



Understanding the Perspectives of Frontline Health Workers (ASHAs, Anganwadi workers & ANMs) in Bundelkhand Region to Improve COVID 19 Containment Efforts

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Self Reliant Initiatives through Joint Action



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SRIJAN has formed Bundelkhand Sustainable Development Forum (BSDF), a consortium of six like-minded organisations. Along with SRIJAN's own team at Tikamgarh, Research Assistants based out of these organisations, namely Haritika at Chattarpur, Akhil Bharatiya Samaj Sewa Sansthan (ABSSS) at Chitrakoot and Yuva Kaushal Vikas Mandal (YKVM) at Hamirpur district, assisted in the data collection process of this study.

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Table of Contents:

Executive Summary.....	8
Introduction.....	11
Field Context.....	15
Research Methodology.....	20
Challenges and Limitations of the Study	27
Analytical Framework.....	29
Findings & Analysis	32
1.0 Introduction to COVID 19 work	32
1.1 Training for COVID 19 work.....	32
1.2 Mobility and Movement	39
2.0 Community Response.....	44
2.1 Differences in engaging with men & women.....	49
3.0 Payment, Work and Emoluments.....	55
4.0 Policy and Local Governance.....	61
4.1 Information Dissemination.....	62
4.2 Quarantine Centres.....	63
4.3 COVID 19 Vaccination.....	68
5.0 Safety and Security of CHWs.....	71
Recommendations from the CHWs to the Government	79
Bibliography.....	85
Annexures.....	88



Abbreviations

ANM: Auxiliary Nurse Midwife

AWW: Anganwadi Workers

ASHA: Accredited Social Health Activist

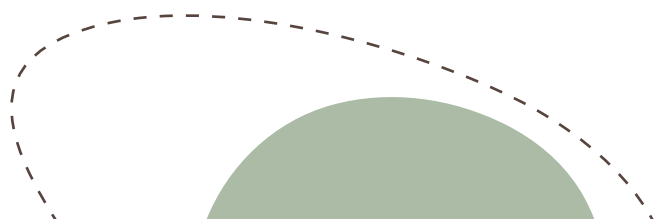
CHCs: Community Health Centres

CHW: Community Health Workers

PHCs: Primary Health Centres

RMNCH: Reproductive, Maternal, Newborn and Child Health

UNDP: United Nations Development Programme





Executive Summary

Community health workers have been the backbone of the fight against the COVID 19 pandemic in India as well as globally. However, most debates on COVID 19 have focused on the pandemic and its response by governments, medical professionals and international organizations but the voice of local community members has been paid less attention.

63% of CHWs across four districts reported that no additional payment was promised to them for COVID 19 work.

As these health workers live in the community they work in, their perspectives – which will be rooted in their community embeddedness – are of utmost importance for designing community based COVID 19 responses. As the world is now moving into administering COVID 19

vaccines globally, it is important to capture and document the lessons learnt from the past year. In most countries, the role of local community health workers for COVID 19 efforts such as contact tracing, community surveillance and promotion of safe practices has been of supreme importance. Thus, it is imperative to understand their perspectives and experiences and incorporate them in health crises' responses. Our short-term study funded by the Azim Premji University aims to address this research gap and contribute to the research literature on CHWs' perspectives on COVID



19 containment efforts. In our three-month study, we interviewed 500 CHWs across two phases and captured their perspectives and insights.

MAJOR HIGHLIGHTS OF THE STUDY

CHWs reported receiving some training for COVID 19 but they mentioned that the training insufficient for them to do their assigned duties effectively. Additionally, movement and mobility turned out to be the biggest impediment for the health workers in





being able to carry their responsibilities.

According to the CHWs, the community was aware about COVID 19 precautions, but they faced challenges in speaking and discussing with them, making it difficult for them to create awareness around COVID 19. Furthermore, while CHWs spoke to household heads, women and the entire family at various places, the CHWs reported women as being their preferred point of contact.

1. Majority of CHWs spent 4-6 hours in doing COVID 19 related activities, but 63% of CHWs across four districts reported that no additional payment was promised to them for COVID 19 work. Of those who were promised some amount, 28% received the full amount, 29% received partial payment, whereas 43% did not receive anything
2. In several villages, there were no separate quarantine centres for men and women, which created discomfort for women and girls due to lack of separate toilets and hygienic spaces
3. CHWs demanded mass community awareness before the rolling out the COVID 19 vaccine in the villages. Furthermore, if there are any side or adverse effects of the vaccine, CHWs may be at risk from the community
4. Safety and security of the CHWs remained a neglected area, as they faced extremely vulnerable while carrying their responsibilities. Of around 500 CHWs, 41 reported facing verbal or physical attacks



Introduction

Post the national lockdown announcement on March 24, 2020, the Central and State Governments swung into action to prepare the health system and infrastructure for the expected rise in COVID 19 cases. Among the many steps for preparation, a key step involved organizing and leveraging the Community Health Workers (CHWs) that includes ASHA workers, Anganwadi workers, and ANMs, to lead awareness and containment efforts at the community level. India has more than 8 lakh ASHAs, 12 lakh AWWs, and 2 lakh ANMs, who work for the most marginalized, vulnerable, and far off populations especially in rural parts of India, and therefore, without the support of these workers, it would have been impossible to reach out to the entire population and fight the COVID 19 pandemic. As the pandemic rapidly spread worldwide, different policies and programmes were conceptualized and implemented to try and mitigate COVID 19's impact. Furthermore, in addition to clinical research on the virus strains and potential vaccines, social scientists did rapid research studies on the pandemic's impact. A key concern highlighted by researchers and academics worldwide was the missing voices of community health workers in

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Thus, we at SRIJAN felt that as health workers are a crucial category for COVID 19 efforts such as contact tracing, community surveillance, and promotion of safe practices, it is imperative to understand their perspectives and experiences from a research perspective and incorporate them in COVID 19 policy responses.

policy prescriptions and initiatives^{1,2}. Therefore, our study aims to address this gap and understand the perspectives and experiences of CHWs in fighting the COVID 19 pandemic in Bundelkhand, one of the poorest regions in rural India.

Prior to the pandemic, in India, there have been challenges for CHWs such as low wages, deplorable working conditions, lack of adequate compensation, and social security (Bhatia, 2014; John, Newton Lewis & Srinivasan, 2019; Nanda et. al, 2020). During the lockdowns and subsequent months, news reports emerged highlighting similar conditions at play during COVID 19 as well, where health workers were attacked³, stigmatized⁴, and overburdened with work. Thus, we at SRIJAN felt that as health workers are a crucial category for COVID 19 efforts such as contact tracing, community surveillance, and promotion of safe practices, it is imperative to understand their perspectives and experiences from a research perspective and incorporate them in COVID 19 policy responses. In India and as well as other countries, CHWs are usually recruited

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- 1 <https://www.cgdev.org/publication/protecting-community-health-workers-ppe-needs-and-recommendations-policy-action>
 - 2 <https://www.washingtonpost.com/opinions/2020/07/03/community-health-workers-are-essential-this-crisis-we-need-more-them/>
 - 3 <https://www.hindustantimes.com/india-news/asha-worker-attacked-for-collecting-data-on-covid-19-ve-patients-in-odisha/story-AZxHd8YHM1zGLnPkBdMUmN.html>
 - 4 <https://timesofindia.indiatimes.com/city/bengaluru/asha-worker-on-covid-19-duty-heckled-attacked-5-arrested/articleshow/74956822.cms>



from the local communities and thus, have the same lived experiences as the community populace.

They are experts in navigating complex systems of care, serving as a link between clinical and community-based services and the people who need them most⁵. Most debates on COVID 19 in India and globally have focused on the pandemic and its response by governments, medical professionals, and international organizations but the voice of local community members is usually missing. Furthermore, efforts and initiatives on COVID 19 have either neglected or not paid enough attention and allocated resources to address their concerns⁶. SRIJAN has been present in Bundelkhand for more than 20 years. Despite being abundant in natural resources, the region is marred by its feudal system, caste barriers, low participation of women in decision-making, high mortality rates and chronic drought. Our initial scoping work found that villages in these areas experienced a massive inflow of migrants as soon as the Government of India announced the national lockdown as a result of subsequent loss of jobs and work in Indian cities and towns. This influx of migrants put significant pressure on public services and public health workers. Services such as regular immunizations, Anganwa-

As these health workers live in the community they work in, their perspectives – which will be rooted in their community embeddedness – should be of utmost importance for designing community-based COVID 19 responses.

5 https://www.nejm.org/doi/full/10.1056/NEJMp2022641#article_citing_articles

6 <https://www.inkstonenews.com/health/coronavirus-womens-advocates-ship-period-products-center-outbreak/article/3050653>



di services, and schooling have been affected as workers in these sectors have been diverted to deal with COVID 19 containment and response efforts. As these health workers live in the community they work in, their perspectives – which will be rooted in their community embeddedness – should be of utmost importance for designing community-based COVID 19 responses.



Field Context

Bundelkhand Region

Bundelkhand spreads over Madhya Pradesh and Uttar Pradesh, covering 14 districts (refer figure A), and is home to 18 million lives, out of which 14 million reside in the villages. At 30%, the region has a significantly larger Scheduled Caste and Scheduled Tribes population, and a large backward community. Despite being abundant in natural resources, its feudal system, caste barriers, low participation of women in decision-making, deep patriarchal roots, high birth and mortality rates, and chronic drought has made socio-economic upliftment in Bundelkhand a challenge for the policy makers and development partners in India.

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As per a Human Development Report 2012 by NITI Aayog & UNDP¹, Bundelkhand stands lowest on the indicators of Human Development Index². Life in this region

1 This report is one of the most comprehensive reports which explains the socio economic situation of the Bundelkhand region in depth. Therefore, we will be using this report extensively throughout this paper for referring to the demographic and social indicators.

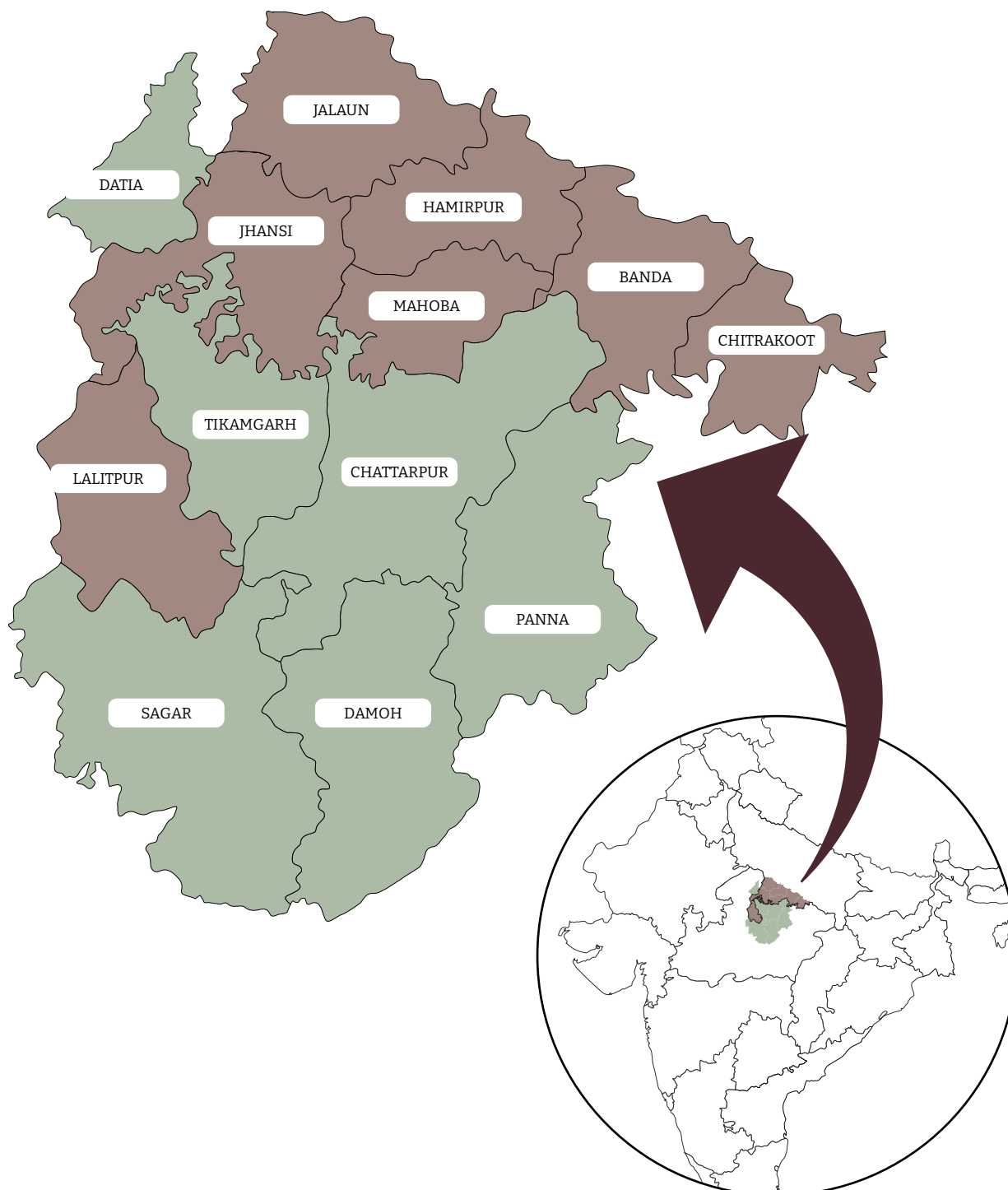
2 https://www.undp.org/content/dam/india/docs/human-development/District%20HDRs/Bundelkhand%20Report_23Jan2018.pdf



is affected by the topography and geographical features, including vagaries of climate, and human-made environment issues. In the absence of sustainable technologies for agriculture and water management, more and more people turn to casual labour, and to leasing land to sustain themselves. As a result, their livelihoods have become peripatetic and precarious. Bundelkhand area was historically a water rich area due to the presence of traditional water bodies which were made by the erstwhile kingdoms of Bundelkhand.

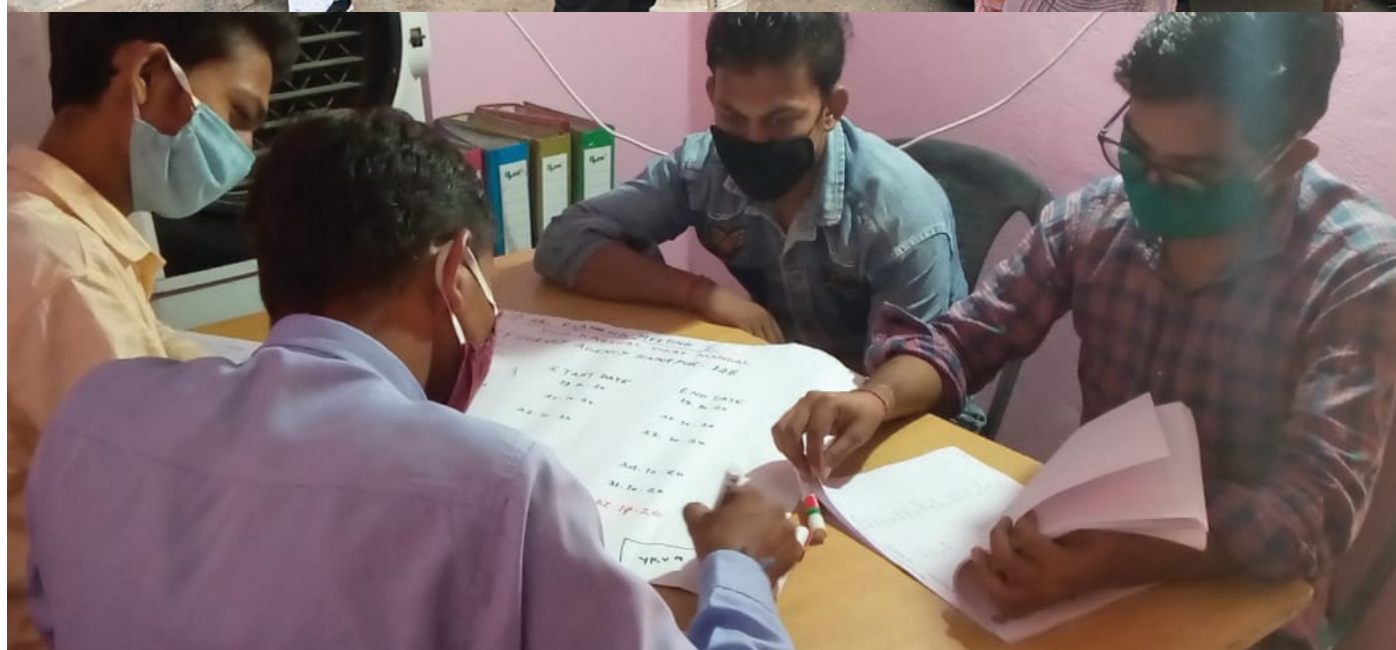
Over time, these water bodies were neglected and it had a drastic impact over the livelihood and food security of the region. The recent years of drought, with an ineffective drought mitigation system, increasing debt burden have contributed to large-scale migration. Seasonal migration in the absence of alternate and skilled employment is a common feature. Migration provides an escape from the regional stagnation and social discrimination that prevails in Bundelkhand and is a strategy for breaking from economic and social bondage. Further, the four districts i.e. Chattarpur, Hamirpur, Chitrakoot and Tikamgarh out of total 13 districts of Bundelkhand are among the list of 250 most backward districts of India, and are characterized as 'backward' and 'human development poor' by the Human Development Report 2012 by NITI Aayog & UNDP. Furthermore, Chitrakoot and Chattarpur districts are part of the Aspirational Districts Programme steered by NITI Aayog³.

3 https://my.msme.gov.in/MyMsme/List_of_AspirationalDistricts.aspx



**Fig. A Map of Bundelkhand-traversing Uttar Pradesh
and Madhya Pradesh**







Research Methodology

Our study used a mixed-methods approach as integrating qualitative and quantitative methods offers a more comprehensive understanding “that is woven from strands of particularity and gener-

Since the CHWs' experiences are shaped by different demographic, social, cultural perspectives and local geographical circumstances especially in rural communities, we wanted adequate representation of health workers belonging to different communities.

ality, contextual complexity, and patterned regularity, whole and its constituent parts” (C. Greene, 2005). While the quantitative surveys in phase one enabled us to understand the perspectives of health workers in statistical and numerical terms, the subsequent qualitative interviews in phase two helped us to get a better understanding of the processes and reasons behind those statistics and numbers.

Since the CHWs' experiences are shaped by different demographic, social, cultural perspectives and local geographical circumstances especially in rural communities, we wanted adequate representation of health workers belonging to different communities. Bearing this in mind, for phase one of our study i.e. the quantitative survey wherein we interviewed 538 health workers across four dis-



tricts, we utilized the stratified random sampling method which involves dividing the population into homogeneous subgroups and then taking a simple random sample in each subgroup (P. Donnelly et. al, 2004, p.98). To arrive at this group and include different demographics, we decided upon 5 Indicators (See Table A in Annexure 1). Indicator 1 i.e. "Remoteness of the village (distance from district HQ)" and Indicator 2 i.e. "Accessibility during monsoon", were included since mobility is a critical factor in rural areas especially for the health workers to be able to carry their responsibilities. Indicator 3 i.e. "Composition of the Village on the basis of Religion and Caste", was included since the population of Bundelkhand has a significant proportion of SC and ST population at 30%. The unit of analysis for this indicator was the SC/ST population of the villages within the districts. Indicator 4 & 5 i.e. "Number of COVID-19 cases" and "Influx of migrants that returned to the Village" respectively, were fixed in the context of COVID-19 situation especially in India. A matrix was further developed, on the basis of which different indicators were ranked and scored (on a scale of 1 to 10) across 357 villages. Using this matrix and scoring each village across the five indicators, we attempted to choose a diverse sample and finalized a list of 214 villages across the four districts.

The questions were categorized under five themes: a) Introduction to COVID 19 work b) Community Response c) Payments and Emoluments d) Policy and Governance e) Safety of Workers.

Thus, we collected quantitative data (refer Annexure 2) from 538 health workers across the four districts through structured questionnaires via Google Forms. The questions were categorized under five



themes: a) Introduction to COVID 19 work b) Community Response c) Payments and Emoluments d) Policy and Governance e) Safety of Workers. The aim was to understand the overall scope of the situation, areas of concern, general perspectives of the front-line health workers, and trends in statistical terms. This data collection exercise was conducted by 12 Research Assistants (RAs) across the four districts of Bundelkhand: Tikamgarh & Chattarpur (Madhya Pradesh), and Hamirpur & Chitrakoot (Uttar Pradesh). These 12 RAs belonged to SRIJAN's field partner organizations listed above. The first draft of quantitative questionnaires was prepared by our investigators and research team of SRIJAN, which was then shared with the representatives from the partner organizations, leaders at the field offices, and RAs. Firstly, a detailed discussion on the questionnaires was done and feedback was provided by the RAs, based on their ground-level observations and experiences in their respective field locations. After incorporating their suggestions, the questionnaires were revised and prepared on Google Forms. Before the commencement of the phase one data collection on 26th October, a small pilot was conducted in Tikamgarh with 15 interviewees, to practically test the inclusivity and validity of the options in each question, before the questionnaire was eventually finalized. Furthermore, given the COVID 19 situation, the RAs trained exclusively on following safety protocols while conducting the face-to-face interviews. To ensure the safety of both, interviewers and respondents, a protocol was in place, wherein the RAs were provided with adequate safety gears including masks, gloves, and sanitizers, and were further advised to practice physical distancing (6 feet distance) while conducting interviews in person. Along with Google Forms, hard copies and offline forms were also used to collect data in areas that lacked proper internet connectivity. Each district had an anchor, who supervised and monitored the RAs, to maintain the quality of data and ensure protocol compliance. The raw data received from the field was



cleaned and validated using Microsoft Excel by the Research Team at SRIJAN. After extensive discussion, analyses, and validation of data, a total of n= 500 out of 538 responses were chosen for data analysis.

In the second phase of our study, at first, we analyzed the quantitative data from phase one to identify the major trends and patterns. Qualitative interviews offer “researchers the opportunity to uncover information that is probably

not accessible using techniques such as questionnaires and observations” (Blaxter et. al, 2006, p. 172). Hence, these patterns were leveraged to prepare a qualitative questionnaire for phase two of the study, to further explore and understand these trends in depth. We adopted a semi-structured interview approach wherein the questionnaire had 10 talking points cum questions. This list of talking points-cum-questions were discussed with the RAs and their feedback on language, tonality, and content was reviewed and incorporated. In this phase, since the qualitative interviews were to be conducted face-to-face, additional training was provided to the RAs, in which they were trained to take informed consent of health workers, and clearly understand if they were fine with their interviews being recorded. Along with informed consent, the health workers were further assured by the RAs that their identity will be protected, and would not be published anywhere without informing them. Using the finalized ques-

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tionnaire, around 36 health workers were interviewed by our 12 RAs (9 in each district). These 36 health workers were chosen through a sampling and filtering process of our phase one data. We chose two questions as filters (Q1 and Q2) for choosing a final list of potential respondents for phase two. Considering the nature of our inquiry, and the feedback received from the RAs based on their interactions, the question "Among different castes and communities, did any particular community face more challenges or problems?" was taken as a first filter. Except those who did not give any response i.e. were left blank, everyone else with an answer or opinion was taken as a part of the sample. As the RAs suggested, this question was crucial since as per their experience, not every health worker was well acquainted with the local community, geography and conditions, and hence was not in a position to answer questions about the community. In addition to this, a second question, "Did you face any challenges in the community during your COVID 19 work?" was chosen as a filter. Those who faced some challenges, were categorised in Group A, and those who did not face any challenges were categorised in Group B. This step was taken to include every opinion and avoid any biases, in an attempt to better understand ground realities. This filter gave us a list of 161 workers across four districts out of which the RAs were asked to randomly choose nine workers from both Group A and B, in every district with a distribution of 3 ASHAs, 3 AW/Ws and 3 ANMs per district. These interviews were translated from Hindi to English by a team of two translators. The coding and organizing of the data was done on NVIVO12, a qualitative research software, to systematically organize the data according to our themes and analyse them further. After an initial draft of the report, a "sense check meeting" was conducted with the RAs and anchors. The objective of this was to share the findings of our report with the field team and analyze if these findings were

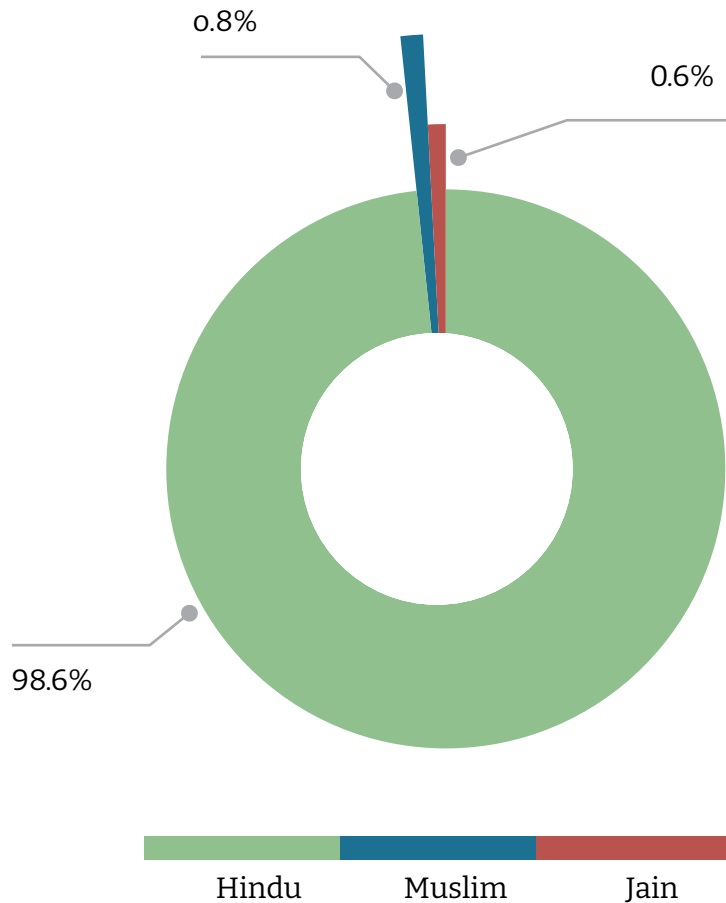


Fig B: Religion wise distribution of respondents

in sync with their general observations and perspectives. A couple of additions and suggestions were incorporated. Of the 500 health workers, 99% were Hindus, rest were Jains and Muslims. Among Hindus, about 47% were OBCs, 33% were upper castes, 19% SCs and just 1% ST (refer figure B and figure C). This caste composition is in line with studies on ASHA workers in other states, which also found that OBCs and SCs constitute a significant proportion of ASHA workers (Fathima et. al, 2015; Bhanderi, Varun & Sharma, 2018).

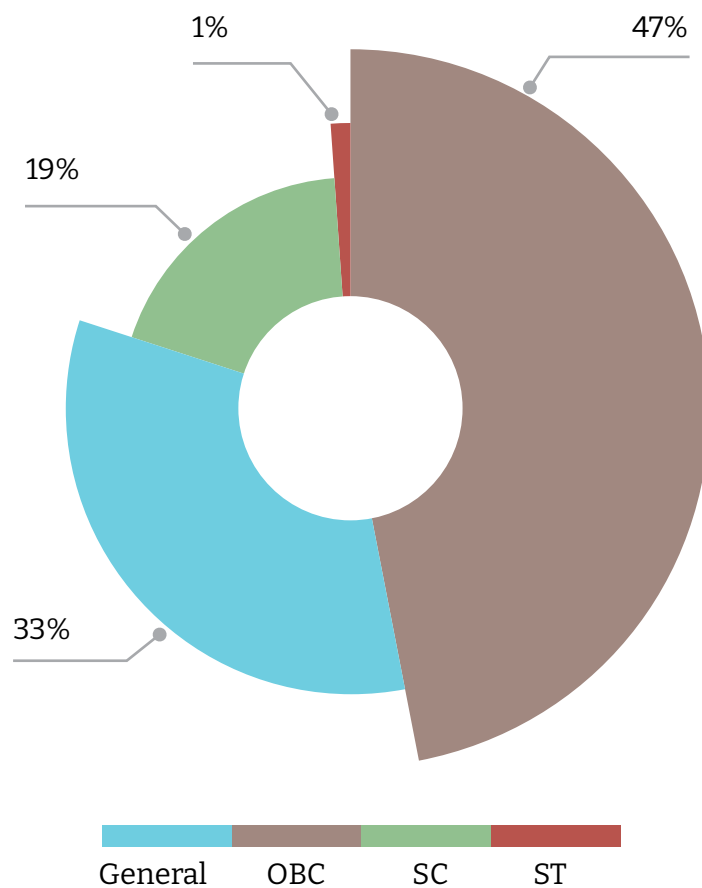


Fig C: Caste distribution

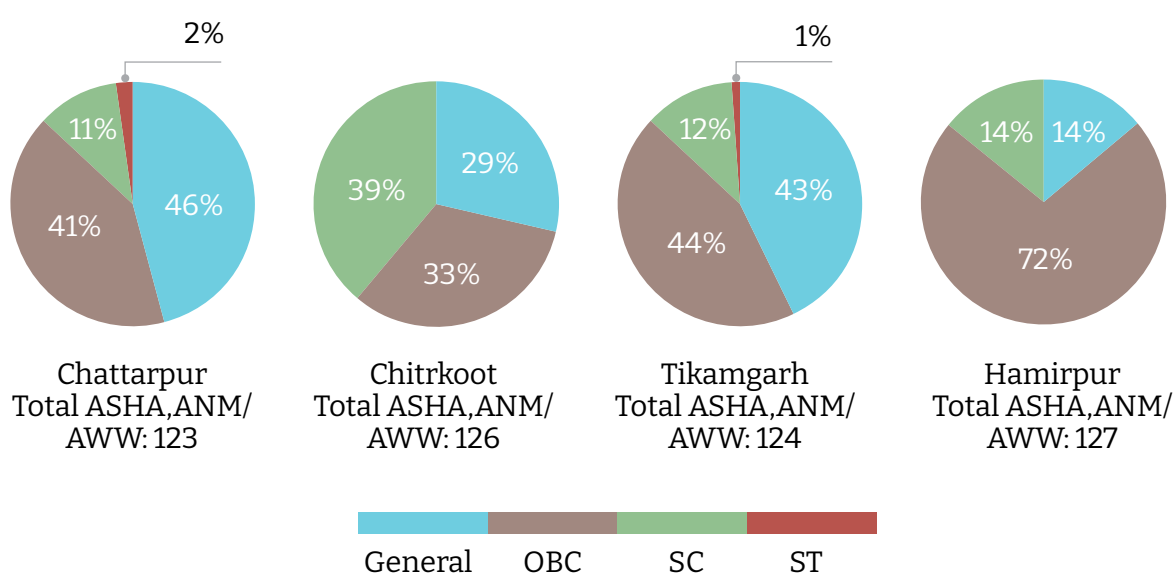


Fig D: District wise caste distribution



Challenges and Limitations of the Study

Despite our best efforts, there are some challenges and limitations in our study. The first limitation was that due to the COVID 19 travel restrictions and short time frame involved, the investigators could not travel to the field site and therefore coordinated the study from Delhi. However, given SRIJAN's extensive network of community-based organizations in Bundelkhand, this factor didn't have much of an impact on the study overall. If the travel situation was conducive, their visits to the field could have led them to do some interviews themselves, thereby, improving the understanding of the field

The third limitation was that given the sensitive nature of the topic and research questions around COVID 19, it appeared that these health workers, who are government functionaries, were a bit hesitant to speak freely on some questions.

context. The second limitation was that these field partners and organizations may have chosen health workers (purposive sampling) whom they knew from past work or acquaintances. Though the research team



did an extensive sampling of workers, some of the views may have been overrepresented due to this factor and these results may or may not be generalizable across the rest of rural UP & MP. The third limitation was that given the sensitive nature of the topic and research questions around COVID 19, it appeared that these health workers, who are government functionaries, were a bit hesitant to speak freely on some questions. The Human Development Report Bundelkhand 2012 by NITI Aayog and UNDP highlights the prevalence of social discrimination on the basis of caste, and the extreme marginalisation of SC, ST, and tribal population. The report also sheds light on the discrimination these groups face from Anganwadi workers in accessing public health facilities. Since it is the duty of CHWs to serve everyone in the community equally and our report's main focus was to gather only their perspectives in the limited time frame, it was quite difficult to capture the caste dynamics and related issues during the COVID-19 lockdown. Nonetheless, though our RAs tried gathering data to the best of their abilities by asking questions in a different way, the entire research process was conducted in an ethical manner keeping in mind the safety and positionality of the health workers. Furthermore, due to their positionality as government functionaries, we expect that some answers may either be over or underrepresented.



Analytical Framework

The CHWs in this study i.e. the ASHAs, Anganwadi workers, and ANMs who are the forefront of India's public health system especially in rural India are women. Coupled with the cultural, geographical, and social barriers that a woman faces, their productive responsibilities cannot be viewed independently from all these factors. Our interaction with these workers revealed that to enable these women to be able to carry their responsibilities to their fullest potential, we need to first understand them in the light of the disadvantages that the society puts them in due to their gender, and then address them strategically. The need for a gendered analysis of the COVID 19 pandemic response is also compounded by the fact that the origins of these health worker programs are themselves gendered and rooted in instrumentalism (Ved et. al, 2019). Thus, the process towards empowerment of CHWs which will give these workers the agency to be able to fight COVID 19 and future pandemics, handle emergency situations, and unseen responsibilities in the future, cannot be devoid of gendered approaches.

To highlight this need, importance, and crucial presence of gender in CHWs productive work, we used 'gender' as an analytical framework for this study. Multiple scholars and researchers have



conceptualized frameworks and theories for doing gendered analyses (March, 1999). In context of our study, we particularly found resonance in Moser's framework (Moser, 1993). The framework aims to bring gender in the traditional planning process, and challenges the idea that the planning procedure is technical in nature (March, 1999, p.56). The framework highlights a gender needs assessment tool. This concept is based on the idea that women as a group have different needs than men, and hold a subordinate position to men in most societies (ibid.). Moser defines these as the needs which, if they were met, would enable women to transform existing imbalances of power between women and men. Women's strategic gender needs are those which exist because of women's subordinate social status. The social status on the other hand, differs contextually. In India, Srilatha Batliwala's (2019) recent analysis on power structure, digs deeper into this suppressed and subordinate social status of women. She explains how patriarchy is one such ideology i.e. set of ideas that upholds this power imbalance and justify the gendered inequality. The ideology advocates that men are superior to women, and the latter should stick to the gendered roles and not question the structure. She further adds that these ideologies are further translated into everyday practices that lead to the creation of social norms and rules. In gender social norms, these are translated into rules for women and girls, that dictate "rules of behavior, division of labor, mobility, appearance, and so forth" (ibid., p.76). However, we need to bear in mind that in India, women might have different social status than men, but they do not exist as a single group. Gender, though important, doesn't exist in isolation as it interacts with other aspects of a woman's identity. Owing to India's diversity, these identities are determined by caste, ancestry, socioeconomic class, religion, sexual orientation and geographic location, and play an important role in determin-



ing the social position of an individual (Anne, Callahan & Kang, 2011). Hence our analysis will take into account this intersection of multiple identities, also known as intersectionality, as coined by an American race scholar Kimberle Crenshaw (1989). Therefore, for a gendered analysis of this study, we find resonance with the work of Moser- who emphasises on the importance of gender sensitive planning, Batliwala- who builds on the ideologies, norms, culture and structures, that explains the necessity of having a gendered perspective, and lastly, Crenshaw- to emphasise how gender interacts with other social, cultural and economic aspects.



Findings & Analysis

1. INTRODUCTION TO COVID 19 WORK

Under this theme, we explored the CHWs' experiences and perspectives regarding their COVID 19 related work and duties. The primary tasks of these CHWs were: spreading awareness on COVID 19 safety practices, door to door screening, community surveillance, contact tracing, and managing and supporting quarantine centres. In our study, we examined the challenges, concerns, and successes in the context of these tasks. As highlighted in the methodology section, the data from phase one helped us zero in on important trends and patterns, which we explored in our qualitative phase. We present some of the major findings here.

1.1 Training for COVID work

Given the critical role of CHWs, the Ministry of Health & Family Welfare (MoHFW) formulated official guidelines and ¹training modules for COVID 19 related work and ²duties. However, media reports across the country suggested that many of these CHWs did not re-

1 https://www.mohfw.gov.in/pdf/2COVID19PPT_25MarchPPTWithAnimation.pdf

2 <https://www.mohfw.gov.in/pdf/PreventionandManagementofCOVID19FLWEnglish.pdf>



{“We could have worked much better if training was given. We did all the work from our own understanding”} TIK_03

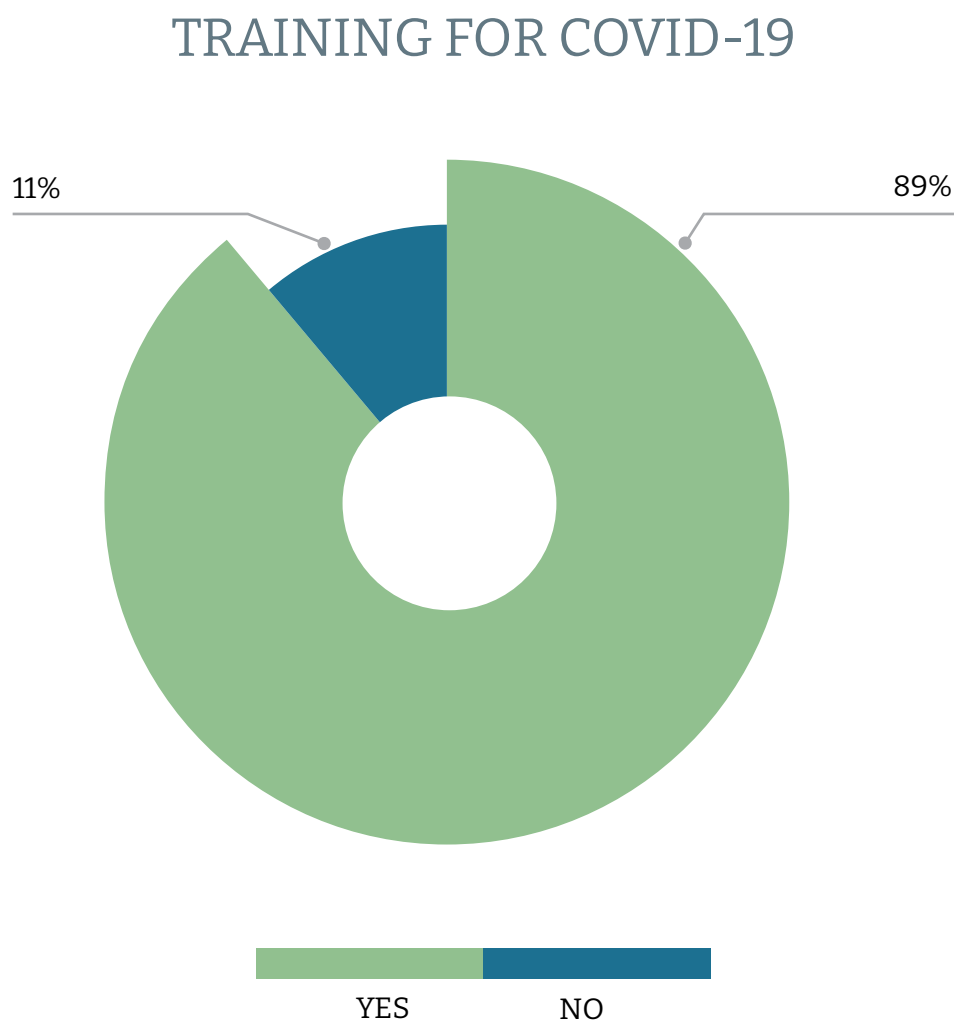


Fig. 1.1: Proportion of workers who received training for covid 19 duties and work



ceive any formal or proper training for their allocated duties^{3,4}. However, an ongoing study report⁵ by the Centre for Policy Research in Himachal Pradesh revealed that ASHAs in the state were given a one day training. Therefore, we were interested to examine if or not

Data from phase one revealed that 89% of CHWs across four districts reported receiving some form of training for their COVID 19 duties (Figure 1.1). Within districts, CHWs in Chitrakoot reported the highest proportion of workers who received training (Figure 1.2).

the CHWs in the Bundelkhand region were provided training and in what ways, were they given training for their work?

Data from phase one revealed that 89% of CHWs across four districts reported receiving some form of training for their COVID 19 duties (Figure 1.1). Within districts, CHWs in Chitrakoot reported the highest proportion of workers who received training (Figure 1.2).

Figure 1.3 also reveals that overall, a higher proportion of ASHAs received training for their work as compared to AWWs and ANMs, with a slight exception in Tikamgarh district. We further inquired about training, its nature, and quality in depth in our qualitative phase. Broadly, those CHWs who received some form of training would have liked more training and support. They stated that they needed additional information to do their tasks more efficiently.

"More such training should be conducted on a frequent basis to increase more awareness" HP_02⁶,

3 <https://theprint.in/opinion/asha-workers-are-hailed-as-covid-warriors-but-only-62-have-gloves-25-have-no-masks/506623/>

4 <https://reliefweb.int/report/india/million-women-working-india-s-covid-19-frontlines>

5 <https://cprindia.org/news/8949>

6 These codes refer to the CHWs and their responses, as coded in the qualitative research software

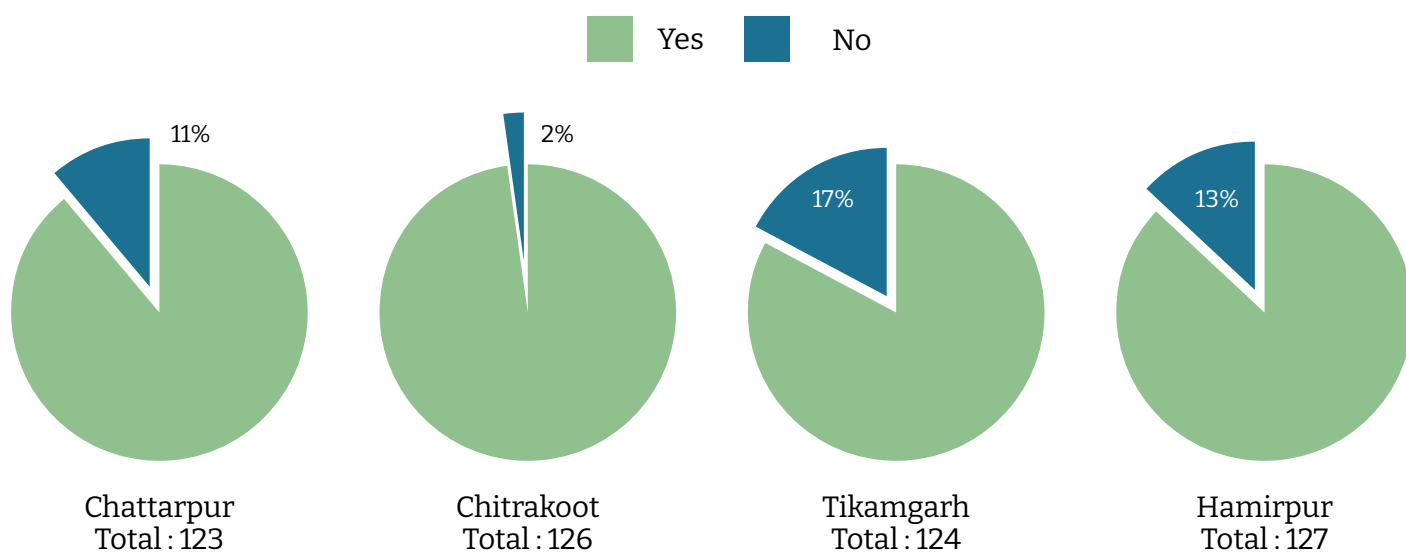


Fig. 1.2: District wise training received as reported by CHWs

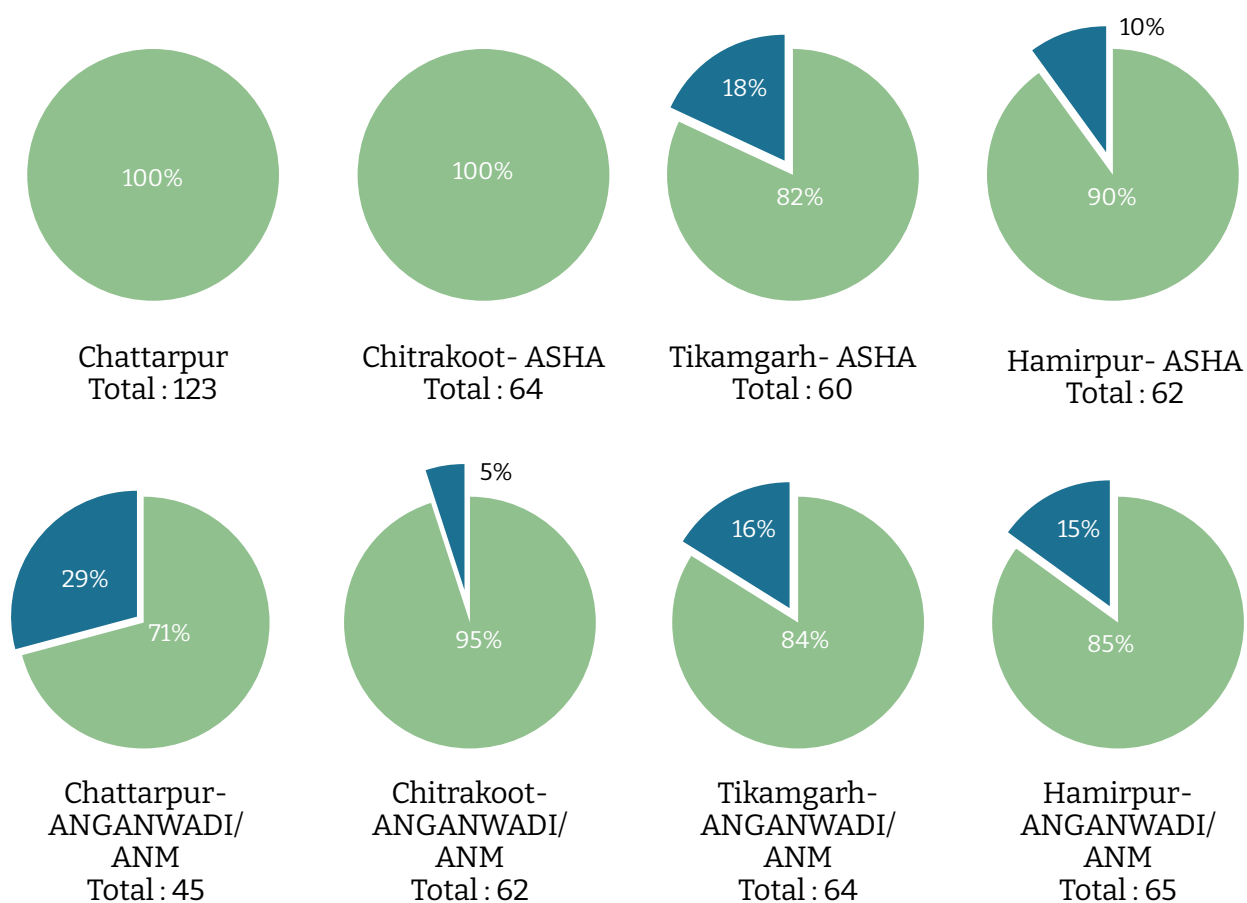


Fig. 1.3: Disaggregated data on training



*"Do you think the training was sufficient for you to do your work?
No, I think more information should be given this is not sufficient",
CHIT_03*

*"What according to you can be done in future to ensure you are able
to do your work smoothly?"*

*Proper guidance and training should be given to us in order to protect
our village" CHIT_05,*

Some workers received the information needed to carry on the responsibilities on their phones via messages, whereas some were called to the district administration office. In certain villages, in the initial stages, the CHWs did the work as per their own knowledge, as the training was provided to them at a much later stage.

*"Training was not provided to us before we started our work. We could
have worked much better if training was given. We did all the work
from our own understanding" TIK_03*

On the other hand, some CHWs felt that there was no need for any training, especially in Tikamgarh.

*"Training was not important and this is a common disease which can
be tackled", TIK_05*

Yes, training was important and we should have received it. Jab zarurat hoga tab le lenge" TIK_07

NVIVO 12. HP stands for Hamirpur, CHIT for Chitrakoot, TIK for Tikamgarh and CHAT for Chattarpur. The number refers to the respondent within these districts. Codes have been used in place of actual names to protect the identity and confidentiality of the CHWs.



This lack of training was particularly of significance as in the absence of proper training and detailed guidelines, it appeared that misinformation, fake news and myths were also propagated.

"When it comes to spreading awareness then the training that was given to us was sufficient. We used to ask people to hold on their breath for 5 seconds if they were able to hold then they do not have corona" CHAT_07

*"When the disease outbreak happened in India the villagers were discussing the COVID infection spreading through hens. **"Maas kaam khao"** (Eat less meat). People were saying as a precaution we should eat less meat-based products" TIK_08*

TIK 08 and CHAT 05's comments are indicative of the larger misinformation malaise in India, which is affecting the COVID 19 fight^{7,8}. In April 2020, the Indian authorities made an assessment on misinformation about meat-eating and found that COVID 19 had contributed to losses of up to 130bn rupees (£1.43bn) in the poultry industry⁹. To

{*"When the disease outbreak happened in India the villagers were discussing the COVID infection spreading through hens. **"Maas kaam khao"** (Eat less meat). People were saying as a precaution we should eat less meat-based products"*} TIK_08

7 <https://www.brookings.edu/research/how-misinformation-is-distorting-covid-policies-and-behaviors/>

8 <https://www.orfonline.org/expert-speak/how-fake-news-complicating-india-war-against-covid19-66052/>

9 <https://www.bbc.com/news/world-asia-india-53165436>



tackle the rising menace of COVID 19 misinformation, on December 28, 2020, the WHO launched a mobile application to provide users with the latest updates on the coronavirus disease (Covid-19). Called the WHO Covid-19 app, it seeks to provide “trusted info from both the experts at the WHO and regional partners, with regular updates and notifications as scientific findings progress¹⁰”. However, if CHWs are not equipped with the correct information and guidelines, it could be a big setback.

In addition to proper training, CHWs suggested having teams rather than individualistic work. *“Potential teams should be formed in order to spread more awareness”* said CHIT_01, a desire shared by many in various responses to indicate that their numbers were not enough to cover everyone, leaving them overburdened forcing them to walk for long hours and distances. One CHW felt that the presence of a team would have led to the citizens taking the pandemic more seriously.

“They should also create a team so that people believe that corona exists” CHIT_02

Overall, it can be concluded that though 89% of the CHWs reported that they received training in some form, the detailed responses indicated that the information, preparedness, and training that the

{“Potential teams should be formed in order to spread more awareness”} CHIT_01

10 <https://www.hindustantimes.com/world-news/who-launches-covid-19-app-to-counter-pandemic-misinformation/story-hCWecP5rt2gsNZWvVEWj0M.html>



CHWs received about the COVID-19 pandemic to spread awareness and carry other responsibilities, was insufficient in many cases. Most CHWs actively requested for more training for them to be able to carry their responsibilities in a more efficient manner. Some lacked the necessary tools to help the community. Lack of proper information received by the CHWs also gave way to misinformation and practices without any scientific evidence. The seriousness of the pandemic itself seemed to be undermined in some villages, as the CHWs felt that the disease was not serious enough to receive any training. The responses by CHWs point to the lack of active communication with these health workers, wherein the training they received could have been better and enabled them to execute their tasks and responsibilities more efficiently.

The seriousness of the pandemic itself seemed to be undermined in some villages, as the CHWs felt that the disease was not serious enough to receive any training

1.2 Mobility and Movement

Accessibility and connectivity to mobility services continues to be a challenge in rural India despite the Indian government's focus on improving rural road infrastructure (UITP, 2016). The challenge of inadequate mobility impinges on the access to necessary health care facilities and in case of the younger population, access to educational opportunities, especially for girls (ibid.). Thus, it was not surprising that mobility and movement emerged as a major challenge in our study. The phase one survey revealed that 46% of CHWs cited mobility and movement as one of the biggest



impediments in fighting the COVID 19 pandemic (refer fig 1.4). Villages in the remote and rural belt of Bundelkhand lack basic connectivity, approachability, and availability of all-weather roads. With a lockdown in place and no movement of any public transport, particularly in this geography, it is crucial to understand how the CHWs were carrying their responsibilities in the face of such major hurdles.

The phase one survey revealed that 46% of CHWs cited mobility and movement as one of the biggest impediments in fighting the COVID 19 pandemic (refer fig 1.4). Villages in the remote and rural belt of Bundelkhand lack basic connectivity, approachability, and availability of all-weather roads.

The worrying figure was further explored within the qualitative survey to understand the CHWs' concerns in further depth. TIK_08's comment summed up the challenge faced by the health workers as they walked long distances to carry their responsibilities.

"We faced a lot of difficulty to cross the uneven roads and proper means to return home from other villages after work"

The intensity of the challenge was such that CHAT_04 felt, "Transport was our only challenge"

Mobility even during normal times is a challenge in rural Bundelkhand, which was exacerbated due to the lockdown in place. The CHWs strongly recommended that if the government allocated them responsibilities, it should also think how they will fulfill

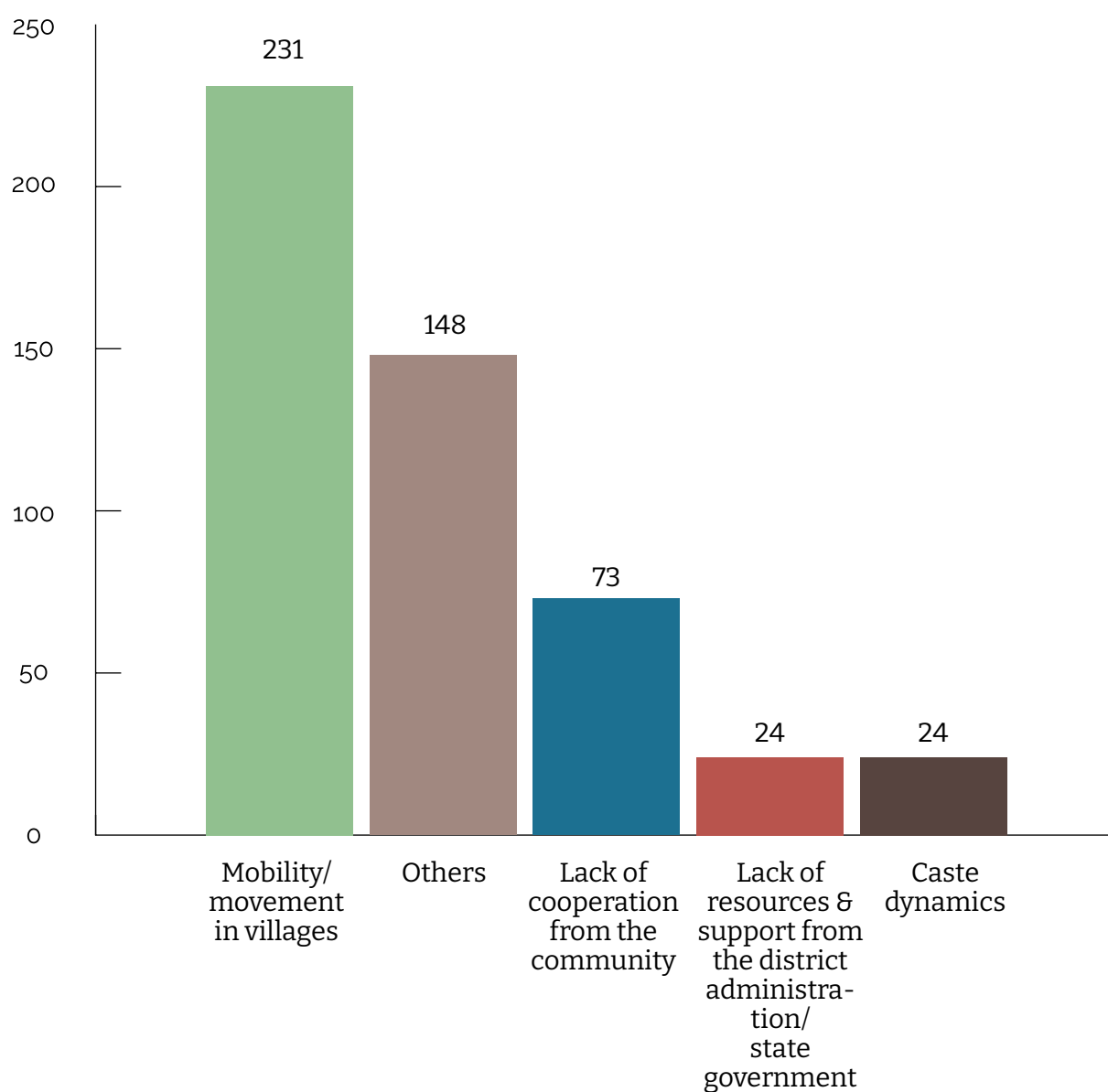


Fig. 1.4: Biggest impediment to fighting COVID 19 in your village



them without proper means of transportation. The issue of lack of public transport for health workers and medical professionals during the lockdown was also raised by the Indian Medical Council in March 2020.

"If they are giving us to do so much work then they should give us proper transport facilities likewise we are even ready to work" CHIT_03

"Transport facility should be given to us so that we can carry out our duties effectively" CHIT_04

"For future I would say logistics and transportation issue should be given importance by the government" TIK_06

Apart from door-to-door visits, the CHWs have to also visit district offices to attend meetings, collect medicines and other necessities as and when they run out of resources. For such work, everyone either travelled on their own private vehicles or pooled in with others. However, the expense of such visits was borne by the CHWs.

"We were not having transport facilities so we used to travel on other people's motorcycles whichever was available. Somehow we used to manage but then because of this we used to reach late" CHIT_01

"I did not go to be frank I went 2-3 times by paying 100 rs for travel and then I did not go and when it's inside the village then I use to walk and go everywhere for work" CHIT_05

Respondent TIK_08 suggested that such facilities should be made available to them within the village itself, so that they don't have to travel outside the village.



"To handle any such emergency situation in a smooth manner I would say it would be good if there is a proper established system to deliver medical kits, medicines and other essential items in the village itself from Palera."

RA: So, did you go to Palera everytime you are out of stock?

Yes, most of the time. Sometimes, we used to call the concerned person and managed to get the stock delivered if any vehicle was crossing through this village"

The only workers who did not face any issue with mobility were the ones who had a private vehicle at home. TIK_07, who travelled via her own private vehicle for work during the lockdown shared,

"Travelling within the village was not a tough affair. But I know many other women have faced difficulties during this period because of lack of transportation". TIK_02 as many others, reiterated the same: "If one owns a vehicle, there is no challenge, otherwise there is a lot of difficulty in travelling".

As our research revealed, the CHWs strongly raised this lack of accessibility and connectivity during the COVID 19 pandemic. Thus, the governments should focus on improving mobility and provid-

{*"To handle any such emergency situation in a smooth manner I would say it would be good if there is a proper established system to deliver medical kits, medicines and other essential items in the village itself from Palera."*} TIK_08



ing adequate transportation for CHWs to execute their duties effectively. In a paper on transport policy making and COVID 19, Zhang (2020) writes that transport policy measures must be a part of the big picture of the fight against COVID-19 and future public health crises. Zhang also proposes a framework PASS (P: Prepare–Protect–Provide; A: Avoid–Adjust; S: Shift–Share; S: Substitute–Stop) approach for transport policymaking that accounts for COVID-19 and future public health threats (ibid.). Though discussing this framework in depth is beyond the scope of this report, this framework could be adopted by governments in India to address this issue. Furthermore, transport policy must have a gendered approach because it is much more challenging for women to have access to safe and secure transportation in their villages and towns. Improving access to rural transportation should be a priority, but such improvement projects and policies should take into account the needs of women specifically.

2. COMMUNITY RESPONSE

Due to this unexpected onset of the pandemic in India (and the situation's gravity being more serious post the lockdown announcement), there was obviously a strong need to engage with India's 1.4 billion population, educate them about COVID 19 and spread awareness on challenges and precautions associated with it. Since the burden of this engagement with the masses especially in rural India was on CHWs' shoulders, from a policy and research perspective, it is imperative to understand the common population's perception and response to the crisis. Therefore, in the quantitative phase, we inquired about the local community's awareness,



response and general attitude towards the pandemic from these CHWs, the results of which are illustrated in figure 2.1 and figure 2.2.

From their responses, it appears that CHWs believe that to a significant extent (figure 2.1), the local populace was fully or somewhat aware of COVID 19, and related precautions and measures. A follow up question explored as to whether or not, this awareness translated into following precautions, as illustrated in figure 2.2. However, this data must be treated with caution as all these CHWs are government functionaries and their primary COVID 19 related task was to spread awareness and make people aware and careful. Thus, while analyzing the phase one data, it appeared that these numerical figures may be an overestimate, which led us to explore this issue in depth in the qualitative phase. While some CHWs reiterated that people were aware, many CHWs reported that the community members were hesitant regarding sharing accurate information and facts as demonstrated by the following comments:

"People were hiding from us and not sharing their full information"
CHIT_05

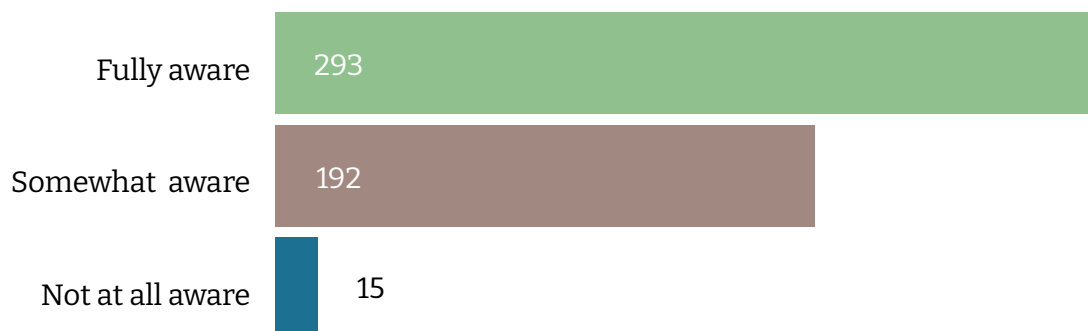


Fig. 2.1: Awareness of local community on COVID 19 precautions and safety measures



- Yes, wearing masks and practicing social distancing
- Yes, wearing masks
- No, not taking any precautions

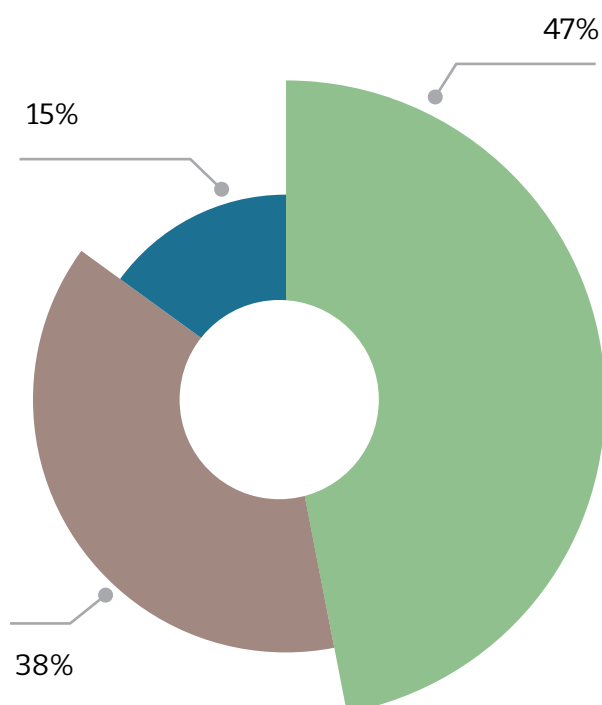


Fig. 2.2: Are they following the safety precautions and measures?

- Did not face any challenge
- Faced little challenges but no significant impact on my work
- Yes, faced a lot of challenges

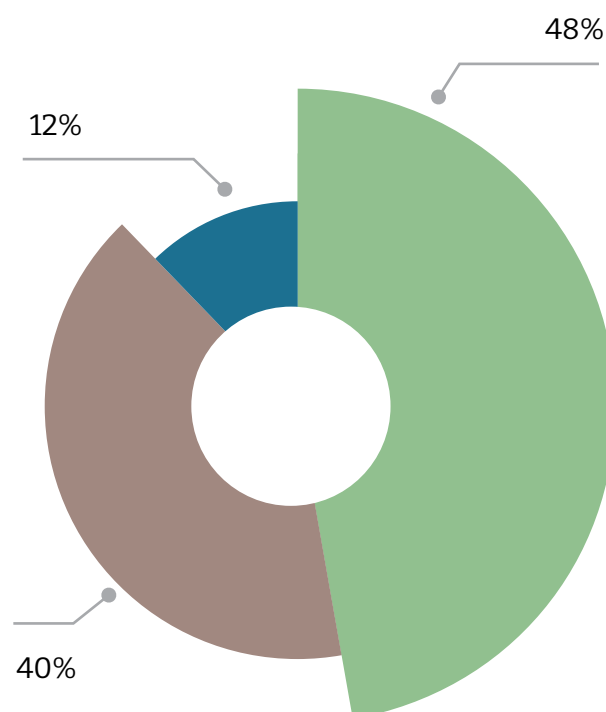


Fig. 2.3: Did you face any challenges in your community during your COVID 19 work?

"People were afraid that they would take us to one place and leave us alone," expresses CHAT_03

These statements indicate that some people in these districts have a distrust of the government health system and are afraid of being



taken away and quarantined by the health administration if they share their personal information. This distrust of government institutions is evident in other contexts as well. For example, several media houses reported that incoming passengers were popping paracetamol tablets^{1,2} to bypass thermal screening by officials³. Multiple studies in India have revealed the distrust of the populace in CHWs, doctors, and health professionals in general, which often leads to violence against them (Sharma, Webster & Bhattacharya, 2014; Kane & Calnan, 2017; Sharma et. al, 2019). We will explore this aspect in detail in Section 5 but the findings suggest that while people were aware and cooperative to an extent, the CHWs did face challenges in talking to them and making them aware about COVID 19 precautions.

We also explored the perception of COVID 19 among the community which varied greatly and served as a significant challenge for the CHWs. As Figure 2.3 reveals, 52% of CHWs reported some or great challenges in doing their duties. Among those who reported challenges, about 68% CHWs reported that people were not willing to talk due to COVID 19 stigma (Figure 2.4). During the qualitative phase, when we further examined their perspectives, a few health

{“People were afraid that they would take us to one place and leave us alone”}_{CHAT_03}

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- 1 <https://thelogicalindian.com/news/passengers-reveal-consuming-paracetamol-before-flights-to-evade-thermal-screening-21388>
 - 2 <https://www.thehindu.com/news/national/telangana/hiding-covid-19-symptoms-is-homicide/article31141393.ece>
 - 3 <https://www.newindianexpress.com/states/tamil-nadu/2020/mar/24/passengers-pop-paracetamol-tablets-to-bypass-thermal-screening-at-coimbatore-airport-2120726.html>

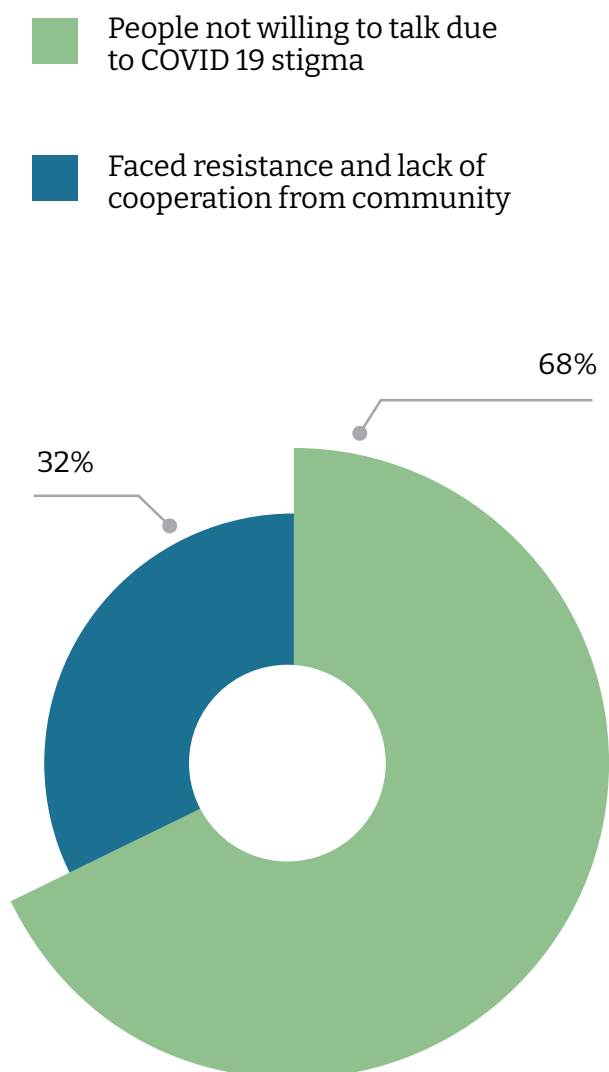


Fig. 2.4: What challenges did you face?

by the doctors, which again highlights their distrust in doctors and healthcare professionals. It appears that these assumptions were mostly fueled by the fact that COVID 19 symptoms are not unusual in general life: cold, cough, nausea, etc, as demonstrated by the following comments:

workers termed it as a 'Mahamari' (crisis), a term which is also regularly used by Hindi news channels to describe the pandemic. The fear-inducing nature and implied meaning of this word proved a hassle for the CHWs as they had to hear unpleasant sentences and were mistreated due to unfounded assumptions of the community. Furthermore, being health workers, often it was assumed that they may be COVID 19 infected themselves. Though this issue was not an area of inquiry in our study, the impact of popular terminologies on health crises and their perceptions in India could be an area of potential research. Furthermore, there were contrary perceptions of COVID 19 as well. CHWs mentioned that several people ignored the seriousness of the pandemic. They assumed it to be fake, and a hoax created



"Sabhi bolte hain ..ye sab doctor ki afwaha hai..Kya pehle nahi hoti thi sardi jukam!", (Everyone says this is just a myth propagated by the doctors. Weren't cold and cough present before?)
TIK_01

"Faltu mai pareshan kar rhae hain doctor log, sardi zukam hi toh hai" (The doctors are troubling us unnecessarily, it is just common cold), CHAT_04

the lack of seriousness accorded by several people was challenging for the CHWs as people denied them entry, refused to listen, and appeared irritated by their visits.

Thus, the lack of seriousness accorded by several people was challenging for the CHWs as people denied them entry, refused to listen, and appeared irritated by their visits. Both these issues, lack of seriousness and the fear around the virus, made the work of CHWs quite challenging.

2.1 Differences in engaging with women and men

India has a patriarchal society where men dominate women and hold a sway over familial decisions. In the context of CHWs, who are the backbone of the maternal reproductive and child health programs and schemes in India, there is sufficient research which tells us that being women, the CHWs' interactions with men of their villages is limited due to gender norms and sometimes, resistance from men. Furthermore, the ASHA workers, who are considered the Bahu (daughters-in-law) of their villages are supposed to maintain the status quo, i.e., patriarchal dominance. These issues are further problematized when

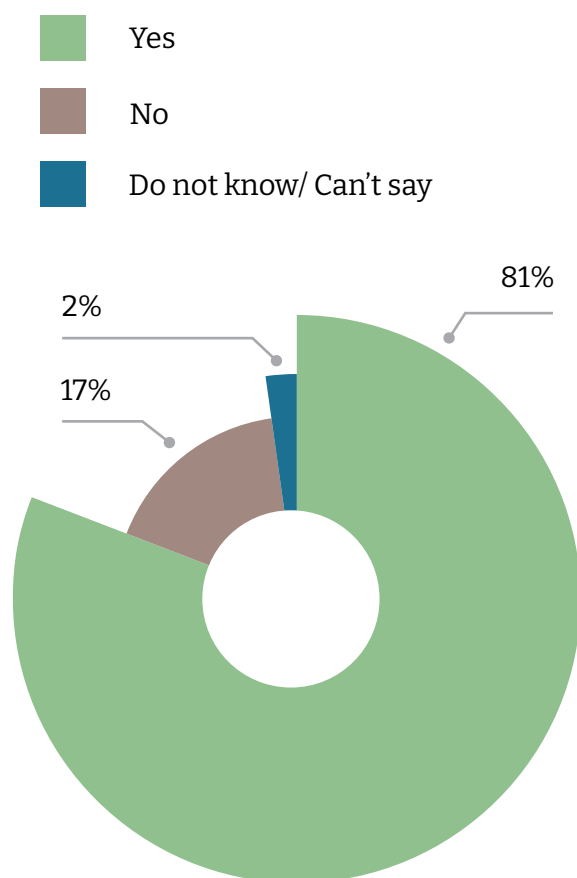


Fig. 2.5: Are people generally willing and Cooperative in getting tested for Coronavirus if required?

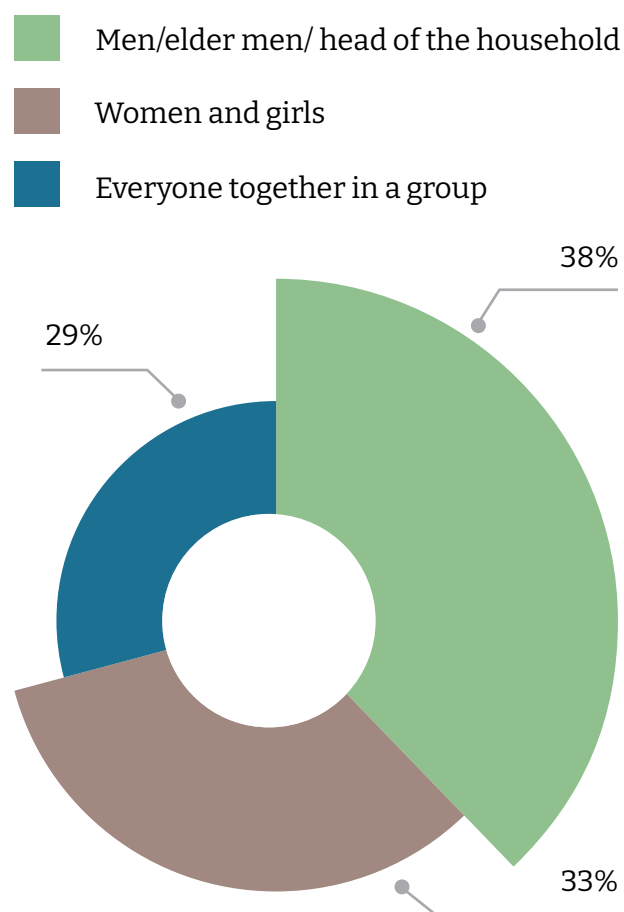


Fig. 2.6: CHWs point of contact while visiting households

it comes to caste, class, village, and language among other aspects of the identity. Therefore, taking a cue from the existing literature, we wanted to understand if there were any differences experienced by the CHWs in engaging with men viz a viz women and children. Our quantitative survey revealed that during their home visits, only 29% of the workers talked to everyone in the household, whereas 33% spoke to women and the rest 38% to men or head of the household as Figure 2.6 shows. Within districts, in Chitrakoot, CHWs reported the maximum proportion of talking to everyone together (Figure 2.7).

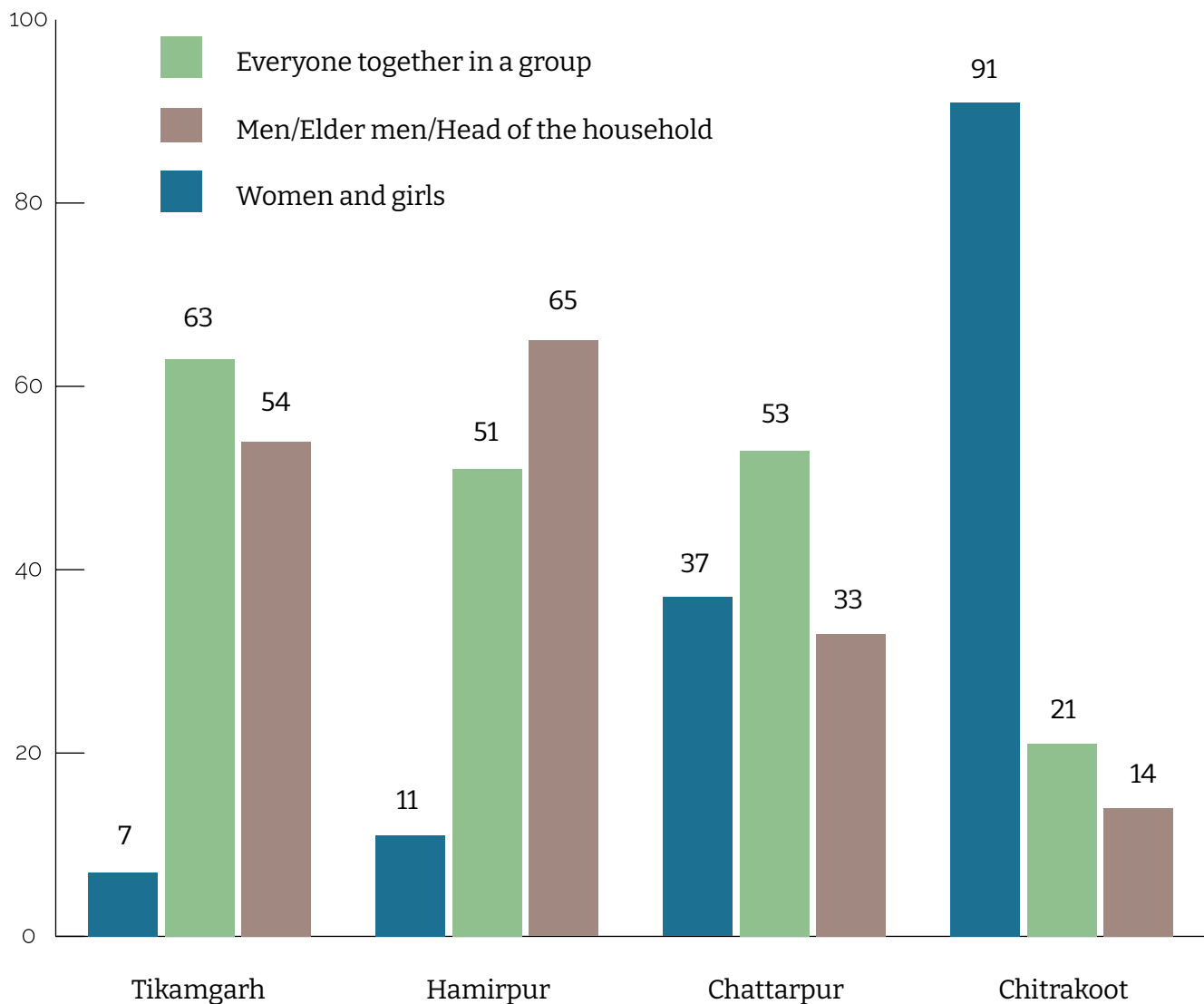


Fig. 2.7: While visiting households whom do you talk to and give instructions?

The data was not unidirectional to reach any tangible conclusion, but nonetheless we asked the CHWs to share their preferred point of contact in the household again, along with the reason for the choice, in our qualitative phase. In the second phase, the CHWs mentioned that usually they asked for speaking to the mukhiyas or head of the household first, and then reached out to the female members in case the mukhiya was not present, keeping in mind the



local gender norms. However, the CHWs also added that they felt more comfortable talking to the women because the household women were easier to communicate with and more understanding. On the contrary, according to some workers, men avoid interacting and barely listen.

"We used to speak generally with women. Elder members in the village would not speak freely and demand respect. Male members of the family avoid interacting easily with us" TIK_08

"Yes, talking to females is more comfortable, then men as they do not talk properly at times. They are not ready to listen as they think we do not have corona then why do will listen to all this" CHIT_05

Apart from comfort, CHWs believe there are better chances of the suggestion being implemented in the household.

"Usually, women will listen to our instructions but men do not pay attention and communicate properly to village members" TIK_01

The feedback from these CHWs that men do not give serious consideration to CHWs' work and suggestions also finds ground in the

{*"Compared to women, men used to have more updates regarding corona from tv, news. So we had to put in more efforts to educate women about corona and its awareness"*} CHAT_01



patriarchal setup of Bundelkhand as also echoed in the Human Development Report Bundelkhand 2012. In the Indian society, women are accorded a lower status than men, and are supposed to be limited to reproductive duties. The power shift wherein CHWs being women are in position to guide and instruct the community on the dos and don'ts, doesn't fit well within the gendered rules. Hence, there are chances of them being ignored, avoided and taken lightly. Furthermore, we posit that the primary reason underlying comfort with women is also compounded by the fact that these CHWs have worked for RMNCH⁴ programs for several years, for which they mostly engage with women and children and have limited or no interaction with the men. Some CHWs referred to the harsh treatment they received as they went door to door and felt that women are more supportive, understanding and welcoming. "Corona nahin chipka hai usse", shared a health worker from Chitrakoot, how women of the village backed her up as many people dreaded her presence in their household, thinking she might be infected. Another perspective that emerged was that men were already more updated about COVID-19 through television and the internet, so the CHWs had to invest more effort in educating women about COVID-19.

"Compared to women, men used to have more updates regarding corona from tv, news. So we had to put in more efforts to educate women about corona and its awareness" CHAT_01

This perspective is correlated by statistical data as well. Only 29% of internet users in India are female according to a 2017 study by

4 Reproductive, Maternal, Newborn and Child Health



UNICEF India⁵. An analysis of recently released NFHS-5 data revealed that in Bihar, 4 in 5 women have never used the internet. Therefore, it is likely that men already had more information about COVID 19 and related issues given their high propensity to have access to the internet⁶ and online news.

Hence from our interaction with the CHWs about their responsibility to conduct the door to door campaign and spread awareness, we found a general preference towards speaking with women, which is rooted in comfort and better mutual understanding. Considering that CHWs being women themselves have always interacted with women and girls in the past throughout most of their work lives, this added responsibility required them to interact with the entire community. Additionally, how the community perceives these workers, and treats them, especially the head of the households who are significantly men in rural India (only 13% of households in rural India are headed by women⁷), is not only imperative to further measures for CHWs inclusion, safety and acceptance but also for better implementation of initiatives. While in this section we explored the community's response to the CHWs, in Section 5 we will further understand this aspect of interaction from CHWs perspective.

5 https://www.unicef.org/publications/files/SOWC_2017_ENG_WEB.pdf

6 <https://www.indiaspend.com/gendercheck/4-in-5-bihar-women-have-never-used-the-internet-702855>

7 <https://www.livemint.com/Politics/RjAdjOgWkNMqHGI1DqX8tJ/Census-reveals-gloomy-picture-of-life-in-femaleheaded-house.html>



3. PAYMENTS, WORK AND EMOLUMENTS

Payments and wages have always been a contentious issue for CHWs, especially ASHA workers because their incomes are significantly based on incentives (on a per activity/milestone basis). The salaries of AWWs and ANMs are usually fixed but over the years, there have been several protests by these workers demanding higher pay, better working conditions, and regularisation of jobs. In the context of COVID 19, all the 500 CHWs interviewed were given additional responsibilities to handle the pandemic. Furthermore, as Figure 3.1 shows, more than 85% ASHAs worked for 4 hours daily or more on COVID 19 duties, whereas the corresponding figure for AWW and ANMs was 77%. Given the already low wages of CHWs

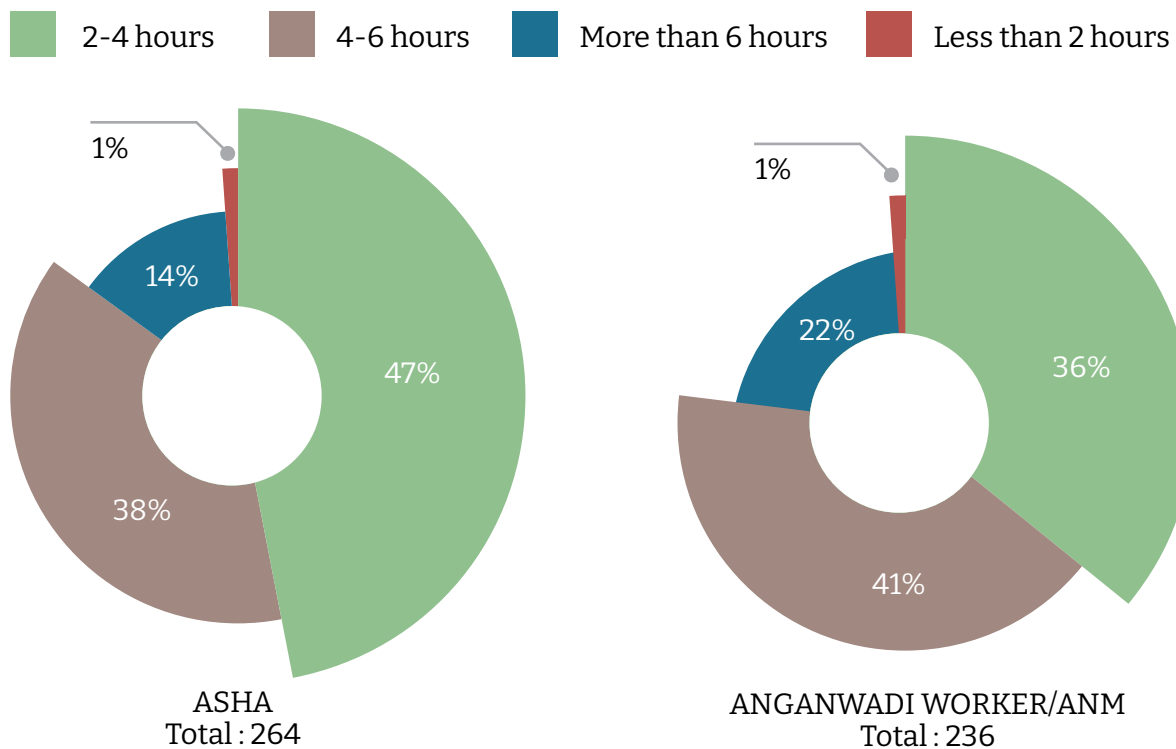


Fig. 3.1 On an average, how many hours did you spend in a day on COVID 19 related duties?

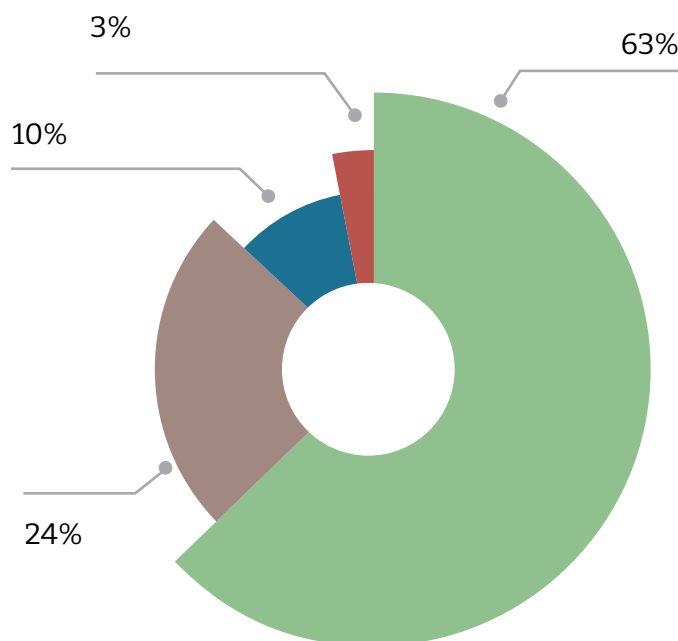


Fig. 3.2: Were you promised any extra remuneration for COVID 19 work?

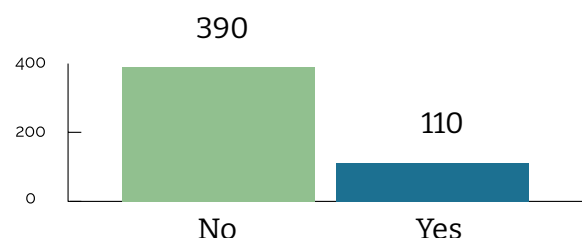


Figure 3.3: Were you promised any extra pay for door to door survey?

especially ASHAs, we wanted to understand if the workers have been compensated for this extra effort. Our quantitative survey found that 63% of CHWs across four districts reported (Figure 3.2) that no additional payment was promised to them for COVID 19 work. This trend is consistent with media articles which reported that CHWs were being made to do COVID 19 related work but at no or meagre pay^{1,2} which eventually led to a massive protest by more than six lakh ASHA workers in August 2020³.

- <https://thewire.in/labour/covid-19-adds-woes-india-underpaid-overworked-care-workers>
- <https://www.hindustantimes.com/delhi-news/asha-workers-continue-to-fight-for-better-salaries/story-tF1HakHmfxfjeBZpEtMTiO.html>
- <https://www.livemint.com/news/india/covid-6-lakh-asha-workers-on-strike-from-to-day-11596759580611.html>

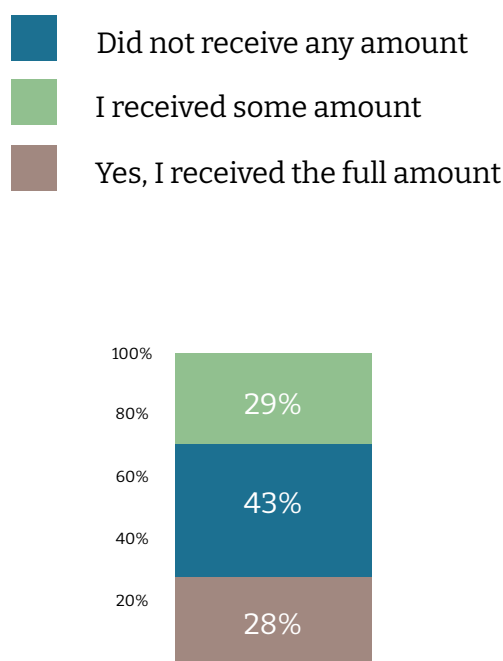


Figure 3.4 Did you receive this promised remuneration?

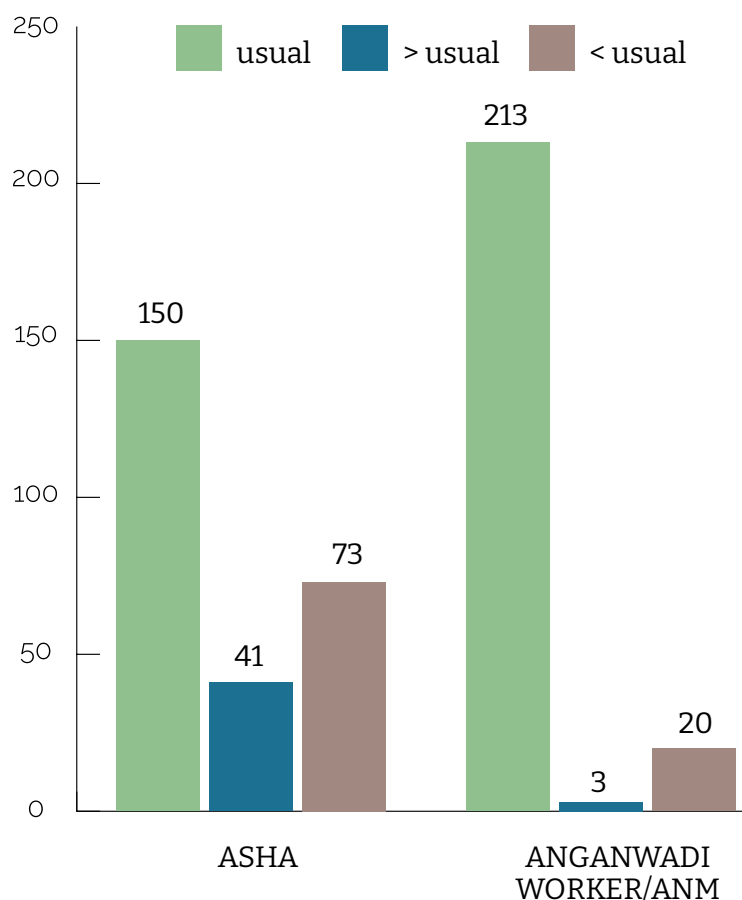


Figure 3.5 Did you earn more or less than your monthly salary during the lockdown period?

Of those who were promised some amount, 28% received the full amount, 29% received partial payment, whereas 43% did not receive anything (Figure 3.4). 73% of CHWs reported receiving the same income during COVID 19 lockdowns as they used to receive prior to COVID. Among CHWs, a higher proportion of ASHAs (Figure 3.5) reported receiving less money than usual as compared to AWWs and ANMs. Some ASHAs even reported receiving more than their usual pre-COVID incomes.

In hindsight, we realized that CHWs may have confused this question with their regular payment, and therefore, we further investigat-



ed this aspect in the qualitative phase. Though many CHWs were promised extra payment as discussed above, almost all CHWs reported that they did 'hear' about some extra incentives for COVID-19 work through various sources. Some CHWs heard it from health officials, doctors and nurses, and others through mainstream news. Additionally, an RA from Chattarpur shared that according to him, the regular payment of CHWs (which would otherwise be claimed for reproductive maternal health related work) was diverted and given to them for the COVID-19 work. As a result, the amount they earned as a worker remained the same, which is somewhat corroborated by the graphs in figure 3.4.

It is quite evident that though not many CHWs were officially promised any amount for COVID-19 work, almost everyone had it in the back of their minds that they would receive some amount for the additional duties they were performing. This hearsay and some promises raised expectations among CHWs but they were quite disappointed with the eventual situation as the following comments from Tikamgarh district portray.

"Haan haa..sarkar ne bola tha 14 din ka khane ka khracha denge, tankha denge, par diya kuch nhi!" (Yes, yes. The government said that they will pay for 14 days of costs, give salary but they did not give)-
TIK_02

{ "We were informed that for all extra tasks carried out during COVID times, we would be provided 10,000 INR as a bonus. But, nobody came and still no information we have received on this matter" }
TIK_08



"We were informed that for all extra tasks carried out during COVID times, we would be provided 10,000 INR as a bonus. But, nobody came and still no information we have received on this matter" TIK_08

In the context of maternal reproductive child health (which is usually the primary role of CHWs) Maya Unnithan, a medical anthropologist, who has worked with these CHWs for decades writes that it is the perceptions, work vulnerabilities and the nature of working conditions (hierarchic, bureaucratic, apathetic and non-consultative) that determine the quality of the services the ANM and ASHA can offer, which affect their desire and motivation to do so (Unnithan, 2019, p. 131). Unnithan's arguments are relevant here as our study shows that these CHWs are made to work long hours without any definite payment schedule or often with no pay at all. A study by Sarin et. al, (2016) found that low incentive rates relative to the level of effort required to complete ASHA responsibilities, compounded by irregular and incomplete payment, put pressure on ASHA and their families. From our research it appears that similar processes are at play as the CHWs are still being underpaid or not paid and burdened with extra work with no definite promise of pay or emoluments. This lack of adequate or no pay for the extra burden of COVID 19 is representative of the general situation of these CHWs especially ASHAs.

It is noteworthy that 85% of CHWs reported spending their own money to buy safety gear. Within this 85%, 44% spent Rs 500-1000 (Figure 3.5), which is significant considering the average remuneration earned by these CHWs especially ASHA workers. Sarin et. al, (2016) found that quite often, ASHAs spend money themselves for their work as well as support patients in some cases. As it is, the existing wages for CHWs, especially ASHAs and AWWs are quite low. With the onset of the COVID 19 pandemic, these CHWs

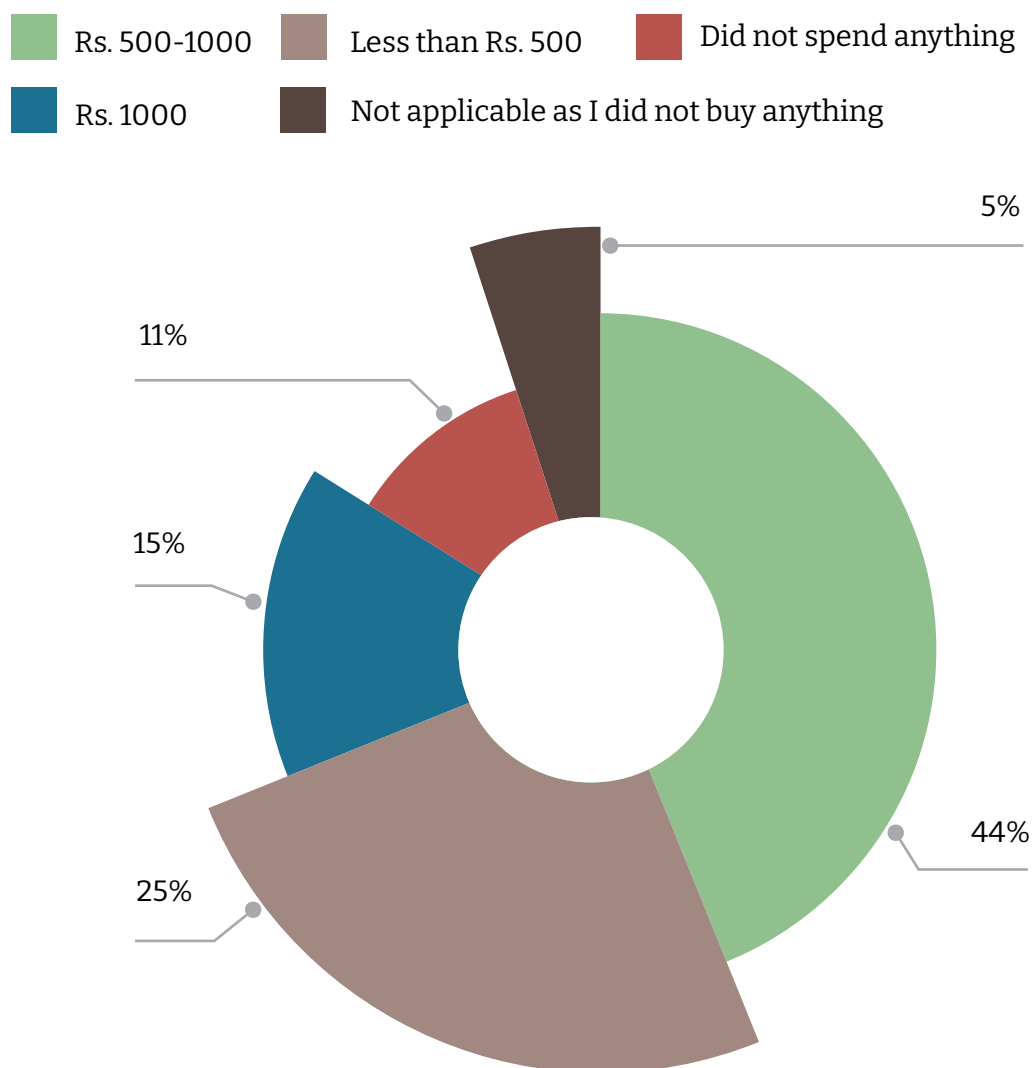


Fig. 3.5 How much money did you spend (monthly) on an average on masks and sanitizers to protect yourself?

further felt the pinch as they were not complemented for the extra work they carried but also had to spend money on buying their own sanitizers and masks, something which they were supposed to get as part of their work safety gear.



4. POLICY AND LOCAL GOVERNANCE

The previous three themes focused on issues directly impacting the CHWs and their ability to execute their tasks efficiently. However, it is also important to understand their perspectives on the COVID 19 related governance matters. Rural areas in India pose particular difficulties for implementing effective responses owing to underdeveloped health infrastructure, uneven state capacity for infection control, and endemic poverty. Therefore, it is important to understand the critical role of local governance in coordinating pandem-

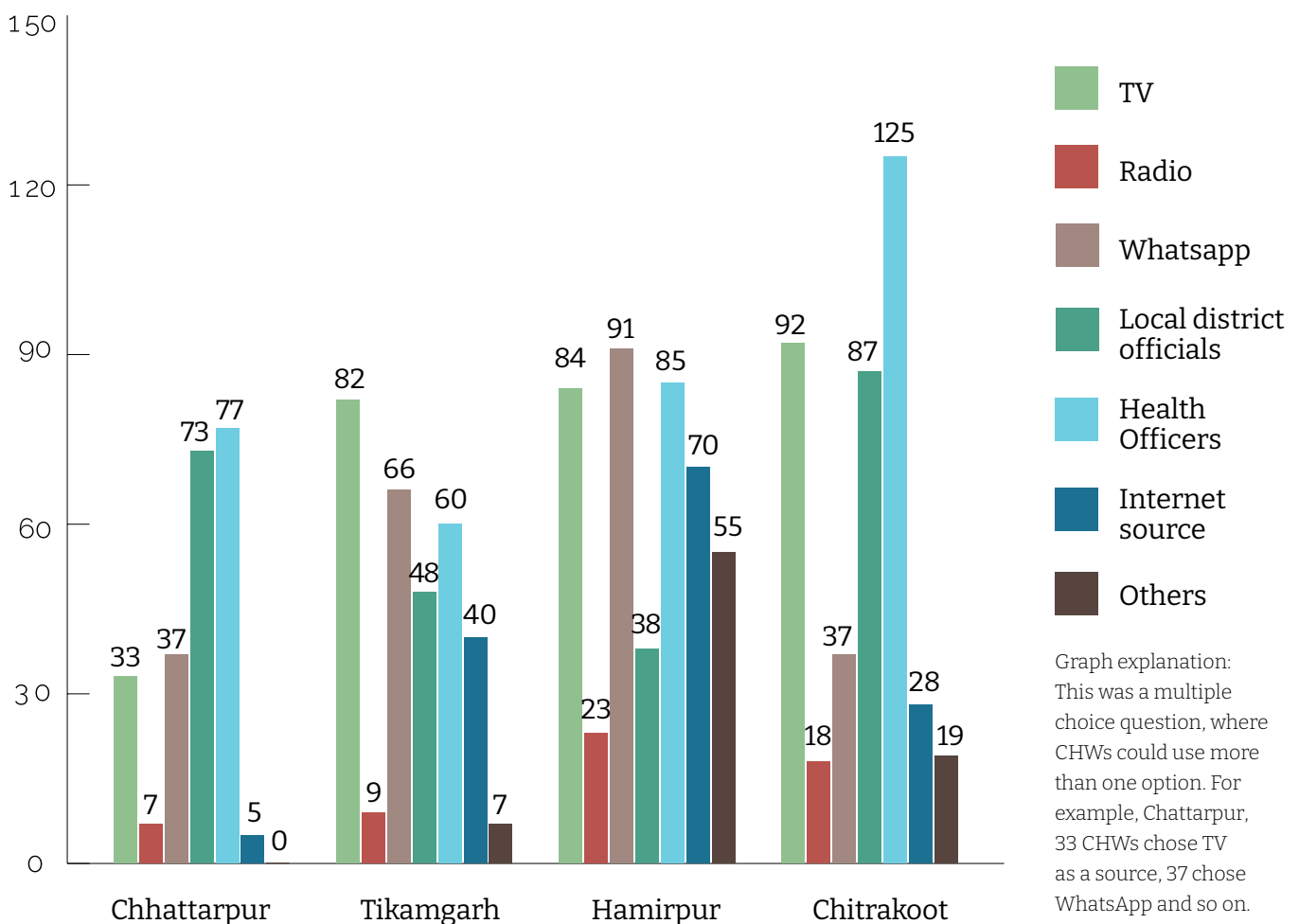


Fig. 4.0 Which source of information is most trusted by people for COVID 19 related information?



ic response (Dutta & Fischer, 2021), and how it can be improved in future. Within this theme, we chose to focus on three aspects. One, information dissemination of COVID 19 and related practices. Two, quarantine centres in villages. Three, COVID 19 vaccination.

4.1 Information Dissemination

In the previous sections, there were discussions about how CHWs rued the lack of sufficient training for executing their duties efficiently and due to lack of this training, some CHWs propagated myths and misinformation with no scientific basis. Thus, to fight COVID 19 effectively, there is a strong need to disseminate information carefully and through the right channels. During our phase one, we found that WhatsApp, local government and health functionaries were the most trusted sources of information regarding COVID (Figure 4.0). Further, the graph shows that in the case of Chitrakoot and Chhatarpur, people mostly trusted Health officers while in Tikamgarh, it is TV and in Hamirpur, it is WhatsApp. Going by data, the source of information most trusted by people of Bundelkhand is TV.

On further investigating the high trust in health officials¹, especially in Chitrakoot, CHWs revealed that the community trusts them as a reliable source of information, due to the rapport they have built with them over the years.

"they all believe in us as we have been in this village since so many years," shares HP_02.

The community realises that the CHWs are trained and will not pass on any false information. Additionally, WhatsApp was reiterat-

1 Health officials refer to the CHWs as well as local public health staff



ed as a primary media of information for COVID 19. Since the CHWs themselves receive information from district officials on WhatsApp, the usage of the app itself for consuming information is high. The CHWs added that the community does rely on WhatsApp for information but not everything they receive was true or reliable.

"Kai bar to gumrah kar deni wali batein falai jaati ha..kabhi toh corona ke barein mein gaane" TIK_02. (Many a time, misleading messages are spread. Sometimes, COVID 19 related songs are forwarded).

TIK_02's views hold relevance not just in Tikamgarh district but the entire country as misinformation, unscientific advice and fake news related to COVID 19 has spread widely through WhatsApp². Realizing this 'infodemic', in March 2020, WhatsApp teamed up with the Government of India for the purpose of sharing only authentic information. The WhatsApp bot, called MyGov Corona Helpdesk is designed to share authentic information and bust myths. However, our research suggests that the Government, especially at the district level, must invest more resources in dispelling fake news and myths³. This is particularly important given the upcoming vaccination drive because vaccines are extremely prone to myths and fake news leading to people refusing to get vaccines. There are examples from where lessons can be taken.

4.2 Quarantine Centres

The word 'quarantine' has become synonymous with COVID 19. Many media houses reported that in urban areas, the state govern-

² <https://www.freiheit.org/india-misinformation-and-healthcare-infodemic-india>

³ <https://www.indiatoday.in/technology/news/story/whatsapp-teams-up-with-government-who-to-curb-misinformation-related-to-covid-19-1660105-2020-03-26>

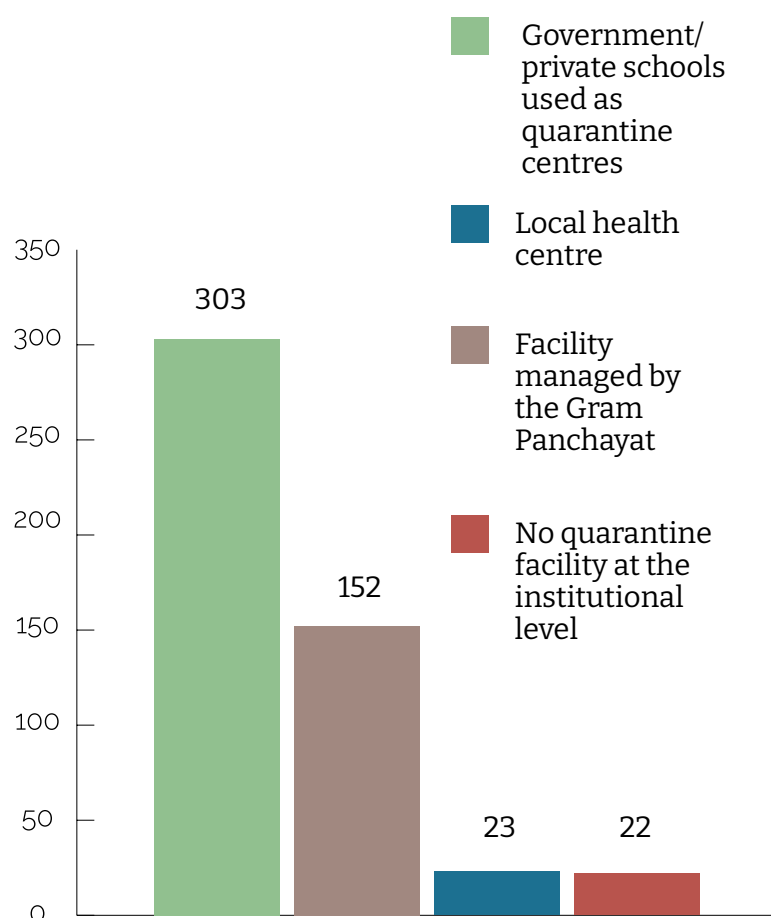


Fig. 4.1 Where are the local institutional quarantine facilities for migrants/residents in your village?

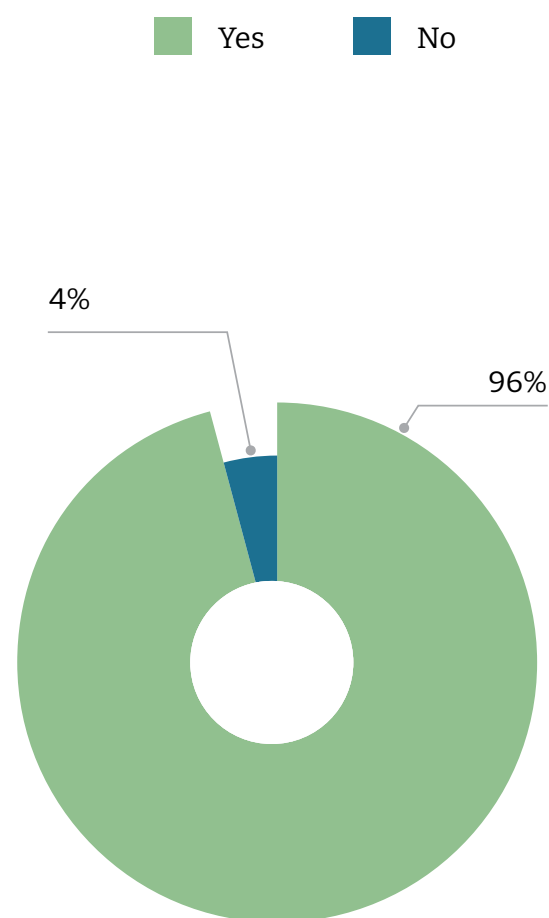


Fig. 4.2 Have people been cooperative in going to the quarantine facilities?

ment and urban local bodies allocated hospitals, healthcare centres, and big halls as quarantine centres. One of the responsibilities of the CHWs was to lead the people with symptoms and those travelling from outside the village to the quarantine centres. In rural Bundelkhand's context, we were curious to know the different types of quarantine centres and the challenges associated with them. Our phase one data revealed that around 60% CHWs (see figure 4.1) reported that quarantine centres in their villages were in government schools, while in 35% said that quarantine facilities were managed by gram panchayats and local health centres. Further questions

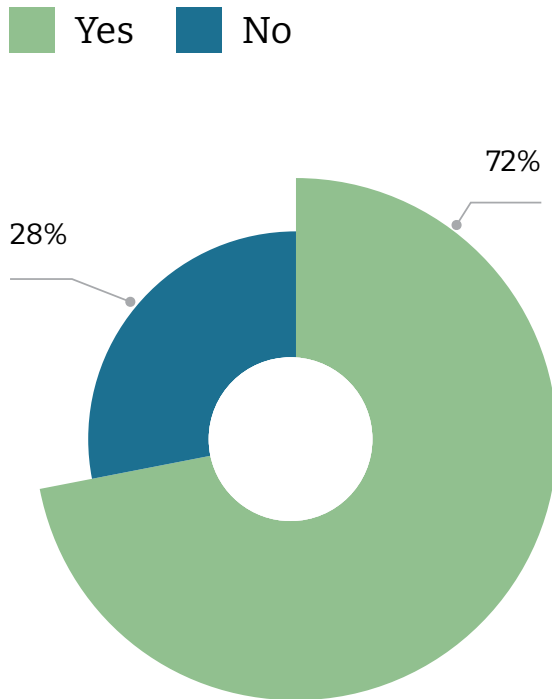


Fig. 4.3 Have women and girls been comfortable in going to these quarantine facilities?

related to quarantine facilities revealed that 96% CHWs said that people were cooperative in going to quarantine facilities (Figure 4.2).

We further found that 28% of CHWs mentioned that women and girls were not comfortable going to the quarantine centres. Though 72% CHWs felt that women and girls were comfortable, the 28% who were uncomfortable was significant to be investigated further (Figure 4.3). Within districts, from a percentage perspective, 50% of CHWs in Tikamgarh reported

that women and girls were not comfortable in these centres. When we inquired about this discomfort in our qualitative phase, the first concern common across all districts was that there were no separate facilities for women and men. This led to the discomfort and hesitation of the women and their families in sending them to the quarantine centres.

"Men and women ..how can they use the same facilities and stay together?": TIK_ 04.

This hesitation and separation is primarily due to the local gender and cultural norms in Bundelkhand as well as India largely, where



women are not supposed to stay or venture near stranger men. Given that Bundelkhand is a highly patriarchal society and women are often associated with dignity and family respect. Hence they are often put in the background- hidden and protected. This further leads to their suppression, domination and subjugation. Therefore, quarantine centres and health centres at large should bear these cultural and gender norms in mind and set up facilities accordingly. Secondly, being in a quarantine centre was a new phenomenon, both for the workers and the community, therefore, there was an ambiguity surrounding the same. Furthermore, in addition to having the same centres for both women and men, most lacked proper facilities like bed, bathroom, and hygienic sanitation facilities. As the women had to share the centres with men, and lacked proper facilities considering their hygiene and sanitation needs, they resisted, felt uncomfortable, unsafe and had an unpleasant stay at the quarantine centres.

"The facilities were general, same for both men & women, women have different needs" HP_04.

"Sahi bat hai ladki ya waha nahi jana chahti thi kyuki koi suvidha nai thi nah toh nahne ki, nah toh letne ki toh konsi ladies waha ruk sakkti hai" HP_07 (Yes, it is correct that girls did not want to go there because there was no facility to bathe or lie down so which woman can stay there?) Thus, Moser's approach of using gender based planning is relevant

{*"The facilities were general, same for both men & women, women have different needs"*}_{HP_04}



here. The incidence particularly highlights how the interventions need to be gender sensitive and not purely technical.

From a policy perspective, the CHWs suggested if such scenarios arise in the future, the authorities need to give priority to women's safety and comfort, and have different centres for them.

They suggest that at the very least, some partitions should be there between two facilities, to respect the privacy of women and basic infrastructure facilities should not be compromised. This suggestion assumes significance in light of the fact that more than 60% of quarantine centres (Figure 4.1) were in government schools. The NITI

The NITI Aayog & UNDP report on Bundelkhand reveals that in these districts, even in usual times, parents worry about the safety of girls in schools since many lack boundary walls or fencing and classrooms do not have doors.

Aayog & UNDP report on Bundelkhand reveals that in these districts, even in usual times, parents worry about the safety of girls in schools since many lack boundary walls or fencing and classrooms do not have doors. The lack of female teachers worries many parents. Parents also said that if girls have to travel over three to four kilometres to reach school, then they would prefer not to risk sending their girls to school. This highlights that the schools in rural Bundelkhand not only lack proper facilities and infrastructure but are also perceived to be unsafe for girls. Given this background, where families voluntarily do not send their daughters to school, the situation would have been extremely uncomfortable for those girls and women who were asked to quarantine in these centres. Across India, there have been few cases



of women patients being sexually assaulted⁴ and raped⁵ in these quarantine centres⁶, thereby, strongly stressing the need to have separate and safe quarantine centres for women.

4.3 COVID 19 Vaccination

We found that there are two important issues to consider during the COVID 19 vaccination process a) efficient messaging and awareness b) trust building in the community to avoid potential backlash against CHWs.

One of the primary responsibilities of ASHA workers is to help the community access health delivery services through home visits, providing support with first-aid, and during immunization sessions (Sharma, Webster & Bhattacharyya, 2014). Their previous experience with immunization and close association with the community makes it imperative to understand their

perspective as the nations globally make progress with COVID 19 vaccination trials and procurement processes. At the time of writing this report, several developed nations such as the US, UK, and Germany have already vaccinated thousands of people. Certain parts of rural India are still remote, lacking proper access to technology and healthcare services, making it all the more essential to understand how the vaccination process for COVID 19 can be more inclusive and reach everyone. Hence in phase two of the

4 <https://zeenews.india.com/maharashtra/woman-raped-at-coronavirus-covid-19-quarantine-centre-in-navi-mumbai-accused-arrested-2296562.html>

5 <https://www.thehindu.com/news/cities/mumbai/covid-19-patient-allegedly-rapes-woman-at-quarantine-centre-in-panvel/article32119189.ece>

6 <https://www.firstpost.com/india/attendant-held-for-raping-20-year-old-at-covid-19-quarantine-centre-in-thane-8812111.html>



study⁷, we inquired about potential challenges about vaccination. We found that there are two important issues to consider during the COVID 19 vaccination process **a) efficient messaging and awareness b) trust building in the community to avoid potential backlash against CHWs.**

Every CHW mentioned spreading sufficient and necessary awareness in the community about the vaccine is the most critical task. Based on their previous experience of vaccinations and immunization, they told us that broadly, the local community would be apprehensive about getting vaccinated. The CHWs requested for clear, bold, and sufficient messaging and information from the Government to the community for their better understanding and subsequently making their tasks easier.

"They should send bold and clear messages that this vaccine is for their (community's) benefit and nothing will go wrong with it. Spread awareness as much as possible" CHIT_05

"Gain the trust of people that it won't cause any harm", HP_01

"More helping hands, proper facilities, running campaigns won't create challenges for us" HP_02

The need for clear and efficient messaging regarding vaccines is also evident from the myths and misinformation propagated during

7 When we started the conceptualization of phase one questionnaires, the new around vaccination didn't gain much traction in India but after approval of multiple vaccines in western countries, the government started preparing for the same. Hence, we decided to explore the CHWs' perspectives on vaccinations, which is slated to start in Jan/Feb 2021.



the pandemic as discussed in section one. As it is, even before the vaccine has officially been approved for usage in India, there are concerns around fake news and misinformation on the upcoming vaccination drive but initiatives are underway to mitigate the challenges. For instance, Google is rolling out a new information panel⁸ in Search to counter misinformation about coronavirus vaccines⁹. The United Kingdom will be the first country to get the feature because it has already rolled out the Pfizer vaccine for COVID in the country. Other countries will get the new Google feature as soon as they start to approve coronavirus vaccines. Even Twitter has said that it will begin removing misinformation about COVID-19 vaccinations from its site. It listed among posts that will be removed as those including false claims that the virus is not real, debunked claims about the effects of receiving the vaccine and baseless claims that suggest that immunizations are used to harm or control people¹⁰. The second issue which CHWs raised is that the government will have to gain trust of the people that this vaccine is effective and won't cause any harm to anyone. A recent study conducted by LocalCircles among 18,000 people across 242 districts in India found that 70% of them are hesitant to take a vaccine against the novel coronavirus¹¹. The key reasons for the hesitancy were the limited information about side-effects, efficacy levels, and a growing belief that one would not be infected with the disease due to high immunity levels¹². The concerns around side effects was also raised by CHWs who requested adequate awareness of the possible side effects because anything

8 <https://www.indiatoday.in/technology/news/story/google-launches-information-panel-to-combat-covid-vaccine-misinformation-1748558-2020-12-11>

9 Same as footnote 25.

10 https://www.business-standard.com/article/current-affairs/twitter-says-it-will-start-removing-covid-19-vaccine-misinformation-120121700074_1.html

11 <https://indianexpress.com/article/india/nearly-70-indians-unwilling-to-take-covid-19-vaccine-finds-study-7109474/?fbclid=IwAR3kxICmLruc0wEUhLZ2v4tW8QFUDxohGnCO-3I39egi-a7q4MMasx2cX3hk>

12 Same as 29.



goes wrong or in the case of any side effect, the repercussions will have to be borne by CHWs which can even lead to violence.

*“Tika to lagwayenge ...gaon k log. Side effect na ho fir hume danda parega”:*TIK_01 (People will get the vaccination, but if there are any side effects, we will face the consequences)

As the LocalCircles survey and our own study finds, the trust of vaccines among people holds immense importance as these CHWs, being women, are more vulnerable to any immediate reaction from the community. In the case of lack of adequate information or awareness as well, CHWs shared that they will have to deal with the excess load of queries they will receive, for which people will ring them up day and night. Second to awareness, the health workers felt that there is a need for more human force to be able to administer the vaccine. This is similar to the CHWs' demand that COVID 19 work should be in teams rather than individualistic work carried out by them as discussed in section 1. Hence, adequate communication around COVID 19 vaccine is necessary for better acceptance, cooperation and the safety of the CHWs, who being women, are all the more susceptible to potential backlash in case of any mishap and side effect.

5. Safety and security of CHWs

It needs no mention that the safety of CHWs is of utmost importance. In our study, we have conceptualized and investigated the concept of 'safety' of CHWs in a multidimensional manner **a) safety during travelling in villages b) physical safety of CHWs in the**



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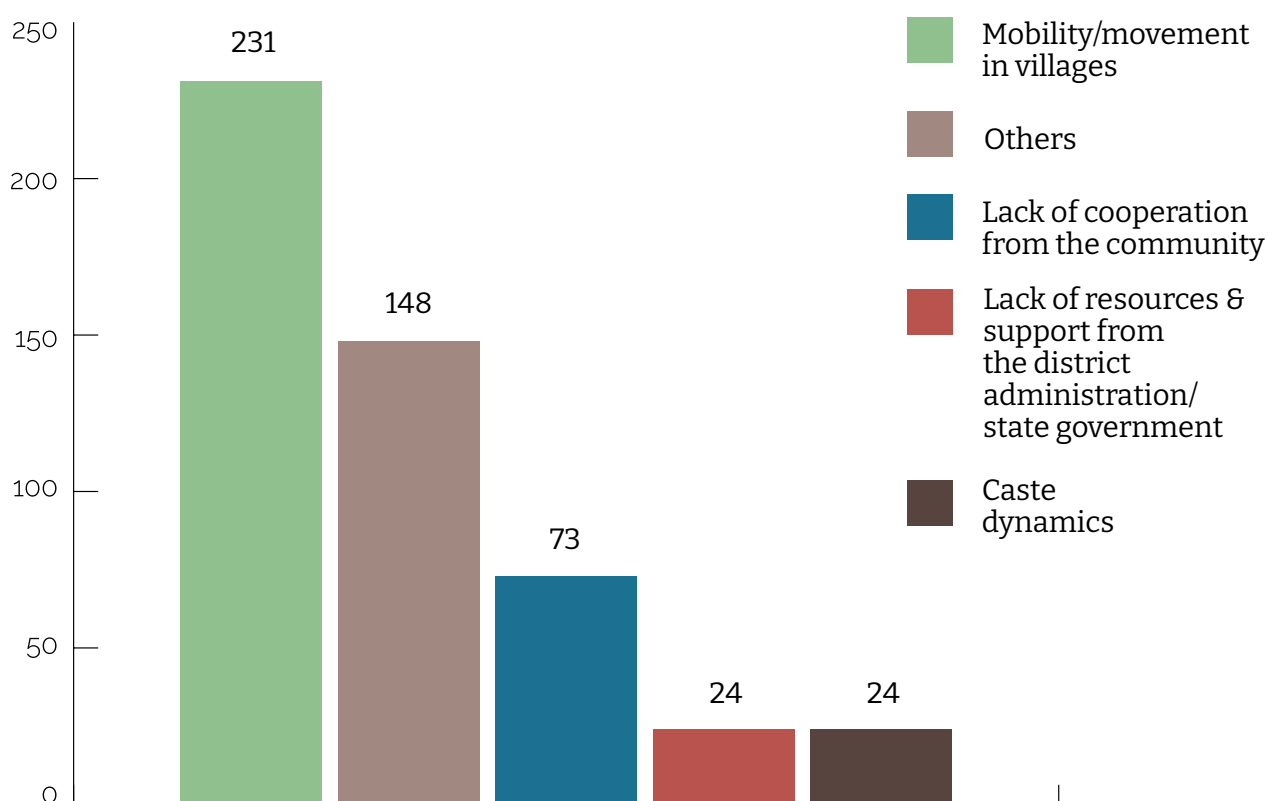


Fig. 5.0: Impediments to fighting COVID 19

community during COVID 19 duties c) occupational safety of CHWs from COVID 19. Firstly, we will analyze the CHWs' perspectives on physical safety and security and then, we will move to occupational safety.

A) Safety during travelling in villages: In India, there is considerable discussion about the physical safety of women in society, and a plethora of laws and guidelines from successive governments has been forthcoming in a bid to improve the situation, these efforts have not had any noticeable impact in Bundelkhand. One of the primary causes for attacks on women is the perception of power and domination, and the subjugation of women as a display of



that power – a patriarchal attribute that is reinforced constantly in Bundelkhand. The incidence of crimes against women is high, in both MP Bundelkhand as well as UP-Bundelkhand. As per the NITI Aayog & UNDP report, even the general issues of safety and security for women are far worse in Bundelkhand, as compared to the parent states and the neighbouring regions. While crime record data does not necessarily reflect the entire picture, as most crimes against women/ marginalized communities go unreported, these numbers are indicative. In assaults against women, MP-Bundelkhand accounted for 16% of such crimes reported in the state, as against 11.9% of the population share. Similarly, such crimes in UP-Bundelkhand were 6.1% of the state's total, against a 4.8% share of population. Furthermore, as CHWs are female, they face multiple risks. Globally, female health workers, particularly those from marginalised groups, are often in more precarious or part-time contracts with lower remuneration and benefits, even when in the same occupational group as men¹.

In our quantitative survey, a significant proportion of CHWs reported mobility and movements² as a key challenge during COVID 19 work. We discussed mobility and movements in section 1, but that discussion was from the perspective of transportation. Here, we discuss challenges associated with mobility in terms of safety. Some CHWs shared that during the lockdown period, with no one around, they were supposed to travel alone to be able to carry their responsibilities. This particularly made them feel unsafe.

TIK_o8 shared, "Darr lagta to tha didi..Akele jana padta tha" (We felt scared didi, we had to go alone).

1 <https://www.bmj.com/content/371/bmj.m3546>

2 This sub-theme: Mobility and movements, intersects with the safety of workers as well as general COVID 19 work, hence we have used the same data point (Figure 5.0) in both the sections.



"There was no facility for us, there was no public, no police for our protection": HP_o6

"I was equally afraid to travel alone and moreover scared.. what if I get infected with the disease?" TIK_o8

An RA from Tikamgarh based on his interaction with CHWs reiterated that during the lockdown period, streets were empty. Without the regular crowd and presence of police on the streets, the health workers felt unsafe. Therefore, for CHWs, safety turned to be a double edged sword. Without proper safety gears, empty streets and lack of proper transportation, CHWs, in their own words, "risked their lives" to protect the community.

B) Safety during COVID 19 duties:

In this subsection, we are primarily referring to the safety and security of CHWs while doing their COVID 19 duties in the community. Due to the stigma associated with COVID 19 in India, there were reports³ of CHWs being abused or attacked during community surveillance and contact tracing work⁴. In phase one, we found that while 39 CHWs faced verbal attacks, only 2 faced physical attacks as well (Figure 5.1).

As discussed previously, due to the nature of the disease, the community was skeptical about the workers visiting their households. As a result of which, while some people welcomed the workers well, due to the rapport they built over the years, others hesitated to talk and even greeted them with foul language. The behaviour

3 <https://www.deccanherald.com/state/top-karnataka-stories/bengaluru-asha-worker-on-covid-19-duty-attacked-820626.html>

4 <https://news.sky.com/story/coronavirus-asha-healthcare-workers-in-india-share-their-stories-of-abuse-and-discrimination-12085390>

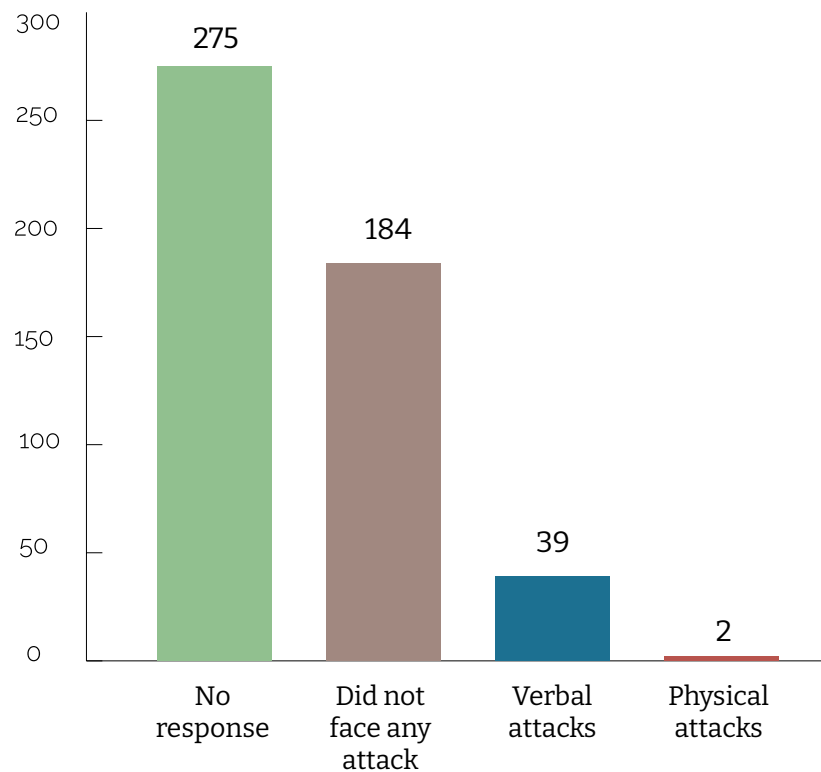


Fig. 5.1 Did you face any verbal or physical assault during COVID 19 work?

added to the discomfort of the health workers to conduct this task. “*Char batein suni padti hai par karna padta hai*” sums up HP_05, the overall spirit of the health workers, that despite some odds, they continued to do their work assigned during the lockdown period.

On further discussion with the CHWs on how safe they felt while carrying out their responsibilities, and how the community responded to them, we found out that the ill-treatment that the CHWs received from the community was what particularly made them feel unsafe. TIK_02 confirmed about her village that “It’s true, in our village we have faced discrimination while working from people in the community”. The concern was repeatedly highlighted by multiple health workers. Below are some of the



experiences of the health workers:

"RA: What was the major challenge while going and interacting with communities?

Sabse zyada dar logon ke baat karne ka tarika (I was most scared by the way people talk)" TIK_01

"Yes, I did face safety challenges. Many people did not want to attend our visits. I was often disregarded and told abusive words but I did my job!", TIK 05

"We faced lots of difficulties, we used to travel by walking, people who travelled from outside used to abuse us and speak shit about us and say that there's nothing like corona. We still use to hear all that abuse", CHIT 03

Furthermore, the safety concern is such that in case they are given further responsibilities for vaccine delivery or monitoring, the CHWs demanded for some provision to be made for their safety by the block officials. Additionally, within the safety concerns, the suggestion to formulate teams came up, as working on an individual level made the CHWs feel more vulnerable.

C): Occupational safety of CHWs: By occupational safety, we investigated if CHWs were given adequate protective gear to execute their COVID 19 tasks properly. There were reports from several

{*"Yes, I did face safety challenges. Many people did not want to attend our visits. I was often disregarded and told abusive words but I did my job!"*}_{TIK_05}

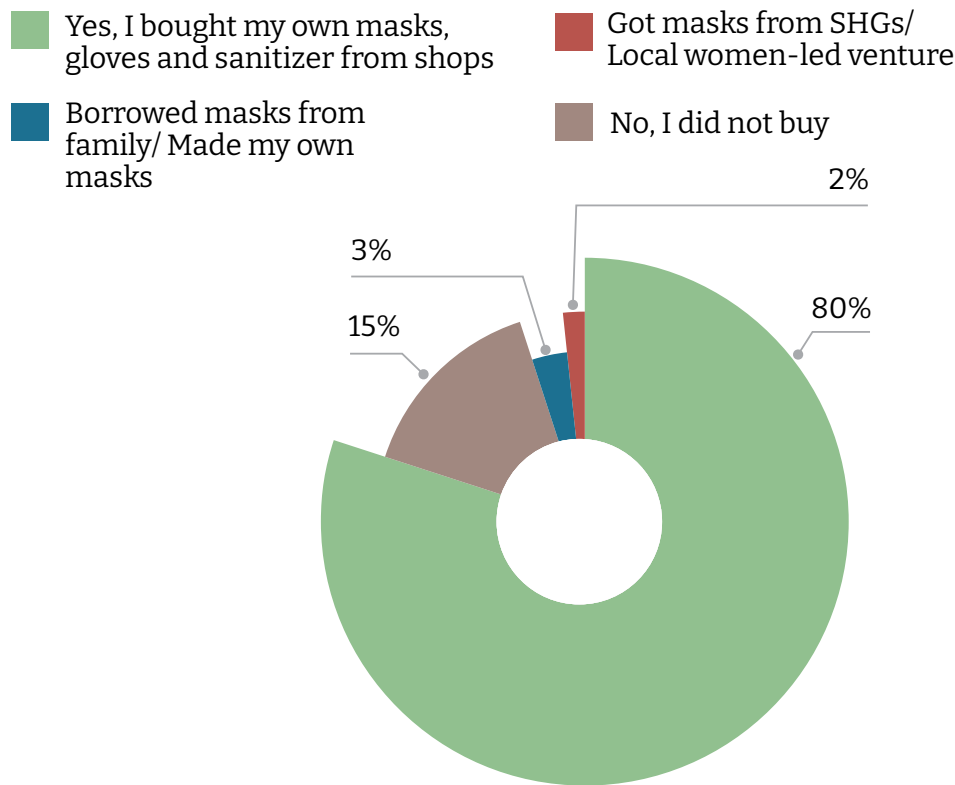


Figure 5.2 Did you buy your own masks, gloves, and sanitizer?

contexts where ASHAs protested⁵ against lack of safety gear such as masks, sanitizers, and gloves⁶. In our research, we found that 80% CHWs bought their own masks, gloves and sanitizers (Figure 5.2). It was evident that CHWs were disappointed for not being provided with these safety gear and demanded proper facilities.

We ask for masks and sanitizer for our protection as these facilities were not given to us. HP_07

5 <https://www.hindustantimes.com/india-news/asha-workers-seek-equipment-training-to-deal-with-coronavirus-pandemic/story-capjLpsVBGSxmqs43VrD4L.html>

6 <https://www.hindustantimes.com/delhi-news/asha-workers-body-demands-ppe-kits-after-one-of-them-contracts-covid-19/story-ArE1YUPX5lWEpKIQD7Gh1N.html>



"They should provide proper facilities like masks, sanitisers which were not given to us for our safety. The mask was also given to 1-2 people only" HP_05

"Do you have any suggestions for the government/district administration for deploying workers for vaccine delivery?"

We request them to send mask and sanitizer for our protection along with the vaccine" HP_07

With regards to the overall safety of CHWs, it can be concluded that the condition of the workers was precarious and vulnerable. The workers without any transportation facilities and a total lockdown in place, not only found it difficult to travel but also felt unsafe as being the only ones out of their homes. Secondly, lack of support from the community, not only made their tasks difficult, but also added to their safety concerns due to ill-treatment and verbal abuse. Lastly, lack of proper safety gear pushed the health workers to make provisions for themselves out of their already meagre salaries. Our research clearly reveals that the work of CHWs during COVID 19 lockdown in India was a territory in which they were pushed without adequate support, measures and preparedness.



Recommendations From The CHWs

We believe that CHWs best understand their needs, situations, and what can be further done to improve their circumstances, conditions and truly empower them to work at their best potential. Therefore, we asked the CHWs to provide their recommendations in order to ensure they are able to do their work smoothly in the future. What suggestions would they like to offer to the Government, to help the CHWs tackle such a pandemic or a public health crisis in an efficient manner in future? Building upon the voices of the CHWs, their own demands, challenges, and our three month study in which we sought to understand their perspective about COVID 19 in Bundelkhand region, we present some recommendations and points to ponder to the state and central government, enabling them to further strengthen our public health delivery system and efficiently handle such crises in future.

- **“Spread awareness as much as possible so that people can believe in us. Government body is needed for the same”, CHAT_03**

Our sections on Community Response & Safety and Security of CHWs highlighted that the CHWs' COVID 19 work was not accorded high priority. The community did not cooperate with them as they would have liked to and often ill-treated them. This ill treatment



is rooted in the patriarchal background of Bundelkhand, where women are expected to be limited to their traditional gender roles. Additionally, there is less interface between these CHWs and the community in general. They need to be given the respect and acknowledgement they deserve, for the community to better realise their importance, and understand the work they do for the welfare of the community. We call for actions wherein this existing gender imbalance can be challenged. For the community to better accept, understand, trust and cooperate with the CHWs, there's a strong need to increase the interface between them and the community, one way to ensure which is to include them in local democracy i.e. the Gram Sabha Panchayats, and within the village development processes.

► **“Proper guidance and training should be given to us in order to protect our village”, CHIT_05**

Our section on ‘Training for COVID 19’ as well as other sections highlighted that though the CHWs received some form of training, it wasn't enough for them to be able to carry their responsibilities. Most health workers did the work as per their own understanding, which was not adequate given the seriousness of the situation at hand and the challenges that the CHWs faced. Firstly, we call for training that helps the country better leverage its human resources such as CHWs and systematically respond to such crises in future. The CHWs need to be adequately trained for emergency situations in addition to the training they receive for maternal health. Secondly, the current training structure of CHWs is mostly geared towards interacting with women and children, while this additional responsibility required them to communicate with the men as well. Hence,



the training needs to further equip them to be able to communicate effectively with everyone keeping in mind the local gender and cultural norms.

- ▶ **“Proper team should be created as this is not one woman show, we need more human force for effective results”, CHIT_02**
- ▶ **“Training should have been provided to us by the block officials. Also, they should send some senior people with us to do surveys”, TIK_01**

The CHWs highlighted the need for more human resources, potentially teams or groups of CHWs for the tasks at hand. Post the initial phase of the lockdown, they were managing COVID 19 duties along with their regular maternal health responsibilities. Additionally, as women, travelling alone during such times not only made them feel unsafe, but also more vulnerable to possible backlash from the community. Firstly, in such emergency situations and circumstances, the safety concerns specific to women and health workers need to be considered. Working in groups and teams or being accompanied by senior officials for home visits may bolster their confidence and work. Secondly, their numbers might not be enough to reach out to everyone within the village, making them overburdened with work, and also leading to the possibility of marginalized and hard-to-reach populations being left out of the services. To lessen the burden on CHWs and benefit the community, more CHWs should be hired.

- ▶ **“If they are giving us to do so much work then they**



should give us proper transport facilities likewise we are even ready to work”, CHIT_03

► **Our transport and safety should be given more priority” CHIT_04**

The nation came to a halt with the lockdown that was announced in India in March 2020. With no public transport, empty streets, challenging geography, lack of all-weather roads, and scorching heat, the CHWs in the region of Bundelkhand found mobility as the biggest challenge in their fight against the COVID 19 pandemic. Further, as women, transport was equated with safety issues that came with travelling and navigating long distances alone. As CHIT_03 sums up, if the CHWs are given additional responsibilities, more consideration needs to be given as to how they will fulfill them without lack of additional pay and logistical support. Transport and safety challenges need to be seriously addressed to further support the CHWs. Public transportation in villages needs to be improved for effective last mile delivery of health services and especially the upcoming COVID 19 vaccination process. Though the government already has several infrastructure projects underway, special attention must be paid to the needs of CHWs with respect to transport and safety.

► **“Government should ensure in the future to deliver the medicines, sanitizers, masks, and other medical kits on timely basis and without any major challenges to face in coordination with the officials” TIK_08**

The occupational safety of the CHWs turned out to be one of the



major concerns. The basic equipments that should have been provided to CHWs for their COVID 19 duties were not given, prompting them to invest from their own pockets. Equipment such as medicines, sanitizers, masks, medical kits, among others, that are necessary for protection of CHWs and effective delivery of services, should be ensured without any delay and or hassles. A major chunk of time, energy, and resources of the CHWs goes wasted in simply getting access to them, which is worrying given the limited time and resources in responding to public health crises and pandemics.

- **“Kindly give our message to the government from our side that as we have been serving them for almost 10 years now they should make us permanent and should also increase our pay scale”, CHIT_04**

Our research highlighted how CHWs especially ASHAs have a considerably lower pay. Additionally, they were not compensated for the COVID 19 responsibilities they handled. The Government needs to ensure dignified wages and timely payment to CHWs, especially ASHA workers whose income depends on incentives. Though this issue has been a contentious one for several years, COVID 19 reminds us that adequate and timely payment is crucial for CHWs to combat public health crises. Furthermore, steps should be taken to regularise their jobs and give them social security benefits as associated with any public sector job.

- **“Government should see if they can provide good facilities to women in future. Men and women ..how can they use the same facilities and stay together?” TIK_04**



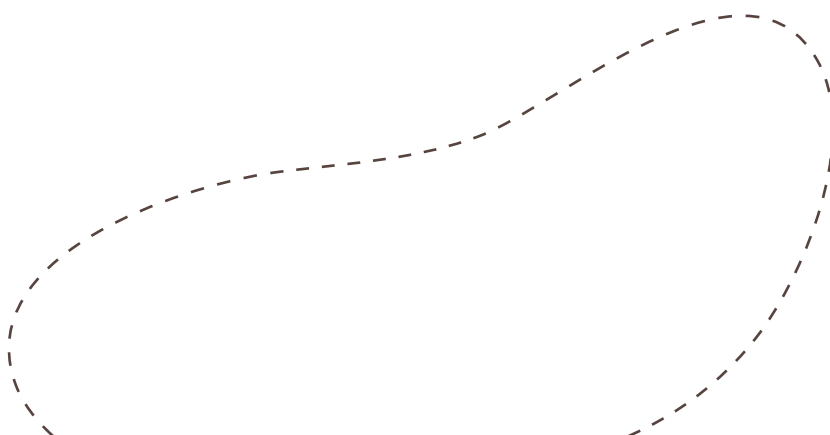
The findings from our research on COVID 19 quarantine centres reiterated the significance of cultural and local gender sensitivities in policy planning processes during emergency health situations. In future, the Government should ensure the comfort, needs, safety and privacy of women and girls during the intervention planning process.

-
- **“The government did not even recognise our efforts, and we are sad for that. Ek praman patra to dena chahiye tha (They should have given us a certificate at least)”, TIK_02**

The CHWs have been extremely integral to India's fight against COVID 19. Unfortunately, their work has not received the recognition it deserves. The work not only needs to be compensated with fair pay, but also acknowledged in some way, which will boost their morale and confidence. For instance, Meghalaya¹ and Telangana² felicitated ASHA workers for their dedicated service and painstaking during COVID 19 pandemic. Such efforts should be replicated across India which will make the CHWs more welcome and motivate them for their work.

1 <https://theshillongtimes.com/2020/09/29/asha-anganwadi-workers-felicitated-by-mla/>

2 <http://www.uniindia.com/kishan-reddy-felicitates-asha-workers/south/news/2229254.html>





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Annexure 1

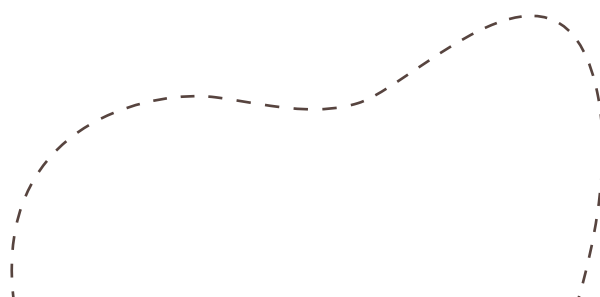
Table A.1

Indicator 1	Remoteness of the village (distance from district HQ)	Above 20 Kms (8-10)	10-15 Kms (5-7)	Below 10 Kms (less than 5)
Indicator 2	Easily Accessible (during monsoons)	Difficult to access (8-10)	Moderately Accessible (5-7)	Easily Accessible (less than 5)
Indicator 3	Composition on the Village on the basis of Religion and Caste (Unit of analysis is SC/ST population)	More than 40-50% (8-10)	20-30% (5-7)	Less than 20% (less than 5)
Indicator 4	Number of COVID-19 cases (5% of total population)	More than 10% (8-10)	5- 10 % (5-7)	Less than 5% (less than 5)
Indicator 5	Influx of migrants that returned to the Village	40-50% (8-10)	20-50% (5-7)	less than 20% (less than 5)

Annexure 2

Phase 1: COVID 19 study questionnaire

This survey is being conducted as a part of a study to investigate the role of ASHA/ANMs/Anganwadi workers in fighting the COVID 19 pandemic in rural India.





Basic Demographic Details

1. Name of Research Assistant and organization*
 - 2.a What is your name? (ASHA/ANM/Anganwadi worker)*
 - 2.b District and Village*
 - 2.c Caste and Religion of ANM, ASHA or Anganwadi workers
-

Introduction to COVID 19 Work

Q1. Have you been given COVID 19 related duties ever since the lockdown began?

- ☐ Yes
☐ No

Q2. What all activities were included in COVID 19 work? (*Multiple choice*)

- ☐ Contact Tracing
☐ Surveillance and follow up
☐ Awareness about COVID 19 practices
☐ Managing quarantine centres/assisting patients, doctors in quarantine centres
☐ Accompany suspected cases for testing

Q3. Did you only work on COVID 19 or your maternal health work as well during the lockdown? *Mark only one square.*

- ☐ Yes, only COVID 19
☐ COVID 19 as well as maternal newborn health work
☐ Not much work related to COVID 19

Q4. During lockdown, how many hours a day did you do COVID 19 related work? *Mark only one square.*

- ☐ Less than 2 hours



- ☐ 2-4 hours
- ☐ 4-6 hours
- ☐ More than 6 hours

Q5. Were you given any training by your ANMs/PHCs for COVID 19 related work? *Mark only one square.*

- ☐ Yes
- ☐ No

Q6. If yes, how was the training provided? *Check all that apply.*

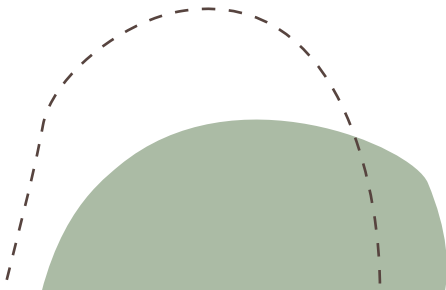
- ☐ Online training
- ☐ Given written manuals and guidelines
- ☐ Verbal instructions by supervisors/doctors

Q7. Did you receive any special guidelines/training for tackling COVID 19 among pregnant women, new mothers and infants? (ONLY FOR AW/Ws & ANMs) *Mark only one square.*

- ☐ Yes
- ☐ No
- ☐ Cannot say

Safety of ASHA Workers

Q8. What were the protective equipments provided to you for COVID 19 work? (Multiple choice) *Check all that apply.*

- ☐ Sanitizers
 - ☐ Masks
 - ☐ PPE suit
 - ☐ Soap
 - ☐ Nothing was provided
- 



Q9. How many masks were given for your COVID 19 during the lockdown period?

Q10. Did you buy your own masks, gloves, and sanitizer? *Mark only one square.*

- ☐ Yes, I bought my own masks, gloves, and sanitizer from shops
- ☐ No, I did not buy
- ☐ Borrowed masks from family/made my own masks

Q11. How much money did you spend on an average on masks and sanitizers to protect yourself? *Mark only one square.*

- ☐ Rs. 1000
- ☐ Rs. 500-1000
- ☐ Less than Rs. 500
- ☐ Did not spend anything

Q12. Did you or any other ASHAs/ANMs/ Anganwadi workers get infected by COVID 19? *Mark only one square.*

- ☐ Yes
- ☐ No
- ☐ Do not know

Q12. Were ASHAs/AW/W/ANMs (including you) able to get a Corona test on time if required? *Mark only one square.*

- ☐ Yes
- ☐ Could not/ were not able to get tested
- ☐ Test was not required

Q13. If yes, how many ASHAs (including you) till now have been



infected by COVID 19? *Mark only one square.*

- ☐ 1-5
- ☐ 5-10
- ☐ More than 10

Q14. Did you or any other worker receive any compensation from the government after getting infected by COVID 19? *Mark only one square.*

- ☐ Yes
- ☐ No

Q15. Overall, do you feel that you were supported satisfactorily to do your COVID 19 duties? *Mark only one square.*

- ☐ Yes
- ☐ No
- ☐ Cannot say

Payments and Emoluments

Q16. How much do you earn monthly as an ASHA worker? *Mark only one square.*

- ☐ 2500- 3000
- ☐ 3000 to 5000
- ☐ More than 5000

Q17. How much do you earn as an Anganwadi Worker/ ANM? *Mark only one square.*

- ☐ 2400-3000
- ☐ 3000-5000
- ☐ More than 5000



Q18. Did you earn more or less than your monthly salary during the lockdown period? *Mark only one square.*

- ☐ More than usual
- ☐ Same as usual
- ☐ Less than usual

Q19. Was any extra payment promised to you for COVID 19 work? If yes, how much? *Mark only one square.*

- ☐ Rs. 1500 per month
- ☐ Rs. 500 per month
- ☐ Nothing was promised
- ☐ Others

Q20. Was any additional payment provided for the door-to-door survey? *Mark only one square.*

- ☐ Yes
- ☐ No

Q21. Did you receive this promised payment for COVID 19 work? *Mark only one square.*

- ☐ Yes, I received the full amount
- ☐ I received some amount
- ☐ Did not receive any amount

Q22. Did you receive the payment on time? *Mark only one square.*

- ☐ Yes
- ☐ No

Q23. Did you face any challenges in accessing the payment? *Mark only one square.*

- ☐ Yes



☐ No

Q24. How many houses did you cover per day for COVID 19 surveillance? *Mark only one square.*

- ☐ Upto 10
- ☐ 10-15
- ☐ 15-25
- ☐ More than 25

Q25. How much do you think should be the payment for COVID 19 work? *Mark only one square.*

- ☐ Rs. 1000/week
 - ☐ Rs. 500 per week
 - ☐ Should be on the number of houses covered
-

Community Response

Q26. Do you think your local community is aware of the COVID 19 precautions and safety measures? *Mark only one square.*

- ☐ Fully aware
- ☐ Somewhat aware
- ☐ Not at all aware

Q27. Are they following the safety precautions and measures? *Mark only one square.*

- ☐ Yes, wearing masks
- ☐ Yes, wearing masks and practicing physical distancing
- ☐ No, not taking any precautions

Q27A. Are people generally willing and cooperative in getting tested for Coronavirus if required? *Mark only one square.*



- ☐ Yes
- ☐ No
- ☐ Do not know/Can't say

Q28. While visiting households, whom do you talk to and give instructions? *Mark only one square.*

- ☐ Men/Elder men/Head of the household
- ☐ Children
- ☐ Women and girls
- ☐ Everyone together in a group

Q29. Did you face any challenges in the community during your COVID 19 work? *Mark only one square.*

- ☐ Yes, faced a lot of challenges
- ☐ Faced little challenges but no significant impact on my work
- ☐ Did not face any challenge (Skip to question 40)

Community Response Part 2

Q30. What challenges did you face? (If option 1 or 2, in Q29) *Mark only one square.*

- ☐ Faced resistance and lack of cooperation from the community
- ☐ People not willing to talk due to COVID 19 stigma

Q31. Did you face any discrimination and ostracization from local people as you are an ASHA worker working on COVID 19? *Mark only one square.*

- ☐ Yes, faced discrimination by people
- ☐ Negligible discrimination
- ☐ None at all



Q32. Did you face any verbal or physical assault during COVID 19 work? *Check all that apply.*

- ☐ Verbal attacks
 - ☐ Physical attacks
 - ☐ Did not face any attack
-

Community Response Part 3

Q33. Which source of information is most trusted by people for COVID 19 related information? *Check all that apply.*

- ☐ TV
- ☐ Radio
- ☐ WhatsApp
- ☐ Local District officials
- ☐ Health Officers
- ☐ Internet source
- ☐ Others

Q34. Who is the most preferred point of seeking COVID 19 treatment? *Mark only one square.*

- ☐ Government doctors
 - ☐ Private health practitioners
 - ☐ Fakir/Vaid
 - ☐ Local Pharmacy
-

Policy and governance

Q35. Do you think the district administration's response to COVID 19 is satisfactory? *Mark only one square.*

- ☐ Yes
- ☐ Somewhat Ok
- ☐ No



Q36. Where are the local institutional quarantine facilities for migrants/residents in your village? *Mark only one square.*

- ☐ Local health centre
- ☐ Facility managed by the gram panchayat
- ☐ No quarantine facility at the institutional level
- ☐ Government/private school used as quarantine centre

Q37. Have people been cooperative in going to the quarantine facilities? *Mark only one square.*

- ☐ Yes
- ☐ No

Q38. How would you rate the condition of these facilities (On a scale of 1-10)? *Mark only one square.*

- | | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|-----------------------------|
| <input type="checkbox"/> 1 | <input type="checkbox"/> 3 | <input type="checkbox"/> 5 | <input type="checkbox"/> 7 | <input type="checkbox"/> 9 |
| <input type="checkbox"/> 2 | <input type="checkbox"/> 4 | <input type="checkbox"/> 6 | <input type="checkbox"/> 8 | <input type="checkbox"/> 10 |

Q39. Have women and girls been comfortable in going to these quarantine facilities? *Mark only one square.*

- ☐ Yes
- ☐ No

Q40. COVID 19 requires washing hands regularly. Has the local administration taken any steps to improve water supply during or after the lockdown? *Mark only one square.*

- ☐ Water supply has improved (More pipelines)
- ☐ Water tankers
- ☐ Local water conservation efforts
- ☐ Supply of water was satisfactory

Q41. What is the biggest impediment to fighting COVID 19 in your



village? *Mark only one square.*

- ☐ Lack of cooperation from the community
- ☐ Lack of resources and support from the district administration/state government
- ☐ Caste dynamics
- ☐ Mobility/movement in villages
- ☐ Others

Q42. In current circumstances, who is providing you maximum support in your work? *Mark only one square.*

- ☐ ASHA Workers
 - ☐ Anganwadi Worker
 - ☐ CHO (for HWC)
 - ☐ MO
 - ☐ Block level official
 - ☐ Community based organisations
 - ☐ Other
-

Intersectional Perspective

Q43. Is there any discrimination based on caste in the context of COVID 19 facilities? *Mark only one square.*

- ☐ Yes
- ☐ No

Q44. Does your identity have any impact on your COVID 19 work? *Mark only one square.*

- ☐ Yes
- ☐ No

Q45. If yes, then which part of your identity affects or impacts your



work? *Check all that apply.*

- ☐ Gender
- ☐ Caste
- ☐ Religion
- ☐ Village
- ☐ Being a government functionary
- ☐ Marital status

Annexure 3

Phase 2: Qualitative Questionnaire

Name of health worker:

Type of worker (ASHA/ANM/AWW):

Age:

Phone:

Name of Research Assistant:

Point 0: Since when have you been living in this village?

0.1 For how many years have you been working as an ASHA in this village?

0.2 How did you hear about COVID?

0.3 How is the general perception about COVID in this district?

0.4 So what all did you do in your COVID 19 related duties? Could you share a bit?



Point 1: How were you contacted for COVID 19 work?

0.1 Okay then?

0.2.a Do you think the training was sufficient for you to do your work?

0.2b What additional training do you think would have been helpful?

Point 2. How do you usually travel for your work?

2.1 So how were you travelling during the lockdown, for work & household surveys? /

2.2 In our survey, it emerged that 50% of the workers cited mobility/movement within the villages, issues as their biggest impediment towards fighting COVID 19. Could you elaborate a bit on what exactly are the mobility challenges?

2.3 What according to you can be done in future to ensure you are able to do your work smoothly?

Point 3: While doing household surveys and spreading awareness, which family member did health workers mostly speak to the most while talking to families? Were there any differences in your experiences when you spoke to men vs when you spoke to women and girls?

3.1 Were there any safety issues and challenges while doing door to door surveys and spreading awareness? How comfortable you were in doing the door to door survey & spreading awareness? What were the challenges?

3.2 Did any health worker face any discrimination? (..) Did the caste or religion of the health workers had any impact on their work?

3.3. Thinking health workers might be COVID infected, or carrying





the infection, were they welcomed by people?

Point 4: Tell us more about these quarantine centres? Around 30% of workers said that women and girls are not comfortable going to quarantine centres. What could be the reasons according to you?

4.1 What additional steps should be taken in future to improve these centres for women?

Point 5: How do people primarily source water in your area?

5.1 What is the system/pattern followed for collecting water from wells and pumps?

5.2 How were the citizens managing during the lockdown period?

5.1 Were there any local water conservation efforts in your area during lockdown? Can you tell us more about them? (exact motive)

Point 6: The data suggests that people have trust in the local govt health officials and district officials regarding COVID 19 information. Could you share more on that?

6.1 Which source of information is most trusted by people for COVID 19 related information? (WhatsApp also comes up in trends, what exactly do they receive?)

Point 7: Did health workers face any challenges based on their caste, class, gender, or due to any other aspect of their identity in the community during the COVID 19 work? What challenges did you face? (What is the stigma?) (ek ek karke)



7.1 Is there any stigma related to COVID 19? If yes, what types of stigma and why?

7.2 What was the major challenge while going and interacting with communities?

Point 8: By mid next year, the Corona vaccine may be administered with the help of health workers like you. What do you think could be the challenges in administering this vaccine?

8.1 Given your past experience of giving vaccine to children and spreading awareness, do you think there could be safety challenges for administering vaccines?

8.2 Do you have any suggestions for the government/district administration for deploying workers for vaccine delivery?

8.3 What suggestions would you like to offer to the Government, to help you tackle such a pandemic in an efficient manner in future?

Point 9: Were you promised any payment for COVID 19 work? If yes, how much?

9.1 Did you receive this payment?

9.2 Did you get this payment on time?

9.3 Did you face any difficulties in accessing this payment?

For only Tikamgarh:

Point 10: Our survey suggested that SC/ST and migrants faced most challenges during the lockdown period. Could you please elaborate on why they face challenges? And what were those difficulties?

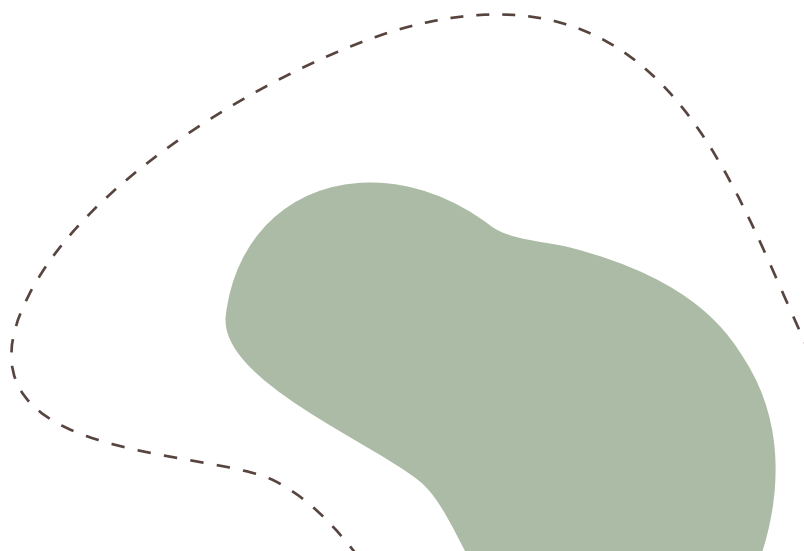


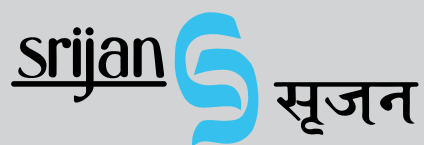
For only Chitrakoot:

Point 10: Among different castes and communities, did any particular community face more challenges or problems during the lockdown period? Could you please elaborate why they faced challenges? And what were those difficulties?

For only Chattarpur:

Point 10: Among different castes and communities, did any particular community face more challenges or problems during the lockdown period? Could you please elaborate why they faced challenges? And what were those difficulties?





Self Reliant Initiatives through Joint Action

SRIJAN is a public charitable trust
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