parameter from the lens of gender and working in difficult terrain like dense forest areas with wild animals, khatta/plains, flood prone villages.

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ANNEXES

ANNEXURE 1: Socio-demographic profile of Population in districts of Uttarakhand

S. No	District	Population	Density/km2	Rural	Urban	ST%	SC%
1	Haridwar	1,890,422	801	63.3%	36.7%	0.3%	21.7%
2	Dehradun	1,696,694	549	44.5%	54.5%	6.6%	13.5%
4	Udham Singh Nagar	1,648,902	649	64.4%	35.6%	7.4%	14.4%
5	Nainital	954,605	225	61.1%	38.9%	0.8%	11.6%
6	Pauri	687,271	129	83.6%	16.4%	0.3%	17.8%
7	Almora	622,506	198	90.0%	10.0%	0.2%	24.3%
8	Tehri	618,931	170	88.7%	11.3%	0.1%	16.5%
9	Pithoragarh	483,439	68	85.6%	14.4%	4.0%	24.9%
10	Chamoli	391,605	49	84.8%	15.2%	3.1%	20.3%
11	Uttarakashi	330,086	41	92.6%	7.4%	1.1%	24.2%
12	Bageshwar	259,898	116	96.5%	3.5%	0.8%	27.7%
13	Champawat	259,648	147	85.2%	14.8%	0.5%	18.2%
14	Rudraprayag	242,285	122	95.9%	4.1%	0.2%	19.7%

Source: Census India, 2011

ANNEXURE 2: District wise distribution of ASHA workers in Uttarakhand population and Natural Hazards Percentage

S. No	District	Tehsils/Block	Area per Km ²	Total ASHA	ASHA Worker/ Avg Population	Geographical forest area	Wildfire	Earthquake	Floods	Landslides
1	Haridwar	3	2360	1730	1092	24.8%	8.1%	0.6%	8.9%	4.3%
2	Dehradun	6	3088	1449	1170	52.1%	21.1%	1.1%	0.9%	0.3%
4	Udham Singh Nagar	7	2542	1346	1225	17.0%	14.2%	0.0%	1.7%	0.8%
5	Nainital	8	4251	1030	926	71.6%	12.6%	2.7%	5.7%	3.1%
6	Pauri	9	5329	1010	680	63.7%	14.1%	5.8%	18.1%	1.8%
7	Almora	9	3144	943	660	54.7%	53.4%	2.7%	6.5%	4.2%
8	Tehri	7	3642	1081	572	56.7%	24.5%	3.7%	4.5%	4.4%
9	Pithoragarh	6	7090	983	491	29.3%	9.9%	3.9%	11.4%	0.4%
10	Chamoli	6	8030	663	590	33.7%	39.9%	2.6%	9.1%	9.2%
11	Uttarkashi	6	8016	627	526	37.9%	29.5%	1.9%	50.4%	19.4%
12	Bageshwar	4	2241	451	576	56.3%	35.2%	7.2%	27.8%	4.3%
13	Champawat	4	1766	359	723	69.4%	28.1%	3.3%	1.1%	5.5%
14	Rudraprayag	3	1984	346	700	57.6%	48.9%	3.6%	26.6%	13.9%

Source: Census India, 2011

ANNEXURE 3: District wise distribution of Healthcare facilities in Uttarakhand

S. No	District	District Hospitals*	CHC	PHC
1	Haridwar	4	4	2
2	Dehradun	5	7	2
4	Udham Singh Nagar	2	6	2
5	Nainital	7	4	6
6	Pauri	5	5	7
7	Almora	4	4	16
8	Tehri	2	3	8
9	Pithoragarh	2	4	6
10	Chamoli	1	5	5
11	Uttarakashi	1	3	3
12	Bageshwar	1	2	2
13	Champawat	1	2	6
14	Rudraprayag	1	2	2

Source: Department of Medical Health and Family Welfare, Government of Uttarakhand, 2024

[Note- In Uttarakhand, the numbers of District hospitals are cumulative of district/Base/Female/Male/Combined Hospitals available 24*7*365 facilities]

ANNEXURE 4: Codebook

CODES	MEANING	EXAMPLES
"Punya" being the motivation to work for the community	ASHAs think that even if they don't get respect or money they are doing good deed "Punya" by working for pregnant women	I become very happy after the delivery when mother and child are healthy and my family also says that it is also a kind of good deed.. puniya ka kaam hai ye. .that helping any woman that saving her life and helping her in delivering her baby, the I think that is m earning puniya
ASHA's role in reduction of maternal deaths by encouraging women to speak about their sexual health and seek medical care		1.Ladies don't tell their issues like itching, pain during urination, these things they hide, still since the time we have become ASHA workers they are opening up, itna dabaye rehte the na, mai to bohot hi bhukut chuki hu,they used to not tell, used to hide due to shyness, that they are facing these issues ... It was us when we used to say we are also women and you as well, so why are you hiding and feeling shy, tell us what are the problem ... they used to say we don't understand... when we would insist on telling then only they will tell... before women used to take mala-d, for taking that also they used to shy away... (widely opening eyes and with happy face), ab to aurate bohot sudhar di hai ... ghar ja jake.. pyar se bhi khti hu aur gusse se bhi..(we have corrected many woman , by going there houses, sometimes tell them with love and other time angrily)
ASHAs self-identify as altruistic caregivers	They work for community thinking it is good deed.	I see myself as social worker, as I am doing the social work related to heath.
ASHAs under scrutiny for social norm transgressions even by one of them	The reputation of all the ASHA workers is affected just because of one ASHA worker's action, the narrative changes for all the ASHA worker. There is added social pressure that an ASHA should work in that particular way	1. One lady..(laughs).. happened with one ASHA.. that.. she started talking to some person in her own village.. that man's wife came to known; she came to me talking about that your one ASHA is doing this.. then one day I called her and made her understand that you are an ASHA, because of you we all will be seen the same way.. all of us will be disgraced.. if you won't do this then only we will support you.. later she stopped.. now what she said was that he helped her so I used to just talk.. now that woman would have felt that her affair is going on with him.. but we stopped that thing there itself.. we said when we will go with you then people will also think that we all are

		same..aisa hota hai na jiske sath raho uski sangath pdhti hai, par jaruri ni hai tum bigadhe ho to hum bhi, sath mai chalene par samaj dikhega to sochega mai bhi vahi hu..
Career Constraints and Regrets	They feel there is no career upgradation, frustration and limit to their career for being an ASHA worker, they also compare with others' growth	1. We just wonder why we wasted so many years like this. We could have worked somewhere else—by now, we would have even gotten a permanent job, even if we had worked in a factory, we would have gotten something for these years—at least 3-4 years' worth of benefits, and we would have received a bonus too, even if we didn't get anything extra, and our salary was just ₹8,000-9,000, we would still be able to eat comfortably. 2. in 2010 I was about to leave... in company it is good, although the women who are working for 8 hours, earns 10-15k from there and PF is there, Diwali bonus is there, those who were hard working, wise, both husband and wife have made property, you can't tell their condition then and now... now us, we are like sui ki tarah sil gaye, na hum idhar ke reh gaye na udhar ke..
Carelessness and negligence towards personal well-being and health	ASHA forgets about their own health, forget meals, ignore medical conditions, and prioritize their work and family	1. we don't get time, after giving food to all if late then leave without having food, someday till evening, leave ourselves only, aurate khud ko hi chodhti hai aur kis ko, bache usko time pe khilane hai, pati ke kam karne hai, bacho ke kam krne hai, uske bad jo chuth gaya vo khud k liye, apne liye bachata kaha hai (laughs) 2. in my field I specially tell them that whether it is night or day , just call me I will come..in fact my husband says that I have gone mad because I can't sleep after I get call.. I sit whole time, I just wait for whole time, I drink tea, and pack bag, keep all stuff.. I keep doing all this ..in case they call in emergency I should not be late . 3. during covid.. during that time health was bad, my tumour ruptured, I didn't know I had tumour, but had pain in between, but couldn't go for further and took medicines, it was ok and I was careless, from 13th march I started bleeding, but they didn't give me rest, 14 the august I finally got the surgery done in private, my

		department didn't support me to provide me the treatment in government hospital..
Caste related discrimination	ASHA worker work gets affected due to caste system in the society, they are restricted to perform their duties because of it	1. caste wise also, higher caste people will say who will listen to them, they just come like that, what to do, do you work, when we used to go to polio program, they won't come outside their house ma'am to get polio dose for their children, they come just like that, some even come like that, they wouldn't even bother to carry their child from inside the house to the courtyard
Challenges in accessing timely and safe transport for ASHA during maternal health emergencies	Due to non-availability of transportation ASHAs and the family of pregnant woman have to book personal vehicle, which cost the family and sometimes ASHA, also when the government services are permitted for specific usage	1. we go through "Khushiyan Ki Sawari." Government, it is ..102, then we used to take them. It won't go to private.. that is not for private, and for that it does not come. 2. just when we have to go for delivery at night..they ask us to go with them then we have to leave behind everything , sometimes we don't get the transport to travel..108.. then personal vehicle is done..like when 108 is far away..won't reach here on time.. and we can't wait then we have to do our own vehicle.. 3.sometimes it doesn't come on time, it gets delayed.. it happened with my patient recently, ambulance said they are coming, they have reached here and there, till then the child was born at home, now the placenta also fell, they said now what is the point to go to hospital, so 108 people said you should have said us on time, I said don't angry me, at 1:30 I called you , you are reaching here 3:30, is it my mistake or yours? Check your phone, you are coming at 3:30 when called 1:30

Challenging terrain and forest area	Difficulties faced by ASHA due to geography of the area where they work, like hilly , forested terrain, difficulties in transportation in reaching remote areas, floods, landslides.	1. grass is there, now like this farms are there, this is path, ase meedhe meedhe rasta hai (narrow path in between farmland) during rains grass will be there, they won't cut this, there is so much problem now we have to go from this, anyhow we have to go.. 2.The road from our place is around 2.5-3 kms, so have to walk through all this road, if roads can be made till the village, then vehicles facility is good, then pregnant woman and we won't face much issues. 3.but sometimes she is not able to go to other villages, forest area is there, animals fear, in hilly area it is very far away.. so much difference like up and down terrain, high area.. even if you go to my area.. 4.here as you can see the houses are so far away, the path will be irregular, terrain will be high and low, like this the houses are and we have to go for the survey in this.. 5.but in khatta it is big issue, there comes the nalla, and in between the road has big pits, now no one get how deep the pits are... in this how can someone go, khatta has major issues...
Commitment and responsibility for the community	there is sense of dedication among ASHA workers to work for their people despite their personal challenges be it payments, social pressure and to some extent personal sacrifices	1. Ab jab tak hum chal sakte hai rat ko deliveriya, jaise rat ko jana padhta hai, hum chal skte hai to tab tk hum kar skte hai tab tk , fir to dusre ne karna hi karna hai.. hum to samaj seva mai, koi nahi dekhega to upar wala to dekhega .. koi mandey de na de sarkar ke bharose nahi hai hum to upar wale ke bharose hai 2.this is my own thinking that If I am taking a pregnant woman then she is my responsibility, whatever cooperation I can provide I will, and those things which I don't know that also I do by asking, I even call the doctor and do that..
Community practice of ritual cleansing with cow urine affecting hygiene requirements		in my area it was not much but village people would say, you went there so juth-jath, like there is delivery, although for hospital we don't consider, but now in hospitals they consider it a lot, like cow's urine(gounth)...as they go home, any people have avatar of god and

		goddess, many sister and people say it, I put gounth on myself, take bath and then have food..
Community support for ASHA workers	Communities assist ASHA to perform their duties, cooperate to easily carry out her work.	1. when we tell them we are somewhere or ill, can't come they get it.. they also work with our things.. like for ultrasound, they come with us when we get time, don't deny it, they also understand that they need to pay us for the transport fare..some do that some still don't but they get it.. 2.but now they have got knowledge, that ASHA is there, working between us, giving immunization to our children, again and again came to our house, as we go for so many times for polio drops, motivated them for it, motivated for immunization.. told them the benefits of immunization and like before there used to be death of women and infant, now it is not at all happening, 1 in 100 or not even that.. out of 10, 1 may happen otherwise it won't.. now people learning are seeing each other and understand when other's daughter - in -law went and it was good, did hospital delivery and did get cleaned, after that came and took our daughter-in-law... so people are awakened, now they don't say anything
Community's distrust on ASHA's role and other healthcare providers		they think that ASHA took her from here..the patient, the bahu, although everybody is there with her and the permission is taken from family only to perform operation, doctors don't say and ask us that they will perform operation in that patient, we don't have a say in this they seek permission from family that this is the situation and the complication and can do the operation but later the elder woman and other think it could have been normal, why operation is happening, so they say because ASHA was with them and she would have insisted for the operation..
Community's misconception regarding ASHA's payment		now people understand .. although we are going by husband's money.. people think that we get a lot..and why we would say that we get this and that.. even if we say they don't trust.. ANM knows , doctor knows.. CHO, representative they all know how much we get but local village don't know, they think that we are salaried

		government employee..we are not government employee although money is through government...this is our demand that make us permanent employee. They say yes.. but do nothing..
Community's perception and expectation regarding ASHAs' work	Within community there is narrative for ASHA, regarding their work, availability and payments.	1.they think it is our work, they should give us time, they say you get the money because in paper it comes that ASHA get for everything, we get good money... 2.like society sometimes think through ASHA we are getting help..ok.. they are taking help from us; some thinks this is my duty..and she will tell us... it is same 30%.. for every problem are these 30% ...
Conflicts, taunts and pressure by family due to lack of regular payments making them dependent on family for financial resources		1.ab gharwale bhi naraz ho jare hai, badi naukari karne vali ayi hai, kya milra hai naukari se ... yess. 2. Family will be like what you get after going whole day outside.. they earn like this much still they don't go for work so much..a lot is heard..but actually this is true.. for work we get nothing.. 3. aye din kalesh, aye din kalesh..ek ache s suit pehne k liye bhi husband ke age hath failana pdhata hai..there is constant dependence on husband for everything
Coping and risk prevention strategies for safety, emotional well-being and work-related challenges		we look after ourselves, just look into the forest while going, nobody can accompany us, they will say you are being paid for this, why I should come, so we safeguard ourselves on our own. What else we can do (laughs)
Difference for hills and plains ASHA for overall work-related challenges		for them the hospital is nearby and we don't get benefit.. Plains ASHA they go to private hospital for test, so they earn from there also..they get the benefit from this.. our is only government hospital test and delivery.. our no other extra earnings..

Differential attitude of communities towards experienced and younger ASHAs	Age and experience of ASHA worker leads to difference in the community acceptance and	1.for newer ASHA it is comparatively easy because when I became ASHA there was no one aware about so many things, people used to refuse to go to hospital for delivery, we used to motivate them, by simply sitting at their home, gossiping, when meeting in marriage or anywhere, we used to slide the topic.. initially I used to think what and how I should say but after sometime I started talking..I faced a lot.. elders used to say on face that it is your business what benefit we will get.. little by little told them benefits of hospital delivery, government also gave them benefits.. but now mostly people are aware they themselves come to us ask things, they want to go hospital.. so new ASHA has this benefit.. money has increased from before but work is also increasing..
Disrespect and verbal humiliation by the higher authorities		initially when my kid was 1.5 months, I took to hospital, they said they won't admit ..the delivery will happen tomorrow, we came back to our houses. Next day I woke up early was preparing the breakfast, then they called that she is having intense pain, you need to come. she called, I came to the road, I didn't get the vehicle, I said you carry on, I will just feed my child and come. You keep going, I came back and fed the child and left cooking chapati in between, tucked in my child and left... came to road and I didn't get the vehicle, meanwhile the child birth happened... madam scolded me so much, she tore all the papers, you won't get any money...
Distant house in villages to cover for survey, vaccination and other given work		In village one house is here and another will be very far away, there will be forest area so we have to go anyway, there can be wild animals.
Duties imposed on ASHA's during crisis like COVID-19	The challenges faced by ASHA during corona, as as lone warrior working in fields	1.the experience was like, puri duniya andar hai aur hum bahar hai.. ASHA hoke bhi , bina mandey hoke bhi puri apni duty nibha rhe hai ... and also I was ill , had operation during that time.. had two operations... (told related to her operation) 2.t feels scary , there is no such facility for us, mam during corona, all the people were inside, ASHA worker, one health department were outside, all the public was sitting inside and our duty was on field, quarantine that, he is coming, quarantine him, we were outside the

		whole day, all the people were safe inside their houses, for us, there was no safety
Emotional burden on ASHAs		1.ASHA bechari bohot jhel ri hai, vha bhi sunti hai aur yha bhi sunti hai ... aur age centre mai jao vha bhi sunti hai 2.after that incident I took her to the hospital and pleaded the doctor (hath jode) and they also scolded me that it is already 2 o'clock, it is closing time... where were you ill now. After telling them the incident they did... As I cried in front of them, searched for her throughout from one place to another... I told she died by jumping on lake, I thought what I will say to the family ...I could not forget that day (wiping her tears) ...
Emotional toll due to financial instability		1.if we depend on this money then our family will be THAP (humra Parivar thap rhta).. bhukkha rhne tak ki naumat ajati (sarcastic laugh) 2.there is no discomfort in our work but vaha par itna jhand Hona pdhta hai jab har ek insan puchta hai humko milta kya hai..like every other person wants to know what we get, like see we are sitting here.. they all are asking why today sitting here..they ask us that you do so much work, what you earn.. what is our payment.. how much we get.. at that time I feel very disheartened ya bezzati jaisi..how to say 3000.
Expectation for fair compensation, recognition and support from authorities		1. changes should be one about saamanyata ka adhikar hona chye, it should be given to our work as well, the amount of work they have given us, it should be given with respect whatever the amount of money centre gives us.. 2.like if we go for delivery then well but if we can't go the amount should be given for our hardwork.. we have seen her for 9 month and in future also we will see, PNC, her kid also... that all should be given to us.. like for one month this much will be given, clear. Third if they say that willingness, there should be no pressure on us..

Exploitation of ASHAs due to under paid labour, overwork and Institutional neglect		1. we don't have any holiday, they call us at night 10 or 11 pm also, delivery cases, we have to go anyhow 2. I said, the amount of work they give, this money is nothing..what we can say, we can't say anything, no bargaining.. unhone humri gardan pakadh ke nadi mai dubol Rakha hai.. ASHAo k upar shoshan ho gya hai.. 3. they know, they don't want to understand , they don't want to waste their time, they think we remain at home, she should take the bahu and get all the work done, if they can they think that baby also from pregnant woman she can take out...
Extensive support from cross-community		what I think is Muslim families are good.. they never did anything wrong.. for food and drink . They also think .. that we are hungry then they themselves tell us to go there and have food.. and now they know.. what I know I have never faced any kind of difficulties from their side.. I personally don't prefer.. but their nature is good that I never faced problem..
Familiarity with the community providing sense of safety	When an ASHA works in her own known place she feels safe and secured and she doesn't feel the same when she goes out of her village, to distant hospital, so being familiar with people gives her perception of security.	the way my village is in that case there is no fear related to safety because sometimes I have come alone with them and sometimes they have to drop to my house, so never felt unsafe with them .. 2.I never felt..because we all are local, I am local ASHA and local village people.. and I have made very nice relation, I am telling about myself not about other ASHA..if I go out even at 12PM then no one will tell me anything.. I have this much trust towards my village people..but at many places people say she are scared; I even go at night 10PM through scooty..if they ask me to come, I even go.. 3.by god's grace I have never felt because my husband is teacher here, his students are here their deliveries are happening, till now I have not got this kind of thing from the field.. I have gone tension free, went like a family member, they are my neighbors...

Family's concern for ASHA's safety while travelling alone or at night, due to fear of crime, fraud and COVID-19		1.my father used to call me a lot, my mother told me he is not eating food, because you are going for duty, 'if something happens to me, what will I do?' You don't be careless, have warm water, use sanitizer, use soap, wear good clothes, look after people from distance, have a mask on your face... I made separate clothes for myself, used to dip them in hot water and re-wear them again, didn't use otherwise and kept them outside 2.nowadays so many frauds are happening, we see on TV about the use of photos, this and that... we are scared sometimes but have to send as proof.
Fear and self-safety concern among ASHA in village and distant places due to drunk people, animal attack, fear of verbal abuse and assault		1. people in hospital also matter..as you can see that case happened, her it happens.. the rape with doctor... Kolkata.. see in same way government has not given us any facility that ok we can stay with patient.. there we face a lot problem.. 2.while going don't feel but while coming like what intention will patient will have, they are patient we know them but suddenly on the route they may think, on the route where they will take the vehicle, this is the fear..
Financial insecurities leading to multiple jobs	Need to do extra Jobs and not just rely on ASHA work due to less and delayed payment	1. from ASHA work we can't meet the family needs.. can't run the house.. little we get.. 2. along with this I do weaving and of others report making.. written work I do..through that I can survive, agar mai itni jagah hath pair na failau to 400 Rs mai mera kya hoga... 3.nowadays there is inflation, a person has to do so many things than they get something, only from one work you will get nothing.. My thinking is if I will do just one work, I won't get that too on time, so if this doesn't provide me another one will, like this I say then only they support ..

Frustration, Anger and lack of job satisfaction among ASHA workers	frustration among ASHA due to uncertain future, temporary status, improper payments and anger over exploitation due to low pay, recognition and loss of passion to work.	1. to me my ANM says you used to do so good work, even I used to do cold chain, register, operation and all alone I used to do, now the situation has become I have load of family, I don't go, I leave, now I also think that that in this there is no money so I don't want to do.. even when I used to work in hospital I used to do all the good work..now I don't do, I have reduced.. because now I think I will do that work where I will get something rather than this. 2.Before I got Best ASHA award for TB because my work was good, now it is .. I am saying to you frankly, ab mera man mar gaya hai is kaam s 3.In start, when it started there was old poor woman, I am also poor, but she had 3 small children, I saw that and thought I should give Sooji to her children in that illness as it is said it helps, and I use to look after her... I am not self-praising; I used to do this much in starting but with time I understood nothing I will get from this... 4.chodhne ka khayal to kadam pe ata hai..laughs..when there is so much pressure.. tab man karta hai kyu bane hai hum..
Gender based defamation and Character attack		1. badi ayi ASHA yha ayi hui hai humare ghar mai ye kari hai vo kari hai, (takes breath) humari bahu ko bhadka rahi hai 2. village people, when went for duty then they say inka to kam dhanda kuch bhi nahi hai y sirf ghumte rhte hai, these are challenges..
Gendered expectation in work and community		1.I said before it should not happen later if I go for work, then you will say that you went, if you are allowing me as ASHA worker for it, then only I am ready to be an ASHA worker otherwise I am not... 2.there is difference between ladies' work and gents' work.. Like they can go anywhere.. like me when I go somewhere may be somebody has bad intention.. I am human only . How would I know what the other person is thinking.. it has happened with so many ..those who have bad intention can do wrong to you.. there is this difference between man and woman that to man nobody can do anything....

Gendered responsibilities and Family's obligation		in others family it happens, they say yaar us kaam ke liye yaha padhi hai, gaon mai to apne dekha nahi hai , hote hai naraz hote hai..inka ye kam jada jo ho gya humra kaam, humko chodh deti hai, bhot pareshaniya jhelni padhti hai , har ASHA ki, it is not like that every ASHA's family has motivation..there are many problems
Good social relations and respect in the community	How ASHA are accepted in society as an individual, their relationship with community	1.I am loved by the people that they care for me you won't even feel that I am Muslim woman being loved by the Hindu families.. 2. I don't like going.. not just in Hindu families but any functions in my community.. I don't like going because I don't want people thinking that she is ASHA that is why she is being called for the function.. so, I don't want..I just feel that they have given me this much respect by calling that is enough.. it is not just about going.. those who want to respect me they even send me gifts or come home..like saree suit.. pithiya bhi lgate hai.. even after naming ceremony.. 3.here all people know me about my work, they say about me to other she does good work, call her.. in fact, Pradhan ji recently talked to me that there is OBC seat, you should stand for election, you will get good support..
Hesitance to interact with males in the community about family planning activities of the government		1. difference will be this that woman would openly tell their problem, like you are my daughter you won't be openly talking about periods, or woman problem, related to child, so you will hesitate to share with man 2.at village we do As I am ASHA worker, if I want to tell them about women and family planning, I won't tell directly to male, I will tell their wives, because in village these kind of talks village people feel a lot, saying to me, being a women saying to me, so directly don't tell to them but indirectly tell to the males... those who are younger to us, can say to them, to elders how can I, as they are relatives to us, so many talks can happen..

Hierarchical disparities and power dynamics within the health system	within the health system the ANM, CHO impose their work on ASHAs and because of their higher position in system they force them and overuse their power	1. it happens like we give report to ANM, CHO report we only give..the report we made, in that ANM also signs, then only that report will further proceed..format are there in that sign required.. sometimes ANM bhi apne ap ko doctor s kam nahi smajahti hai..
Inappropriate compensation for the work compared to other professionals		1. mam per day laborer also earn 700/day.. for month he also reaches.. for month he also gets 19000-20000, we are not even that.. neither weekly we are.. in one week there is 1 Wednesday, on that day whatever we earn that, 2000-3000 whatever government gives us as incentive money.. it comes in 2-3 months.. 2.when I see television news comes their salary increases in that department and other.. for ASHA nothing has increased at that time I feel bad, for everyone else it increased but for us it did not .. if it did then 200-300..
Inappropriate payment for the Labour		similarly it is us who knows when we go for immunization... like one child when that child completes 9 months, then we get 100 rupees since the birth of a child after 9 months when child will get rubella and pertussis injection then we get 100rs, then child will get at 18 months, we get 75 Rs, now tell where is our earnings??? Now for leprosy there is 1000 Rs, in my village there is no patient...
Increased social interaction, improved confidence and independence after becoming an ASHA worker		1. they used to that I don't know how to travel by vehicle, how she will go to the main market, most important thing is I have learnt to go to X place, really mam, if I have to go, I needed somebody to accompany me from the family either husband, MIL, BIL.. means I needed to someone to come with me even for short walk.. I have learnt how to go, to talk.. in society...little hesitation has gone means now I can ask at least.. 2.difference is there, like before man used to do outside work, they will only do but now if I am going so I can do all the work related to market, tehsil, so in my house if there is work I will be doing , they feel I can do it , like other women I also used to in group, somebody

		need to accompany, but now it is not like that can do child admission and other work..
Increased workload due to temporary population		I am telling you I have 862 population; I will have only 862 rations only.. if I count whole population then I will have 2000-2500 why because Nepali people are also there, tenants are there..how can they have two places card..because we have to work for these population where we don't get any benefit, they are in our population but we don't get any honorarium for the services to them.. so why we have to even count them.. as it is increasing there are extra ASHA workers for them.. count those who have AADHAR card just and keep 2 ASHA in town for 1000 population.. difficulty is not there; everyone's work is going well.. it is good.. for some employment you can say or timepass, it is an excuse to come out of house to a woman, because my aim was this, I wanted to go out, like I did studies, I did graduation at that time, I wanted to use my education, if I would have remained inside then I would have forgotten writing my name, so I can go out, I can tell my children, although they are well aware but still...
Lack of basic work-related arrangements at the hospital	no facilities for ASHA to stay in hospital as in room, food,kits, medicine, no mask, sanitizer, gloves provided	1. what facilities they have given, no transport, no stay arrangements we have to do it on our own.. no food.. nothing.. at least increase our incentives if they can't provide room for staying.. 2. now it is like there we go for delivery.. at night .. there should be one room for us.. ASHA ghar.. like we have brought the patient there.. so we can rest .. and there should be some food Facilities..

Lack of clarity regarding payments received against claims	There is no proper channel through which they can see how much they are paid for the services, they receive it in account as total amount and when asked they are not given clarity	1. see we don't know where our payments are cut and for what we have received, as in we submit all the reports and vouchers they collectively pay us like 1000, now we don't know for what it is.. mine has not come of 2 times.. we don't get the list of anything.. 2. yes, now if they provide us the list, we will get to know, like the budget came we have calculated for 2-3 months, now we don't know out of this for what came and not.. how we should tally... problem is either it should come total till that with what we should match for that we don't know..
Lack of Institutional Support		1. now, nobody.. the supervisor who was on duty in polio he also didn't come.. they should have come mam, my whole village supported me, came forward for me, all the women came, in police station also.. 2. no such kind of facilities here, like 3 years back my husband had attack, suddenly got attack, husband was alone and with me were two children, at that time I sat at home for 2 months because had family responsibilities and it was my husband's house.. so at that time I asked someone else to do my work, I did not take any benefit, I didn't get any kind of benefit...
Lack of recognition, criticism and despite ASHA workers' efforts		1. The person sitting far away won't think that difficulties are for us, they (patient) might be not coming, vo to sidhe humre upar thopte haina ki ye nahi ari hogi (they directly blame us for not coming) ... 2. 10 Rs they are giving.. y to bikhari.. jo bhikari bhi mang raha hai usko bhi to 20 Rs de re hai.. plains people are doing now hilly areas one is left... we don't get anything from 10Rs, for 1 person.. how many they are.. we have to take sputum .. what is the benefit.. 2. ASHA ko har koi sunna k jata hai, matlab kya smjhate hai y ASHA ko.. ASHA ke sath hum mahila bhi hai, gaye gujare ni hai ghr mai izzat to hai hi.. mai y chhti hu agr chote bhi worker hai to izzat s bolana chye.. ab koi umar ka hai, sab chote ni hai.

Lack of training, digital literacy and instruction during COVID-19		no training was given, just go and do the quarantine, training was not given just told by the supervisor to do this on phone, so many ASHA could not do properly, some got more payment some were not able to upload..so they stopped now they do it on their own..
Low and Irregular Payments	inconsistent and irregular payments to ASHA worker	1. that too doesn't come on time, 3-4 month .. that too now earlier it used to take come in 6 months.. 2.since august it has come, every month they don't give... 3. there is no time, sometimes we get 2000rs, sometimes we receive in 4 months, sometimes in 5 months, there is no time
Menstruation-related stigma		1. in village we stay as per village things, but when going out we can't do like this.. so in village we stay like other people.. family cook food and provide 2. what is the point of saying it loud, we tell at home, but in village if told it becomes chaos, ye kar gayi vo kar gayi, valla, palla... bohot mante hai vo log, apko pata hi hai gaye ka mutra dalte hai.. only one thing we don't enter temple, do our work outside their house and avoid going inside houses..
Misconceptions and myths regarding the vaccination and other health related scheme by government		polio pilane k liye to bilkul hi kh dete the ki..gaon mai chala dia .. ab gaon ki hi thahare aurato, vo kahane vale thahare ki polio pila dia to age ko bacho ke bache ni honge

Money-mongering and corruption	The payments ASHA make to the staff and other hospital workers to get their work easily done in future for their patients. This is forced on them to make the payment otherwise they face the consequences in future.	one time what happened .. some funds come.. during covid also it came..5000-5000 in instalments..10000 total..then village accountant, she was lady.. so.. she looked for me.. was ready to come to my house for 5000Rs. asking me why you are not spending..I said madam with 5000 how I will, that is work of representative's work.. at that time Pradhan did sanitization in whole village and mask.. so she used to be with Pradhan, she didn't say to him..then Pradhan said to me why don't you give this 5000Rs for the village accountant transport charges.. I said this we didn't get for travel charges for them..I didn't debt it because it will be spent..when we have to by then only debit the amount..i said n=right now I have not debited, and for this if she is saying then I am not going to give, whatever you want to do just do..she was after me ..come to my home ..is said to sir also that ASHA ko har koi sunna k jata hai, matlab kya smjhate hai y ASHA ko..ASHA ke sath hum mahila bhi hai, gaye gujare ni hai ghr mai izzat to hai hi..mai y chti hu agr chote bhi worker hai to izzat s bolana chye.. ab koi umar ka hai, sab chote ni hai..then sir said don't say like this worker is worker, small or big at position.. then I am saying now that village accountant would be earning..50k at least must be getting .. so she the greed for 5K ...she..
Need for more training and upgradation of skills of ASHAs rather than repetition of traditional training methods and new post		now it is February, it is going to end, so till now there is no information about our trainings.. now when march will they have to show funds, so before 10th march they will keep some training, they will teach us the same thing which we have studies in 2006-2007 course.. what I mean to say is when you have hired us in hospital, give us practical knowledge..
Negotiating resistance and maintaining harmony in ASHA's work within the community		yes, it was very much needed, if we tell them there, they will bring vehicle and take the patient, now their family members will think that this ASHA complained, so this we did not do, that is why there was mutual understanding with the people that why people were safe, from my village nobody died.. we were also safe.. we did this..

No fixed salary, just service-based incentives		what is there in this.. now at least getting something.. there is no salary for us.. it depends upon cases.. now we are getting 3000 per month..
No fixed working hours for ASHAs		1. our is not timing work, if there is some urgent work, if there is some delivery we have to leave it..whatever emergency we have at home we have to go, although family also get upset, we have to endure thing from them also. 2.We don't have a particular time, they can call us anytime, there is our centre, we have our meetings there for vaccination related, they can call us anytime, and no particular time is there, they can send us at 5 pm also, sometime call us at 8 o clock, there is no time.
No Holidays and personal time for ASHA workers		because at 12:30 AM I received a call for delivery, now for pregnant I have to go at any time.. like 2 days back I was so ill, that since 2PM I had excessive vomiting till 6AM continuously, as My husband was calling to check my health, I am not eating much.. I didn't drink water, still I was ready to go for the delivery... in this situation also, this is also big problem for us..
Perceived exclusion in outside workplace		here our sisters, mam they all behave nicely , there is no problem we stay with them, nobody treats us like outsider, consider us like them they all treat us good; everything is good here .. but there they treat us badly, behave very poorly in Y hospital.
Physical and mental impact on ASHA's health due to work	due to work pressure ASHAs health degrading physically and mentally	1.I went in such hurry because she would have died, so I ran like anything.. at night... my legs were swollen that I slept for 3 days 2. you see above 40 years ASHA workers are suffering from depression, having medicines, they are eating depression medicine.. you search for it (slapped the table), if it won't come, more than half, it will come, three ASHA are here having depression medicines
Practical help by other ASHAs in work and personal struggles due to sisterhood		1.we talk among ourselves, the ASHA in our centre, with whom we feel we can share and get cooperation, like if I have emergency and delivery is also there, I can't go then we adjust among ourselves... 2. since very beginning I used to prepare reports for all other ASHA worker, of K place, still I do , I teach them but since my other work has started, I taught them..

Praise and recognition from peers and community		Our image, in front of people is .. she is best, before doctor, like in my area.. they ask me first, if they have to do checkup for their children or sometimes they won't call doctor they ask me first like this is happening.. when I say go to doctor .. they ask what should be done.. I make them understand ..that doctor is doctor.. means in front of society we have much value..
Pressure to work irrespective of harsh weather conditions		if it rains and call comes for meeting at PHC/CHC, even if it rains, we have to go anyway, once when my younger son was about to be born, in the month of January, too much snow fell and I had to go for polio duty, still went there I had to go..I wore shoes, wrapped polythene around feet, so cold water doesn't seep in .
Referrals of patients due to non-availability of doctors, medical equipment to distant hospitals		from here to Higher reference centre Y, they say go to Y ... they say we don't have this and that, operations can't be done, from here CHC itself they write for Higher Reference centre, ... there they see the slip and don't take the patient, then we take to Y ...that's why from all the places everybody come there, from very far away... as in hilly area.
Resistance of the community to access services, blaming ASHAs in case of issues		hardships... (emphasis on the word)?? when we first(emphasis) became the ASHA..itni khathaniyaa ayi , itni khathaniyaa ayi na....(there were so many hardships , so many hardships), nobody agreed.. nobody was ready to drink polio, aur bi dhanth dete the, badi ayi ASHA yha ayi hui hai humare ghar mai ye kari hai vo kari hai, (takes breath) humari bahu ko bhadka rahi hai ..unko khali aisa khari hai.. areee, khali unko khate the (politely).. tikka lagane ke liye manakrte the na vo log ...polio pilane k liye to bilkul hi kh dete the ki..gaon mai chala dia .. ab gaon ki hi thahare aurato, vo kahane vale thahare ki polio pila dia to age ko bacho ke bache ni honge

Resistance to be an ASHA worker due to familial responsibility, education and less payments		Mam nobody was ready to be ASHA worker.. I refused one time but again came back to me these people (laughing).. Aganwadi didi... ANM must have seen... ANM came to my house.. polio duty was on.. actually my distant Mother-in-law, she hid the child ..laughing .. she didn't give the child to have polio(laughing), then I said , my house is next to her, then I said madam sit , maybe she may have thought she is good.. then she said to AWW to go to her only... to make ASHA... I am alone from my house.. neither I have brother-in-law, no mother-in-law nor father-in-law.. there is nobody.. I said whether I will do household chores or will do this work.. I was not ready.. after that they went to another... lady...she was also not ready.. they went to 2-3 more ladies... they came back to me.. then AWW didi said they will you help as much as they can.. I said neither I have certificate nor other things..
Role expansion and added duties other than programme goals		1. yes, they have given so much work from past.. before just maternal and infant rate.. now everything Tb.. aur.. everything is given to ASHA.. 2. we were mainly responsible for pregnant women and newborns. But now, our duties have expanded to include many other tasks.

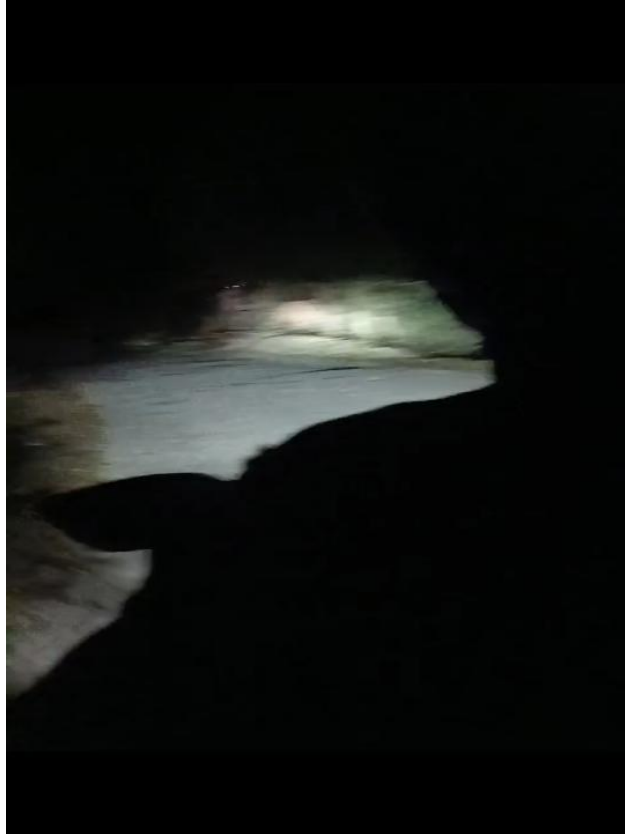
Sacrificing festivals and personal engagements due to work obligation	1. There have been situations where I had to leave functions midway. It hurts because people don't always understand our work. 2. It affects a lot. Even if there is a festival, we might get an emergency call and have to leave everything to attend to a patient. Sometimes, we can't fully enjoy celebrations because of our responsibilities. 3. During Diwali, I feel why did I do, I have so much work at home, and I have to go, on Diwali I had to go, then went there did checkup still delivery didn't happen, whole day was spent, then I admitted her and came home, there were so many calls, and if you have left something in between you won't feel at peace in other work, she is calling me they are not seeing me, didi you come, can't happen right, can't do any other work at home, this affects a lot ... ASHA, any ASHA in their family marriage, functions won't in whole be attentive because they have to see phone... they have got the employment, to go out of house but because of timing, they have also left their house work, they have left everything... like before women used to not go anywhere, remain at home now meeting people, talking to them, telling them their story, listening to other problem.. getting knowledge also... but time is also not there, like today I have marriage of my nephew and I have to go for polio duty, so I will leave the wedding, I left my nephew's wedding due to polio duty..
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ANNEXURE 5: Photos shared by the participants as part of Photovoice











ANNEXURE 6: Gender Analysis of ASHAs work processes in a district of Uttarakhand

S.NO.	CODE	TRANSCRIPT EXCERPTS	GENDER ANALYSIS	ILLUSTRATION
1.	Trying to balance work and domestic responsibilities	I feel that the woman has to be active, doing all the work of family without making faces and doing the duty..	Role	The gender norms where women are expected to do all domestic responsibilities silently without complaining as part of their work towards family
2.	Conflicts, taunts and pressure by family due to lack of regular payments making them dependent on family for financial resources	Aye din kalesh, aye din kalesh...ek ache se suit pehane ke liye bhi husband ke age hath failana padhta hai...there is constant dependence on husband for everything...	Norm	Patriarchal norm dictate that women must seek approval to access any resources, usually male member look after the finances and they are provider. The women role is dependent on husband for need and looking after family needs. This shows condition of women when not financially secure and highlights the position of women at personal space.
3.	Gender based defamation and character attack	and where you were for so many days, from family it has never come but people from community I have heard.. like there was delivery, there were 3-4 people on the backseat including patient, they were vomiting also.. there was issue with sitting so I sat I front, that woman's MIL said I had affair with another person in front, that is why I sat in front.. so, this I heard from the village people .. so, I thought of confronting her as the rumour reached to the house	Norm	Patriarchal norms in community that police women's mobility and interaction, especially with men. The stigma around women sitting in front seat with the driver, possibly men, often seen as unacceptable behaviour

4.	ASHAs under scrutiny for social norm transgressions even by one of them	if one doesn't go for delivery then one person talks to another saying it must be ASHA, she doesn't come, when she comes? Many more rumours, so we get bad reputation in front of those also where we had good terms, our efforts become useless.	Norm	Women don't hold autonomy for decision making for themselves. Often forced to take up the work and kept under radar of morale policing for the action they take. The action of one women is generalized for all harming the dignity and credibility of one's effort
5.	Social stigma around working women	My brother-in-law mocked—'DM ban gayi hai purse latka ke.' In beginning I carried polythene instead of purse out of shame. Even grooming was judged.	Norm	Patriarchal norms expect women for modesty and ridiculed for their career progression
6.	Gendered responsibilities and family's obligation	women have to see household, she has to see other problems also like house chores, women have to cook food, man need not to cook food, men need not do house chores.. men get the time, in comparison to woman man has time because woman after finishing her house work she will see the others also, she has to go, do the check-ups and provide medicine but man will just go with patient and come back and need not to do anything..	Norm and role	Women are responsible for both household chores and given task work, but the burden is not same in comparison to man, who have no obligation to household related activities. The women household work is invisible, but it is tedious and exhausting.
7.	Sexual harassment	Once I took lift from a car. The driver misbehaved... villagers say—'What type of woman she is?' One truck driver told me—'Not all drivers are bad, sometimes it's about what kind of lady she is'	Norm	Women mobility at night is associated to label of loose woman, not dignified work if requires night work. Normalization for the harassment if seen outdoor at night.

8.	Gender based defamation and character attack	Her husband said—‘Tum firuvabani ki ho, sabko firuva bana rakha hai.’ Then I cried.	Norm	ASHAs are disrespected for their work and belittling it by blaming for the influence on another woman. Women movement other than household activities is not considered modest and feminine, and supposed to be restricted.
9.	Carelessness and negligence towards personal well-being and health	we don’t get time, after giving food to all if late then leave without having food, someday till evening, leave ourselves only, aurate khud ko hi chodhti hai aur kis ko, bache usko time pe khilane hai, pati ke kam karne hai, bacho ke kam krne hai, uske bad jo chuth gaya vo khud k liye, apne liye bachata kaha hai (laughs)	Values and roles	Women are expected to prioritize their family over their own needs and health- normalization for self-sacrifice is for women, not men. The values learnt by a woman since childhood and society is reflected here by not caring for themselves and accepting it. Th last line highlights reduced access to resources due to division of labour with laugh highlights the awareness of situation but normalized.
10.	Career Constraints and Regrets	I usually say to my husband, you are fool, why did you send me to this, here what I am getting, other women are getting good money, why you didn’t allow me to go for them..	Roles and Power differences	Women don’t have power to make decision for themselves, their primary role restricts them to looking after family and their needs. They have no autonomy for decision making, often taken by the male member of the family either husband or FIL, out of patriarchy.
11.	Challenges in accessing timely and safe transport for ASHA during maternal health emergencies	there will be delivery , govt vehicle won’t be there, we come on our own vehicle, during night, different types of people are there in the vehicle, we don’t come as per our choice of vehicle, we just feel like, we go	Norm and roles	Forced to compromise their safety due to their role in family, Systemic neglect of women for the safe transportation

		home, when it's time to go home, ma'am, we just take whatever ride we can get. Sometimes, we even travel by truck, because a woman thinks about her home only right, like I have to do this work, that work tomorrow		
12.	Community practice of ritual cleaning with cow urine affecting hygiene requirements	in my area it was not much but village people would say, you went there so Chuth-chath, like there is delivery, although for hospital we don't consider, but now in hospitals they consider it a lot, like cow's urine(gounth)... yes, as they go home, any people have avatar of god and goddess, many sister and people say it, I put gounth on myself, take bath and then have food.. many people face problem because of this, my husband also, he faces problem, so even if I come home at 12AM, I have to take bath, I will call them to boil water I have to take bath anyway, then only come inside, whether it's cold or what... even if I come so late, I have to take bath then put gounth and come inside...	Norm	Women's are considered the ritual pollution and need purification, by putting cow's urine and baths. Patriarchy is seen.
13.	Conflicts, taunts and pressure by family due to lack of regular payments making	ab gharwale bhi naraz ho jare hai, badi naukari karne vali ayi hai, kya milra hai naukari se ... yess.	Norm	Women's are discouraged and even ridiculed if there is no financial benefit to it. They are undermined and

	them dependent on family for financial resources			emotionally blackmailed for the labour they do.
14.	Disrespect and verbal humiliation by the higher authorities	She told that the doctors said to ASHA “randi”, they have blamed ASHAs for so much... so like this happened.. they think we do some bad business here	Power difference	Women are abused due to hierarchical power, and ASHA's at the lowest cadre humiliated for the work they do, they are also under the scrutiny due to one's action of some wrong act and then mistreated generally. Would it happen to a male health worker if present at same position?
15.	Distant house in villages to cover for survey, vaccination and other given work	we get only 100 rupees, 75 for today's booth and 100-100 for two days.. late night we come home.. when gone in morning... morning 9 o'clock we go after breakfast and return at night.... itni dur dur gharo mai jana thehera, numbering karna thehera, to rat ko phuchte hai 2 din mai, to paisa aisa hi milne vala thehera, 375 rupee for 3 days...	Role	The role of ASHAs to cover the long distance as part of their work without adequate compensation. Under valuing their labour and women exploitation due to gender insensitivity
16.	Duties imposed on ASHA's during crisis like COVID-19	during Corona.. when the whole world was living inside then ASHA workers.. we outside.. we didn't get even the sanitizer, mask .. all that we bought from our own money..	Power difference	ASHA workers were forced to work during corona due to the power imposed by the authorities over them to self-sacrifice and provide the care. Inability of authorities to provide safety measures shows that women's are overlooked.
17.	Exploitation of ASHAs due to under paid labour, overwork	One thing is people have this wrong assumption, every work that comes ASHA will do. Everybody thinks ASHA is hired so she is our servant,	Norm	Women's work is undervalued and often unpaid at home and in the community. The role of ASHA suggests their ever-availability for the

	and institutional neglect	like servant who has to do all the work. Likewise, these people think ASHA is there so she will do all the work... At least understand ASHA's work.		community, often over powered by the people.
18.	Fear and self-safety concern in ASHA in village and distant places due to drunk people, animal attack, fear of verbal abuse and assault	y izzat s khelna hi hua, kyuki ajkal tum kisi pe vishwas ni kar skte, late night you go, you don't know, nowadays doctors are also like that, they are, I have heard they are,, now late night going in 108, in man's mind it will also come, she is at late night, if he is not good, who will like that my wife goes late night alone with some other man, although my husband didn't think, now my son drops me and bring me back at night.	Norm	Women night time movement is unacceptable and also it is threat to family honour. This also highlights how women become a subject of sexual harassment or violence due to their presence at odd hours, which restricts their mobility and also raises concern.
19.	Gendered responsibilities and Family's obligation	We finish household work first, then go for duty. When we return, we complete the remaining chores.. He supports me and my family, but Yes, but my work remains the same, I have to manage everything. There I don't get any help from family side.. Even if ASHA work increases, household responsibilities don't decrease.	Role and responsibilities	Women are supposed to fulfil their role of women who provides at home irrespective of the how tiring her work is. That is expected norm for a woman and lack of distribution of labour at home.
20.	Hierarchical disparities and power dynamics within the health system	CHO madam... immediately they will call us... they think we are low class workers	Power difference	Display of power due to position, class or caste.

ANNEXURE 7: Participant Information Sheet (English)
Achutha Menon Centre for Health Science Studies (AMCHSS)
Sree Chitra Tirunal Institute for Medical Sciences and Technology
Trivandrum- 11

**Exploring Gendered Challenges and Vulnerabilities: A Qualitative Study of
ASHA Workers in Uttarakhand**

Informant serial number:

Participant Information Sheet

Greetings, I am Dr. Nidhi Tripathi, a Master of Public Health (MPH) student at the Achutha Menon Centre for Health Science Studies (AMCHSS), Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum, Kerala. I am doing a study to fulfil mandatory requirements for my MPH degree. The topic I'm working on "Gendered Challenges and Vulnerabilities: A Qualitative Study of ASHA Workers in Uttarakhand". The guide for this study is Dr. Mala Ramanathan, Professor Senior Grade at AMCHSS, Trivandrum, Kerala.

You are invited to participate in my study, but before making your decision, I would like to explain why I want to do this study and the potential benefit. I will also explain the study procedures and expectations. I will provide information related to privacy and confidentiality during the study. I request you to carefully read through it, before you decide whether or not to participate in my study.

Please read the information sheet and the consent form carefully and feel free to ask any doubts and concerns. I would be happy to clarify it.

Purpose of the study

The purpose of this study is to understand the challenges and risks ASHA workers face while performing their duties in Uttarakhand. I would also like to know about the experiences you face particularly because you are a woman and also the challenges in the physical environment. I would also like to understand the risk factors that affect your work and expose you to unsafe environment. I wish to do this study as the difficulties faced by ASHA workers in Uttarakhand should be well documented for future solutions.

Procedure

If you are consenting to be a participant in this study, I will conduct detailed interview with you. The interview will comprise questions focused on the challenges and risk factors you face while performing your duties, risks you face because you are a woman, etc. This interview will take about 30-40 minutes of your time. With your consent, I will audio record this interview and will also write notes to document important points during the interview. This is to make sure that all aspects of our conversation are fully captured and accurately represented. Since you provided oral consent during the phone call for taking photographs (or did not give consent), photographs may have been taken of locations and situations where you felt unsafe. This method is known as "Photovoice." I will discuss these photographs with you. These photos will be discussed only with you to understand what they mean to you and why they are important. I believe this will help to better understand the physical contexts in which you work. All interviews will be transcribed, and the information will be translated into English.

Potential risks and discomforts

Participating in the study imposes no risk to your health and work. However, sharing and discussing unpleasant experiences can cause emotional discomfort and stress.

Possible benefits

Although there are no immediate benefits from participating in the study, but your insights will help to improve our understanding of gender-specific challenges faced by ASHA workers. This research may inform policymakers aiming to improve working conditions and safety aspects of ASHA workers.

Cost and financial benefit

There is no provision of financial benefits for participating in the study. Your participation is completely voluntary. Any transportation related cost related to the interview will be covered by the researcher.

Confidentiality

Care will be taken to ensure that the privacy and confidentiality of all the participants are maintained. The audio recordings will be deleted after transcription and translation. All personal data will be handled with utmost care, and only I, the researcher, and my supervisor will have access to it. The final research report will have no personal identifiers.

Withdrawal from the study

Participation in this study is voluntary. You are free to withdraw from the study at any point during the interview or afterwards. No form of penalty or negative consequences will be yielded for the same.

Contact information

If you have any questions related to the study or would like to verify my credentials, you may contact me or the member secretary of our institute's ethics committee.

Dr. Nidhi Tripathi Principal Investigator MPH 2023, AMCHSS, SCTIMST, Trivandrum- 695011 Contact number: 7456055200 Email: nidhi.tripathi062@gmail.com	Dr. Srinivas G Member Secretary Institutional Ethics Committee, SCTIMST, Trivandrum- 695011 Office: 04712524689 Email: iec.mem.sec@sctimst.ac.in
Dr. Mala Ramanathan Guide Professor Senior Grade, AMCHSS, SCTIMST, Trivandrum- 695011 Contact number: 91-471-2524234 Email: mala@sctimst.ac.in	

Would you be willing to participate in the study?

ANNEXURE 8: Participant Information Sheet (Hindi)
अचुथा मेनन सेंटर फॉर हेल्थ साइंस स्टडीज(AMCHSS)
श्री चित्रा तिरुनाल इंस्टीट्यूट फॉर मेडिकल साइंसेज एंड टेक्नोलॉजी
त्रिवेंद्रम-11

लिंग आधारित चुनौतियों और संवेदनशीलताओं का अन्वेषण: उत्तराखंड में आशा
कार्यकर्ताओं का गुणात्मक अध्ययन

सूचना धारक का क्रमांक:

प्रतिभागी सूचना पत्र

नमस्ते, मैं निधि त्रिपाठी, अचुथा मेनन सेंटर फॉर हेल्थ साइंस एंड स्टडीज, श्री चित्रा तिरुनाल इंस्टीट्यूट फॉर मेडिकल साइंसेज एंड टेक्नोलॉजी, त्रिवेंद्रम, केरल में मास्टर ऑफ पब्लिक हेल्थ(MPH) छात्रा हूँ। मैं अपने MPH डिग्री के अनिवार्य आवश्यकताओं को पूरा करने के लिए एक अध्ययन कर रही हूँ। जिस विषय पर मैं काम कर रही हूँ वह है "लिंग आधारित चुनौतियों और संवेदनशीलताओं का अन्वेषण: उत्तराखंड में आशा कार्यकर्ताओं का गुणात्मक अध्ययन"। इस अध्ययन की मार्गदर्शक डॉ. माला रमणाथन हैं, जो त्रिवेंद्रम, केरल में AMCHSS की प्रोफेसर सीनियर ग्रेड हैं।

आपको मेरे अध्ययन में भाग लेने के लिए आमंत्रित किया गया है, लेकिन निर्णय लेने से पहले मैं आपको बताना चाहूंगी कि मैं यह अध्ययन क्यों करना चाहती हूँ और इसके संभावित लाभ क्या हैं। मैं अध्ययन की प्रक्रिया और अपेक्षाओं को भी समझाऊंगी। अध्ययन के दौरान गोपनीयता और निजता से संबंधित जानकारी भी प्रदान करूंगी। मैं आपसे अनुरोध करती हूँ कि आप इसे ध्यान से पढ़ें और फिर तय करें कि आप इस अध्ययन में भाग लेना चाहते हैं या नहीं।

कृपया सूचना पत्र और सहमतिपत्र को ध्यान से पढ़ें और यदि कोई संदेह या चिंता हो तो मुझसे अवश्य पूछें। मैं इसे स्पष्ट करने में प्रसन्नता महसूस करूंगी।

अध्ययन का उद्देश्य-

इस अध्ययन का उद्देश्य यह समझना है कि उत्तराखंड में अपने कर्तव्यों को निभाते करते समय आशा कार्यकर्ताओं को किन चुनौतियों और जोखिमों का सामना करना पड़ता है। मैं यह भी जानना चाहती हूँ

कि एक महिला होने के नाते आपको विशेष रूप से किन अनुभवों का सामना करना पड़ता है और भौतिक वातावरण में कौन सी चुनौतियाँ होती हैं। मैं उन जोखिम कारकों को भी समझना चाहती हूँ जो आपके काम को प्रभावित करते हैं और आपको असुरक्षित वातावरण में ले जाते हैं। मैं यह अध्ययन इसलिए करना चाहती हूँ क्योंकि उत्तराखंड में आशा कार्यकर्ताओं द्वारा सामना की जाने वाली कठिनाइयों का भविष्य में समाधान के लिए अच्छी तरह से दस्तावेजीकरण होना चाहिए।

प्रक्रिया

यदि आप इस अध्ययन में भाग लेने के लिए सहमति दे रही हैं, तो मैं आपके साथ एक विस्तृत साक्षात्कार करूँगी। इस साक्षात्कार में आपके कर्तव्यों का निर्वहन करते समय जिन चुनौतियों और जोखिम कारकों का सामना करती हैं, विशेष रूप से एक महिला होने के नाते जिन जोखिमों का सामना करती हैं, उन पर केंद्रित प्रश्न शामिल होंगे। इस साक्षात्कार में आपका लगभग 30-40 मिनट का समय लगेगा। आपकी सहमति से, मैं इस साक्षात्कार की ऑडियो रिकॉर्डिंग करूँगी और महत्वपूर्ण बिंदुओं को दस्तावेज़ करने के लिए नोट्स भी लिखूँगी। इसका उद्देश्य हमारी बातचीत के सभी पहलुओं को पूरी तरह से और सटीकता से प्रस्तुत करना है।

चूँकि आपने फोन कॉल के दौरान मौखिक रूप से फ़ोटो लेने के लिए सहमति दी थी/नहीं दी थी, जिसमें उन स्थानों और स्थितियों की तस्वीरें खींची गई होंगी जहाँ आपने असुरक्षित महसूस किया। इस विधि को "फोटोवॉइस" कहा जाता है। मैं उन फ़ोटो पर आपसे चर्चा करूँगी। इन फ़ोटो पर केवल आपसे चर्चा की जाएगी, ताकि यह समझा जा सके कि फ़ोटो का आपके लिए क्या महत्व है और यह क्यों महत्वपूर्ण है। मुझे विश्वास है कि इससे आपके कार्य के भौतिक संदर्भों को बेहतर ढंग से समझने में मदद मिलेगी। सभी साक्षात्कारों को लिपिबद्ध किया जाएगा; जानकारी का अंग्रेजी में अनुवाद किया जाएगा।

संभावित जोखिम और असुविधाएँ

अध्ययन में भाग लेने से आपके स्वास्थ्य और कार्य पर कोई जोखिम नहीं है। हालाँकि, अप्रिय अनुभवों को साझा करने और चर्चा करने से भावनात्मक असुविधा और तनाव हो सकता है।

संभावित लाभ

हालाँकि अध्ययन में भाग लेने से कोई तात्कालिक लाभ नहीं है, लेकिन आपके विचारों से आशा कार्यकर्ताओं द्वारा सामना किए जाने वाले लिंग-विशिष्ट चुनौतियों की हमारी समझ को सुधारने में मदद मिलेगी। यह शोध नीति निर्माताओं को आशा कार्यकर्ताओं की कार्य स्थितियों और सुरक्षा पहलुओं को सुधारने में सहायता कर सकता है।

लागत और वित्तीय लाभ

अध्ययन में भाग लेने के लिए कोई वित्तीय लाभ प्रदान नहीं किया गया है। आपकी भागीदारी पूरी तरह से स्वैच्छिक है। साक्षात्कार से संबंधित किसी भी यात्रा की लागत शोधकर्ता द्वारा कवर की जाएगी।

गोपनीयता

सभी प्रतिभागियों की निजता और गोपनीयता बनाए रखने का ध्यान रखा जाएगा। ट्रांसक्रिप्शन और अनुवाद के बाद ऑडियो रिकॉर्डिंग को हटा दिया जाएगा। सभी व्यक्तिगत डेटा को पूरी सतर्कता के साथ संभाला जाएगा और केवल मैं और मेरी मार्गदर्शक इसे देख सकेंगे।

अध्ययन से हटने की स्वतंत्रता

इस अध्ययन में भाग लेना स्वैच्छिक है। आप साक्षात्कार के दौरान या बाद में कभी भी अध्ययन से हटने के लिए स्वतंत्र हैं। इसके लिए किसी भी प्रकार की सजा या नकारात्मक परिणाम नहीं होगा।

संपर्क जानकारी

यदि आपको अध्ययन से संबंधित कोई प्रश्न है या आप मेरी प्रमाणिकता की पुष्टि करना चाहते हैं, तो आप मुझसे या हमारे संस्थान की नैतिक समिति के सदस्य सचिव से संपर्क कर सकते हैं।

डॉ. निधि त्रिपाठी मुख्य अन्वेषक MPH 2023, AMCHSS, SCTIMST, त्रिवेन्द्रम-695011 संपर्क नंबर: 7456055200 ईमेल: nidhi.tripathi062@gmail.com	डॉ. श्रीनिवास जी सदस्य सचिव इंस्टिट्यूशनल एथिक्स कमेटी, SCTIMST, त्रिवेन्द्रम-695011 ऑफिस: 04712524689 ईमेल: iec.mem.sec@sctimst.ac.in
डॉ. माला रमणाथन मार्गदर्शक सीनियर ग्रेड प्रोफेसर, एएमसीएचएसएस, ससीटीआईएमएसटी, त्रिवेन्द्रम- 695011 संपर्क नंबर: 91-471-2524234 ईमेल: mala@sctimst.ac.in	

क्या आप इस अध्ययन में भाग लेने के लिए इच्छुक होंगे?

ANNEXURE 9: Informed Consent Form (English)
Achutha Menon Centre for Health Science Studies (AMCHSS)
Sree Chitra Tirunal Institute for Medical Sciences and Technology
Trivandrum- 11

**Exploring Gendered Challenges and Vulnerabilities: A Qualitative Study of
ASHA Workers in Uttarakhand**

Informant serial number:

Informed Consent Form

I confirm that I have read/heard and understood the information sheet for the study “Exploring Gendered Challenges and Vulnerabilities: A Qualitative Study of ASHA Workers in Uttarakhand”, as provided in the information sheet. I have been given the opportunity to ask questions, and all my doubts and concerns were addressed to my satisfaction. I have also been informed about any possible harm, discomforts, and benefits (if any) of this study. I also understand that my privacy and confidentiality will be maintained throughout the study, including the submission of the final document. I acknowledge that my participation in the study is voluntary and that I am free to withdraw at any time, without providing any reason, and without any consequences to myself.

By signing this form, I agree to participate in this study.

I agree to be interviewed

I agree that this interview be recorded

I agree to take and share photos for the study

A copy of this form has been given to me.

Date:

Place:

Name of the participant	Signature/Thumb impression
	Witness (In case of thumb impression)
Principal Investigator Name	Signature

ANNEXURE 10: Informed Consent Form (Hindi)

अचुथा मेनन सेंटर फॉर हेल्थ साइंस स्टडीज(AMCHSS)
श्री चित्रा तिरुनाल इंस्टीट्यूट फॉर मेडिकल साइंसेज एंड टेक्नोलॉजी
त्रिवेंद्रम-11

लिंग आधारित चुनौतियों और संवेदनशीलताओं का अन्वेषण: उत्तराखंड में आशा
कार्यकर्ताओं का गुणात्मक अध्ययन

सूचना धारक का क्रमांक:

सहमतिपत्र

मैं पुष्टि करती हूँ कि मैंने "लिंग आधारित चुनौतियों और संवेदनशीलताओं का अन्वेषण: उत्तराखंड में आशा कार्यकर्ताओं का गुणात्मक अध्ययन" के लिए दी गई सूचना पत्र को पढ़ा/सुना और समझा है। मुझे प्रश्न पूछने का अवसर दिया गया है और मेरे सभी संदेहों और चिंताओं का समाधान मेरी संतुष्टि के लिए किया गया है। मुझे इस अध्ययन के संभावित हानियों, असुविधाओं और लाभों (यदि कोई हो) के बारे में भी जानकारी दी गई है।

मैं यह भी समझती हूँ कि इस अध्ययन के दौरान मेरी गोपनीयता और निजता बनाए रखी जाएगी, जिसमें अंतिम दस्तावेज़ की प्रस्तुति भी शामिल है। मैं स्वीकार करती हूँ कि इस अध्ययन में मेरी भागीदारी स्वैच्छिक है और मैं किसी भी समय बिना कोई कारण बताए और बिना किसी परिणाम के इससे हटने के लिए स्वतंत्र हूँ।

इस फॉर्म पर हस्ताक्षर करके, मैं इस अध्ययन में भाग लेने के लिए सहमत हूँ।

- मैं साक्षात्कार के लिए सहमत हूँ
 - मैं सहमत हूँ कि यह साक्षात्कार रिकॉर्ड किया जाए
 - मैं इस अध्ययन के लिए फोटो लेने और साझा करने के लिए सहमत हूँ
- मुझे इस फॉर्म की एक प्रति दी गई है।

☐
☐
☐

तारीख:

स्थान:

प्रतिभागी का नाम	हस्ताक्षर/अंगूठे का निशान
	साक्षी(अंगूठे का निशान होने की स्थिति में)
मुख्य अन्वेषक का नाम	हस्ताक्षर

ANNEXURE 11: Tool (English)

Phone Script

Hello, My Name is Nidhi Tripathi. Am I speaking to (ASHA worker name)?

[Wait for confirmation]

I got your Number from NHM office, “A” district, Uttarakhand, can I speak to you if it is convenient for you at this moment or I should call later?

I am doing study on ASHA workers, so I wanted to talk to you about your work. Are you using WhatsApp on this Number? If yes, may I send you the permission letter which I have received from the CMO office, to conduct the study?

If no, could you please provide me another number where I can send it to you, so that you can read and then, after about 15 minutes, I will call you.

[After 15 minutes]

Hello, (ASHA worker name). I sent you the permission letter. Did you receive it, have you read it? Can I speak to you further regarding it?

I am doing research work on ASHA workers, I want to know about the challenges an ASHA worker face during their work, and especially how your work affects your safety and well-being. I would like to learn more about your experience as part of my study will be conducted in Nainital that is why I have got list of ASHA workers from the NHM office, as they have given me permission to talk to you regarding my study.

May I know that you have camera in your phone? Do you know how to use it?

I am asking these things because as part of my study I would like you to take photos of places, symbols, situations or you felt unsafe, felt difficulties to do your assigned work as ASHA. You can take photos of what keeps you motivated to be an ASHA worker and what challenges you face on daily basis.

You can take 5-6 minimum photos you want, if you want more then there is no limit to that but you have to caption those photos so that on the day on the day of interview, we can have discussion about those photos as well. You can add a brief caption (text to the photo you clicked) explaining why you took it. You can send it to me on my WhatsApp number. These pictures with caption will help to discuss, so you can recall why you clicked it. You can take these pictures over a period of 7 days and after that we will fix date, time and location where I can interview you.

I have to also mention, while taking picture, please take care to not include any people who are visible- There should be no pictures of children <18 years and if you are clicking someone's direct picture (full face), please take their consent.

So, may I know whether you will be able to participate in my study and will be able to click pictures? Regarding the interview, it will take 30-45 minutes of talking with me. I will meet you at a place of your convenience so that others cannot hear what we are talking about. All the information collected during this period will be kept confidential and only I and my teacher (guide) will see and hear it. Your Name, place of work and other personal information won't be mentioned anywhere.

I am considering it as oral consent for your side, which you are willing to participate in my study.

May I also know what day is fine with you for interview? At what place and time will be convenient to you? I don't want to cause hindrance to your work schedule, so we discuss it as per your schedule and suits both of us.

On the day of interview, I will be taking written consent from you for participation in the study.

Thank you! May I follow up with you in few days to fix up the date for interview?

Thank you again.

In-depth Interview guide

Greetings! My name is Nidhi Tripathi. I was in contact with you regarding my research work through phone and WhatsApp. Thank you very much for agreeing to participate in this study. I hope through this interview I can understand the difficulties ASHA workers (You) face while performing all your duties along with familial responsibilities. As you have already understood the facts in the Information Sheet, I hope all your concerns have been addressed and you have voluntarily agreed to participate in this study. So,

General question for rapport building

1. Can you describe your usual working day as an ASHA worker?
2. Do you face any difficulties performing the given duties, when you go out for fieldwork in the community, what kind of difficulties do you face in performing your tasks?
(For each of the difficulties mentioned, ask :)
3. How do you deal with this situation? How do you cope with those situations?
4. What motivated you to be an ASHA worker? How do you feel about being the ASHA worker?

Economic Challenges related

1. How much you earn as ASHA worker for the work you do at the end of month? Can you describe the challenges you face related to finances while performing your tasks?

2. Can you tell me about situations where you felt financially burdened during your work? How did it impact your ability to do work? Did it impact your work life and personal life?

[Probe: As I talked to some ASHA workers, they said that there is delay in payments, is it same for you? How long it takes to get the incentives? How are you managing this situation? Does it affect you work? How does it affect?]

3. Can you tell, how are finances related decision made in your house? Are you involved in decision making? Is it different after becoming ASHA worker or same? How it has impacted your role in your family?

4. What do the superiors and the office have to do to ensure timely disbursement of incentive to your account? What problems do you experience in this regard?

Socio Cultural Challenges related

1. In many villages there are customs and traditions that people follow, as you do too in your village. How have these customs affected the work you do? Can you give examples of this?

2. When you work within the community, how have they looked at you in terms of your position- is it as a woman of the village or as a person from the health system? When people say things or do things that are not acceptable or respectful, how does it make you feel? What are the situations you have felt being isolated by the people?

[Probe: any personal experience or observation where you felt it is not acceptable and you or other ASHA worker is being isolated?]

3. Do you face any issues when you enrolling women to go to the public hospital for delivery? What kinds of resistance do you experience regarding institutional delivery? When do you experience resistance and when do you experience encouragement?

4. How different is it for you when you work in the field? Would it be the same for a male worker in your place as an ASHA worker? Do you feel like you are treated differently than a male healthcare worker?

[Probe: Have you heard any ASHA workers telling these instances?]

{Hint: Do you feel that your role as an ASHA worker — sometimes working late nights, staying out, and talking to men — causes issues within your family or with people around you?}

Environmental Challenges related

1. What issues do you face during the rainy season or winter, and how does this affect your work?

2. How do you perform your duties when there is a landslide, and it leads to road blockages?

3. How much time it takes to do field visit? Do you have to reach people house to house for services? How does this affect your safety and well-being?

Gendered Challenges related

1. Can you tell me about situations, like during festivals or late at night, when you have to take pregnant women to the hospital? How do your family (elders, husband, and children) react to it?
2. Can you describe your responsibilities at home? Who lives with you in your home?
[Probe: Who is usually doing the house chores like cooking, cleaning and taking care of children?]
3. You have responsibilities at your home to your family members and you also have duties as an ASHA worker. How do you manage both? Who supports you and helps?
[Probe: How does your family support your work? Has any work you do as an ASHA worker caused any tussles within the home? How are you managing this?]
4. Does your family or the family of the pregnant woman accompany you or the pregnant woman to the hospital at late hours? Who usually accompanies you?
5. Can you describe any situations in which you felt unsafe?
6. How different is it for you when you work in the field? Would it be the same for a male worker in your place as an ASHA worker? Do you feel like you are treated differently than a male healthcare worker?
7. Do you feel that your role as an ASHA worker — sometimes working late nights, staying out, and talking to men — causes issues within your family or with people around you?

Physical Risks related

1. When you take pregnant women to the hospital at late hours, what kind of situations do you face?
2. Can you describe any situations in which you felt unsafe?
{Hint – As u have to walk long distances to reach people to provide services, How does this affect your safety and well-being?}
3. How was your experience as an ASHA worker during COVID-19? How did you deal with the challenges during emergency situations like COVID-19?

Emotional Risks related

1. How do you deal with situations when families don't cooperate or when you are refused services at a Primary Health Center (PHC)?
2. How do you see yourself as an ASHA, are you part of the community or the health system? How the community sees you?
3. How does the community treat you as an ASHA worker? Are there any instances where you felt mistreated by the community and your family?

Impact on Work related

1. You have been working as ASHA for a long time here. You have described so many of your experiences and the problems you faced and dealt with. Are there any other

problems, especially things you experienced on the work front that we did not talk about?

[Probe: Can you give an example? How did you manage it? Was there a specific strategy? Did you receive support? If not, what motivates you to keep going despite these challenges?]

Impact of ASHA role on Household related

1. As you have worked as ASHA workers, have you noticed any changes in your relationships within your family? Are there any disadvantages or benefits faced by family members because of your role as AHSA workers in society? Have they talked any concerns related to your work?

As, I had informed you previously regarding the Photographs you have to take and share with me with a caption, which you had consented to me orally. Now I would like to discuss those photographs with you.

PHOTOVOICE QUESTION-

SHOWeD Method by Wang and Burris(Wang and Burris, 1997)

1. What do you **See** in this photograph?
2. What is **H**appening in this photograph?
3. How does this relate to **O**ur (ASHA workers) lives?
4. **W**hy does this situation/issue exist?
5. What can we **D**o to address these issues?

Thank you so much for answering my question with such patience. Greetings!

ANNEXURE 12: Tool (Hindi)

फ़ोन स्क्रिप्ट

नमस्ते, मेरा नाम निधि त्रिपाठी है। क्या मैं (आशा कार्यकर्ता का नाम) से बोल रही हूँ?

[पुष्टि की प्रतीक्षा करें]

मुझे आपका नंबर एनएचएम कार्यालय, "A" जिला, उत्तराखंड से मिला, क्या मैं आपसे बात कर सकती हूँ अगर यह समय आपके लिए सुविधाजनक हो या मुझे बाद में कॉल करना चाहिए?

मैं आशा कार्यकर्ताओं पर अध्ययन कर रही हूँ, इसलिए मैं आपसे आपके काम के बारे में बात करना चाहती थी। क्या आप इस नंबर पर व्हाट्सएप का उपयोग कर रहे हैं? यदि हां, तो क्या मैं आपको अध्ययन आयोजित करने के लिए सीएमओ कार्यालय से प्राप्त अनुमति पत्र भेज सकती हूँ?

यदि नहीं, तो क्या आप कृपया मुझे एक और नंबर प्रदान कर सकते हैं जहां मैं इसे आपको भेज सकूँ, ताकि आप पढ़ सकें और फिर, लगभग 15 मिनट के बाद, मैं आपको कॉल करूँगी।

[पंद्रह मिनट के बाद]

नमस्ते, (आशा कार्यकर्ता का नाम)। मैंने आपको अनुमति पत्र भेजा है। क्या आपको यह प्राप्त हुआ, क्या आपने इसे पढ़ा है? क्या मैं इस संबंध में आपसे आगे बात कर सकती हूँ?

मैं आशा कार्यकर्ताओं पर शोध कार्य कर रही हूँ, मैं यह जानना चाहती हूँ कि एक आशा कार्यकर्ता को अपने काम के दौरान किन चुनौतियों का सामना करना पड़ता है, और विशेष रूप से आपका काम आपकी सुरक्षा और कल्याण को कैसे प्रभावित करता है। मैं आपके अनुभव के बारे में और अधिक जानना चाहती हूँ क्योंकि मेरे अध्ययन का एक हिस्सा नैनीताल में आयोजित किया जाएगा, इसीलिए मुझे एनएचएम कार्यालय से आशा कार्यकर्ताओं की सूची मिली है, क्योंकि उन्होंने मुझे अपने अध्ययन के संबंध में आपसे बात करने की अनुमति दी है।

क्या मैं जान सकती हूँ कि आपके फ़ोन में कैमरा है? क्या आप जानते हैं कि इसका उपयोग कैसे करना है?

मैं ये बातें इसलिए पूछ रही हूँ क्योंकि अपने अध्ययन के हिस्से के रूप में मैं चाहती हूँ कि आप उन स्थानों, प्रतीकों, स्थितियों की तस्वीरें लें जो आशा के रूप में अपना निर्धारित कार्य करने में आपको असुरक्षित महसूस हो, कठिनाई महसूस हो। आप इसकी तस्वीरें ले सकते हैं कि आपको आशा कार्यकर्ता बनने के लिए क्या प्रेरित करता है और आपको दैनिक आधार पर किन चुनौतियों का सामना करना पड़ता है।

आप 5-6 न्यूनतम तस्वीरें ले सकते हैं, अगर आप अधिक लेना चाहें तो कोई सीमा नहीं है, लेकिन आपको उन तस्वीरों को कैप्शन देना होगा ताकि इंटरव्यू/साक्षात्कार वाले दिन हम उन तस्वीरों के बारे में चर्चा भी कर सकें। आप एक संक्षिप्त कैप्शन (आपके द्वारा क्लिक की गई तस्वीर पर टेक्स्ट) जोड़कर बता सकते हैं कि आपने इसे क्यों लिया। आप इसे मेरे व्हाट्सएप नंबर पर भेज सकते हैं। कैप्शन के साथ ये तस्वीरें चर्चा करने में मदद करेंगी, ताकि आप याद कर सकें कि आपने इसे क्यों क्लिक किया। आप ये तस्वीरें 7 दिनों की अवधि में ले सकते हैं और उसके बाद हम तारीख, समय और स्थान तय करेंगे जहां मैं आपका साक्षात्कार कर सकूँ।

मुझे यह भी बताना है कि तस्वीर लेते समय कृपया इस बात का ध्यान रखें कि दिखाई देने वाले किसी भी व्यक्ति को शामिल न करें - 18 वर्ष से कम उम्र के बच्चों की कोई तस्वीर नहीं होनी चाहिए और यदि आप किसी की सीधी तस्वीर (पूरा चेहरा) ले रहे हैं, तो कृपया उनकी सहमति लें।

तो, क्या मैं जान सकती हूँ कि क्या आप मेरे अध्ययन में भाग ले सकेंगे और तस्वीरें खींच सकेंगे? इंटरव्यू के संबंध में मुझसे 30-45 मिनट बात करने में समय लगेगा. मैं आपसे आपकी सुविधानुसार जगह पर मिलूंगी, ताकि दूसरे लोग यह न सुन सकें कि हम किस बारे में बात कर रहे हैं। इस अवधि के दौरान एकत्र की गई सभी जानकारी गोपनीय रखी जाएगी और केवल मैं और मेरे शिक्षक (गाइड) ही इसे देखेंगे और सुनेंगे। आपका नाम, कार्यस्थल और अन्य व्यक्तिगत जानकारी का कहीं भी उल्लेख नहीं किया जाएगा।

मैं इसे आपकी ओर से मौखिक सहमति मान रही हूँ, जिसे आप मेरे अध्ययन में भाग लेने के इच्छुक हैं।

क्या मैं यह भी जान सकती हूँ कि साक्षात्कार के लिए आपके लिए कौन सा दिन उपयुक्त रहेगा? आपके लिए कौन सी जगह और समय सुविधाजनक रहेगा? मैं आपके कार्य शेड्यूल/सूची में बाधा उत्पन्न नहीं करना चाहती, इसलिए हम आपके शेड्यूल/सूची के अनुसार और हम दोनों के अनुकूल इस पर चर्चा करते हैं।

साक्षात्कार के दिन, मैं अध्ययन में भाग लेने के लिए आपसे लिखित सहमति लूंगी।

धन्यवाद! क्या मैं साक्षात्कार की तारीख तय करने के लिए कुछ दिनों में आपसे संपर्क कर सकती हूँ?

फिर से धन्यवाद।

गहन साक्षात्कार मार्गदर्शिका

नमस्कार! मेरा नाम निधि त्रिपाठी है। मैं आपसे अपने शोध कार्य के सिलसिले में फोन और व्हाट्सएप के माध्यम से संपर्क में थी। इस अध्ययन में भाग लेने के लिए सहमति देने के लिए आपका बहुत धन्यवाद। मुझे उम्मीद है कि इस साक्षात्कार के माध्यम से मैं उन कठिनाइयों को समझ सकूँगी, जिनका सामना आप एक आशा कार्यकर्ता के रूप में अपनी सभी जिम्मेदारियों के साथ-साथ पारिवारिक दायित्वों को निभाते हुए करती हैं। जैसा कि आपने पहले ही सूचना पत्र में दिए गए तथ्यों को समझ लिया है, मुझे उम्मीद है कि आपकी सभी चिंताओं का समाधान हो गया है और आपने स्वेच्छा से इस अध्ययन में भाग लेने के लिए सहमति दी है। इसलिए,

संबंध निर्माण के लिए सामान्य प्रश्न

1. क्या आप आशा कार्यकर्ता के रूप में अपने सामान्य कार्य दिवस का वर्णन कर सकते हैं?
2. क्या आपको दिए गए कर्तव्यों को निभाने में किसी कठिनाई का सामना करना पड़ता है, जब आप समुदाय में क्षेत्र कार्य के लिए बाहर जाते हैं, तो आपको अपने कार्यों को करने में किस प्रकार की कठिनाइयों का सामना करना पड़ता है?

(उल्लेखित प्रत्येक कठिनाई के लिए, पूछें)

3. आप इस स्थिति से कैसे निपटते हैं? आप उन परिस्थितियों से कैसे निपटते हैं?
4. आपको आशा कार्यकर्ता बनने के लिए किसने प्रेरित किया? आप आशा कार्यकर्ता बनकर कैसा महसूस करती हैं?

आर्थिक चुनौतियों संबंधी

1. आशा कार्यकर्ता के रूप में आप महीने के अंत में जो काम करते हैं उसके लिए आप कितना कमाते हैं? क्या आप अपने कार्यों को करते समय वित्त से संबंधित चुनौतियों का वर्णन कर सकते हैं?
2. क्या आप मुझे उन स्थितियों के बारे में बता सकते हैं जब आपको अपने काम के दौरान आर्थिक रूप से बोझ महसूस हुआ? इसका आपके कार्य करने की क्षमता पर क्या प्रभाव पड़ा? क्या इसका असर आपके कामकाजी जीवन और निजी जीवन पर पड़ा?

[जांच: जैसा कि मैंने कुछ आशा कार्यकर्ताओं से बात की, उन्होंने कहा कि भुगतान में देरी हो रही है, क्या आपके साथ भी ऐसा ही है? प्रोत्साहन प्राप्त करने में कितना समय लगता है? आप इस स्थिति को कैसे प्रबंधित कर रहे हैं? क्या इसका असर आपके काम पर पड़ता है? यह कैसे प्रभावित करता है?]

3. क्या आप बता सकती हैं कि आपके घर में वित्त से जुड़े निर्णय कैसे लिए जाते हैं? क्या आप निर्णय लेने में शामिल हैं? क्या यह आशा कार्यकर्ता बनने के बाद अलग है या पहले जैसा ही है? इसका आपके परिवार में आपकी भूमिका पर क्या प्रभाव पड़ा है?
4. आपके खाते में प्रोत्साहन राशि का समय पर वितरण सुनिश्चित करने के लिए वरिष्ठ अधिकारियों और कार्यालय को क्या करना होगा? इस संबंध में आपको क्या समस्याएँ अनुभव होती हैं?

सामाजिक सांस्कृतिक चुनौतियों संबंधित

1. कई गांवों में ऐसे रीति-रिवाज और परंपराएं होती हैं जिनका लोग पालन करते हैं, जैसा कि आप भी अपने गांव में करते हैं। इन रीति-रिवाजों ने आपके काम को किस प्रकार प्रभावित किया है? क्या आप इसका उदाहरण दे सकते हैं?
2. जब आप समुदाय के भीतर काम करते हैं, तो वे आपकी स्थिति के संदर्भ में आपको कैसे देखते हैं - क्या यह गाँव की एक महिला के रूप में है या स्वास्थ्य प्रणाली से जुड़े एक व्यक्ति के रूप में? जब लोग ऐसी बातें कहते हैं या ऐसे काम करते हैं जो स्वीकार्य या सम्मानजनक नहीं हैं, तो इससे आपको कैसा महसूस होता है? ऐसी कौन सी स्थितियाँ हैं जब आपने लोगों द्वारा अलग-थलग महसूस किया है?

[जांच: कोई व्यक्तिगत अनुभव या अवलोकन जहां आपको लगा कि यह स्वीकार्य नहीं है और आपको या अन्य आशा कार्यकर्ता को अलग किया जा रहा है?]

3. क्या आपको प्रसव के लिए महिलाओं को सार्वजनिक अस्पताल में भर्ती कराते समय किसी समस्या का सामना करना पड़ता है? संस्थागत प्रसव के संबंध में आप किस प्रकार के प्रतिरोध का अनुभव करते हैं? आप कब प्रतिरोध का अनुभव करते हैं और आप कब प्रोत्साहन का अनुभव करते हैं?

4. जब आप फ़ील्ड में काम करते हैं तो यह आपके लिए कितना अलग होता है? क्या यह आपके यहां पुरुष कार्यकर्ता के लिए आशा कार्यकर्ता के समान ही होगा? क्या आपको ऐसा लगता है कि आपके साथ पुरुष स्वास्थ्यकर्मी की तुलना में अलग व्यवहार किया जाता है?

[जांच: क्या आपने किसी आशा कार्यकर्ता को ये उदाहरण बताते हुए सुना है?]

{संकेत: क्या आपको लगता है कि एक आशा कार्यकर्ता के रूप में आपकी भूमिका - कभी-कभी देर रात तक काम करना, बाहर रहना और पुरुषों से बात करना - आपके परिवार के भीतर या आपके आस-पास के लोगों के साथ समस्याएं पैदा करती है?}

पर्यावरण चुनौतियों संबंधी

1. बरसात या सर्दी के मौसम में आपको किन समस्याओं का सामना करना पड़ता है और इसका आपके काम पर क्या प्रभाव पड़ता है?
2. जब भूस्खलन होता है और इससे सड़क अवरुद्ध हो जाती है तो आप अपने कर्तव्यों का पालन कैसे करते हैं?
3. क्षेत्र भ्रमण/फील्ड विजिट करने में कितना समय लगता है? क्या आपको सेवाओं के लिए घर-घर लोगों तक पहुंचना होता है? यह आपकी सुरक्षा और भलाई को कैसे प्रभावित करता है?

लैंगिक चुनौतियाँ संबंधित

1. क्या आप मुझे ऐसी स्थितियों के बारे में बता सकते हैं, जैसे त्योहारों के दौरान या देर रात, जब आपको गर्भवती महिलाओं को अस्पताल ले जाना पड़ता है? आपका परिवार (बुजुर्ग, पति और बच्चे) इस पर क्या प्रतिक्रिया देते हैं?
2. क्या आप अपने घर में अपनी जिम्मेदारियों का वर्णन कर सकती हैं? आपके घर में आपके साथ कौन-कौन रहता है?

[जांच: आमतौर पर घर के काम जैसे खाना बनाना, सफाई करना और बच्चों की देखभाल कौन करता है?]

3. आपके घर पर आपके परिवार के सदस्यों के प्रति जिम्मेदारियाँ हैं और एक आशा कार्यकर्ता के रूप में भी आपके कर्तव्य हैं। आप दोनों को कैसे प्रबंधित करते हैं? कौन आपका समर्थन करता है और मदद करता है?

[जांच: आपका परिवार आपके कार्य में कैसे सहायता करता है? क्या ASHA कार्यकर्ता के रूप में किए गए किसी कार्य से घर में कोई तनावनी हुई है? आप इसे कैसे संभाल रही हैं?]

4. क्या आपका परिवार या गर्भवती महिला का परिवार आपके साथ या गर्भवती महिला के साथ देर रात अस्पताल जाता है? आमतौर पर आपके साथ कौन जाता है?
5. क्या आप ऐसी किसी स्थिति का वर्णन कर सकते हैं जिसमें आपने असुरक्षित महसूस किया हो?
6. जब आप फ़ील्ड में काम करते हैं तो यह आपके लिए कितना अलग होता है? क्या यह आपके यहां पुरुष कार्यकर्ता के लिए आशा कार्यकर्ता के समान ही होगा? क्या आपको ऐसा लगता है कि आपके साथ पुरुष स्वास्थ्यकर्मों की तुलना में अलग व्यवहार किया जाता है?
7. क्या आपको लगता है कि आशा कार्यकर्ता के रूप में आपकी भूमिका - कभी-कभी देर रात तक काम करना, बाहर रहना और पुरुषों से बात करना - आपके परिवार के भीतर या आपके आस-पास के लोगों के साथ समस्याएं पैदा करती है?

शारीरिक जोखिम संबंधी

1. जब आप गर्भवती महिलाओं को देर रात अस्पताल ले जाते हैं तो आपको किस तरह की परिस्थितियों का सामना करना पड़ता है?

2. क्या आप ऐसी किसी स्थिति का वर्णन कर सकते हैं जिसमें आपने असुरक्षित महसूस किया हो?

{संकेत - चूंकि आपको सेवाएँ प्रदान करने के लिए लोगों तक पहुँचने के लिए लंबी दूरी तय करनी पड़ती है, यह आपकी सुरक्षा और भलाई को कैसे प्रभावित करता है?}

3. कोविड-19 के दौरान आशा कार्यकर्ता के रूप में आपका अनुभव कैसा रहा? आपने कोविड-19 जैसी आपातकालीन स्थितियों के दौरान चुनौतियों से कैसे निपटा?

भावनात्मक जोखिम संबंधित

1. आप उन स्थितियों से कैसे निपटते हैं जब परिवार सहयोग नहीं करते हैं या जब आपको प्राथमिक स्वास्थ्य केंद्र (पीएचसी) में सेवाएं देने से इनकार कर दिया जाता है?
2. आप खुद को आशा के रूप में कैसे देखते हैं, क्या आप समुदाय या स्वास्थ्य प्रणाली का हिस्सा हैं? समुदाय आपको कैसे देखता है?
3. आशा कार्यकर्ता के रूप में समुदाय आपके साथ कैसा व्यवहार करता है? क्या ऐसे कोई उदाहरण हैं जहां आपको समुदाय और आपके परिवार द्वारा दुर्व्यवहार महसूस हुआ हो?

कार्य संबंधी प्रभाव

1. आप यहाँ लम्बे समय से आशा के पद पर कार्यरत हैं। आपने अपने बहुत सारे अनुभवों और उन समस्याओं का वर्णन किया है जिनका आपने सामना किया और जिनसे निपटा। क्या कोई अन्य समस्याएँ हैं, विशेषकर वे चीज़ें जो आपने काम के मोर्चे पर अनुभव कीं जिनके बारे में हमने बात नहीं की?

[जांच: क्या आप एक उदाहरण दे सकते हैं? आपने इसे कैसे प्रबंधित किया? क्या कोई विशेष रणनीति थी? क्या आपको समर्थन मिला? यदि नहीं, तो इन चुनौतियों के बावजूद आपको आगे बढ़ते रहने के लिए क्या प्रेरित करता है?]

आशा कार्यकर्ता के रूप में आपकी भूमिका का परिवार पर प्रभाव से संबंधित

1. आशा कार्यकर्ता के रूप में काम करते हुए, क्या आपने अपने परिवार के साथ अपने संबंधों में कोई बदलाव महसूस किया है? क्या आपके आशा कार्यकर्ता की भूमिका के कारण आपके परिवार के सदस्यों को कोई नुकसान या लाभ हुआ है? क्या उन्होंने आपके काम से संबंधित कोई चिंता व्यक्त की है?

जैसा कि मैंने पहले आपको सूचित किया था, आपको फ़ोटो लेनी हैं और मेरे साथ एक कैप्शन के साथ साझा करनी हैं, जिसके लिए आपने मुझे मौखिक रूप से सहमति दी थी। अब मैं उन फ़ोटो पर आपके साथ चर्चा करना चाहूंगी।

फोटोवॉयस प्रश्न-

वांग और ब्यूरिस द्वारा SHOWeD विधि (वांग और ब्यूरिस, 1997)

1. आप इस तस्वीर में क्या देख रहे हैं?
2. इस तस्वीर में क्या हो रहा है?
3. इसका हमारे (आशा कार्यकर्ताओं) जीवन से क्या संबंध है?
4. यह स्थिति/मुद्दा क्यों मौजूद है?
5. इन मुद्दों के समाधान के लिए हम क्या कर सकते हैं?

मेरे प्रश्न का इतने धैर्य से उत्तर देने के लिए बहुत-बहुत धन्यवाद। अभिवादन!

ANNEXURE 13: IEC CERTIFICATE



श्री चित्रा तिरुनाल आयुर्विज्ञान और प्रौद्योगिकी संस्थान, त्रिवेन्द्रम
तिरुवनन्तपुरम - ६९५०११, केरल, इंडिया
SREE CHITRA TIRUNAL INSTITUTE FOR MEDICAL SCIENCES AND TECHNOLOGY, TRIVANDRUM
Thiruvananthapuram - 695 011, Kerala, India
(An Institute of National Importance under Govt. of India)

Grams : Chitramet, Phone : +91-471-2443152, Fax : +91-471-2550728 / 2446433, E-mail : sct@sctimst.ac.in, Website : www.sctimst.ac.in

Institutional Ethics Committee

CDSO Registration No: ECR/189/Inst/KL/2013/RR-24
DHR Registration No: EC/NEW/INST/2022/2775

SCT/IEC/2324/DECEMBER/2024

09.01.2025

Dr. Nidhi Tripathi
MPH Student, AMCHSS
SCTIMST, Thiruvananthapuram

Dear Dr. Nidhi Tripathi,

The Institutional Ethics Committee held on 30th December, 2024, reviewed and discussed your application to conduct the study titled "EXPLORING GENDERED CHALLENGES AND VULNERABILITIES: A QUALITATIVE STUDY OF ASHA WORKERS IN UTTARAKHAND" (IEC /2324) .

Principal Investigator	Dr. Nidhi Tripathi, MPH Student, AMCHSS, SCTIMST
Co-Principal Investigator(s)	Dr. Mala Ramanathan, Professor, AMCHSS, SCTIMST
Duration of the study	6 months

The following members of the Ethics Committee were present at the meeting held on 30th December, 2024

SL. No.	Member Name	Highest Degree	Gender	Scientific /Non Scientific	Affiliation with Institution(s)
1.	Dr. Manoj Murhekar	MD (Preventive & Social Medicine)	Male	Social Scientist	No
2.	Dr. Annapurna.Y	MD	Female	Basic Medical Scientist	No
3.	Adv. Priya Kaimal	LLM, MBL	Female	Legal Expert	No
4.	Dr. Indu PV	MBBS, DPM, MPhil, PhD	Female	Clinician	No
5.	Dr. Rejnish Kumar	MBBS, MD, DNB	Male	Clinician	No
6.	Smt. Rekha Radhakrishnan	M.A (Eng.); B.Ed	Female	Lay person	No
7.	Dr. Biju Soman	MBBS, MD, DPH, MSc, DLSHTM	Male	Basic Medical Scientist	Yes
8.	Dr. Syam K	MBBS, MD, DM	Male	Clinician	Yes
9.	Dr. Srinivas G	PhD	Male	Basic Medical Scientist (Member Secretary)	Yes

The following documents were reviewed:

1. IEC Application Form
2. Funding details and Budget
3. Covering letter addressed to the Chairperson, IEC, SCTIMST dated 09.12.2024 forwarded by HOD
4. Phone script
5. In-depth Interview guide in English and Hindi
6. Informed Consent Form in English and Hindi
7. Participant Information Sheet in English and Hindi
8. Checklist Form
9. Proposal
10. Declaration Form
11. CV of PI and Co-PI

IEC Decision

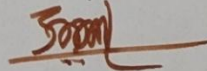
The IEC approved the conduct of the study in the present form.

Remarks:

The Institutional Ethics Committee expects to be informed about the progress of the study, any SAE occurring in the course of the study, any changes in the protocol and patient information/informed consent and asks to be provided a copy of the final report.

There was no member of the study team / Guide who participated in voting / decision making process. The ethics committee is organized and operated according to the requirements of Good Clinical Practice and the requirements of the Indian Council of Medical Research (ICMR).

Sincerely,



Dr. G. Srinivas
Member Secretary, IEC

MEMBER SECRETARY
INSTITUTIONAL ETHICS COMMITTEE (IEC)
SCTIMST, THIRUVANANTHAPURAM



ANNEXURE 14: PLAGIARISM CERTIFICATE

4/29/25, 11:25 AM

Similarity Report

Exploring Gendered Challenges and Vulnerabili...

By: Nidhi Tripathi

As of: Apr 29, 2025 11:23:53 AM
21,761 words - 35 matches - 26 sources

Similarity Index

2%

Mode: Similarity Report

paper text:

CHAPTER 1 INTRODUCTION 1.1 Background In 2005,

the National Rural Health Mission (NRHM), under Ministry of Health and Family Welfare (MoHFW) introduced the ASHA

10

(Accredited Social Health Activist) programme as part of health sector reforms. The ASHA programme was a strategic initiative aimed at enabling access to health for rural India. The programme was designed

to strengthen rural health systems and to improve health outcomes

24

by focusing on maternal and child health (National Health Mission, 2024). These key health indicators aligned with the success of

the Millennium Development Goals for health (Millennium Development Goals (MDGs

20

), 2018) following the commitment to Minimum Needs Programme introduced by NRHM. The ASHA programme was introduced in 2005, after the success of the "Mitanin programme in Chhattisgarh" which served as the programme model for resource-limited settings. Chhattisgarh, after state formation in 2000, faced issues related to poor maternal **source** and infant mortality health indicators due to lack of health infrastructure and human resources (Vir et al., 2014). The state focused on introducing a local health system where people from the community were appointed to tackle the health problems. Mitani are "female friend" called in Chhattisgarhi language, where women are selected from each hamlet and trained to assist in the community mobilization (State Health Resource Centre, 2024). Since 2002,

ANNEXURE 15: PERMISSION LETTER

कार्यालय मुख्य चिकित्साधिकारी [REDACTED]

पत्रांक-एन0एच0एम0/आशा / 2024-25 / 2201

दिनांक- 23 / 12 / 2024

सेवा में

ब्लाक प्रभारी चिकित्साधिकारी-साठवा0केन्द्र / प्रा0स्वा0केन्द्र
[REDACTED]

विषय- डॉ. निधि त्रिपाठी को मास्टर आफ पब्लिक हेल्थ में आशा कार्यकत्रियों पर अध्ययन करना है जिस हेतु उचित सहयोग प्रदान करने के संबंध में।

महोदय,

उपरोक्त विषयक अवगत करना है कि डॉ. निधि त्रिपाठी को मास्टर आफ पब्लिक हेल्थ में आशा कार्यकत्रियों को कार्य के दौरान आने वाली समस्याओं पर अध्ययन करना है। जिस हेतु डॉ. निधि त्रिपाठी द्वारा जनपद के विकासखण्डों में कार्यरत कुल 25 आशा कार्यकत्रियों से व्यक्तिगत संवाद किया जायेगा। जिस हेतु आप अपने अधीनस्थ कार्यरत आशा कार्यकत्रियों से उचित सहयोग प्रदान हेतु आदेशित करना सुनिश्चित करें ताकि इनके द्वारा अपना अध्ययन कार्य किया जा सके।

प्रतिलिपि-

1- अपर मुख्य चिकित्साधिकारी एन.एच.एम. को सूचनार्थ एवं आवश्यक कार्यवाही हेतु।

2- डॉ. निधि त्रिपाठी को इस शर्त पर अनुमति प्रदान कि जा रही है कि इनके द्वारा अपने रिसर्च पेपर की फाइनल कॉपी अद्योहस्ताक्षरी कार्यालय में एक प्रति जमा करवानी होगी और साथ ही इस रिसर्च के डाटा का कोई भी व्यवसायिक प्रयोग नहीं कर सकती है।