WOMEN AND VOLUNTARY WORK: A CRITICAL GENDER PERSPECTIVE ON ASHAS IN THE KAMRUP DISTRICT OF ASSAM

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INTRODUCTION

Rina Baideo was in her fifties when I first met her. She was working as an Accredited Social Health Activist (ASHA) in the Kamrup district of Assam. On the day of our first interview, I met her at around four o'clock in the afternoon, on her way home from her workplace, the Primary Health Centre (PHC) of the village. Rina Baideo told me to come to her home. When I called her before going to her home, she was still at the PHC, packing her belongings to head back home. She said it would take her half an hour to reach home, and told me to come after that. In response, I asked for her permission to walk with her on the way back home. I also live in the same village; her workplace was near my home. Each day she walks 2 km from her home to the workplace. From my house, it took 15 minutes to reach the PHC. Upon reaching the gate, I saw Baideo coming out of her workplace. It was our first

meeting. So, I introduced myself to her. Immediately, a smile appeared on her face and she nodded. We spoke for a while in front of the office, by the side of the main road. I explained why I wanted to meet her as we started to walk. She smiled and said, 'Kunba thakili bhal lage khuj karba keteba keteba, rastatu taratari khekh howe kotha pati pati geli.' (Sometimes it feels good to walk with the company; the conversations make the road shorter.) As we proceeded towards her home, I initiated the discussion about her work timings. She said, 'Dekhsai nohoi, amar ghor jawa timeor eku hisab nai, COVID howar pai tu aru beleg beleg kamu korba lage ami.' (Look at our condition! We had no proper time to go home from our workplace; once COVID started, we were assigned many different responsibilities.) Baideo narrated various incidents from her everyday life experience,

> I was unemployed. Our entire family was struggling for everyday survival. My husband has been doing different kinds of work for our livelihood. However, we were not able to manage our needs and those of our three children. Everyone in our locality was aware of our economic condition. Our local ANM (Auxiliary Nurse Midwife), who was also a resident of our locality, informed me about the vacancies for ASHA workers in our village. I immediately agreed to join the work, and she took me to the sub-centre Primary Health Centre. The ANM Baideo completed all my joining procedures in the office, and after that she explained the nature of my work.
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> In the beginning, the nature of my work was different from what it is now. The primary responsibility allocated to us was to assist pregnant women in having healthy deliveries by staying in contact with them from the start of their pregnancy, so that their babies might be delivered at a nearby government hospital. Post-delivery, we had to keep track of the babies' regular vaccinations. As the work was considered voluntary, there were no fixed work hours. Initially, my duties were scheduled for two hours on specific days of the week. On the vaccination day, my duty would start at 9 AM and continue

> till 3 or 4 PM. Apart from delivery work and vaccinations, we were assigned a few other responsibilities.
>
> On the day I started to work, I was told that I would be paid a minimal sum dependent on my work performance. This amount was called manoni. In Assamese, manoni means an honorarium of a minimal amount to commence work. Apart from that, a few other incentives were also given: 250 rupees for an injection for every baby aged one and a half years, 250 rupees for home care for babies, and 250 rupees for injections like tetanus toxoid. During the pandemic, our working hours increased, and we were assigned a variety of jobs in addition to our previous employment, such as door-to-door visits, ensuring home quarantine of people who had travelled from out of state, checking oxygen levels, delivering medications, and testing those with symptoms. It was frightening to leave the house and work in a public place where we could become infected at any time.

My conversation with Rina Baideo opened up varied topics for discussion. Baideo talked about the nature of work and employment from a subordinate gender perspective. During the COVID-19 pandemic, the state government assigned different types of work to ASHA workers. As mentioned, these workers are 'voluntary' community health workers; they are not regular employees. ASHAs help to bridge the gap between state healthcare facilities and the community to improve rural health by creating awareness of the existing health infrastructure. Naila Kabeer et al. have critically analysed the care work provided by women during the COVID-19 pandemic through a feminist-political glance (2021, 3–9). They point out that the pandemic impacted women's unpaid care work within the private household and their paid care work in the labour market. In this context, M.S. Sreerekha argues, 'women's bodies and the way they are produced/socialised into our societies as responsible mothers/caretakers together make women less valued as workers in the world of production and work' (2017, 1–36). She substantiated the argument

by adding, while the senior positions within such schemes like the AWW (Anganwadi Workers) in these days are taken by more and more middle-class women from families which are also with political affiliations, other posts like the helpers of the anganwadis, Mid-Day Meal workers, or ASHAs who are not directly under the ICDS, are mostly from extremely vulnerable poor families, lowest in the hierarchies mostly of both caste and class, struggling in search of a livelihood through this work (2017, 1–36).

ASHA workers are officially recognised as field-based community health workers. The ASHA project was started in the year 2005 under the National Rural Health Mission (NRHM). The NRHM established rules for selecting ASHA workers, including the requirement to be a 'married woman' who lives in the community.

These guidelines state that each ASHA worker covers about 500 people in a village. The minimum educational qualification is 10th standard; however, depending on the availability of candidates, this criterion may be implemented or relaxed. After the selection, they are given 23 days of training.

Women's voluntary work has been a part of academic space and women's movements all over the world. Christa Wichterich (2021) pointed out, 'Women are recruited from their communities, typically came from deprived households, are above twenty-five years old, and maybe married, widowed, deserted, or divorced.' This shares similarities with the process of recruitment of ASHAs in Assam. In the field site, the economic status of the candidate is a major deciding factor in who joins the position of ASHA.

MAPPING THE FIELD SITE

The field site is a rural area located in the Kamrup district of Assam. In the field site, the majority of the population belongs to the Scheduled Castes and a small group of people are from the Brahmin caste and

Other Backward Classes. Although the majority of the residents are from the Scheduled Castes, they have been subordinated by the present upper-caste minority. However, in my everyday conversations, I observed that residents were not able to articulate the existence and intersection of caste, class, and gender in their surroundings. It has been 'normalised' and 'internalised'. Their everyday lives are impacted by plenty of stereotypical norms; these are considered to be normal in everyday conversation.

While contextualising subordination based on the intersection of identities, I could reflect on my everyday experiences. Being a scheduled caste woman, I encountered and observed different forms of marginalisation in the village. However, I could not articulate it without critical perspectives. These experiences were also normal for me—until I developed a critical perspective towards my 'social location'. Once I started to articulate various dynamics of power structures, I could contextualise various incidents from my memories. Memories provided the space to contextualise the connections between existing social systems and the functions of power dynamics. Further, the subordination developed by these power structures is based on caste, class, gender, and age. Kimberlé Crenshaw's (1991) articulation of intersectionality provided me with the critical perspectives to articulate my experiences. She discussed that the intersection of constructed social identities initiates layers of subordination among African-American women in their everyday lives. Gender-based subordination is not limited to the social construction of gender in a specific social system. Women's gender identity is also surrounded by other identities based on race, class, region, religion, age, power structure, and many other socio-cultural factors.

My childhood memories usually lead me to different conversations and observations. One of these is the Manasha Puja celebration held in a nearby upper-caste Brahmin village. Manasha is known as the Snake Goddess. The major attraction of this celebration is the possession of a group of men from a specific socio-economic identity, named deula. The deulas perform different activities such as dancing

in front of the goddess in their trance-state, foretelling the future, and providing medicines. From childhood onwards, I heard that no one from our village could join as a deula in the celebration. Whenever I asked for a reason, I was told that it was because one of the rituals in Manasha Puja includes the sacrifice of birds and animals. In my village, animal sacrifice is not permitted in any community celebration. A few men from our village claimed to have been possessed and tried to enter the space meant for the deulas. However, they couldn't get through because they failed the process set up to protect that sacred place to maintain the social stratification of that particular social setting. Apart from that, no woman has been possessed and claimed to be a deula during Manasha Puja. The space of possession is male-dominated. People from my village could only go and participate in other activities, such as watching the deulas during their performance, taking suggestions from them regarding diseases, and offering bird and animal sacrifices for their prosperity.

This entire experience from my childhood memory can be analysed from an intersectional perspective. Why could a particular subordinate group of people not qualify as per the criteria to perform a ritual set up by an upper-caste group? Is it because the ritual is practised by an upper-caste group and their perception of the subordinate group is of their being 'polluted' as compared to the upper-caste group's 'purity'? Why were women not possessed during this specific ritual in general, especially those from my village? Do women carry another layer of subordination apart from their caste identity? These questions have become an integral part of the everyday lives of a subordinate group since my childhood. In a patriarchal society, women face layers of subordination in claiming their rights and raising their voices.

In the field site, clothing has traditionally been restricted by patriarchal rules that specify what is "appropriate" based on gender, maintaining control over women's bodies and expression. Even seemingly simple actions like drying clothes are not immune to patriarchal influence. Here, women mostly wear mekhela-sador as their daily attire. The mekhela-sador is a traditional Assamese garment

for women, which comes in three pieces. The mekhela is the lower cloth and the sador, the upper cloth, worn along with a blouse. Women in this area dry their mekhelas in a corner of their houses. I only started to observe this nuanced and ingrained gendered norm once I began to read and do research in gender studies. Although I have observed it since my childhood, but not been able to articulate the context. The constructed patriarchal norms in the village normalised the belief that the lifespan of men, who are considered the breadwinners of the household, goes down if they walk under a mekhela. After hearing about this belief, I consciously put my mother's and grandmother's mekhelas along with other clothes to dry under the sun many times. In the beginning, one or two times, I was told not to do it. When I asked the reason behind it, both my mother and grandmother mentioned it as a practice followed since their ancestors' times. Afterwards, each time I put the mekhela under the sun, my mother simply changed the location of the mekhela without correcting me.

It is also interesting at this juncture to share the taboos associated with suwa (menstruation) in my locality. In Assamese, 'suwa' is also referred to as 'pollution/impurity'. When I was in school, each month, my mother isolated herself for three days. During those three days, my aunts would come to our house to cook, and sometimes my father prepared meals. My mother would be engaged in cleaning the surroundings of the household, and the dhan aru saul jara (cleaning of food grains). During her menstruation, she always asked me to give her the few small pieces of cloth that were kept behind the entire shelf used to stack clothes. After using these cloths, she would clean them and keep them in the sun at the back of the house, a place hardly visited by any member of the family. Later on, when I reached puberty, I realised the use of these cloths. When I recall the first day of my dhuweni (menarche), I can now contextualise it within the various social stigmas and the discourse of purity and pollution.

When I was in class nine, we had a part-time domestic help named Namila Baideo. She was a widow with a young son, working to support their daily needs after losing her husband just a few years into her

marriage. I still remember the day of my first menarche. I was scared and confused, and I began to cry in the washroom. Namila Baideo, who happened to be working nearby, heard me and rushed in to see what was wrong. I was upset and explained the situation to her through tears. Shortly after, my mother arrived, and together they calmed me down and tried to help me understand what was happening. I was kept in a separate room for four days, and on the fourth day, a ritual was performed where I was symbolically married to a banana tree. My parents hosted a feast for the villagers and relatives to mark the occasion.

However, Namila Baideo's presence at the event was not welcomed by many. Because she was a widow, some in the neighbourhood and extended family believed her involvement could bring misfortune to my future married life. Despite everything she had done to care for me, she was stigmatised simply because of her marital status.

The above narrative highlights the experiences of subordination encountered by a woman based on her intersection of identities in the field site. Namita Baideo's widowhood was constructed as a stigma. Her presence would become a curse to other women in different ceremonies. Being a widow, she was isolated from various spaces. Constructed social norms considered her a polluted body and a carrier of bad luck. The boys in our locality were teased and told 'Dhuweni khaba geli dari nogole,' which means that those who attend the menarche feast would not grow a moustache. It was also said that the lifespan of the men and boys would go down if they encountered a woman during her menarche. Thus, a woman going through her menarche is considered 'polluted' in the social system. These experiences helped me to understand a few aspects of the everyday experiences of an ASHA from a critical gender perspective. This research study, thus, aimed to understand the lived experiences of the ASHAs through their narratives in the Kamrup district of Assam. Different perspectives of understanding the social location and vulnerabilities of these ASHAs can be developed from the field site narratives.

HISTORICISING THE EMERGENCE OF ACCREDITED SOCIAL HEALTH WORKERS

The appointment of ASHAs began in 2005 by the Government of India under the National Rural Health Mission. The mission document of the NRHM states that the role of the ASHAs is to improve access to healthcare services for rural households. At present, a total of 10,47,324 ASHAs are engaged all over India (Ambast, 2021). According to the National Health Mission (NHM), one of its key goals is to provide a trained female health activist to each village in India. NHM encompasses its two Sub-Missions, the National Rural Health Mission (NRHM) and the National Urban Health Mission (NUHM). ASHAs are selected from the village itself, and work as an interface between the community and the public health system. The selection process for ASHA workers involves various community groups, Anganwadi institutions, the Block Nodal Officer, the District Nodal Officer, the village Health Committee and the Gram Sabha. ASHAs are appointed as 'voluntary workers', and so, they receive performance-based incentives for promoting universal immunisation, referrals and escort services for reproduction and child health, for creating awareness regarding healthcare programmes, and for the construction of household toilets. The ASHA worker is to be the first point of contact for any health-related needs of deprived sections of the population, especially women and children, who find it difficult to access health services. They are expected to create awareness among the community about health planning and increase the utilisation and accountability of existing health services. An ASHA is assigned the duty of providing counselling to women on pre-delivery and safe delivery measures, breastfeeding, complementary feeding, immunisation, contraception, and the prevention of common infections including reproductive tract infections and sexually transmitted infections, as well as providing care for the infants by providing vaccination information. Further, they facilitate community members in accessing healthcare services available at local Anganwadis, primary health centres and sub-centres.

Other responsibilities include storing essential primary medicines like oral rehydration therapy, iron folic acid, chloroquine, disposable delivery kits, oral pills and condoms, among others. The ASHA worker's job is not possible without institutional support, including Women's Committees (like self-help groups or women's health committees), the Village Health & Sanitation Committee of the Gram Panchayat, and the peripheral health workers, especially ANMs and Anganwadi workers.

WOMEN AND VOLUNTARY WORK

Nisha Srivastava and Ravi Srivastava (2010) have critically analysed the different contexts of women who work in rural India, pointing out that employment reduces poverty and enhances women's status. When they speak of women's status, they are referring to improvements in women's economic independence, social recognition, bargaining power within households, and overall self-esteem, all of which shift gendered power relations in rural society (Srivastava & Srivastava, 2010). This employment is liberating when it includes provisions to improve well-being and capabilities. Otherwise, low pay and distress will push women in to misery.

Nira Baideo, another research participant was in her 50s when interviewed. Her interview was taken at her home. On a Sunday morning, at around eleven o'clock, I reached Baideo's home. She was busy with household activities while waiting for my visit. When she saw me in the courtyard, she greeted me and told me to come inside the house. Considering the sensitivity of the pandemic, I requested her to sit with me in the courtyard. A smile of discomfort appeared on her face and she said, 'Coronai ki kori disi, aloha ahli sotalot bohba laga hosi' (Look what Corona has done to us, even my guests are sitting in the courtyard.) With those words, Baideo brought out two chairs and placed them in the courtyard. We sat down comfortably and initiated

the discussion. She wanted to know the purpose of my visit in detail research as I briefly explained it over the telephone. After listening to everything, Baideo started to talk about the initial days of her work and the reason behind joining as an ASHA. She narrated,

> I lost my husband when my younger son was two and a half years old. I have three children—two sons and one daughter. After the death of my husband, I started to work in other households and agricultural fields to support my children. It was a difficult time. In the year 2006, one of my aunties, who is working as an ANM at the Government Medical Hospital in the area provided the information regarding a vacancy for ASHA workers. She was aware of my economic instability and informed me about the available position. I agreed immediately and asked her to put my name in. I got the position in the same year.

Another ASHA worker I met, Hira Baideo, said,

> I am 50 years old. I studied till the 10th standard. I have three daughters. My husband passed away after the birth of my third daughter. Our ANM Baideo told me about the work done by ASHAs and the openings for positions in our area. I joined in the year 2007, even though my name was suggested many years ago.

Nira Baideo was in her forties when interviewed. She also joined as an ASHA to overcome the economic instability in the family. She shared,

> I started the work in the year 2006. My mother noticed an advertisement on television and told me about the work of ASHA. After listening to her, I spoke to our ANM and requested her to suggest my name for any vacant post. 'Amar abostha bor beya, dadere sakori nai' (our economic condition was bad, as my husband did not have a regular job). After I started my work as an ASHA, it helped our daily livelihood.

Another research participant, Romila Baideo was also in her fifties when I met her at the PHC. On that day, considering the crowd in the PHC, Baideo suggested that I go to a small tea shop and talk. Baideo told her ANM about the meeting and both of us left for the tea shop. Once we had settled down, Romila Baideo asked me to start the conversation. After receiving her consent, I asked her to explain the nature of her work and the reason why she began this particular work. She responded,

> My husband sold almost all our property, except the place where we are staying. He drinks a lot. I have three children, two sons and one daughter. Sometimes, my mother provides me with economic support; however, she can't always help me. Since no one in the family had a regular source of income, our economic condition started to deteriorate with time. Our ANM Baideo was aware of my condition and told me about the work and vacant position for an ASHA in our locality.

Sujay R. Joshi and Mathew George (2012) pointed out that one of the basic reasons that women opt for ASHA work is their poor socio-economic background. ASHAs start the job to support their families economically. The narratives of the research participants shared that their economic instability was pushing them to sign up for the work. Unskilled and low-skilled women remain vulnerable and disadvantaged when it comes to accessing opportunities that require skills. Annette Lansink (2009, 128) discussed that women remain vulnerable due to inequality in the distribution of resources over a long period. It disadvantages them with regard to access and control over economic and financial resources.

ACCREDITED SOCIAL HEALTH WORKERS: REGULAR WORK OR VOLUNTARY WORK

Accredited Social Health Activists (ASHAs) serve an important role in India's public health system, yet their contributions are generally

underpaid. Despite being the foundation of community health outreach, their working circumstances are nonetheless moulded by inadequate and uneven incentive structures. They are voluntary workers. Kavita Bhatia (2014) discussed the responses of ASHA's towards the implementation of policies to improve the work culture and incentives of ASHAs. Several studies point out the imbalance of task-based incentives of ASHAs. IIPS (2011) has noted that ASHAs asked for a fixed timely incentive. National Health Systems Resource Centre (NHSRC) (2011) has advised changing the pattern of payment to a fixed-plus-incentives system' (Bhatia, 2014). In the interviews, the stories of different ASHA workers reflected different perspectives towards their work and the incentives they received. Nira Baideo shared,

> After training, I was given the responsibility of providing care to pregnant women. That was the only responsibility I was assigned. The process starts with the registration of pregnant women in their third month of pregnancy and continues with regular check-ups for injections at different intervals such as the fourth, seventh, eighth, and ninth months. Agote paisai nasil (in the beginning, there was no income). Only 600 rupees were given against each delivery. Sometimes, if the family preferred to take the pregnant woman to a private nursing home, we could not claim that amount. We had no recognition and our work was considered voluntary work. We could leave work whenever we wanted to. Amar sarkari eku nai (our position is not considered under regular government employment). Slowly, our workload increased and now it is not possible to count the number of responsibilities assigned to us. We have polio vaccination duty and much more. During COVID, we were loaded with work. Once we receive the information about a COVID-19 infection, we should first inform the ANM Baideo. Then, we accompany Baideo to collect the sample for the COVID test for the infected person and the family members. If COVID is confirmed, we need to make arrangements for transportation, to shift the infected

> person to the COVID Centre. Apart from this, we were assigned many other tasks without incentives.

In another interview, Hira Baideo narrated,

> When I joined, ASHAs did not have regular, assigned working hours. We are not paid monthly honorariums. Each week, I was asked to go to the PHC for three to four days. At that time, only a few hours of work were assigned to us. We needed to stay longer only during the time of the monthly vaccination of infants. For that work, a minimum incentive was provided. Although the work did not provide better economic support, the distressing economic condition of my family did not allow me to quit the work. At present, my workload is equivalent to the regular employees of the PHC.

Narratives from the field site showed that initially the workload was limited, but increased eventually. Multiple duties were assigned to them during the pandemic without appropriate incentives being provided. They have been working for eight to fourteen hours a day. The assigned workload and working hours do not match the description of a volunteer worker. Rather, they work like regular employees. This trend is visible in most low-income countries where women's work is not recognised as work, but rather as an extension of care work, performed for the family, towards their community. With the categorisation of volunteers, neither the central nor the state government has any legal obligation to pay a minimum daily wage to the ASHA workers. There are over sixty tasks under the NRHM for which the state can set incentives for the ASHAs. Nira Baideo narrated,

> At first, I was given work related to pregnancy. As mentioned in our training, the work of the ASHAs is to monitor the birth and death rates of children and mothers in the locality assigned to us. Amar kam tu asil gorbhoboti mohilak khalas kora, batchak mati beji diya (our work was limited to helping pregnant women deliver babies in the government institution, and providing vaccinations in the nearby PHCs). Now, we

> have a countless number of tasks. During COVID, we were assigned the work of going door-to-door to create awareness and collect information about the number of people who have come from outstations. If found, they were to be made aware of quarantine. Further, we were collecting samples to test for coronavirus infection from the unwell villagers. If someone infected with the virus was staying at home, we provided health services. To provide all these facilities, we have to walk from our home to the PHC and from there to different places. Apart from this work, we were assigned the task of Malaria test sample collection, and routine check-ups for diabetes and blood pressure levels among the community members. The incentive per slide was fifteen rupees. The latest work assigned to us is a cancer test for the villagers.

The daily work, changing working patterns and incentives for ASHA workers are connected to the intersection of their identities. A single woman with children and a married woman from an economically unstable family may begin the work of ASHA to contribute to their family's economic position. For them, even a minimum amount is also a contribution to the family. Although there have been continuous changes to their patterns of work without much change in honorarium. Their intersection of identities does not allow them to leave the work. According to Shruti Ambast (2021), 'Rajasthan and West Bengal pay a fixed minimum of around Rs. 3000. However, even when combined with performance-based incentives, the ASHA's average monthly earnings do not match the minimum wage for a highly skilled worker.'

STRUGGLE FOR BASIC FACILITIES IN THE EVERYDAY LIVES OF ASHA WORKERS

Sinha, Gupta, and Shriyan (2021) extensively discuss the struggles of ASHA workers in an overburdened, understaffed, and under-

resourced health system. Further, the pandemic has added many other layers of subordination to their already-underpaid voluntary work. The narratives from the field site revealed the limited availability of healthcare infrastructure. In this context, the research participant Nira Baideo shared,

> Before the pandemic, regular visits to pregnant women were welcomed. With each family, a new bond develops due to regular visits. These visits were full of conversations, drinking tea and sometimes eating food together. In each household, the washrooms were accessible for use during our duty hours. During the delivery time of women, we have to go with the pregnant woman and wait until their child is delivered successfully, at any hour of the day. Most of the time, we have to spend the night at the hospital. At night, it is not possible to come back home without any company due to the lack of transportation. At the beginning of the pandemic, we were provided with some basic training, for one or two hours, to provide services to the community. We were provided with a few masks, two pairs of gloves, and a bottle of sanitiser to be shared by three of the ASHA workers working in the primary health centre. During that difficult time, the government deducted a thousand rupees from our honorarium for the welfare fund of the state. However, it was returned in the next month. The same deduction happened during the flood in Assam. Another thousand rupees was deducted for a welfare fund. Both times, the deducted amount was returned to our account after a few days. However, when it was deducted, we felt helpless and vulnerable. Our monthly income is already minimal for our livelihood.

In another conversation, Hira Baideo narrated,

> I used a cycle to reach work. Once I met with an accident and fractured my leg. Since that time, I have stopped cycling. At this age, I cannot even think of cycling. Now, walking is the

> only option I have. Ajikali aru rastat bike soluwa sinaki manuh pale khudhe, ASHA Baideo kot jabo, sinaki hole uthi ahu aru, ki korim (nowadays, I get a lift from people I know who ride two-wheelers on the road). Apart from this, I have to accompany pregnant women to the hospital and stay with them until the delivery. Earlier, we used to stay with the patient overnight. Now, I have stopped staying with them. When it comes to meeting our neighbours, I do understand the fear among all of them regarding the virus. I don't go to our neighbours' houses. In case of an emergency, I go to their courtyard to talk to them from a distance. Sometimes, the neighbours say, "Baideo namatu de amar ghorot, duty kori ase nohoi, beya napabo" (elder sister, please don't feel bad, we are not inviting you to our house because you go to work each day).

In the similar context, Nira Baideo shared,

> In our last meeting in the block office, our in-charge Baideo mentioned the insurance scheme for ASHA workers. According to Baideo, in the year 2013, an insurance scheme of 1 lakh was implemented for each ASHA worker, and it is still applicable. I feel good working with the villagers. The amount of respect I have received since becoming an ASHA was never given to me by the villagers before. I don't know about others, but I feel good when I go to the field. In this work, I was not paid enough for the workload assigned to me.

The conversation with Rina Baideo highlighted,

> We are getting three thousand rupees per month. It again depends on the work we do. Monthly, three thousand rupees is a decent contribution to my family income. However, there might be some deductions based on our performance. The three thousand rupees is not regular. Fundot paisa nathkili need (it depends on the funds; if money is not available, we don't get our monthly honorarium each month).

Ranu Baideo told me,

> We have five members in our family, including me, my husband, two daughters and one son. Both our son and younger daughter are studying. My elder daughter has passed her graduation and joined as a contractual factory worker in a company located in the city. She could not continue her studies because of our economic instability. The amount I receive from my work does help our livelihood; however, it is not sufficient. Ki koribi aru, company jaba lage, noholi ghar nosole (What can we do, without her job in the company, it has become difficult to manage our everyday needs.)

NAVIGATING LOSS DURING A PANDEMIC

The coronavirus pandemic has become a reason for loss for the entire world. People lost their family members. It further leads to loss of work, loss of friendship, and loss of access to education and health. For the ASHAs in the field site, the loss has different meanings. They lost their family members, lost friendships that had been developed through their work during community visits, as well as experiencing the loss of close interaction with family members, loss of access to cooking in their kitchen, loss of access to water in community water bodies, and loss of family time.

Rina Baideo was a frontline worker during the pandemic period, and speaks quietly while sharing her experiences. She narrated,

> It was scary; all my family members were also scared. Not only for me, but in our locality, people stopped visiting each other's houses. Being a frontline worker, my condition was different. I was not left with an option. I used to go for my duty and after coming back, I would directly go to our washroom and then enter the house.

Baideo's voice started to quake and she broke down in tears. Our conversation stopped for a while; however, her shaking voice and the tears in her eyes spoke of her emotions, her sorrow and loss. Her emotional state stopped me from asking her anything after that point. I sat quietly. Slowly Baideo started again, 'Amar dutare COVID hol, dutai hospital gelu, moi ghuri ahlu, kintu teo nahil aru.' (Both my husband and I tested positive for COVID-19 and we were admitted to the hospital. I recovered and came back home. I could not bring back my husband.)

In another conversation, Nira Baideo told me, I lost my younger brother during the pandemic. He was suffering from jaundice and later got infected with the COVID-19 virus. Apart from the workload, I was emotionally weak with the loss of my family member.

The fear of the pandemic and the issues with the process of vaccination created trouble for the ASHAs. In the village, various narratives have been spread concerning the side effects of vaccination. In the beginning, I was also in a dilemma because of those narratives. My aunty from my neighbourhood heard somewhere that an elderly woman in our village became bedridden after she was injected with the first dose of the COVID-19 vaccine. The spread of this information increased fear and uncertainty for many people in the locality. On the other side, as part of the survey, ASHA workers had to visit each household to create awareness regarding the COVID-19 vaccine. Giribala Baideo shared,

> In my locality, I have not been able to convince three members of one household. Apart from that, many of our fellow workers were treated badly by the villagers whenever we tried to create awareness regarding the first dose of the vaccination. The villagers are waiting for others to take it first. A few incidents of aggressive argument did occur where the ASHAs were chased away in one area.

STRUGGLE, RESISTANCE AND SOLIDARITY

Women's struggle, resistance, and solidarity have been an integral part of the women's movement worldwide. In the first, second, and third waves of feminism, women's groups fought for legal, political, and social rights. Gail Omvedt (1977) critically analysed the context of the women's movement with the changes in social structure. The exclusion of women from control of the means of production and productive work pushes them into care work and home maintenance. 'Women's movements are those which arise as conscious, organised efforts of groups of women (often supported by men) to change this system of economic, political and cultural inequality'. The ASHA workers' movement in India is a nationwide struggle by community health workers demanding regularisation, fair wages, and recognition of their vital role in the public health system.

In this context, Rina Baideo narrated her experiences.

> At present, we receive three thousand rupees per month due to the efforts of the ASHA workers' union. They have been raising the problems encountered by the ASHAs in their everyday lives. Each month, I give twenty or twenty-five rupees to our association. It is located in Guwahati. Although I was not called to every meeting, I joined the protest movement called by the union. We raised our voices. We protested in front of different offices. Our leaders arranged a protest march. We sat down in front of the DC office at Kachari, Guwahati.

Further, Nira Baideo mentioned,

> The uniform we received is also a result of resistance. Our uniform is a white saree with a blue border. When I wear the uniform during my visit to the community, I receive respect from the community, especially the children on the road who address me as 'ASHA Baideo' and request that I not give them injections. The work of ASHA provided different forms of space to visit different offices and attend meetings, direct

> interactions with healthcare service providers and to build an image among the villagers.

Giribala Baideo, a member of the All-Assam ASHA Workers Association was fifty-eight years old when I spoke to her. The interview was conducted over the telephone because she was fifty-eight years old during the COVID-19 pandemic. She shared,

> Without an appointment letter, what can you expect from our work, Baideo? We don't have an appointment letter, and that is why we cannot claim any form of benefit that a regular worker could. I have been associated with the work since 2006, which was the initial year of implementation of the ASHA scheme. After joining the work, eventually, we stated openly that the work was not providing us with any form of economic benefit. For the first time, in the year 2010, we developed our santha (union) to raise our voices and demands against different forms of subordination. ASHAs from different parts of the state showed solidarity with us. A few ASHAs joined us in Guwahati. However, due to some local strikes, transportation was not available on that day. Those who could not join us on that day called us and encouraged us to continue with our constructive initiative. In the beginning, one well-wisher from Dhuburi district helped us with all the procedures. We had taken a room for rent for the union office at Hatigaon, Guwahati. Our initial demand included thirteen issues. In the discussion with the authority, all thirteen issues were taken into consideration. Insurance of one lakh rupees was sanctioned for each ASHA worker.

Apart from insurance, the demand for restrooms for the ASHAs has been partially fulfilled. In some hospitals, a separate room was built for ASHAs. However, it is also used by other members of the hospital. Giribala Baideo further shared the difficulties encountered in meeting the higher officials. The union organised protest rallies in different district headquarters. In those protests, they go to the district

headquarters of the state to make their issues visible. She further mentioned,

> In the year 2011, twelve ASHAs from Assam, including me, went to Delhi. Our agenda was to meet the Health Minister. Again, on January 1, 2015, a three-member team that included Giribala Baideo and Rina Baideo went to Delhi. This time, with the help of proper connections, within three days, the group could interact with the then-Health Minister.
>
> We gifted one smarak patra (commemorative letter) and discussed the issues of the ASHAs in the region of Assam. Sir listened to us. He promised to solve the issues raised in the discussion. Once we came back, in March 2015, one thousand rupees was sanctioned by the central government as a monthly payment, with immediate implementation. We were happy to see the outcome of our visit to Delhi.

According to Baideo, this was one form of the solidarity and support from all the ASHAs and different helping hands from the state and the central government. Further, in March 2017, the Government of Assam sanctioned one thousand rupees of honorarium to the ASHA workers. However, they only started to receive that amount in March or April of 2018. It was paid depending on the availability of funds. Many times, the state held back the monthly payment and gave it to them as a lumpsum later.

Giribala Baideo explained further,

> We are not even able to pay the monthly rent for our office room. The rent is 2500 rupees.

Apart from insurance, 25,000 rupees was sanctioned for each ASHA for their treatment under the Ashar Kiron Scheme. It includes major surgeries and hospitalisation for severe diseases. However, awareness is required to popularise the scheme among the ASHA workers. A long process needs to be followed to claim the amount. Not all the ASHAs may be comfortable and familiar with the paperwork. It needs proper awareness and guidance.

Baideo continues,

> Let me tell you another sad incident. In the year 2012, one scheme was launched named "Zero Home Delivery". The target for an ASHA was to bring all the delivery cases to the government hospital from the locality assigned to them. The reward for the task was ten thousand rupees for each ASHA. We were happy and worked hard to fulfil the criteria to receive the amount. In our locality, most of the ASHAs fulfilled the criteria and waited for the reward. Finally, when the time came to receive the award, the authority followed a lottery selection and provided ten thousand rupees to two of the ASHAs from our locality. Out of approximately eleven hundred ASHA workers, only two of the ASHAs were provided with the reward. In the entire state of Assam, ten or eleven ASHAs were awarded.

Each ASHA worker I spoke with was looking forward to a better work-life balance. In between our conversations, some of them asked me, whether I was aware of any form of change in their work, whether it was going to be a regular post or not. What about their honorarium? What about their workload? As I explained the purpose of my work at the beginning of our conversation, I wondered whether I was not able to convey the purpose of my research study clearly, or if the ASHA workers had not shared their experiences with anyone before me. Occupying a subordinate gender identity and working a job that is not considered regular work, all of them had different stories to share. The conversation further disclosed the gap in the communication channels between the ASHAs and the responsible authorities, which has resulted in the inaccessibility of available resources for ASHAs.

CONCLUSION

Improvement of community health through community participation is a positive way to reach a larger group of people. ASHAs are one kind

of voluntary agent developed by NRHM to bridge the gap between healthcare facilities and people in communities. This research work tries to understand the everyday life of ASHAs, concerning their voluntary work. All the ASHAs interviewed, shared differences in experiences since the beginning of the work. The pattern of work has been changing continuously. During the COVID-19 pandemic, they became frontline workers. This role gave them different responsibilities. Their allotted workload was similar to regular employees. Despite being voluntary frontline workers, they did not receive the benefits provided for all other frontline workers. Their work remains invisible when it comes to benefits.

The ASHAs from the field site joined this work due to their intersection of identities. All of them try to contribute to the economic status of their families. Some are single mothers and some are the sole earning member of the family. Apart from economic support, these women also become close to the community, and they could access a few public spaces through their ASHA work which was not accessible to them prior to this. It provides them with the space to meet different people and make new friends. With different interactions, they become confident and conscious about their work. ASHA workers create a shared political consciousness and communicate their issues through collective participation in union meetings and grassroots mobilisation. This rising solidarity empowers people to resist exclusionary mechanisms and seek respect, rights, and dignity from the health-care system. Their battle is part of a larger movement for equity and justice, which positions individuals as active agents of change rather than passive receivers of policy.

NOTE

Baideo: In Assamese vocabulary, baideo is a word of respect for elder woman.

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