UNDERSTANDING THE CHWS' RESPONSE TO COVID-19:

CHALLENGES AND OPPORTUNITIES

BIANCA SHAH
ANKUR SARIN
SHUCHI SRINIVASAN

Table of Contents

Understanding the CHWs' response to COVID-19: Challenges and opportunities

Introduction

Scholarship suggests that Community Health Workers (CHWs) play a critical role in the implementation of health and nutrition policies, critically affecting maternal and child health outcomes (Rammohan, Goli, Saroj, & Jaleel, 2021). Not surprisingly they have been providing several essential services during the time of the Covid-19 pandemic. They have been entrusted with responsibilities that go far beyond routine service delivery during regular times and the specific terms under which they have been hired (Bhaumik, Moola, Tyagi, Nambiar, & Kakoti, 2020) (Mishra & Santosh, 2021) (Accountability Initiative, 2021). Their contributions have often been lauded and highlighted in public forums and broader community health systems literature. However, evidence repeatedly states that despite the recognition of the importance of their work, the interests of the very women actually playing the role of CHWs are repeatedly ignored, devalued and invisibilised (Bhatia, 2014). In this essay, we describe the nature of invisibilisation and situate it in a broader pattern of invisibilisation of care work, work that continues to be significantly gendered.

In India, CHWs perform critical outreach roles and are typically mapped to broader health and nutrition based schemes. In this article we discuss the work of two such CHWs- the Anganwadi Workers (AWWs) who are mapped to the nutrition policy the Integrated Child Development Scheme (ICDS) and the Accredited Social Health activist (ASHAs) who are mapped to the National Health Mission (NHM). Ideally, each AWW and ASHA is mapped to per 1000 population and routinely interact closely with the community on a regular basis. Anganwadi workers (AWWs), who are a part of the Integrated Child Development Scheme (ICDS) primarily focus on early childhood nutrition and education, and nutrition of pregnant lactating women. They are stationed at Anganwadi centres (AWC). Whereas Accredited Social Health Activists (ASHAs) are the "interface between the community and the public health system", whose primary role is to mobilise the community, facilitate them in accessing health related services, particularly institutional deliveries and home-based new-born care, and promote good health practices[1].

[1] In addition, ASHAs facilitate the community in accessing services like immunisation, Ante-Natal Check-up (ANC), Post Natal Check-up (PNC), conduct regular follow up visits to new-borns and pregnant and lactating

Over the course of the pandemic the duties of CHWs have been changing as per the need or demand. Initially ASHAs and AWWs were involved in conducting household (HH) surveys for identifying beneficiaries with symptoms, and reporting their travel history, engaging in information dissemination about COVID-19 management, supporting the community to quarantine as needed, among others (Ballard, et al., 2020) (Behan Box, 2021) (Bhaumik, Moola, Tyagi, Nambiar, & Kakoti, 2020) (Sinha, Gupta, & Shriyan, 2021). As India attempts to deal with the current second wave of COVID-19 spread, the role and engagement of CHWs has increased manifold. Their roles now encompass measuring temperature and oxygen levels across HHs, posted at isolation centres and attending to patients there, closely monitoring the COVID positive patients, providing essentials to HHs with a patient, and supporting vaccination drives etc.

While crucial, a number of studies also notes that CHWs did not receive adequate support towards delivering their role (Accountability Initiative, 2021) (Ballard, et al., 2020) (Behan Box, 2021) (Sinha, Gupta, & Shriyan, 2021) (Thareja & Singh, n.d.). A study finds that the officers above the CHWs in hierarchy were able to get more support from the government in terms of PPE and transport facilities (Sinha, Gupta, & Shriyan, 2021). Another study points out to the lack of training at least in the initial months of the pandemic, issues in accessing toilets while on duty, physical and mental exhaustion, exposure of physical and sexual assault while on duty, delays in honorariums and incentives, among others as inadequate support to CHWs (Behan Box, 2021). These factors directly affect the performance of CHWs, especially in a pandemic, and addressing these concerns is essential for better management and handling of COVID-19.

Since the onset of the pandemic, the network/machinery of ASHAs and AWWs was among the first ones to get activated to respond to the resulting crisis. Chronologically speaking, on 24th March 2020, a nationwide lockdown was announced and by 27th March a Facilitator Guide was published by the Ministry of Health and Family Welfare, which identified ASHAs, AWWs, and ANMs as frontline health workers. They were to play a role in stopping the spread of COVID-19 as they have “the responsibility, the reach and the influence within the community” (Ministry of Health & Family Welfare, Government of India, 2020).

---

women, look after childbirth and deliveries, maintain village health register, refer children with Severe Acute Malnutrition to NRCs/CMTC and take them for follow-ups to these facilities, among others.

Even as they share a common identity, the services provided by these CHWs varied across states and districts. For example, ASHAs in the state of Haryana were involved in identifying people with comorbidities, measuring temperature and oxygen levels, mobilising people to get the vaccine, and were also posted at the vaccination centres. Whereas, ASHAs in the state of Gujarat were involved in measuring oxygen levels, identifying people with comorbidities, were posted at covid care facilities and were responsible to look after patients - give them medicines, monitor their temperature and oxygen levels, etc. While ASHAs in the state of Madhya Pradesh were responsible to facilitate quarantining, checking for symptoms, and referring patients to the sub-centre/PHC. The variation in these responsibilities that the CHWs were tasked with suggests the wide latitude of expectations that the public health system has placed on them. These expectations, as we argue in the paper, have been accompanied with little tangible attention or compensation.

The theoretical framework of Feminist Political Economy (Armstrong, 2013) serves as a motivating framework for us and we relate it to the literature of invisible work (Hatton, 2017). We try to understand how the work done by frontline healthcare workers - ASHAs and AWWs is invisibilised by the organisations they are employed in and in particular through socio-legal mechanisms. We situate this analysis in the context of a pandemic, when they were given additional responsibilities and yet remained invisible from the policies for better working conditions, pay, job security and other benefits.

The experiences of CHWs in the response and management to COVID-19 pandemic in 2020 in the Indian state of Gujarat serve as the empirical site for our primary data. However, we draw on a variety of literature including official policy announcements to describe the systematic invisibilisation that attempts to dilute the contribution of the CHWs to pandemic management. In doing so, this paper also has suggestions for program and policy and mechanisms to strengthen CHW's role and performance in facing the second and potential third wave of COVID in India.

Invisible Work

Invisible work is commonly conceptualised as "labour that is economically devalued". Hatton (2017) suggests that this invisibilisation happens through socio-cultural, socio-legal and socio-spatial mechanisms. These mechanisms could intersect in different ways and degrees

and the type of work commonly referred to include those performed by illegal migrants, home care as well as waste work.

Literature on care work covers activities such as care work performed by nurses (Allen, 2015) (Armstrong, 2013), care for children, aged people and people with disabilities or illness both in formal and informal settings and residential/domiciliary care or at care organisations (Baines & Armstrong, 2019) (Palmer & Eveline, 2012), etc. Body work is understood as work that deals with "assessing, diagnosing, handling, treating, manipulating, and monitoring bodies". Frontline work in health and social care is also identified as body work, one of its characteristics involving "emotional labour". Sociologists working in the sectors of health and illness have recognised this work to be "emotional draining, labourious and demanding" (Twigg, Wolkowitz, Cohen, & Nettleton, 2011).

These definitions do not neatly capture the work done by CHWs which while care oriented is deeply gendered. ASHAs and AWWs are typically married women who work on the catchment areas which are their husband's villages (Scott, Javadi, & Gergen, n.d.) (Roalkvam, 2014). These women are expected to deliver towards their household roles and their official roles in jobs which lose job definitions and unclear work-hours. These contextual aspects add further complexity to the nature of work performed by the CHWs. Therefore, drawing from these definitions, we understand the work done by CHWs as work involving assisting the community in accessing health care services; assessing, diagnosing and monitoring people, especially children and pregnant and lactating women tasks that are traditionally deemed congruent with the characteristics deemed feminine. This necessitates the combining this perspective with the Feminist theory literature on care work to analyse our findings.

Scholars of Feminist theory argue that there is sex-segregation in the labour force and women end up in certain kinds of jobs that offers low wages. Because of the sex-segregation in jobs, discrimination in wages against women is not individualistic in nature, rather it is systemic/institutional (Armstrong, Cornish, & Millar, Pay Equity: Complexity and Contradiction in Legal Rights and Social Processes, 2003) (Baines & Armstrong, 2019). This, they argue, is one of the ways their work is undervalued or invisibilised because it is being primarily undertaken by women. They have further argued that the skills required for jobs that are primarily undertaken by women are not a "product of nature" and many of these skills are acquired over years and that they are also required for the job (Armstrong, 2013).

They argue that identifying something as a skill, its recognition and assessment is also gendered. This is another aspect of invisibilisation of work done by women (Armstrong, Cornish, & Millar, 2003).

Methods

This primary data that this study draws on is a rapid assessment survey across select districts of Gujarat in May and June 2020. Using a structured data collection survey instrument we asked CHWs questions related to themes of roles and responsibilities and the support received by them in meeting their routine and revised roles. The survey also focused on the intra-village coordination amongst Panchayat, health team and AWWs to get a holistic picture. Though predominantly structured and quantitative, the survey questions also attempted to capture greater nuance associated with experiences and perceptions of the respondents. The interviews were carried out telephonically[2]. While not ideal, the telephonic route was the only practical mode of undertaking the research during the pandemic and in keeping with the social distancing norms. In addition to the practical benefits in line with the revised context, telephonic data collection also allows the respondent to schedule a time for communication and allow the respondent to feel more at ease and comfortable in communication (Novick, 2008).

In addition to this, we analysed the announcements made by the central and state government to understand the formal response of the government to support CHWs. The announcements published on the websites of (i) Ministry of Women and Child Development and (ii) Ministry of Health & Family Welfare were checked for these announcements. The announcements made between mid-March 2020 and April 2021 (the period of immediate response to the pandemic) were considered for the study.

Data Collection and Analysis

The study uses mixed methods, drawing on both qualitative data from in depth interviews, as well as descriptive statistics from survey data. The AWWs were selected from six districts of Gujarat. The districts in the dataset were divided into "blocks" and "Seja", which further consisted of multiple villages. These districts were divided into 71 blocks. Instead of selecting multiple villages from certain blocks, we decided to select one village per block.

[2] There were a few challenges because interviews were conducted telephonically. One of the major challenges was in reaching out to the respondents because in a lot of cases, their contact numbers were either outdated, invalid, out of reach or phones were not with the respondents. Moreover, the interviews could not be conducted because respondents were occupied with their work and a common time could not be worked out for an interview. Another set of challenges included building trust and rapport with them over a call. In our experience, it is easier to speak to respondents in-person, they open up more when the conversation is happening face to face, instead of over a call. Therefore, we expected that the CHWs will not be very comfortable in sharing the issues and challenges.

Our sample included all the blocks, as across block variation is likely to be higher than within block variation. Therefore, the sample was designed such that one interview had to be conducted per block. One village was randomly selected from each block, across all districts. Therefore, the sample of AWWs included 71 villages spread across 71 blocks of 6 districts. The data collection for AWWs was done in May 2020. A total of 69 interviews (sample size was 71) were done during this period.

The ASHAs for the study were selected from three districts of Gujarat. The data used for this exercise was organised PHC-wise, since the ASHAs are appointed at PHC level. The data had a list of ASHAs for every PHC in each taluka[3] of a district. The number of ASHAs selected in the sample were proportionate to the total number of ASHAs in the district. A fixed number of ASHAs were randomly selected from each taluka of a district. For example, if 15 ASHAs were to be selected from a district which has 5 talukas then 3 ASHAs were selected from each taluka of the district. We made sure that two ASHAs from a PHC are not included in the sample, to ensure more geographical spread from each district. Therefore, the sample included 60 ASHAs from 60 PHCs spread across three districts. The data collection for ASHAs was done in June 2020 and a total of 63 interviews (sample size was 60) were conducted.

Since there was no common unit between the datasets for ASHAs and AWWs, the sample design was different in both the cases. However, in both the cases, AWWs and ASHAs were selected randomly.

At the end of the data collection, responses and notes of all the interviews were translated into English. The responses were reviewed for accuracy and consistency. In some cases, respondents were also contacted later for clarifications. The responses were coded and dominant themes were identified from the interview responses and notes for analysis.

The announcements made by the government related to CHWs were identified and translated. We summarised those to understand the kind of support provided by the government to CHWs.

[3] Taluka is an administrative unit, below the district and above the village, town and city level.

Ethical considerations

At the start of each interview, the potential respondents were informed that their participation was optional and voluntary. They were also informed that they could choose to not respond to any of the questions and withdraw their consent at any point. In such cases, we discontinued conducting the interview. Since the interviews were done via telephone, verbal consent was taken for the interview. Drawing on our prior experience, we did not record the interviews. We had experienced that respondents become too conscious when asked for recording their responses. This would have been even more difficult since we were conducting telephonic interviews and we had no rapport with the respondents beforehand.

Findings

Increased demand for mobility with little support

Our survey data finds that all the ASHAs across study districts reported conducting HH visits related to COVID-19. During these visits, more than 90% reported checking for symptoms, identifying people with symptoms, and disseminating information; 80% reported distributing medicines; and 30% reported distributing masks. More than 70% of the AWWs reported helping the health team in conducting household surveys. Along with conducting the surveys, they were also involved in checking for symptoms, identifying people with comorbidities and distribution of food, masks and medicines. This was in addition to the routine activities they undertake in a non-pandemic situation.

However, the mode of delivering routine services had changed. The services had to be delivered at the door-step of the beneficiary. For instance, instead of hot-cooked meals given to 3-6 year olds attending the Anganwadi centre (AWC), Take Home Ration (THR) packets were distributed. These children are dependent on the AWC for their nutritional needs. 75% of the AWWs reported conducting household (HH) visits to distribute THR packets for children in the age group of 6 months-3 years, 3-6 years, and pregnant and lactating women. The AWWs reported carrying around heavy packets of THR during their HH visits, without any kind of support.

The survey with AWWs was conducted during the lockdown period and only 4% of them mentioned receiving any kind of support for travel. None of them reported getting any support from the ICDS department or the health department. Though most AWWs stayed in the same village as their AWC, a few raised commuting as an issue owing to reasons like lack of transportation, roads being blocked, being stopped by the police despite having their ID cards, etc. during the lockdown. The issue of commuting was even more acute in urban areas where the AWW did not necessarily stay in the same area as the AWC and where lockdown was more strictly implemented.

In an instance, an AWW explained that since only one person was allowed on a vehicle, and she couldn’t drive, commuting became an issue for her in the lockdown. In one of the instances, an AWW said that earlier she used to travel by jeep (private shuttle), but after the imposition of the lockdown she had to walk for half an hour to reach the AWC.

The survey with ASHAs was done after the lockdown was lifted. 35% of the ASHAs complained about facing commuting issues, of which 78% reported that they faced issues because of lack of transportation facilities. Around 10% of the respondents explained that the PHC was far, which is why travelling to these centres was an issue even after the lockdown was lifted. They had to walk to the PHC. Around 10% ASHAs mentioned that the health centre provided them transport facilities to the PHC. A worker from Narmada mentioned that they were even provided transport facilities for their HH visits and fieldwork.

From our analysis of orders and notifications passed by the state and central government, the provision of travel assistance or allowance to CHWs was absent. Moreover, the fact that the provision of transportation facilities was not uniform across the study districts also validates that it was not being announced formally by the government. The requirement of support in commuting for conducting the tasks allotted to CHWs was not recognised by the government. The tasks required for the activities allotted were not detailed out and hence its cost was not recognised. An important component - commuting - essential to conduct their activities in a pandemic situation was not recognised as work.

Increased responsibilities with limited investments in capacity and support

Around 40% of AWWs reported not having undergone any training regarding COVID-19. This number was as high as 95% in one of the districts under study. 80% of the AWWs in this district reported being involved in conducting HH surveys without receiving any kind of training. When we asked specifically about the content of the training, only 50% of the AWWs reported topics like information about COVID-19, personal protection and precautions to be taken, and maintaining social distance being covered in the training. While about 20% of AWWs reported helpline numbers being covered in their training. In other words, 80% of the AWWs did not receive information on helpline numbers. This was reflected when about 50% of the respondents reported not knowing or remembering the helpline number when asked at the time of the survey. Less than 10% AWWs reported having received any material like posters, or other IEC materials. Only 30% of AWWs reported having received training about PPE. Therefore, the trainings were inadequate not only because they were not conducted uniformly across the study districts but also because the content of those trainings did not cover a few important topics.

However, these numbers were much higher for ASHAs, where about 95% of them reported having received training related to COVID-19. In case of ASHAs, more than 90% reported topics like information about COVID-19, personal protection and precautions to be taken, and maintaining social distance being covered in the training. About 60% of the ASHAs reported helpline numbers being covered in their training, which was considerably lower than the other topics being covered. Around 50% of the ASHAs reported having received any material like posters, or other IEC materials. 70% of the ASHAs reported receiving training about PPE. Even though the trainings seem to be conducted for ASHAs, they still did not seem adequate content-wise, as about 40% ASHAs reported not receiving any information about helpline numbers.

Information dissemination was a critical function of the CHWs especially in the initial days of the pandemic. AWWS reported that the information dissemination was done only by the AWWs and ASHAs during their HH visits. In other cases also they were involved in information dissemination, but they were not solely responsible. They reported that the Panchayat was involved in only 25% of the villages. Whereas all ASHAs reported being involved in raising awareness. They also reported lesser involvement of Panchayat (in less than 40% of the villages), health centres (in less than 15% of the villages) and other actors like police, *Talati*, NGO and channels like village Health and Sanitation Committee (in less than 15% of the villages).

"The sarpanch has taken steps to reduce the spread of disease from the people coming from outside, he makes sure all shops remained close outside of their assigned time. Community members continue to ask for food from other villagers but there was little to do.. The PDS shop sells the products at double the previous price and ATM is very far away, there are no public vehicles hence it is an issue for everyone not having a private vehicle."

Increased risk and inadequate investments in safety

Similarly in case of PPE, more AWWs reported not having PPE than ASHAs. About 85% of the AWWs reported having masks but only 67% of them reported receiving the masks from the government. The remaining 31% reported that the masks were self-bought. Even though about 85% AWWs reported having masks, only 65% reported covering their faces (with either masks or cloth) during the HH visits. Only 40% of the AWWs reported having sanitisers and gloves. However, none of the AWWs reported using gloves during their HH

visits. The number of AWWs reported having gloves ranged from less than 20% to around 60% across districts.

Whereas 95% ASHAs reported having PPE and 90% of them having received it through the health centre. The remaining 10% also reported receiving it through the ICDS department and/or Panchayat. Almost all ASHAs also reported having sanitisers and around 85% reported having gloves as well. However, only 35% ASHAs reported using gloves during their HH visits. Only 3% ASHAs reported having to buy PPE, these ASHAs were from the same district. However, only 13% of them reported that they were happy with the quality of masks and sanitisers.

80% of the AWWs reported maintaining social distance while conducting their HH visits, while only 60% said that they covered their face with a cloth/*dupatta*/mask. About 40% of the AWWs reported washing/sanitising their hands before and/or after each HH visit. A few AWWs also informed that they would wash/sanitise their hands only after they finish conducting surveys for the day. Hardly 10% of the AWWs reported washing/sanitising the HH members' hands before and/or after their visit.

All the ASHAs reported that they wore masks and/or covered their mouths with a cloth while conducting the HH visits. Moreover, more than 80% of the ASHAs also reported following the practice of sanitising/washing their hands before and after the survey. Maintaining social distance as a practice being followed was reported by around 90% of the respondents. However, only around 10% of them reported that they also washed/sanitised the HH members' hands before and/or after the survey.

We find that the support to CHWs in terms of providing IEC material, PPE and training sessions affected the protective protocol they followed during their HH visits. The protocol followed by them seemed to fall short of the COVID-appropriate behaviour. The lack of support could have further affected their work of raising awareness among the community, especially in a pandemic situation. Even the information about the virus and its effect was novel and rapidly evolving. The limited training regarding PPE could also affect their safety and exposure. Moreover, this could further hamper them in raising awareness about the use of PPE among the community, which is crucial in the pandemic. This was even more crucial in the initial phases of the pandemic when following covid-appropriate behaviour was a new change.

The pandemic also demonstrated CHW's commitment to the community and towards the beneficiaries. The break in routine service delivery also emerged a cause for worry amongst many who were unsure about the status of the health and wellbeing of the beneficiary populations. As one AWW pointed out:

"Most of the parents are farm labourers, they leave children here (at AWC). Some people have left their kids at their relatives' place as they are in other villages for labour. ..(AWW) am worried about food and nutrition of these children. I don't have a WhatsApp group, and get the information through calls. There was no training/meeting for the AWWs and were told by the ANMs that they should accompany them in HH visits."

This was also corroborated by another AWW who said that "No meeting/ training was conducted related to covid, they gave information to HH on their own during their HH visits related to AWC".

Insurance, Incentives and Salaries

Unlike ASHAs, AWWs were not promised any additional incentives for the COVID-related duties they were asked to do. ASHAs were also covered under the "Pradhan Mantri Garib Kalyan Package: Insurance Scheme for Health Workers Fighting COVID-19", whereas the AWWs were not. The insurance scheme was meant to cover (i) loss of life due to COVID-19 and (ii) accidental death on account of COVID-19 related duty. The AWWs were also involved in conducting/allotted COVID-19 related duties, and they were also defined as frontline healthcare workers by the central government. Nevertheless, they were not covered under this insurance scheme (Ministry of Health & Family Welfare, 2021). They were covered under other insurance schemes like Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY), Pradhan Mantri Suraksha Bima Yojana (PMSBY) and Anganwadi Karyakarti Bima Yojana (AKBY) (Ministry of Women and Child Development, 2021), but there is no clarity on compensation in case of death due to COVID-19 or while conducting COVID-19 related duty.

Delay in ASHAs and AWWs receiving their salaries has been a phenomenon acknowledged as a challenge even in the pre-covid times (Sinha, Gupta, & Shriyan, 2021) (Workers in Their Own Right, 2019). ASHAs from one of the study districts complained about not receiving

their salaries on time. At least ten ASHAs explicitly expressed their concerns about their salaries and incentives being inadequate compared to the work they were expected to do. They felt this especially because their workload has considerably increased in the current pandemic situation. One of them complained that they are expected to work even on Sundays, but the salary has not increased and when they raised this to the higher authority, they were told that it is their duty to serve the village and this work is essential so it should not be stopped. Another ASHA pointed out that they do all the work that is done by the nurses, except the vaccination, even then they do not receive sufficient salaries.

A few ASHAs also raised the issue of not getting incentive for doing the COVID-19 related surveys, despite the fact that they were promised an incentive. In case of ASHAs, they were promised a fixed incentive for conducting COVID related duties (Ministry of Women and Child Development, 2021), whereas this was absent for AWWs.

Discussion

Our findings indicate limited avenues for support to CHWs to carry out their roles and responsibilities. These findings are also in line with findings from other studies conducted with CHWs during the pandemic (Accountability Initiative, 2021) (Behan Box, 2021) (Mishra & Santosh, 2021) (Sinha, Gupta, & Shriyan, 2021). One aspect of supporting the CHWs in their work is the provision of support in terms of travel assistance and/or allowance, protective gear, training sessions, financial compensation for the work and other benefits in terms of insurance, among others. This means that whether or not these provisions were made for the CHWs is a good indicator of support provided to them and by extension, their work being recognised as work and needing support.

Further, we also advocate that in addition to offering the technical input, there must also be appropriate follow-up to ensure the input is well received and if there are gaps in access. For instance, to get a better understanding of the training given to CHWs, it is important to know the content, frequency, mode, format of the training session - whether there is space for the participants to raise their doubts or questions, etc. about the training. Similarly, an important aspect about PPE is its adequacy and quality. The survey data does not capture if the sanitisers given were sufficient to last till the time they were refilled, or if the masks provided were reusable or disposable and if they were disposable, how many masks were given, among others.

The limited knowledge and material among CHWs affected their safety and also their communication with the community, limiting their work. What also emerged was that whilst ASHAs and AWWs were offering continuous support to the community, and NHSRC guidelines specified all CHWs to wear necessary PPE. However, the PPE rational use guidelines in India describe CHWs as low-risk cadres (Directorate General of Health Services, Ministry of Health & Family Welfare). This discrepancy in official messaging is also congruent in the on-field availability of PPE equipment. Our study finds that the provision of support was not present ubiquitously, but it was also not completely absent among CHWs either.

Therefore it is clear that while certain elements of the CHWs work was visible to the government, with the government critically relying on them, there were other elements that remained entirely invisible.

We categorise the work of CHWs in two categories as either visible or invisible to the state. This visibility also centrally affects the nature of support the CHW appears to receive. COVID related duties such as symptoms identification to duties in isolation centres, etc. - are visible and hence acknowledged but the positive adaptations they undertook to support the community in spite of resource shortages, were overlooked. Further, in terms of providing support to conduct these activities, their work was invisibilised as well.

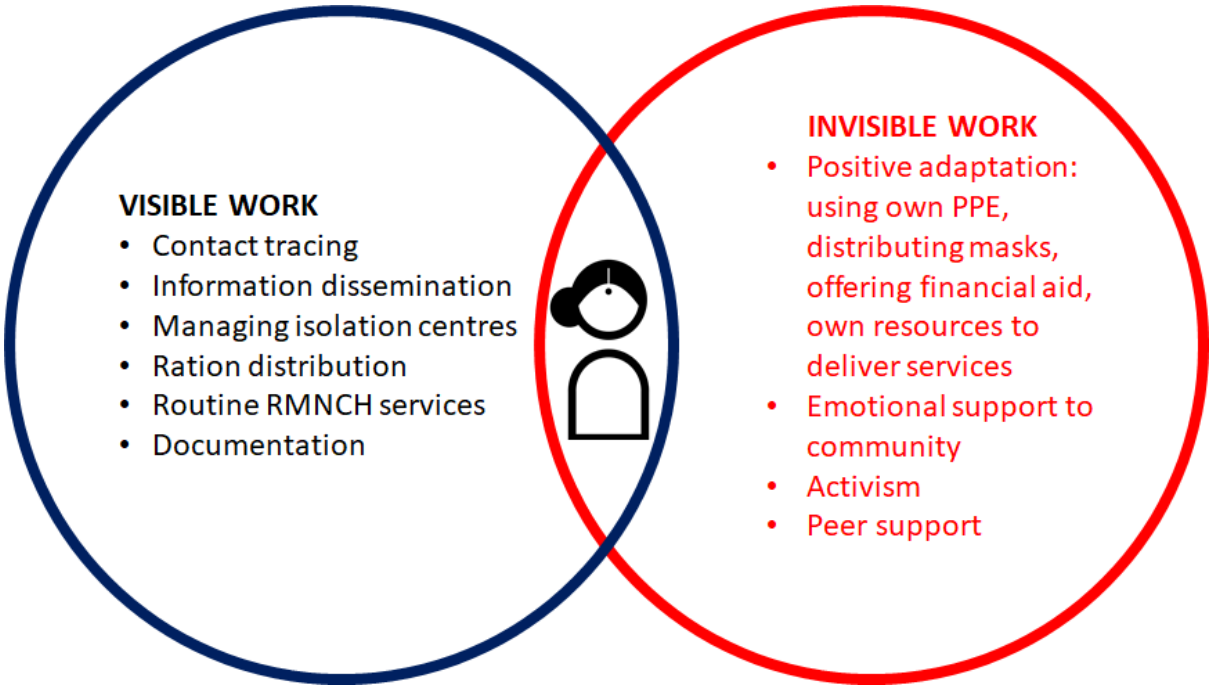

Figure 1: Invisibilisation Paradox and CHW's work

We find that despite the activities they have been carrying out, both in response to the pandemic and the routine activities, they received limited support from the government to carry out these activities/tasks.

The lack of provision of support to CHWs could be a result of their work not being recognised as work. Even in pre-covid times, they have been struggling to get recognised as workers. Even during the pandemic, when their workload had substantially increased, there was little recognition of their work and them as workers. The literature on Feminist theory suggests that it is so because the work done by them is not considered skillful or technical enough to be recognised as work. ASHAs across the country have been protesting demanding for pending salaries, low wages and safety equipment (ASHA workers across country to go on strike on Monday, 2021) (Karnataka ASHA workers protest demanding pending salaries,

safety equipment, 2021) (Coronavirus: Around 6 lakh ASHA workers launch protest, demand better pay, health insurance, 2020). Anganwadi workers have been protesting for better pay and job security (Sit-in protest by anganwadi workers continues, 2021) (Rao, 2021) (Mallick, 2019).

COVID has also demonstrated the CHWs ability to fight the invisibilisation enforced upon them with efforts to mobilise, unionise and protest. This display of strength to protest and to be seen as visible, was constant in the past few years. However, COVID also displayed the health system's reliance on the frontline workforce. Their work of mobilising the community; assessing, diagnosing and monitoring them; raising awareness; promoting covid-appropriate behaviour among others is not recognised as requiring skills. However, handling and managing a pandemic is difficult to imagine without CHWs fighting at the frontline.

Recognising the contribution of CHWs and visibilising their struggles to deliver is central to ensuring well-functioning health systems. This also necessitates efforts to ensure greater representation of CHWs' perspectives in program delivery. This is especially critical as India is preparing for frontline response to a potential third phase of the pandemic and for long-term recovery and resilience effort.

Bibliography

Ministry of Health & Family Welfare, Government of India. (2020, March 27). Retrieved from Ministry of Health & Family Welfare: https://www.mohfw.gov.in/pdf/FacilitatorGuideCOVID19_27%20March.pdf

Sinha, D., Gupta, M., & Shriyan, D. (2021). High Risk without Recognition: Challenges Faced by Female Front-line Workers. *Economic & Political Weekly*.

Behan Box. (2021). *Female Frontline Community Healthcare Workforce in India during COVID-19.* Behan Box.

Hatton, E. (2017). Mechanisms of invisibility: rethinking the concept of invisible work. *Work, employment and society*, 336-351.

Allen, D. (2015). *The Invisible Work of Nurses: Hospitals, Organisation and Healthcare.* Routledge.

Armstrong, P. (2013). Puzzling Skills: Feminist Political Economy Approaches. *Canadian Review of Sociology*, 256-283.

Palmer, E., & Eveline, J. (2012). Sustaining Low Pay in Aged Care Work. *Gender, Work and Organization*, 254-275.

Baines, D., & Armstrong, P. (2019). Non-job work/unpaid caring: Gendered industrial relations in long-term care. *Gender, Work and Organization*, 934-947.

Twigg, J., Wolkowitz, C., Cohen, R. L., & Nettleton, S. (2011). Conceptualising body work in health and social care. *Sociology of Health and Illness*, 171-188.

Armstrong, P., Cornish, M., & Millar, E. (2003). Pay Equity: Complexity and Contradiction in Legal Rights and Social Processes. *Changing Canada: Political Economy as Transformation*, 161-182.

Department of Health & Family Welfare, Government of Gujarat. (2020, March 20).

Rammohan, A., Goli, S., Saroj, S. K., & Jaleel, C. A. (2021). Does engagement with frontline health workers improve maternal and child healthcare utilisation and outcomes in India? *Human Resources for Health*.

Mishra, A., & Santosh, S. (2021). *Aren't we frontline warriors? Experiences of grassroots health workers during COVID-19.* Azim Premji University.

Ballard, M., Bancroft, E., Nesbit, J., Johnson, A., Holeman, I., Foth, J., . . . Schec, J. (2020). Prioritising the role of community health workers in the COVID-19 response . *BMJ Global Health*.

Thareja, A., & Singh, A. (n.d.). Community Health Workers: The COVID Warriors of Rural India. *International Journal of Policy Sciences and Law*.

Bhaumik, S., Moola, S., Tyagi, J., Nambiar, D., & Kakoti, M. (2020). Community health workers for pandemic response: a rapid evidence synthesis. *BMJ Global Health*.

Accountability Initiative. (2021). *Experiences of frontline workers in Rajasthan and Himachal Pradesh during the COVID-19 Pandemic.* New Delhi: Accountability Initiative, Centre for Policy Research.

Bhatia, K. (2014). Community health worker programs in india: a rights-based review. *Perspectives in Public Health*, 276-282.

Novick, G. (2008). Is there a bias against telephone interviews in qualitative research? *Research in Nursing and Health*, 391-398.

Ministry of Women and Child Development. (2021, February 11). Welfare of Anganwadi and ASHA workers. Delhi: Press Information Bureau.

Workers in Their Own Right. (2019). *Economic & Political Weekly*.

ASHA workers across country to go on strike on Monday. (2021, May 23). The New Indian Express.

Karnataka ASHA workers protest demanding pending salaries, safety equipment. (2021, May 24). The News Minute.

Coronavirus: Around 6 lakh ASHA workers launch protest, demand better pay, health insurance. (2020, August 07). The Scroll.

Sit-in protest by anganwadi workers continues. (2021, February 24). The Hindu.

Mallick, S. (2019, February 26). Anganwadi workers hit the streets in protest. Down to Earth.

Rao, S. (2021, March 2). 'Govt treats us like free labour': Angwanwadi workers protest in Bengaluru. The News Minute.

Directorate General of Health Services, Ministry of Health & Family Welfare. (n.d.). Retrieved from Ministry of Health & Family Welfare: https://www.mohfw.gov.in/pdf/GuidelinesonrationaluseofPersonalProtectiveEquipment.pdf

Ministry of Health & Family Welfare. (2021, February 09). Security Measures for Asha Workers during COVID- 19. Delhi: Press Information Bureau. Retrieved from Press Information Bureau.

Ministry of Health & Family Welfare. (2020, March 29). Pradhan Mantri Garib Kalyan Package: Insurance Scheme for Health Workers Fighting COVID-19. Delhi: Press Information Bureau.

Roalkvam, S. (2014). Health governance in India: Citizenship as situated practice. *Global Public Health*, 910-926.

Scott, K., Javadi, D., & Gergen, J. (n.d.). *India's Auxiliary Nurse-Midwife, Anganwadi Worker, Accredited Social Health Activist, Multipurpose Worker, and Lady Health Visitor Programs*. Retrieved from CHW Central: https://chwcentral.org/indias-auxiliary-nurse-midwife-anganwadi-worker-accredited-social-health-activist-multipurpose-worker-and-lady-health-visitor-programs/

Government Resolutions passed by the state government

GR number *Parach*/102020/SFS-13/Z, Department of Health & Family Welfare, Gujarat Government (20.03.2020)

GR number NCV-102020-G.O.I.-15 G, Department of Health & Family Welfare, Gujarat Government (14.05.2020)

GR number NCV-102020-SFS-2-G (P.F.), Department of Health & Family Welfare, Gujarat Government (22.06.2020)

GR number NCV-102020-SFS-2-G (P.F.), Department of Health & Family Welfare, Gujarat Government (17.07.2020)

GR number-*Ashaf*/1020/N.B.-07/Gh, Department of Health & Family Welfare, Gujarat Government (27.07.2020)

GR number: EAST/102020/516/B, Department of Health & Family Welfare, Gujarat Government (15.09.2020)

GR number:FPW-102020-1350-B 1, Department of Health & Family Welfare, Gujarat Government (09.10.2020)

GR number NCV-102020- G.O.I.- 15-G, Department of Health & Family Welfare, Gujarat Government (09.11.2020)

GR number:FPW-102020/1142/B 1, Department of Health & Family Welfare, Gujarat Government (18.01.2021)

GR number: ICD/112021/54/B, Department of Women and Child Development, Gujarat Government (15.04.2021)

GR number: ICD/112020/2035/B, Department of Women and Child Development, Gujarat Government (31.03.2021)

GR number: ICD/112012/536/B, Department of Women and Child Development, Gujarat Government (24.06.2020)

GR number: ICD/1120009/732241/B, Department of Women and Child Development, Gujarat Government (18.07.2020)

GR number: ICD/102018/1232/B1, Department of Women and Child Development, Gujarat Government (09.07.2020)

GR number: ICD/112020/83/B, Department of Women and Child Development, Gujarat Government (08.04.2021)

GR number: ICD/112020/83/B, Department of Women and Child Development, Gujarat Government (08.04.2021)

GR number: ICD/102020/1067/B, Department of Women and Child Development, Gujarat Government (31.03.2021)

GR number: ICD/112021/98/B, Department of Women and Child Development, Gujarat Government (26.04.2021)

GR number: ICD/112020/156758/B, Department of Women and Child Development, Gujarat Government (30.05.2020)

GR number: ICD/112020/409/B, Department of Women and Child Development, Gujarat Government (17.06.2020)

GR number: ICD/112020/156758/B, Department of Women and Child Development, Gujarat Government (30.06.2020)

GR number: ICD/1121017/177856/B, Department of Women and Child Development, Gujarat Government (17.03.2020)