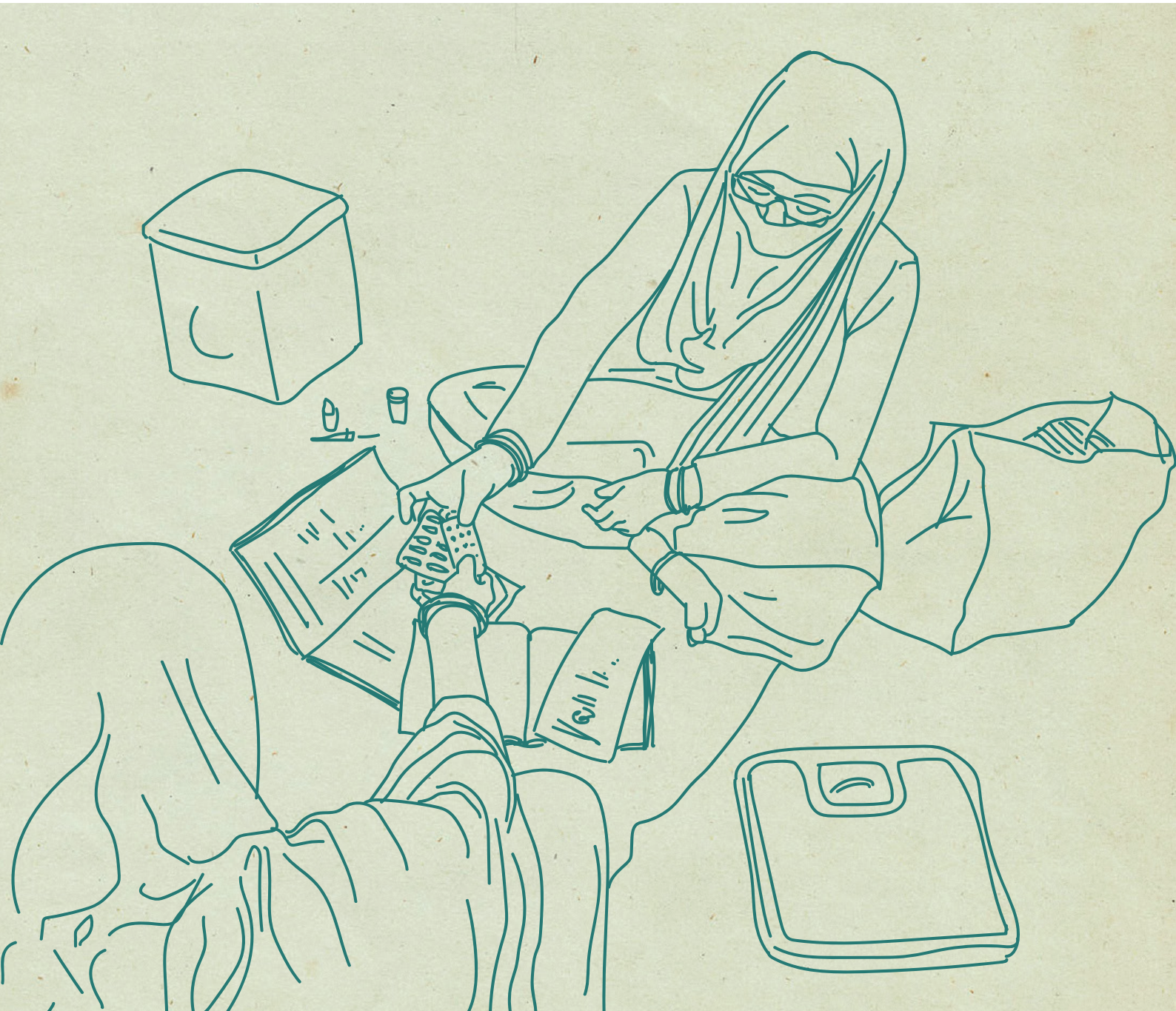
Azim Premji University

Aren't we frontline warriors?

Experiences of grassroots health workers during COVID-19



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Glossary

ASHA - Accredited Social Health Activist is a village level health worker. She is recruited on a voluntary basis by the community members and is accountable to the community. She is responsible for mobilising community members to access public health services along with her broader role of creating awareness about health and its determinants in the village. This programme was introduced in 2005 as part of the National Rural Health Mission.

ASHA Facilitator - The ASHA facilitator provides mentoring support to a cluster of ASHAs (10 -20 ASHAs), builds capacity and monitors the progress of individual ASHAs in a given area.

ASHA Block Coordinator - The ASHA Block Coordinator is responsible for implementing the ASHA programme in the assigned block, monitors the activities of ASHAs and ASHA facilitators, organises and supervises their training and ensures implementation and provision of health services by them.

ANM - Auxiliary Nurse Midwife is a community health worker who serves a population of 5000. She is posted at the sub-centre, the lowest of the three-tier primary health care organisations in India. The ANMs' roles have changed over time, from being focused initially on midwifery to include broader maternal and child health services, family planning services, nutrition and health education, immunisation, treatment of minor ailments and outreach clinics in the villages. ANMs have been part of health bureaucracy since the 50s.

AWW – Aanganwadi Worker is a village level worker who is part of the Integrated Child Development Service (ICDS) programme that the Government of India introduced in the mid-1970s. AWWs work at the intersection between the health and the education needs of children. They provide preschool education to children between 3 and 5 years old and are also responsible for providing supplementary nutrition to both children below the age of six and pregnant and nursing women.

LHV - Lady Health Visitor is a health care provider available at public health centres. They provide a variety of services to urban and rural communities, including basic nursing care, maternal child health services, and training of community workers.

Mitanin - Mitanin programme was started in 2002 in the state of Chhattisgarh which lays the foundation for the ASHA programme. Mitanin in the local language means 'a female friend'. Mitanins are community health volunteers who are responsible for awareness, mobilisation for health and its social determinants in the village/urban areas.

Mitanin Trainer - A resource person who provides training, mentoring and monitoring support to the Mitanins (similar to the ASHA facilitators).

PHC - A Primary Health Center is part of the three-tier public health infrastructure. It is the first point of contact between the community and the medical officer. It is expected to provide integrated curative and preventive health care.

VHND - Village Health and Nutrition Days are an important initiative introduced under the National Rural Health Mission in 2005 to improve access to maternal, child health and nutrition services at the village level. These are organised once every month in each village.

Preface

'Aren't we frontline warriors?' asks a community health worker in a webinar that we had organised in May 2020 where grassroots health care workers were at the centre stage sharing their experience of working during COVID-19.[1] This question resonates with several other community health workers who have been braving their lives against all odds to protect the communities against COVID-19. Yet a sense of lack of recognition of their contributions distinctly looms large! The idea of this compendium arises from the felt need of the community health workers to be heard. It was evident during the webinar that spaces for sharing such experiences are few while opportunities for garnering support and shared learning are many.

We bring stories of twenty health workers who share their everyday experiences of working during COVID-19. These stories emerge from individual telephonic conversations with each one of them between July – November 2020. These stories travel from ten states including Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Chhattisgarh, Arunachal Pradesh, Madhya Pradesh, Odisha, Rajasthan and Maharashtra. We draw these experiences from the cadre of health workers who work at the interface of the community and health system. They range from the Accredited Social Health Activists (ASHAs, also known as Sahiyas in some states), ASHA facilitators (ASHA Saathi/Sahayogini), Auxiliary Nurse Midwives (ANMs), Mitanin (community health volunteer) and Mitanin Trainers. Each experience is unique as it traverses the specific geography, community, family, health system and tells us how COVID-19 itself has unfolded in specific areas. While each story is unique, the commonalities lie in the lessons that reiterate the critical role played by community health workers as 'frontline soldiers'.Their experiences unveiled several challenges including accountability fault lines but at the same time also indicate opportunities for collaboration, support and strength in fighting the pandemic.

This work furthers the conversations that we (the team at the Azim Premji University along with Seher, a unit of the Centre for Health and Social Justice; Delhi, Innovative Alliance for Public Health and Forum for Medical Ethics Society, Pune) had initiated as part of the network of COPASAH (Community of Practitioners on Accountability and Social Action in Health) theme 5 on 'Community and health care workers: Forging alliances' during the international symposium in November 2019.[2] We reached out to the twenty health workers

[1] https://fmesinstitute.org/wp-content/uploads/2020/07/Blog-13-HEaL-Institute-%E2%80%93-IJME-Covid-19-Insights-July-16-2020.pdf

[2] https://www.copasahglobalsymposium2019.net/theme-5-health-care-workers.html

whose stories are covered here through the existing health workers' networks including Innovative Alliance for Public Health, National Alliance for Maternal Health and Human Rights (NAMHHR), ASHA Sangathans (networks) and COPASAH.

The stories were elicited and documented by the team at Azim Premji University [including Arima Mishra, Sanjana Santosh and Deepak Kumar] with critical inputs from Sandhya Gautam, our colleague at Seher- a unit of Centre for Health and Social Justice who has been with us in this journey from the beginning. We thank the Institutional Review Board of Azim Premji University for approving the ethical protocols. To protect the confidentiality, we have anonymised the names of the health workers in the stories. Thanks also to Edward Premdas Pinto, Santosh Mahindrakar, Sunita Bandewar and Sana Thapa for their support. We greatly appreciate the support provided by Rachel Varghese, one of our alumni for carefully proofreading the document. While many of us have facilitated it, the compendium belongs to the health workers who are its real architects. We cannot thank them enough for allowing us to be part of their everyday journey and to share their stories widely.

Arima Mishra
Sanjana Santosh
Azim Premji University

“Aren’t we frontline warriors?”

Navigating fear, resistance, apathy in a pandemic

Srishti works as an ASHA Facilitator in Bhind District of Madhya Pradesh. She started as an ASHA in 2007 and took on this supervisory role in 2014. As an ASHA Facilitator, Srishti supports, guides, and monitors the progress of 10 ASHAs. Workdays during the COVID-19 national lockdown were long and tiring for Srishti; she had to start early and find a ride to reach her field area as public transport was unavailable. At times, ASHA Facilitators got together to arrange vehicles to visit the ASHAs in villages. However, there were days when Srishti had to walk for six hours to meet an ASHA. She explains how ASHA Facilitators and ASHAs dealt with everyday challenges during the pandemic.

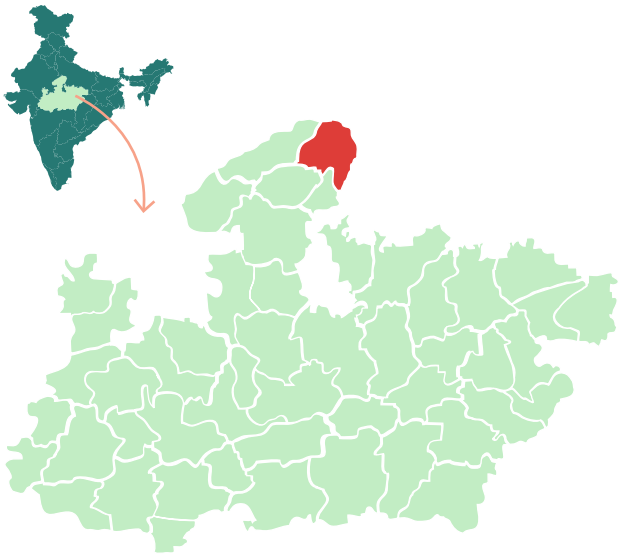
Bhind District

Population: 1703562 (2011)

State: Madhya Pradesh

Language: Hindi

Headquarters: Bhind



Managing fears and protecting oneself

Srishti admitted that all the ASHAs, herself included, fear contracting COVID-19. This fear was further aggravated by the fact that they were not given protective masks or sanitisers by the Health Department. She explained that as an ASHA Facilitator, she could return home after supervision and sanitise herself. However, ASHAs were in close contact with the families in quarantine, collecting malaria slides, and attending meetings, making them more prone to infection. Anxieties rose further when they learnt that a person infected with COVID-19 could be asymptomatic; they had no way of knowing if they were infected as there were no tests being conducted.

When villagers started considering them as potential carriers of the virus, and the single set of disposable masks provided by the government proved inadequate, the ASHA Sangathan (a network of ASHAs) decided to step up to invest in buying soaps and masks to support Sangathan members as they could not afford to buy masks daily (their daily incentive was about Rs.30). Facilitators pitched in with Rs.1000 to buy cloth and some ASHAs stitched masks for everyone.

Srishti was also worried about infecting her own family and children and had been living separately. She recalled missing her son's birthday (he was staying with his maternal uncle in another town) because she did not want to risk infecting him.

Communicating and facilitating home quarantine

Srishti highlighted two key challenges while helping families isolate members who returned from other states or districts post the first lockdown in March-June 2020. First, some families were returning after many years; their homes were either not in a habitable condition, or did not have enough space, toilet facility, or a water connection to quarantine safely. Secondly, it was difficult for poor families without enough money and food to stay home, and they often needed to venture out to seek work. When ASHAs insisted on quarantining, communities asked Srishti to buy essential supplies for them.

Srishti said, *"How can ASHAs ask families to focus on washing hands with soap and stay home when they are hungry? It is not feasible for poor families to follow these practices. So we suggest that they may go to the field to work. However, we insist they cover their mouth and nose with a clean cloth."* Srishti explained that it is important that villagers not lose their trust in the ASHAs; as a facilitator, her role was to ensure *"I bind the community with the ASHA."*

Disruption in routine health care services in communities

Although routine health services and meetings were suspended initially, home visits for antenatal care, malaria tests, and other health services resumed post-April 28, 2020. Srishti said ASHAs faced difficulties in providing maternal health services during the pandemic as many women insisted on giving birth at home, fearing possibly contracting the virus in the hospital. In such cases, ASHAs assisted dais (traditional midwives) in home births and

sought institutional care in case of complications. However, despite assisting in cases of home births, ASHAs were not paid the incentives that would have been due to them for facilitating childbirth in a hospital.

Another challenge has been the inability to respond to general ailments such as fever, diarrhoea and back pain due to the weak supply of medicines. Srishti explained that before the pandemic, ASHAs collected necessary routine medicines during their regular monthly meetings from the Primary Health Centres, but now they are unable to acquire them since meetings are suspended and Primary Health Centres do not stock basic medicines.

'We too need recognition. Aren't we frontline warriors?'

Despite performing several tasks before and through the pandemic, Srishti is disappointed in the health system's neglect and non-acknowledgement of the work of ASHAs. She says that ASHAs are treated like 'stepchildren'–blamed for problems and not considered with empathy. What upsets her deeply is the lack of recognition in government lists and circulars—in Srishti's words, "as though we do not exist." The repeated unresponsiveness to demands for an increase in economic incentives for ASHAs through memorandums, letters and videos to the Chief Minister's Office and the Health Department, even as economic packages are promised for even "those sitting at home" are proof of this "step-motherly" treatment. *"While the gratitude expressed towards frontline workers mentions doctors, nurses, waste collectors and others, no one mentions ASHAs, even when we work in risky conditions... and often go beyond our designated tasks. Aren't we the frontline warriors?"* she asks.

Srishti described how despite the absence of a strong supportive Health Department or even the local self-government, ASHAs have pulled in resources through the ASHA Sangathan to make their own protective gear, arrange for vehicles to visit villages, and even fed migrant families on their return to villages with the help of Aanganwadi Workers. *"No one can forget the corona times. We would also like to be remembered for our efforts during the pandemic and not be forgotten,"* she said.

“I have the support of the villagers; What else could I ask for?”

Importance of family, community and health system support in a crisis

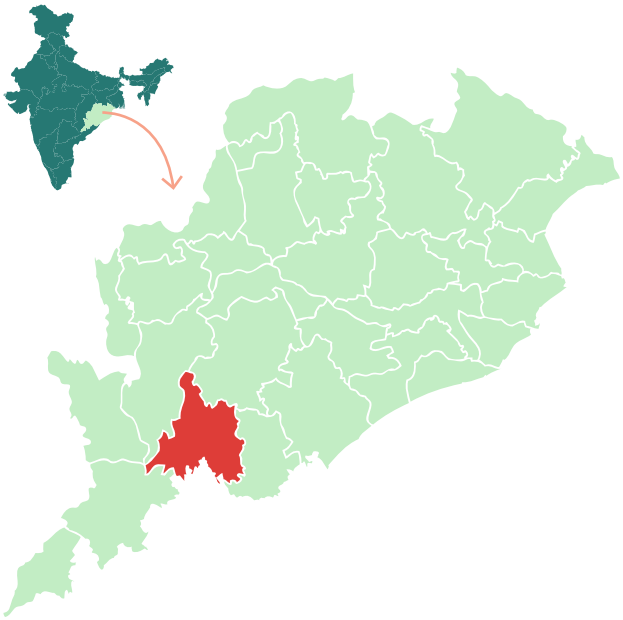
Kimati is an ASHA in Rayagada District of Odisha. She has been working since 2010 in a village, which was recently added to the urban administration of Gunupur Municipality. She is known in her area, both due to her family’s influence and her own active participation in self-help groups and other village activities. People in her village suggested her name for the ASHA post, and since then, she has been working with much social support, she said. Her father was a Sarpanch (village head) in a nearby district, which enabled her to be politically active and motivated “to serve people.” Kimati said the support of the community and health officials has facilitated her work and made it so much easier and fulfilling.

Rayagada District

Population: 961,959 (2011)

State: Odisha

Language: Odia



Community and family support

According to Kimati, she does not have any hindrance in dealing with people from different caste and tribal communities and is able to establish a rapport with all of them through her work. She takes pride in the way she has been able to convince the community about wearing masks and maintaining physical distancing. *“Children like to play together; women like to sit around and talk to each other. I tell them, ‘Sure you should play, do sit and talk*

too, but a little away from each other. If you want to invite the disease, you can continue doing what you do, sitting close to each other. If you want to be free from the disease, then maintain the distance, talk with the mask on'." She said that the trust she has earned from the community all these years has helped to enforce COVID-19 protocol.

With the help of the Auxiliary Nurse Midwife (ANM), Kimati has ensured that routine health services for maternal and child care continue. She sees that pregnant women who return to their natal home in the village for childbirth are quarantined, tested, and supported, even emotionally, as there is an added fear of COVID-19 infection.

She credits her husband and daughter for their steadfast support, which enables Kimati to pursue her work fearlessly. *"My husband is extremely supportive. When I return from COVID-19 duty, he is the one who gives me warm water for bathing. He has never objected to my coming home late from work."*

Health system support

Kimati, in her conversation, repeatedly mentioned the support she receives from the health system. *"I get complete support from my ANM didi (sister); the LHV (Lady Health Visitor) is almost like a mother; I can call and talk to Superintendent sir. All of them know me, trust me and know that I am dedicated to my work. Whatever help I need—when I don't know how to respond to a situation, or what medicines to give, I consult the ANM and LHV."*

This support has greatly helped her in striving towards achieving better health for people in her village. She proudly noted that women from tribal communities in her village give birth to children weighing 3.0 kg to 3.5 kg. She describes how she ensures pregnant women are given iron, folic tablets and other supplements, which she procures from the hospital, from the fourth month of pregnancy. She also encourages women to prepare nutritious meals [she shares the recipe too] from the Take-Home-Ration packets provided through the Aanganwadi Centres.

The support of health officials has been critical during COVID-19. Kimati was given clear information on what needs to be done during the pandemic, and provided adequate masks, sanitisers, and gloves. Though she was initially afraid of venturing out on COVID-19 duty, she felt encouraged by senior officials who visited the wards many times. Kimati said she feels greatly rewarded and respected by the health system.

Beyond titles, plate banging and clapping

Kimati's experience of working as an ASHA during the pandemic and even otherwise has been hugely positive and rewarding because of the support she receives from the community, her family and the health system. So much so that Kimati does not talk much about the payment for her work. *"I have the support of all the villagers. What else could I ask for? If I am standing waiting for a vehicle and someone is passing by, he would stop and ask 'Didi where are you going? Let me drop you'. This work is not meant for earning more money but to serve people. Please pray for me that greed (for monetary incentives) should not set in. I get so much satisfaction with what I do. The fact that I have met so many big(referring to higher authorities at the district level) people, that is a great thing. I get a lot of respect from people. I feel happy that I got to do something during such a critical health crisis, which has gripped the whole world."*

Going beyond bestowing titles and display of gratitude of care, tangible and everyday support involving acknowledgement and cooperation from health workers, community and family, provision of safety gear as well as access to higher authorities for redressal and doubts, is what makes Kimati feel encouraged and even fearless during the pandemic. *"My house faces a temple. When I go out, I tell God: 'You need to take care of me. I am going out on my duty.' I am confident nothing will happen to me."*

“How do we help others when we are emotionally stressed ourselves?”

Balancing professional demands and self-care in a pandemic

Shilpa has been working as an ASHA in Gwalior city in Madhya Pradesh for 12 years. She is responsible for a population of 1200-1500, i.e. about 250 families. During the initial days of the pandemic, Shilpa and other ASHAs in her ward had to do multiple surveys of the same area as the parameters for house listing kept changing. Travelling to the field site in the absence of transport facilities further drained them. In some cases, they were also posted in containment zones but were not given enough personal safety gear. Shilpa’s experience during the pandemic reflects the absence of a space where ASHA workers can effectively raise their concerns, learn and share knowledge, and work without fear.

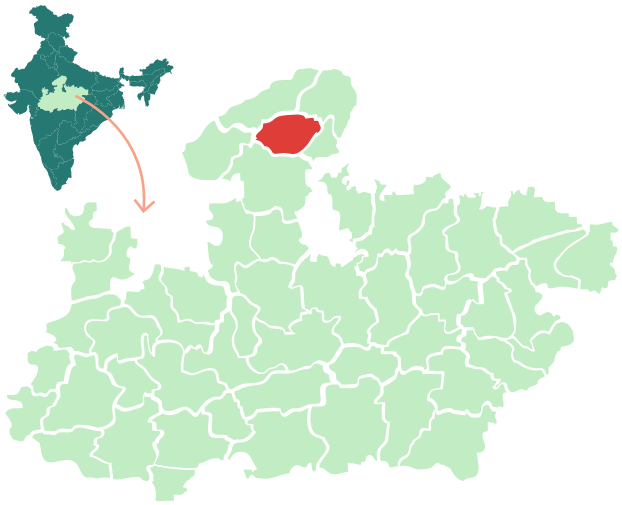
Gwalior District

Population: 2030543 (2011)

State: Madhya Pradesh

Language: Hindi

Headquarters: Gwalior



What happens to the data collected?

Shilpa said that ASHA workers in her ward did multiple surveys of the same area. Initially, they were told to use the Anganwadi registers for entries; then the same survey was repeated using Census listing forms, and then they were made to do it again with a digital device. The ASHAs were told to repeat the survey when localities were declared containment zones. She said, *“We collected data three to four times and sent it, and still got calls from the ward office asking for more data. So basically, we should do daily routine work and also make and send lists every day because these people who sit in the office*

keep changing." Moreover, the health authorities never explained the purpose of these frequent surveys conducted in the same localities within a short period. Consequently, the ASHAs had to face the heat from the community members who were not sure about the reason for the recurrent surveys. She said that the data collected on people's symptoms was not followed up with the requisite medical treatment, which created distress within the community.

"We keep giving information, but problems are not solved. A doctor was assigned for the whole ward but even he ended up collecting information on symptoms and sending them to the ward office as he did not have enough medicines for the patients. We wrote down the names of heart patients who requested medicines but no action was being taken on this information."

Despondent health workers

Despite being a health worker, Shilpa said she felt helpless during the lockdown when she could not assist people as health facilities around her were ill-equipped or not available. Due to the pandemic, most private hospitals were closed and the workload on government district hospitals was higher than usual. With the workforce and hospital beds diverted for COVID-19 cases, regular health services and even medical provisions for existing ailments were hit. Shilpa said, *"Now, all patients, whether those with heart ailments, a fever, or even from the neurology department stand in the same queue for medicines. Earlier, there would be different counters but now the government has ruined the system and people stand in a queue from 7 am to 6 pm, and sometimes even wait back till the next day."* The absence of a strong primary healthcare system has forced people to travel to distant places on foot, she pointed out.

Shilpa expressed her frustration about not being able to help people despite doing her duties and tasks as efficiently as possible. She recalled an incident, which left her wringing her hands. *"This person had cough and showed symptoms of tuberculosis, but he refused to go to the hospital. I tried a lot to get him help by calling the ambulance, calling the mahila (woman) police station since we were given these numbers, and also the madam in-charge (woman officer) at the zonal office, but there was no reply from anyone. I also called the 104 Helpline but no check-up or test was done nor did any doctor come to treat him."*

In the case of maternal health, the nearest Community Health Centre (CHC) has not had a female doctor for a year and so all the women had to be taken to the district hospital for childbirth. In one case, Shilpa accompanied a pregnant woman for delivery but could

not stay back with her in the hospital as she had to report for COVID-19 duty the next day. Later she found out that the woman delivered her baby in the general ward itself amidst other patients. Shilpa was told that doctors didn't tend to the woman as she was from the containment zone and had insisted she get tested first. *"What can we do? We cannot leave a woman in that emergency condition alone to fend for herself because she has not been tested,"* says Shilpa.

No space for grievance redressal

Concerns about inadequate safety gear and the absence of public transport forcing them to walk in the summer heat to do surveys were often dismissed by their immediate bosses, said Shilpa. ASHAs were expected to complete the surveys and sometimes even report back the same day to the ward office. There were also delays in payments; many family members also lost their jobs and health workers also became sole earning members in their homes. Requests for a raise resulted in rude responses and threats. Shilpa said, *"When I raised the issue of payments, I was told that if I'm not satisfied with my job, I can give it to someone else. They ask us to give in writing that we are unhappy with the department, and also threaten to record our conversations. Basically, they are saying, 'Don't make demands, don't talk about your situation. If you are facing troubles, do not share with anyone but if you have been given work, you must do it."*

As an ASHA worker for 12 years, Shilpa recalls facilitating immunisations for Rs.75 years ago. She said that if she had been working at some other place, she would have added to her skillset, and would have been more appreciated. Now she feels she has wasted 12 years of her life as there is neither money nor recognition for her hard work.

The suicide of an ailing man, after a few days of reporting to Shilpa during survey that he had no money or medicines, left her deeply distressed. Shilpa said she feels helpless, de-skilled and unheard despite dedicating years to the State Health Department. She said, *"Sometimes I feel so emotionally distressed with the lockdown, the unending work, and financial problems. We are talking about other people's health but our own conditions are precarious. We ourselves are emotionally stressed."*

“This is not the work of one person”

Collaboration, coordination, and communication in a pandemic

Hema is an Auxiliary Nurse Midwife (ANM) for two villages of Kanker District, Chhattisgarh, with a population of 2741, comprising communities from Scheduled Castes, Other Backward Castes, and Scheduled Tribes. She is 53, and has been working as an ANM since 1988. She lives with her husband and two children. Her husband is retired army personnel, her son runs a small business, and daughter works with the Red Cross while doing her post-graduation in a college in Kanker. Hema has worked in districts across the state, but she prefers Kanker and the block she is posted in. She said, *“People are simple here and I like working with them. In the other districts, I found it difficult to make educated people understand; they complicate things.”*

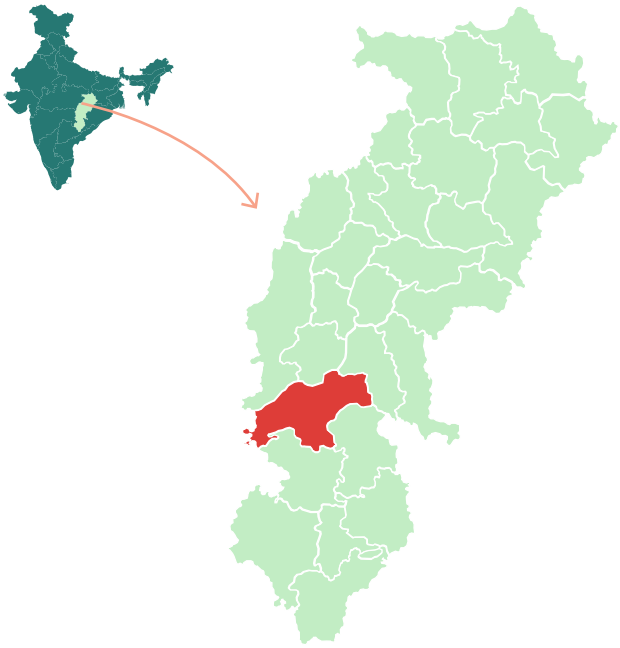
Kanker District

Population: 748,593 (2011)

State: Chhattisgarh

Language: Chhattisgarhi, Hindi

Headquarters: Kanker



Collaboration and communication: Mitigating fears

Hema first became aware of COVID-19 through the media and then, through a Health Department meeting. Initially, she found the situation chaotic as no one had a clear understanding of the virus, but after training from the Health Department, she was better informed. In training, she learnt that the virus originated in Wuhan and is spreading rapidly. She admitted that the virus’s contagious nature made her fearful, both for herself and

her family. As a health worker, she felt responsible for protecting the lives of people, and understood that she needed to get over her fears and apprehensions. *"We really panicked because this was so sudden; coronavirus did not give us any time to prepare or think through things,"* she recalled.

Although her family has been supportive, both Hema and her daughter were discouraged from venturing out for work. However, both of them convinced her son. *"We all are going to die anyway, but before dying, we might as well do something good and worthwhile for humanity and for our community. Our job is to serve people, and we cannot stay back. This was my thought and we moved ahead."*

Hema encountered obstacles from the community too. Villagers believed migrants returning from other states were carriers of infections and started blocking village roads. They would not even allow her to enter the village. She remained undeterred and conducted extensive counselling sessions and community meetings to dispel fear and ignorance. She made villagers understand the nature of the virus and explained that blocking roads would only create problems for villagers in emergencies.

Hema quickly realised that media reports on COVID-19 were causing panic among the village communities. She understood that she must collaborate with the community. A strong awareness campaign was critical to set things right. She also knew she couldn't do this by herself. "This work needs more than one person," she realised. She set up a team that included her daughter, the anganwadi worker, mitanin (village health worker), Sarpanch (village head), other local leaders, and also involved a youth organisation in the block, to disseminate COVID-19-related information, and dispel any fear and rumour about the virus. *"I only had information, no treatment for COVID-19. It was important to communicate that only prevention is the way. I instructed the team to meet every person—from children to old people, visit every household in the village, and make them aware by asking them to adopt preventive measures like physical distancing, regular hand washing, and use masks when going out."*

She also requested village shopkeepers to keep a bucket of water and soap outside their shops. She conducted small meetings by gathering villagers in circles outside shops to reiterate COVID-19 protocol. The shopkeepers were urged to ask customers to wash their hands when they came to the shops. Furthermore, she asked women coming to draw water at the hand pumps to maintain a distance from each other and queue up to fetch water. She also focused on care of children and the elderly as they are most vulnerable to the virus.

With the support of other health workers and local leaders, Hema has ensured that migrant workers returning home stay in quarantine centres. Initially, people were resistant to stay at the quarantine centres. *"I had to take extra effort to make them understand by explaining the risks this posed to their family and other people in the village. Then they agreed."*

She recalled, *"There was a lot of fear earlier. The community and I were both afraid. But, like they say in that advertisement— "Darr ke aage jeet hai," (Beyond fear, there is victory)—it is the same with us. Earlier, there were no COVID-19 cases, but we were so fearful. Now, there are many positive cases but the situation is calmer. We are alert and ready. Through our efforts, people have become aware."*

Coordinated efforts in the health system

Hema and her colleagues got 10 masks and three bottles of sanitiser each for their fieldwork. Those in the testing teams were given PPE kits too. She said that coordinated efforts were in place for testing and tracing. While quarantining those who returned home to the villages, Hema and her colleagues at the block systematically collected detailed information about migrant returnees from village representatives, and shared it with the Health Department through WhatsApp. This was followed by a designated team who would come for testing and collecting samples. Hema was given a thermal testing kit recently and she now checks body temperature too. She asserted that having the support of block officials has helped her. She often communicated directly to block officers and they were attentive to her concerns. She said, *"Since they listen to us, we are able to work. If we were ignored, then it would be difficult to work."*

Hema described how routine health services continued with new protocols. She followed physical distancing norms while conducting the Village Health and Nutrition Day, immunisation sessions, and ante-natal check-ups. There have been no inconveniences in childbirth cases as the Community Health Centre is 5 kms from the village, and easily accessible. Even for Family Planning and other OPD services, the sub-health centres were fully functional. On an average, they saw 10 to 11 patients daily with complaints of dysentery, fever and cough. COVID-19 did not affect OPD visits as the area has been in the Green Zone since the beginning. Although people were scared, they visited the sub-centres for minor illnesses.

"In such a crisis, the government department at the block level and the village community have come together; we are working unitedly, and we have fought COVID-19. Village representatives and different cadres of health workers have all worked together," she said.

However, Hema minced no words in expressing her anger and discontent about payments. She has not received any communication on the additional pay for COVID-19 duty or about the Rs. 50 lakh insurance promised to health workers. *"On one hand, flower petals were showered on us, people were clapping. On the other hand, the government is deducting our salary. I am dedicated to this country but at such critical times, deducting salaries and delaying increments of healthcare workers is inappropriate. When we are working by putting our lives at risk, you are making people clap, and are showering flower petals while deducting salaries! This is disrespectful. This is not fair."*

“I feel like a multi-purpose worker”

Juggling duties at shifting workplaces

Pakha has been an Auxiliary Nurse Midwife (ANM) for 12 years in the Lower Subansiri district in Arunachal Pradesh. She was in a contractual position till 2015, which was then regularised. She worked at the sub-centre for a few years, and later was given additional responsibility at the General Hospital. She works in two blocks that are largely inhabited by indigenous communities of the Apatani and Mishing. The Apatani community practices pani kheti (wetland cultivation), while the Mishing engage in terrace paddy cultivation and shifting agriculture. While the Apatani habitation is compact, with each house next to the other, the habitation of the Mishing community is dispersed and distant from the block headquarters.

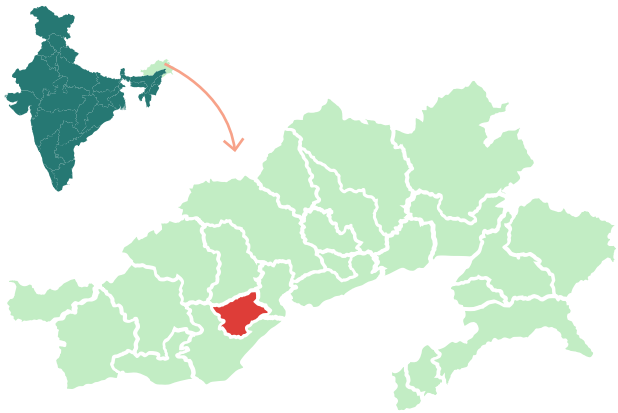
Lower Subansiri District

Population: 82839 (2011)

State: Arunachal Pradesh

Language: Apatani, Nyishi

Headquarters: Ziro



Juggling between the hospital and the Sub-centre

At the General Hospital, Pakha works as a General Nursing and Midwife (GNM) in the Obstetrics and Gynecology (OB-GYN) ward and the blood bank. She also works as an ANM at the sub-centre allocated to her, and provides ante-natal care, family planning services, and immunisation. She has had to juggle both responsibilities with COVID-19 work too. Performing diverse roles make her feel like “a multi-purpose worker”. She and other ANMs, who also double up as GNMs, have shared their distress with relevant authorities several times, requesting to be posted only in sub-centres as ANMs. While their concerns are acknowledged, Pakha and her colleagues have been told there is a shortage of GNM personnel.

Pakha recounted an instance when work demands were simply too difficult to manage. *"I had already reached the hospital and reported for duty at the OB-GYN ward. I was then told about the survey duty for COVID-19. I told the matron that either I am given duty at the hospital or the survey duty. How could I have left the ward and gone? That day I did my ward duty, returned home for lunch, and then stepped out again for survey work. From the next day, I went directly for the survey duty".*

Navigating COVID-19 tasks

In the initial days of the pandemic, Subansiri District was not affected by COVID-19 and Pakha continued to be on hospital duty. In August-September, the district got its first few cases. Pakha said this was probably because of people travelling to Itanagar, the state capital, where they would likely have been infected. While several parts of the country were grappling with migrants trudging back to their hometowns, Pakha said that people in her area do not migrate at all and hence, COVID-19 infections due to mobility is less.

When the pandemic began, a training was held for the hospital staff, but Pakha was on maternity leave then and could not attend. So, she asked her colleagues about COVID-19 and they advised her to look up the internet and reiterated the protocol of handwashing, physical distancing, wearing masks, the symptoms of the disease, and steps to be taken if symptoms are seen. On the personal front, maintaining protective measures took on additional significance as Pakha has a small child, and she worries about him. When she returns home from COVID-19 work, she ensures she bathes and washes her clothes before going near the child. *"One has to take utmost precautions with a small child at home; what else can we do?"*

She was given COVID-19 survey duty in containment zones once a few cases were reported in September. Unlike health workers in other parts of India, Pakha got masks, gloves and sanitisers for the survey visits. *"For the survey, four of us went to the containment zones– ASHA, ANM, Female Attendant, and a Doctor. We went to check for symptoms, testing, and tracing primary and secondary contacts." She adds that the five ASHAs she works with are "very good, enthusiastic, and cooperative."*

Undertaking the survey and communicating COVID-19 protocol were not easy. During the survey, while some people cooperated, others did not. They categorically dismissed them—*"This corona and all is nonsense; don't bother us."* Pakha said such reactions from community members were dealt with patience. *"We reminded them that COVID-19 could be risky for their children, relatives, and family members with co-morbidities. It is not just about themselves, but also their own family members, and they must hear us out."*

Being an ANM

Pakha shared that she preferred to work as an ANM and not juggle between multiple roles. *"I like work that is related to maternal and child health—contraceptive counselling, ante-natal care, immunisations. As an ANM, we used to do population enumeration in the communities– total population, eligible couples for family planning, registration of pregnancies, antenatal check-ups, immunisation and making micro-plans with the ASHAs and sharing those with the authorities,"* says Pakha. She hopes that the promise of filling up the GNM vacancies by the higher authorities is met soon and she continues to work as an ANM. *"I wish to be attached to a sub-centre. This will help me stay focused and not have to continually shift between being a GNM and an ANM,"* she says.

“We do our work but unless people agree to get treatment it is of no use.”

Challenges of convincing people to trust

Suchana is an ASHA for two villages in Jalaun District in Uttar Pradesh. She has completed her matriculation, and lives with her husband, five children and parents-in-law. Her husband is a school teacher, with a degree in Education. Since the pandemic, Suchana has not received her monthly honorariums, but has been working longer hours. Her husband is unhappy about her doing this work since the income is quite low. With the partial suspension of basic health and transport services, she has struggled to provide timely healthcare and address fears and rumours in the community about the pandemic.

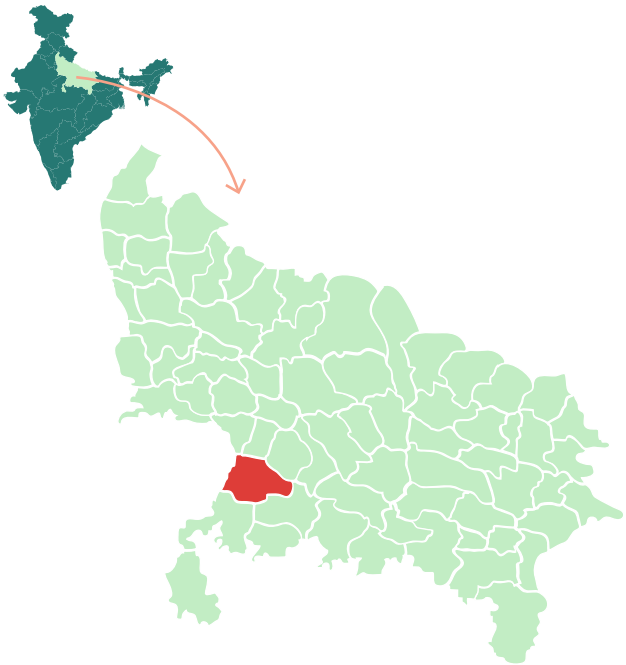
Jalaun District

Population: 1,670,718 (2011)

State: Uttar Pradesh

Language: Hindi, Urdu

Headquarters: Orai



Suspicion about ASHA workers

People have become suspicious of ASHA workers, said Suchana. This is because, she explained, ASHAs write down the respondent’s names during surveys done for contact tracing, note down COVID-19 symptoms, and identify high-risk individuals. She visits each house daily in the villages for this survey, and also accompanies people for testing and quarantining where needed. However, continual surveys have resulted in animosity against ASHAs and people even hide their symptoms.

"I face a lot of problems. People are fearful, and keep asking us why we are writing their names and whether this will cause any issues. They refuse to tell their names, and we have to make multiple visits. They say 'Don't give my name. I won't go to get tested'. People also refuse routine immunisation services for their children as they think this would give them a fever, it will hurt them, or the child will get sick. We have to explain many times that it will not hurt. I assure them that the ANM will give medicines in case any child develops a fever."

Providing timely health service

Even though there aren't many COVID-19 positive cases in Suchana's area, and few major ailments even otherwise, there are minor illnesses that occur regularly that need attention. Due to the suspension of public transport during the national lockdown, ill-equipped primary health centres, and no private clinics, people found it difficult to get treatment for common fevers and injuries. Ambulances were available only in emergencies for pregnant women. To avoid queues at the district hospitals, people often ignored their ill-health or dealt with it in their own way. *"They say, 'Who will travel that far to the hospital to get checked?' They have to cross villages and rivers to reach the hospital. The nearest hospital is about 5 km away. There is no transport from here so people have to go walking and the thought of long queues itself is discouraging. They think it is useless to go to the hospital because they fear getting infected in the hospital. We do our routine work but unless people agree to get treatment it is of no use."*

Suchana tries her best to do routine health work during the pandemic, ensuring she ties a clean cloth over her nose and mouth while on duty. She visits the households in the village daily, and alerts everyone to the menace of dengue as it is the monsoon season. She reminds the villagers about keeping drinking water clean, using mosquito nets and being alert to symptoms of ailments. She also ensures maternal health services, especially institutional deliveries, are not hampered. This is in addition to reiterating the COVID-19 precautions on physical distancing and hand-washing frequently, particularly before and after meals, based on the communication instructions about the pandemic from the Health Department.

‘We work but less economic incentive indeed is a concern’

Suchana said juggling household work alongside her ASHA duties does not bother her as much as the absence of economic incentives. The missing honorariums are a problem and often demotivating. *“I wake up at 3 am, start cooking at 4 am, and then leave for field work. If I leave at 8 am, I am back by 1 pm. Sometimes I leave later and return home by 4 pm. I do not have problems with the work but what we get in terms of the economic incentive is so less. I get Rs. 2000 a month and that is quite low. Even my own expenses are not covered in that amount. We work hard and I have no problem working but less economic incentive is indeed a concern”* She said that her ASHA colleagues from other villages too have the same concerns.

“I am helpless. I can’t do anything. On the one hand, people are not getting much needed healthcare, while on the other hand, we are not getting our monetary incentives.”

Working on the borderline of exhaustion, risk, distrust and no pay

Aziya is a 20-year-old ASHA at Kishanganj district in Bihar, overseeing a Muslim-majority population of about 1300 near the Indo-Nepal border. She completed her matriculation from a private school in Nepal, and started working as an ASHA in 2018. She was married off when she turned 15 and has two children. During the lockdown, Aziya was posted for COVID-19 duty at the border to monitor migrants crossing over from Nepal. She undertook this work alongside monitoring and providing routine services in her own village. She recounts her experiences during the pandemic, highlighting the dangerous working conditions faced by frontline workers, community distrust, and delay in honorarium payments.

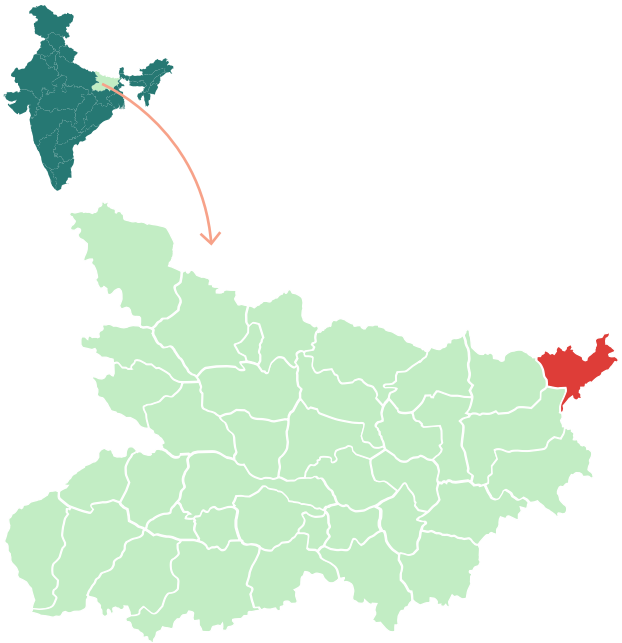
Kishanganj District

Population: 1,690,948 (2011)

State: Bihar

Language: Maithili, Hindi

Headquarters: Kishanganj



Working on the border

Aziya came to know about COVID-19 when ASHAs were called for a meeting at the Indo-Nepal border with block officials. The ASHAs were supposed to test people entering Bihar and, if required, restrict them. The duty was for 15 days and ASHAs had to visit twice a day for a few hours. However, as there was no public transport, Aziya walked more than two hours each day as it took an hour to reach the border from her village. For two to three days, she was given lunch at the border; but after that, she had to go home for lunch and travel back for duty every day.

Initially, the ASHAs did not have thermal testing machines. Even when it was available, it was accessible only for a few hours. So they checked whoever they could within that time. *"With the help of a testing machine, we checked and recorded the temperature of more than 1000 people in 15 days. Although there were many migrants at the border, the people who sent us the thermal testing machines took it away after two to three hours. Had the machine been available to us for more time, we would have checked more than 5000 people."*

Working in close proximity with migrants had Aziya and other ASHAs worried. Two ASHAs from nearby villages had tested positive for the coronavirus along with some villagers. On August 13— celebrated as ASHA Day, all ASHAs were supposed to be checked for COVID-19. However, no one was tested.

Community distrust

Besides her work at the border, Aziya was also involved in door-to-door visits in her community for surveys. She also maintained and tracked test reports of migrant workers returning to the village. Such kind of work involved monitoring people, which led to resentment among villagers who considered Aziya with suspicion and distrust.

"The villagers were not supportive. When I would make home visits, they would shoo me away saying 'All this is nonsense, there is no disease in the house. These are gimmicks of powerful politicians to harass us and you are supporting these politicians.' They refused the presence of disease in their area. Many people would not reveal they were migrant workers who had returned home to the village. When I tracked and visited their house for the survey, those migrants came to my home, furious that I had collected their information and fought with me."

This distrust also spilt over to routine services such as immunisation. People accused Aziya of putting their children in danger.

"When I would go for vaccination drives, people would challenge me saying I would kill their child by injecting poison. I would negotiate with them saying I would kill myself first before the death of their children, if anything negative were to happen. The doctor at the Primary Health Center doctor also came to explain things to them. It took a lot of effort to win the trust of people."

Delayed care, delayed payments

When the national lockdown began, regular health services in Aziya's area came to a halt; moreover, she didn't get monetary incentives for immunisation and institutional child deliveries. Immunisations didn't take place in April and May and antenatal checkups for pregnant women were also suspended. Aziya recalls how the lockdown and the pandemic affected maternal and childcare services: *"Only child deliveries were being conducted in a Primary Health Center in another block. However, the fear of contracting COVID-19 made women reluctant to go to the hospital for childbirth. In one village, an infant died after 30 days of birth from fever and cold. The mother did not recognise the symptoms, and since health checkups were not taking place during the lockdown, it was not detected; it was too late for the mother who could not take the child to the hospital on time. Even distribution of family planning items such as condoms and information about vaccinations was affected as we could not meet women privately in their homes or even during the village health and nutrition days."*

Before the pandemic, Aziya earned about Rs. 4000 to Rs. 5000 but post the lockdown even after some activities resumed gradually, she was only paid Rs. 2000 and some additional incentives. Moreover, she did not receive payments from April till July but was expected to report for duty. In August, the ASHA union decided to strike to demand pending payments—due for four to five months, incentives for work on the border, and for a reduction in workload during COVID-19.

Working while facing flak and hostility from villagers and without much back-up support from the Health Department often left Aziya exhausted. To add insult to her exhaustion, the ASHAs were working without pay. *"I am helpless. I can't do anything. On the one hand, people are not getting much-needed healthcare, while on the other hand, we are not getting our monetary incentives."*

“Had we been given PPE kits, our work would have been much safer.”

Managing risk, migrants, and increased workload.

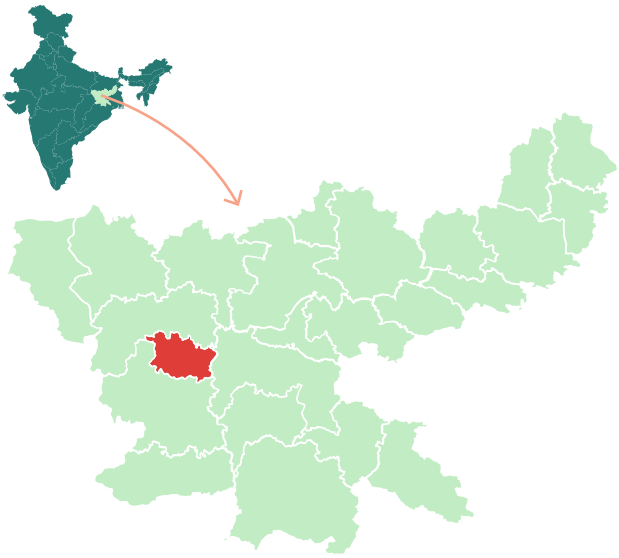
Kavita has been working since 2005 as an ANM at a sub-centre in Lohardaga District of Jharkhand. She was a contract worker for nine years before being made a permanent employee in 2015. She serves three Gram Panchayats that have seven Anganwadi centres and a population of 5900. Two ANMs are posted at this sub-centre but now the second ANM is on maternity leave, and Kavita has to manage by herself. Kavita lives at the sub-centre itself, 30 kilometres away from her home to provide services to her location, and visits her family on weekends. Since Jharkhand is a migrant region, Kavita and other frontline health staff had to deal with migrants returning during the lockdown. With inadequate support from the health department, Kavita explains how she managed the increased workload and risk of infection.

Lohardaga District

Population: 461,738 (2011)

State: Jharkhand

Language: Santhali, Hindi

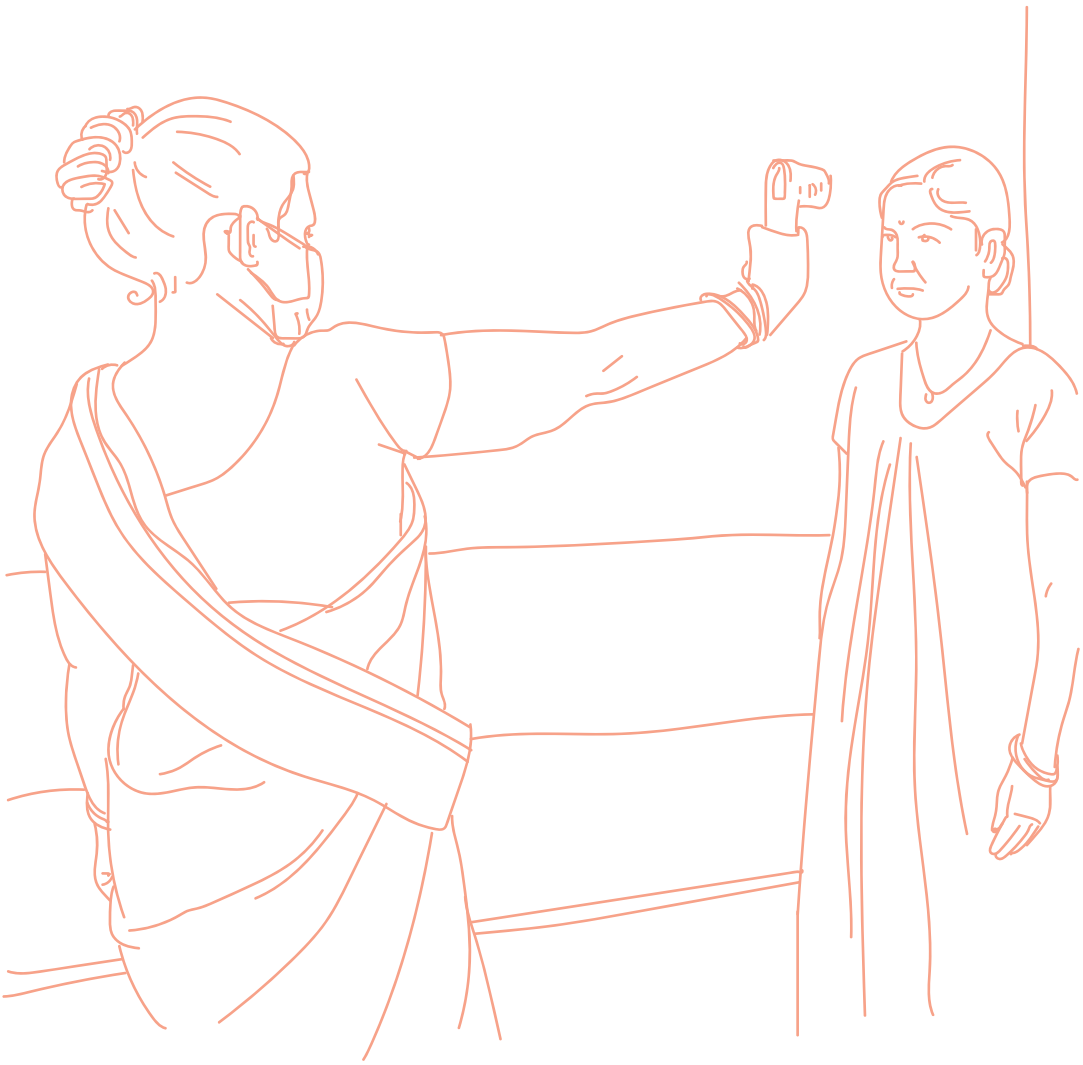


Dealing with migrants and physical distancing

During the lockdown, many migrants returned to Lohardaga from Maharashtra, Bihar, Tamil Nadu and Gujarat. These workers were tested at the district and then quarantined in their home villages. Kavita conducted surveys of home-coming migrants, recorded their travel history, and educated them about the use of masks and sanitisers. At times, she has

had to make night visits to provide healthcare services to people in quarantine centres. Kavita also made visits to those who were home quarantined to check on their health. The disruption in public transport added to Kavita's challenges in making these visits. Due to lack of adequate quarantine facilities in villages, people were quarantined in poultry farms, panchayat buildings, and schools, with men and women being kept separately. These quarantine centres often did not have adequate toilet and bathroom facilities, forcing people to walk to distant spaces for open defecation, explained Kavita.

The biggest challenge she faces is ensuring people follow physical distancing norms as many people do not pay heed despite repeated reminders. Kavita recalled an instance where she had to take action: *"A person who returned from Mumbai was put under home quarantine. Even after several requests to maintain physical distancing, he kept roaming in the village during his quarantine period. One day, he secretly went for dinner to his relative's place. Finally, I had to complain about him to higher authorities and he was taken into custody along with his host."*



Difficulties in resuming routine work

Kavita said Out-patient services were affected as the health staff stopped coming to the sub-centre. Even contraceptive health services were stopped as the focus shifted to COVID-19 care. The Mamta Vahan service (free ambulance facility for pregnant women) was disrupted too, and women had to make their own arrangements to reach health facilities when they went into labour. Resuming immunisation services was challenging as people were scared and mothers refused to step out for vaccinations, fearing COVID-19 infection. To allay fears, Kavita held special meetings to explain the benefits of routine immunisation for children and how it would not infect them.

Though Kavita had the support of the six Sahiyas [ASHAs] who work with her, Panchayat members, Block Programme Manager and other ANMs to monitor and test returning migrants, she faced strong resistance from those who did not pay heed to the seriousness of the pandemic. People had other grave concerns such as unemployment; the landless were greatly distressed too. It was difficult to make villagers maintain physical distancing when finding work and earning money to run their family was on their mind.

Managing risk and vulnerabilities

It is challenging to work during a pandemic in a region seeing strong migrant inflow. The absence of an established relationship between returning migrants and frontline health workers hampers trust-building. At the same time, the non-availability of safety equipment lowers the confidence of health workers to withstand the pressures of a crisis.

ANMs did not have adequate protective gear or safety equipment to deal with the many migrants returning from places marked Red Zones during the pandemic. This heightened vulnerabilities, and exacerbated risks as ANMs were also providing routine healthcare services like immunisations and handling child deliveries. The lack of public transport posed its own challenges.

Kavita said, *"When migrant labourers started returning home, I was scared as I was not given any safety equipment from the government. I had to purchase a sanitiser for myself. Only a few days ago, I received some gloves and masks, which I am using during child deliveries. Had we been given PPE kits from the beginning, our work would have been much safer."*

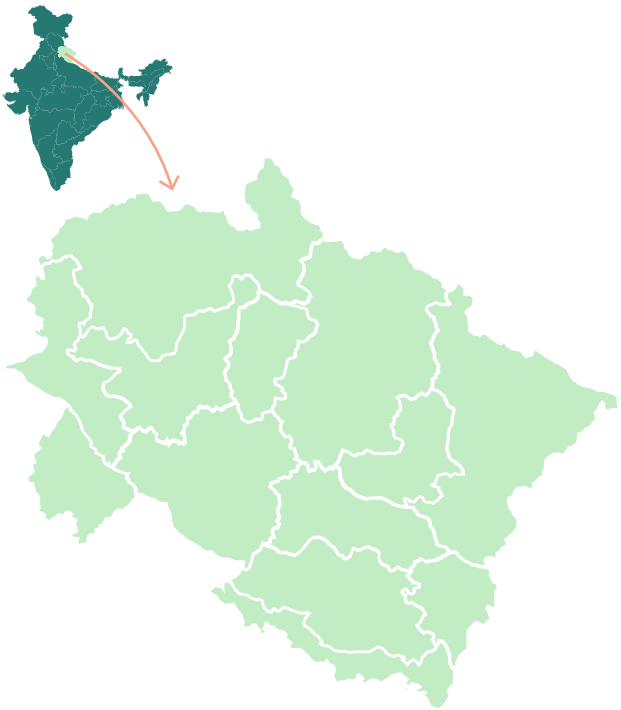
“The biggest gap in the ASHA programme is the rhetoric that ASHA workers are everything.”

Reflections of a Block ASHA Program Coordinator during the COVID-19 Pandemic

Gautam has been a Block Coordinator of the ASHA programme in Uttarakhand since 2009. Previously, he worked at an NGO in the same district. His assigned block is located on difficult hilly terrain on the border with China, making travelling to field sites a challenge. The block is about 129 km from district headquarters, i.e. about four hours away. The village in the block farthest from headquarters is about 55 km away, and it takes four days to reach there on foot.

As Block Coordinator, Gautam is responsible for the capacity and leadership development of ASHAs, coordinating and supporting field work, monitoring and supervision of community health programmes, national health programmes, documentation, i.e., updating population data and the monthly health action plan of the Village Health, Sanitation and Nutrition Committees for each village with the support of ASHAs, among other tasks. He walks 10 km daily for work.

Gautam supervises 116 ASHA workers and seven ASHA facilitators, who work across 21 Sub-Health Centres, two Primary Health Centres, and one Community Health Centre, providing health services to a population of 50,000 in the block.



Preparing oneself and ASHAs for COVID-19

Gautam came to know about COVID-19 from television news. Initially, he believed that the coronavirus was largely present in foreign countries and India would not be affected. Hence, he said, he was unaware of COVID-19 and its symptoms. He became better informed through the training at the Health Department, and gradually trained the ASHAs in his block.

Gautam said it was a challenge to convince ASHAs to work when the lockdown was announced. *"Initially, ASHAs were scared to work. They would not step out of their homes. I explained to the ASHAs the danger the virus poses for the country and the need and importance of ASHAs at this critical time to protect people. I motivated them to come to the front and fight the virus. At that phase, there were no protective resources available for ASHAs such as masks and sanitisers; many people didn't even know what a sanitiser was."* The role of the ASHA is critical during this pandemic, said Gautam, as they are working on the frontlines, with the community, including at quarantine centres. In the first phase of the lockdown, Gautam and his team surveyed 3645 migrants, who returned home from outside the block and were quarantined. The second round against COVID-19 involved thermal screening wherein he, the ASHAs and the medical team screened all the people quarantined—either in their homes or at designated locations. In the third phase, a block-level survey was held to identify persons exhibiting COVID-19 symptoms.

Poor salaries and low motivation

According to Gautam, the National Health Mission has prepared a Community Process Guideline and finalised monthly salary for Block Coordinators at Rs. 38,800 and for ASHA Facilitators at Rs. 22,000. However, this has not been implemented in many states, including Uttarakhand. Block Coordinators are paid only Rs. 9,000 per month.

"The ASHAs are paid poorly," said Gautam. *"They get Rs. 2000 per month and additional task-based incentives. The ASHA facilitator gets Rs. 350 per visit and she can do a maximum of 20 visits per month. The Government should think about them too and give a fixed monthly honorarium at least."*

Irregular payments to these frontline health workers deeply affect their motivation to keep working. The inadequate pay does not even cover costs incurred during fieldwork. However, they continue to work despite the risk and inefficiencies of the health system. Moreover, even though the ASHA programme is the largest network of grassroots health workers, they don't have enough influence to dialogue with the authorities, said Gautam.

"Even if they try to come forward, they are suppressed by officials who threaten to sack them. So due to the fear of losing their job, nobody comes forward or raises their voice against the exploitation."

The extent of work involved in planning and supervising the ASHA programme is grossly underestimated and considered unimportant, said Gautam. Block Coordinators also plan and implement various disease prevention programmes through the ASHAs, as part of the National Health Mission (NHM); this often requires detailed and varied methods of monitoring and planning. However, their contribution is often overlooked.
"Although I get my salary on time, I feel ashamed to tell anyone my salary," said Gautam. *"Our salary in comparison to our work is just exploitation. Besides the ASHA programme, we implement other NHM programmes as well. But the NHM has cheated us. By the end of the month, we are already indebted to the shopkeeper, milkman, and landlord till we get the next month's salary."*

Gautam said there was neither motivation for health workers to keep doing their work during such difficult times, nor was there any effort to better their working conditions. *"The entire burden of work is on us, i.e. the Block Coordinator, ASHA Facilitator, and ASHA. If any programme is a success, the leaders and Health Department say, "Hamaari ASHA (Our ASHA)." But if there is any failure, the authorities, including medical officials, blame me because I look after the ASHA programme. It feels like we are being tortured by the State government. I don't fear working hard but working in very odd circumstances with no one to take care of us. Block coordinators as they are in charge of a broad area have more travel and lodging expenses. However, none of the incentives and insurance schemes given to others during the pandemic apply to us. If a Block Coordinator dies working on the frontline, nobody is going to take care of his family."*

Creating a support system for ASHAs

Block Coordinators have had to ensure ASHAs are mentally prepared to work with communities at the grassroots during the pandemic. Gautam explained, that as a Block Coordinator, he reminds himself that an ASHA worker is also a woman working at the frontline, who may not be receiving the support of her family or the village community. Mere training or technical skill building is not enough, he asserted.

Gautam said that there had been an undue and unfair systemic emphasis on activities ASHAs need to do without adequately considering their actual working conditions. This is a disservice to ASHAs as well as the health system. Political gimmicks of acknowledging and rewarding ASHAs without creating a better working environment or even a support system for ASHAs is counter-productive, said Gautam.

"Being a woman and working on the frontline involves many hurdles. As a Block Coordinator, I visit ASHAs to support and help them work with village authorities. I even visit their homes to convince their family members to encourage them. The biggest gap in the ASHA programme is the rhetoric that "ASHA workers are everything." We have to understand that an ASHA is like a delicate bel (creeper), which cannot sustain itself. The government has ignored Block Coordinators and ASHA Facilitators who play that supportive role towards ASHAs. The harsh truth they forget is that ASHA is a woman, often not so very educated and belongs to a normal family. She is an ordinary daughter-in-law or daughter of a village."

During the pandemic, some ASHAs stopped doing surveillance activities and surveys and demanded pay hikes. Of the 116 ASHAs in the block, almost 50 per cent went on strike while the rest continued to work. Instead of resolving the issues, Gautam, as Block Coordinator, was forced by higher-ups to call in medical staff, ANMs and members of VHSNCs to complete the tasks of ASHA workers.

Systematic De-skilling

The increased focus on task-based incentives and achieving targets does not build any skill in health workers, said Gautam. ASHAs end up as a labour resource, merely used for piling on or shifting onerous tasks without considering if they are capable or trained for it. Due to this, there is also immense pressure on ASHA Facilitators and Block Coordinators to ensure that ASHAs who feel ill-equipped and under-trained don't lose motivation.

"Ideally, refresher training should be given to ASHA workers at regular intervals and especially during COVID-19. There should be an education programme for ASHAs too, as many of them are illiterate and lack the capacity to carry out designated tasks with ease. Many times, the criteria for selecting ASHAs are compromised as nobody expected that ASHAs would be given so many responsibilities," said Gautam.

He said that health workers keep working for years without a safe space for raising issues. *"ASHAs get their honorarium in intervals after many months but their work targets can never be delayed. Naturally, they are demotivated. It takes so much effort by the Block Coordinator and ASHA Facilitator to ensure that the targets are achieved. Often, we are at the receiving end of the anger and frustration of ASHAs as they cannot express their resentment to any official in the Health Department."*

Gautam said that health workers keep on working for years without a space for raising issues and continue to perform tasks in the hope that things will get better. However, not only is the work economically unrewarding, it also does not upgrade their knowledge or add to their skillsets.

"I am 40, and have given my precious time to this work. I feel totally vulnerable at the hands of the government," said Gautam. *"I feel helpless as I cannot move to another job as no one would appoint me based on this experience of managing the ASHA programme."*

“Ever since ASHAs have been working in villages, there are no health problems.”

Acknowledging the interdependence among frontline health workers

Praveena works as an ANM, and lives with her husband in Jalaun District in Uttar Pradesh. She has been working as an ANM for the past 30 years, and there are six villages under her jurisdiction. After the national lockdown was announced, Praveena said ANMs and ASHAs were called to the Block office and were explained the details about COVID-19. They received training for a few hours where they were instructed to advise people to maintain a distance, wash hands, use masks, and also follow these guidelines themselves.

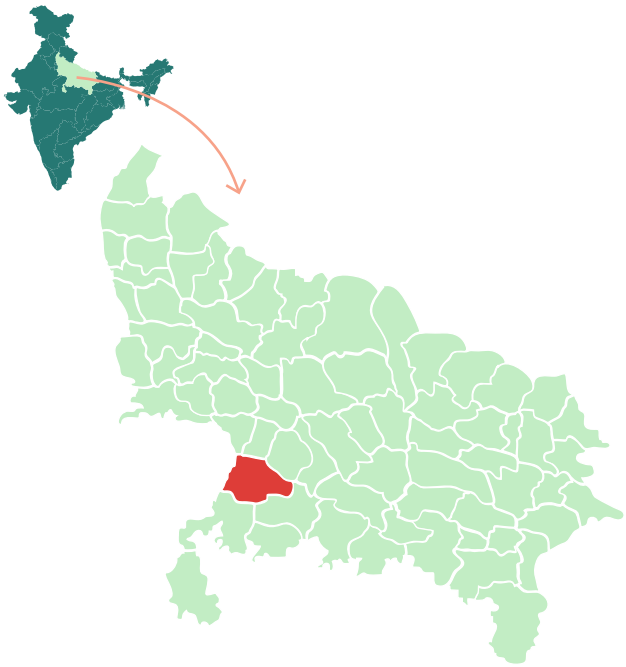
Jalaun District

Population: 1,670,718 (2011)

State: Uttar Pradesh

Language: Hindi, Urdu

Headquarters: Orai



Working with the ASHAs

Praveena works closely with the team of ASHAs for the six villages she supervises, and asserted that ASHAs are the backbone of community health. *“Ever since ASHA workers have been working in villages, there are no health problems. ASHAs are responsible for a whole load of work. They take care of pregnant women, take them for delivery, check on*

the mother's health and child health, monitor their immunisation and do surveys. This is done alongside eye illnesses, tuberculosis, and leprosy vaccine work. Problems arise only when ASHA are unable to come to work."

Initially, both Praveena and the ASHAs were unable to travel to the field during the national lockdown. However, they slowly managed to resume routine services in May 2020 and do COVID-19 surveys too.

Dealing with fear and distrust in the community

Praveena recalled much fear and distrust within the community when health workers disseminated information or even facilitated enforcing COVID-19 protection measures. Community members were scared of being tested and quarantined, and health workers were perceived to be spreading the infection. *"During surveys, if people had symptoms such as a cough and fever, they were hesitant to tell us because we would ask them to get quarantined or tested. They would also argue and verbally abuse us. Initially, there was a lot of fear and distrust but they gradually understood that testing is important."*

Routine immunisations were the first to be hit by the widespread community fear. Praveena recalled how routine instances of children getting fever post-immunisation were perceived to be a COVID-19 symptom. Consequently, the ANM was at the receiving end of people's anger. *"A child in a village got fever after immunisation; So the family was scared. We repeatedly spoke to them and explained why such immunisation was necessary, only then were they convinced and agreed. These fears were not there before COVID-19; it is only after COVID-19 that any sign of a fever creates panic."*

While Praveena knew the general importance of hygiene and sanitation, COVID-19 made it a critical measure for protection and prevention. She said, *"Washing hands and sanitising everything has now become an everyday routine."*

“People are important but we have needs too.”

Working in difficult terrains on delayed payments

Pooja has been an ASHA worker in Pithoragarh District of Uttarakhand since 2010. She is 54 years old, and has completed her matriculation. Her two daughters are married and she lives with her son and husband. She provides health services to a small population of 245, with most families in the village belonging to the upper castes. In the hilly terrains of Uttarakhand, the impact of the COVID-19 national lockdown was felt quite differently, she said. Besides having poor transport facilities, houses in the area are far apart and secluded. The nearest sub-centre is two km away from her village while the primary health centre is about eight km away. The nearest referral community health centre does not have enough staff, so she accompanies pregnant women to another community health centre, about 35 km away for delivery. Consequently, the lockdown accentuated the isolation, making access to health even more difficult for the community. Pooja recalled the challenges of working in such difficult terrain during the pandemic.

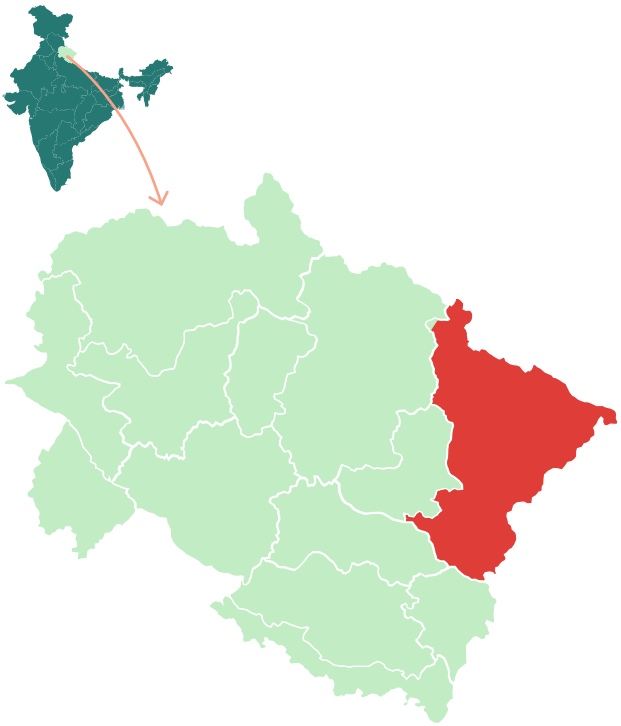
Pithoragarh District

Population: 485,993 (2011)

State: Uttarakhand

Language: Hindi, Kumauni

Headquarters: Pithoragarh



COVID-19 and routine duties

Pooja became aware of COVID-19 at a gram panchayat meeting. She was informed about the 14-day quarantine for migrants returning to the village, and to ensure villagers wash hands and wear masks. Pooja said she did all the assigned COVID-19 tasks alongside her routine ASHA duties. She urged villagers to make their own masks. Several people were returning home to the village from different states, and it was her responsibility to ensure they were quarantined and their symptoms monitored. Thus far, there have been no critical cases. However, if anybody displayed symptoms, the person has to get tested at the Primary Health Centre. If found infected, they have to go to the district hospital, about 125 km away. With no regular transport available, reaching the plains was difficult. For institutional childbirths, only 108 ambulances and mini-autos were available to reach the district hospital.

Pooja said creative thinking is necessary to ensure routine health services continue. She recalled, *"Initially when ANC, PNC, and baithaks (group meetings) were stopped, we started monitoring and counselling women over the phone. If anybody was sick, they would call or I would call them. Instead of doing separate meetings for women and children, I called for regular village meetings in clusters to talk to everyone and give all the information while maintaining the physical distance. This took longer than earlier but it is the only way to ensure routine services are not affected by COVID-19 norms."*

However, she has not been successful in facilitating care for common illnesses such as fever and typhoid as she does not have the medical supplies for these conditions. The medicine stock at the primary health centre is limited, with no medicines for diarrhoea or other common illnesses. *"Older people, in particular, keep complaining about backache, fever, and headaches. These body pains are always there but we don't have any medication for them."*

Dealing with migrants and delayed payments

After the first lockdown ended in May 2020, many migrants returned to villages in Pooja's Block. Some of them would reach the village after 10 pm. This meant she had to be vigilant round the clock to quarantine them as soon as they came. Such monitoring at night was difficult. Her husband was supportive and accompanied her in such cases. She also found it difficult to convince people to quarantine themselves. *"Sometimes people don't understand or listen to us. They answer rudely when we insist on quarantine. They do not want to go anywhere for quarantine once they have reached home. Initially, we kept people in government quarantine centres. Now, if there are enough rooms at their home, we are asking people to home quarantine."*

Pooja also explained how the COVID-19 situation has affected the livelihood of the community and her own economic situation due to delay in payments. *"People do not have enough money. Even I am facing problems with my home finances. I get paid Rs. 2000, and we get this once in seven to eight months. If we get a monthly payment of Rs. 2000 or even on alternate months, we can still live properly, and manage home and work expenses too. My last payment was received three months ago, in June."*

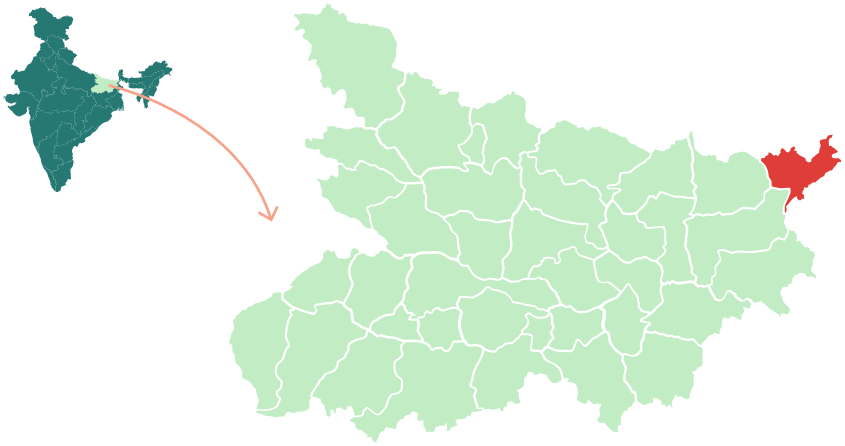
Earlier other cadres like Aaganwadi workers and teachers were also involved in surveys, but now only ASHAs do this. She recalled the ASHA strike in her block during the pandemic. ASHAs have repeatedly been communicating their needs but have not received any response from higher authorities, she said. *"We have been doing our job and following all instructions. We cooperated with the system for everything. We listened to them when they said, 'People are everything—they are most important.' But we have our needs too."*

The absence of economic security bothers Pooja the most. She fears what would happen to her family if she falls ill while on duty. She suffers from lower back pain and knee aches, and feels insecure about her family's future. *"Forget increments, we should get our payments on time! Some of us have to leave our housework and do ASHA work. You can't stop working because you don't get paid. How will we eat if we just rely on ASHA payments for food and necessities? It is not possible to survive only on ASHA work. My husband runs a small hotel. My son is studying for his Class 10 exams. What will happen to our families if something happens to us?"*

“I have left myself in the hands of destiny.”

Navigating loneliness, emotional distress and apathy

Ruchi Devi has been working as an ANM since 2007 and is posted in the small remote district of Kishanganj in Bihar. Since the outbreak of the pandemic, it has become difficult for her to visit home, which is far from her posting. She is the sole bread earner for her husband and two sons. She has not met them in several months and misses having them around. Living away from her family, the continuous struggles of serving in communities during the COVID-19 pandemic, and dealing with the emotional turmoil of these uncertain times alone have been debilitating for her. Her experience is a reflection on staying calm amid chaos, building strong community support, staying motivated and resilient against all odds and fighting a system, which has overlooked the concerns of her cadre.

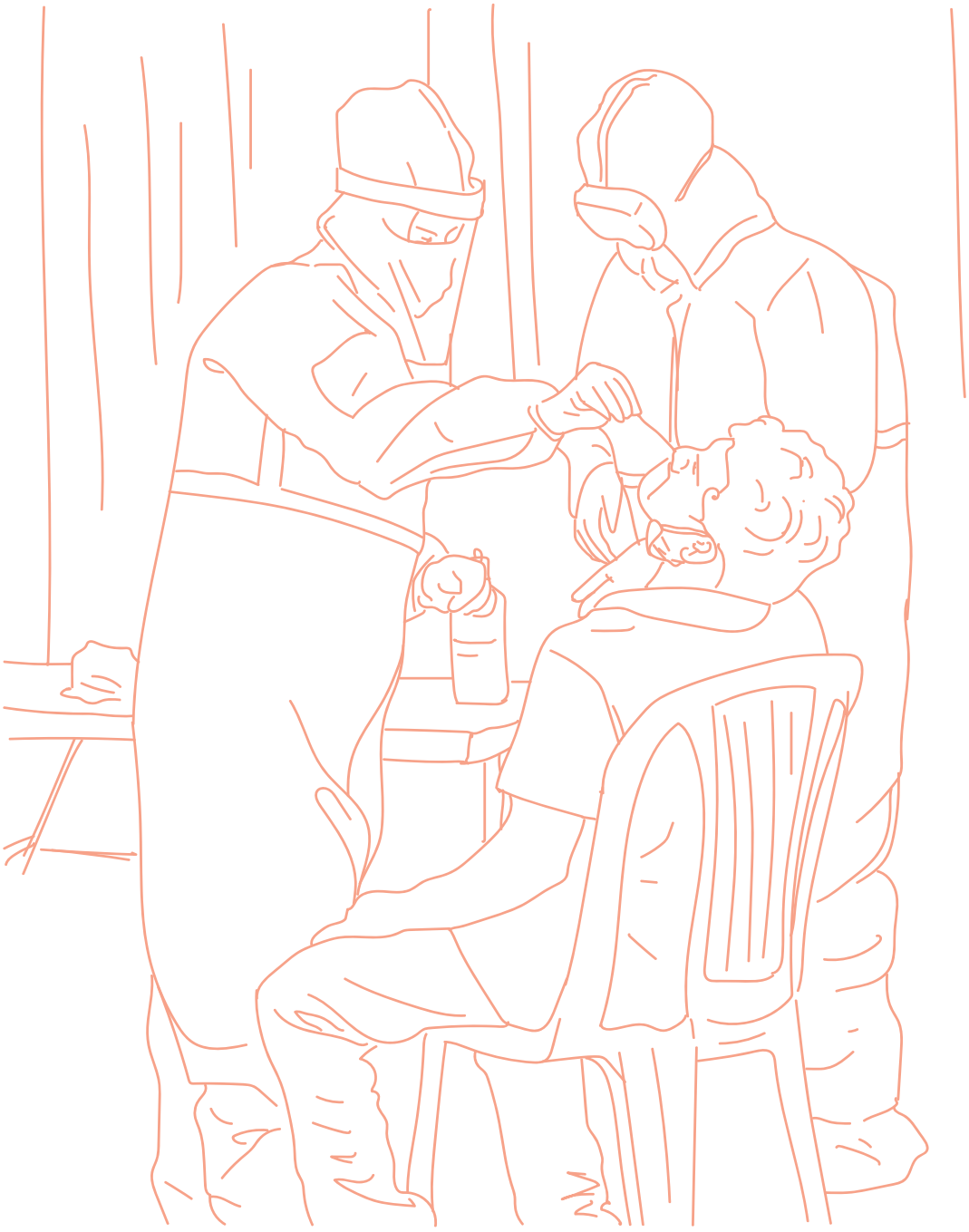


The struggle to provide care

Ruchi Devi provides health services to eight villages, and caters to a population of 10,000, comprising people from different castes and religious communities. She was posted here a few months after the onset of COVID-19, and is relatively a new face in the communities she is serving. The sub-centre where she is posted lacks the basic necessities of chairs, curtains, water supply, and electricity to function as a proper healthcare facility. The department’s new building has been constructed by the department, but it is quite far. The nearest Primary Health Centre (PHC) facility is 5 km away and the District Hospital is a further 100 km away, and takes up to three hours to reach. The distance affects the quality and timeliness of healthcare services in the area.

Overwhelmed and underpaid

Ruchi Devi said she had not been paid for the past six months. She said all 24 ANMs in the block had been deprived of timely payments. She and other healthcare workers have complained about this but their protests have been disregarded. The official response is 'there is no money in the salary account to make payments'. Ruchi said that, *"ANMs like me are only meant to follow orders; We are overworked and underpaid, and yet, we continue to save lives."* Block-level health officials do not visit field sites to provide support and guidance; however, ANMs and other workers are expected to work in the communities and put up a brave fight against COVID-19. Such unfair standards make her question if her life is valued by the health system at all.



Managing COVID-19 duties

While Ruchi Devi confesses to being worried about contracting the coronavirus, she is also pragmatic about it. *"If I get scared, how will I work? Being in the Health Department, we cannot afford to fear the disease. What has to happen will happen."*

She became aware of COVID-19 through the Primary Health Centre in March 2020, particularly the need to not disregard symptoms such as fever, cough and cold. In April and May, there were a significant number of visits by district authorities to her area, and they used thermal testing machines to check for fever, cough and cold. As part of her duty, she takes people with suspected symptoms to the Primary Health Centre for COVID-19 testing. She made door-to-door visits to identify symptoms, and asked families to maintain a physical distance, wear masks, and wash hands frequently. She also encouraged them to have hot turmeric milk, and a herbal decoction that included tulsi (basil).

Ruchi manages a team of six ASHAs who cover two villages each. She is responsible for briefing the ASHAs and shares all relevant information about the pandemic. Besides the ASHAs, Vikas Mitra (a community cadre created by the Scheduled Castes (SC) and Scheduled Tribes (ST) Welfare Department to link SC-ST families to government schemes) and Mukhiya (village head) helped her disseminate information about quarantine rules, precautionary measures, and in the distribution of sanitisers, masks and soaps in the area.

Enforcing COVID-19 precautionary measures has not been easy. Ruchi narrated an incident when she faced resistance from the community. *"On immunisation days, I ask villagers to follow social distancing norms. They respond by scolding me, saying 'We won't get the disease. If we get the disease, then why have you come here to vaccinate our children?'"* While ASHAs more often face these challenges, Ruchi explained that such resistance requires explaining the same information in greater detail, providing the necessary support to ASHAs for effective dissemination of information.

Living away from loved ones

Ruchi Devi works 500 km away from her home and family. She lives alone in a rented space at her work location. It has been more than a year since she has seen her family. This takes a toll on her mental and emotional health. Her previous posting was nearer to her home. She braves the loneliness saying, *"I do not fear anything as I have to work and have left myself in the hands of destiny."*

“I work with dedication to protect our people from COVID-19.”

Braving suspicion and stigma in a pandemic

Vithika works as a Mitanin Trainer in Kanker district, Chhattisgarh. She supervises 22 Mitanins in eight villages. She lives with her family comprising her husband, in-laws and two young children. She was working as a Mitanin from 2011, and became a Trainer in 2015. As a Mitanin Trainer, she conducts meetings with 22 Mitanins three times a month, maintains records and registers, pays home visits along with the Mitanins, distributes medicines, and assists in the implementation of district and block-level health programmes.

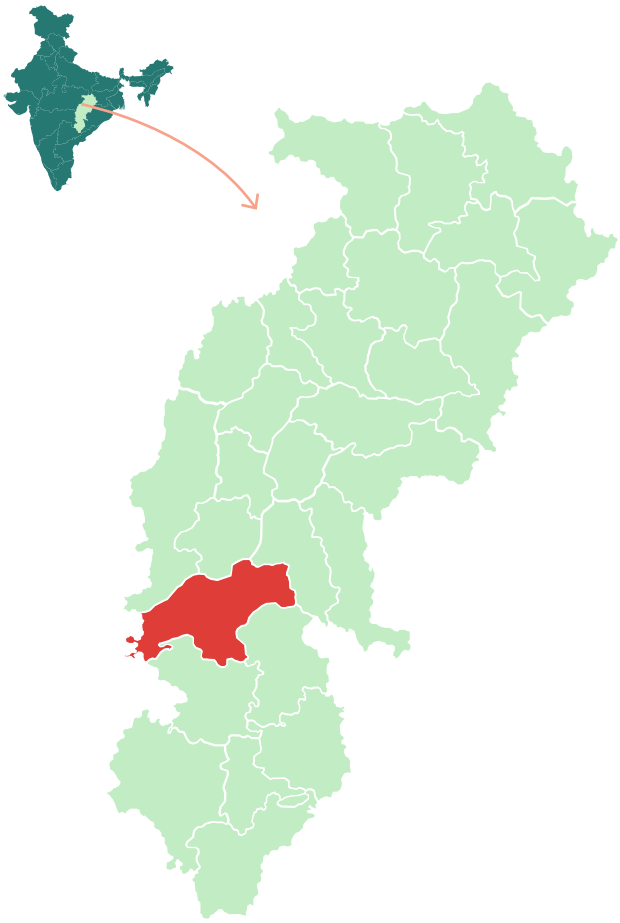
Kanker District

Population: 748,593 (2011)

State: Chhattisgarh

Language: Chhattisgarhi, Hindi

Headquarters: Kanker



Increasing workloads amid COVID-19

Vithika and other Mitanins were informed about the details of COVID-19, its symptoms and preventive measures at a block-level meeting organised by medical officers and other officials. Vithika then led information-dissemination meetings while observing the requisite precautions. She reduced the number of Mitanins per meeting and now meets up to six of them at a time. With the support of block-level health officials, the village panchayat, and a local NGO, she and other Mitanins received masks, sanitisers, and gloves, allowing them to work with ease. COVID-19 has added to her workload and now she writes awareness slogans about COVID-19 on walls and conducts door-to-door visits with Mitanins to advise about preventive measures.

Vithika also maintains a record of people coming to the village from different districts and states. The area has seen 58 migrant workers returning, of which 44 were kept in home quarantine and 14 in isolation centres. She makes door-to-door visits, particularly to those in home quarantine, to monitor their health status, and advise them to use masks and wash hands regularly. However, not everyone cooperates. She recalled an instance when villagers did not allow a migrant to be quarantined at home. Vithika had to arrange a quarantine facility in an ashram (spiritual hermitage) on the outskirts of the village and only after he completed his quarantine was he allowed to return to the village.

Struggle for basic health services

The COVID-19 outbreak has affected routine health services. Many child deliveries happened at home. Nutrition services such as hot cooked meals for children of ages three to six years at Aanganwadi centres (AWCs) were interrupted as the AWCs were shut. She negotiated with the Aanganwadi Worker (AWW) to provide the dry ration to parents of the children, which the AWW did. She said that 780 gm of rice, 520 gm of pulses, and 650 gm of wheat flour per child for a week were distributed. Other health services such as immunisations and family planning services were managed by controlling the number of beneficiaries per session and following precautionary measures.

Vithika said that she doesn't mind the extra work and understands the gravity of the situation. However, delayed payments and frequent hostile resistance from the community is demotivating. Despite her family members discouraging her from venturing out during the lockdown, Vithika convinced her family and continued with her work. She said, *"Everyone at home says, 'Why does she have to venture out and risk her life and that of family members?' But I have worked with dedication to protect our people from COVID-19."*

“Almost a decade has passed working as a contractual staff.”

The precarious situation of a contract health worker

Neena has been an ANM since 2011 at a sub-centre in Gumla District of Jharkhand, working on a contract with Rs. 12,000 as her salary. She lives with her family near the sub-centre. The building housing the sub-centre has no electricity or water supply, and is not fit for living purposes, she explained. Being a health worker on contract is repressive asthey do not have even the minimal voice in the health system that a permanent employee has.

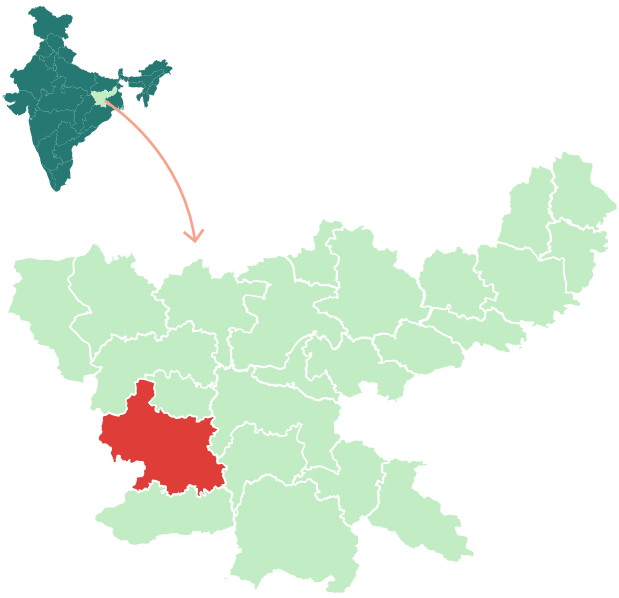
Gumla District

Population: 1,025,656 (2011)

State: Jharkhand

Language: Santhali, Hindi

Headquarters: Gumla



Low income, no benefits for contractual staff

Neena explained that the funds for maintaining the sub-centre under the National Rural Health Mission were reduced from Rs. 10,000 to Rs. 5000, forcing ANMs to incur maintenance costs from their own pocket. This expense is felt more deeply by contractual workers who are paid less than permanent ANMs but are expected to perform all tasks equally. Working in a space with poor infrastructure, low funds, on an even lower salary leaves Neena discouraged and unmotivated. Explaining her frustration, she said *“We have lived in poverty. Now our children will also live the same, even after me working for almost 10 years.”*

Before the COVID-19 outbreak, Neena had applied for a vacancy that would have regularised her contract but the pandemic has delayed everything. She says that the last regularisation of ANMs was done in Jharkhand around 1991. Only ANMs working on Reproductive and Child Health (RCH) have been regularised. She feels stuck and contemplates if she would ever become a permanent staffer, and whether it would make a difference. *"Even if the government regularises us now, what would we get? Almost a decade has passed working as a contractual staff."*

The employment status of ANMs has also determined whether their work received any acknowledgement or appreciation during the pandemic. While all permanent ANMs have been provided (or, in the least, promised) health insurance and additional incentives to work during COVID-19, contractual ANMs have not received any extra payment or social security benefit.

All work, no training during COVID-19

During the COVID-19 lockdown, Neena was relocated several times. She worked at the district level for 15 days, then at quarantine centres for 15 days, and was again reallocated to her sub-centre. She said contractual workers were subject to such reshuffling often, and she along with other contractual ANMs met the Civil Surgeon to address the matter. Now the duty of all ANMs is on a rotation basis.

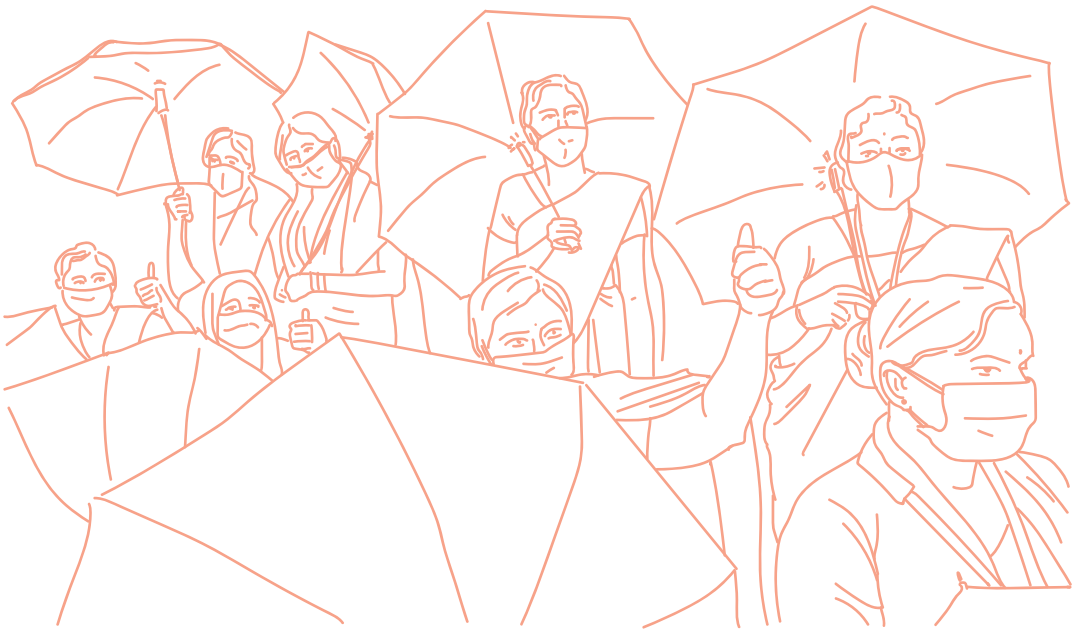
Neena has not received any training related to COVID-19. Only contractual ANMs who worked at the district level were given some training. Neena said she made herself aware of the pandemic through newspapers, television news, and social media. Although she was not formally trained, she was expected to perform all the regular tasks. Neena works from 10 am to 6 pm, performing multiple tasks including providing services at quarantine centres, counselling patients, ensuring social distancing norms are followed, monitoring migrants returning to villages, maintaining records and referring cases to hospitals besides her regular preventive, curative, and maternal and child health services.

Working under fear of infection and no safety gear

Neena said that the health department had not provided any safety gear such as masks or gloves, nor does she have enough sanitiser, and she feels scared when she goes to the village. She had to purchase her own masks and sanitisers for her work. She harks back to the concern of villagers being more worried about work and food arrangements than maintaining physical distancing. *"They don't have enough money to purchase soap. When I ask them to wash their hands with soap they chide me away saying 'Here we don't have enough to eat. How do we get soap?"*

During the national lockdown, outreach sessions such as the Village Health and Nutrition Days (VHNDs) were temporarily stopped. When they were resumed, women refused contact with health workers, fearing getting infected. When Neena finally managed to convince them to immunise their children, it was difficult to maintain physical distancing as sub-centres became crowded. Though she conducted all tasks using masks and sanitisers, she said that small sub-centres were inappropriate for such group immunisations. *"It was not possible to keep reminding them about maintaining physical distancing while simultaneously doing vaccinations at the peak of summer. It would have been good if all these services were provided at the district hospital during such a crisis to avoid any risks."*

It is sheer necessity and helplessness that keeps health workers like Neena going in the face of poor pay, non-existent infrastructure, and inadequate safety measures. The non-acknowledgement of their labours is demeaning and with the pandemic deepens this wound.



“We tolerate too many things. We have officials sitting on our head.”

Mediating between ASHAs, community and health authorities

Karuna is an ASHA Sanghini (Facilitator) for three Gram Panchayats in Azamgarh District, Uttar Pradesh. There are 20 ASHAs reporting to her, with each ASHA overlooking about 25 households. Karuna’s work involves helping and guiding the ASHAs to perform routine health tasks, COVID-19 surveys, and quarantine duties.

She said that given the amount of work and risks undertaken by ASHAs, they had not been given commensurate protective gear. The two masks initially given to them have worn out over the months, and Sanghinis have had to buy masks for their ASHA reportees with their own money. Karuna said that she felt sandwiched between the increasing pressure from the department to monitor people even with mildest symptoms and the reluctance of villagers to visit hospitals and tendency to self-medicate.

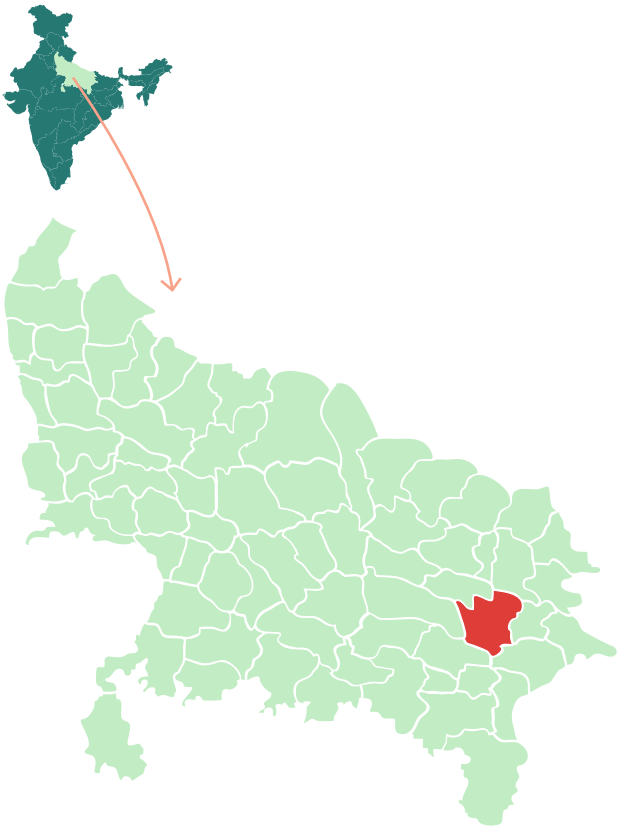
Azamgarh District

Population: 4,616,509 (2011)

State: Uttar Pradesh

Language: Hindi, Urdu

Headquarters: Azamgarh



Difficulties in routine work

A critical challenge faced by ASHAs during the pandemic is that they are unable to do home visits satisfactorily, and monitor babies and new mothers the way they would do earlier. Maintaining a physical distance prevents ASHAs and ASHA Facilitators from discussing reproductive health issues privately and freely with beneficiaries. *"We are working the same way we used to,"* said Karuna, *"but the problem is that we cannot visit, touch and check anyone anymore. We talk to them over the phone and ASHAs are telling everyone about COVID-19 precautionary measures. But we cannot communicate effectively about family planning. We are not able to tell mothers how to use protection and other details. We are hovering near their doors while talking to them."*

Karuna explained that ASHAs are unable to do activities such as Village Health and Nutrition baithaks (meetings) and immunization meetings during COVID-19 as public meetings are a health risk. Furthermore, as there are other COVID-19 related surveys and quarantine duties to be done, ASHAs are unable to conduct the required number of routine health meetings needed to meet their monthly targets, she said. Consequently, their incentives are being slashed. *"The ASHA is not able to conduct the number of the MCH (Maternal and Child Health)meetings, but the information that we give in these public meetings are shared by visiting each house. But even then ASHAs are not being given meeting-linked incentives. How can we complete the number of public meetings in a situation like this? In the online meeting, we raised this issue that our ASHAs are unpaid even after we send photos of every field visit on WhatsApp to our higher authorities."*

Sandwiched between community and authority

A major challenge for ASHAs and ASHA Facilitators during the COVID-19 pandemic has been tackling rumours, community fears, and distrust towards them. People are often scared to get tested and believe in hearsay. People with mild symptoms refused to go to the hospital. *"They do not want us to take them for a test and insist they will self-medicate and manage,"* said Karuna. Many people in the community believe that if someone tests positive for COVID-19, the person will surely die if admitted to a hospital.

Some incidents have also led to community distrust in public hospitals. An ASHA faced a lot of abuse because a patient died due to COVID-19. During the final cremation rites, his family found the corpse without eyes and with cuts all over the body. This scared people into believing that the hospitals were stealing organs and killing people under the guise of the coronavirus.

"The family members were told to not open the wrapping on the body as the person had been COVID-infected, and to directly perform the final rites. However, they insisted on a final look before taking the body to the cemetery. When they opened the covers, they saw that the body had been cut open. It seemed like a post-mortem had been performed. If the patient was COVID-positive, then how is that possible and how was it allowed? So now, people believe that those who are taken away to hospitals as suspect coronavirus cases end up like this. Now if ASHAs take anyone to the hospital and if they turn out to be a critical case or if anything happens to them, we become culprits in the eyes of the community. They will beat us up."

The ASHA facilitators have to continually build the confidence of ASHAs and help them explain to the community that not everyone who is found COVID-19 positive will be taken to the hospitals, and that they will be guided on how to quarantine at home. There have been instances wherein Karuna has had to help ease community tensions, and protect ASHAs from the anger and distrust of the villagers.

In one case, two days after an ANM completed a round of tetanus vaccinations, a pregnant woman started bleeding and had a miscarriage. The family blamed the ASHA who had accompanied the pregnant woman for the injections, and started to verbally abuse her. When this was reported and an intervention sought from the higher authorities, they in turn blamed the ASHAs and the ASHA Facilitator saying that such cases occur when information dissemination is poorly done, and they wholly held them responsible for the situation.

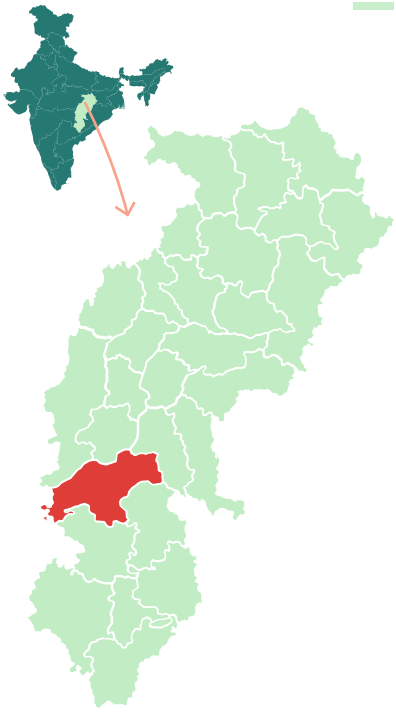
"They were all ready to beat up the ASHA. Other people around also tried to mollify the family. I also explained to the family over the phone and later again in-person because they were verbally abusing the ASHA at her home. We tolerate too many things. We have officials sitting on our head and people in the community; sometimes I don't know what to do. Higher authorities also blame us if we tell them these incidents. They tell these things happen because you are not giving enough/proper information."

Karuna said that such situations put a lot of mental strain on ASHAs. The ASHA Sanghinis too bear the strain of being responsible for the ASHAs as they turn to them for guidance. The cut in incentives and delay in payments has further demotivated them. Karuna said that the meagre incentives (Rs. 1000 for Facilitators and Rs. 500 for ASHAs) are not worth the effort and risks taken to arrange VHND meetings during a pandemic while facing hostility from village communities and apathy from the authorities.

“Now we don’t fear it.”

Overcoming stress, anxiety, fear and panic

Sunita has been a Mitanin in Kanker District of Chhattisgarh since 2014, serving a population of 303 in over 75 households in two hamlets. She is also part of the self-help groups in the block along with other Mitanins and Anganwadi workers (AWWs). Sunita lives with her husband and in-laws. Being a Mitanin, she prefers taking cases to hospital, attending the weekly Village Health and Nutrition Day (VHND) and immunisation sessions at the Anganwadi centre, and discussing various health and nutrition issues with Mitanins and Mitanin Trainers from the other Gram Panchayats at cluster meetings.



COVID-19 and routine work

Sunita heard about COVID-19 when the hamlets were visited by the Mitanin Trainer and Block Resource Person. They told her about the contagious nature of the virus and briefed her about the preventive measures. A pamphlet had been given to each Mitanin trainer about the symptoms and prevention of COVID-19, which helped Sunita and the other two Mitanins working in the village. *“It helped in writing COVID-19 awareness slogans on walls and in home visits,”* she said.

Apart from this information, no formal training took place. The Health Department provided two masks and a bottle of sanitiser; Sunita also received two masks from the Gram Panchayat.

Sunita’s work during the pandemic included writing awareness slogans on walls in the village and disseminating information on preventive measures. She also counsels people kept at a quarantine centre, set up in a local primary school. Four migrants returned to the hamlet and were isolated at the quarantine centre. They are looked after by Sunita along with the ANM and Panchayat functionaries.

Integrated networks: The Gram Panchayat and the health institutions

The Gram Panchayat ensured the distribution of masks in every household and also provided soap, masks, and sanitisers to vulnerable families in the village. During the lockdown, people followed the health advisory, stayed home, and procured vegetables from their fields and kitchen gardens. Sunita assisted in two childbirths by calling a 108 vehicle, and accompanied the pregnant women to the hospitals. She stayed with new mothers for three days.

Sunita also said the immunisation rounds stayed on track in the block, and all children were vaccinated on time. The pre-and post-natal check-ups also continued, family planning services were in place, and all pregnant women did regular checkups during the VHND. There was one vasectomy case from her area and she directed him to the local Community Health Centre for male sterilization. She said there was increased demand from the village women for contraception pills during the lockdown.

As serving children hot cooked meals at the AWCs was not possible during the lockdown, dry ration was delivered for children and pregnant women at their doorstep by the AWCs. The ration packets consisted of pulses, rice, soya chunks and potatoes for a month.

COVID-19 challenges: Agitated home and communities

It has been challenging for the Mitanins to persuade the village community to maintain physical distancing. Sunita was afraid of getting infected but continued to make door-to-door visits following precautionary measures. The resistance by her family to her COVID-19 work has been constant. She had to persuade and reassure her husband continuously that she was observing all preventive measures. However, he insists that she not come home after visiting the quarantine centre, and stay there itself. She received Rs. 2000 in May for two months of conducting home visits and writing awareness slogans on village walls.

Sunita has often felt burdened about ensuring regular health services, performing COVID-19 tasks, and managing her household simultaneously during the pandemic. She says she is driven by a commitment and zeal for serving her community. *"Now we don't fear it. Ab Mitanin bane hai, toh karna toh padega he."* (I am a Mitanin now, I have to do it).

“Just calling us ‘Corona Warriors’ means nothing.”

Demanding recognition and respect during a pandemic

Khatun has been working as an ASHA for the past 12 years. She is in her 40s, and overlooks 64 households of a large village in Khurda district of Odisha. She has three teenage children and her husband has a small fish business. The village has two more ASHAs besides Khatun, and comprises multiple religious and indigenous communities, including the Sabara tribe. Catering to the varied expectations of a diverse community set-up makes Khatun’s work challenging. Her experiences highlight that supports from different stakeholders helps the ASHA work successfully.

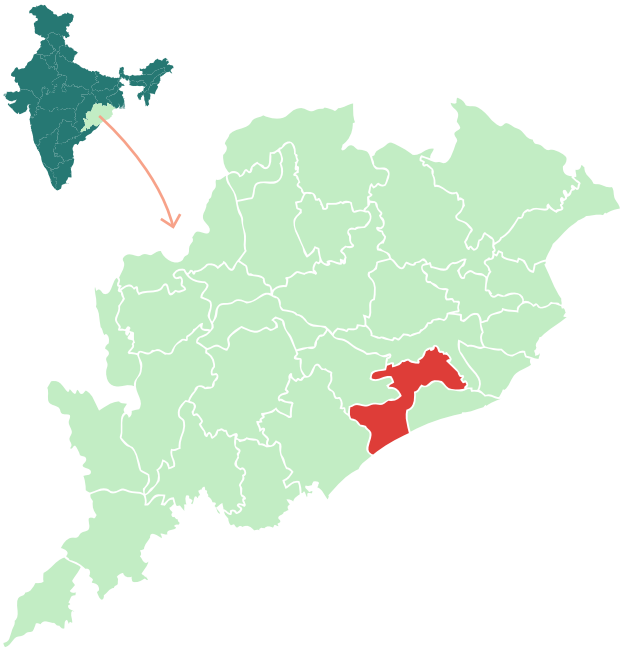
Khurda District

Population: 2,246,341 (2011)

State: Odisha

Language: Odia

Headquarters: Bhubaneswar



Support from unusual corners

In the initial days of the lockdown, the Sarpanch (village head), Ward member, and Anganwadi worker (AWW) came along with her to every household. They inquired if anyone had symptoms such as a cold, cough, fever, sore throat, remind folks to stay home, advised anyone who ventured out for essentials to take a bath once they returned, and to keep a distance of 2 feet from one another, especially the elderly. However, after some days, the Ward member and Sarpanch stopped coming for home visits as they were not given any incentives. The AWW, however, continued to work together with Khatun.

Khatun said she does not get much respect from her own community in the village because a Muslim daughter-in-law venturing out for work was frowned upon. However, her family, particularly her husband, is supportive and has encouraged her. He would even drop and pick her up from work. *"My husband motivated me. He said I am a health worker and if I get scared, it will not work. My duty is towards the health of the villagers."*
Khatun received support for her work from the Hindu community. She said she found it difficult to communicate with the indigenous tribal communities, who had their own ways of doing things, and were not open to her suggestions on measures for COVID-19 protection.

Who respects the 'Corona Warrior'?

Convincing villagers to stay home was not easy, recalled Khatun, and she tried her best to resolve issues. *"They would say that if they stay inside how would they manage their diabetes, as it requires exercise. I would give them ideas to use the open space outside their house or even their terrace for their daily dose of exercise!"*

Khatun was also put on duty at quarantine centres. She would visit people isolated there, check for their symptoms, and ensure they had adequate food and timely medicines. However, her frequent visits to the quarantine centres made villagers view her as a disease carrier. They would stop grocers from selling to her or restrict her movement within the village to avoid infection. These experiences have made Khatun believe her work is not respected enough.

She said she has observed that disrespectful behaviour towards an ASHA is permissible and has no consequence anywhere. Khatun raged: *"Who cares for us? We assist ANMs just like nurses assist doctors, but people in the hospital treat us like we do not exist. Even the security guards treat us badly, pushing us around saying, 'hey ASHA, move.' This is so insulting. Are we just 'hey' (in the local language, addressing someone with 'hey' is considered derogatory). We never speak to them with, 'hey Security!' To whom do we complain?"*

"On the one hand, people say we are 'Corona Warriors,' but what does it mean if the government cannot respect us? How do we expect villagers to respect us when they can see for themselves how we are treated in the hospitals?"

“I have not let COVID-19 enter the village.”

Merits of a functional and equipped health system

Savitri is a 42-year-old ASHA sahyogini in the Baran district of Rajasthan. She is serving a village population of 1011 and has been working since 2005. She lives with her in-laws, husband, and four children. In Rajasthan, all ASHAs are link workers between the Department of Medical Health and the Department of Women and Child Development.

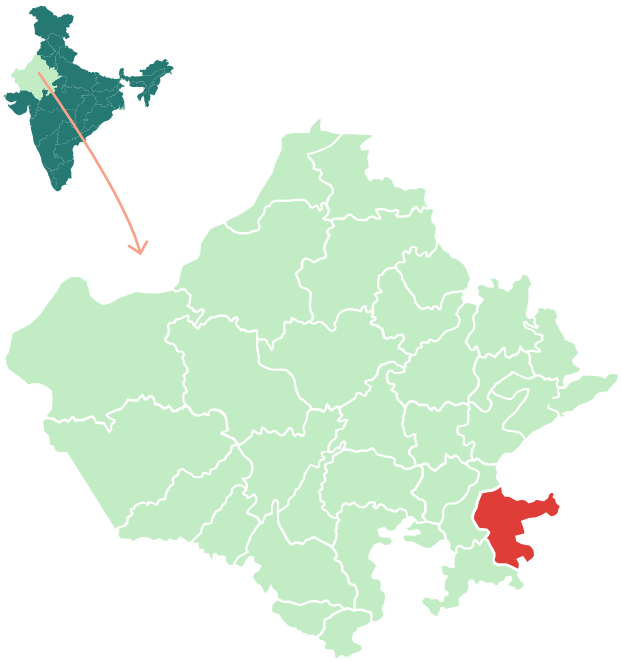
As an ASHA worker, she receives a monthly salary of Rs. 2700 from the Women and Child Department, and additional work-based incentives from the Department of Medical Health. She received an additional fixed honorarium of Rs. 1000 per month for three consecutive months beginning May. Sometimes it takes more than two months to get her honorarium. She has been an active member of the ASHA Union at the district level. The union has been instrumental in engaging the government and demanding a hike in their remuneration.

Baran District

Population: 1,223,921 (2011)

State: Rajasthan

Language: Rajasthani



Additional COVID-19 work

Savitri came to know about COVID-19 at a meeting in February 2020 at the Primary Health Centre in the village where all the ASHAs and ANMs were present. She said she was not really scared about the virus's contagious nature as the doctor reassured and advised them not to be fearful but take precautionary measures at all times. The doctor also gave detailed instructions on preventive measures and what needed to be done.

Savitri surveyed the elderly population (above 60 years of age) and pregnant women in the village along with the Anganwadi worker (AWW) in the village. In Rajasthan, the AWW has been given a cellphone for updating such data online. Savitri visits the households with the AWW, and in some cases, collects and enters the data online from her phone too.

COVID-19 has definitely increased her workload. Earlier, she would visit ten houses in a day, but now she has to visit 20 households daily. The work environment and responsibilities have changed too. Now she manages homes where people are in self-isolation and keeps a close eye on their health.

Teamwork and support

Savitri has no remorse about the additional work given as part of COVID-19. She has received immense support from the ANMs, AWW, officials at the Primary Health Centre (PHC), school principal, and panchayat members. She said the ANMs and AWW accompany her in her door-to-door health awareness visits, stopovers to enquire about the health status of people at the quarantine centre, and to share information with the PHC doctor. She has received two bottles of sanitisers and about a dozen masks from the PHC. As she has started using home-made masks, she has not lacked any. She said such coordinated effort had helped a lot.

Savitri is assured of help and support from other officials in the health department too. She has been given clear instructions that she should reach out to them at any time for any help. Such assurance has also been received from panchayat representatives who periodically check on her for any specific support needed.

She narrated an incident wherein she sought the intervention of the principal of the local Higher Secondary School (converted into a quarantine centre) when the villagers isolated there were not heeding her requests to maintain a distance and wear masks

when conversing. The principal visited the quarantine site, firmly reiterated the protocols to be followed and the significance of such precautionary measures. She said this timely intervention facilitated her work greatly.

Continuing routine health services

Savitri's tasks of providing regular health services were disrupted in March-April with the lockdown and resumed in May. However, many services in the PHC continued to be delivered. She accompanied beneficiaries to the PHC for vaccinations, and maintained a record of it. Child deliveries took place in the village PHC; when necessary, cases were referred to the nearby Community Health Centre or the District Hospital. She accompanied two cases of childbirths to the district hospital. In both cases, she stayed put till the babies were born as only one person was allowed to stay with the mother to avoid crowds at the hospital. The 108 ambulance services for pregnant women were also accessible.

COVID-19 also has made Savitri realise the significance of safety measures. Home visits to check on new mothers and babies now include an added preventive measure of wearing masks and applying sanitiser, she said. Immunisation services and distribution of take-home-ration for pregnant women and children have also resumed at the Anganwadi as part of the Village Health and Nutrition Days (VHND).

Savitri ensured family planning services were not affected even if the VHND did not take place in the first month of the lockdown. She distributed oral contraceptives and accompanied a woman to the PHC for a birth control procedure during the lockdown.

Savitri reiterates the importance of teamwork and community support in promoting health of villagers. She proudly said, *"My experience of working against COVID-19 has been good. I received support in the village to protect the community from COVID-19. I have not let COVID-19 enter the village. We don't have any positive case so far."*

“My door-to-door visits made people think I am spreading corona in the village.”

Coping with suspicions and stigma in a pandemic

Jaya Devi is a Sahiya Sathi (similar to an ASHA Facilitator) in Gumla District of Jharkhand. She started working as Sahiya in 2007 and was promoted to Sahiya Sathi in 2011. She facilitates the work of 14 Sahiyas. She provides health services to 515 persons across 115 households. During the national lockdown and the COVID-19 pandemic, Jaya’s experiences reflect the endless tasks frontline workers perform even as they risk their own lives while being committed to other people’s well-being. Working in a region that saw many migrants returning home due to the national lockdown made Jaya’s tasks more challenging.

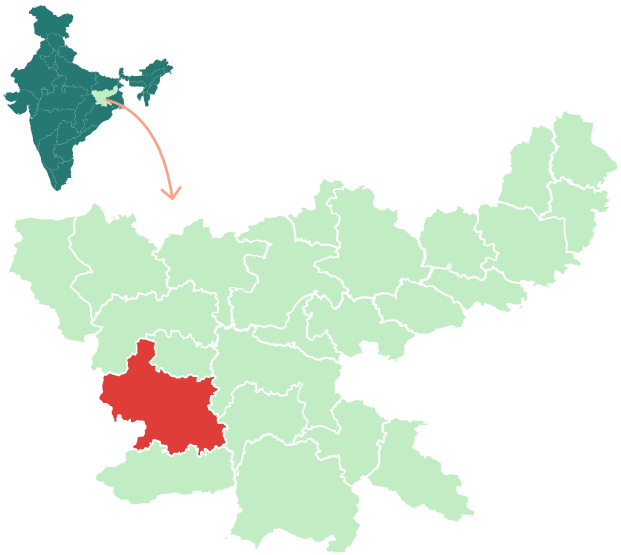
Gumla District

Population: 1,025,656 (2011)

State: Jharkhand

Language: Santhali, Hindi

Headquarters: Gumla



COVID-19 duties and absent resources

As part of COVID-19 activities, Jaya was involved in conducting household surveys twice a day, checking for symptoms such as cold, cough, and fever, visiting newly returned migrants, ensuring they are quarantined for 14 days, monitoring people in self-isolation, and maintaining records of the residents as well as migrants.

Jaya said that although her work has increased, she must complete all her tasks as it is necessary for the villagers’ health and well-being. She received COVID-19 training in a meeting held by the Medical Officer and the Block Programme Manager, which she then further disseminated among Sahiyas working under her.

Jaya was well-supported by the Auxiliary Nurse-Midwife (ANM) in making joint visits to the villages. Ward Members and Panchayat Members also cooperated to ensure smooth monitoring of villagers. However, the absence of adequate safety gear made her feel unsafe. She had received a small bottle of sanitiser and two masks, which were not enough to work throughout the pandemic. This also affected how health workers provided services as close proximity with villagers was considered risky and dangerous.

Jaya said she was conflicted about making any physical contact with women and children, while providing maternal and child health services. *"As I did not have gloves, I did not provide many services that require touching, such as weighing newborn children and checking their temperature. I would ask the mother to check the temperature and weight to get a common understanding. I would only see the eyes of the newborn baby and get an idea about its health,"* she recalled.

Challenges of quarantining migrants

Jaya recalled the challenges of conducting COVID-19 checks among migrants returning to the village. They would tell her not to visit their house. The fear of being taken away to institutional quarantine centres would often make migrants dismiss any possibility of being infected and shoo her away. *"Furthermore, my door-to-door home visits made people think I am spreading Corona in the village. However, I got the support of the Mukhiya (village head) and Ward Members in making people understand the disease."*

Initially, migrants returning from other states were quarantined in schools or panchayat buildings. Now, health workers are asked to isolate them in their own homes. However, in many cases, home quarantine is not possible as migrant adults come in contact with small children despite family members taking the most precautions. Families with one or two rooms in the house find it difficult to maintain physical distance.

Jaya recalled an instance wherein families of two adults returning from Goa requested a quarantine facility as small children were in their homes. So she along with the ANM and Anganwadi worker worked to set up the Aaganwadi centre as one. However, the village head told them that the government had cancelled institutional quarantine and the migrants should isolate themselves at home. Fortunately, everyone in both families was safe after 14 days.

Quandaries of providing basic services

Cases of cough, cold and fever among children have increased in Jaya's area as there have been no routine check-ups for minor ailments. In May, three months after the announcement of the first lockdown, immunisation services were stopped in the villages as no vaccines were being supplied to her area. The person who distributed vaccines in the van was assigned duty at a quarantine centre, resulting in a supply shortage.

Jaya narrated how a shortage of basic health supplies has affected family planning and delivery of other routine health services. *"Contraceptive pills and condoms are not available for the past three months. Eligible couples come to me demanding it but whatever stock I had is exhausted. Even the Nishchay Kit (pregnancy testing kit) is not available. Many women come to me asking for the kit to check if they are pregnant but return empty-handed."*

Jaya narrated that the absence of safety gear and fear of being infected stopped her from visiting beneficiaries. At times, even the women were afraid to approach her for birth control services like Copper-T. It also affected the delivery of maternal and child health services. *"I have not been able to check pregnant women for their blood pressure and haemoglobin. At this point, I am totally unaware of any of their danger signs or symptoms. I am not even accompanying pregnant women to the hospital during childbirth as hospital staff and ANMs have been instructed to avoid crowded hospitals. Only in a few cases, where there are no family members accompanying the pregnant women, I accompany them."*

Jaya received Rs.1500 per month as an honorarium for COVID-19 work. In the past three months, she received Rs. 4500 through regular incentives. She said she is motivated to work despite the low pay and absent safety equipment because of the support of her family. Her husband is a social worker too and supports her working for the community.

“They know if there is a health problem, I will take responsibility.”

Importance of building community and health worker rapport before the pandemic

Sabita is an Auxiliary Nurse Midwife (ANM) in Palghar District of Maharashtra. She married young and has two children, aged 22 and 18 years. After being a housewife for many years, she undertook the 18-month training programme for ANM and started working in 2012.

Sabita was first posted in a tribal-dominated area for five years. She took on different community roles, including cooking meals for the community children and was fondly called Sister Moushi, (Moushi means Maternal Aunt). When she was transferred to another sub-centre, the Sarpanch (village head) arranged a farewell party in her honour and the villagers gifted her 25 sarees. She now works in a region dominated by the Warli tribal community.

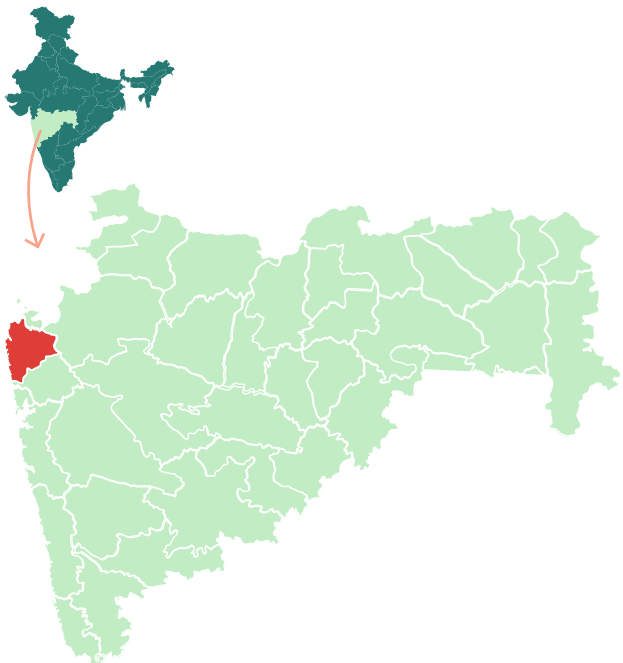
Strong familial and community support backed with adequate health infrastructure have helped Sabita be dedicated to her passion for community health. Her experience also highlights the importance of rapport building by health workers, allowing for smooth delivery of health services in a crisis.

Palghar District

Population: 2,990,116 (2011)

State: Maharashtra

Language: Marathi, Hindi



Familial and community support

In the three years of her second posting, Sabita has established a strong rapport with the community, and built a relationship of trust and teamwork with officials in the Primary Health Centre (PHC). She proudly narrates how she has sustained this relationship: *"Irrespective of the workload, I ensure I reach the PHC at 8.30 am. We have two Medical Officers, a nurse and cleaning staff. If I keep quiet even for a day, everyone gets worried as I am always full of energy. In my initial visits, villagers would ask me if I was from their caste. I would reply, 'I was one of them.' People have a lot of trust in me. They know if there is a health problem, I will take responsibility."*

Since the lockdown began, she stayed at the PHC as her home is two hours away. Sabita said without her family's support; she would not be able to focus on her work. *"I have been staying in the PHC quarters, away from my family for the past three months. During this time, I lost my mother-in-law too, and I could not meet her in her last days. My daughter took care of everything, even the last two days when my mother-in-law was in the Intensive Care Unit. My family supports me a lot, otherwise, it is not possible for me to do my work. They tell me to carry on my duty."*

She reiterates the Medical Officer has been supportive, and has explained why there is no need to fear COVID-19 and also clarified how to protect themselves during this pandemic. This kind of support and clear communication has helped as Sabita said she was initially apprehensive and worried about how to manage the pandemic in their area.

Creative ways of building trust in the health system

Besides providing basic Maternal and Child Health services, Sabita conducted COVID-19 surveys, and ensured quarantining and monitoring cases. She teamed up with the PHC staff and community leaders to came up with ways to assure and inform people about the COVID-19 situation.

Sabita and other multi-purpose worker, village head,ASHA, and the Anganwadi Worker (AWW) made joint visits as a team to each house in the village. They told villagers not to be afraid of the coronavirus, and encouraged people to request their relatives to stay where they are and limit movement. These joint visits made a big impression on the villagers, and they willingly followed social distancing norms. They also assigned the Sarpanch [village head] the task of tracking incoming migrants and also movement within the village.

Another creative way of helping the community during the pandemic was the "Minor Illness Drug Kit." This provision included basic medicines for common ailments and the Oral Rehydration Solution and was kept in the Anganwadi Centre. The ASHAs were instructed to distribute these in the village during the pandemic to ensure common ailments are taken care of and people do not move out of the villages for minor ailments.

Sabita continued immunisation services in the village itself. She used the AWW centre and asked pregnant women and lactating mothers to come one at a time for vaccinations. No one resisted.

Initially, when the PHC did not have any safety gear, the staff would use the childbirth kits and other available gear during home visits and for check-ups till they received the required masks and PPE kits. Thus, even if initially, there were fears among the community, these creative initiatives kept them in check.

Going beyond routine services

Throughout the lockdown, the PHC was open 24x7, providing all health services, including treatment for snake bites (common in the area), institutional deliveries, and other major illnesses. In its initial days, health workers were hesitant to touch patients fearing being infected by COVID-19, but people often took offence at such behaviour.

Sabita explains that having built a strong rapport in the community, a lot of healthcare and healing also involves behavioural and emotional exchanges. During the pandemic, people considered check-ups involving touching the forehead or any such physical contact as more attentive care than simply testing them for their complaints without any touch involved. The health workers then explained why they were not making any physical contact and compensated it with their counselling and conversations.

Sabita narrated another instance where the PHC had to refer a pregnant woman with complications to another medical institution. However, the family members refused as they were not confident of other hospitals. Sabita and the PHC staff persuaded the family members, reassuring them that the staff would be available on the phone if needed. Sabita said that such reassurance is necessary for people to know that "we are there to take responsibility."

Sabita reiterated that the continued support of the community, PHC staff, and her family has helped her stay motivated and stay committed to her work.

Lessons and Reflections

'Crisis Reveals Character'

Dr. Johnny Oommen, a physician and public health specialist, during a colloquium titled 'Responding to COVID 19 from a rural hospital' organized by the Azim Premji University[3] on November 20, 2020 succinctly remarked, *"We need to use our normal, peace times to build capacity to cope with crisis. Crisis reveals character, if you don't have it before, you are unlikely to find it during the crisis"*. The experiences of our health workers echo this. A health ecosystem functioning well before the pandemic has better chances to handle the crisis. Stories from Maharashtra, Odisha, Chhattisgarh illustrate how established and robust channels of communication between front-line health workers and block, district level health authorities, clear communication on COVID-19, cooperation among frontline health cadres, regular payments and availability of equipment (masks, sanitiser, hand gloves) and medicines are essentials of a functioning health system. Yet in most other stories, lack of timely payments and safety gears which are the most basic health system support were missing, frustrating the health workers. In many cases, there were no channels for grievance redressal and reporting mechanisms that left most health workers feeling isolated and treated as dispensable bodies. There were instances as Shristi's story illustrates where health workers were writing letters to Chief ministers and the Prime minister because all the channels in the local health system failed to respond to their problems despite repeated requests. There were multiple instances of harassing the workers with contradictory instructions and repeated tasks, threats to remove them from employment if they complained, deduction of incentives due to inability to hold regular outreach sessions, leaving the health workers alone to deal with community mistrust, rumour and anger outbursts and expecting health workers to arrange for their own safety gear and transport during surveys and fieldwork.

As the pandemic is unfolding, frontline workers' experiences reveal their resilience as well as helplessness and the health system's unpreparedness. In cases where frontline workers were working in a well-functioning health ecosystem with clear communication channels and regular payments prior to the pandemic, the pressures and fear of COVID-19 work were minimised and health workers were motivated and even creative. Sabita's and Hema's stories show how despite working in remote health centres their overall COVID-19 experience was positive due support from higher officials and planned health system efforts at block/district level.

[3] https://www.youtube.com/watch?v=MIG6oOhNOIw

Trust and teamwork do Matter

Experiences of Kimati, Hema, and Sabita demonstrate why and how trust and teamwork matter. They show how the relationships of trust built over a period of time with the community facilitated their work during this challenging time. While Kimati confidently shares 'I have the support of all the villagers, what else could I ask for?' and discusses how this support has enabled her to not only enforce COVID-19 related measures but ensure that routine health services continue. Yet her experience also shows community support is important but not enough. She reiterates the continuous support and recognition she receives from the block level officials including the ANM, LHV, Block Medical Officer and others. This is reinforced by Sabita who drew attention to the role of teamwork. She shares how the Gram Panchayat head, Aanganwadi worker, ASHA and herself all go together to each household in the village to communicate about COVID-19 conveying the sense of shared responsibility. This is extended to the Primary Health Centre as well where the entire team of ANM, nurses and Medical Officer had shared understanding of how to navigate through this pandemic while providing regular services in the Primary Health Centre. Such trust and teamwork have enabled Sabita to carry on in this challenging time despite the fact that she had been staying from her family for three months.

Where such teamwork at the health system was missing, Srishti's experience shows how health workers' own sangathans (networks) have provided critical support [sharing relevant information on COVID 19 protection through the website of the World Health Organization to preparing masks and arranging vehicles for each other] to fight the pandemic. There is a need for strengthening and acknowledging the role of such networks.

Aziya, Karuna and Khatun's stories very clearly bring out the difficult task of frontline workers dealing with communities who are scared and unable to trust them. While it is very easy to put the onus of rapport building and community participation solely on the health workers, the working conditions of health workers within the system and the service provision of local health centres are the foundations upon which this trust and rapport is built. In many ways, the pandemic experience forces us to see a direct link between the value and respect given by the health system to the frontline workers' labour and the motivation of front-line workers and the community's trust in them. Rather than attaching nominal value and praise to their efforts, it is important that the emotional and physical labour required for community health practice be truly appreciated both monetarily and systematically through regular training and communication.

Community health workers as active 'thinking' agents and not just data collectors

The stories bring attention to how the work of frontline health workers is beyond designated tasks. The continuous effort to build rapport, navigating through rumours, fears and myths in the community, dealing with local authorities and leaders with creative ideas are crucial aspects of community health that are assumed to be a natural characteristic of female health workers. These stories provide more evidence showing that we cannot treat community health workers as mere data collectors but as 'thinking' community health professionals. Yet some of the stories like that of Shilpa and Gautam point out how the health department has systematically deskilled them and put them in a position where they are not considered useful despite their years of work and experience. All the knowledge and field experience gained by health workers over the years which ideally should help them navigate community expectations during the pandemic is shadowed by their underpayment and lack of respect from the department and as a result disrespect from the community as well in some contexts.

Our aim is to present experiences of frontline workers through these stories as they see it and have shared with us. Rather than painting a one-dimensional picture, we want to draw attention to them as a dynamic group of people who are worn out, unpaid, and neglected during the pandemic but are also resilient, committed, creative, and active actors in the health system. We see that there are multiple frontlines at the family, community and health system level and the pandemic is testing them on all the levels. They are indeed the frontline warriors!

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