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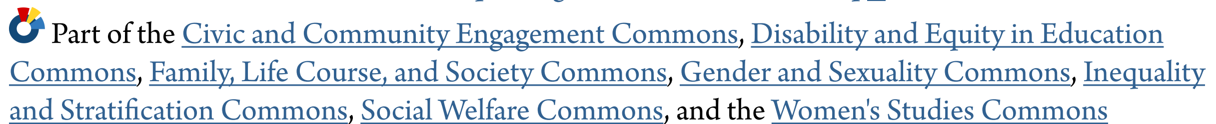
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Employing Empowerment:

Developing the Discourse for Women's Empowerment in Uttarakhand, India

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School for International Training
India: Health & Human Rights
Spring Semester, 2011

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Table of Contents

Abbreviations&&&&&&&&&&&&&&&&&&&&&&&&&&&&&&&p.3

Introduction&&&&&&&&&&&&&&&&&&&&&&&&&&&&&&...p.4

Research Questions & Hypotheses&&&&&&&&&&&&&&&&&&&&&..

Methodology&&&&&&&&&&&&&&&&&&&&&&&&&&&&&&.p.6

Main Report

I. The Women's Continued Plight in the 21st Century&&&&&&&&&&&&&&...p.9

II. Education & Capability&&&&&&&&&&&&&&&&&&&&&&&&.....p

III. Structural Violence & The Fatality of Hierarchies&&&&&&&

IV. The ASHA Program in Context: Dehradun District, Uttarakhand&&&&&

V. Understanding the ASHA&&&&&&&&&&&&&&&&&&&&&&&&.....p

Selection of the ASHA&&&&&&&&&&&&&&&&&&&&&&&&&&&&p.27

Training of the ASHA&&&&&&&&&&&&&&&&&&&&&&&&&&&&p.28

Payment of the ASHA&&&&&&&&&&&&&&&&&&&&& &&&&&&&p.31

The Role of the ASHA&&&&&&&&&&&&&&&&&&&&&&&&&.....p.32

VI. Where the ASHA Does Not Reach&&&&&&&&&&&&&&&&&&.&.

Misras Patti, Uttarakhand (CENI & KGHERF)&&...p.36

Jamkhed, Maharashtra (CRHP)&&&&&&&&&&&&p.39

VII. Maukti Pol&&&&&&&&&&&&&&&&&&&&&&&&&&&&&...&p.41

VIII. The Inadequacy of the ASHA: A Popular Critique&&&&&&&

IX. An ASHA Profile: Sunita Devi&&&&&&&&&&&&&&&&&&&&..&&.

X. The Negligence of the ASHA Administration&&.&&.&..&.p.46

XI. Globalization & Empowerment: A Conclusion&&&&&&&&&&&&

Bibliography&&&&&&&&&&..&&&&&&&&&&&&&&&&&&&&&&.p.56

Abbreviations

NRHM National Rural Health Mission
ASHA Accredited Social Health Activist
ANM Accredited Nurse Midwife
CMO Chief Medical Officer
VHW Village Health Worker
BHP Basic Health Promoter
GRC Gender Resource Coordinator
NGO Non-Governmental Organization
PHC Primary Health Center
CHC Community Health Center
DARC District ASHA Resource Center
RLEK Rural Litigation & Entitlement Kendra
CFHI Child Family Health International
IGHEF Indian Global Health and Education Forum
PRAGATI Panchayati Rule and Gender Awareness Training Institu
WHO World Health Organization
CRHP Comprehensive Rural Health Project
DHFWS District Health and Family Welfare Society
HIMS Himalayan Institute of Medical Sciences
SBMA Shri Bhuvneshwari Mahila Ashram
NCIH National Council of International Health
MDGs Millennium Development Goals

Introduction

The following research study was conducted between the dates o 2011 in the district of Dehradun, Uttarakhand, and in surroundi investigation focuses on the empowerment of marginalized wom government programs, particularly through their employment in t the role of Accredited Social Health Activist (ASHA) and relate models developed by NGOs. The study will consider how employment empow the health sector works to decrease gender inequities by impro increase the woman's confidence, training her to be an advoca and those of her community) through education, while simultaneously the social development and poor health indicators of marginali evolutionary methods of women's empowerment, spearheaded b of India, will be discussed and used to identify the limitations of the government program. The training, implementation, monitoring, and financi grassroots-based scheme, require careful consideration and continu implemented schemes; where the context is one of historic structural vio translation of policy into practice is essential. NGO additions programs will be used to detect specifically where written polic The rhetoric of globalization and the accepted universal human impressive arguments and evidence provided by research subje one is neglected services by India's public health sector appear inaccessibility to the provider and vice versa.

Research Questions & Hypotheses

The Accredited Social Health Activist (ASHA) Program of the N
(NRHM) has the potential to accomplish goals essential to successful d
and poverty eradication: it can improve health indicators throu
resources, can better connect marginalized, rural populations w
reach) government health services, and can empower women by offering th
can improve their status in the village, through both economic
implemented in a cursory manner, the ASHA program can furthe
discrimination, financial insecurity, and can exploit the health worke
improve health indicators, rather than a means to ensure a soc
equity.

Having the federally recognized position of ASHAs is considered a perfect c
development and empowerment of the female population within
Although there is a looming gap between policy and practice, I
essential in ensuring the legitimacy of the program as successful in
the detrimental structure of society. Furthermore, the ASHA ca
the beneficiaries and the providers. Such a liaison is crucial w
they are still reaching the most marginalized, especially when it is
and inherent but unintended structural violence.

Women have shown the need for an intermediary who both unde
rhetoric but also understands the women and the context of public heal
order to instigate development and the maintaining of a health

successful, this intermediary must understand and employ her

outlined in the Indian Constitution. It is concluded that the shortcom

empowerment programs stem from improper or hasty implement

of policy into practice. Successful women s empowerment NGOs prog

can be used to highlight the government s inadequacies.

Methodology

The majority of the research findings are derived from formal a

varying range of research subjects: hospital staff the Doon (interns, nur

District Hospital, and the Doon Women s and Children s Hospit

Centers (PHCs), Community Health Centers (CHCs), and the Ma

Center, all existing in the district of Dehradun approximately thirty ASHAs

various health centers, at home, at a training at the Mehuwala

Pratipur near health health camp organized by the NGO Mamta), ANM

Community Health Center), Anganwadis (at the Pratipur village of

Doiwala), and Basic Health Promoters (BHPs) in the village, Pa

Family Health International (CFHI) and Indian Global Health an

Small focus groups (consisting of six subjects, with one large focu

ASHA training session) were conducted in order to spark discu

between a group of equals. These focus groups were informal a

them, a great deal of useful information was gained.

A survey of approximately 12 subjects was conducted in Kehrig
surrounding the Mamta office. Adolescent girls and young, new
questioned about a range of topics: the ways in which their perceived self
support within their family, and available resources to women i
cases, there was conversation with multiple generations at onc
the research as it offered a picture of how gender issues have progressed o
sixty years in one, specific area. No men were present during t

The NGOs which were primarily utilized in the following resear
Sanstha (Mamta), Rural Litigation & Entitlement Kendra (RLEK), PRAGATI
and Gender Awareness Training Institute), Astitva, Child Famil
and the Indian Global Health and Education Forum (IGHEF). Th
and the District Help Line were both consulted for information regar
for women s protection.

~ ~ ~ ~ ~

Development for women
is not planned within a framework of equality. The
is no system or framework with a clear mandate or
requisite authority
to ensure that policies and recommendations are act
Development programmes often separate women from
homogenizing women rather than recognizing diversity
instead of evolving mechanisms to ensure that the most-privileged benefit from eve
intervention.
Where there are efforts, these are largely islands of innova
little is being done to integrate their strong points
development programs.[1]

~ ~ ~ ~ ~

[1] Desai, Armaity S. Higher Education and Human Rights.

I. The Continued Plight of Women in the 21st Century

At the foundation of every program, whether it be a commu
education agenda, a good governance initiative, and ultimately, lies the
entity: policy. In examining the shortcomings of any program, c
policy meets barriers that prevent it from translating from theo
context in which that strategy is applied, and then determining w
specifically, the context inhibits the program from reaching its
or economic obstacle can be identified. In India, noted, woman
what is shown on paper is totally different than the practicalit
faults of the women s empowerment programs, directed and imp
government, one must first begin with an evaluation of modern. An analysis of
gender policy will outline the rights and freedoms which a wom
by her federal and state governments. After fully understanding
in India, one can credibly argue how specifically gender equity must be promoted
carefully and sensitively enforced legislation, based at the grassroots level, r
mere legislation.

The characterization of traditional Indian social structure
dominant discourages, among other things, the vocalization of m
concerns and the care-seeking behavior of the female. Beena Walia, a Se
founding member of Mamta Samajik Sanstha, a Dehradun-based non-profit
organization dedicated to women s empowerment, with a unique
that the conditions of public and private society are such that,

any security.[2] For the female, a patriarchal society translates directly into limited power to ma decisions, decreased ability to control her access to outside re and confidently direct her own mobility within the public realm United Nations Population Fund expressed during an interview on 15 March regardless of their socioeconomic status, find themselves supp constructs that have maintained their strength (even if only in economic, and educational developments of the nation. Even when c authority is held by male and female in the workplace, Mr. Jat gender alone stands in the way of complete equality.[3]

Legal documents attempted to combat such gender inequality years a themselves, possess tangible contradictions. Within Article I of the International Covenant on Economic, Social, and Cultural Rights of 1976, it is

All people have the right of self-determination. By virtue of that right they freely determine th political status and freely pursue their economic, social, and c.[4]

And yet, it is stated in Article II of Part II, that,

Developing countries, with due regard to human rights and their nationa determine to what extent they would guarantee the economic ri[ghts recognized in the present] Covenant.[5]

This second statement reduces pressure on developing nations freedom of marginalized populations (in the case of this study, within Article III it is further stated that State Parties must gu genders. Although attempting merely to address the gap of their countries' levels of r development, such an article ultimately deems economic and so

[2] Walia, Beena. NGO, Mamta Samajki Sanstha. Personal Interview. 20 April, 2011.
[3] Jat, Mr. Tej Ram. Interview. 15 March, 2011.
[4] Talwar, Rajesh. The Third Sex and Human Rights. 133.
[5] Talwar, Rajesh. 134.

cultural environment in which they are being applied, reducing
conservative society to experience equal rights which the written law writt
to ensure. Within Women & Law in India, Flavia Agnes offers
consistent inadequacy of India s written legal code to properly
which one could argue stems from a lack of transparency:

> Unfortunately, the anomalies and anti-women bias within the Hindu code were not discussed widely in public forum. They remained books and legal manuals. There seemed to be almost a co beneath which these inadequacies were concealed. This led to a fiction that th Hindu Code is sufficiently modernized and hence it is the which ought to be extended to other religious denom liberate women. The Acts were neither Hindu in character nor based on modern principles of equality but reflected the worst tende[6]

In her paper for The Essex Human Rights Review, Kathleen Ho considers such i
that result directly from social or legal structure, but also cultural explanations: m
explanations which actually divert attention from drafted or pu
whether accepting culture as a shared standard of life can actu
women and other minority groups, or if controlling culture, and
instead allowing culture.[7] Molding law to cultural norms makes for
transition of policy into practice, as policy is inevitably better
framework. Effective law reforms take this form. If the impediments and
law are not addressed, it will be impossible to transform poten
principle, thus defeating the purpose of circulating any set of laws.

It is, however, not an easy task to ensure the proper balan
culture as a driving force while still ensuring that a written law
inequities that stem from cultural or socio-political impedance. In h

---

[6] Agnes, Flavia. Women & Law in India. 81

[7] Ho, Kathleen.

gender developments, Flavia Agnes discusses the consistent fa
both properly represent and address a culture in gender. Crucial provisions
empowering women [have] had to be constantly watered down to
consensus.[8] Diluting or concealing the ultimate demands of a law w
acceptance or even a full understanding of the law. Rights must be enforced that t
actual as they are conceptual, if any transformation within a di
Although many argue that India's blooming democratic edict ha
gender inequalities, the current state of affairs suggests quite the opposit

On Wednesday, April 20th, 2011, in Haridwar, Uttarakhand, after a sca
young woman eloped with an employee, several local panchaya
women from working outside the home. The panchayat leaders held that the
allowing women to have jobs were too great, and could bring disgrace to their
families.[9] If any woman was found attending work, she would be fin
be subject to a public beating. The Times of India's article on the affair re
"Working Women of Haridwar Village Face Panchayat's Wrath." On the th
March, it was publically confirmed that the women of Haridwar's
Godawali and Sarai villages had begun to return to work, after
Uttarakhand Women's Commission and other legal women's righ
hasty legal counteraction, the direct fact that such a pass in a forum

---

[8] Agnes, Flavia 81

[9] Dehradun Times. Ban on women from taking up jobs withdrawn in Uttarakhand. Accessed 25 April, 2011. Available from Indian Express

according to the Uttarakhand Panchayat Bill of 2008, they are legally required to

percent reservation for women[10], proves that women are still far from equal in

PRAGATI, a women s empowerment NGO working throughout

specifically on ensuring equality within the local governance, which is, in th

through the village Panchayats. Shefali Rawat, who works at th

explained the challenges associated with women s leadership i

explained, are proxies of their husbands. Pradhan patti, we call it.

their village panchayat, they are still unaware of their rights.

elected positions to take initiative, to do something beneficial for society, but in male

dominated Uttarakhand, they do not take initiative. They still f

chores.[11] Thus even with a fifty-percent reservation in the system of loc

women in Uttarakhand still find themselves under the wrath of those with who

legally and theoretically equal.

How, therefore, does one address the challenges of the twenty-first century, which

the inevitable collision of modern policy and its actual practice

India, which is so often torn, when it comes to gender expectat

notion of liberalism? The most difficult task is not writing or p

society as a whole first understands the laws, and then accepts and allows for the ta

decree (in this case, women) to benefit from the law s intended

the Indian context, one can reference, among others, the follov

that have been introduced to safeguard Constitutional rights to equal[12]

---

[10] This is an increase from the one-third reservation in local Panchayats and Municipalities found in the 73rd and 74th Amendments of the Constitution of India, of 2003.

[11] Shefali Rawat. NGO, Pragati. Personal Interview. 5 May, 2011.

[12] Dash, Siddhartha. Women Empowerment in India. Orissa Review. December 2004.

rights: fifty-percent reservation for women in the local panchayat, t
Commission, the Accredited Nurse Midwife (ANM), Accredited Social
and Anganwadi initiatives through the NRHM, the Right To Edu
Domestic Violence Bill of 2005, and the endorsement of the 19
All Forms of Discrimination Against Women (CEDAW), which ha
subsequent emancipation efforts. Yet, as Flavia Agnes argues
Efforts at Gender Justice, reforms themselves, although capable, are not
the sole vehicle for ushering in [the positive changes][13] when the social st
and traditional composition of a nation is so resistant to unive

II Education & Capability

The notion of empowerment is projected; it is an agenda that pr
amendments to gradually but steadily revolutionize societal str
empowerment requires an evolution of the mindset, the efforts mus
generations. Under the Hindu Succession Act of 1956, it is stated that sons an
legally hold equal rights, yet, still, as Dr. Savita Kotiyal of the
explained, the health of girls is more deteriorated than that of her brothers because of
treatment in her household.[14] The larger the family,[15] Dr. Savita continued, the less
concerned the mother and father become with the health of the
fed less than male siblings, denied education, and in some families with w

[13] Agnes, Flavia 80
[14] Kotiyal, Dr. Savita. Interview. 25 April, 2011
[15] Large families are not uncommon in the areas surrounding the Mazar Hospital, with quite a few reaching between eight and twelve children. It is within a family of this size that Dr. Savita Kotiyal has noticed deteriorating sanitation, nutrition, and general well being of the girl child.

Joshi, an intern of three years at Mazra Hospital, has worked, to

forgotten. In response to the daunting sex ratio, legislation ha

public and private society, providing incentives for having a gi

determination of an unborn child, and Girl Child Day in 2009 to

[target] the scourges of female foeticide, domestic violence,[16] a

paralleled by televised awareness campaigns.

Despite this focused legislation of the past decade on imp

child, the problem still remains: society does not offer women

allow women to safely practice the liberal values and freedoms

The Study of Gender in India: A Partial Review emphasizes, th

is transitioned out of her birth family and into her husband s fa

woman leaves her household following marriage, entering into

she faces multiple subordinate statuses: wife, daughter-in-law, sister-in-law, and mother.

Patrilocal residence and patriarchal family structures.[17] As will be placed the

further discussed, being situated at the bottom of the hierarchy

in one s freedom of agency and autonomy within the public and

society s claimed opportunities. In Development as Freedom, Amartya Sen considers the

distinction (which is crucial to apply when considering the imp

discrimination) between what is theoretically available to a pe

capable of accessing: A person s capability refers to the alter

functionings that are feasible for her to achieve. Capability is thus a kind of freedom.[18]

---

[16] Govt to declare National Girl Child day on January 24, The Economic Times 6 January, 2009

[17] Bandana Purkayastha, Mangala Subramaniam, Manisha Desai and Sunita Bose The Study of Gender in India A Partial Review, 2005 17.

[18] Sen, Amartya. 75

In the third round of the National Family Health Survey, co

2005-2006, it was concluded that: Access [of women] to spaces

both education and wealth, however, is quite limited. Less than h

the freedom to go alone to these places in every[19] See the table below an

data table from which this conclusion stems:

NFHS, India 2005-2006

In the state of Uttarakhand, the percentage of women who were

destinations was 42.8 percent, a slightly higher percentage tha

argument supporting the education from this figure, by noting a

[19] Gender Equality and Womens Empowerment in India. 64

increase in the woman s freedom when more than nine years of

which suggests capability s direct correlation with education. To

come out of the darkness, said a primary school teacher of Mi

how to create equality between girls and boys: a group too ofte

empowerment programs. Correlating the education of the girl directly wi

ability and confidence to participate in society, Mamta Samajik

educational programs and vocational skill development for adol

the most neglected by government schemes but the most important to

empowerment.[20] The organization feels that mainstream society has t

promising roles for educated and confident young women, and t

channeled through adolescent girls groups which are run by peer counselors trained by Mamta,

these young women will have the self-assurance to enter into society as equals

understands, too, that if a young woman is able to contribute, even in

the smallest of ways, she can confront and challenge the conce

inevitable financial burden to the family.

Regarding the education of girls, India Development Gateway reported

that:

> Illiterate women have generally high levels of maternal mortalit
> nutritional status, low earning potential, and little auton
> household& Additionally, the lack of an educated populat
> impediment to the country s economic development.[21]

In response to the disparity in the enrollment patterns between

government has taken significant steps towards ensuring the e

[20] Singh, J.M. Personal Interview. 26 April, 2011

[21] Girl Child Education in India. Development Gateway. Available from Govt of India, DIT.

Education Bill of 2009 ensures free public schooling for every

fourteen, identifying its target groups as the urban poor, and the child belonging t

child belonging to weaker section.[22] It holds accountable every tier of govern

demanding that state and local governments direct earmarked f

Universal education is a fundamental means to mitigate poverty and development, a

necessity to uplift an individual and a society socially, econom

Arole of Comprehensive Rural Health Project (CRHP), an NGO

explained, through the CRHP, it is ready to see that communitie

where the women are empowered.[23] But the essential question remains: Can g

education alone can lead to the empowerment of India s women

from gender discrimination? [The government] has given girls education[24]

Urmilla of Kehrigaon, said, when questioned about the governm

women.

In Human Capital Attainment and Gender Empowerment: The, it is

concluded that high educational attainment alone will not promote

the social and cultural fabric of a country or state ensures equ

life.[25] The chief barrier to attaining equitable outcomes is the boundaries of the way in

which the woman s role is defined by society. Unfortunately, when the ro

problem derives primarily from a mental obstruction rather than

adequate societal framework, the key to empowerment lies in the re

a mindset, rather than in a revision of the system. Today s cha

---

22 The Right of Children to Free and Compulsory Education Act. 26 October, 2009

23 Ravi Arole, CRHP. Personal Interview. 5 May, 2011.

24 Urmila. Personal Interview. 21 April, 2011. Kehrigaon.

25 Mitra, Aparna and Pooja Singh. 1127.

they are uncovered only when the day-to-day realities of the woman s functioning

private society are uncovered and then challenged. The first fundament

Mr. J.M. Singh, Chief Functionary of Mamta Samajik Sanstha sa

grow.[26] The first step in restructuring an inequitable society is en

society allows for the girl child to grow at a pace equal to that

III Structural Violence & The Fatality of Hierarchies

The idea of structural violence holds that specific social s

and development of certain groups, especially those most margin

Farmer, founder of the renowned NGO, Partners In Health, stru

the globe s inequities in health. Grassroots health programs m

violence through concerted focus in both economic and social a

to break down the barriers which formerly sustained the dispar

groups. Translating policy into practice where structural violence is addressed.

of most programs is established hierarchy, which is meant to d

ensure the functioning of a program s monitoring system. Throu

found that the hierarchies of the NRHM s programs act more to delineat

power, rather than to benignly ensure the proper functioning of

fatal thing, stated an experienced NGO spokeswoman: who requ

the government, NGOs, it is all divided. It is all discrimination[27]

Discouraging for those who seek amendments of the public

acceptance of the system s functioning. Indian people often believe

[26] Singh, J.M. Personal Interview. 26 April, 2011
[27] Gupta, Deepa. NGO Activist. Personal Interview. 27 April, 2011

Bahrabur Village said, in health,[28] in politics, in the village Deepa Gupta, a domestic vi

outreach worker at Delhi-based NGO, Astitva, raised a valid question

implemented in the society, how can they fight it? Although co

among NGOs working on agendas of empowerment, this has argued

the ability to confront the implications of structural violence. T

focuses on the empowerment of female workers from poor socio

that, if encouraged and supported, suppressed women have the to improve their

livelihoods even within an oppressive system. It has been show

times face such severe gender discrimination in their husband

literally have no one to talk to, it is crucial that the intermediary between

and her confrontation with the system, whether it be at home o

is the first: the step in which an outreach worker, or local heal

change, be the the person to question and then themselves challen

they start to challenge it, change starts, stated Deepa Gupta,

intermediaries.

The initiatives of PRAGATI, which focus on strengthening the government program t

which guarantees women 50% reservation in the Gram Panchaya

justice at the local level by training elected women to challenge the injustices. PRAG

believes strongly that giving women 50% of seats in local governments, bu

training them to use this position to it s greatest potential, do

implementing such a decree. Because politics have been male-dominated, the histor

woman must be carefully trained in her position is meant to signify anythin

training has been given to teach elected women of their faculti

[28] Anonymous. Personal Interview. 4 May, 2011

encourage them take initiative in their communities, within wom

panchayats, there are greater positive structural changes.[29] PRAGATI provides a good exa

of an NGO s effort to make government policy, practice.

Both the 50% reservation for women in the Gram Panchayat and ASHA program

represent initiatives of the government which defy elements of

nation and which therefore require great attention to implemen

Towards Empowerment, an article published in Garhwal Post 3rd of November, 2008, it

is stated that, apart from ensuring women the 50% reservation

must also increase women s literacy rate, improve road conne

basic amenities like health, water, and electricity in the villages. For wit

empowerment of women representatives in panchayat raj bodies.[30] Due to

the gender violence, whether it be direct or indirect, be visible or

taken in a cursory manner. Gender equity must be promoted in legislation in order

to restructure the current framework which so tactfully disempo

class, and gender.

IV. The ASHA Program in Context: Dehradun District, Uttarakhand

The Accredited Social Health Activist (ASHA) program is a

functionary plan developed by India s National Rural Health Mi

the state of Uttarakhand on 12th of October, 2005.[31] The description of the

---

[29] Women as steps to power in Uttarakhand hills. The Times of India. 5 November, 2008

[30] Towards Empowerment. Garhwal Post. 3 November, 2008

[31] Mission Flexipool Text. Section 2, NRHM Additionalities. Ministry of Health & Family Welfare. 2007.

ASHA, as outlined by the NRHM, classifies her as the link betw

health provider.

> ASHA will be the first port of call for any health related sections of the population, especially women and children, who find it diffi access health services& [She] will be a health activist in create awareness on health and its social determin community towards local health planning and increased utilization and accountability of the existing health services. She will also prov package of curative care appropriate and feasible for that level and make timely referrals.[32]

ASHAs are given, Mr. Tej Ram Jat [illegible] positions a are stationed at very strategic locations within which they familiarity with local customs. The female health worker legitimacy by supporting public institutions, and thus establishing their po within a public framework that is supportive of gender equit women s access to health resources.

It is the general understanding that there is to be one ASH but this does not remain true across the board due to geographical di in implementation, mostly in very rural or hilly areas. The A implemented by the state government and [illegible] at t similarities across states and even districts. The successes an program depend on the proper or improper implementation Uttarakhand, for instance, has given sufficient time and effort program is active in most parts of the state, whereas Maharashtra many rural areas. It is preferred that the ASHAs be between the age of 25 and 45 years, married and has completed formal education through eighth class. This, too, is relaxed

32 Guidelines on ASHA - Annex 1 NRHM. 29 July, 2010.

depending on the context. The NRHM requires that adequa
disadvantaged population groups [is ensured] with the objecti
truly serves those most marginalized.[33] The ASHA is to be closely linked to the
local governance within her village and Panchayat so as to en
and monitoring.

Because the ASHA program is inextricable from the contex
important first to be familiar with the setting, on state and distric
hoping to understand fully the grassroots workings of the ASHA
of Uttarakhand, which is bordered by the Indian states of Uttar Pradesh and Himachal
the west, there are thirteen districts.

Source: PRAGATI pamphlet

Within Dehradun district, the district in which the majority of t
Dehradun city, the capital of Uttarakhand. As required by the NRHM agenda, the

33 Guidelines on ASHA – Annex 1 3.

hospital within Dehradun: the Doon District Hospital. Also with
blocks as represented in the below image:

Source: Shobit Rawat Singh, 25 April, 2011

Within each of Dehradun s six blocks there is one Community H
branching from each CHC are a certain number of Primary Heal
Doiwala block, for example, there are five PHCs: Pawala, Bhaniawala, Du
and Raiwala. Under these PHCs are sub-centers, where one Accredited Nurse Midw
posted. Within Doiwala block, there are twenty-seven sub-centers. These are the most
peripheral level of contact with the community in the public health infrastructure[34]
meant to serve a population of 5,000, although in many cases i

Dr. Chandra Pant, Chief Medical Officer of Community Hea
explained the required reporting schedule which exists between the public centers
organized by the federal government through the NRHM scheme
month, required reports (the foundation of which comes from th

[34] Guidelines on Accredited Social Health Activists (ASHA). NRHM. 1.

ANM) are collected by the sub-centers and delivered to each PHC. In the ca

Doiwala Block, this means a total of 27 reports are given to th

reports are then passed to the CHC by the PHC supervisor, the Medical Offic

(MOIC). After compiling the reports from periphery PHCs, the C

the reports to the state level by the end of each month. The pr

district meeting, organized the first week of every month, which al

CMOs are meant to attend. Each of these reports, which make t

weeks) from village-level to state-level, begin with the local surveys and reports compiled in the

village by the ASHA and ANM.

Within each of Dehradun District's six blocks, there are ro

there are 1,410 ASHAs in the district of Dehradun, with each b

1/6th of the total ASHA population, with slight disparities between village

geographical differences. The grassroots workings of the ASHA

the systems of local governance, which provide block-level support to

NRHM initiatives. In the NRHM's Guidelines of ASHA-Annex I, it is stated that: "Th

compensation to ASHA based on measurable outputs would be g

supervision and control by Panchayat. For this purpose, a revo

Panchayat.[35] In each block, there exists an average of thirty gram (village) Panchayats

which oversee the activity and address problems faced by villa

Misras Patti, for instance, is one Gram Panchayat north of Dehradun city, in the hills

of seven villages. The pradhan, or leader of the Misras Patti Panchayat is a f

Gita Devi. Under the Misras Patti gram Panchayat, in which the

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35 Guidelines on ASHA-Annex 1. National Rural Health Mission (NRHM). 29 July, 2010. Accessed 20 April, 2019.

1,600, there is one ASHA, even though the population exceeds
over which an ASHA is meant to serve.

Along with the 1,410 ASHAs in District Dehradun, there are 56 facilitators:
program executed in 2010 to establish another tier within the A
providing better monitoring and support for the ASHA. Accordin
Social Worker and Student Gary Rochow who has been working with DARC fo
explained the facilitator as the one who monitors the ASHA, s
and informs the DARC of concerns at the village level.[36] Another recent
program, which began in 2008, is the District ASHA Resource Center
initiative which functions as a public-private partnership under the NRHM. It is
District Health and Family Welfare Society (DHFWS). The DARC
essential components of the ASHA program: the training and the
within the district. The increasing popularity of establishing public-private partnerships unde
NRHM seeks to ensure the proper allocation of funds; it is specifically that
such public-private partnerships will help ensure the increase in pu
2-3% of the GDP and also ensure proper financial monitoring on
article from Economic Times, published on the 25th of February, 2010, the 2010 NR
annual report states: "Release of funds to state health societies and co
block levels require further streamlining to ensure prompt and"[37]
states the article, voicing their support for such methods that ai
tiers.

[36] Singh, Shobit Rawat. Personal Interview. 27 April, 2011.
[37] India Needs 6800 More Hospitals, NRHM Has Many Glitches. Economic Times 25 February, 2010.

V. Understanding the ASHA

Selection of the ASHA

As per NRHM guidelines, the ASHA must be a resident wom
catchment area, she must be married, widowed, or divorced, 10th standard pass, and must
be willing to work with and represent all classes and castes. It is en
the ASHA be herself a member of SC/ST, but it is not required.
available resource to all groups, especially those who experience the most
the most difficulty in accessing and seeking proper health trea
through a democratic election, coordinated by her Gram Pancha
local ANM and the Block Development Officer. In many cases, he o
heading the election will inquire whether there is any village w
and the election moves forward from that point. When question
take on the elected role as her community's ASHA, Mrs. Pitambari Godiyal of
replied that it had been a long-held dream to do social work.[38] Many other ASHAs
responded that they had a desire to help connect the members
services.

There does exist suspicion surrounding the justice of the sele
surrounding the election process of the Anganwadi and ANM. In
nature of NRHM initiatives as grassroots, community-driven, the election process
under the supervision of local governments. Centralizing progr
governance seeks to increase transparency, ensure local accou
hierarchy rather than intrude with a foreign system, it leads to

[38] Godiyal, Pitambari. Personal Interview. 26 April, 2011

variation in the levels of commitment and the program's succes

According to an anonymous NGO spokesperson, one concern with placing t program in the hands of the local governance is that the requir election, the one which is meant to ensure that the chosen ASH is not employed. Powerful people choose the ASHA, choose someon interested in, even someone who herself is not interested in be[39]

Training of the ASHA

Wednesday, 27 April, 2011, was day five of the ASHA training of the Ra Block ASHAs at the Manuwala Panchayat Ghar. The training was provid trainers of Dehradun's CARD. The five-day (each day consisting of sev training with travel stipend and lunch provided) consisted of M focus on Home Based Newborn Care (HBNC). The modules are des the NRHM and are then provided to a state's ASHA trainers, wh hospitals, and NGOs. It is the intent that with adequate traini mitigate such medical cases that result[40] from preventable causes yet amou India's poor health indicators. Participating in the three Raipur Bloc ASHAs, representing approximately thirty villages in the Block. Fifteen out of thirty-three ASHAs had just begun their training that week.

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[39] Anonymous Interview. 26 April, 2011.

[40] The Tribune, Chandigarh, India, Dehradun Edition. Five-day training for ASHA workers begins. 21 March, 2011. Mussoorie.

Harris Napier, 27 April 2011

Pancham Singh, the Community Mobilizer of DARC, who has ten years, is in charge of overseeing the training of ASHAs in which is conducted by the individual DARC Block Coordinators. The 22nd of February, 2011, and after Wednesday, the 27th of April, five trainings in all six blocks would be completed. The training appeared to be very a communication between ASHA and Raipur Block Coordinator throughout. While interviewed or surveyed ASHAs were questioned about the qual complaints were heard; the words comprehendible, engaging, were common adjectives used to describe the training. The ASHAs at the Raipur Block training were n questioned regarding the quality of the lessons, but all appear engaged. For example, during one part of the Raipur Block training, the ASHAs were shown how to properly wrap a newborn after birth. The Block C every ASHA came to the front of the room to practice the prope responsive to each other, both criticism and praise.

Block Coordinator ASHA. Harris Napier. 27 April 2011

The Community Mobilizer, too, paid a short visit during the session to question the ASHAs about their experience with the weekly training, and about the concerns that they may be having in the field. Multiple ASHAs stood to share their problems, the majority of which surrounded in which they were received in public health facilities by senior doctors and Community Mobilizer, who ideally acts also as an advocate for their concerns at the upcoming district meeting, at which other Medical Officers (CMOs) would be present.

Supplementary or additional trainings provided by NGOs ar District. RLEK, PRAGATI, Astitva, and Mamta, all provide addit ASHA. Mamta, in particular, works with ASHA to provide a platform where she women together to talk[41] making that one of the greatest problems of th remains her struggle to motivate groups to come together and t essential part of the ASHA's role, however, in creating health awareness, fa wayside, or is even completely ignored, because there exists n

[41] Singh, J.M. Personal Interview. 26 April 2011.

initiate such discourse. Through Mamta s health camps, the NG

and keep her active as a health promoter[42] by encouraging her to take a leading r

alongside the Mamta-trained Gender Resource Coordinators (GRCs). Lik

supplementary trainings provided to the ASHA by local NGOs more s

actively in preventative work. The ASHA designation is seen as

local awareness and momentum for community health projects,

the ASHA is not performing (as per the initial training) to her full po

Payment of the ASHA

The ASHAs receive incentive-based pay, which they can theoretically c

government medical facility. The incentives themselves are det

government and depend on which matters of health are at the vanguard of Inc

public health crisis. It is the state s responsibility to accompa

incentive that they deem appropriate. In order to motivate both

incentive provided to the ASHA is, in most cases, paralleled by an incenti

patient: for instance, if a delivery is taken to a government ho

provided payment. In Uttarakhand, the government-issued incentives include: 600 ru

bringing a safe delivery to the government hospital, 250 rupees

neonatal care of the delivered infant, 150 rupees per child for

vaccinations, 350 rupees for completing the DOTs Tuberculosis treatment,

rupees for the sterilization of a male within their catchment ar

of a female within their catchment area, 500 rupees for bringin

government facility, and 50 rupees for constructing a public latrine in the

[42] Singh, J.M. Personal Interview. 26 April, 201

payment is that which she receives for bringing a delivery to th
the form of a check, written directly after the delivery.

The other payments are more fragmented in their distribution, and, acco
Singh, the government process [of their payment] is long and[43] The motive behind
incentive-based pay is to ensure the continued activity of the ASHA
conversation with Sareeta, Kamlesh, and Rukmani (12th pass, ANM degree holding ANMs
over 20 years of service, all of whom receive a fixed salary of
Doiwala CHC, all three ANMs vouched for the incentive-based pay of the ASHA work
questioned about the average monthly salary of an ASHA worke
responded that it normally fell between 2,000 and 3,000 rupees
ASHAs reported that they sometimes made 2,000 rupees monthly, rarely
fell above 2,000. The implications and critiques, both negative
based pay will be further discussed in another section of this p

The Role of the ASHA

In a statewide figure calculated through an evaluation in 2009 of the NRHM p
Uttarakhand state, 74% of women surveyed were aware of the A[44] Creating
awareness of the ASHA herself is a crucial step that must be u
be paralleled by solidifying the ASHA position and its corresponding entailm
community. The role of the ASHA is one which itself is debated
private forums. Who is she responsible to, both as a member o
service-provider for a specified population? What is she responsible fo

[43] Singh, J.M. Personal Interview. 26 April, 2011.
[44] Concurrent Evaluation of NRHM (2009) Uttarakhand 20.2

between the work of an ASHA and the work of an ANM? How much work is she expected to do as primarily a volunteer? In many cases, the answers dep

One common claim that evidences a clear impediment of th ASHA's steadfast affiliation with the pregnant woman. According to Deepa Gupta, Assist the ASHA does not work with the man, does not talk with the m[45] As demonstrated by the research findings, the only instances in which the female healt and women appear to be in dialogue are bandaging of wounds. Though wounds, particularly tho accidents with livestock and farming machinery, and first aid a services provided by the ASHA to the male village members. Re from Patti Mishra, an area approximately 20 kilometers from the clos she is consulted by both men and women from the seven village come most often seeking first aid treatment, and the women, for check-ups urban areas, the ASHA is often only used as a resource for wor Through a survey and a set of short interviews conducted in Ke arose an interesting distinction between the rural and urban ASHA. In one house, there were two village women, one of whom was pregnar who was not. When questioned about the presence of an ASHA responded there was no ASHA, and was interrupted by the younger, pregna who responded that there was: she was, in fact, helping her wi

In an interview with Pinki, a mother of two children, living two hours from Dehradun, she describes the ASHA as a health worker who is jus pregnant women.[46] In support of this argument, are the results compile

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[45] Gupta, Deepa. Personal Interview. 27 April 2011.
[46] Pinki. Personal Interview. 21 April 2011.

women (between the ages of 16 and 50), taken on the 21st of April, 2011, in Kehrigaon, P

Nagar. Only those women who were pregnant or in their child-bearing years consulted the

ASHA for health advice; all others consulted a female family m

PHC.[47] Even those who had small children chose to consult the An

ASHA. One quite popular critique of the ASHA program, especially

is that the ASHA is not a primary health worker,[48] but completing service

only the duties for which she receives honorarium, significantly pregnancy and chi

the most common. Similar such critiques will be discussed late

Unlike the ANM, who spends an average of two to three da

facility (usually the sub-center at which they are posted), the ASHA conducts wor

within the perimeters of her catchment area. Depending on her

though, she may visit a health center a few times a week to me

patients. During this study it was observed that the ASHA both visits village membe

houses and is visited in her own home by village members. In t

in particular, it was discovered that the ASHA visits the most r

walk) only once a month to conduct the demographic survey which is require

superiors. In villages where there is an established Anganwadi

found posted there, assisting the Anganwadi with the care of c

assists the ANM with outreach activities, vaccinations, and survey

is responsible only to a population of 1,000, in comparison to

8,000, she is able to work more intimately with the people. [illegible] the size of the

ASHA s population, Rukmanu (an ANM of 23 years, posted at th

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[47] Survey. 21 April, 2011. Kehrigaon, Prem Nagar, Dehradun District

[48] Anonymous NGO Interview. 26 April, 2011

necessary to meet with [corresponding ASHA] every day.[49] According to Anita Thapa, ASHA of six years, based in Badon Wala, there is also close co different areas; a closeness she holds which derives from the

In conclusion, although the actual role of the ASHA in her community is hi and providing any general description of her activities will inev among one contender or another, her position [illegible] development agenda. Below is an array of short responses prov Anganwadis, village women, village men, NGO workers, and gov in one way or another, accurately answer the question:

What is the role of the ASHA?

The ASHA is the messenger and the motivator.

The ASHA brings awareness.

The ASHA is acting like the coordinator between the ho

The ASHA is for the pregnant woman.

The ASHA is not a not a [illegible], but a health worker

The ASHA is the ANM s helper.

The ASHA program is like a link between the city an

The ASHA is the bridge.

VI. Where the ASHA Does Not Reach

According to a recent publication in The Economic Times, India is considered short 16,000 doctors, with an average doctor patient ratio of 1/30,000, regardless o

[49] Rukamu Personal Interview. 19 April, 2011.

attempt to incentivize practice in rural areas.[50] Not only do rural areas prove inferior in the

provision and availability of health services, they also prove d

grassroots initiatives, such as the ASHA program. Because the

health services to rural areas, and to establish better connections between rural a

facilities, the program must ensure the existence of areas in w

health services are unavailable. If the CHC is empty or closed, it is i

the ASHA to complete her work. Because of the ASHA s limited

provide only a limited scope of services, at which point she re

trained health providers. Two case studies presented below off

government ASHA scheme; one which is better accommodated t

Misras Patti, Uttarakhand (CFHI & IGEF)

In Misras Patti, a hilly area about an hour and a half outsi

Health and Education Forum (IGEF), with funding from the international NG

Health International (CFHI), manages a Basic Health Promoter

BHP program is the CFHI clinic, which provides services five d

doctor, Dr. Paul, one pharmacist, Virender Singh, and the nurses :

for thirty-day rotations every four months. Although the ASHA prog

area, CFHI feels that that the distance between the villages di

ASHA from working closely with her assigned population. The o

the Misras Patti ASHA is required to provide services, is space

precipitous dirt roads and no phone network. In areas like Misras Patti, the ASHA

program must be amended to reflect the limitations of such top

[50] The Economic Times, 9 March, 2011.

potential. Because of the proven benefits of having a local healt BHP

program, the model of which is quite similar to the ASHA progr

has trained five BHPs, each from a different village surroundin

was initially provided by CFHI, through, the consultant NGO, SB under the supervision of

Dr. Rajeev Prasad Bijalwan. The BHPs also received an additio

Himalayan Institute of Medical Sciences at Jolygrant, a trainin

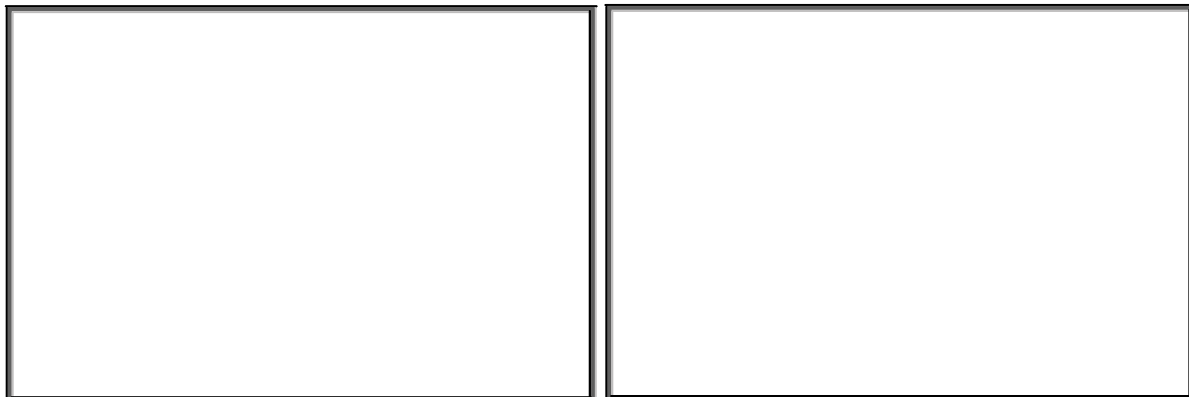
supplementary trainings are seen not only as experiences which can further develop

the BHP, but also as opportunities for the BHP to leave her vil

confidence and understanding of government health programs.

BHP s rotations in the clinic are also trainings and they are seen as such b

well.



Certificates provided to the BHP for completing HIMS and SBMA trainings. Harris Napier

CFHI and IGHEF s BHP program acts to extend basic health to rural villages

and simultaneously to sustain the functioning of the clinic itself through the

BHP s clinic rotations. One of the primary ways in which the BH

the context is seen through the program s requirements: education. Sunita Devi, a BHP

years, completed 5th standard, and Nirmala Devi of Bahrabur, a more se

has received no formal education and is illiterate. CFHI s prog

ASHA initiative incentive piece-rate pay: BHPs are given a fixed salary o

month both because CFHI believes that a fixed salary is import

in avoiding exploitation, and because task-based pay frankly would not work in

context. When questioned about the differences between the ASH

model, Nirmala Devi responded as follows:

> Our program is different than the ASHA working program in th
> way. We are much more attached to the village pe
> compared to the ASHAs. Our center of control is much c
> than it is for the ASHA since the ASHA program is a g
> program.[51]

When reading this quote it is important to take note of the way

program as "our program," the BHPs take joint possession of CFHI's project. Wh

about whom she goes to with concerns about her work, Sunita I

hesitation, that she calls or visits Dr. Paul directly. When the

the area's designated ASHA, she initially responded that she had been

[her job].[52] The question was asked again and phrased as: "If you h

problems regarding your work, who would you speak with?" Reena s

would seek the help of the ANM, posted 7 kilometers from Patti

name of Dunga's ANM, Reena responded that she could not rem

disconnect between the health worker (who has been deemed the people's

of the NRHM mission) and those from whom she is meant to rec

the objective and reduces effectiveness of such a program. As

to varying degrees of societal detachment in which the ASHA program is run

[51] Nirmala Devi. Personal Interview. 4 May, 2011.
[52] Ms. Reena, ASHA. Personal Interview. 4 May, 2011.

disconnect only worsens as the setting becomes more rural or
ASHA program must, in order to improve health indicators, func

Jamkhed, Maharashtra (CRHP)

An exemplary model highly pertinent to this research, and
NRHM s limitations, is the Village Health Worker Program of the Comprehensive
Project (CRHP), an NGO based in Jamkhed, Maharashtra. Altho
Uttarakhand, and implemented in a context quite dissimilar to
program has acted as an internationally recognized Community Health Worker mo
decades, and has subsequently provided training to national an
both in India and outside. The VHW model is described in the f

> The Village Health Worker acts as the local agent of positive health and social change. She is selected by the community and receives training in health, community development and organization, communication skills, and personal development from CRHP. Her primary role is to freely share the knowledge she obtains with everyone in the community, to organize community groups and to facilitate action, especially among women, the poor and marginalized. At the outset, many of these VHWs were often illiterate women from the untouchable (Dalit) caste. The concept and utilization of the VHW has been internationally recognized and often emulated for its dramatic positive impact on public health at the community level.[53]

CRHP runs its VHW program under the concept [illegible]
at the village level[54] and itself, the best agent for bottom-up reform is to train an
endorse an able village woman as a primary health care provid
momentum of the program, VHWs return to the CRHP campus every two weeks for tra
support groups. Equally as important to CRHP as improving hea

[53] Community Rural Health Project. Web. Accessed 2 May, 2011.
[54] Arole, Ravi. NGO, CRHP. Personal Interview. 5 May, 2011

the empowerment of women of Scheduled Castes and Tribes an
discrimination at the village level.

An important element of CRHP is its intentional disassocia
continued momentum of their VHWs program for forty years results from th
organization s unwavering commitment to the morals of equity
work of CRHP s staff and volunteer health providers. Although
organization refuses to hold a relationship with the government, in fear of di
philosophy which sustains their grassroots social and medical
government, concluded Ravi Arole, son of the CRHP s founder
and funding of CRHP programs, we will support the government
work to the government.[55] Because of their disconnection from the gover
struggles under the tight budget-line of an NGO, although the ser
which are pursued by thousands.

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[55] Arole, Ravi. Personal Interview. 5 May, 2011

The following account was written by the staff of CRHP, in resp
by Village Health Worker, Muktabai Pol, at the 1989 National Council of Internation
(NCIH) Conference in Washington D.C., USA, which Muktabai a
The short and poignant speech exemplifies not only the missio
VHW, but also illustrates the necessary features of a grassroots health pro

In a huge conference hall in Washington DC, over a thousand
attention to Muktabai Pol, a village health worker from

The listeners include officials from WHO and UNICEF, ministers of health, he
and representatives of universities from many parts o

Muktabai shares her experience of providing primary health c

She concludes her speech by pointing to the glittering lights in the hall

This is a beautiful hall, and the shining chandeliers are a tre
to travel thousands of miles to come to see their beauty. The
beautiful and exquisite, but expensive and inaccessible.

She then pulls out two wick lamps from her purse. Sh

This lamp is inexpensive and simple, but unlike the chandeli
another lamp.

She lights the other wick lamp with the first. Holding up both lamps in her outs
she says,

I am like this lamp, lighting the lamp of better health. Worke
another and thus encircle the whole earth.

This is Health for All.[56]

[56] Community Rural Health Project. Web. 200

VIII The Inadequacy of the ASHA: A Popular Critique

One of the most common critiques of the NRHM s ASHA pro
does not function to her greatest capacity, and that her actual
which she receives pay, not on the community whom it will most benefit. Sh
be a health resource and advocate for her community, but is of
Mamta raised a valid point, which provides a dependable gauge
functioning of a health worker and the program as a whole. Be
one thing, but being available is another. You must be available, argued J.M.
Singh. [The ASHA] has the knowledge, he continued, but if s
knowledge, nothing can be gained.[57] The question must be raised, however, as
disengagement is actually the fault of the ASHA herself, or of
seeks ultimately to improve the livelihoods of those most marginal populations
of India, it is essential that all possible measures are taken to
worker. The potential of the village health worker model to imp
uncontested, but equally so is the potential of the program to fail. There are fr
the ASHA program, but few are able to present a preferable pro

The second most widely disputed matter regarding the ASH
be paid appropriately for her work. Rukmani, an ANM of over twenty yea
contact with the Doiwala CHC provided an interesting perspect
based pay for the ASHA. Her critique also suggests an unfortu
ASHA and the ASHA s closet adviser: the ANM. If [ASHAs] got
work. They would sit in the home, she stated, laughing. We a

57 Singh, J.M. Personal Interview. 26 April, 2011

and the ASHA, or her helper.[58] Although she claimed to be joking, this was

instance in which such an account had arisen. The limit of the

views her role as less significant when compared to the ANM, w

closely: she holds herself responsible for a less significant wo

who has received a much more extensive training, and thus hol

considering her work to have greater value in the community. Furtherm

the urban areas of Dehradun District, many of the ANMs have c

Degree, and subsequently demand more respect from the ASHA

completed up to tenth standard in urban areas. The difficulty is findi

balance between demanding too little and demanding too much:

ASHA ensure that the most marginalized women can be employe

commitment of the female worker is essential in order to prese

ASHA as valuable both to her superiors and to the ASHA herse

Rukmani again vouched her support for the incentive-based pay for ASHAs, based on t

that the female ASHA requires the presence of incentives in order to be su

order to ensure the active work of the ASHA within her commun

Because the ASHA is guided by financial incentives, she is

primary health worker, but an incentive-oriented worker:[59] An association that invites co

among NGOs especially. Mr. J.M. Singh of Mamta explains that

incentive-driven health worker, curative services are somehow enh

issues.[60] Those indicators which are improving, Mr. Singh explaine

ASHA is getting money. Unfortunately, it is rare to see an ASH

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[58] Rukmani. Personal Interview. 19 April 2011

[59] Singh, J.M. Personal Interview. 26 April 2011

[60] Singh, J.M. Personal Interview. 26 April 2011

active health education), which are theoretical, written expectations of th

linked to any financial incentive and the progress of which can

collecting raw data, as polio drops or hemoglobin can. Many N

that the ASHA should be expected of more, and should offer mo

materials and training provided to her. The ASHA program potential

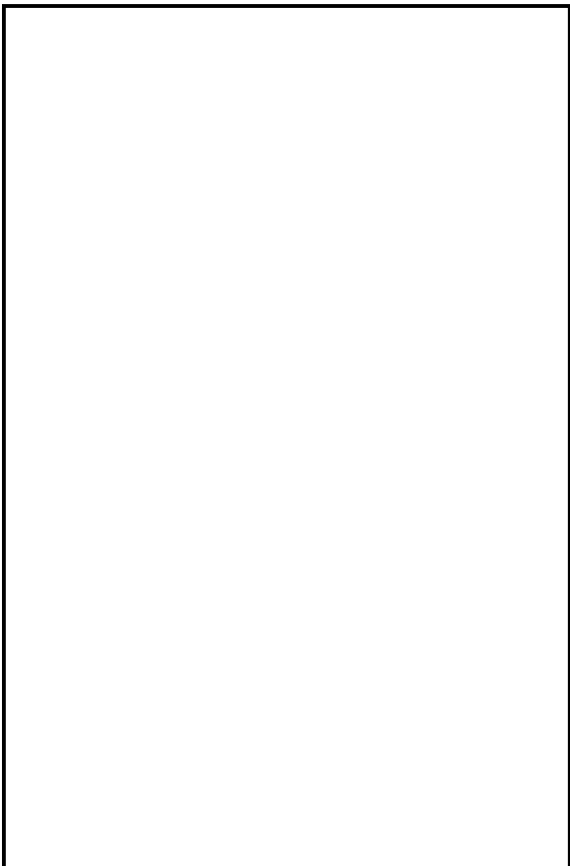
development and health decision-making within the community, and recognize

of utilizing human resources at the village-level, but claim that due to the realitie

program, we waste our energy to ASHAs.[61]

[61] Anonymous. Interview. 23 April 2011

Sunita Devi



Selo Village
Arcadia Grant
Sahaspur Block
Dehradun District, Uttarakhand

Sunita Devi is in her sixth year working as the ASHA of Selo village, in which she serves a total of 150 households, amounting to a population of approximately 1,000. She says her work can be summed up by three steps: counseling, motivation, and awareness. The closest Community Health Center (CHC) is five kilometers away in Prem Nagar. Her primary honorarium is the 600 rupees she receives for bringing a safe delivery to the district hospital, in this case, the Doon District Hospital. Her story sounds like that of any other ASHA; she is on call to a population of 1,000 at all times of day and night, she is overworked, underpaid. What is unique about Sunita's story is that she lives in an area in which the majority of families are from a military background. How does this transform Sunita's work? Because the majority of families are military families, 90% of deliveries are taken to the Doon Military Hospital, a center which offers free services to military families. Unfortunately, the Doon Military Hospital is also a hospital in which the ASHA does not receive a 600 rupees salary for a safe delivery. The 600 rupees, Sunita explained, is meant not only as pay to the ASHA for bringing the delivery to the institution, but also as pay for the treatment provided to the mother in the six to eight months before the delivery: it is the culmination of many, many months of care provision. Therefore, in 90% of pregnancies, Sunita spends six to eight months (on average) caring for the mother, and is paid nothing. Yet, what really angers Sunita is not the lack of pay, but the way in which she is treated by hospital staff. "The system is not caring for ASHAS," she told me, "it demoralizes us." The conditions at Doon District Hospital, in comparison to private or military hospitals, are bad; they are understaffed, short with patients, and sometimes do not have enough beds. "Nobody likes to send their wife to Doon because of conditions. We are the only ones who encourage people to go to Doon, and the doctors still don't have so much respect." She explained that she feels her role is well-identified by the people of her village, but not by the supervisors. "Only ASHA can tell the frustration of ASHA," she told me, when I asked her how she would change the system. "The ASHA is the bridge," she said. "Earlier the death rate, the MMR, IMR, were higher. They are now reduced because of us. So why is the system trying to weaken the bridge?" The ASHAs deserve more pay, consistent pay, because of their importance as grassroots mobilizers. They deserve respect that extends beyond the borders of their village. They deserve to be recognized publicly as accredited social health activists, as their title implies. Our interview finished with the following correspondence:

Sunita: "Now all ASHAs are thinking we should leave the job."
Me: "You are thinking of striking?" I asked her.
Sunita: "No," she responded, carefully straightening her sari across her lap, "stopping our work entirely."

26 April, 2011

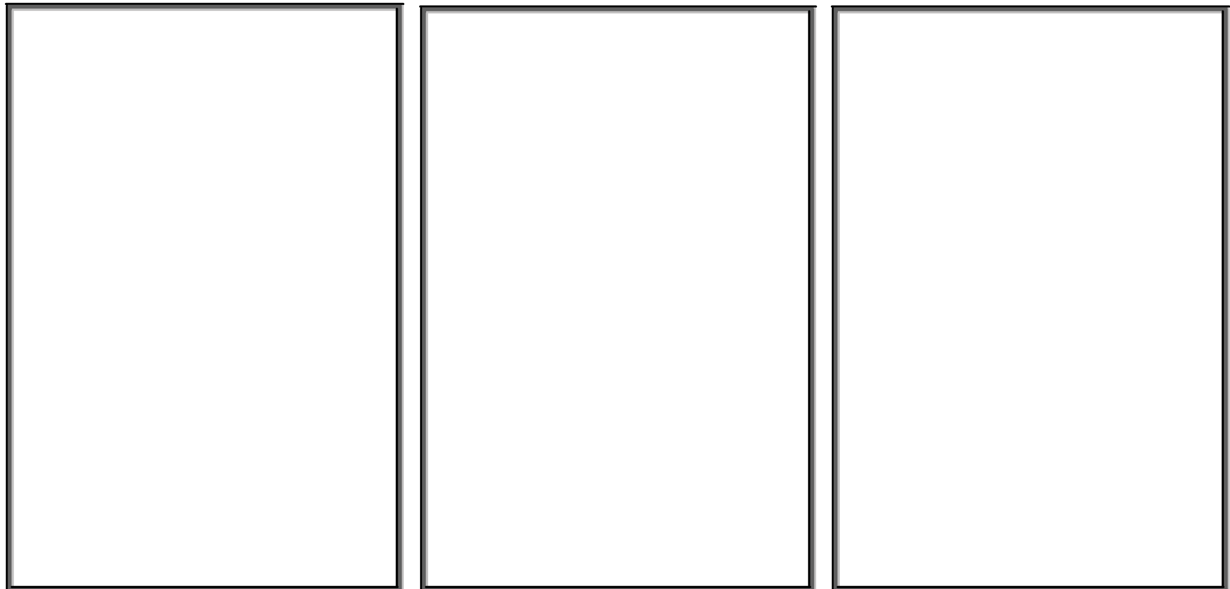
X. The Negligence of the Administration

ASHA ke pas asha hai

Source: Dehradun Jagran, 27 April, 2011

Negligence of the Administration: The above title of news obvious struggle to jump over a leaking sewer in front of a gov article compares the struggle of leaping over the exposed sewer, to that of the ASHAs w the conditions are such in front of a political institution, how c villages: the environment in which the ASHA must work, advoca change? The below photographs from the 20th April, 2011 ASHA protest, which co a march from Gandhi National Park to the Dehradun District Se Devi, an ASHA working in Badripur since 2005, explained that demand a fixed salary for their work: 2,500 rupees per month as their

were given more pay, we would have more strength to do our w Devi said,[62] as she pushed past police, standing at the border of the protest.



Harriet Napier

An article published in the Daily Pioneer, on 27 April, reporte

> Furious ASHA workers from across the State gathered at Dehradun on Tuesday and shouted anti department sloga took out rally to secretariat via Astley Hall and Subhash road. Wo expressed their concern over the issues that memorandu many a times to officials but they are not fulfilling their As agitators were stopped by the police personnel at secretariat, ASHA workers sat on Gandhi road and shouted an slogans[63]

Rukmani, the Doiwala CHC ANM who opposed the idea of p fixed salary, claiming that it would lead to inactivity, felt her incentives were too low. In a similar way in which she felt a fixed salary would committing time to her work, she claimed low incentives do the prices rising every day, it is becoming difficult for ASHAs to continue their work

[62] Devi, Kamo. Personal Interview. 26 April, 2011

[63] ASHA Workers Protest at Gandhi Park. Daily Pioneer. 10 May, 2011

which often requires she replace traditional income generating

her expected duties as ASHA. According to Annex 1, Guidelines states on t

the work of ASHA, as honorary volunteer, will be so tailored

her normal livelihood.[64] Yet if an ASHA is the one woman a pregnant woman car

rely, on whom the system tells all pregnant women they should, how can she

with her normal livelihood if she must be available to all pregn

of day?

Although referring to physicians, the following statement

Raman, an Indian public health expert, can be applied to any h

ASHA: "Merely giving allowances as incentives won't work in the

The remuneration is comparable to the ..."[65] Kamla Seni, an ASHA workir

in the village of Pratipur, further explained the problem of incentive based pay, using her own

experience as her example. When questioned about her average, she said,

sometimes zero rupees, sometimes two thousand. With the pri

ASHA that from bringing a pregnant woman to the CHC or PHC

is meant to receive 600 rupees) her absolute salary is greatly

pregnant women within her 1,000 population catchment area. In

have become even more unpredictable: So many times I have b

eight, nine months, then the family has delivered in a private hospi

receive no pay,"[66] explained Manju Rawat, a highly educated ASHA of G

Considering the dilemma of pay in the context of women s em

inconsistent pay, in fact, is worse than a lower, consistent pay; one wh

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[64] Guidelines on ASHA-Annex 1. NRHM. 29 July, 2010.

[65] Rural India is short of 1,600 doctors. The Economic Times. 9 March, 2011. Accessed 2 May, 2011.

[66] Rawat, Manju. Personal interview. 26 April, 2011.

may be more likely to secure through more traditional profitabl
agriculture. As the woman s status within the family is often as
provide stability; stability in the family, in bearing children, in cooking, and in
the house, an unstable income, one which additionally requires
contributions, can injure the well being of her family, and cons
unintentionally emphasizing the inability of the female to provide a stable inc
exacerbate her status as a monetary burden to her family. Poli
goals of the intended program: How is empowerment defined? Is it that empowering
with the job as ASHA will change the way in which she is received by her
If the ultimate aspiration is to train a village woman with basic
figure who can both assist her community in maintaining good h
connect villagers with primary health services when necessary,
missions such as immunizing a set number of children, bringing
hospital, incentive-based pay can be used. Incentivizing her work will ensure he
improvement of specific indicators, and will allow for transpare
financial security.

Conversely, if the ultimate or equal goal is that of combati
techniques of her pay must be more closely considered. If the
female the status of a consistent provider, equal to that of her male counterpart, i
level of reliability in her income-generation is secured. A simple policy ac
could be ensuring monthly events (such as Village Health and Sanitation D
are paralleled by fixed incentives. Requiring certain activities
also invites greater transparency and accountability; if the ASHA is re

report to the government center where she will receive her pay
be made of her progress and the progress odsfsthmeorpeprogram itself
responsibility from the ASHA, increasing the value of her work
services themselves.

Equal to the ASHA s concern regarding the financial compe
frustration with the way in wahmicdhtrsehaetedis bryecnueirvseeds and doctors.
the ASHA has undoubtedly changed the work of public sector d
Pitambari Godiyal, an experienced ASHA of Baniya Wala said j
doctors were cla[67]pplnianglflPHelsC.s and CHCs visited during this rese
declared that there had been an increase in the patient popula
ASHA program began. The State Women s Commission of Dehra
cases xoufasleharassment and domestic violence, said that more w
support since the ASHAs began their work. In 2003, the first ye
Comission, only forty cases were reported, wherheas2i0n1t0he rece
31 April, 2011) there were 1,155 cases. In many of these cases
the survivor was accompanied to the[68] ASSWHCA soffhiacvee bpyr oavne nA StHbAe.
a way to outsource information asthweeldcaarse asewaeykintgo bienbraevaisoe of
formerly hesitant populations.

With the increasing popularity of seeking treatment in priv
expressed confusion as to why public doctors treated them so
one[69] bringbing business to the public sector facilities. As is written
Health Mission Additi-o2n0a1l2i,tiesp,a2t0i1e1nts are the best ambassador

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[67] Goidyal, Pitambari, ASHA. Personal Interview. 26 April, 2011.
[68] Ms. Sushina. State Women s Commission Chairman. Personal Interview. 25 April, 2011.
[69] Devi, Sunita. Personal Interview. 26 April, 2011.

and Hospitals& it is important to take care of their needs and p
care. Their apprehensions should be addressed so that they have the courage to
same facility. In this business, every satisfied customer brings[70] This
is especially so when considering the treatment of the ASHA: t
advocate for government services. If the ASHA is not pleased with t
and doctors, why should she act as an advocate for them to he
auntys for whom she works in the village?

One ASHA participating in the DARC gaming in Raipur Block said that wh
advocate for a patient in the hospital, she is often scolded by
not the doctor. This is not your job.[71] The doctors frequently undermine the ASH
[her] to village women.[72] The ASHAs said they guessed their mistreatme
senior doctors feeling frustrated by the increase in work. Anita
too, claimed that she had been, on many occasions, the subject of emotional
superiors. Shobhit Singh Rawat, a Social Worker and Psycholog
with DARC for the past year, explains the dilemma from his per
see is that the doctor is not cooperating with the ASHA.[73] And they are both working for the
he stated. Sunita Devi expressed another related and very inte
is frequently such that it appears to reduce the legitimacy and
the time of pay, the job becomes very strange, Devi explained. The
feel official. Sometimes they pay 210, sometimes 220& it come

[70] NRHM Additionalities, Part B. 2011-2012. NRHM Program Implementation Plans 2011-2012. 52.
[71] Anonymous ASHA Focus Group. 27 April, 2011
[72] Mrs Rawat, Manju. Personal Interview. 26 April, 2011
[73] Singh, Shobhit Rawat. Personal Interview. 27 April, 2011

his pocket-money.[74] If the superiors do not treat ASHA's role seriously,

and themselves express a shared value for the benefits of the

expected to take seriously her work? Overall, the system is no[75] Sunita

Devi concluded.

Translating policy into practice is again where the predicament dwells. Be

examination of women's empowerment must include a holistic c

discrimination that is still a driving force in Indian society, we

improving indicators with successfully empowering the female

the familiarity and trust that ideally exists between ASHA and

identification as a village member, she can too easily be explo

public health system can improve health indicators. Combating

bottom, from the center of control and policy to the village itse

of all grassroots health programs by the goal of empowering the ASHA be

herself, through her employment as valued health provider, the

must be carefully structured, secured, and her compensation, u

to reach its greatest potential, it is essential that the position of the ASHA

system as one of great value and importance, and upheld as su

XI. Globalization & Empowerment: A Conclusion

What is empowerment without reward? The purpose of fighting for empowerment

there exists something better on the other side. Because empo

the human rights of a person, theoretical empowerment, if not

[74] Devi, Sunita. Personal Interview. 26 April, 2011.

[75] Devi, Sunita. Personal Interview. 26 April, 2011.

further denial of one s human rights. As Sen explains, it is not

theoretically has (here we must consider goods to be the title

corresponding) but the way in which the society invites and a

employ such goods.

> If the object is to concentrate on the individual s real
> pursue objectives, then account would have to be taken not only
> of the primary goods that persons respectively hold, but also
> relevant personal characteristics that govern the conversion of
> primary goods into the person s ability to promote her e [76]

It is thus not a question of the gamut of resources that society as a whole pre

rather the manner in which the individual, as defined by their expectations, is

able to access and utilize said resources. The resultant questi

initiatives of empowerment, are empowering? A context in which federal

initiatives targeting women s empowerment are deemed vital wi

natural progression of empowerment has been impossible. This

factors hindering the development of the woman within both society a

addressed within the empowerment agenda in order for said ag

status of women. Giving girls the opportunity to complete their

giving women a safe and culturally appropriate environment in which they can

have completed their schooling, defeats the purpose of giving

three young girls, and resident of Kehrigaon, aged fifteen.[77] In a survey of young wom

in Kehrigaon, it was concluded that the greatest difficulty face

the mere ability to leave the home. It is important to note that

women whose input led to such a conclusion had competed their Bachel

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[76] Sen, Amartya. 74
[77] Urmila. Personal Interview. 21 April, 2011

have given education, Urmilla stated, referring to the governm[78] Giving a female a certificate diploma identical to that of her male counterpart developing a mindset of gender equality, but if the society in w gives her equal opportunity is not prepared for her, her written equ

In order to present a compelling argument for women s emp discourse must be utilized. Globalization invites, or better yet consider the health of their people in an evolutionary manner. between two subjects inhibits interaction becoming obsolete, tl implement effective, inclusive programs is becoming greater. The Mill Goals, for instance, are a valid representation of the intersection between globalization and health. Health activists can use the rhetoric of globalization to persons share a set of common rights independent of geograph connectedness to the outside world. Health indicators are becoming pr difficult to track, and yet, the marginalized still find themselve services. Implemented programs do not reflect a holistic consi structural violence, and thus fail to amend the very structural imp inequity among groups. Development discourse must comprise technological benefits of globalization, but also of the infrastructure accomp necessary to activate associated benefits, such as equal status

After policy has been written and implementation has begu affair must be considered. What sustains local development of glob agendas? As much as policy makers would like believe otherwis which to sustain grassroots programs. Relying on volunteerism

[78] Urmila. Personal Interview. 21 April 2011.

requires an extent of commitment on the part of the health wor

exploitive. The WHO s dialogue on the importance of payment i

programs cannot be phrased better.

> Early community health worker programmes assumed a pool of willing volunteers but, in time, lack of payment proved to be a major cause of workforce attrition. There is virtually no evidence that volunteerism can be sustained for long periods. Most of the evidence reflects low activity rates and high drop-out leading to the ultimate collapse of community health worker programmes where payment, or other appropriate and commensurate incentives, are not adequate. The question of what represents adequate remuneration remains controversial and there is a paucity of evidence to indicate what combinations of incentives, including financial and non-financial incentives, are sufficient to motivate and retain community health workers. The burden of evidence indicates that stipends, travel allowances and other non-financial incentives are not enough to ensure the livelihood of health workers and that the absence of adequate wages will threaten the effectiveness and long-term sustainability of community health worker programmes.[79]

Successful Community Health Worker programs are not, as man

initiatives. They can be, however, extremely sustainable, and t

which to extend the right to health to those most marginalized.

and pay of local health workers has the ability to render outsta

outcomes and gender relations at the grassroots level, with for

vanguard of such initiatives. If fully implemented, the community health w

(whether it be that of the ASHA, the BHP, or the VHW) can con

structural, social, economic and medical impediments that mai

[79] WHO, PEPFAR, & UNAIDS (2006, August). Task Shifting Global Recommendations and Guidelines. WHO. 36.

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