Undermined, Invisibilised and Silenced

Covid-19, Community Health Workers and the State Negligence in India

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List of Abbreviations

ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
CHW	Community Health Workers
FGD	Focused Group Discussion
GoI	Government of India
ICC	Internal Complaints Committee
ILO	International Labour Organization
IWDA	International Women's Development Agency
NGO	Non-Governmental Organization
NHM	National Health Mission
NITI	National Institution for Transforming India
NRHM	National Rural Health Mission
PoSH	Prevention of Sexual Harassment
UP	Uttar Pradesh
WHO	World Health Organization

Abstract

The Government of India (GoI) employs approximately one million women as Community Health Workers (CHWs) or ASHA (Accredited Social Health Activist) workers. These women, considered to be honorary workers operate on incentives without social security and are at constant risk of violence. CHWs gender and precarious labor conditions place them as one of the least prioritized cadres by the state. Their security concerns are invisible in official data indicating the culture of silence around the issue. As per the Sexual Harassment Law in India, each employer is mandated to institutionalize an Internal Committee (ICCs) to address harassment complaints. In a decade of this law being introduced the ICCs are reported absent or rarely functioning in case CHWs. Lack of security among the CHWs is a denial of their human rights, disregard of women's labor and the state is to be held accountable for this. This research proposal aims to explicate the root causes behind the devaluation of women's healthcare labor that leads them to be at risk. The key question to explore is why is a state that deployed a female cadre to empower its healthcare neglecting their need for a safe environment? The primary objective is to critically situate the state as an employer through a feminist intersectional lens. It aims to provide a feminist labor analysis of the working conditions of women in the public health system of India. It will offer a detailed interrogation into the everyday concerns of CHWs, and explore the structural reasons for state negligence. Finally, it intends to delve deeply into their everyday security concerns, reach the root cause of the neglect by the state and proposes to develop a framework to ensure a secure working environment for the one million CHWs.

Key Words: Women's labor, Security, Violence, State, COVID-19, Community health workers

Chapter One: Introduction

According to the World Health Organization (WHO), the term Community Health Worker (CHW) includes health workforces selected, trained and working in the communities from which they originate. CHWs should be members of the communities where they work, selected by the communities, answerable to the communities for their activities, and supported by the health system but are not necessarily a part of its organization, and have shorter training than medical professional. (World Health Organisation, 2007). 70% of healthcare workers in the world are women and are yet one of the bottom most in the hierarchy (Delivered by women, led by men, 2019). CHWs are a crucial link between the health system and the community, their input, knowledge and skill contribute to the overall improvement of health indicators of a nation. Its these CHWs are who take the state- and nation-wide health and nutrition schemes to the last mile. (Delivered by women, led by men, 2019). Women tend to dominate the care giving workspaces and are often assumed to be unskilled and devalued labor (International Labour Organization, 2018). Since these CHWs are mostly women across the globe, their social and gender profile becomes crucial to interrogate because it is this social positioning that makes them hyper vulnerable to violence, exploitation and a subject of patriarchal blindness.

The recent report *Delivered by women, led by men* states multiple findings of the lack of security that these women face globally while performing their duties. Along with rampant societal discrimination, CHWs face sexual harassment with various countries lacking legal and social protection. Availability and accessibility to social protection form the cornerstone to gender equality at workplaces and yet 59 countries are still in need of workplace sexual harassment laws, 100 countries fall behind in legal solutions and 110 countries continue to not criminally penalize for sexual harassment at the workplace (George et al., 2020).

Workplace gender biases, discrimination and inequities are systemic, and gender disparities are widening, globally. Female health workers are expected to fit into systems designed for male life patterns and gender roles, for example, no paid maternity leave, with many countries lacking or poorly implementing laws on matters that underpin their dignity at

work, such as sex discrimination, sexual harassment, equal pay and social protection (Delivered by women, led by men, 2019). They face rampant harassment from male colleagues, male patients and members of the community. This violence is often not recorded and always underreported due to fear and stigma (George et al., 2020). In Rwanda, female health workers experience much higher rates of harassment than male colleagues, and in Pakistan, lady health workers have reported harassment from both management and lower-level male staff (Delivered by women, led by men, 2019).

In one of the more horrific episodes, in January 2016, news reports were published about the gang rape and death of an ASHA (Accredited Social Health Activist) worker (a cadre of CHWs) in Muzaffarnagar, Uttar Pradesh (UP), India. During a home visit, a young man who was the brother-in-law of the woman she had visited, approached her to have a relationship with him. She refused but he continued to insist. For the next three months, he called her incessantly and stalked her. Shortly, videos on WhatsApp started to make rounds where that man along with a few other men were raping her while she resisted and struggled. A large number of men in the village with a smartphone and internet saw the video but it is unclear if anyone helped her to file the complaint. In all likelihood she was distressed and shared the incident with her husband, expressing an intent to file a complaint. Soon after in the third week of January, she was found dead by the road. (Dasgupta, Velankar, Borah, Hazarika Nath, 2017).

Over a million CHWs employed by the Government of India (GoI) are at unremitting risk of gender-based violence. This all-women's workforce, known as the ASHA workers play a key role in linking India's public healthcare system and the community. According to the National Health Mission (NHM) guidelines, their principal tasks involve creating awareness and providing information to communities on matters of nutrition, sanitation, hygiene, family planning and existing public health services. Their job responsibilities have been continuously expanding and with the advent of COVID-19, they are left further exploited and violated. The nature of their work and their gender further keeps them out on the streets and communities for miles at even odd hours in the night making them vulnerable and prone to violence and there is a lack of effective and accessible avenues for complaint redressal (Martha Farrell Foundation & PRIA, 2018). As the pandemic hit the world, the violence

against the CHWs has surfaced demonstrating the power imbalance in the health workforce (George et al., 2020). The CHWs across the world have reported instances of discrimination and violence both from within the community and other healthcare staff impacting the emotional, mental and physical well-being (George et al., 2020). Numerous cases of assault on ASHA workers by community members in India have been recorded, especially in the states of Haryana, Delhi, Telangana, Uttar Pradesh, (Behen Box, 2020).

Whether in health emergencies or regular work days, these women in India face enormous and constant gender-based risks due to the nature of their work. They are at risk of violence while travelling and conducting home visits. Further, their social contexts can be challenging, caste-based violence, ethnic conflicts are a reality for most communities in India. The GoI (the state hence forward) has been inadequate in providing these women with supportive institutional mechanisms to address their concerns (Rao & Tewari, 2020). They do not have protective gear, physical and monetary security, transportation support, or any other structural support to address their concerns or complaints (Josephine M., 2020). The state which, is their employer, appears to be complicit to this disparity, perpetuating a culture of silence, and the prevalent stigma around the issue and lack of awareness about harassment exacerbate the matter and form obstacles in creating a secure system (George et al., 2020).

Through this research proposal, I aim to situate the state at the axis of the exploitation and violence against the CHWs, specifically the ASHA Workers. This proposal is directed to document and highlight the different forms of violence experienced by CHWs in the field, underscoring the obstacles towards preventing and tackling violence against CHWs during the response to COVID-19, their accessibility towards the complaint redressal mechanisms and link it to the role of the state. Moreover, the primary themes to be explored are the devaluation of women's labor as healthcare workers, the fault lines in the implementation of India's sexual harassment law with the eventual intention of offering a feminist analysis of the role of the state and its complicity in providing CHWs with a safe working environment.

1.1 Background of the Research

India has a history of devising community health programs; some were not successful due to flaws in policy implementation while some were subverted due to lack of political will (Bhatia, 2014). From 1990 India instituted various state level CHW schemes but it was only in 2005 that a national CHW Scheme (ASHA Workers) was introduced under the National Rural Health Mission (NRHM) (Bhatia, 2014). The primary goal of this program was to promote uptake of skilled birth attendance in collaboration with facility-based auxiliary nurse midwives (ANMs) and the Anganwadi worker (AWW), the other two positions institutionalized by the state for community healthcare.

CHWs or ASHA Workers have a specific criterion for selection, which is that they are women who are residents of the rural community. In between the age of 25 years to 45 years, these are women who are married or widowed or divorced and need to be literate and have an educational qualification up until high school (10th standard) (National Health Mission, Ministry of Health and Family Welfare, Government of India, 2018). They are selected through a rigorous process involving various community level personnel and government officials and are the first point of contact for the community's health needs, focusing on maternal and child health services (National Health Mission, Ministry of Health and Family Welfare, Government of India, 2018). Each ASHA in the rural areas is meant to cover a population of 1000 and receive a performance-and-service-based compensation for facilitating immunization, referral and escort services for institutional deliveries. ASHAs also accompany pregnant women and children requiring treatment to the nearest health facility (Saprii et al., 2015).

The cadre of CHWs had been categorized as honorary workers to operate on incentives because the deliverables or job profile was initially expected to consume two to three hours on average for a few days of the week. However, a recent survey showcased that many worked on average six hours or more a day on a regular workday (Accountability Initiatives, Centre for Policy Research, 2021), (Sinha et al., 2021). Even among ASHA workers who are incentivized on a case basis, more than a quarter had a full working day, and a further 46% mentioned four to six hours workday (Sinha et al., 2021).

The ASHA workers in India have often acted as a silent army for the state, which is activated in times of emergencies (Bisht & Menon, 2020). Naturally, in the initial times of COVID-19 response they were galvanized again, this time with lesser preparation and heightened risk (Dhupkar, 2021), (Ravichandran, 2020), (Rao & Tewari, 2020). As the lockdown was announced in India and the vaccinations and counselling began, the ASHA workers found themselves at the forefront of combatting the pandemic. Their revised responsibilities in addition to existing ones, included home screening, contact tracing, policing quarantine centers, working in containment zones and acting as the first point of contact for the community members (Accountability Initiatives, Centre for Policy Research, 2021). ASHA workers were also involved in distributing essential medicines, conducting home to home Covid-19 evaluations and providing the community with public health sensitization. In addition to this, the ASHA workers are providing services related to communicable and non-communicable disease, antenatal care, cataract and cancer among other duties (Behen Box, 2020).

Enhanced violence against healthcare workers during a crisis is a global phenomenon and similarly, in India the added responsibilities not just increased the workload but also the risk of violence (George et al., 2020). The pandemic induced panic among the masses, communities were boycotting the virus infected individuals and myths and misconceptions around vaccines were prevalent. The CHWs who were visiting homes to provide services since the community centers were shut down were hurled at with abuses, physically and verbally.

As per a recent report, the respondents mentioned varied instances of community backlash. This backlash originated from community members' fear of contracting Covid-19 from CHWs, frustration with household surveys and testing, and the resistance of reverse migrants with regards to testing and quarantining. The backlash did not contain itself to verbal abuse but extended itself to refusal to follow Covid-19 protocols and in some instances extreme physical violence (Accountability Initiatives, Centre for Policy Research, 2021). As the community workers approached people for vaccination or isolation or self-care, they were hurled at with verbal abuses and physical violence. With news articles

coming out on a daily basis, India's public health system crumbled and its patriarchal blindness towards its CHWs surfaced.

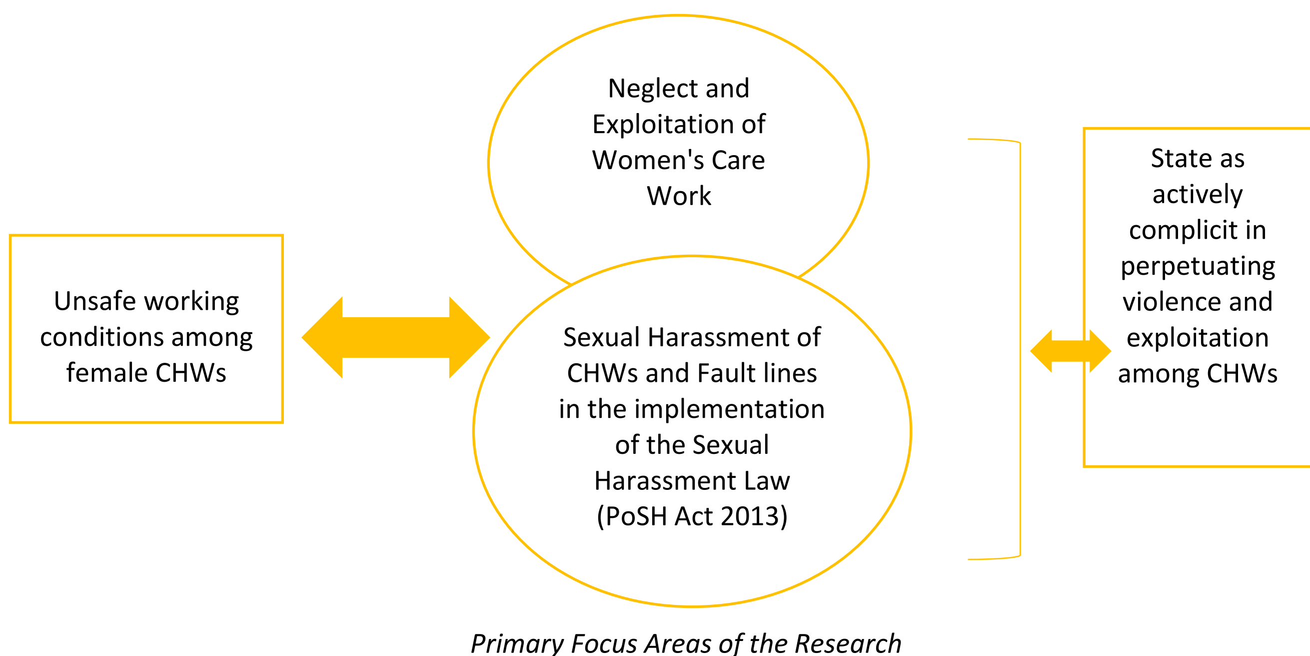
India does have a policy in place with regard to the sexual harassment at workplace. On 9 December 2013, the GoI brought the Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013, commonly referred to as the PoSH Act in action to make workplaces safer for women by preventing, prohibiting and redressing acts of sexual harassment against them in the workplace (Arora, 2020). The law considers both formal and informal workers and applies to all public and private bodies but 95% of women working in the informal workforce have faced barriers in accessing the law. Further, the GoI has not been able to demonstrate comprehensive data around its implementation or efficiency (Bhuyan & Khaitan, 2021). There is a rampant lack of data both within the state and central governments. No records are maintained around the complaints filed or results of these complaints, even when the data exists it is dissimilar and dispersed (Bhuyan & Khaitan, 2021). Lack of information has led to a lack of accountability from any state or central institutions, companies or districts around the compliance of the law reiterating that legislation alone does not solve the issues of violence.

The increasing workload, neglect of the need for permanent employment, lack of mechanisms, and accountability on state actors point straight at the devaluation of women's labor which results in an insecure working environment. This thought leads us to reflect on the root causes of this blatant neglect and naturalization of violence. An all women community health program has been in existence since 2005, and considering the rate at which women in India are at security risks it is alarming how the labor of the CHWs has not only been undermined but the prerequisites of improved working conditions have been invisibilised. Given the requirement of the PoSH Act, the fact that these women have been in the system for nearly two decades with limited security mechanisms, does this make the GoI an unethical employer being complicit in the violence inflicted, devaluing and exploiting women's labor?

1.2 Statement of the Problem

A day in the life of CHW requires her to visit long distances sometime in public transport and often on the foot. She needs to provide home to home services, accompany pregnant women to health facilities at odd hours. The incessant work load coupled with social positioning, lower level of education, low income status and voluntary work status puts them in an exploitative, insecure and vulnerable positions. While there are several causes forming the current state of the CHWs this research aims to focus on the following:

1. The exploitation of Women's Care Work and
2. Harassment of Women in Health Care Work and Fault lines in the implementation of the Sexual Harassment Law
3. Role of the State



Primary Focus Areas of the Research

The exploitation of Women's Care Work and the Role of the State: With over a million female CHWs forming the backbone of India's healthcare their contribution, labor, security and safety is not just compromised and devalued but invisibilised. The status, exploitation and precarious working conditions have been recognized despite their activist status attributed by the state (Ved et al., 2019) but the solutions are yet to be offered. Historically community health workforces dominated by women have struggled to be recognized as skilled and equal labor. This form of care labor is not recognized as it is often perceived to be

an extension of their natural roles as women, diminishing the validity of the care work, they put into the functioning of societies and economies (A. George, 2008). Researches have demonstrated that these inadequacies are compensated by the labor themselves through personal adjustments which prove to be detrimental to them in various socio-economic and emotional ways. When the issues of women in the care workforce are invisibilised, they end up being naturalized in a systemic way which leads to silencing of their rights on the personal front, skewed and inequitable health systems at a larger level (A. George, 2008).

The state deployed the CHWs under the National Rural Health Mission (NRHM) in 2005. There are currently a total of 10,47,324 ASHA workers across India (Government Of India, Ministry Of Health And Family Welfare, 2020). NRHM guidelines state that an ASHA would be an ‘honorary volunteer’, not receive any fixed salary and her work would not interfere with her ‘normal livelihood’ (Ambast, 2021). The ASHA workers have been deployed for over a decade and the fact that they continue to be categorized as honorary workers or activists reflects on the systemic patriarchy embedded in our institutions. This systemic oppression leads to the continued devaluation of women’s work, especially in the care economy. It also flags the neglect and unwillingness of state institutions to recognize these women’s labor along with their poor working conditions. Viewed in the context of the social division of labor, the work that ASHA workers do primarily deals with families, women and children, their work falls under the care work category and is thus inherently is looked upon as inferior. Women’s care giving work is often unpaid and when paid or incentivized, the working conditions are neglected and challenges are invisibilised. Deploying the Devaluation Theory's basic premise, women are culturally devalued in society. As a consequence, female occupations and tasks are assumed to be less valued than male tasks (Magnusson, 2008).

Specifically, in the case of CHWs, a set of actors play consecutively to lead to the eventual devaluation. Their hierarchical positioning has a role to play in this, they are at the lowest rung of the workforce, finding themselves fighting harassment and inequalities at every level of their work life (Vecchio et al., 2013). Further, they are invisible to the government, which is yet to make any distinctive reforms or strengthen their protection (Ratho, 2020). It is their gender and hierarchical inferiority that provides them with little or no space to negotiate their workspace and working conditions. Their current designation as honorary workers

reduces the power to negotiate for their rights (Bhatia, 2014) and acts as a limitation for setting any standard service conditions for them by the government. The state designed a CHW program to involve women from the communities to reach the most marginalized in the remotest region (Agarwal et al., 2019) of the country but the systemic oppression has instead undervalued their work, invisibilised their security issues and working conditions and silenced them by not providing robust redressal mechanisms. (Kasliwal, 2021). There is no one answer to this larger issue but a complex web of forces that build a trajectory to devalue these women's labor, exposing them to gender based violence while simultaneously not providing an outlet for them to report these issues. At the core of their situation lies their gender and perceived weakness.

The role of the state is essential to emphasize because it is the employer and the guarantor of human rights. It is the state in this specific case that needs to ensure protection, provide social security and maintain a safe working space for women. The lack of infrastructure, supplies accompanied by heavy job roles is a known reality of the CHWs (Nanda et al., 2020). Apart from these logistical requirements they also lack respect and trust, are often publicly reprimanded by senior supervisors, offered only incentives with delayed payments. The condition of the CHWs might not be induced by the state but the state has shown complicity in the way it has treated the CHWs (Nanda et al., 2020). These women have been recruited because of their inherent connection and the ability to mobilize community members but get tangled between gender bias, lack of recourses, diminished power and agency. While the state succeeded in feminizing the last mile health workforce, the workforce has lost its voice. The issues of their security concerns, harassment and complaint redressal have received limited attention but even for the issues that have received ample attention including wages, lack of infrastructure and resources, there has been no path breaking reforms (Nanda et al., 2020) and it is only the state that can improve and institutionalize reforms.

Harassment of Women In Health Care Work and Fault Lines in the Implementation of the Sexual Harassment Law: Approximately three decades ago, Bhanwari Devi, a government social worker in Rajasthan, India was gang-raped while being at work, trying to stop a child marriage in a family. She was employed by the state to work in the communities but as the violence took place the state refused to take any responsibility. The case was instead picked

by feminist groups with the agenda of making workplaces safer for women and making the protection of women a responsibility of the employer. While Devi is still awaiting justice, her case led to sexual harassment laws at the workplace in India. Under these laws the employers are mandated to take steps to protect female employees from sexual harassment at the workplace and provide procedures for resolution, settlement, or prosecution. However, the guidelines failed to explicitly address sexual harassment of women in the informal sector—a group of 95 million. Keeping the limitations in mind in 2013, the scope of the law was broadened to cover the women working in the informal sector, including domestic workers. public and private sectors, or government institutions. This covered women workers at their workplace and any place visited by the employee during her employment (Human Rights Watch, 2020).

The WHO defines workplace violence as, "Incidents where staff are abused, threatened, or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being, or health (Stephens, 2020)." Workplace violence includes all kinds of physical psychological harm. Violence and security concerns among the CHWs in India is a multifaceted issue reflecting heavily on the discrimination and neglect deployed by the GoI. It begins with the inherent exploitation of women's labor, poor working conditions and lack of security. Further, it stretches to poor implementation of PoSH, lack of institutional mechanisms to report the issue, and goes onto systemic patriarchy creating a culture of silence where even if women realized and wanted to report the gender-based violence, a nexus of ineffective redressal mechanisms and a stigmatized society act as an obstacle.

"The law defines sexual harassment as physical contact and advances, or a demand or request for sexual favors, or making sexually colored remarks, or showing pornography, or any other unwelcome physical, verbal, or non-verbal conduct of sexual nature. Any of these acts whether direct or implied, constitute sexual harassment under the law. Under this act, employers are mandated to establish an Internal Complaints Committee (ICC) with at least ten employees. The government is also responsible for sensitizing the workers through reading materials and training along with maintaining clear records of the data on the number of complaints filed and redressed" (Human Rights Watch, 2020).

Even before the Covid-19 outbreak, global reports indicate high levels of workplace violence against female healthcare workers (Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action, 2020). There has been considerable research stating that during the COVID-19 women are more likely to be victims of an assault and are less likely to commit physical violence (Connley, 2021). The instances of sexual harassment multiplied during the Covid-19 completely breaking down the already at-risk public health system of India whose backbone is the one million CHWs.

As they struggle to manage the pandemic continues, there are constant reports of violence against healthcare workers within the COVID-19 across nations, the majority of whom are women (UK Aid & Fraser, 2021). Moving from one place to another without any private transport exposes the CHWs to a risk of assault. Additionally, the Indian rural mobility is inherently biased and inconvenient for women, lack of safe and timely public transport, poor and dim lit roads, lack of street lights leave women vulnerable to violence, including sexual violence. Emergencies and pandemics put frontline workers at heightened risk (Atnafie et al., 2021). There has been incessant media reporting of violence and abuse on ASHA workers while leading the response to the pandemic.

An ASHA worker and her team of data collectors were surrounded and abused by the community members. They were fortunate enough that one of them had a mobile phone and they could call for help who could contact a locally influential person and the police to rescue them. (Chatterjee, 2020). In another case, a CHW had hot rice thrown at her face as she was spreading awareness around COVID-19. (Mohanty, 2020). Incidents of snatching the mobile phone, being beaten by stones and being spat at have also been common (Press Trust of India, 2020). Their children have not been spared too and the violence has extended to the families, in one incident, Neerja (name changed) was hit by a steel rod because her mother was a CHW who has stuck a quarantine notice as part of her daily responsibilities. (Prasad, 2020). The assaults have been gruesome and more violent in some cases, in Odhisa, India a CHW was attacked in her home because she had publicly objected to a man’s comments as she was fulfilling her responsibilities of COVID-19 work (Mohanty, 2020).

While the Sexual Harassment Law have been directed to be implemented for almost a decade now, the informal workers have a long way to go in seeking justice. The sexual harassment committees that are to be institutionalized by both public and private bodies appear to be mythical for informal workers. According to a recent survey, only 29% of the districts have created the ICC, 15% of districts did not have any ICCs and 56% of the districts did not answer the survey request. In the capital of India, only 8 districts reported having any ICCs (Martha Farrell Foundation & PRIA, 2018). Additionally, it was revealed that apart from the non-existence of committees, there was a considerable lack of awareness regarding roles and responsibilities among the members of the committee. This not only denotes an ineffective mechanism but indicates the lack of seriousness and accountability that prevails in the government system. Lack of awareness of roles also implies a lower capacity to handle complaints. While India would have been able to bring in a law against sexual harassment of women at the workplace, its implementation is a challenge.

There nuanced challenges of the implementation lie in both the demand and the supply side. While surely there is a need to strengthen the constitution and functionality of the of local internal committees at the district level, as stated by the law. There is a need to create a conducive environment for these community health workers to approach these committees. Workplace violence in health and social care imposes heavy costs upon affected women, as well as health systems and societies.

Through this research proposal, I argue that while not actively inducing but the state is complicit in violence and exploitation of women working in community healthcare which deprives them of a safe and dignified place of work. The proposal will record detailed experiences of violence among the ASHA workers (the cadre of CHWs in focus) and analyze the redressal mechanisms offered by the state to unearth the causes behind the neglect of its largest health workforce. Further, the prevalence of gender-based violence will be explicated along with the intent behind this neglect and lastly, an intersectional framework would be devised for the state to ensure the security of CHWs in India.

Chapter Two: Research Design, Methodology and Conceptual Framework

2.1 Research Questions

2.1.1 Main Research Question

The Government of India has put in place a grassroots system of providing the last mile access for healthcare to people across the country through the cadre of female CHWs. However, the prevalence of violence and sexual harassment faced by female CHWs undermines the effectiveness of the system. **In what ways is the state complicit in perpetuating violence and exploitation against the female CHWs?**

2.1.2 Sub-questions

1. What are the different forms of violence experiences by the CHWs of India?
2. How accessible, functional and effective is the state mandated complaint redressal mechanisms for CHWs?
3. What has been the experience of CHWs with the complaint redressal mechanisms?
4. Why is the state complicit in violence that is weakening the health system?
5. What are the ways in which working conditions can be secured for the CHWs?

2.2 Research Objectives

2.2.1 General Objective

1. To identify ways of tackling state complicit exploitation and violence against CHWs.

2.2.2 Specific Objectives

2. To explicate the insecure working conditions among female CHWs in India.
3. To analyze the implementation of existing redressal mechanisms installed by the state.
4. To understand the deep-rooted patriarchal tolerance and naturalization of violence which leads to the exploitation of female labor.
5. To provide an intersectional framework to tackle violence and exploitation of female CHWs in India.

2.3 Hypotheses

The state is actively complicit in the violence against CHWs by devaluing women's healthcare labor and invisibilizing accountability in redressal mechanisms.

2.4 Methodology and Methods of Data Collection

2.4.1 Research Design

The research project will be conducted using a qualitative methodology through a phenomenological perspective (Guest et al., 2012). Qualitative research is a form of social inquiry that focuses on the way people interpret and understand their experiences and the world in which they live. It is a suitable method to incorporate the complexities of the context of the real world and take into consideration the experiences of various kinds of people all around the same phenomenon (Guest et al., 2013). Qualitative research will be utilized because this research would require a humanistic approach to anchor it. Experiences of insecurity and violence among CHWs have been sparsely documented due to the complexity and sensitivity of the issue. Often research in public health has lacked a feminist analysis and tends to look at communities as a homogenous group. Gender norms, roles and relations make women experience the world differently and heavily impact their vulnerability to diseases and long-term gendered effects. However, a lack of data and a gender lens in public health calls for an integration of an intersectional feminist analysis (Smith et al., 2021). Qualitative analysis can provide these insights, it can bring out the nuances of violent experiences and related redressal mechanisms.

The research design will also involve of both theoretical and empirical approaches. Existing reports from the Human Rights Network, International Labour Organization (ILO) frameworks, Vishakha Guidelines from India, Sexual Harassment Law in India among others to prevent gender-based harassment of CHWs will be analyzed. A feminist intersectional lens will be applied to recording the experiences of community healthcare workers. In depth interviews will be conducted to gather evidences, details and nuances of CHWs experiences of violence and the experience of redressal mechanisms. Further to understand the role of the state and its complicity which lead it to be exploitative towards the CHWs, the

government officials, Non-Governmental Organizations (NGOs) and labor union members will be interviewed.

2.4.2 Research Sites

The research would be conducted in the rural pockets of Lucknow, Agra, Varanasi, Chitrakoot and Meerut in Uttar Pradesh (UP), India. Uttar Pradesh is the heartland of India, from the perspective of political control, population and socio-economic inequity perspective. With a projected population of 235 million in 2021 (Ministry of Home Affairs, Government of India, 2011), it covers 7.3% land area of India, a total of 240.928 square kilometers (Uttar Pradesh: Social Demography, 2004). The state is divided into 18 divisions, 75 districts, 13 Municipal corporations, 226 municipal boards. (Uttar Pradesh: Social Demography, 2004).

The geography of UP matters because it has the largest numbers of districts hence it has the largest number of CHWs or ASHA workers. ASHA workers are appointed at a population of 1500 person each and hence UP has the largest workforce deployed in it. Further violence against women has been a grave concern for the state especially during the pandemic. While the country saw a rise of 46 per cent in complaints of crimes against women in the first eight months of 2021 and more than 50% of these cases were from Uttar Pradesh (Hindustan Times, 2021). One cannot interrogate the security concerns of women at work without applying an intersectional lens. This is integral in a context such as India, where caste, geography, social norms play a huge role. In UP lower caste, and gender are directly proportional to being more vulnerable to violence. UP and especially the lower caste in UP has always had some of the worst human development indicators in India (Mehrotra, 2006).

Lastly, the researcher is a native of Uttar Pradesh and has extensive work experience of working with the government, NGO and community health workers in the state. Further, the researcher is familiar with the various local languages and dialects present in the state which would make the navigation in the research cites and groups easier.

2.4.3 Methods of Data Collection

The research will employ both primary and secondary data collection instruments. Empirical evidence and data from national and global reports will be analyzed. In-depth interviews

with CHWs, NGOs working with CHWs, labor unions representing the CHWs will be conducted to record the experiences of gender-based harassment, redressal mechanisms and the role of the state. Additionally, relevant government officials at the national, state and district level will be interviewed to understand and analyze their perception and attitude towards the violence and exploitation among CHWs and the functioning of redressal mechanisms. The participants will be chosen through snowballing and by utilizing existing inroads of the researcher in the Government of India, and NGOs. The NGOs will be further requested to connect the researcher with the local labor unions. The government officials concerned with policy making with regard to community health workers will be interviewed at the national and state level. While the government officials concerned with the implementation of the redressal mechanisms will be interviewed at the district level.

The researcher will also conduct focused group discussion (FGD) with the CHWs to understand varied perceptions, challenges, attitudes, beliefs, opinions and ideas around their security at work. The ASHA workers will be clubbed in various groups based on of geography, age, number of years of experience, caste so that the intersectional aspects of the issue can be understood. Since the research area is a sensitive issue, the researcher will utilize her existing relationships in the national and state bureaucracy in gaining approval and access to the appropriate participants. As I have observed in my previous research experience, letters of support from academic institutions play a vital role in opening doors and gaining access. Contacting gatekeepers and establishing trust will play a key role in acquiring appointments with the participants.

2.4.4 Methods of Data Analysis

The data will be thematically analyzed from a feminist intersectional lens. Themes and categories will be established to conceptualize and process the data. The data will be analyzed for three key categories, one dedicated to emphasizing the experiences of CHWs around violence during the pandemic, the second would be dedicated to enumerating the structural root causes that deprive the CHWs of a safe working environment and lastly the government's and experts perception of the role of the state as a complicit actor. Analyzing the structural obstacles will include the availability of a complaint redressal mechanism and functioning, effective and accessibility of these processes. The role of the state section

would analyze the perception of the officials towards the CHWs, their insecurity and recent demands and how this perception acts as a determinant for devaluation of women's labor as CHWs. Sections of interviews and FGDs focused on the solutioning will be systematically analyzed to develop the proposed intersectional framework to tackle the current situation of CHWs.

2.4.5 Ethical and Security Considerations

Considering the sensitivity of the issue, it would important to protect the identities of the CHWs. The researcher will be mindful about interrogating trauma and vulnerabilities since documenting personal stories could get triggering and distressing for the participants. The researcher will also have the expectation setting matched because this research is focused on knowledge production and documenting of nuances and complexities of the issue which would be targeted at influencing policy making and implementation changes. The positionality of the researcher as a feminist would be key in such a scenario along with understanding the boundaries of documentation and invading privacy.

2.5 Structure of the Research

The research project will have seven chapters. Chapter one will give a context to the research topic, introduce the problem statement, the research goals, research questions, the methods, and the study methodology. Chapter two will discuss the conceptual and theoretical framework elaborating on existing literature concerning violence in the workplace, women in care work and devaluation of women's labor. Chapter three will enumerate the different experiences of violence faced by the CHWs. Chapter four will present an intersectional analysis of the accessibility, functionality and effectivity of state mandated complaint redressal mechanisms. Chapter five will define, analyze and discuss the root causes behind the state's complicity in perpetuating violence and exploitation of CHWs. Chapter six will provide a feminist analysis and an intersectional framework to address the state's complicity and exploitation of women's labor in healthcare. Chapter seven will include the conclusion, recommendations, and limitations.

2.6 Conceptual and Theoretical Framework

The research project will primarily function under the intersectional feminist theory and the emerging theories of care work with a focus on devaluation theory. The interaction between these two theories will form the bedrock of the analysis of the security of CHWs and the role of the state.

Intersectionality Feminist Theory: The term intersectionality coined by Kimberlé Crenshaw in 1989 (Crenshaw, 1989) established the need to take into consideration various overlapping identities of women into account while viewing their oppression and empowerment. International Women's Development Agency (IWDA) defines intersectionality as a dynamic way of integrating overlapping or intersecting the effects of various types of discrimination. It highlights how discrimination, oppression and denial of rights do not operate in isolation. Factors including religion or race (or caste in the Indian context)/ethnicity can make one more vulnerable than others. In other words, one's life experiences are based on how multiple identities intersect with sexism and power to amplify gender discrimination (International Women's Development Agency, 2018). In this context, the researcher would analyze the lack of security among CHWs, the role of the state, keeping in mind their education status, geography, cultural background, class, caste and gender and how their interwoven identities interact with the state. This theory will also be utilized to analyze the state's complicity in perpetuating violence.

Emerging Theories of Care Work with a Focus on the Devaluation Theory: Devaluation theory is one of the five emerging theories of care work. Its basic premise states that since women are culturally devalued and so is their labor. Hence the labor or occupations associated with women are also devalued in capitalistic and patriarchal societies. Historically, empirical research has found that this also has a negative effect on wages and occupational prestige (Magnusson, 2008b). The devaluation perspective argues that care work is badly rewarded and hardships are invisibilised because providing care is quintessentially a woman's role. Since from the very foundation jobs such as teaching, nursing and healthcare are jobs that are side-lined and devalued and works in tandem with the organizational theory of sexual harassment to undermine and de-prioritize gender-based violence of CHWs.

Apart from the devaluation theory and perspective, there are four other frameworks. The "public good" framework highlights how low pay of care is a failure of markets to reward public goods. The "prisoner of love" framework suggests that since care is directly related to love which are both women's domains, the employers often get away with devaluing it and even paying the workers lesser. The "commodification of emotion" framework argues for rewarding the women with emotional satisfaction than putting an economic value on it. Lastly, the "love and money" framework argues against dichotomous views in which markets are seen as antithetical to true care (England, 2005).

Chapter Three: Relevance of The Research and Discussion on The Topic

3.1 Relevance of the Research

In the process of devaluing women's labor and being complicit in the violence at the workplace, the state institutions have invisibilised and naturalized the physical, emotional and mental suffering of women at work. As patriarchy updates itself and women set out to work in the informal sector, sexual harassment also becomes systemic, complex and unidentifiable. Since it is invisible, it is a problem that has not been on the radar of policy makers to solve. This research offers to systemically study, recognize and expose the root cause behind invisible issues so that concrete and nation-wide solutions can be identified and implemented with regard to harassment of women at workplaces and its long-term impacts. From experience, the policy implementers and state personnel often tend to look at issues with a compartmentalized and homogenous lens leading to misappropriation of solutioning. The process of sensitizing state personnel to even recognize violence against women is not done at one level, and awareness raising in the women themselves to acknowledge their rights on the other can only be solutions when the problems are laid bare in detail. That is what this research aims to do, it is a unique attempt to provide a feminist analysis of the state's complicity that leads it to emerge as exploitative to a female cadre it deployed for bridging the last mile gap.

The research proposal approaches the lack of gender-based security among healthcare workers from a feminist lens. Public health has both been criticized and lauded for missing and adopting approaches that were gender disaggregated including the DALY approach for the former and prevention of diabetes or breast cancer (Hammarström, 1999) for the latter. The feminist research has highlighted the need for approaching the entire public health system from a gender lens, where women are not reduced to just subjects and contributors but also actors. Public health benefits from the labor and contribution of women and hence there is a need to view it from a feminist perspective (Hammarström, 1999). The research would not only add to the knowledge of feminist public health but also bring a feminist standpoint towards thestate being actively complicit in exploiting women's labor in last mile

delivery of healthcare. The proposal would analyze how the prevalence of violence and security concerns not only further burdens CHWs but also surfaces the systemic patriarchy in institutions.

Additionally, the research would attempt to fulfil the gap of providing an intersectional framework to tackle the state's complicity in violence and exploitation of CHWs. Taking stock of the decade long program, while the ASHA workers have immensely contributed to various public health crisis in India (Scott et al., 2019) but their needs, demands and empowerment do not seem to be addressed. The health systems research and focus have been on extracting their labor under the name of performance, building their capacity through training so that they can deliver better with the least focus on their complaints (Scott et al., 2019). This research aims to fill this gap by minutely documenting the experiences of CHWs, their accessibility of the redressal mechanism and collating probable solutions to this, in consultation with experts and government officials.

With millions of women employed by the state, it is essential that their working conditions are reviewed and their working environment is evaluated from a feminist lens. This research would generate additional knowledge in the area of labor, health human resource and the role of the state with the interdisciplinary approach that it will adopt. Further, while the research is focused on women's labor in healthcare the learnings and findings have the potential to throw light on a larger systemic reality for women workers across sectors. Especially in the professions of care, where women dominate the workforce and yet are either a subject of harassment or their issues remain invisible (International Labour Organization, 2018). Women workforce faces huge challenges when it comes to finding jobs, gender pay gap or social security all contributing to harassment at the workplace. Harassment at the workplace is one of the top five issues of working women (Thomson Reuters, 2019) and this analysis was limited to women in the formal sector, the situation of women in the informal sector does not have enough data points or knowledge attached to it once again making the problem invisible henceforth leading to a lack of solutioning. This research could be a source for knowledge and analysis of various aspects of women' labor, informal workforce, harassment at the workplace and the role of states which are the largest employers across economies.

3.2 The Genesis of the Topic

Understanding the root-causes behind challenges the CHWs face on a regular basis has perturbed me extensively in the last seven years of my public policy and advocacy career. It is concerning not only because it concerns millions of women in the last mile workforce but because it is a phenomenon that can be traced across industries. This topic first emerged while documenting the successes, struggles and motivations of the CHWs program in India. My professional journey in 2015 began through an advocacy project about women's right to choose contraception, largely under the umbrella of family planning. While designing various advocacy materials, drafting policy briefs and just familiarizing myself with India's public health care system I was introduced to this army of female community healthcare workers known as ASHA workers who provided the services till the last mile. Over the last seven years I have had the opportunity to work and interact with hundreds of CHWs from across India, I have heard their stories of motivation, challenges, discontentment and dissent.

On the other hand, in my recent experiences of working with NITI (National Institution for Transforming India) Aayog, the policy think tank of GoI, I had the opportunity of designing guidelines that would directly impact these CHWs and in the due process, I realized the burden of work these women carried and the consistent devaluation of it. These CHWs are the backbone of Indian public healthcare and the state is failing them at every step. In March 2020, when Covid-19 hit the world, in many developing countries including India these women took to the front of the response. As elaborated earlier they were not provided with enough gear or social security to protect themselves. They were violated, physically, professionally and on the basis of their gender. Applying my academic feminist theories, I wondered if it is the labor or the gender of the laborer or both that result in violence, exploitation and devaluation.

The need of CHWs might have been invisibilised by the state but the CHWs are not silent. In the last few years, they have been consistent in protesting, presenting their concerns and demanding better working conditions (Chitlangia, 2020). The ASHA workers across many states have been protesting against their working conditions, low wages, lack of pension, and social security among others.

As a public policy analyst, a feminist and a working woman myself, it personally irks me to notice that it is the contribution of CHWs which has prevented India from fighting life threatening health conditions such as malnutrition, polio and now Covid-19 and yet the support they receive from the state is disproportional to the value of work contributed (Nanda et al., 2020). As and when I collected success stories and case studies from the rural pockets of India for various programs, ASHA workers formed the cornerstone for it but seldom has their contribution been acknowledged systematically (BBC News, 2020). The side-lining of the contribution of their labor is not new and has only exasperated with the advent of Covid-19 (S. Bhatia et al., 2021).

There is another side to this coin, it is also during Covid-19 that the CHWs received public appreciation in media but that has not resulted in any systemic and effective changes with regards to their protection and exploitation (Nanda et al., 2020). But what this provides us is the window of opportunity to optimally utilize this time to enhance knowledge production around the challenges they face. Their issues require substantiation for the state so that better mechanisms for conducive functioning can be developed and this research could form the base for all of the above.

3.3 Conclusion

The issues surrounding one million women deployed in the last mile healthcare delivery in India cannot be viewed independently of their social situation. Their gender and identity as women working in the lowest rung of the hierarchy are counterproductive not only for them but also for the health system at large. Social determinants of health refer to the sociological environment in which people are situated, naturally it impacts their life and well bring. Education, housing, access to facilities etc. are referred to as social determinants of health. Gender has been recognized as a social determinant of health by the WHO but gender should be taken into account not only when diagnosing a patient or a community but also as a functional actor. This is where this proposal has its roots, it has the potential to revisit how one views the public healthcare system in India and deploy a feminist lens to it. Women in public health have largely been subjects while this proposal puts them at the center as actors.

The second aspect that this proposal wishes to fulfil is to analyze the complicity of the state which is heavily counterproductive for its gender and health indicators. The state has provided legislation to protect women in workplaces but legislation alone do not solve the issue because the implementation of their roots lies in societies. The proposed research has the potential to offer insights into issues that have been long invisibilised or shelved. The state needs to re-evaluate their approach towards women workforce in healthcare and adopt a feminist intersectional approach to view the issues of CHWs as neglecting their security concern is not only a denial of their human rights but also building a system to fail.

The research proposal has been drafted keeping in mind the need for implementation of these ideas as well. The framework, the researcher aims to develop would be designed keeping in mind the implementation of PoSH in India, ensuring awareness building among the CHWs around their rights and strengthening of the state machinery to provide an enabling environment to the CHWs. Given the intensive work experience the researcher possesses in the policy making circles of India, the results of the research will be shared with senior bureaucrats and have been designed in a way that can offer unique empirical outcomes.

While the feminist viewing of the CHWs lies at the center of this proposed research, it is directly related to the long-term impacts on healthcare as well. An empowered, protected and secure CHW can be a game changer for India. Covid-19 response and the vaccination program has stagnated the health results and reversed the gains the country made in the last decade. The pandemic especially the second wave exposed an already broken public health system of India. Any public health system does not exist in isolation, it is directly related to the labor employed in it. It would not be a long stretch to mention that if India is able to provide a secure and conducive work environment to its million CHWs its probability of improving maternal and child health indicators, nutrition status will be higher (Govender & Penn-Kekana, 2008). Providing a dignified work environment to its CHWs can have multiple large-scale impact on India’s healthcare, especially now when it is recovering from COVID-19.

As next steps, the researcher aims to apply to leading women and gender studies departments across the world to seek funding and guidance for a PhD with an aim of enhancing existing knowledge and contribute to the discourse of the modern-day nuances of harassment at the workplace for women and its linkages with the state.

Appendix: Tentative Work Plan

Activities	Year 1				Year 2				Year 3				Year 4			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Proposal Review and Strengthening																
Literature review																
Methodology Revision																
Data Collection																
Data Synthesis																
Data Analysis																
First draft and review																
Second draft and review																
Third draft and review																
Addressing Comments from the supervisors and the doctoral Committee																
Finalizing the thesis																
PhD Défense																
Addressing comments from the Examiners and the Défense																
Final Submission to the academic committee																
Graduation																

Bibliography

Accountability Initiatives, Centre for Policy Research. (2021, March). *Experiences of Frontline Workers in Rajasthan and Himachal Pradesh during the COVID-19 Pandemic*. Centre for Policy Research. https://cprindia.org/research/reports/experiences-frontline-workers-rajasthan-and-himachal-pradesh-during-covid-19-0

Agarwal, S., Curtis, S. L., Angeles, G., Speizer, I. S., Singh, K., & Thomas, J. C. (2019). The impact of India's accredited social health activist (ASHA) program on the utilization of maternity services: a nationally representative longitudinal modelling study. *Human Resources for Health*, *17*(1). https://doi.org/10.1186/s12960-019-0402-4

Ambast, S. (2021, June 29). *Why do ASHA workers in India earn so little?* CBGA India. https://www.cbgaindia.org/blog/why-do-asha-workers-in-india-earn-so-little/

Arora, K. (2020, November 12). *Sexual Harassment At Work: Understand The Rules Of The PoSH Act In 6 Minutes*. Ungender | Empanelled by GoI. https://www.ungender.in/sexual-harassment-at-work-understand-the-rules-of-the-posh-act-in-6-minutes/

Atnafie, S. A., Anteneh, D. A., Yimenu, D. K., & Kifle, Z. D. (2021). Assessment of exposure risks to COVID-19 among frontline health care workers in Amhara Region, Ethiopia: A cross-sectional survey. *PLOS ONE*, *16*(4), e0251000. https://doi.org/10.1371/journal.pone.0251000

BBC News. (2020, April 17). India coronavirus: The underpaid and unprotected women leading the Covid-19 war. *BBC News*. https://www.bbc.com/news/world-asia-india-52279025

Behen Box. (2020). *FEMALE FRONTLINE COMMUNITY HEALTHCARE WORKFORCE IN INDIA DURING COVID-19*. https://behanbox.com/wp-content/uploads/2021/03/APU-Report-Final.pdf

Bhatia, K. (2014). Community health worker programs in India: a rights-based review. *Perspectives in Public Health*, *134*(5), 276–282. https://doi.org/10.1177/1757913914543446

Bhatia, S., Saha, D., & Pal, S. (2021). *Understanding the Perspectives of Frontline Health Workers (ASHAs, Anganwadi workers & ANMs) in Bundelkhand Region to Improve COVID 19 Containment Efforts*. SRIJAN, New Delhi, India. https://srijanindia.org/wp-

content/uploads/2021/01/Understanding-the-perspectives-of-frontline-health-workers_print.pdf

Bhuyan, A., & Khaitan, S. (2021, February 23). 8 Years On, Poor Compliance With Sexual Harassment Law. *Indiaspend*. https://www.indiaspend.com/women/8-years-on-poor-compliance-with-sexual-harassment-law-729370

Bisht, R., & Menon, S. (2020, May 1). ASHA Workers Are Indispensable. So Why Are They the Least of Our Concerns? *The Wire*. https://thewire.in/rights/asha-workers-coronavirus

Chatterjee, P. (2020, May 2). Recently, ASHA workers have faced violence. What makes them so vulnerable? *Gaonconnection | Your Connection with Rural India*. https://en.gaonconnection.com/recently-asha-workers-have-faced-violence-we-must-address-the-underlying-structural-reasons-that-make-them-vulnerable/

Chitlangia, R. (2020, April 19). Asha workers on Covid-19 duty demand timely, better wages. *Hindustan Times*. https://www.hindustantimes.com/delhi-news/asha-workers-on-covid-19-duty-demand-timely-better-wages/story-x3g8ewZPlDzFe89ceNhu8J.html

Connley, C. (2021, January 12). How women could be uniquely impacted by the coronavirus. *CNBC*. https://www.cnbc.com/2020/03/18/how-the-coronavirus-could-impact-women-in-health-care.html

Crenshaw, K. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Anti-discrimination Doctrine, Feminist Theory and Antiracist Politics. *University of Chicago Legal Forum*, *1989*(1). https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8/?utm_source=chicagounbound.uchicago.edu%2Fuclf%2Fvol1989%2Fiss1%2F8&utm_medium=PDF&utm_campaign=PDFCoverPages

Dasgupta, J., Velankar, J., Borah, P., & Nath, G. H. (2017). The safety of women health workers at the frontlines. *Indian Journal of Medical Ethics*, *2*(3). https://doi.org/10.20529/ijme.2017.043

Dhupkar, A. (2021, June 22). Attacked, abused and underpaid: The plight of Maharashtra's Covid warriors. *The Times of India*. https://timesofindia.indiatimes.com/india/attacked-abused-and-underpaid-the-plight-of-maharashtras-covid-warriors/articleshow/83718678.cms

England, P. (2005). Emerging Theories of Care Work. *Annual Review of Sociology*, *31*(1), 381–399. https://doi.org/10.1146/annurev.soc.31.041304.122317

George, A. (2008). Nurses, community health workers, and home carers: gendered human resources compensating for skewed health systems. *Global Public Health*, *3*(sup1), 75–89. https://doi.org/10.1080/17441690801892240

George, A. S., McConville, F. E., de Vries, S., Nigenda, G., Sarfraz, S., & McIsaac, M. (2020). Violence against female health workers is tip of iceberg of gender power imbalances. *BMJ*, m3546. https://doi.org/10.1136/bmj.m3546

Govender, V., & Penn-Kekana, L. (2008). Gender biases and discrimination: a review of health care interpersonal interactions. *Global Public Health*, *3*(sup1), 90–103. https://doi.org/10.1080/17441690801892208

GOVERNMENT OF INDIA, MINISTRY OF HEALTH AND FAMILY WELFARE. (2020, March). *LOK SABHA UNSTARRED QUESTION*. Government of India. http://164.100.24.220/loksabhaquestions/annex/173/AU3418.pdf

Guest, G., Namey, E., & Mitchell, M. (2013). Qualitative Research: Defining and Designing. *Collecting Qualitative Data: A Field Manual for Applied Research*, 1–40. https://doi.org/10.4135/9781506374680.n1

Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action. (2020). *Securing the Safety and Wellbeing of Women Frontline Healthcare Workers in the COVID-19 Response*. https://gbvguidelines.org/en/documents/securing-the-safety-and-wellbeing-of-women-frontline-healthcare-workers-in-the-covid-19-response/

hindustantimes.com. (2021, September 7). 46% rise in complaints of crimes against women in 2021; UP, Delhi top list: NCW. *Hindustan Times*. https://www.hindustantimes.com/india-news/46-rise-in-complaints-of-crimes-against-women-in-2021-up-delhi-top-list-ncw-101631013445931.html

Human Rights Watch. (2020). *No #MeToo for Women Like Us Poor Enforcement of India's Sexual Harassment Law*. https://www.hrw.org/report/2020/10/14/no-metoo-women-us/poor-enforcement-indias-sexual-harassment-law

International Labour Organisation. (2018). *The gender gap in employment: What's holding women back?* https://www.ilo.org/infostories/en-GB/Stories/Employment/barriers-women#intro

International Women's Development Agency. (2018, May 11). *What does intersectional feminism actually mean?* IWDA. https://iwda.org.au/what-does-intersectional-feminism-actually-mean/

Josephine M., S. (2020, October 5). It is all work and little or no pay for ASHA workers in Tamil Nadu. *The Hindu*. https://www.thehindu.com/news/national/tamil-nadu/it-is-all-work-and-little-or-no-pay-for-asha-workers/article32768228.ece

Kasliwal, R. (2021, January 22). *COVID19 adds to the woes of India's underpaid and overworked care workers*. Observer Research Foundation. https://www.orfonline.org/research/covid19-adds-to-the-woes-of-indias-underpaid/

Magnusson, C. (2008a). Gender, Occupational Prestige, and Wages: A Test of Devaluation Theory. *European Sociological Review*, *25*(1), 87–101. https://doi.org/10.1093/esr/jcn035

Magnusson, C. (2008b). Gender, Occupational Prestige, and Wages: A Test of Devaluation Theory. *European Sociological Review*, *25*(1), 87–101. https://doi.org/10.1093/esr/jcn035

Martha Farrell Foundation & PRIA. (2018, August). *Who Safeguards A Woman's Right To A Safe Workplace? A Study Of Local Committees Across India Using RTI Data*. https://www.marthafarrellfoundation.org/uploads/pdf_files/1555302838_RTI%20Study%20PDF.pdf

Mehrotra, S. (2006). Well-Being and Caste in Uttar Pradesh: Why UP Is Not like Tamil Nadu. *Economic and Political Weekly*. Published. https://www.jstor.org/stable/4418785

Ministry of Home Affairs, Government of India. (2011). *Uttar Pradesh Population 2011–2021*. Census 2011. https://www.census2011.co.in/census/state/uttar+pradesh.html

Mohanty, D. (2020, April 24). Asha worker attacked for collecting data on Covid-19 patients in Odisha. *Hindustan Times*. https://www.hindustantimes.com/india-news/asha-worker-attacked-for-collecting-data-on-covid-19-ve-patients-in-odisha/story-AZxHd8YHM1zGLnPkBdMUmN.html

Nanda, P., Lewis, T. N., Das, P., & Krishnan, S. (2020). From the frontlines to centre stage: resilience of frontline health workers in the context of COVID-19. *Sexual and Reproductive Health Matters*, *28*(1), 1837413. https://doi.org/10.1080/26410397.2020.1837413

National Health Mission, Ministry of Health and Family Welfare, Government of India. (2018). *Accredited Social Health Activist (ASHA)*. National Health Mission. https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=150&lid=226

Prasad, P. (2020, May 10). Beaten, burnt out and broke: How Haryanas ASHA workers, on frontlines of fight against COVID-19, are coping. *Firstpost*. https://www.firstpost.com/health/coronavirus-outbreak-beaten-burnt-out-and-broke-how-haryanas-asha-workers-on-frontlines-of-fight-against-covid-19-are-coping-8352321.html

Press Trust of India. (2020, April 22). Coronavirus: ASHA workers endure abuse and assault on field in Nagpur. *India Today*. https://www.indiatoday.in/india/story/coronavirus-asha-workers-endure-abuse-and-assault-on-field-in-nagpur-1669824-2020-04-22

Rao, B., & Tewari, S. (2020, June 9). Distress Among Health Workers In Covid-19 Fight — Article 14. *Article 14*. https://www.article-14.com/post/anger-distress-among-india-s-frontline-workers-in-fight-against-covid-19

Ratho, A. (2020, July 7). *How are female essential workers faring amidst COVID19?* Observer Research Foundation. https://www.orfonline.org/expert-speak/how-are-female-essential-workers-faring-amidst-covid19-69314/

Ravichandran, N. (2020, July 14). As COVID-19 Sweeps Karnataka, ASHA Workers, AYUSH Doctors Strike for Better Pay. *The Wire*. https://thewire.in/rights/covid-19-karnataka-asha-workers-ayush-doctors-strike-pay

Saprii, L., Richards, E., Kokho, P., & Theobald, S. (2015). Community health workers in rural India: analysing the opportunities and challenges Accredited Social Health Activists (ASHAs) face in realising their multiple roles. *Human Resources for Health*. Published. https://doi.org/10.1186/s12960-015-0094-3

Scott, K., George, A. S., & Ved, R. R. (2019). Taking stock of 10 years of published research on the ASHA programme: examining India's national community health worker programme from a health systems perspective. *Health Research Policy and Systems*, *17*(1). https://doi.org/10.1186/s12961-019-0427-0

Sinha, D., Gupta, M., & Shriyan, D. (2021, August 15). High Risk without Recognition: Challenges Faced by Female Front-line. *Economic and Political Weekly*. https://www.epw.in/engage/article/high-risk-without-recognition-challenges-faced

Smith, J., Davies, S. E., Feng, H., Gan, C. C. R., Grépin, K. A., Harman, S., Herten-Crabb, A., Morgan, R., Vandan, N., & Wenham, C. (2021). More than a public health crisis: A feminist political economic analysis of COVID-19. *Global Public Health*, *16*(8–9), 1364–1380. https://doi.org/10.1080/17441692.2021.1896765

Stephens, W. (2020, July 30). *Violence Against Healthcare Workers: A Rising Epidemic*. AJMC. https://www.ajmc.com/view/violence-against-healthcare-workers-a-rising-epidemic

Thomson Reuters. (2019). The Top Five Issues for Working Women Around the World. *The Atlantic*. https://www.theatlantic.com/sponsored/thomson-reuters-davos/the-top-five-issues-for-working-women-around-the-world/762/

UK Aid, & Fraser, E. (2021, March). *VAWG Helpdesk Research Report: Impact of COVID-19 Pandemic on Violence against Women and Girls*. UK Aid. https://www.sddirect.org.uk/media/1881/vawg-helpdesk-284-covid-19-and-vawg.pdf

Uttar Pradesh: Social Demography. (2004). Government of UP. https://up.gov.in/

Vecchio, N., Scuffham, P. A., Hilton, M. F., & Whiteford, H. A. (2013). Differences in wage rates for males and females in the health sector: a consideration of unpaid overtime to decompose the gender wage gap. *Human Resources for Health*, *11*(1). https://doi.org/10.1186/1478-4491-11-9

Ved, R., Scott, K., Gupta, G., Ummer, O., Singh, S., Srivastava, A., & George, A. S. (2019). How are gender inequalities facing India's one million ASHAs being addressed? Policy origins and adaptations for the world's largest all-female community health worker programme. *Human Resources for Health*, *17*(1). https://doi.org/10.1186/s12960-018-0338-0

World Health Organisation. (2007, January). *Community health workers: What do we know about them?* https://www.who.int/hrh/documents/community_health_workers.pdf

World Health Organisation, Global Health Workforce Network, Women in Global Health. (2019). *Delivered by women, led by men: A gender and equity analysis of the global health and social workforce*. World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/311322/9789241515467-eng.pdf?sequence=1&isAllowed=y