Understanding the Impact of Coronavirus Pandemic on Women: An Intervention Research on Women FHWs in Delhi NCT JICA (ID)10-27002

Final Report

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Reference: Final Report submission for the assignment titled 'Understanding the Impact of Coronavirus Pandemic on Women: An Intervention Research on Women FHWs in Delhi NCT for JICA India Office (ID:10-27002)

Dear Mr. Saito Mitsunori,

We sincerely thank you for giving us an opportunity to undertake the assignment on 'Understanding the Impact of Coronavirus Pandemic on Women: An Intervention Research on Women FHWs in Delhi NCT'.

As per the scope of the assignment outlined in the Terms of Reference (December 23, 2020), we are pleased to submit the Final Report. This final report includes the result and outcomes of the need assessment study and pilot intervention and recommendations drawn from both along with the outcomes of the dissemination workshop held on 31 January 2022.

We eagerly look forward to your feedback and inputs to satisfactorily close this report. Further, we would be happy to provide any clarifications or additional information necessary. We can be reached on the mentioned contact details or on my email id, kaustabh.basu@pwc.com

Best wishes,

Kaustabh Basu

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1. Introduction

Understanding the context in which the study was designed

In March 2020 the World Health Organization (WHO) declared the outbreak of coronavirus to be a pandemic, Public Health Emergency of International Concern[1]. Given the then limited knowledge available on the virus, including on its cure and treatment, globally countries were forced to take strong decisions to arrest the threat of a communicable disease. Its unprecedented spread further created panic among masses. As a preventive measure, several countries announced local or national lockdowns, limiting movement, and restricting interaction with the intent to slow the rate of transmission.

India, one of the world's most populated countries, executed a fifty-five-day national lockdown within months of reporting the first positive case[2]. The "Janata Curfew" was implemented by Prime Minister Narendra Modi to draw public attention (and public involvement) in what was called the "War Against Coronavirus"[3]. The Ministry of Health and Family Welfare (MoHFW) took responsibility for monitoring the spread of **Covid 19**. Given the country's high population density, and the quick spread of misinformed paranoia which inhibited citizens from promptly reporting on symptoms, **necessitated door-to-door contact tracing through front line health workers (FHW).**[4]

The country mobilized nearly three million FHWs on Covid response activities[5]. This group included the Auxiliary Nurse Midwives (ANMs) and Accredited Social Health Activists (ASHAs[6]). Given the sheer quantum of work and the quick turnaround time needed in the hour, Anganwadi workers (AWWs) were also engaged in Covid relief measures and the vaccination drive. **More than ninety percent of this cadre are women**; most recruited from the local communities that they serve. Each of these categories of front-line workers have a different profile of responsibility, catchment area, mode of work (institution based/ field based) and renumeration scheme. Within a short span of notice, the respective line authorities mobilized the FHW with requisite training, information, and gears to support the FHW's safety while in field and at work.

It is important to note that the Covid response initiatives are tasked in addition to their regular profiles on primary health care outreach and community nutrition programmes. Exhibit 1 below briefly captures the broad segregation in the respective profiles of the front-line workers that were engaged for the public health initiatives on Covid response.

Exhibit 2: Profile and background of frontline health workers

	Auxiliary Nurse Midwives (ANMs)	Anganwadi Workers (AWW)	Accredited Social Health Activists (ASHAs)
Program/ Scheme	Ministry of Health and Family Welfare	Functionary under Integrated Child Development Scheme by Ministry of Women and Child Development	National Health Mission by Ministry of Health and Family Welfare
Role	ANMs are the crucial component that connects ASHAs and the communities with the public health system	The Anganwadi worker is a functionary who manages the Anganwadi. The main function of AWW is providing supplementary nutrition and non-formal pre-school education	ASHAs are the first port of call for any health-related demands of deprived sections of the population, especially women and children
Based at	Health sub-centre or PHC	Anganwadi centre	Village/ urban HHs/wards

[1] Cited from https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-Covid-19---11-march-2020 Accessed on 10 June 2021
[2] Cited from https://www.nytimes.com/2020/03/24/world/asia/india-coronavirus-lockdown.html Accessed on 10 June 2021
[33] Cited from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7405894/ Accessed on 10 June 2021
[4] Cited from https://www.mohfw.gov.in/pdf/2COVID19PPT_25MarchPPTWithAnimation.pdf Accessed on 10 June 2021
[5] Cited from https://www.hindustantimes.com/opinion/indias-women-and-the-workforce-101615128493639.html Apria
[6] https://www.unicef.org/coronavirus/unicef-responding-Covid-19-india

Coverage	Population of 3,000-5,000 at sub-centres and 10,000 at urban primary health centres	Population of 1,000	Population of 1,000
Honorarium/ incentives	Salaries paid through Government health budgets	"Honorary workers" who receive a monthly honorarium	Receives performance-based incentives for a range of activities

The post pandemic era: an ecosystem of panic and heightened vulnerabilities for woman frontline health workers

In the last three years, all three cadres of workers reported a higher burden of work and field duties during the pandemic. ASHA and AWWs have been responsible for the bulk of Covid-19 related surveys, policing of quarantine centres, monitoring of containment zones, distribution of food rations over their regular set of non-Covid tasks. On an average, work hours have increased from six to eight hours a day to almost twelve to fifteen hours of work per day, while being on call for almost twenty-four hours. **Thus, the burden of work doubled for them.**

This doubling of work must be seen in cognition with the increasing burden of care in the pandemic era. With the shutting down of schools, Angandwadi, and care giving facilities, childcare became an added responsibility for the female FHWs. Significant rates of reverse migration impacted availability of house-help and daily wage labourers in urban areas. This further increased the burden of home care on woman. This is termed as the 'double-shift' of unpaid labour which disproportionately impacts women at large and often negatively influence their workforce participation. In this regard, it is noteworthy that among several developing countries, community health workers were supported with childcare. For example, Italy introduced a "Babysitter bonus" of up to 1,000 Euros (1104 US$) to pay for home-based childcare; in Austria, France, Germany, and the Netherlands, where childcare facilities and schools have generally been closed, some facilities remain open, with a skeletal staff, to look after the children of essential service workers[7]. **No such childcare support was made available to women FHW in India thereby increasing their burden of paid and unpaid work.**

This period was marked by an **increased instance of violence against women**. The National Commission for Women (NCW) registered an increase of 94 percent in complaint cases where women were assaulted in their homes during the lockdown in 2020[8]. This rage, accompanied by the fear from health workers (observed during the lockdown), rendered women community health workers at an increased risk of physical security. **Incidence of women FHWs being abused, assaulted, and pelted with stones were reported** from multiple Indian states including Karnataka, Odisha, Telangana, Uttar Pradesh, Haryana, and Bihar. Traditionally, FHWs invested on social capital, building a network of relationships and trust within the communities they worked in, to gain access and acceptance. While on field, the families that the FHW visited provided the FHWs with access to toilets and drinking water. However, the Covid paranoia particularly in the first phase and the growing distrust on the healthcare system severely impacted FHWs interactions in the community. **Women FHWs worked in an environment that posed threat to their physical and health safety.**

In an environment wherein the country was forced to work-from-home to break the chain of contamination, this cadre was and continues to be made to engage closely at the community thereby exposing themselves to a greater risk of infection (at work). Though the government proposed distribution of sanitizers, gloves, face-shield, head cap and PPE kits to all frontline workers, Oxfam India survey (2020) reported that only 75 percent of ASHAs were given masks, 62 percent were given gloves, and only 23 percent received full bodysuits. Women FHW were in a heightened health risk. It is broadly reported that **women FHW had to incur out-of-pocket expense on sanitation products** to protect themselves from COVID 19 virus.

Despite the above vulnerabilities, the women were not proportionately compensated for their additional efforts. ASHA workers who receive incentive-based honorariums saw their **incomes drop** between Rs 1000-5000 during the pandemic due to suspension of routine tasks such as immunization, pre and ante natal care etc[9]. ASHA and AWWs reported experiencing **debt burden** due to inadequate remuneration and delay in payments amidst job

The pandemic surfaced multiple vulnerabilities that women FHW were faced with in executing their tasks. They were stationed at an intersection of risk to Covid exposure, violence, job retention, and an increased burden of unpaid labour: a complex situation that heightened stress, anxiety, and fear

[7] Cited from https://www.ilo.org/global/about-the-ilo/newsroom/news/WCMS_741060/lang--en/index.htm
[8] Cited from https://www.alliance.edu.in/ijls/ijls-2021/assets/documents/COVID19-Lockdown.pdf
[9] Enlisted as part of a 2005 national Programme to boost healthcare services across rural India - from maternal care to vaccination drives - ASHA workers are treated like volunteers and not covered by state governments' minimum wage legislation

losses in their families. Further, the pandemic exacerbated debt situations as many have had to invest in android mobile phones for their children's online classes, out of pocket expenditure for protective gear, on food and medical expenses despite an overall loss in family income during the period of lockdown[10]. Unlike provisions of stay made available for doctors and nurses working with Covid patients, no such facility was made available to the frontline workers. Thus, the fear of passing the virus to the family was deep seeded. This fear was reflected by neighbours who ostracized and shun down the FHW and their families as possible carriers of the virus. The Indian Medical Association (IMA) reported more than 1800 deaths among health workers (including those of ANMs and ASHA) due to corona complications[11].

May 2021, ASHA declare a nation-wide protest the government for not being provided essential safety kits, and requesting minimum renumeration and release of insurance compensation

September 2021, ASHA and AWW went on a nation-wide strike to push for their demand of risk allowance and insurance cover while on Covid duty, and regularisation of appointments

August 2020, ASHA workers go on a two-day national strike asking for better and timely pay, and a legal status that ensures minimum wages, to sustain their work of helping Indian officials track down high-risk contacts of Covid-19 patients across slums and hard-to-reach rural parts of the country

Government's response to support the women FHW

To support the FHW and address the needs raised by them for a conducive work environment, the government has progressively announced plans and schemes. These includes enhancement of **performance-based incentives** to ASHA up to ₹1,500-₹2,000 a month; AWWs allowed performance linked incentive of INR 500 per month for performance in the ICDS-CAS under POSHAN Abhiyaan[12]; provision of five million rupees to the family of every health worker who died fighting Covid[13].

Further, the national insurance scheme supported by the central government includes accidental loss of life on account of contracting COVID-19. There is no age limit and requirement for individual enrolment for this scheme. The insurance cover is under the ambit of the 'Pradhan Mantri Garib Kalyan Package (PMGKP) Insurance Scheme for Health Workers Fighting COVID-19' announced in March for an initial period of 90 days. It was first extended for a period of 90 days and then further extended for another 180 days. the insurance is now scheduled to be ongoing for a period of one year with effect from April 2021.

Only 287 claims have been approved under the scheme as of April 2021 and 419 insurance claims have been settled as of June 2021.

The scheme is being implemented through an insurance policy from New India Assurance Company (NIACL). The entire amount of premium for this scheme is being borne by the Ministry of Health and Family Welfare, government of India. Additionally, states announced specific schemes, for example the Delhi government (April 2020) announced that for frontline workers expired by contracting the disease. during discharge of his/her duty, his/her family shall be compensated with four lakhs-, posthumously[14]. As of December 2021, this payment has only been made in one state.[15] The relevant state government paid Rs 4 lakh each for kin to 8,849 persons who succumbed to Covid-19 as on November 21[16].

[10]Cited from https://behanbox.com/wp-content/uploads/2021/03/APU-Report-Final.pdf
[11] Cited from https://www.bbc.com/news/world-asia-india-58621933
[12] Cited from https://pib.gov.in/PressReleasePage.aspx?PRID=1578557 Accessed on January 10th, 2021
[13] includes ASHA,ANM and other health workers with the exception of AWW https://scroll.in/article/968700/these-frontline-workers-died-of-COVID-19-their-families-are-now-struggling-to-get-insurance-money Accessed on June 15th 2021
[14] Cited from http://health.delhigovt.nic.in/wps/wcm/connect/4f01a3004dfc6f8688b3ebd194e333e1/ROC.pdf?MOD=AJPERES&lmod=-1778861831&CACHEID=4f01a3004dfc6f8688b3ebd194e333e1%27 Accessed on June 15th, 2021
[15] Cited from https://economictimes.indiatimes.com/news/india/bihar-becomes-only-state-to-pay-rs-four-lakh-each-to-kin-of-Covid-19-victims/articleshow/87971678.cms?utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst

[16] Cited from https://economictimes.indiatimes.com/news/india/bihar-becomes-only-state-to-pay-rs-four-lakh-each-to-kin-of-Covid-19-victims/articleshow/87971678.cms?utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst

Payment has been made for only 95 insurance claims as of January 2021[17] and 419 claims[18] as of June 2021. **To address the issue of delays arising out of states sending relevant documents for claim settlements, the government has developed a new system where now a standardized certificate availed from the district magistrate (DM) and endorsed by the nodal state health authority that will be regarded as sufficient evidence to process the claims for FHWs[19].**

AWWs and AWHs are entitled for paid absence of 180 days of maternity leave, two sets of uniform per year, insurance coverage under the Pradhan Mantri Jeevan Jyoti Bima Yojana (for 18-50 years age functionaries), Pradhan Mantri Suraksha Bima Yojana (for 18-59 years age functionaries) and Anganwadi Karyakarta Bima Yojana (for 51-59 years age functionaries)[20] **However**, i**n the COVID context, there has been reported challenges to availing leaves and restriction in flexibility of leaves supported for FHWs[21].**

For ASHAs, national guidelines envisage a support system that is functional at various levels of program implementation (State, District, Block, Sub-Block level) and is responsible for training and mentoring, provide supportive supervision and handholding. The guidelines also direct states to establish grievance redressal mechanisms for ASHAs at district level. However, all states are yet to execute and report upon the same.

Given the complexity of the situation and the multi-fold vulnerability that women FHW face in executing their work efficiently, there is a need to identify small and simple actionable steps to support women FHW wellbeing and socio-psychological health

Study rationale and objectives

In the current situation, the public health and nutrition services has not only enhanced the critical role played by the FHWs in protecting the community and the nation but has enhanced their vulnerabilities widening the gender gap.

To support this need, **Japan International Cooperation Agency (JICA)** commissioned **PricewaterhouseCoopers (PwC)** to design and implement an intervention research that can identify action-oriented solution(s) to support improve female frontline workers' wellbeing and efficiency in delivering their responsibilities on field. PwC in association with **MAMTA Health Institute for Mother and Child**, designed and conducted the pilot to understand the impact of Covid19 on women Frontline Health Care Workers.

Through this study, JICA intends to generate **critical insights** for practitioners, policy makers and programme implementers on the need, options, and ways to ensure gender equity and justice in programme delivery in a post COVID-19 development context. Further, the learning generated through the assignment would provide **actionable solutions** to create a protected and equitable environment for the large number of human resources working on the frontline to help the citizens.

The study was designed in two parts (1) Qualitative on-field needs assessment study with women FHW to understand their key socio and psychological concerns, available support, and requirements towards efficiently delivering their assigned tasks for Covid response; and (2) Designing and implementation of pilot testing of a model to support enhance the wellbeing and efficiency of the women FHW during and post Covid response.

The study was executed in the Delhi NCT region with the permission and support of the two related government departments namely **Department of Health and Family Welfare (DoHFW) and Department of Women and Child Development (DWCD).** ASHA workers and ANMS are under the purview of the DOHFW and similarly, AWWs function as part of DWCD. Interactions with senior officials, including the directors, of both departments helped in building an in depth understanding of the health system in India, especially in context of first line

[17] Cited from https://www.livemint.com/news/india/insurance-scheme-for-frontline-COVID-health-workers-payment-made-in-95-cases-11601998279428.html Accessed on January 10th, 2021
[18] Cited from https://indianexpress.com/article/business/economy/fm-stresses-on-faster-claim-disposal-for-COVID-workers-7346019 Accessed on 10 June 2021
[19] https://indianexpress.com/article/business/economy/fm-stresses-on-faster-claim-disposal-for-COVID-workers-7346019/ Accessed on June 15th, 2021
[20] https://pib.gov.in/PressReleasePage.aspx?PRID=1578557 Accessed on January 10th, 2021
[21] http://www.ras.org.in/impact_of_the_pandemic_on_accredited_social_health_activists_(asha)_in_india Accessed on June 15th, 2021

emergency response. Further, both departments played a key role in the mobilisation process for the pilot intervention.

Specific objectives of this intervention research are to:

- Understand the critical needs and factors that causes and perpetuates the gender gap in the life of the FHWs
- Identify possible mechanisms to improve the wellbeing of the FHWs through evidence creation
- Contribute to the collective learning drawn from the intervention research targeted towards a sustainable gender responsive support system for FHWs

Limitations of the intervention study:

Though the intervention study was designed to be implemented within the context of the pandemic, it is essential to understand the operational limitations that arose from these special circumstances:

- Extension of the expected timeline for the pilot intervention had to be stretched because of the onset of the second and third wave of Covid 19
- Delay in permissions from appropriate authorities due to the COVID-19 protocols and rules led to the led to the diminished time for implementing the pilot
- At multiple points of the intervention study, ASHA workers and ANMs went on strikes demanding adequate payment. During these strikes, we were unable to mobilise these workers to join the workshop as they were not reporting to work.
- Unavailability of ANMs and Supervisors owing to their small number and high-level responsibilities was a challenge.
- It was challenging to mobilise the family members of the FHWs as they were often lived far away
- The three FHW cadres were not similar in their background and experience in the pandemic and hence there are reported variations in their responses.

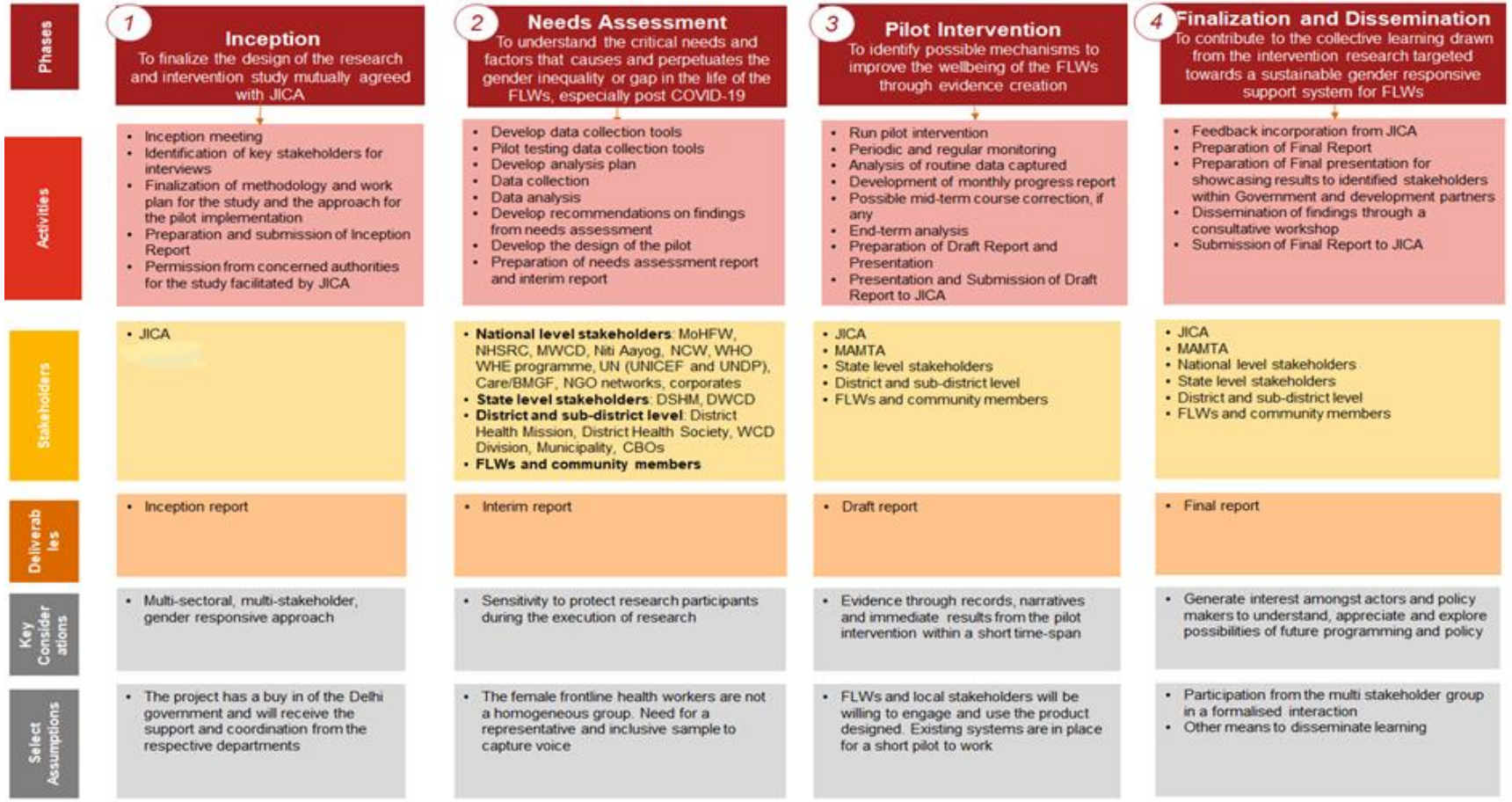
One of the most dynamic features of this study is the aspect of bringing together three distinct cadres of FHWs, namely ANM,ASHA and AWW across two critical government departments and assess the different vulnerabilities and challenges faced by these cadres in their performance and functions towards the COVID response

Study approach

The aim was to scientifically develop solutions that would be easy for women FHWs to comprehend, quick to adapt and simple to carry/ execute for wellbeing and improved efficacy. The focus was to unburden and assist, engage by participation, and convince with quick results. Further, given the increased load of responsibilities on the FHWs, during the implementation of this research, the solutions needed to be less time consuming and adapted to their daily routines. **Focus was to identify solution that come from the field; from the FHW.** PwC partnered with MAMTA Health Institute for Mother and Child to implement this intervention research. The study team worked closely with the departments of Health & Family Welfare, and Woman & Child Development, Government of NCT of Delhi.

The approach was tailored to include 1) Gender responsive outlook 2) Multi-stakeholder participation 3) Comprehensive qualitative assessment 4) Phased and output focused 5) Sensitivity to safety, security, and hygiene. To achieve the same, the study was structured in two key parts (1) a primary on-field needs assessment study to understand the impact of the pandemic on the frontline workers' wellbeing as well as the gender specific risks/ vulnerabilities of COVID19 on women FHWs; and (2) a pilot intervention, designed on the findings of the needs-assessment study, to improve FHWs well-being and access to psychosocial support.

Highlighted below is a summary of the overall methodology and details of each phase include



Assessment Framework

Given the complexity of the situation and the intersection of multiple influencers on the vulnerability of the women FHW (particularly during emergency response and relief measures), the study adopted a three-tier framework that progressively feed into each other and can support long-term sustainable change. The attempt was to engage multiple stakeholders in discussions and consultations. The tiers were looking:

1. **Macro level (policy environment):** indicators on this tier would investigate the following extrinsic aspects
    - Government actions to support FHWs in containing the spread of COVID-19
    - Economic stimulus packages for FHWs as incentives
    - Regulations to safeguard for protection, rights, safety, and security of FHWs
2. **Meso level (institutional and operational environment):** indicators on this tier would investigate the following extrinsic structural aspects at the institutional and community level to handhold:
    - Level of continued demand for services, contact intensity, safety protocols followed, supportive facilities, training/ capacity building for Covid 19
    - Level of integration of technology enabled platforms
3. **Micro level (interpersonal and individual level):** indicators on this tier would investigate
    - Supportive social environment extended by family and community to ensure continuity in service and mental well being
    - Interactions with peer and peer support
    - Interactions with supervisors and ease with social rank order in department hierarchy

Methodology

The study including the pilot implementation was planned for a year and carried out over a period of fifteen months between December 2020 - March 2022. The methodology adopted a four staged phased approach: (1) Inception and Planning; (2) Needs Assessment; (3) Pilot Intervention; (4) Finalization & Dissemination.

The diagrammatic representation below highlights the key elements of the study design methodology adopted.

Study coverage

The needs assessment study was designed considering the large number of stakeholders relevant to the sector across macro, meso and micro levels. It was important to consider consultations from each category. At the

macro level, the selected stakeholders included health officials from state and national level government departments, NGOs and IDAs; at meso level we included supervisors; and at micro level we included FHWs themselves, their family members and community leaders. Stakeholder consultations, in depth interviews and FGDs were conducted with the selected stakeholders.

Sample for qualitative need assessment study included consultations with stakeholders across diverse levels of authority. A summary of the sample distribution for the study is presented below in Exhibit 4.

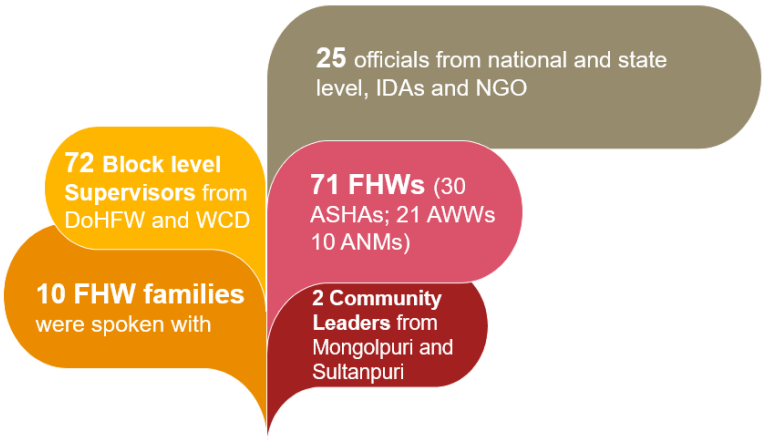


Exhibit 4: Multi-level sample adopted for qualitative need assessment study

Through the pilot intervention, we have reached out to over **250 stakeholders**, including **166 female frontline workers,** across Sultanpuri and Mongolpuri regions of Delhi NCT. A detailed coverage table is included in the pilot section. The training modules designed are provided in Annexure A, B and C:

Stakeholders

- **25 officials from national and state level government, IDA, and NGOs**
- **71 FHWs: 30 ASHA; 31 AWW; 10 ANM**
- **10 FHWs' family members**
- **2 Supervisors**
- **2 Community Leaders**

Location

Mangolpuri & Sultanpuri in New Delhi's North-West District

Structure of this report

This report is structured in five chapters. These chapters progressively present 1) Understanding of the context and methodology 2) Findings from the need assessment study 3) Pilot design, learnings from its implementation, and findings from the pre post assessment survey 4) Brief highlights from the dissemination workshop conducted. 5) Recommendations on the overall study and pilot intervention

2. Needs Assessment Study

Study Findings

The study findings have been analysed basis the insights and inputs received from stakeholders including senior representatives from government departments at the state and national level, IDAs and NGOs, FHWs, family members, supervisors, and community leaders. The findings have been categorised according to the theoretical framework of analysis; into macro, meso and micro levels.

Following is a summary of findings from analysis of data from all stakeholders:

Macro Level	Meso Level	Micro Level
1. Limited awareness of rights and entitlements, available health, and psychosocial support e.g., DMHP and government benefits such as medical insurance 2. Limited focus on gender sensitive approach across policy and programmes 3. Low exposure to Covid 19 related training and orientation and lack of Covid 19 related support in case of virus contraction in self or family 4. Increasing workload impacted role and dynamics across various cadres of FHW. 5. ASHAs in distress with enhanced workload owing to the voluntary nature of their work	1. Availability of positive peer relations as an important source of emotional and professional support 2. Experience of stigma and discrimination in the community since onset of Covid 19 3. Experience of a sense of comfort and safety for FHWs in terms of presence in the community as women 4. Limited availability and challenges faced in access to WASH facilities 5. Limited access to protective gear during early stages of pandemic	1. Experience of stress, anxiety and other mental health challenges faced in management of enhanced roles and responsibilities 2. Experience of demotivation among FHWs due to low remuneration in general and particularly on job insecurity for ASHAs 3. Challenges from performance of dual burden of housework, care responsibilities along with professional roles and responsibilities and experience of gender roles 4. Experience of distress regarding interaction with supervisor and limited opportunity of participation in decision making on planning of role and functions. 5. Family members' support as an important means of coping with the burden of additional roles and hours spent at work

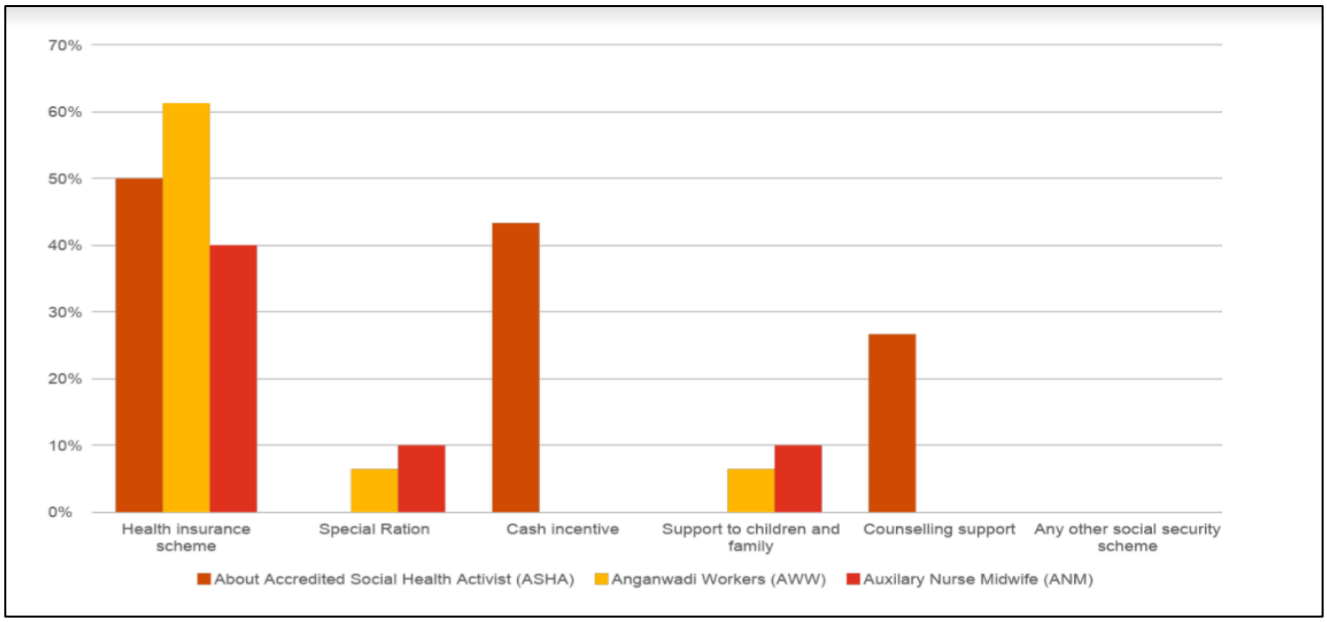
2.1 Macro Level findings

Macro level findings are related to policy response and awareness, access to government benefits and system level changes that affect the roles and responsibilities of FHWs.

2.1.1. Limited awareness of rights and entitlements, available health, and psychosocial support e.g., DMHP and government benefits such as medical insurance: **Less than 3 percent** of the FHWs in the study reported that they have no awareness of the available provisions of rights or entitlements as a woman or as an FHWs. Only one FHW reported being aware of any help line/ support system or a grievance redressal mechanism where they could reach out to in times of need or any crisis while at work. After probing, it was found that the FHW was referring to the police emergency helpline 100. Hence, it emerged that none of the FHWs interviewed were aware of any helpline/ support system or grievance redressal mechanism.

FHWs exhibited limited awareness about the various health and psychosocial support provided by the government. Following is a graph on their awareness of different support provisions.

Graph 4: percentage of AWWs, ANMs and ASHA workers' awareness of government benefits (UniveRSe:71 for each provision)



In the above graph, it can be observed that more FHWs were aware about the **health insurance scheme** than any other benefits from the government. Only ASHA workers were aware about **cash incentives** since they were the only cadre who were given cash incentives for additional Covid19 responsibilities. This is owing to the voluntary nature of their work.

None of the FHWs reported to be aware of counselling support provided by the government such as the **District Mental Health Program (DMHP)** or the national mental helpline number released in association with **National Institute of Mental Health and Neurosciences (NIMHANS)**. Further, not a single ASHA was aware of **special ration support** to children and family, which was seen to be present in the other two categories.

"While at the policy level there is a focus on adoption of a gender sensitivity approach, however, in case of protection against exposure to violence, there is a need for consideration of mental wellbeing that may often be omitted.

The voice of the grass root level workers from FHWs need to be considered during policy level to have more effective design and implementation of said policies."

Excerpts from interview with a national level government agency

2.1.2. Policy and programmes reflect limited sensitivity on gender aspects: There was limited inclusion of gender focused issues into policy and programming. Further, focus on initiatives to enhance support for greater involvement of FHWs such as provision for support in childcare or period leaves was also limited. FHWs (especially ASHAs) reported limited access to WASH facilities while on duty.

Stakeholders at the policy level mentioned that in a pandemic, the existing challenges for vulnerable demographics such as women are exaggerated. Often, there is no special planning for these sections of society. FHWs are especially vulnerable as they are sent to the frontlines in these emergency situations without adequate training or protective resources. No representatives from the cadre of FHWs is involved in the planning and policy formulations. Often these policies lack a gender lens and are often formulated from an urban lens.

Policy level stakeholders also explained that even regular processes such as selection of FHWs, especially with AWWs, is often influenced by patriarchal society. Usually, women related to powerful men are accorded these roles.

2.1.3. Low exposure to Covid 19 related training and orientation and lack of Covid 19 related support in case of virus contraction in self or family: FHWs gave varying answers to whether they received Covid 19

related training. Even within the same cadre, there were differing responses received. Some FHWs reported that they had two online trainings on general Covid 19 guidelines such as social distancing, importance of wearing masks, etc., whereas there were few who reported having had only one online training on the same and others reported that they had not attended any training related to Covid 19 at all.

From the variations in answers, it can be interpreted that the government did provide trainings and orientation, though the outreach of this effort was limited. It is evident that attendance for these trainings were not conducted in full capacity.

Interestingly, **none of the FHWs** from the study sample reported having received in depth trainings whose scope went beyond general guidelines and included information specific to the roles and responsibilities of the FHWs

Further, multiple FHWs reported that when they or their family members contracted the virus, they received limited support from departments, PHCs or clinics. In fact, four FHWs reported that they did not even receive oximeters and special ration that Covid 19 patients were entitled to and which they themselves had delivered to other patients earlier.

Exhibit 6: Case study 1

2.1.4 Increasing workload impacted role and dynamics across FHW cadres:

A complex interplay of dynamics was observed in the role of the three frontline cadres, namely, ASHA, AWW, ANM. The FHWs were keenly aware of differences in status and remuneration between cadres. During their IDIs, each cadre compared their own situations with FHW from other cadres. This was noticed more for ASHA workers than the remaining cadres. Many ASHA workers found the variation between the cadres demotivating particularly in the context of job security that AWWs receive in comparison to voluntary nature of their work with the incentive-based pay approach.

"My fellow ASHA workers have been my constant source of support. They have never refused to help me regardless of how much work they have themselves."

ASHA, D Block, Mongolpuri

On the other hand, many AWWs felt that Covid 19 related additional responsibilities should have been given only to ASHAs as they are assigned community health workers and were disgruntled with the number of additional responsibilities assigned to them.

Further, as the health sector now appears to move more towards technology integration, there is a clear divide formed amongst FHWs. Technology integration through apps, online databases and online means of communication tend to favour those who are conversant with English reading and speaking. Most of the FHWs interviewed as part of the study reportedly struggled with the language issue as not all of them were adequately skilled in use of the English language, for communication. FHWs who did not understand English felt that they had a lower status than those who did.

"I don't understand the instructions and messages that come in English. When we had joined, we were told that English is not required for the job. But as we have switched to smartphones, a lot of the messages come in English. I ask my peers to help me translate these, but I feel embarrassed."

ASHA worker, A Block, Mangolpuri

Exhibit 7: Case study 2

2.1. ASHAs in distress with enhanced workload owing to the voluntary nature of their work and irregularity of payment of COVID incentive: ASHA workers are community health workers instituted by the government on a voluntary basis. ASHA workers reported in the study that the voluntary nature of their job makes them feel that the status of their job is not 'permanent'. They explained that since they are not seen as permanent employees, they are not entitled to any rights and entitlements instated by the government. Furthermore, they do not receive monthly salaries. Rather they receive a stipend of Rs 3,000 and additional incentive-based commissions which are dependent on the amount of work they manage to complete within the month. ASHA workers explained that even the stipend does not remain fixed and guaranteed. There are six categories of work that they must complete for them to receive their stipend, otherwise it is reduced to Rs 500.

Out of the three cadres, ASHA workers received an additional incentive of Rs 1000/- per month for Covid 19 related activities. ASHA workers said that these incentives were given only till April 2021 and post which they were discontinued. ASHA workers expressed their dissatisfaction with the discontinuation of this incentive as their Covid 19 related additional tasks continued well beyond April 2021. Further, multiple ASHA workers reported not being paid on time and even referred to periods in 2015 and 2016 where they did not receive a few months' incentives due to an institutional error. Hence mismanagement of honorarium is an issue that affects ASHAs.

This finding extends beyond the context of stress experienced by FHWs since the onset of Covid-19 pandemic but affects FHWs' overall delivery of services and motivation towards their roles and responsibilities.

2.2. Meso Level findings

Meso level findings are relating to the institutional and operational environment in which the FHWs operate and deliver their services. It gives an understanding of the complex interaction of systemic macro level factors and the more immediate micro level factors.

2.2.1. Availability of positive peer relations as an important source of emotional and professional support: All FHWs in the study reported seeking and extending support to peers. Peer support was identified as an important source of emotional support within and outside the workplace. Many FHWs reported having a friendship with peers beyond their professional relationship and reported speaking with peers at an informal, personal, and emotional level. It is relevant to note that while support was received across peers, this was not extended across cadres, i.e., ASHAs relied on other ASHAs but not on AWWs or ANMs; similarly, for AWWs and ANMs.

In the context of the pandemic, with increased roles and responsibilities, FHWs relied more on peer support to better manage the rising workload. Additionally, as the health sector begins to integrate technology to increase efficiency, FHWs are encouraged to adopt use of smartphones, inculcate skills to enable online data entry and usage of English as a lot of the default settings in technological devices and apps are in English. For all these aspects, FHWs have relied heavily on their peers. Those with better understanding of the language have supported those struggling with the same.

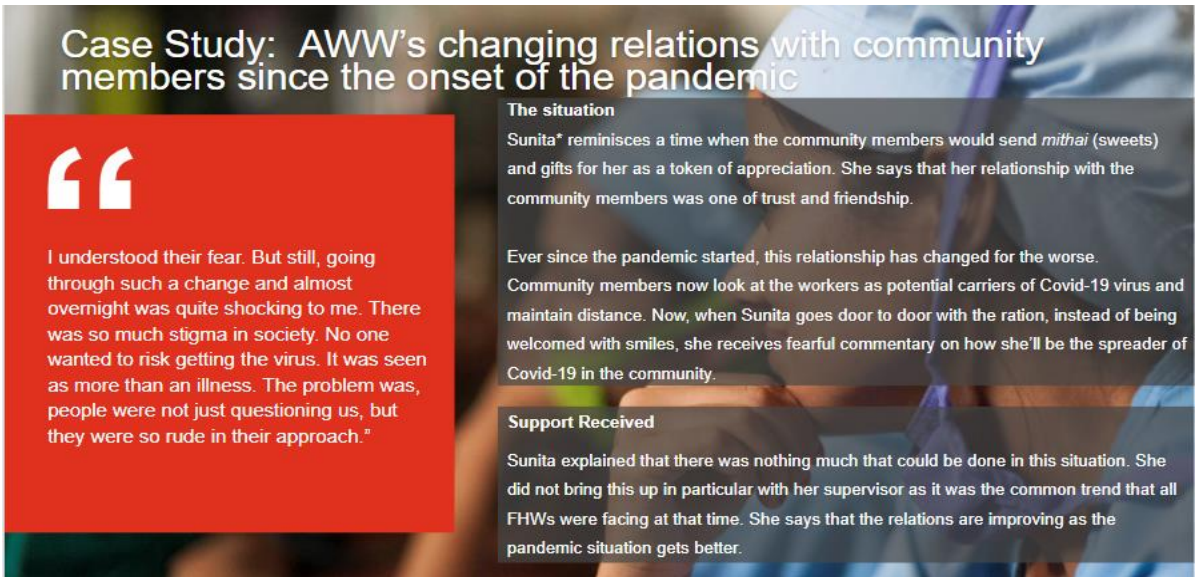
> *"Historically, FHWs in general and specially ASHA and AWW underwent a consistent steady rise in their workload over the recent decades. Any health scheme that is announced rests on their actions at village level. However, these cadres do not have any kind of job security.*
>
> *There is a need to understand the emerging role of FHWs in India and plan and support their engagement accordingly."*
>
> ***Excerpts from interview***

2.2.2 Experience of stigma and discrimination in the community since onset of Covid 19: FHWs relationship with community members began to change for the worse since the onset of Covid 19. FHWs faced discrimination and stigma from the communities they served. Community members felt that FHWs were at higher risk of infection due to the nature of their job and would spread the illness in their community.

> *"Community members did not want us visiting their houses even for regular visits for surveys and check-ups on pregnant women. They said that just the sight of an ASHA in front of their house was enough for others to think that someone in their house is infected, which would lead to social ostracization of the family."*
>
> *ASHA, B Block, Mangolpuri*

A deeper analysis shows that the community members associated FHWs as messengers of bad news. ASHA workers had the responsibility of contact tracing and identifying potential virus carriers. Community members felt that identified by FHW as a contact or a potential virus carrier, would lead to negative consequences in their social life. This was especially exaggerated by the government's rule of marking the houses of contacts and potential virus carriers with a government notice instructing the need for social distance from people within the marked household.

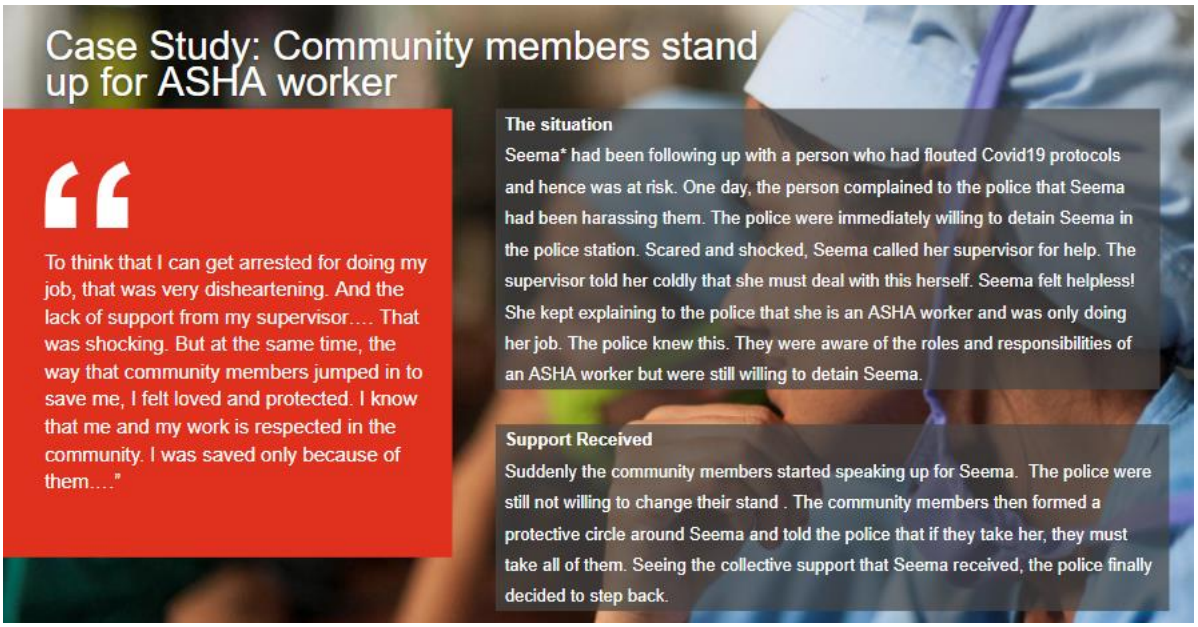
Exhibit 8: Case study 3



2.2.3. Experience of a sense of comfort and safety for FHWs in terms of presence in the community as women: Less than **3 percent** of the FHWs reported having been eve-teased or sexually/physically harassed while carrying out their job responsibilities or feeling unsafe in their locality. Since the FHWs have worked in the same community where they have lived for a long time and they have a pre-established relationship with the community members which brings about a sense of safety that any person would feel in their own locality. Those who reported having experienced harassment said that they were able to handle the situation and did not feel threatened by the experience.

Further, an FHWs reported that despite the stigma and discrimination related to Covid 19, community members still stood up for them when required. Following is a case study of an ASHA worker's experience of community support.

Exhibit 9: Case study 4



2.2.4. Limited availability and challenges faced in access to WASH facilities: Many FHWs reported having faced difficulties in accessing basic facilities while being on field. These facilities include WASH facilities and access to food and water. Amongst the three cadres of FHWs, a higher percentage of ASHA workers faced difficulty in accessing these facilities owing to the nature of their job . AWWs and ANMs are placed in centres where they often have access to WASH facilities and can designate a safe time and place to eat their lunch. ASHA workers on the other hand only report to centres when called. ASHA workers faced limited access to WASH facilities. ASHA workers from a PHC in Mangolpuri reported that they are often not allowed to use existent washroom facilities in the PHCs where the report as they are often reserved for use by the senior staff. With the onset of Covid19, this context of discrimination between senior staff and use of the facilities has widened even further.

> *"The washroom facilities in our PHC are reserved only for doctors. We avoid using it unless it is an emergency. And even then, we have to seek permission from our superiors."*
>
> ASHA worker, Mangolpuri

2.2.5. Limited access to protective gear during early stages of pandemic: **More than 70 percent** of **AWWs and ASHA** workers reported that provision of masks and sanitisers by the departments were not adequate, especially in the early stages of both Covid 19 waves. ASHA workers said that they received masks and sanitisers **only once or twice** (depending on the dispensary). Some AWWs reported not having received masks and sanitisers at all. Family members too reported that FHWs stitched their own masks during the first wave of Covid 19.

In contrast, all **ANMs** reported that they received masks and sanitisers in adequate numbers. The difference can be attributed to the **ANMs' placement in a health centre** where such medical protective gear is more readily available as opposed to ASHAs and AWWs who are not placed in medical centres.

A senior official from a national level government department explained that since the pandemic dawned upon them unannounced, no one had anticipated the drastic increase in the demand for protective gear and kits. The official explained that with limited protective kits and gears, they had to prioritise health workers who were directly dealing with Covid19 positive patients such as doctors, nurses, hospital staff and ANMs.

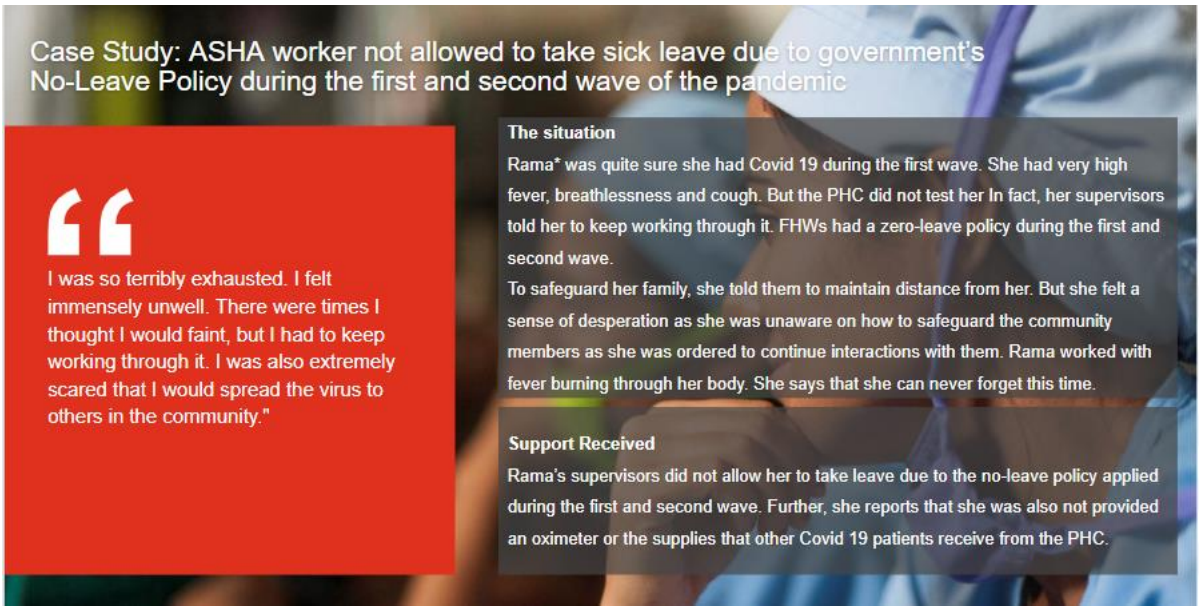
2.3. Micro level findings

Micro level findings pertain to findings emerging from the FHWs' interactions with their immediate environment. These findings are critical as it reflects on the understanding of the FHWs' personal experience of various systemic, operational, and interpersonal complexities that have already been touched upon.

2.3.1 Experience of stress, anxiety and other mental health challenges faced in management of enhanced roles and responsibilities FHWs from all three cadres reported feeling stressed and having difficulty in managing their increased roles and responsibilities since the onset of Covid19. Being part of the first line of responders in such a health emergency, FHWs faced a drastic increase in the work allocated to them since the pandemic started. All FHWs reported working **two to six hours extra** every day during the peak of Covid19 first and second waves. **100 per cent ANMs, 94 per cent AWWs and 67 per cent ASHA workers** reported feeling discomfort due to the long hours of work.

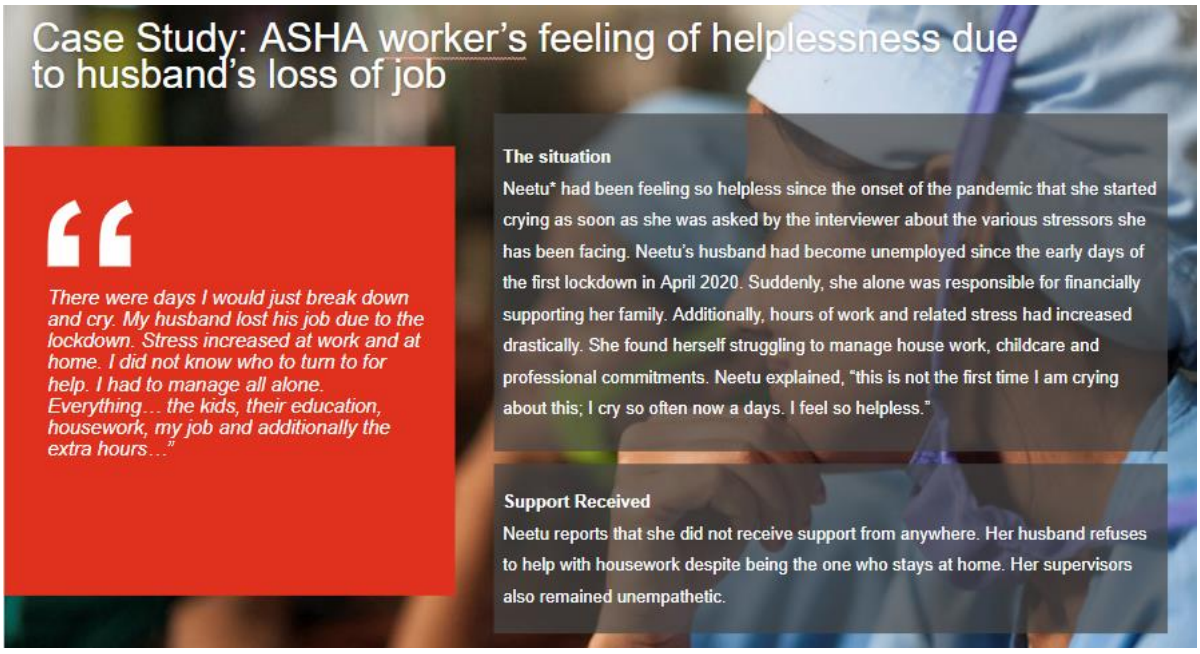
FHWs also reported that they were on a **no-leave policy** during the first and second wave of Covid19. This meant that they did not get a single holiday, leave, or weekends off through the course of the first and second wave. And were not allowed to take holidays even if they themselves were ill. This added to their physical and emotional burden.

Exhibit 10: Case study 5

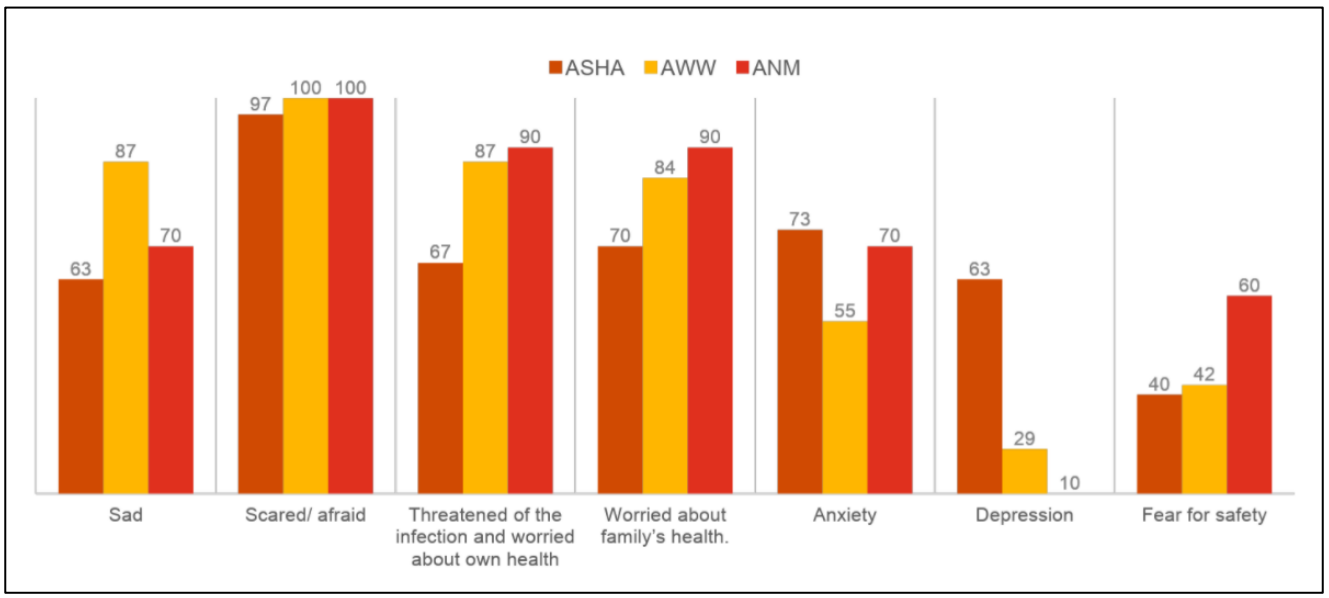


Other impediments that **hindered the efficiency and quality of service delivery for FHWs** including **discriminatory behaviours from community members**, **lack of support from relevant stakeholders** such as supervisors and **dual burden** of household and professional work. Many FHWs reported experiencing sadness, anxiety, feeling of being scared and worried for self and family's health during the peak of the first and second wave of the pandemic. **Many FHWs reported experiencing helplessness.** They explained that in these moments they turned to friends and family for support. Though, some FHWs revealed that they do not have anyone to seek emotional support from home, and hence they feel even more desolate and despaired.

Exhibit 11: Case study 6

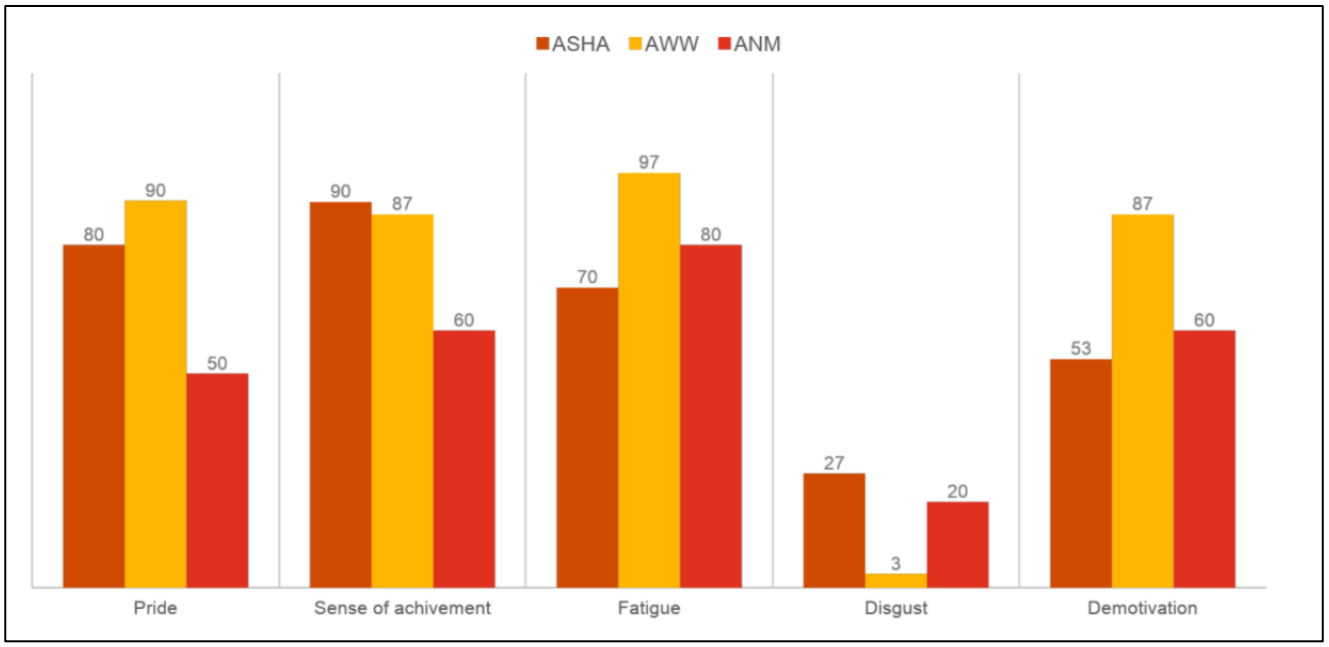


Graph 5: Percentage of AWWs, ANMs and ASHA workers who experienced negative mental states



When asked about their emotions towards the role they played during the pandemic, a large percentage of FHWs reported **feeling a sense of achievement and pride** about the role they played and continue to play in the Covid times. They explained that they understand the importance of their role and were happy to dedicate their time for the greater good of society. At the same time, many of them reported **feeling fatigued and demotivated** in their job.

Graph 6: percentage of AWWs, ANMs and ASHA workers' emotions towards the role they played during Covid19



2.3.2. Experience of demotivation among FHWs due to low remuneration in general and particularly on job insecurity for ASHAs: Almost all FHWs answered '**higher remuneration'** when asked about the nature of help they received in effectively doing their duty and for improving their wellbeing and working conditions. It can be interpreted that the FHWs' felt that their remuneration is inadequate which caused deep dissatisfaction in them as even with the presence of other severe challenges affecting them due to the pandemic, higher pay remained the most significant answer.

For **ASHAs**, the issue was more pronounced owing to the **nature of their employment**. As mentioned earlier, ASHAs are not considered permanent employees and hence are given **performance-based incentives**. Many

ASHAs mentioned that this leads to feelings of **financial insecurity among the workers**. That further enhances their sense of frustration and lack of clarity in career growth.

2.3.3. Challenges from performance of dual burden of housework, care responsibilities along with professional roles and responsibilities and experience of gender roles: FHWs experience the **dual burden** of **household responsibilities and professional responsibilities**. All FHWs in the study reported having to manage cooking, cleaning, and child rearing responsibilities along with increasing roles and responsibilities at work.

It is interesting to note that most of the FHWs are '**sandwich caregivers',** meaning they have to care for younger children and the elderly. On the other hand, most FHWs reported that their husbands do not face such a burden at home.

"My father is extremely proud of my job. Even during the peak of the pandemic, he would tell me to go out and help as many people as possible. He motivated me on days when I felt hopeless. He explained to me that no fear or exhaustion should be greater than one's need to serve others."

ASHA worker, A Block, Mangolpuri

2.3.4. Experience of distress regarding interaction with supervisor and limited opportunity of participation in decision making on planning of role and functions: There is significant difference in the extent of complication of relationship with supervisors amongst the three cadres. ASHA workers seemed to have fewer positive relationships with their supervisors than the other two cadres.

Almost **50 per cent ASHA workers** reported that their **supervisors were not available** during any crisis on field or while at work. Further they narrated incidents of stigmatising and discriminatory behaviour from their supervisors towards them. Furthermore, **all FHWs** said that they are **not part of any decision-making processes regarding their roles and responsibilities** or on the response to the pandemic at the community level. Additionally, **their opinion was not sought** even during allocation of additional responsibilities.

5. Family members' support as an important means of coping with the burden of additional roles and hours spent at work: Family members' support in managing household chores and child rearing activities was repeatedly acknowledged by many of the FHWs during their interviews. They explained that they were only able to manage long hours at work because they had help at home.

Though, it was found that members of the household who aided in the household chores were mostly women and not much help was provided by any male member of the household, including the husband reinforced the stereotype. The **FGDs with family members of FHWs further indicated** similar findings in highlighting importance of family members support in FHWs' delivery of services. It was evident that FHWs managed to carry out their increasing professional responsibilities only with the help of their family members in managing housework and child rearing activities. Family members discussed the ways in which they provided support to FHWs during the said period:

- Child rearing activities
- Cooking, cleaning, and washing
- Taking care of elders
- Being understanding of their long hours and providing emotional support
- Helping in data entry

2.4. Emerging areas from the study

Findings from across levels of analysis clearly indicate that the Covid-19 pandemic drastically increased and added to the stress levels of FHWs. FHWs are first responders at the community level for any medical emergency and provide essential services and dissemination of relevant information. The Covid 19 pandemic led to a large extent of additional roles and responsibilities for FHWs which yielded to a consequent additional rise of work ranging between two-six hours every day during the peak of the first and second wave of Covid-19.

"During the peak of the first wave, when I used to return to the dispensary after completing my tasks in the field, my supervisor would tell me to stand outside the door of her office. She would say that since I have been in the field, I probably am carrying the virus with me.

ASHA worker, Mangolpuri

Based on the study findings, few key factors which impacted FHWs' work efficiency and wellbeing include the following.

- Significant increase in roles, responsibilities and hours spent at work
- Limited awareness of government benefits such as health insurance for FHWs
- Limited awareness of government provision of psycho-social services such as DMHP and mental health helpline
- Limited support received from supervisors
- Dual burden of house and professional work
- Challenge of gender discrimination and harassment faced.
- Limited access to adequate health safety equipment such as masks and sanitisers

FHWs experienced **challenging emotional states** and other mental health issues through the course of the pandemic owing to the combination of the various factors mentioned above. It was found that FHWs often experienced **stress, anxious and depressive feelings, discrimination by community members, and were overburdened, demotivation, and burnt out.**

The study indicated a **strong need for building the capacities** of the FHWs in the areas of **coping with stress, coping with stigma and challenging situations, addressing gender roles and self-efficacy**, with an underlying emphasis on the i**mportance of addressing and acknowledging mental health as an important area of support** in building a **resilient group of community-based cadre**. These findings were used as foundation for developing the pilot design and intervention as discussed in the next section of the report.

3. Pilot Intervention

The training design was developed to **address challenges** faced by FHWs during the pandemic and is as an **output of consultative workshops** with the departmental functionaries, representatives of multiple NGOs working with FHWs in addressing COVID-19, in-depth interviews with FHWS, their family members and supervisors, and **findings drawn from secondary research**. The consultative findings were further validated with the effective strategies that have been implemented already in geographies worldwide with the parameters of **financial feasibility, timeline** to design a pilot training program for this intervention.

Exhibit 12: Measures to address mental health concerns of healthcare workers

Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7415074/

The study findings reflected the **need of addressing the psychosocial concerns of FHWs** to ensure their support in handling pandemics such as COVID-19. The findings at the Macro, Meso, and Micro level were kept in mind while **designing specific capacity-building strategies**/ sessions to influence the knowledge and attitude of FHWs towards building their problem-solving behaviour. It was of foremost importance **to inform FHWs of various provisions that the government has made available for them** for their social protection such as the mental health helpline number, health insurance, etc. **Informational handouts were developed** with a compilation of all available government resources which are provided to the FHWs. **These were distributed** post the workshop. However, the use of such provision is directly related to the realization of the need for such services and their availability. Keeping these aspects in mind, **specific sessions were developed** to make FHWs aware of the importance acknowledging and caring for their mental health, government provisions and building resilience to cope better with daily stresses of work and personal life.

In addition, study findings highlighted **demotivation, low remuneration and inadequate support structures** as major hindrances. This was addressed in the module[22] by introducing an exercise to reflect the value of work delivered by them during the pandemic. The same exercise was also introduced in the **training module of their supervisors and family members** to create a motivational and supportive environment reflecting the value to their work, especially during COVID-19.

At the **Micro level**, major findings have been **increased anxiety and stress** due to **increased work pressure and lack of guidance and support**. Many of them faced **mental health concerns such as sadness, distress, depression as well as demotivation**. They also **showed helplessness** in meeting their household and departmental assignments. Considering the various aspects, the pilot intervention **includes psychosocial components** to enable FHWs identify signs and symptoms of psychosocial concerns and how delaying the same may have negative consequences. The need was also felt to **sensitize** FHWs on managing productive roles and responsibilities while ensuring support from family members as well as immediate supervisors. On the other hand, the supervisors and family members modules[23] were designed to make them sensitive and respectful towards the valuable contribution of FHWs.

Pilot objectives

Based on the above backdrop, the pilot intervention was planned to enable FHWs with an **enhanced understanding** in **resolving psychosocial issues** to be better capacitated to manage wellbeing and present and future work role and responsibilities. The major objectives are listed below.

- To assess and mitigate select psycho-social challenges of female FHWs caused due to the additional roles and responsibilities assigned to them during the COVID 19 pandemic

[22] Please refer to the training module shared as part of Annexure
[23] Please refer to the training module shared as part of Annexure

- To improve the resilience of the FHWs and the key stakeholders in response to a crisis
- To implement a strategy that can be further replicated for the overall well-being of the female FHWs

The above objectives are directed towards addressing challenges identified during the study. All concerns the FHWs faced during the COVID at various levels the mechanism to address the same is mentioned below:

Challenge/ Concerns	Mechanism to integrate in response in the pilot design
Macro-level (policy environment)	
Limited awareness about COVID Suraksha insurance. (Pradhan Mantri Garib Kalyan Package)	Handout on the provision of the schemes as well as mechanism to ensure support of different stakeholders while availing services was introduced in the capacity building module of FHWs
Meso level (community and institutional environment)	
• Pushbacks were faced by FHWs in the communities they serve. This has been especially observed in urban/peri-urban parts of Delhi NCT as the FHWs come from outskirts/rural areas and residents are not very comfortable in letting them in.	• A specific session was structured on the ability to deal with challenging situations while applying of box solution technique, role, and responsibility exercise as well as the value of the work of the FHWs. • Stress management exercise was introduced to support FHWs in the identification and address of stress.
Micro-level (interpersonal and individual level)	
• Isolation was faced by FHWs in the communities they live. Most families have the fear of FHWs contaminating their households and being a carrier • Limited incentives/benefits to keep FHWs motivated such as holidays/leaves/recognition/rewards etc. (Witnessed more in the case of ASHA and AWW) • Limited pieces of training on psych-social issues and support mechanisms for FHWs during the pandemic	• Module/ session on improving the knowledge to ensure support of family and community in delivering their duty. • Handout on various provisions established by the government to motivate and support • The structured session for FHWs and supervisors on the ability to identify and address stress, anxiety while performing added responsibility during COVID Structured sessions on dealing with biased gender norms that limit the self-esteem of FHWs in addressing challenging situations such as COVID-19

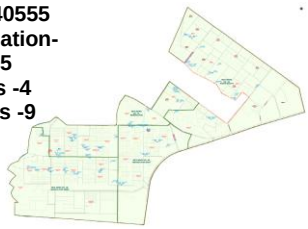
Pilot Coverage

The pilot was implemented in **Mangolpuri and Sultanpuri** of **North West District** in Delhi. The following exhibit reflects the socio-demographic profile of each selected location/ward. The mapping and line listing of the key target group/s was done for the effective reach out across the identified pilot locations in Mongolpuri and Sultanpuri. The detailed summary of the key demographic mapping may be found in the Annexures[24].

Exhibit 13: Geographical location of wards and demographic details

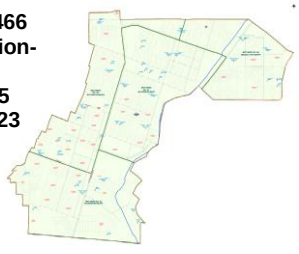
Mangolpuri

HH - 40555
Population-242905
Wards -4
Blocks -9



Sultanpuri

HH –52466
Population-305801
Wards -5
Blocks-23



[24] Please refer to the Pilot Schedule Annexure for the detailed demographic mapping highlighted.

The pilot coverage comprised FHWs, comprising of ASHA, ANM, and AWWs, Supervisors, and community members included community leaders and family members of FHWs. The details of the population covered is illustrated in the table below:

Category	Pilot Target	Achieved	% of Total Target*
Accredited Social Health Activist (ASHA)	70	85	121%
Auxiliary Nurse Midwife (ANM)	10	8	80%
Anganwadi Workers (AWW)	70	84	120%
Supervisors	10	5	50%
Family Members	50	68	136%
Total	**200**	**250**	**125%**

**During the mobilisation period, responses from various population groups differed significantly due to situational reasons. The number of ANMs and Supervisors in the health system is much lesser than those of AWWs and ASHA workers, as ANMs hold a supervisory position with higher number of responsibilities. Hence, we were informed by higher officials that many ANMs and Supervisors cannot be assigned to attend the pilot workshop. On the other hand, we saw a highly positive response from AWWs, ASHA workers and family members of FHWs. A higher number of AWWs and ASHA workers could commit to the intervention as there are a larger number of workers from these two cadres in each block.*

Pilot- Design

The integration of study findings in the development of pilot modules was essential keeping in mind the severity of COVID-19 in the intervention area and the need of involving FHWs in the emergency mechanism. The modules were developed considering the need for capacity building in FHWs for increased resilience and self-efficacy and better coping skills to safely navigate the multiple stressful situations that evolved with the onset of the pandemic. The following components were considered and prioritised while developing the pilot design. The framework below summarised the key assessment indicators, role of stakeholders and expected out comes from each of the components of capacity building:

Table 2: Framework of Pilot designing matrix

Components	Key considerations of design	Indicators for assessment	Role of stakeholders	Expected outcomes
Feasibility (during a pandemic)	• Availability of FHWs for the pilot during current lockdown that pose movement restrictions • Buy-in from relevant stakeholders to support pilot	• Departmental letter assigning FHWs to participate in the pilot	• Departmental officials supporting the need for such initiative	• Concurrence of the department to replicate the process
Geography	• Suitable for the focus geography i.e., Delhi NCT • Availability of necessary infrastructure to organize such a pilot.	• Prevalence of COVID in the area • Readiness of support available in the area to organize such intervention	• Department functionaries • Local CBOs/institutions' readiness to support the initiative	• Support of department and community institutions to address pandemic by involving FHWs

Components	Key considerations of design	Indicators for assessment	Role of stakeholders	Expected outcomes
Financial viability	• Availability of funds for developing/ adapting solution • Cost of human resources required to implement the pilot • Cost of infrastructure-related components for pilot implementation	• Structured module/ tools developed to organize sessions • Resources approved and allocated to organize planned activities	• Support agency • Departmental staffs • Implementing agency	Structured Training packages/ knowledge material and trained human resources available to replicate and sustain the effort. Tools to measure the impact of the training: • **Improved knowledge** in coping strategies, resilience, and management of work-related stress among FHWs • **Improved gender responsiveness** of the family and the system to facilitate the protection of FHWs • **Improved mental health strategies** and communication linkages between FHWs and the available services (psychologists, GBV centers, help line numbers etc.)
Timelines	• 3-4 months pilot • Ability to show achievable outcomes in 3 months	• No of the participants undergone through 8 to 9 hours training session • Pre- and post-assessment to measure desired change	• FHWs • Family members • Supervisors	
Convergence and sustainability	• Buy-in from relevant institutional stakeholders • Adequate scope for dissemination and sharing of best practices for replicability	• Letter of concurrence of the department to organize such pilot • No of sharing meeting with the department on best practice	• Department functionaries	Institutional arrangements/ partnerships to replicate the process

Pilot Training: Methodology and process applied

The pilot design was operationalized by using a stepwise process, wherein focus was on **a**) developing and adapting behavioural change structured modules for key stakeholders b) testing the materials with specific stakeholders c) developing tools to measure the changed) conducting pre- and post-assessment and its analysis and e) sharing the best practice and learning with the concerned stakeholders for replication and scale-up.

- **Development of training modules and tools**: **Three modules were developed** by PwC India and MAMTA HIMC to target the population groups, namely, **FHWs, Supervisors and family members of FHWs**[25]. The content of the modules includes participatory group sessions, audio-visual content, role-play scripts as modes. The content has been aligned with the existing ones of NHSRC, MoHFW, and other resources being used under the government program to build the capacity of FHWs. However, components on psychosocial and gender sensitization were adopted using **Attitudes towards gender norms scale (GEM scale)** and **self-efficacy scale** applied under various interventions under MAMTA- HIMC intervention. These materials were customized considering the current situation and the role of the stakeholders (ASHA, ANM, ANW, Supervisors, and FHW Families) in the demographic context of Delhi NCT. The detailed modules have been attached in a separate document of annexures.

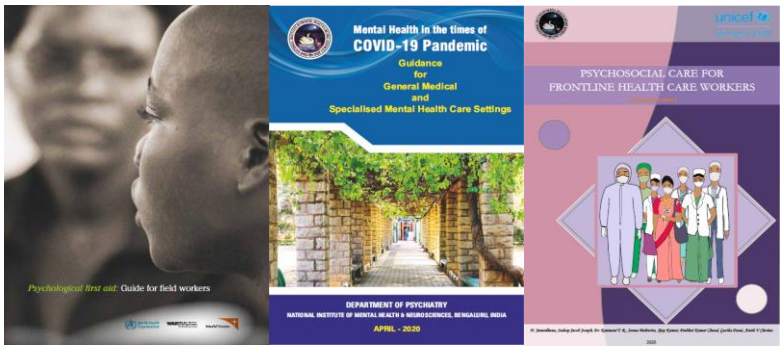


Exhibit 14: Examples of training modules

- **Testing of developed/ adapted materials**: The tested materials and tools were tested while organizing sessions at **two levels**. The **first testing** was conducted with the development project staff who were implementing various community interventions with the support of FHWs. This testing highlighted the need

[25] Details of the mentioned training modules may be found in the Annexures.

of incorporating communication and time management in the module. The need was further supported by the supervisors of FHWs who direct reporting officers of these functionaries are. It helped in integrating time management components within the module, which has been identified as the major cause of stress and anxiety. The second testing was conducted with the identified FHWs to validate and finalize the module for its operation in the field

- **Developing assessment tools to measure change:** Given the timeline of the intervention, **two levels of assessment** have been applied under the intervention pre and post as well as feedback of the participants after 15 days of application of the learning. The **assessment tool** was developed by trained psychologists/experts with relevant experience. The assessment indicators are based on **GEM and Self-efficacy standard tools** that have been adapted in the context of the intervention.

- **Organizing structured sessions:** The pilot intervention has been designed to engage **25-30** participants in each group for approximately nine **hours** spread over **three days**. Each session was further spread over **180 minutes**. The entire course was divided into two parts a) two days of training with a focus on building knowledge, attitude, and skills of FHWs to address mental and psychosocial concerns and b) follow–up for review after fifteen days to inculcate learning into the practice. **Eight such batches** comprising of over **150 FHWs** were organized. In addition, training batches were organized for family members and supervisors to provide a supportive eco-system to the FHWs translate their learning into action. It is important to mention here that FHWs were mobilised with the help of concerned departments such as the DoHFW and the DWCD to ensure continuity and sustainability of the effort. Departmental support has been crucial for integrating the learning for its scale-up.

Exhibit 15: Out of the box activity

- **Pre and post assessment and data analysis:** The pre- and post-training assessment was carried out with each FHW, their supervisors, and family members who participated in the training in it before initiation of the training session/workshop. The pre-training assessment used a semi-structured assessment tool to understand the existing level of knowledge and coping skills among the beneficiaries before attending the training/workshop. The data that emerged from the assessment was tabulated to **understand how the intervention helped in changing FHWs knowledge and approach towards mitigating mental and psychosocial concerns by enhancing their coping skills and in building their resilience to operate in emergency situations like that of COVID-19**.

Pilot- Findings

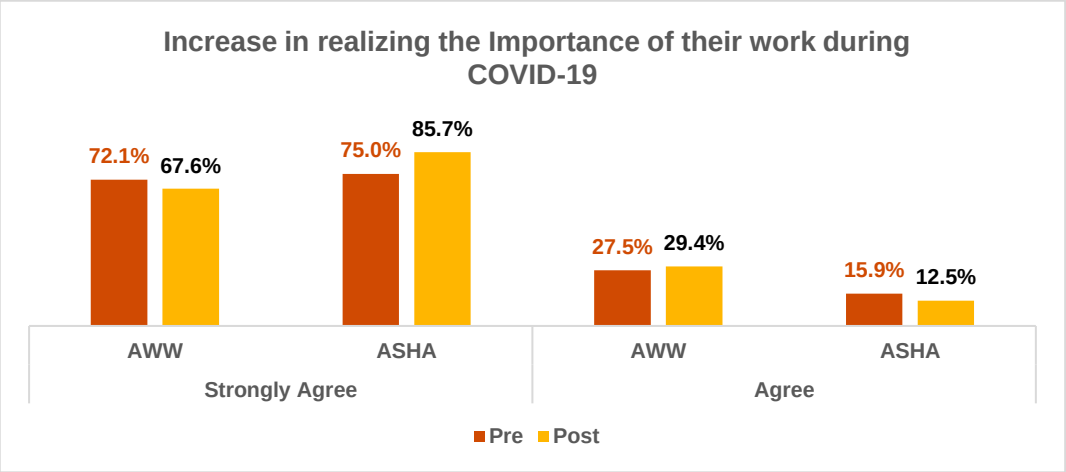
1. Motivation and understanding of the value of their work

The analysis of data reflects the **improved level of value assigned** by FHWs to their work during the COVID-19. Contrary to the pilot study where **demotivation** was found one of the major challenges to engaging FHWs in COVID response, the session was effective in **motivating FHW at integrating value** to their work. The **post-test results** revealed that the level of change regarding improvement of work during COVID **increased** especially amongst ASHA. approximately **10 percent** change from pre-test can be observed in terms of the strong agreement on the importance of their work among the ASHAs.

This training helped to understand and learn how to tackle with the challenging situations.

(AWW, A Block Sultanpuri)

Graph 4: Percentage of AWWs and ASHA workers increase in realising the importance of the role they played during Covid19

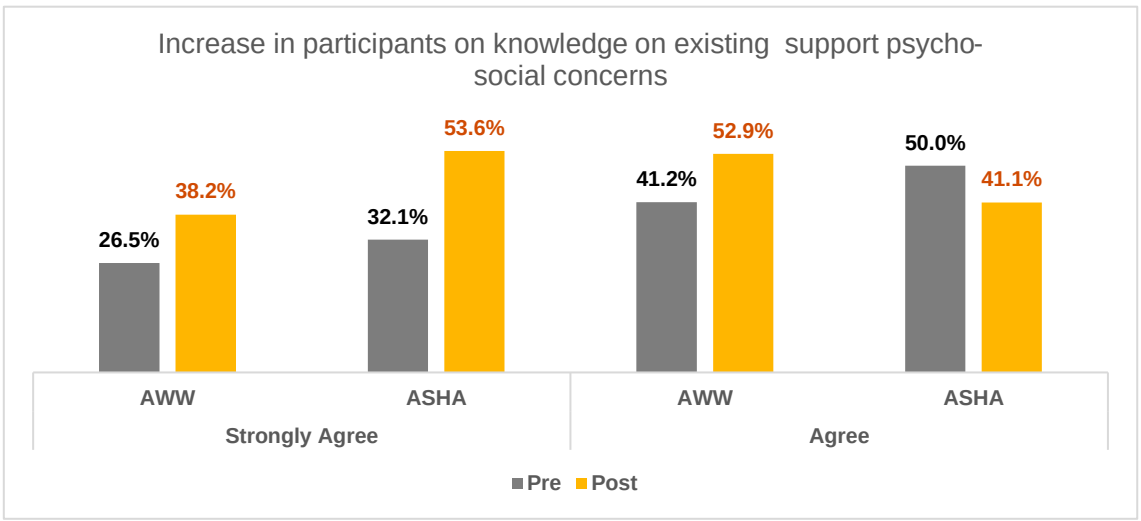


2. Kknowledge on various provisions established by the government during COVID to support FHWs: The **capacity building strategy** helped in improving knowledge and understanding of FHWs on various provisions that the government initiated to protect and support them in their service delivery. **Lack of knowledge** was found as one of the major challenges in ensuring their support. Sessions undertaken highlighted information on available facilities on mental health support provided by the government. The sessions emphasized on the responsibility to support colleagues/ friends in seeking appropriate support when experiencing any psychosocial challenge.

"This training helped to understand and learn how to tackle with the challenging situations."

(AWW, A Block Sultanpuri)

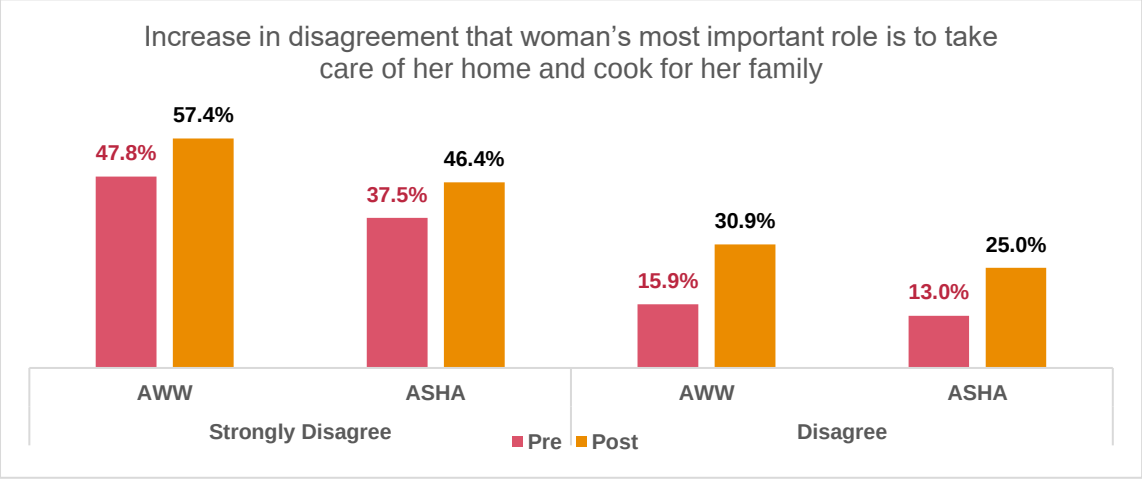
Graph 5: Percentage of increase of AWWs and ASHA workers' knowledge on existing support psycho-social concerns



3. Gender responsiveness of participants and other stakeholders to facilitate effective delivery of work of FHWs:

During the pilot study, **stigma and gender stereotyped division of work** have been found as a challenge in the effective delivery of their work. **Participatory group exercise** was conducted to highlight the existent bias, division of roles and responsibilities amongst men and women leading to discrimination, harassment as well as violence. In addition, it affects the psychosocial and mental health of people resulting in low motivation and self-efficacy to deliver the desired role.

Graph 6: Percentage of increase of AWWs and ASHA workers' disagreement that woman's most important role is to take care of her home and cook for her family



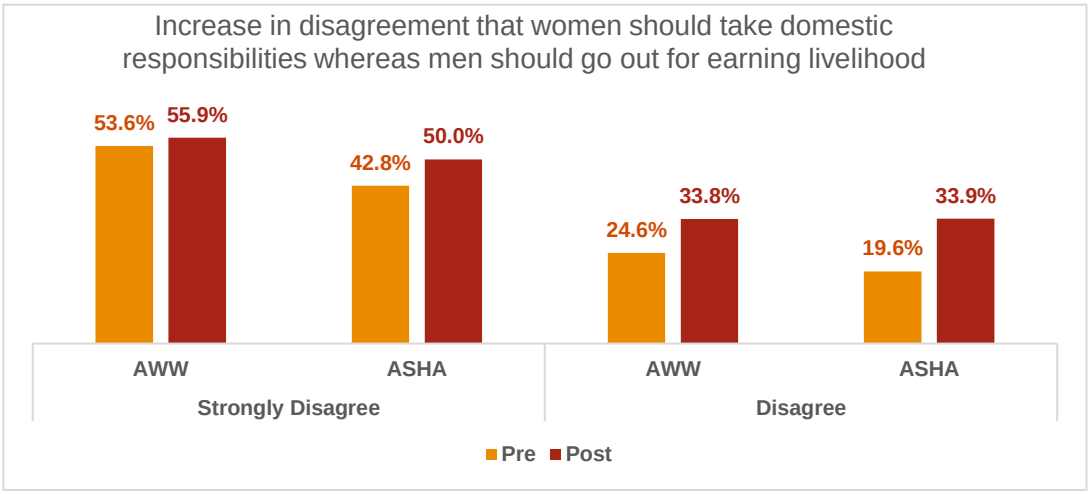
Once one can value their work, it brings motivation, appreciation, and satisfaction, which improves self-esteem and self-efficacy to perform even better. The change in understanding is observed from **13 percent to 25 percent among ASHAs and 16 percent to 30 percent among AWWs**, stated that training has helped them in understanding the biased gender norms, values, and practices as the root cause of gender-based discrimination.

"This training has helped me in understanding that only women are not responsible for household responsibilities and we should not hesitate in seeking support for our husband in household work."

(AWW, D Block Sultanpuri)

Exhibit 16: Discussion on available resources

Graph 7: Percentage of increase of AWWs and ASHA workers disagreement that women should take domestic responsibilities whereas men should go out for earning livelihood

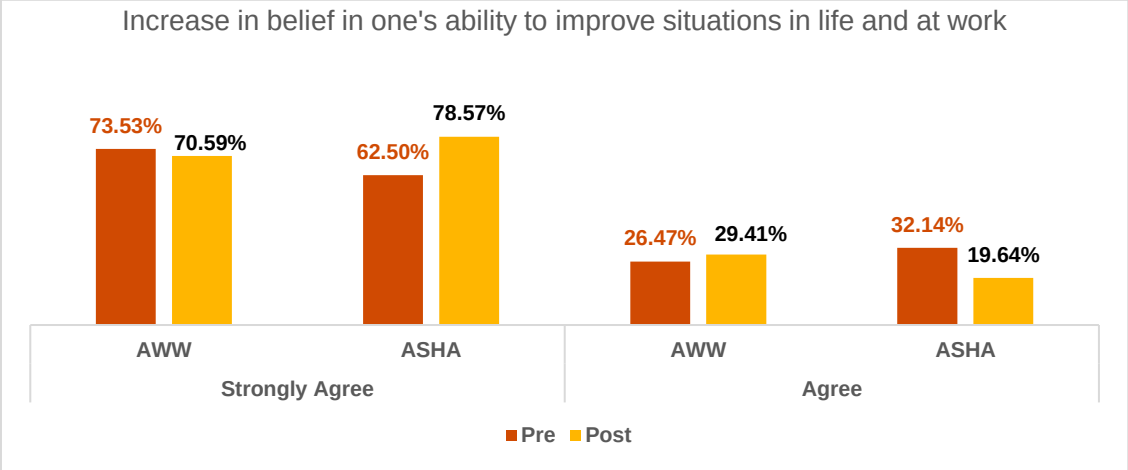


4. **Self-efficacy and resilience: Lack of motivation, low assigned value for their roles and responsibilities negatively impacted FHWs' self-efficacy, self-esteem, and work performance**.

   During the sessions, participants learned the steps of **enhancing self-efficacy** to cope with psychosocial concerns and perform in our life. The finding reflects the **improved level of self-efficacy** from **66 percent to 83 percent** in the pre & post-assessment is observed among the ASHAs who strongly agreed that they can develop alternate solutions to improve their situation or to address their challenges.

> *After the workshop, I feel I can handle situations that would earlier feel out of my control. With effective communication and adequate support from family, friends, seniors and community members, I am sure I can cope with anything!"*
>
> *(ASHA, S Block Mangolpuri)*

Graph 8: Percentage of increase of AWWs and ASHA workers who feel they can improve situations in life and at work



5. **Mental health strategies with the ability to cope with various adverse situations:**

Increased work stress has been identified as the major challenge affecting the work performance of FHWs during COVID-19. Many of the respondents did not understand the impact of mental health on themselves or those around them. The findings of the study reflect improved identification of various types of stressor and related coping mechanism to address the same. The participants were able to realize how mental health can lead to dysfunction in their work and life and hence it is important to care for one's mental health. The pre and post-test analysis reflects a **significant increase in the understanding of physical pain and mental stress and the interconnection** between the two. In exhibit 17 we can see that ASHA workers have marked the physical pain they would feel from a fall isolated to the knee, but mental stress arising of it has been marked as felt all over the body.

Exhibit 17: Body mapping exercise to identify physical vs

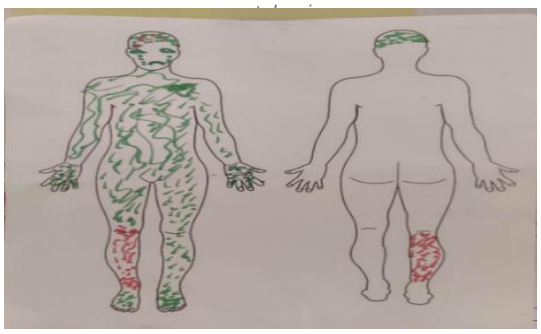
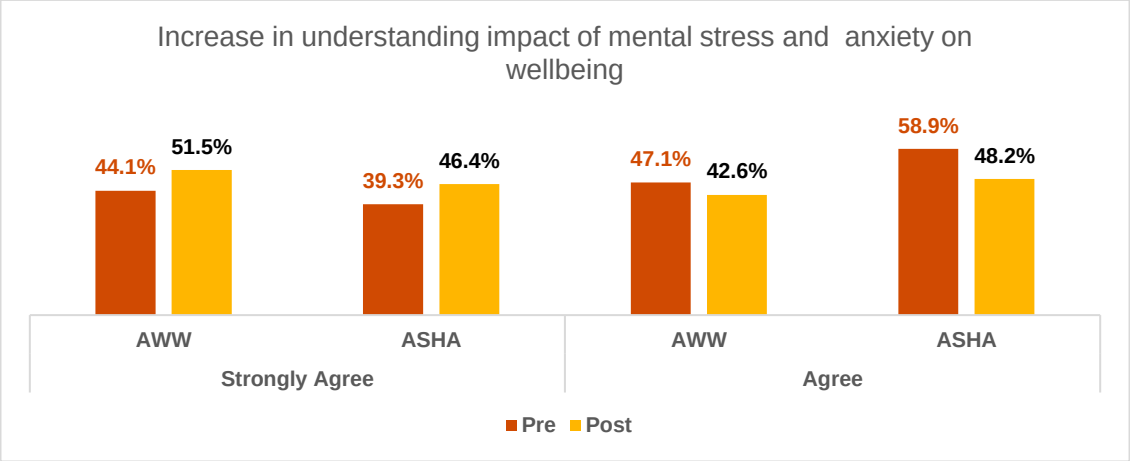


Exhibit 18: Group activity on learning stress management

More than **45 percent of ASHAs** strongly agreed that mental stress affected their work, productivity, and their relations within the family, community, and department. They admitted that mental stress has a high potential to influence their work, productivity, social life, and relationship within the family, and therefore, it is important to address the same by applying life- skills.

Graph 9: Percentage of increase of AWWs and ASHA workers understanding impact of mental stress and anxiety on wellbeing



"This training helped to understand and learn how to tackle with the challenging situations."

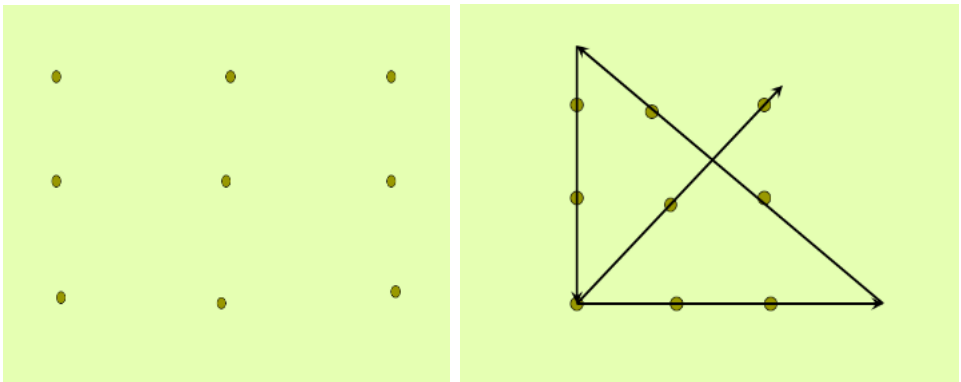
(AWW, A Block Sultanpuri)

6. Skills to find novel solutions to problems:

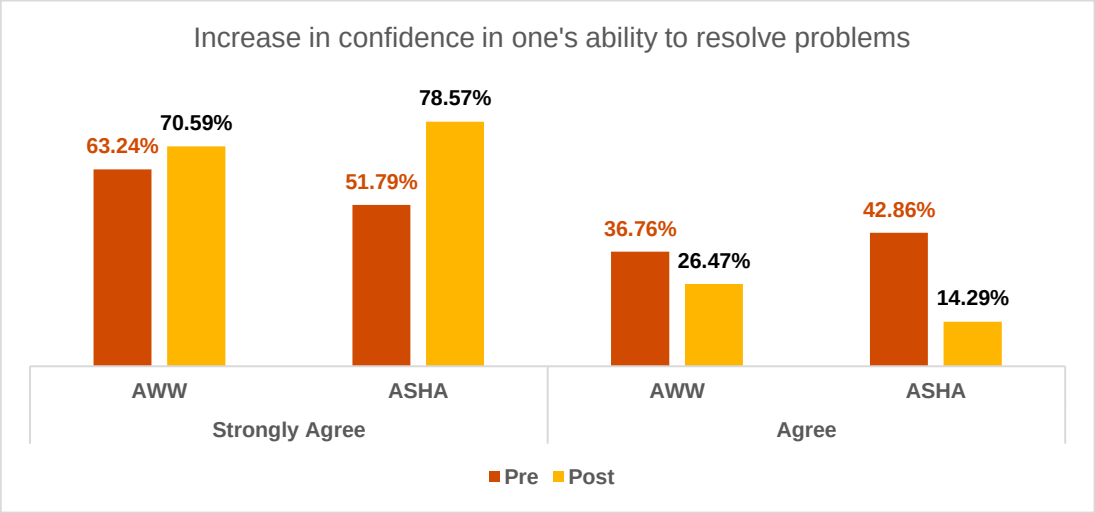
COVID-19 has posed many challenges that were new to the work profile of FHWs. In addition, increased expectation without clarity of roles, improper training, support, and suitable guideline led to confusion, stress as well as demotivation. Realizing this need, an exercise was planned to hone out of the box thinking in FHWs. This helped the participants to build perspective on how to address new problems not only in the Covid 19 context, but which could arise in any dimensions of life.

A significant change in the perception of the participants has been observed reflecting an increase in their capability and confidence to deal with problems that require special solutions or effort. The maximum increase that has been observed in the attitude of ASHA, followed by AWWs.

Exhibit 19: Out of the box thinking activity



Graph 10: Percentage of Increase in AWWs and ASHA workers' confidence in one's ability to resolve problems



Key emerging areas of the pilot intervention

This pilot intervention has been able to reflect the emerging needs of FHWs during COVID and how to address the same for achieving improved resilience and self-efficacy for any other crisis. Emerging areas from the pilot intervention are as follows:

- The pilot helped FHWs to identify the **impact of mental stress on their wellbeing** and importance of addressing the same for improved life and work experience. This awareness is essential to improve access to support system being provided by the government.
- In addition, it led to the realization of the **role of improved self-efficacy** in increasing motivation and ability of FHWs to address new challenges that are not necessarily part of their professional mandate. Improvement of self-esteem and assertiveness to challenge stigma, biased gender norms and build resilience that can be addressed through a structured capacity building programme.
- The training sessions have helped them in improving their understanding to **assess and mitigate psycho-social challenges** along with improved resilience response such as crisis management.
- The training has equipped the FHWs with **knowledge and tools** to balance their work and personal life. Additionally, and it has also **empowered** them to deal with their own **stress with simple self-care and stress management techniques.**
- This training has helped in **increasing the knowledge of frontline workers** about the helpline/ support system and existent grievance redressal mechanism available where they may reach out on requirement.
- The pilot also emphasized the **need for gender** sensitization at all levels including family**, community, and within the health system** to **provide a supportive environment** for female FHWs to operate. The workshop for **family members** helped realize the **importance of the role being played by FHWs** in the COVID-19 response efforts.
- Similarly, **capacity building strategy of supervisors** was helpful in making them realize the importance of the **mentoring approach** to **achieve effective and efficient** work from the FHWs.

Participants' response to the pilot intervention

The feedback from the participants were taken after the completion of the training. The response was highly positive. Participants shared that they enjoyed the activities and learnt about the various topics introduce through the course of the workshop. Out of total participants, 99 percent were satisfied with the quality of the training (Graph 11). All the participants found the training very helpful to address the psychosocial components, gender, life skills etc., and its implications in daily life (Graph 12).

"I learnt a lot through this training. Now a days when I feel sad or anxious, I call up my parents instead of trying to deal with everything on my own"

(AWW, A Block Sultanpuri)

Graph 11: Percentage of FHWs satisfied with quality of training

Graph 12: Percentage of FHWs who agreed with the relevance of the workshop in addressing psychosocial concerns

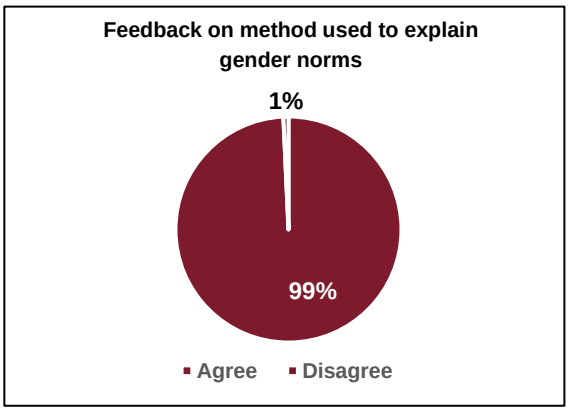
"I had so much fun in this workshop! I ran, jumped, and played! I felt like a child again. I feel like I have no stressful thoughts in my head right now (laughs)."

(ASHA, A Block Mangolpuri)

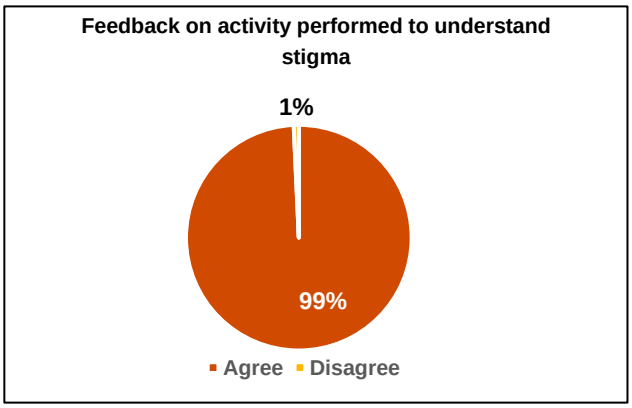
FHWs mentioned that it was refreshing to have an activity-based workshop. Further, some participants mentioned how they felt closer to their colleagues post the workshop.

Almost all FHWs **agreed with the efficacy of activities and methods** (graphs 13 and 14) used to impart knowledge and understanding of various topics included in the modules such as gender norms and understanding stigma.

Graph 13: Feedback on method used to explain gender norms



Graph 14: Feedback on activity performed to understand stigma



4. Workshop Brief

The dissemination workshop was held on **31st January 2022** between 11:30 am -1:00 pm. The overall aim of the event was to execute dissemination of the in-depth **findings of the study and pilot sections of the intervention research** to relevant stakeholders in the health policy and development sectors.

Objective of the workshop

The dissemination workshop was intended to facilitate the sharing of the **key findings, insights and recommendations** emerged from the study and pilot intervention. The findings discussed were significant to inform **future planning and programming** to create a **gender responsive and enabling environment** to work for female frontline health workers. It also aimed to create a space for technical experts and practitioners to exchange, share, and network on areas of empowering vulnerable women by enhancing their resilience to create an encouraging and productive environment for work, especially in times of emergencies.

Key themes for discussion

Against this background, the key findings and insights of the intervention were presented in the dissemination workshop in relation to the following:

- **Bronfrenbrenner's Ecological Systems theory** which places an individual in the context of relationships within communities and the wider society which can be broadly categorized into the **micro, meso and macro levels.** This allows us to systematically understand the effect of the surrounding environment on the FHWs, from immediate settings of family and workspace to broad cultural values, laws, and global phenomena such as the Covid-19 pandemic.

- Analysis of data from the research to understand experiential differences in the roles and responsibilities of the three cadres of FHWs- ANMs, ASHAs and AWWs

- A deep look at the insights vis-a-vis the emerging categorical themes from the pilot intervention:

    1. FHW's Perception and experience of stress, stigma
    2. Self-efficacy
    3. Attitude towards gender norms
    4. Coping mechanisms during COVID
    5. Enhancing resilience at work
    6. Roles and responsibilities at home and work

Stakeholder participation

The workshop witnessed an encouraging response from a wide range of stakeholders. **Senior representatives from government departments such as National Health System Resource Centre, Niti Ayog, Department of Women and Child Development; international development agencies such as JICA, World Bank, UN Women and UNICEF; and organisation and NGOs such as Navjyoti, Catalyst Foundation and IKure** attended the workshop.

The participants were appreciative of the insights and critical findings from the research that has significant value for future programming and policy level inputs. They were keen to know more about the research and further such initiatives and showed intention to collaborate in the future.

Some key points discussed were:

- The pressing need for an institutionalised effort to integrate mental health support, gender mainstreaming and strengthening self-efficacy and preparedness for women in the frontline.
- There is a need to integrate such initiatives to encourage women stakeholders at various levels through motivational inputs
- The need to work towards building social capital for FHWs through collective and multi-stakeholder efforts

- Pilot findings on the impact of the workshop intervention: Looking at pre and post-test findings and emerging recommendations

The Director of Department of Women and Child Development, Dr Rashmi Singh, and renowned academician in the field of gender, development and mental health, Dr Nalini Rao delivered a brief address with the workshop participants. Both speakers provided relevant insights on the identified themes of the research.

Key outcomes

The outcome of the workshop included increased insights on the themes of the intervention research especially at the **macro level comprising policy environment** for FHWs. These included the following.

- In-depth, comprehensive thought processes on gender empowerment must begin at supervisory cadre at every scale/level of work, during early stages of their professional careers for men and women. This ensures a gender sensitive outlook in one's work from the onset.
- The question of who FHWs should reach out to for policy implementation and effectiveness for in-house cadre is necessary to be addressed. Identifying more resource partners for ongoing dialogue would add value to this research and can be used to further the scope of this research.
- The active involvement of field functionaries in the larger shift towards gender empowerment is pertinent. Director, DWCD, gave an example of Sakhi Samanvay Kendra model which aims to set up 500 Anganwadi hubs for incubating individual start-ups and to promote self-help groups for women. SHG group model and its relevance to improve women's social capital was discussed.
- The need to prepare FHWs to engage better for awareness on schemes and benefits and reach out to the government for support through future inductions and focused trainings.
- In the case of women's burden, introducing childcare facilities for support among FHWs with support from women field functionaries was suggested
- There is a continued need for such psychosocial capacity workshops which focus on stress management and building skills for self-efficacy, communication, and increased resilience.

5. Recommendations

The study findings pointed towards the need for empowering FHWs and increasing their capacity to cope with daily stress with more resilience. High levels of stress were reported by the FHWs during the study. Aligned to the findings the recommendations too would be presented for the macro (policy), meso (institutional) and Micro levels (at the individual and inter-personal level) with reference to the findings compiled from the intervention research. However, there will be intersection of efforts at each level to be able to create a positive impact in retaining, developing, and empowering the FHWs and other female workers in the front line.

Exhibit 20: Illustration of a few highlights emerging from the recommendations

An institutionalised mechanism to support FHWs when in stress and facing mental health challenges and psychosocial concerns

Special training beyond general protocols, specific to gender responsive and inclusive roles of FHWs and supervisory cadre for emergency situations such as the Covid19 pandemic

Continuation of such workshops which empower and aid in capacity building of FHWs on skills required to address and deal with psychosocial concerns

Special training on gender sensitisation and enhancement of professional skills to integrate a gender aware approach in their work

Greater access to basic facilities such as water and sanitation and preliminary health support

An intervention to provide FHWs with access to help, information and support to build their financial literacy access to social protection schemes

Management and diversity & inclusion programmes to be organised for supervisory and management cadre at the public health delivery level

While improving FHWs resilience, it is important to work with their supervisors and family members to build their capacity to provide a supportive environment for FHWs

The recommendations in this section are outlined for the national and international development agencies such as JICA, Government functionaries at the state and national level, Government institutions assigned for technical inputs and oversight such as NIPCCD and NHSRC, NGOs and research organizations. The findings and the recommendations are designed to influence future policy, programming practice.

Macro level recommendations

Initiatives and decisions at the macro level is important to mandate certain regulation and provision for the frontline workers for their overall empowerment, growth, and wellbeing. Policies and programmes designed and approved at this level has strong dependence on the meso level for it to be effective and operationalised. The recommendations in this section can be relevant for government and its associated policy making bodies and other international or national development agencies working closely to influence national programming.

- **Incentivization of the frontline workers**: The frontline cadres are often not appropriately compensated as they are not part of the **formal institutional cadre** and often considered as community volunteers. Given the **criticality of their role and its associated vulnerabilities** it is important that they are **incentivized, rewarded, and recognized** for their dedication and effort. Such incentives may constitute both financial and non-financial rewards and incentives embedded within the cadre management policy. This can include acquiring of higher skills for advanced or alternate career options or entrepreneurial ability, to enhance their effectiveness. It may also include recognition in the community platforms such as gram sab has, panchayat programmes and in large state or national level platforms.

- **Protection and well-being of the frontline cadres**: Need for relevant promotion of Departmental/ Ministerial and interdepartmental initiatives to provide **facilities and social protection** to the cadre in the frontline. This should include **review of recruitment, leave, protection from accidents, retirement benefits**. Announcement of such schemes to be **integrated with plans and mechanism** that allows the system to initiate and integrate effort to communicate it to the workers and create mechanisms to ensure they can access it.

- **Gender responsive policies and programmes:** Often policies and programmes are focused on sectoral needs and provisions for the communities. It often consciously does not take into consideration the needs of men, women, transgender and the more vulnerable population for the policies and programmes to function.

  Therefore, **gender analysis** of incumbent policies and programmes should consider the conditions that women face, protection against harassment and violence at all levels (implementation of POSH Act for the frontline cadres). **Gender responsive support systems** include greater participation of men in frontline work, availability of basic facilities such as water and sanitation, childcare facilities for the workers on the frontline. **Grievance redressal mechanism** to be instituted mandatorily for female frontline workers across all departments. This should include women to not only share their grievances anonymously but also compels the system to redress it compulsorily in a stipulated time.

- **Research to guide policy on FHWs** can be instituted to arrive at the various institutional models to provide better recognition, appreciation, and identity to the FHWs. and sanitation, preliminary health support, to name a few. These can be included. From the findings of the study and pilot, there are emerging learnings which can contribute to Gender responsive programming across sectors for frontline workers who are engaged in sanitation, construction, financial services to name a few. Some of the specific areas in which these recommendations will be applicable include the following:
  i. Female workers across sectors are to be empowered about their rights and entitlements.
  ii. Standards of basic minimum facilities for female employees/workers across sectors.
  iii. Soft skill training for management cadre to emphasize on ethical and inclusive behaviour towards staff and community.
  iv. Mental health support and building resilience of staff for any personal, social, and environmental crisis is a critical need.
  v. Female workers to be included in decision making processes regarding their roles and participation in the community.
  vi. National level programming should reassess the model of empowerment, support and incentivisation

Meso level recommendations

The meso or institutional and organisational initiatives are important as the strategies, programmes and initiatives are planned and operationalized at this level. Within the health system or any other sectoral departments and institutions directly engage with the frontline workers. However, the need for macro and policy level initiatives, support and guidance is important for the institutions to operate and function within the government. Some of the specific recommendations in this context are indicated below.

- **Institutionalized mechanism to support the female workers through access to psycho-social support:** This support is to be formalized within the system through a range of initiatives but not limited to access to formal counselling both face to face and online, capacity building and workshops on the topic and through creation of social capital through community and peer support systems to be promoted. This may be initiated as a pilot in association with qualified technical agency and the government (academic organisation or experienced NGO). This should also provide guidance and assistance to supervisors and other functionaries within the system.

- **Protocols and operational guidance provided to workers and functionaries to consider psycho-social aspects:** During a pandemic or any in other emergency situations the institutions within the system generate guidance on dos and don'ts and other operational issues. This often does not include the **specific behavioural, cultural, and other psychological barriers** that women confront while providing her services. Such guidance should clearly indicate a hierarchy of support system for the women to access in case of need and should not be limited to the supervisors only. **Special training beyond general protocols** specific to the roles and responsibilities of health service providers for emergency situations such as the Covid-19 pandemic need to be provided. It **should link the workers with allied support systems in the community, police, and local administration**. This should **empower FHWs** to engage with the community through proactive, positive, and protective approaches.

- **Women's financial literacy and empowerment:** Financial vulnerability, crisis and limited access to social welfare schemes have been expressed by the FHWs. The women workers need to help, information and support through institutionalized support to access financial literacy programmes focusing on FHWs. It may cover capacity to manage their finances and to build their entrepreneurial capability. These women not being full time workers have the potential to take up additional work and initiate economic enterprises themselves or along with their friends or family members.

- **Skill building on mental health and gender equality:** **Skill building** on issues such **as gender equality and mental health** in addition to the standard trainings received during induction and follow ups are required. Such trainings would help FHWs support situations that require mental health intervention and in times when they themselves need support when in stress, trauma, and depression. It is to be recognized as an important part of building resilience within the workforce and enabling them to be more effective in the community through more specialized support. This enables them to effectively challenge the stereotypical role imposed on **women to share responsibilities at work and home, in creating an environment of mutual respect and support**, in accessing specialized support when in need of special help in case of crisis, exposure to violence or any form of abuse or exploitation.

- **Management training on positive mentoring and diversity and inclusion for functionaries.** To be effective and in adherence to the principles of rights and justice, the health system needs to be supportive and congenial to work for the frontline workers and the community volunteers along with their superiors and other seniors. There is an **emerging need to support the management and supervisory cadres with guidance** on ways to create an environment of trust, mutual respect along with ability to ensure efficiency and effectiveness in service delivery. For e.g., in the health systems though ANMs are frontline workers, yet they have a critical role of supporting and mentoring ASHAs who are in close contact with the community and are from vulnerable backgrounds themselves. It is then relevant to empower ANMs, and other supervisory cadres with training on positive mentoring, diversity, and inclusion. This would orient and equip them with **positive management styles of supportive supervision, mentoring and guidance** instead of a top-down traditional mechanism of managing the frontline workers.

- **Collaboration with NGOs and other local institutions:** The health system, women and child development and other related departments need to collaborate with local institutions to provide training

and supportive facilities for mobilization support to ensure participation of local community and in addressing challenges and barriers at the community level. **Localized support** through panchayats or municipal structure and local administration is equally important. **Access to facilities such as meeting, resting, washing and sanitation can be mobilized** from the local community through active engagement of families and local clubs and other community-based institutions.

Micro level recommendations

The recommendations below are ways that would directly empower the frontline workers and enable them to work out improved relationships within the health system and the families. As indicated earlier it is critical that institutional and policy level initiatives are taken to enable women to enhance their self-esteem, ensure access to their rights and entitlements and provides women with an agency and voice.

- **Access to information and help for their own wellbeing**: **Technology based solutions** or capacity building modules may be developed to ensure that each of the FHWs have access to information on their rights and entitlements that include information on various schemes, incentives, and benefits. It is important to recognize that such strategies and innovation need to be **context specific** and simplified for them to navigate and access through personalized help whenever required. Such solutions should also include **information for personal safety, protection and access to health and hygiene facilities**.

- **Participation in decision for improved interpersonal relationships in the system: Participation in planning and collective decision making** is often a significant initiative for women to be felt empowered and valued for their contribution. It also allows the supervisors and other superiors within the system to **acknowledge the field level insights** and understanding that women in the frontline bring along. This would not only improve interaction between the various levels but will also improve mutual respect and improve interpersonal relationships creating a more collaborative and inclusive workplace.

- **Family members of FHWs targeted for extended support and recognition:** Considering the need for immense support of the **family members** of the FHWs it is important to involve them and support them in the process. **Rewarding and recognising** the contribution of the women workers along with their family members not only boosts the self-esteem of the workers but encourages the family member to extend their support in the times of need and crisis such as the COVID 19.The engagement of local self-government, Municipality or the Panchayat in the process is a requirement for the community-based efforts.

Creating relationships Building Value