Violence against Accredited Social Health Activists (ASHAs); A Cross-sectional Mixed Methods Study from Rural North Karnataka

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Title: Violence against Accredited Social Health Activists (ASHAs); A Cross-sectional Mixed Methods Study from Rural North Karnataka

Short running title: Violence against ASHA community health workers

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Abstract:

Background: Accredited Social Health Activists (ASHAs) are female community health workers who primarily work to improve local reproductive, maternal, neonatal, and child health in India. As ASHAs often hail from patriarchal environments and are positioned at the bottom of the healthcare hierarchy, they are vulnerable to experiencing different forms of violence from the various individuals that they interact with. There is a gap in knowledge about the actual working conditions of ASHAs and the violence that they may experience through their work.

Objective: This study assesses the working condition of ASHAs, the extent and types of violence experienced by them, and the corresponding perpetrators of this violence in two districts of Northern Karnataka.

Methods: Using a mixed-methods approach, we surveyed 396 ASHAs to characterize their experiences of violence. We then conducted in-depth interviews with 16 ASHAs to elaborate on survey findings. Data was analyzed using quantitative prevalence statistics and qualitative thematic analysis.

Results: Of the 396 ASHAs surveyed, most ASHAs had faced economic (88.1%) or emotional violence (73.2%), while many ASHAs had faced physical (25.8%) or sexual violence (31.8%). ASHAs faced high levels of economic violence from their beneficiaries and their beneficiaries' families (63.9%), emotional violence from their co-workers (43.9%), and physical and sexual violence from their own families (16.7% and 11.6% respectively). Mixed methods findings revealed that violence was often rooted from their low positioning on the healthcare hierarchy, a lack of respect from community members, and limited autonomy at home.

Conclusion: Evidence from this study suggests that violence perpetrated against ASHAs is highly prevalent, diverse in forms, and arises from the ASHA's immediate circles. Interventions aiming to decrease violence against ASHA workers may require a multi-level approach, with collaborative components empowering ASHAs, sensitizing ASHA families and co-workers, implementing regulations at the health facility level, and increasing community-wide respect for ASHAs.

INTRODUCTION

In efforts to expand accessible health coverage to rural areas, India enacted the National Rural Health Mission (NRHM) in 2005. A main goal of the NRHM has been to reduce regional imbalances in health outcomes by reducing India's maternal and infant mortality rates [1]. One significant component of the NRHM has been the Accredited Social Health Activist (ASHA) program, consisting of ASHAs, or female community health workers (CHWs) primarily working to improve local reproductive, maternal, neonatal, and child health. The ASHA program is thought to be the most visible component of the NRHM and most critical mechanism for community outreach. It is likely the world's largest CHW program with about 1 ASHA per 1000 individuals in India [2].

ASHAs facilitate access to healthcare services for their beneficiaries at the village, sub-center, and primary health center levels. These services include immunization, antenatal and postnatal checkups, and family planning. ASHAs engage in community health work by providing oral rehydration therapy packets, iron folic acid tablets, chloroquine, and contraceptives to their beneficiaries. ASHAs also reinforce safe maternal health practices, dispel unsafe traditions, and screen pregnant women for complications [3]. ASHAs lastly serve as health activists by promoting health advancement in their communities, particularly by creating an awareness of women and children's health [4] in surrounding patriarchal settings [5]. ASHAs work alongside Anganwadi Workers and Junior Health Assistants (JHA), two other categories of Indian CHWs that similarly promote women and children's health [4].

Worldwide, assaults against health workers have become widespread and overlooked conflicts. According to the International Committee of the Red Cross, violence against health workers must be recognized as one of the most prevalent humanitarian concerns of today [6]. The World Health Organization, International Labor Office, International Council of Nurses, and Public Services International have all additionally stressed the need for workplace violence to be addressed within the healthcare context [7]. Furthermore, the United Nations Special Rapporteur's October 2013 report on the right to the highest attainable standard of health stressed the need for increased observation and data collection on attacks against healthcare workers [8]. Although the media regularly portrays expatriate health workers as the primary victims of violence, local health workers are disproportionately affected by violence at higher rates [9]. In India, though the estimates on violence against women (VAW) vary greatly [10], around one-third of Indian woman have reported to have experienced spousal violence [11]. In the state of Karnataka, 20.5% of women have reported to have experienced spousal violence [12]. The consequences of VAW are far reaching. To the survivor, violence can cause immediate physical injuries, mental illness, and health complications [13]. Violence can also result in decreased social functioning, lower work productivity, and reduced educational, occupational, or political participation. Violence against women can hamper a nation's productivity as women have the potential to constitute to about half a country's workforce [14].

Though the ASHA program has become an inherent part of the Indian health system, questions related to ASHA working conditions remain unexplored. As ASHAs often hail from patriarchal environments and operate within an existing village power structure [5], they are vulnerable to

experiencing different forms of violence from the various individuals that they interact with. Studying the working conditions of ASHAs has the potential to improve ASHA work experiences, decrease ASHA dropout rates, advance local reproductive, maternal, neonatal, and child health, and encourage more women to enter the labor force. The objectives of this study are to assess the working condition of ASHAs, including the extent and types of violence experienced by ASHAs, and investigate the corresponding perpetrators of this violence in two districts of Northern Karnataka. This study will provide unique evidence unpacking violence against Indian community health workers, as no such attempt has been done in past. Findings of this study will highlight the issues that ASHAs face and will shed light on how surrounding social structures can enable a more supportive environment for ASHAs to work in.

METHODS

This study employed a mixed-methods research design, connecting themes across the survey and interview instruments to facilitate comparison of quantitative and qualitative data. The quantitative survey aimed to estimate the forms and levels of violence experienced by ASHAs, as well as the key perpetrators of this violence, and the qualitative interviews were conducted to explore the in-depth details and backgrounds of these situations.

Study Design and Sampling Methodology

From February—March 2016, we conducted cross-sectional surveys and qualitative interviews with ASHA workers. Quantitative data was collected across Bagalkot and Koppal, two districts of Northern Karnataka, and qualitative data was collected in Bagalkot. To select the ASHAs for the survey, multi-stage sampling was employed to select 50% of the taluks (sub-districts) in Bagalkot and Koppal, and amongst these taluks, 50% of the Primary Health Care (PHC) centers in which ASHAs worked. Districts for the quantitative data collection were purposively selected based on the following criteria: (i) districts with a large proportion of socio-economically disadvantaged populations (ii) districts with accessible health systems. The district for the qualitative data collection was selected due to a strong relationship with the local health system. The sampling frame for the quantitative survey consisted of all working ASHAs in Bagalkot and Koppal as of February 1, 2014, with the list of all working ASHAs provided by the local offices of NGO Karnataka Health Promotion Trust (KHPT), who works closely with different government departments including the Department of Health and Family Welfare. ASHAs were then stratified by caste and marital status.

From the PHCs selected, systematic sampling was employed to select the 400 ASHAs invited to participate in the survey. Participants who were qualitatively interviewed were chosen purposively based on those who had previously expressed experiencing violence.

Study subjects

Of the 400 ASHAs contacted for the survey, 396 ASHAs completed the survey. 16 separate ASHAs were interviewed, including currently working and former ASHAs, with former ASHAs having been interviewed to compensate for survivorship bias. All study participants received monetary compensation for their time and travel.

Study instruments

Questions used to assess emotional, physical, and sexual violence in the quantitative survey were based on pre-validated tools used in state and national studies including the Demographic Health Surveys (DHS) conducted in India. The specific questions regarding economic violence were crafted through a careful examination of literature and from preliminary conversations with ASHA workers that occurred between September—December 2015. The final survey instrument was pretested for clarity and reliability amongst ASHA workers prior to official data collection.

Qualitative in-depth interviews were conducted after selected current and former ASHAs underwent a 2-day workshop in which the concepts of violence against women and women's empowerment were contemplated through mediums of conversation, art, and theatre. The workshops were devised to provide ASHAs/former ASHAs a safe place to reflect upon their experiences. Post-workshop, each attendee was interviewed through a semi-structured format about her experience as an ASHA worker and violence that she may or may not have faced.

Data Analysis

The primary outcome of the study was prevalence of different types of violence measured as a binary variable—yes if the ASHA experienced the form of violence in the past 6 months preceding the survey and no if otherwise. An ASHA was categorized to have experienced emotional violence if she had been humiliated in front of others, threatened, insulted repeatedly, or severely intimidated. An ASHA was categorized to have experienced economic violence if anyone had forcefully taken her money, forced her to make bribes, bribed her with money, showed hostility towards her for earning money, or showed hostility towards the time she spent earning money as an ASHA. An ASHA was categorized to have experienced physical violence if anyone pushed, shook, slapped, shoved, hit, kicked, dragged, choked, burned, used a weapon, or threatened to use a weapon on her. An ASHA was categorized to have experienced sexual violence if anyone unsolicitedly spoke to her, looked at, touched, or teased her in a sexual way, physically forced sex, or forced the ASHA to do something sexual that she found degrading or humiliating.

The quantitative data was computerized in a database developed using CSPro [15] with built in consistency checks. The data was then exported to STATA 14.0 [16]. Univariate and bivariate analyses were done to understand the background characteristics of the ASHAs surveyed, prevalence of experiencing different forms of violence, and the perpetrators of this violence.

The qualitative in-depth interviews were first transcribed verbatim, and then translated into English. All transcribed interviews and translated documents were then reviewed for accuracy and completeness. The transcripts were imported into the qualitative software Dedoose, a software program designed to assist qualitative data management and analysis [17]. A coding scheme was developed based on the interview guide, field notes, preliminary quantitative results, and available literature. New codes and categories emerged during the analysis were also included in the subsequent coding process. Thematic saturation was observed, and extensive memos were written while coding, which provided space to compare the data across different forms of violence and to draw interpretations, based on these comparisons.

RESULTS

Of the 400 ASHAs contacted, 392 responded, consented to, and completed the in-person quantitative survey. An additional 4 ASHAs of the randomized list were contacted and surveyed for a final count of 396 (Bagalkot (n=200), Koppal (n=196)). The mean age of the respondents was 33.6 years and the majority of them had completed education up to or beyond 7th standard. Most ASHAs were currently married (68.9%), with 77.3% of these individuals having been married at or before the age of 18. The median number of years having worked as an ASHA was 7 years. Most ASHAs were not the main earning members of their families (45.3%) nor the primary decision makers of their families (42.4%). The majority of ASHAs (65.4%) had a monthly income of less than 5000 rupees/month (about $73 USD). Most ASHAs belonged to a union (67.7%) or a self-help group (73%) (Table 1).

Table 1: Profile of ASHAs who participated in quantitative study

General Characteristics		**% (SE)**	**N (396)**
Mean age		33.6 ()	396
Highest grade level of education completed	<7	8.8	35
	7-9	44.4	176
	10+	46.7	185
Religion	Hindu	93.2	369
	Other	6.8	27
Caste	SC/ST/OBC	32.3	128
	Other	67.7	268
Marital Characteristics *			
Marital status	Currently Married	68.9	273
	Deserted/Separated/Divorced/Other	12.9	51
	Widowed	18.2	72
Age marriage to husband	<=15	30.4	83
	16-18	46.9	128
	>18	22.2	62
Highest grade of education that husband has completed	<7	36.6	100
	7-9	20.	56
	10+	42.9	117
Education level between ASHA and husband	ASHA more educated than husband	53.1	145
	Equal education between ASHA and husband	13.2	36
	Husband more educated than ASHA	33.7	92
Husband currently working	No	5.1	14
	Yes	94.9	259
Household Characteristics			
	Other family member	54.8	217

Main earning member of household	ASHA	45.2	179
Primary decision maker of household	Other family member	57.6	228
	ASHA	42.4	168
Mean number of people living in household		5.4	396
Type of household	Non-nuclear	49.5	196
	Nuclear	50.5	200
Mean number of children		2.2	396
Child sex composition	No child	8.8	35
	Sons=Daughter	23.5	93
	Sons>Daughter	38.9	154
	Sons<Daughter	28.8	114
Work Characteristics			
Median years working as an ASHA		7	396
Engaged in employment other than ASHA work	No	65.2	258
	Yes	34.9	138
Monthly household income (from all income sources) (rupees)	1000-3000	44.4	176
	3000-5000	21.0	83
	5000+	34.6	137
ASHA Union affiliation	No	32.3	128
	Yes	67.7	268
Self-help group affiliation	No	27.0	107
	Yes	73.0	289

*Questions in this section pertain to currently married ASHAs

Table 2 presents violence prevalence levels reported by ASHAs who participated in the survey. Virtually all (93.7%) reported facing some sort of violence in the 6 months preceding the survey. Most ASHAs had faced economic (88.1%) or emotional violence (73.2%), while a large percentage of ASHAs had faced physical (25.8%) or sexual violence (31.8%). About 15.4% of the ASHAs surveyed had faced all forms of violence probed for in the survey; economic, emotional, physical, *and* sexual violence.

Table 2: Percentage of ASHAs who experienced violence

Type of Violence	**% Experienced in the past 6 months**	**N (396)**
Any Violence	93.7 (90.8-95.9)	371
Economic Violence	88.1 (84.5-91.2)	349
Emotional Violence	73.2 (68.6-77.53)	290
Physical Violence	25.8 (21.5-30.4)	102
Sexual Violence	31.8 (27.3-36.7)	126
Both Physical and Sexual Violence	15.9 (12.5-19.9)	63
Severe Physical or Sexual Violence*	24.2 (20.1-28.8)	96
All Types of Violence	15.4 (12.0-19.3)	61
No Violence	6.3 (4.1-9.12)	25

*Severe physical or sexual violence was defined as a combination of experiencing both physical and sexual violence in high frequency over the past 6 months

Table 3 shows some of the specific perpetrators who inflicted violence upon the surveyed ASHAs. It can be seen that the ASHAs faced particularly high amounts of economic and emotional violence from the families of the female beneficiaries they served (60.4% and 25.5% respectively) and high physical and sexual violence from their husbands (13.1% and 10.4% respectively). PHC Doctors and Staff Nurses were also reported to have inflicted high amounts of economic and emotional violence upon the ASHAs surveyed.

Table 3: Percentage of ASHAs who Experienced Violence by Key Perpetrators

Forms of Violence	Key Perpetrators	% (CI)	N (396)
Economic Violence	Family of female beneficiary	60.4 (55.4-65.2)	239
	PHC Staff Nurse	32.3 (27.7-37.2)	128
	Other CHWs	27.5 (23.3-32.2)	109
	Husband	23.7 (19.5-28.0)	94
	Female beneficiary	19.4 (15.7-23.7)	77
	PHC Doctor	19.2(15.4-23.4)	76
Emotional Violence	Other CHWs	26.3 (22.2-30.4)	104
	Family of female beneficiary	25.5 (21.3-30.1)	101
	Husband	24.8 (20.6-29.3)	98
	PHC Doctor	15.7 (12.2-19.6)	62
	Female JHA	11.4 (8.4-14.9)	45
	PHC Staff Nurse	10.9 (8.0-14.4)	43
Physical Violence	Husband	13.1 (10.0-16.9)	52
	ASHA's family*	5.1 (3.1-7.7)	20
	Family of female beneficiary	3.3 (1.8-5.6)	13
	PHC Staff Nurse	3.0 (1.6-5.2)	12
Sexual Violence	Husband	10.4 (7.5-13.8)	41
	Family of female beneficiary	7.6 (5.2-10.6)	30

*Does not include husband

Families of Beneficiaries

60.4% of ASHAs faced economic and 25.5% of ASHAs faced emotional violence from the families of their beneficiaries. In many interviews, ASHAs expressed that they received unnecessary blame from the families of beneficiaries due to reasons that were beyond their responsibilities. Numerous ASHAs stressed that their beneficiaries' families felt authorized to seek out unreasonable faults with the ASHA's work. As beneficiaries were community members, a few ASHAs explained that a lack of respect from the families of beneficiaries reflected a lack of respect from the community.

'Since there are many patients at the hospital, it will take a full day to complete checkups. If they [the beneficiaries] come home late, we [the ASHAs] should be ready to get shouted at by the patient's family members. Some families will shout, "Hey ASHA, what have you done, when did you take her for a checkup and how can you be coming back so late".' [ASHA #5]

In the above example, the ASHA was blamed for the beneficiary's late return, even though the ASHA did not have much control of this circumstance. In the next example, the same ASHA is speaking about blame she received from a beneficiary's husband for a fault that was not hers.

'When a pregnant woman is taken to the hospital, she will be given a mothers' card. Without knowing that the JHA collects the card, the husband of the patient was shouting at me blaming that I took card. He was so angry that he tried to beat me… he used to come to my house to quarrel with me about the matter which was unrelated to me.' [ASHA #5]

PHC Staff Nurse/Doctor

ASHAs reported experiencing economic and emotional violence from the PHC Staff Nurse (32.3% and 10.9% respectively) and the PHC Doctor (19.2% and 15.7% respectively). As ASHAs are grassroots workers and are located at the bottom of the healthcare pyramid, emotional and economic violence were expressed to be rooted in work-related disrespect towards ASHAs. Numerous ASHAs expressed that their healthcare co-workers would purposefully insult or humiliate them. In the below example, a hospital doctor is shouting insults at an ASHA.

'The doctor shouted that this was his hospital, and "Why do you come, what is your work, who are you ASHA, what is your value, how much they pay you?"'[ASHA #6]

In all interviews, ASHAs expressed that they were taken advantage of by higher-ranking colleagues. A few ASHAs expressed that PHC Staff Nurses and Doctors had forced them to make monetary bribes.

'When there is a delivery, they [the Staff Nurse or PHC Doctor] will demand rs. 500-1000 from the patient and will force the ASHA to collect it and give it back to them [the Staff Nurse of PHC Doctor].' [ASHA #3]

In the above situations, since the ASHA is the intermediary between the patients and a senior healthcare staff, she is exploited into requesting money from the patients on behalf of those above her. ASHAs expressed that their co-workers who had higher positions felt entitled to make unjustified demands from them.

Other Community Health Workers

23.7% of ASHAs reported economic violence and 26.3% of ASHAs reported emotional violence from other community health workers. In the example below, an ASHA describes an experience in which a fellow CHW responsible for delivering the ASHA's payment is purposefully withholding it.

'For some ASHA workers, even if they do their work efficiently, the Female JHAs come up with faults in our work. Even after working proficiently, the Female JHAs used to tell us that we hadn't worked and purposely delayed our payments.' [ASHA #9]

During the interviews, a few ASHAs mentioned that they were repeatedly made fun of by other CHWs due to poor reading and writing skills. Similar to ASHAs experiences with the PHC Staff Nurse/Doctor, ASHAs strongly emphasized that their relationships with other community health workers were rooted in power dynamics resulting from ASHAs being on the bottom of the community health work hierarchy.

Husband

23.8% of ASHAs reported economic violence from their husbands. Many ASHAs conveyed that they had limited control over their work earnings and were expected to hand over their money to their husbands as soon as they were paid.

'It was my husband who was taking all the money and spending it… He was grabbing all of my earnings. He did not even give me Rs.500 for having worked all through the month.' [ASHA #11]

24.8% of ASHAs faced emotional violence from their husbands. In the qualitative interviews, numerous ASHAs articulated that they had little autonomy over how they spent their time at home. Often times, their husbands reacted violently over the mobility that the job allowed them and the decreased time they spent on housework.

'Since I had to be out in the community while attending to delivery cases, he [the ASHA's husband] became angry…If I leave the house for work, his concern was, "Who will take care of the household work and other duties?"…. During recent months, he has forced me to stay at home and not leave the house for work.' [ASHA #13]

The work of ASHAs involves catering to the needs of pregnant women, and sometimes these needs come at unexpected times. If a woman has a late-night maternal complication, typically the ASHA is expected to assist her. Many ASHAs expressed that their husbands violently disapproved when the ASHA came home late from work.

'Returning home it was 10:30pm at night. Then, at home, there were arguments on why I came home late home…He used abusive words and foul language and he started to shout at me saying, 'What kind of bloody meeting did you have? Which bastard had organized this?'[ASHA #4]

DISCUSSION

In this study, we found an extreme prevalence of violence, with 93.7% of ASHAs having experienced any violence in the 6 months preceding the survey. The high levels of violence were contributed by economic violence (88.1%), emotional violence (73.2%), physical violence (25.8%), and sexual violence (31.8%). A large proportion of ASHAs faced economic violence from the families of their beneficiaries and healthcare co-workers, emotional violence from their healthcare co-workers and their own families, and physical and sexual violence from their own families.

ASHAs were often scapegoated by their beneficiaries' families for situations beyond their control. ASHAs were held responsible when their beneficiaries came home late from the hospital, were inappropriately charged fees by other hospital staff, or were not delivered compensation for giving birth in a hospital. In most interviews, ASHAs stressed that they were disrespected by the families of beneficiaries, often due to their status as women challenging household practices. Their work as health educators disrupted the traditional power dynamics, in which the husband or the mother-in-law knows what is best for a pregnant woman. The poor treatment by the families of beneficiaries reflects the limited respect that the community has for the work of ASHAs.

It is evident that a strong healthcare hierarchy exists within India's public health system [18], and as ASHAs are positioned at the bottom of the healthcare ladder, they thus have limited authority to challenge those above them. ASHAs mentioned that they were disrespected by higher-ranking co-workers, from being forced to collect inappropriate bribes from beneficiaries, to being questioned of her value. Even amongst ASHAs, JHAs, and Aganwadi workers, there were clear attempts of dominance between the different CHWs. These findings are consistent with other evidence suggesting that different cadres of CHWs often feel a sense of competition with one another, rather than cooperation [19].

Being a woman engaged in the labor force in India comes with impediments. Women often have expectations to complete a disproportionate burden of housework and childcare [20]. Similarly, families of ASHAs had an issue with the time ASHAs spent working and not completing "household duties". Previously mentioned excerpts illustrate how often times, an ASHA's family became frustrated with her defying gender norms in which the woman spends most of her time catering to domestic chores and the woman's husband decides how her time is spent. Evidence suggests that in developing countries, women's domestic burdens may pose an impediment to economic participation [21]. In the case of the ASHA program—the world's largest CHW program [2], this idea has not previously been explored.

As very high amounts of economic violence were recorded in this study, there is a need to address the economic violence impacting ASHAs, as well as an overall need to investigate economic violence impacting working women. There is currently minimal research on economic violence, and further exploration of economic violence could enhance comprehensions of violence as a whole. Of the research currently available on economic violence, evidence suggests that abusive partners prevent women from acquiring income by discouraging her economic autonomy [14]. Similarly, many ASHAs conveyed that were expected to hand over their money to their husbands as soon as they were paid. However, as economic violence against women reflects the unequal

economic relationships between men and women in *particular contexts*, there is a need for circumstantial investigations of economic violence in diverse settings. In this study, numerous ASHAs mentioned that they had been bribed or had been forced to make bribes on behalf of others more powerful than them. Little to no research captures similar situations being forced of women.

Limitations

This study has a few limitations. As violence is a complex subject to comprehend and communicate, it is possible that some ASHAs interpreted violence in different ways. Some ASHAs may have viewed violence as non-problematic, and thus did not report related experiences. Certain ASHAs may have blamed themselves for the violence, and thus did not report violence-related situations. As most ASHAs live in well-connected communities, certain ASHAs may not have shared their experiences due to fear of information spread. Though these factors were taken into consideration through in-depth discussions of violence, quality rapport building, and assurance of confidentiality prior to data collection, it is possible that some ASHAs did not reveal their full experiences.

Additionally, it is not possible to determine how much of the violence experienced by ASHAs was specifically experienced as a result of their work as ASHAs. However, as ASHAs have extremely important responsibilities in promoting reproductive, maternal, neonatal, and child health nationally, any amount of violence perpetrated against ASHAs likely serves as an impediment in an ASHA's ability to work, therefore posing a challenge to India's health system and hampering women's workforce development.

While numerous ASHAs reported experiencing economic violence from their beneficiaries and their beneficiaries' families, our research did not explore this theme in great detail during the qualitative interviews. However, this topic will be explored in future research.
Lastly, the information gained in this study was self-reported. Though the experiences of ASHAs could have been more holistically understood through interviews from the reported perpetrators, this study primary aimed to understand the issue from the ASHA's perspective.

CONCLUSION

Evidence from this study suggests that violence perpetrated against ASHAs is prevalent, diverse in forms, and arises from the ASHA's immediate circles. Interventions aiming to decrease violence against ASHA workers may require a multi-level approach, with collaborative components operating at the individual, interpersonal, healthcare facility, and societal level. At the individual level, programs can be implemented that empower ASHAs through reinforcing their rights, boosting their confidence, and equipping them with skills to handle violence perpetrated at them. At the interpersonal level, peer support networks amongst the differing CHW groups can be established to build collective empowerment in together supporting each other in addressing violence. In addition, efforts can be made to sensitize ASHA families about the importance of ASHA work and the tasks associated with being an ASHA worker. At the healthcare facility level, response mechanisms can be institutionalized that recognize the different forms of violence against

ASHAs, penalize perpetrators, and support ASHAs that have experienced violence. At the societal level, community leaders should be sensitized to enable a supportive environment for community health workers to operate in. This in turn, could promote community-wide respect for ASHA workers, improving the ASHA-beneficiary, ASHA-healthcare co-worker, and ASHA-family relationships.

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Paper context: Though the ASHA program has become an inherent part of the Indian health system, questions related to ASHA working conditions remain unexplored. Assaults against community health workers are not only violations of human rights, but also pose a challenge to the national rural health system and impede in women's workforce development. This study provides insight on the amount of violence that ASHA workers face and the perpetrators of this violence. Findings suggest that violence is very prevalent and arises from ASHA workers immediate circles. The study can contribute to the development of actions that lead to improved community health worker working experiences.

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