


A Critical Analysis of the Role of the Accredited Social Health Activists in Managing Health-Care Services in Pre-COVID and Post-COVID India

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Abstract

The paper investigates and critically analyses the contribution of Indian healthcare workers 'ASHA' that is (Accredited Social Health Activists) ASHA program was introduced by the Indian government and is a vital component of community process intervention. ASHA program is one of the largest community health worker programs; it is considered an important contributor to enabling people's participation in healthcare. This paper examines the crucial role ASHA workers play in India's community healthcare system and broader society. It also addresses the current working conditions, job security concerns, and wages associated with ASHA workers. We focus on the experiences – struggles, and hardships of ASHAs who have been at the forefront of fighting the COVID-19 pandemic in India for the last two years. We try to provide a historical review of the specific category of women health workers called ASHA. Through a brief analysis of the working conditions of the ASHA workers in contemporary India, we reveal the increasing inequalities and exploitation in the context of privatization and corporatization of healthcare work at multiple levels, contributing to gradually eroding the rights of women's healthcare workers. The paper aims to examine the changing responsibilities of ASHA workers, assess their contributions before and after the COVID-19 pandemic, and delve into the experiences of ASHA workers during the COVID-19 crisis.

Keywords: Accredited Social Healthcare Activist, Wages, Healthcare, Exploitation, job security, Community healthcare, Covid-19.

Introduction

In this paper, we investigated the vital role ASHA workers play in managing healthcare services in India. The paper tries to analyze how ASHA workers contributed to the state-run healthcare machinery and study the significance of it during the pre and post covid pandemic period.

This paper acknowledges the redefined role of the ASHA workers that have emerged during the COVID-19 pandemic compared to the pre-pandemic era. We try to focus on the experiences – struggles, and hardships of women health workers (ASHA workers) who have been the frontline force in India's fighting the Covid-19 pandemic for the past two to three years. We study the historical perspective specific to ASHA workers. By briefly analysing the working conditions of the ASHA workers in India, try to investigate the inequality and exploitation faced by these healthcare workers during the COVID-19 pandemic and how these ASHAs contributed to the Indian healthcare system. The objective of the paper is to create an enhanced understanding of the current situation of ASHA workers and reassess their contributions. Taking into consideration the current conditions

there is an urgent need to regularize their work with better wages, empowering them with better equipment and most importantly rewarding them with the dignity and respect that they deserve. ASHA the Accredited Social Health Activists initiated in 2005 under the National Rural Health Mission (NRHM). Although employed under a government scheme ASHA workers are designated as 'activists' and they are not considered as the professional workforce. Their work is considered voluntary and temporary though they are employed on long-term open contracts

Transforming Roles, and Addressing Crisis during the Covid-19 Pandemic in India:

Public/community health professionals have a very important and direct role in coping with the epidemic. During the lockdown, ASHA workers have been collecting data on COVID-19 patients, offering counselling, and raising community awareness. They were doing door-to-door surveys in confinement zones/hotspots. The job they conduct puts them at risk of being boycotted and assaulted by certain locals in some instances, as well as being accused of spreading the virus. Not unexpectedly, these female professionals are growing sensitive to COVID-19, as do health workers in other countries (Amnesty International, 2020).

It changed the role of the ASHA worker as a life-protector rather than a profit (Siegman, 2020). The experiences of Indian health professionals during the epidemic are affected by the country's already fragile and overcrowded public health system. There is a significant disparity in infrastructure between rural and urban India. The healthcare system is becoming increasingly privatized and corporatized (Qadeer, 2019). India experienced a significant and unprecedented exodus of migrant workers from the cities back to the villages during the early stages of the Covid 19 pandemic in 2020 (Breman, 2020) . This is a reversal of the earlier processes of various types of internal migration that have occurred in the nation over the past few decades from rural to urban areas. This exodus increased worries and queries about the pandemic's spread, accessibility to basic healthcare, and containment in the immediate context. The majority of migrant workers who relocate from rural areas to urban areas in search of work depend on welfare professionals like ASHAs or Anganwadi workers to assist them with basic needs like childcare, education, or healthcare. This circumstance also generated greater concerns about the safety, security, and vulnerability of migrant workers in the context of what is known as pandemic citizenship (Chowdhory & Poyil, 2021).

The story has radically changed after the arrival of the COVID-19 epidemic. A second wave of the COVID-19 epidemic attacked the country in April 2021, with daily deaths reaching 3,600 by the end of the month. With the country's inadequate healthcare facilities flooded with patients, hospitals ran short of oxygen and ICU beds (Shivji, 2021). There is no official data on how many health personnel perished in the country as a result of COVID-19, but state-wide estimates indicate that the figure is large (Madhav & Gurmat, 2021). While the country's health system struggled to deal with the pandemic's strains, these ASHA workers in India were at the epicenter of a crisis and played an essential role in managing the crises. While many Indians have shifted to work from home during the lockdown, ASHA workers are performing additional Covid duties apart from their regular tasks. (Raina, 2020).

Public Healthcare System and ASHA workers

The public health industry in India is extensive (Sheikh & George, 2010) describe how rural health professionals in India deal with substandard accommodation, unreliable transportation, and unpredictably available prescription supplies. While discussing social welfare programs and their beneficiaries, legislators pay little attention to the state of healthcare professionals. Additionally, because of the nature of their employment, health professionals' personal and professional lives are entwined even while they participate actively in the community. Although these connections are

more informal, Sheikh and George contend that they also establish boundaries and hierarchies that place limitations on public health employees as they attempt to balance their dual responsibilities as healthcare providers and public health workers.

In the past, women's volunteer local groups like Mahila-Mandals have aided networks of community/village health workers in the social welfare sector. Many women in local volunteer organizations participated in social welfare initiatives as workers or as assistants to the workers, whether they were Auxiliary Nurse Midwives (ANM), Anganwadi workers, community/village health workers, or other types of workers. Power and hierarchy issues are entwined with the interaction between the women worker and helper in these programs, and these issues are further formed by caste- and class-related roles in society (Sreerekha, 2017). Many of these female employees have participated in these programs as temporary or contract workers for years. Most of these women were employed as contract or honorary employees, and they were expected to contribute to every aspect of public health, incorporating it into several social welfare schemes.

The Auxiliary Nurse Midwives (ANMs) in India serve in the same capacity as ASHAs today. They are expected to supervise ASHAs as they work. ASHAs have recently taken on a more prominent role in India's community health workers as more ASHAs have joined the mission. ANMs still play a significant part in public health, particularly in India's rural areas. The Auxiliary Nursing Service was established in India in 1942 in response to the severe nursing shortage that existed there during World War II. Over time, they evolved into ANMs and eventually became permanent employees of the public health system. The role of ANMs gradually evolved from that of a midwife to that of a "multi-purpose" public health worker in the 1970s, expanding their work to a multi-purpose' public health worker who works in multiple industries. Between 2014 and 2019, the current government also created a few schemes, such as Beti Bachao Beti Padhao in 2015 while the majority of the new schemes do not directly address concerns relating to care or health work, and the majority of schemes and policies are implemented by women welfare workers, such as Anganwadi or ASHA workers.

While ASHA employees are paid an incentive solely based on the duties they complete, ANM employees receive better pay, better and longer employment contracts, and direct support from the central government. It's interesting to note that ANMs employed men, whereas modern ASHA employees do not. ANMs were regarded as having greater technical training in the nursing sector, making them more skilled and professional. Planning different training programs for midwives that last from six months to two years involves a large number of universities in India (most of which are privately held) that offer degrees in nursing or midwifery, as well as recruitment firms and trainers at various levels. ASHAs with comparable qualifications may occasionally receive similar training. The Indian National Advisory recommended that the work of Anganwadi Workers (AWWs), ANMs, and ASHAs be combined. The community networks working to address public health in India include volunteers and self-help groups at the state and local levels working in the fields of care, sanitation, etc., in addition to the scheme workers who are formally a part of the community health projects. (Kalne, Kalne, & Mehendale, 2022)

In my research on Anganwadi workers in India, it was noticed that many women who work in community service come from underprivileged communities, and they perceive themselves as part of a collective group, working for the community rather than just for themselves. A strong conviction in communal existence motivates many women to engage in welfare work to move beyond the individual and the family and devote themselves to society, even when they have few means and no support structure on which to rely. However, in certain cases, desperation due to poverty and a lack of a source of income drives women to take up this labor (Sreerekha, 2017). It is advantageous and beneficial for governments always benefit from hiring cheap, unemployed women workers since it forces them to willingly serve their own communities (Ibid).

The line between voluntary and forced workers is largely blurred in the case of women who work in healthcare. The history of public health workers in India is a long and complex one that includes both voluntary work and forced labor, largely performed by women in various contexts and forms. The term health workers can also be expanded to encompass a variety of forms of healthcare labor, much like the definition of essential workers, which can be applied to numerous occupations in the informal sector. In fact, forcing women workers to participate in voluntary, honorary, or contract employment in the social welfare sector under initiatives launched by the Indian government has helped redefine and restructure what is regarded as acceptable.

The disparity in contribution against compensation of ASHA workers during the Covid-19 pandemic

They work for an incentive and even if they work on weekends, there is no additional income. In most states, there is no certainty that work will pay or that it will pay fairly. Only women between the ages of 25 and 45 are engaged as ASHAs, and they are compensated based on the services or activities they do. For example, getting a new-born vaccinated helps them to earn ₹150, a medical check-up for a pregnant woman ₹200, accompanying her to a hospital for delivery fetches them ₹400, and assisting with birth control ₹ 500. Each public health center has approximately 10 ASHA employees, with one worker for every thousand people, and there are over nine hundred thousand ASHA workers in India now (Sathi, 2021).

In dealing with the COVID-19 problem, ASHAs have displayed exceptional courage strength and dedication. According to a paper published in September 2020 as part of the Global in Women's Health series (Down to Earth, 2020), many employees pay for their own gloves, masks, and hand sanitizers. In fact, many of them lack access to many other protective measures and are out in the field without masks and hand sanitizers. In the present COVID-19 environment, health professionals in India are overworked and fighting to make ends meet due to growing workloads and attacks on their labor rights. Every day for the past year, ASHA workers have been out in the field, risking infection. They do not come from wealthy families where they can afford to isolate themselves in their homes. The pandemic has reduced their incentive to treat a smaller number of cases. The incentive given to women employees in India under state welfare schemes like ASHA is far less than the minimum wage or living wage required by law. The ASHA scheme paid a minimum incentive of ₹1300 per month when it first started in 2005. In the majority of states, they are still paid between ₹2000 to ₹8000 per annum after fifteen years. These payments frequently come months later, even while battling COVID-19 (The Logical Indian, 2020). They must provide documentation proving their responsibility for doing and finishing each activity in order to be compensated.

Attending any other illnesses, including chronic ones unrelated to COVID-19, must be prioritized. With the spread of the pandemic, many of these health workers' regular activities have been halted furthermore, no one else is responsible for those responsibilities. As a result, their services to those in greatest need, particularly the poor, remain halted. Poor women have no options, unlike women from middle- and upper-income groups who can afford private hospitals and do not necessarily require the assistance of these health workers. They are completely reliant on public health care centers and health workers. The pandemic has created a massive void. Many low-income working-class women who require assistance with pregnancies and childbirth do not have it, resulting in maternal mortality.

During the pandemic, ASHAs are supposed to assist persons who are isolated at home or in their homes. If the region is designated as a hotspot, ASHAs must check 50 neighboring residences for anyone exhibiting symptoms as a preventive precaution, and they are compensated ₹1,000 for their efforts. They assist persons experiencing symptoms with testing and gathering results reports. They

occasionally assist in the distribution of masks, medicines, or even food to individuals in need, in addition to providing further advice for home isolation. In several locations, the epidemic shifted the burden of handling mental illnesses to ASHAs and Anganwadi workers. During the pandemic, public health was jeopardized due to the lack of a mental health care delivery system and access to needed medications. (Patley, et al., 2021).

ASHAs had to visit hospitals regularly during the pandemic, despite being risky ASHAs cannot avoid it if they have to attend to their work. While doctors or nurses are provided with masks, health workers are not. Home visits in the community put them at a higher risk; while back home from the field, neighbors complain of putting them at risk. Stories of physical attacks on ASHA workers and neighbors stopped ASHA workers from completing their tasks or even threatened them forcing them to ask for policed protection is common. As a result of the attacks, some of these women faced physical and psychological trauma along with an uncertain future ahead with no support system in place.

WHO honors ASHA workers for their crucial role in linking the community during the COVID-19 pandemic

As per a report (Chandra, 2022) WHO honors ASHA workers for their crucial role in linking the community during the COVID-19 pandemic “The country’s frontline health workers or ASHAs were one of the six recipients of the WHO’s Global Health Leaders Award-2022 that recognizes leadership, contributions to advancing global health and commitment to regional health issues. India’s 10-lakh-strong health workers have been conferred the honor for their “crucial role in linking the community with the health system, to ensure those living in rural poverty can access primary health care services, as shown throughout the COVID-19 pandemic,” said the WHO’s press statement. An official of the Indian mission in Geneva collected the award. During the pandemic, ASHAs were entrusted with raising awareness about COVID-19 and safety standards, detecting and tracking COVID-19-positive cases, and conducting vaccination drives, frequently without the use of personal protective equipment. These programs were in addition to maternal care, child immunization, and community health care.

After being praised by the Prime-minister and health minister for the achievement ‘The All India Co-ordination Committee of ASHA workers and facilitators affiliated with the Centre of Indian Trade Unions (CITU) reacted “Scores of ASHA workers sacrificed their lives succumbing to COVID-19 and the Government of India doesn’t even have statistics on them. Their families are yet to receive the ₹50 lakh compensation for death due to COVID-19 for frontline workers.” The organization further demanded that there should be payment of minimum wages, social security benefits, and pensions (Chandra, 2022).

Method

We investigated the involvement of ASHAs in the local health response to the COVID-19 epidemic in Maharashtra. Our goal is to provide a qualitative study to understand the participation of ASHAs and communities, particularly in the setting of a pandemic like COVID-19. In this research, we talked with ASHAs in the context of the pandemic and Indian public healthcare systems to learn how helpful the Indian public health system is. With the assistance of volunteers from different healthcare organizations and networks, semi-structured interviews and policy analyses were conducted.

Data Collection

Teams of trained local volunteers interviewed the respondents using a topic guide developed in English and translated local language. 45 ASHA workers and other stakeholders were interviewed from Jan 2021 – June 2021. The respondents were contacted and a suitable time was decided for the interview. The consent of respondents was taken before the interview began.

Result

Table 1: Distribution of Respondents by Position in the ASHA Program Stakeholder Survey (June 2021)

No	Position of Respondent	Number
1	ASHA Supervisor	5
2	ASHA Worker	45
3	Other Stake Holders(Government Officials, NGO Staff and Researchers and Academicians)	8
	Total	58

Source: Stakeholder Survey, ASHA Program, Maharashtra, June 2021

The exploratory approach of the study focuses on the different challenges and issues faced by ASHA workers during the COVID-19 pandemic in India.

Additional workload impacting the routine work and important tasks to be executed

Before the onset of the pandemic, ASHAs carried the majority of the healthcare system's load by helping ANM health workers provide critical healthcare services like infant and mother care, child nutrition, infectious and non-infectious disease management, and social mobilization on healthcare and related issues. Additional responsibilities in tracing and isolating visitors coming to the village from outside.

Village Health and Nutrition Days, a regular event, is a community-based health treatment package that includes prenatal care, regular antenatal care, and postnatal care. Care, growth monitoring, ill child referrals, health issue discussions to raise awareness, and convergence between nutrition and health are all provided on a fixed daily schedule, typically once or twice per month. During the lockdown, ASHA workers have been collecting data on COVID-19 patients, providing counseling and creating awareness in the community. They use to do door-to-door surveys, including in containment zones/hotspots

Lack of Personal Protective Equipment (PPE) for ASHA workers

Despite the sensitivity of their work, ASHAs are advised to wear a triple-layered mask and gloves and keep a one-meter distance. The other stakeholders mentioned that "PPE kit provided to ASHA personnel was basic, inadequate and inappropriate. We are putting their lives in danger only because their labor is voluntary. PPE kit provision has also been inconsistent among states."

Hailed as Corona worriers many ASHA workers carried out work with inadequate protective gear sometimes it was just masks and gloves. ASHAs were working at ground level and visiting several individuals every day; many of them were COVID-19-infected. It is putting ASHAs at high risk of contracting the Covid-19 virus and it was necessary that quality PPE (Personal Protective Equipment) should have been provided to them. In addition to regular duties additional tasks of contract tracing,

spreading awareness on COVID-19 prevention, and keeping an eye on new visitors to ensure they follow quarantine protocol were delegated to them.

Inappropriate financial remunerations and irregularities in the payment of ASHAs

The incentive or remuneration paid to ASHAs is much less compared to the workload assigned to them. It is interesting that they get a monthly honorarium, not a salary plus employment is contractual. Ironically government-employed healthcare workers get a far better salary or remuneration compared to ASHAs with similar work loads. ASHAs are paid on assignment bases and they get incentive-based on the services or activities taken up by them. A particular fixed amount for attending specific assignments like vaccination of an infant, medical check-up of a pregnant woman, accompanying pregnant women to a public health center for delivery, reporting and taking TB patients to PHC, and helping women with birth control. It is observed that the payment is not on time and is at the mercy of officials at local bodies like Zilla Perished or grants sanctioned by the state government. While considering the vital, critical, and risky work carried out by ASHAs what they get in return as remuneration is meniscal and barely helps them to survive and support their families. " Despite being in service for the last 10 to 15 years and yet, most of us barely earn ₹8000 a month working 12-15 hours daily. We have to work hard as the majority of our earnings come as incentive base such as the fixed amount of money for reporting TB case, taking care of pregnant women, taking pregnant women to health care center PHC for delivery and so on" (ASHA 9)

Physical attack and hindrance in work by members of society

During the COVID-19 pandemic, ASHAs faced incidents of physical attack and people preventing them from completing work. Neighbors and relatives of COVID-19 patients tried to prevent ASHA workers from recording vital information and implementing the quarantine procedures. ASHAs were supposed to keep track of new visitors who visited a given locality to keep track and ensure that they followed the quarantine guidelines issued to prevent infection from spreading to a particular locality. To complete the task of contact tracing ASHAs were supposed to keep track of new visitors from outside. Unfortunately, the particular local community was not very happy with the activity and attacked ASHAs or prevented them from completing the work.

In some cases, neighbors of ASHA workers perceived the theme as a threat and feared that they might spread infection to them. This resulted in physical attacks on ASHA workers while some faced trauma like social boycotts. In some cases, members of the public forcefully restricted entry of ASHA workers in their locality treating them as outsiders. With no support system in place to deal with this kind of abusive treatment ASHAs were forced to take the help of the police force in completing the task at hand. "During the COVID-19 pandemic, we had to monitor and report new COVID-19 cases, track the new visitors in the locality from outside and other task such as collecting information on senior citizens who are more prone to infection. But we are treated as unwelcomed guests by locals. We were prevented from entering the locality and sometimes abused or threatened with physical assault. Even our neighbors considered us as a source of COVID-19 spread and tried to boycott us socially which is very disturbing" (ASHA 5)

Completing the technically complex task for which they are not fully trained:

In Maharashtra ASHAs are used to assist, ANMs in transferring data from the paper register to the Reproductive and Child Health (RCH) portal specifically designed to maintain records of pregnant women and mothers of young children in the villages. Aarogya-Setu was launched by the Government of India as a contact tracing app that could provide detailed information about people who have been in contact with Coronavirus-positive patients. All the above tasks were accomplished

by ASHA workers without complete formal training. The Centre sent directives for the mandatory use of its contact tracing app, Aarogya-Setu by all government staff. Some ASHAs were asked to use the Aarogya-Setu app by their supervisors, but they were not able to articulate how it would help them.

ASHA workers use social networking sites like WhatsApp and Facebook to transfer daily reports and photographs to PHC. In the absence of smartphones owned by themselves, ASHAs relied on the smartphone of the family members to accomplish the task. It was clear that no formal training and equipment were provided to ASHA workers to complete the tasks assigned to them. ("All of us were instructed to download and setup the Aarogya-setu app in our phones. Many of us including ASHA workers do not own a smartphone; so we are forced to use phones owned by family members to complete important task like the Child immunization register, Birth and death register, Antenatal check-ups monitoring register, and Reproductive child health registers" (ASHA Supervisor 4)

Focus

It is evident from the analysis of information that India's response to the pandemic relied profoundly on ASHAs. ASHAs were at the forefront of preventing COVID-19 transmission in the community, managing quarantine centers, and generating awareness by preventing incorrect information from reaching at the community level. The findings clearly highlight that there is a requirement for mechanisms in place at the community level for continuous training and engagement through ICT.

ASHAs were promised in April 2020 that they would get 2000rs over the regular incentive they get for their work. The study clearly indicates that the financial remuneration of ASHA workers is the primary concern. Compared to the financial remuneration ASHAs are overburdened with work. There were discrepancies in paying what was promised to them for performing additional COVID-19 work. their honoraria are less than the minimum wages of unskilled workers. (Sundar & Shyam, 2020). It is ironic that ASHAs are not only face exploitation from the community they work for but also by their exploitative employers. With no appropriate remuneration, recognition, and job security it is completely inconvenient for ASHAs to cope with the stress and survive the current situation.

Although many politicians and policymakers are quick to appreciate ASHA workers' contribution during the COVID-19 pandemic and generously praise them. But none of the verbal promises reflected in the policy decisions that favor their demand of "including them within the cadre of permanent healthcare staff with a fixed pay of 18,000 per month along with social security and maternity benefits, fixed tasks and work hours" (Rao & Tewari, 2020). ASHAs are they are expected to do several other tasks which are categorized as non-compensatory activities such as community engagement to build rapport for achieving difficult goals of improving institutional delivery, reducing infant mortality, and controlling the spread of infection (Swaminathan, 2015).

It is essential that ASHA workers get appropriate remuneration along with the provision for other benefits. It is vital that these health workers who are hailed as Corona warriors should be empowered along with their families. Active participation of women health care workers in community health setup will be of utmost importance

Conclusion

Unfolding of different stories revealed different experiences of ASHA workers and community members. The analysis clearly indicates that ASHAs harbored the boat of the Indian community health care system very effectively during the turbulent time of the COVID-19 pandemic. ASHAs successfully accomplished the herculean task of COVID-19 control in spite of abusive treatment by

members of society. ASHAs were exploited by employers by offering minuscule financial returns for performing risky and overwhelming work with no job security and support system. ASHAs played the role of superwomen; they risked their lives during the course of the pandemic pertaining to a lack of resources, and lack of community and state support. Excluding a few verbal praises and promises they received nothing substantial in return for their heroic performance during the COVID-19 pandemic. A simple request of minimal pay as per the law has been turned down by government officials giving reason that 'It may lead to complacency'. Such arguments by government officials are pointless and may lead to some uneasy counter questions about the competencies and work culture of policymakers. There is a danger of such policy decisions being perceived as government-sponsored 'exploitation of the weaker section of society, which is supported by the government itself.

Recommendations

After the impact of the COVID-19 pandemic communities must rethink on importance of basic public healthcare and how health workers like ASHAs play vital roles as life-givers by acting as the backbone of local communities. While performing this role many ASHAs paid a heavy price for the community's survival, now it is urgent and important that the community must introspect and answer what are we going to give in return? It is high time that members of society along with policy makers understand and acknowledge the contribution of ASHAs in the community healthcare system. The principle of reciprocation is expected from policymakers in terms of financial returns, job security, and support systems.

Future Research Directions

Investigate the impact of the COVID-19 pandemic on the mental health of ASHA workers, assessing the psychological toll by examining the long-term effects of stress, anxiety, and trauma. Evaluate the necessity for mental health assistance and interventions to safeguard the welfare of these frontline workers. Comparative Analysis with Other Countries: Explore the roles and challenges confronted by community health workers in different nations amid the COVID-19 pandemic.

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