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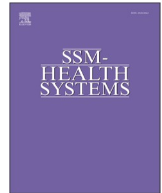
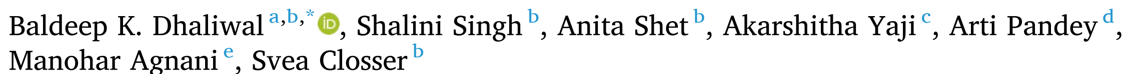


Hidden in plain sight: Sexual violence against community health workers in India



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ABSTRACT

Ensuring the safety and well-being of women in the health workforce is a critical but underexamined dimension of health system functioning. In India, Accredited Social Health Activists (ASHAs) serve as frontline community health workers. They often operate in challenging and insecure conditions, and they are vulnerable to multiple forms of violence due to factors including night work, financial insecurity, and power dynamics in communities. This commentary contributes to our understanding of violence within the health system by analyzing diverse instances of sexual violence against ASHAs. These examples highlight ASHAs' systemic intersectional vulnerabilities, rooted in their marginal status within the health system. By approaching this issue through a health-systems lens, we aim to highlight practical opportunities to enhance coordination, accountability, and workforce well-being across multiple levels of the health system. Recommendations include the need for robust institutional support, protective legislation enforcement, and broad community engagement. This paper advocates for the reimagining of ASHAs' roles in the health system, emphasizing the need for: safety and dignity, inclusive policies that protect all health workers, and situating ASHAs' struggles within the broader global context of health worker vulnerabilities.

India's community health workers: crucial and vulnerable

India launched the Accredited Social Health Activist (ASHA) program in 2005 as a key component of their National Rural Health Mission to strengthen rural health delivery and community engagement (National Rural Health Mission, 2005–2012). The ASHA program was designed to select one woman per village (approximately 1 per a population of 1000) to receive 23 days of training on basic health topics, first aid, and mobilizing the community around key health issues like sanitation and nutrition. ASHAs also receive training on identifying, responding to, and referring cases of violence against women (National Health Mission). In 2015, the program was renamed to the National Health Mission and expanded to incorporate marginalized urban areas. With almost one million ASHAs, it has grown to become one of the largest community health worker (CHW) programs in the world.

Although the ASHA program has improved a range of maternal and child health indicators (Agarwal et al., 2019), ASHAs report being limited by the outcome-based payment structures, limited institutional support, the hierarchical structure of the health system, and low community engagement and respect (Scott and Shanker, 2010). These structural constraints shape the conditions under which ASHAs carry out their work at the frontline of India's health system. ASHAs labor at the lowest level of the health system (National Health Mission), playing a vital role in addressing both general health, as well as sensitive community issues including contraceptive counselling and sexual and reproductive health. While this close community interaction can foster meaningful relationships and strengthen trust in the health system, what is often unspoken is that this exposes ASHAs to risks of violence (Ved et al., 2019).

Existing literature shows that many ASHAs chronically endure various forms of violence, including economic exploitation, verbal harassment, physical assault, and, in some cases, sexual violence in

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public and healthcare spaces (Rao et al., 2021; Zabiliūtė, 2020). Several factors contribute to ASHAs' vulnerability to violence including their low socioeconomic standing (Manjunath et al., 2022), their limited social and institutional support (Bhatia, 2014), and the power dynamics within the system or within their own community (Saprii et al., 2015). Their vulnerability is further reinforced by their ambiguous labor classification: although they perform essential health system functions, they are designated as activists rather than paid employees. While some literature has highlighted that ASHAs face sexual violence (Dasgupta et al., 2017), both published documentation of such cases, and direct disclosures from ASHAs to researchers, remain limited (Rao et al., 2021).

Our team draws on our own work to explore sexual violence against ASHAs in more depth. Our goal is to underscore dynamics within the health system that may increase the risks ASHAs face, and we advocate for institutional, legal, and community-level reforms to protect ASHAs from sexual violence. Our recommendations are shaped by our multidisciplinary team of researchers, policymakers, and legal experts.

Sexual violence in India

Violence against women is a major global health concern (WHO, 2005), and Sustainable Development Goal 5 aims to eliminate all such violence (Walsh et al., 2022). As of 2022, sexual crimes in India rose from about 12 per 100,000 women and girls in 2001, to approximately 20 per 100,000 by 2018. The most commonly recorded offense was 'assault intended to outrage a woman's modesty', followed by rape; in most rape cases the accused was someone known to the survivor (Dandona et al., 2022). According to India's National Crime Records Bureau, approximately 96% of reported rape cases in 2020 involved someone known to the survivor (National Crime Records Bureau, 2020).

Several legal and policy reforms have been introduced in India after the 2013 Verma Commissions' review of response to sexual violence. The Criminal Law (Amendment) Act broadened the legal definition of rape, increased prison sentences for convicted offenders, raised the age of consent to 18, and removed consideration of a survivor's "character" in legal proceedings (VERMA et al., 2013). Following Commission recommendations, India also expanded women-staffed police stations to create safer reporting spaces for survivors, an approach associated with improved violence reporting in other settings (Unnithan and Nalla, 2019; Perova and Reynolds, 2017). However, despite these reforms and increased policy attention, sexual violence in India continues to be a concern (McDougal et al., 2021), and, as seen in global reporting (Dziewanski et al., 2014), much of it continues to go unreported in India (Rukmini, 2021; Unheard and Uncounted Violence against Women in India, 2025). Additionally, most literature on sexual violence in India focuses on societal context, such as gender roles and taboo, and how that impacts reporting (Nieder et al., 2019; Kalra and Bhugra, 2013; Math et al., 2014; Satyanarayana et al., 2015).

This commentary addresses an important gap in the sexual violence literature by centering our focus on ASHAs and examining the distinctive occupational risks embedded in their informal work, particularly as their roles require them to operate across public and private domains. We aim to delve into systemic gaps in this commentary and provide recommendations that may address these gaps from legal, policy, and research perspectives.

Exploring the data: uncovering sexual violence in the health system

In the course of our work across various regions in India, the authors of this commentary have gathered accounts from ASHAs across India about their experiences with sexual violence. These observations and quotations are drawn from multiple qualitative and ethnographic research projects conducted over several years, primarily focused on health systems functioning, health programs, and maternal and child health service delivery. Methods across these studies included in-depth interviews, participant observation, field immersion, and repeated interactions with ASHAs and other frontline health actors.

Disclosure was often made possible through long-term engagement in the field and relationship-based qualitative research. Interviews and ethnographic conversations frequently took place in private or semi-private settings and often occurred after repeated contact, which enabled rapport and trust to develop over time. Many of the authors are Indian or of Indian origin, conducted research in local languages, and most are women. These are factors that, in many cases, contributed to building trust and creating safe conversational spaces for discussing stigmatized experiences. Although ASHAs are trained to support community members with reporting sexual violence, in our research, accounts of personal exposure to harassment and violence did not arise in formal training contexts. The combination of their professional training, institutional positionality, together with qualitative approaches that prioritize openness and repeated engagement, may have shaped the settings in which ASHAs disclosed these sensitive experiences to researchers.

Because discussing sexual violence within a health system is sensitive and potentially dangerous, we cannot provide specific project details or traceable examples without risking participant identification. These studies took place in different states across India, and they were conducted over different time periods. None of the original studies were designed specifically to investigate violence. Instead, ASHAs raised these experiences organically during broader discussions of work conditions, encounters in the field, and relationships with supervisors, health staff, and community members.

This commentary focuses specifically on occupational risks encountered by ASHAs in the course of their work; we recognize that sexual violence occurs across many settings, and that ASHAs' roles themselves often blur boundaries between public and private spaces.

What ASHAs tell us about risk for violence

Although these projects were not originally designed to study violence, cross-study qualitative and ethnographic review revealed consistent themes in ASHAs' accounts of sexual violence, including night travel requirements, unsafe transportation, household visit vulnerabilities, and financial precarity (Table 1).

One particular risk ASHAs described was the need to travel at night. In one focus group discussion, ASHAs explained that night work was often unavoidable, especially in cases of deliveries. "*We have to go. We know our patients can't go without us – they need us with them.*" Yet, ASHAs noted in this and other interviews, working at night carries significant dangers.

ASHAs also reported that, despite guidelines indicating they should have designated places to rest after escorting pregnant women to hospitals, these provisions are rarely available in practice. "*Even the medical students kick us out. They say 'all ASHAs get out',*" one ASHA commented. Others noted that because of this, they were often forced to return home alone late at night. An ASHA recounted her colleague's ordeal: *"The auto driver who took her back…he really misbehaved with her. He said, 'my phone has died, I need to call my family'. We are ASHAs. We give and help. So, she*

Table 1
Recurrent risk contexts reported by ASHAs across studies.

Risk Context	Description	Data Source Type
Night travel	Escorting deliveries and emergency care requires late-night travel	Interviews; FGDs
Unsafe transport	Dependence on drivers or informal transport	Interviews; Ethnographic observation
Door-to-door visits	Entering potentially unfamiliar spaces	Ethnographic observation
Financial precarity	Incentive pay encourages riskier tasks	Interviews

gave him her phone. He turned it off and put it in his box. Ma'am…he then forced himself on her."

Further, our field observations have shown that even daytime visits can carry risks. When following ASHAs in their door-to-door work, we have observed ASHAs seeming particularly nervous when entering areas where they could not immediately see a woman. When one author asked an ASHA why she seemed uncomfortable that day compared to others, her eyes darted – quickly checking all corners – while she explained that an ASHA had recently been raped. "*My parents called and told me this happened in their area while she was going to help a woman during a delivery.*"

Although physically being in the field poses significant risks, ASHAs' vulnerability to sexual assault and harassment is further heightened by their financial insecurity. "*All of us only do this work because we need the money,*" one ASHA said in an interview. In many rural areas of India, women have few other job choices. Another ASHA explained, "*There are no other options, so I have to do this work.*" ASHAs, technically considered 'volunteers', navigate a complex incentive-based payment system. As each incentive-based task offers different compensation (NHSRC India, 2024), ASHAs report prioritizing higher-paying tasks like institutional deliveries, despite increased potential safety risks. This increases an ASHAs' vulnerability, further increasing the possibility of exploitation and harassment (Rao et al., 2021). More complexly, ASHAs occupy a precarious position at the intersection of multiple expectations: they are accountable to the health department, to the communities they serve, and to their own need for fair working conditions (Singh et al., 2024).

These accounts reflect not only the social realities ASHAs navigate, but also the ways operational and infrastructural arrangements can influence exposure to risk. These tensions can leave ASHAs without institutional support from the health system and limited support from the community they serve.

Institutional, legal, and community-level reforms to protect ASHAs

The themes described above align with and extend existing national and international literature on gendered vulnerability among frontline and community health workers (Mumtaz, 2003; George et al., 2020; George, 2008; Steege et al., 2018; Closser et al., 2023). In this section, we situate our cross-study qualitative observations within this broader literature, but we aim to document the institutional, legal, and community-level implications and potential areas for reform. Addressing violence against women in health professions requires a multi-level approach, starting with strengthening institutional support, implementing legal reforms, and building evidence to recognize the challenges faced by the female workforce.

Policymakers can take steps to ensure well-functioning workplace safety systems for female healthcare workers across all levels of the health system. They should prioritize regular reviews and discussions to improve the implementation of existing ASHA safety measures, including implementing designated rest areas in health facilities, expanding ASHA violence-prevention training to also include health systems and community members (Mobilizing for Action on Violence Against Women, 2017), and establishing a well-functioning grievance redressal system (Mishra, 2016) and One-Stop Crisis Centers (Ministry of Women and Child Development, 2019) in each district.

Health system managers can strengthen existing links between ASHAs and community engagement structures such as women's collectives, village health committees, and Gram Panchayats (village councils). This can help ASHAs form deep rooted connections with the community, address social determinants of health, advocate for community needs, preserve their community identity, and help access support and solidarity during crises. Chhattisgarh's Mitanin program – the inspiration for the ASHA program – offers replicable lessons on how existing community engagement structures can support ASHAs and other frontline workers in preventing, assessing, and mobilizing collective action on violence concerns (Nandi and Schneider, 2014).

Equally essential are legal reforms. Despite legislative efforts at both state and national levels, ASHAs remain inadequately protected, revealing a significant gap between legal provisions and actual protections. Although the Indian Constitution delegates healthcare legislation to individual States and Union Territories (Constitution of India, 1950), the enforcement of specific protections for healthcare workers by state governments has been inconsistent. While some states, such as Andhra Pradesh, Tamil Nadu, Maharashtra, West Bengal, and Karnataka, have enacted laws to safeguard healthcare workers (Protection of healthcare service personnel, 2020), implementation across India remains uneven. While a temporary amendment to the Epidemic Diseases Act (1987) during the height of the COVID-19 pandemic offered brief national protection, it has since lapsed (The Epidemics Disease Act, 1987).

India's federal structure allows the Indian Parliament to intervene in matters where healthcare overlaps with criminal law, disease control, and disaster management. In this capacity, they have introduced – though not yet legally notified – the 2022 Prevention of Violence Against Healthcare Professionals Bill (Prevention of Violence Against Healthcare Professionals and Clinical Establishments Bill, 2022) and the 2023 Healthcare Professionals Protection Bill (Government of India, 2023). Although these bills broadly refer to health volunteers, they fail to specifically mention ASHAs, potentially limiting the protection that may be offered to ASHAs if ratified. Further, while ASHAs should be covered under other legislation, such as the Sexual Harassment of Women at Workplace Act (Government of India, 2015) and the Bharatiya Nyaya Samhita (Indian Penal Code, 2024), enforcement is weak, and ASHAs' rights often remain neglected in practice. It is essential that these wide-ranging legal measures are fully implemented to ensure that ASHAs and other grassroots health workers receive the same protection as other healthcare professionals.

Lastly, researchers and academics have a role in ensuring CHW safety; we must shine a light on these injustices when we hear them, probe even when uncomfortable, and conduct research in a way that provides safe spaces for those with limited power to speak up. Embedding gender-sensitive safety measures into ongoing health system monitoring and planning processes could help ensure that safety concerns are addressed proactively, and in alignment with national and state priorities. Efforts to improve protection may also benefit from collaboration across health, legal, and community-governance sectors, consistent with intersectoral approaches to health systems strengthening.

A call to amplify the voices of vulnerable health workers globally

While some accounts of sexual violence (Mumtaz, 2003; Parimal, 2023) and analyses of gendered elements of violence against vulnerable health workers have emerged in the academic literature (George et al., 2020; George, 2008; Steege et al., 2018), they often avoid specific issues of CHW violence as CHWs operate in a space between the health system and the community. Our work contributes to this discussion by foregrounding how operational arrangements that CHWs are particularly vulnerable to, including travel requirements, incentive-based payment structures, and supervisory hierarchies, can function as potential multipliers of violence. Ongoing discussions surrounding healthcare worker safety (Saaliq, 2024) must include vulnerable health workers like CHWs; without their voices, we perpetuate the dangerous notion that the safety of some professions matters more than others.

Conclusion

Drawing on cross-study qualitative and ethnographic research across multiple Indian states, this commentary highlights an under-recognized dimension of ASHA work: exposure to sexual harassment and violence linked to the routine features of frontline service delivery. Across

interviews, focus groups, and field observations, recurring themes included risks associated with night travel, unsafe transport arrangements, door-to-door work, and financial precarity within incentive-based systems. Together, these patterns suggest that the risk for sexual violence is amplified by how CHWs' work is organized and conducted.

The issues we have written about are not unique to India, as the systemic power imbalances that create violence exist globally (Foucault, 2012). When imbalanced relationships exist between formal employees, CHWs, and even national and global actors (Sriram et al., 2018), CHWs are placed at increased risk. Situating ASHAs' experiences within a broader international CHW context underscores the shared challenges many health systems face in ensuring safe working environments for community-based providers. Globally, CHWs face similar risks as ASHAs, often in environments where protections are minimal, and accountability is scarce (Closser et al., 2023). From Sub-Saharan Africa to Southeast Asia and Latin America, women serve their communities under vulnerable conditions, but they often do not benefit from the support available to their counterparts in more formalized health system positions. These cross-country patterns mirror what we observed in ASHA contexts: gendered frontline roles combined with weak formal protections create structurally similar vulnerability across CHW programs.

Balancing workforce flexibility with adequate safeguards remains a complex yet critical policy goal globally. Comparative learning across countries may help identify models for integrating CHW protections within larger health system strengthening frameworks. Supporting CHWs is not simply about preventing tragedies; it is about affirming that the lives of those at the margins matter as much as those in more visible or powerful positions. Amplifying the voices of the most vulnerable is essential to creating a health system where every woman is afforded the dignity, safety, and protection she deserves.

CRediT authorship contribution statement

Anita Shet: Writing – review & editing, Formal analysis. **Akarshitha Yaji:** Writing – review & editing, Formal analysis. **Arti Pandey:** Writing – review & editing, Formal analysis. **Manohar Agnani:** Writing – review & editing, Formal analysis. **Baldeep K. Dhaliwal:** Writing – original draft, Formal analysis, Conceptualization. **Shalini Singh:** Writing – original draft, Conceptualization. **Svea Closser:** Writing – original draft, Conceptualization.

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Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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References

Agarwal, S., Curtis, S.L., Angeles, G., et al., 2019. The impact of India's accredited social health activist (ASHA) program on the utilization of maternity services: a nationally representative longitudinal modelling study. Hum. Resour. Health 17, 68. https://doi.org/10.1186/s12960-019-0402-4.

Bhatia, K., 2014. Community health worker programs in India: a rights-based review. Perspect. Public Health 134, 276–282. https://doi.org/10.1177/1757913914543446.

Closser, S., Sultan, M., Tikkanen, R., et al., 2023. Breaking the silence on gendered harassment and assault of community health workers: an analysis of ethnographic studies. BMJ Glob. Health 8, e011749. https://doi.org/10.1136/bmjgh-2023-011749.

Constitution of India. 1950.

Dandona, R., Gupta, A., George, S., et al., 2022. Administrative data deficiencies plague understanding of the magnitude of rape-related crimes in Indian women and girls. BMC Public Health 22, 788. https://doi.org/10.1186/s12889-022-13182-0.

Dasgupta, J., Velankar, J., Borah, P., et al., 2017. The safety of women health workers at the frontlines. Indian J. Med. Ethics 2. https://doi.org/10.20529/IJME.2017.043.

Dziewanski, Dariusz, Racovita, Mihaela, LeBrun, Emile, 2014. War and Peace: Violence against Women and Girls. Cambridge University Press, Cambridge.

Foucault, M., 2012. The history of sexuality: an Introduction. Knopf Doubleday Publishing Group, Westminster.

George, A., 2008. Nurses, community health workers, and home carers: gendered human resources compensating for skewed health systems. Glob. Public Health 3, 75–89. https://doi.org/10.1080/17441690801892240.

George, A.S., McConville, F.E., De Vries, S., et al., 2020. Violence against female health workers is tip of iceberg of gender power imbalances. BMJ m3546. https://doi.org/10.1136/bmj.m3546.

Government of India. Handbook on POSH Act by WCD. 2015.

Government of India, 2023. Healthcare Professionals Protection from Violence and Harassment Bill.

Indian Penal Code. Bharatiya Nyaya Samhita. 2024.

Kalra, G., Bhugra, D., 2013. Sexual violence against women: understanding cross-cultural intersections. Indian J. Psychiatry 55, 244. https://doi.org/10.4103/0019-5545.117139.

Manjunath, U., Sarala, R., Rajendra, D., et al., 2022. Assessment of workload of ASHAs: a multi-stakeholder perspective study for task-sharing and task-shifting. J. Health Manag 24, 62–73. https://doi.org/10.1177/09720634221079084.

Math, S.B., Viswanath, B., Maroky, A.S., et al., 2014. Sexual crime in India: is it influenced by pornography? Indian J. Psychol. Med 36, 147–152. https://doi.org/10.4103/0253-7176.130976.

McDougal, L., Krumholz, S., Bhan, N., et al., 2021. Releasing the tide: how has a shock to the acceptability of gender-based sexual violence affected rape reporting to police in India? J. Inter. Violence 36, NP5921–NP5943. https://doi.org/10.1177/0886260518811421.

Ministry of Women and Child Development, 2019. One Stop Crisis Centre. Press Information Bureau.

Mishra, C., 2016. Safety measures for ASHAs.

Mobilizing for Action on Violence Against Women: A Hand Book for ASHA. 2017.

Mumtaz, Z., 2003. Gender-based barriers to primary health care provision in Pakistan: the experience of female providers. Health Policy Plan 18, 261–269. https://doi.org/10.1093/heapol/czg032.

Nandi, S., Schneider, H., 2014. Addressing the social determinants of health: a case study from the Mitanin (community health worker) programme in India. Health Policy Plan 29 (2), ii71–ii81. https://doi.org/10.1093/heapol/czu074.

National Crime Records Bureau. Crime in India. National Crime Records Bureau, Ministry of Home Affairs, Government of India. 2020.

National Health Mission.About accredited social health activist (ASHA). National Health Mission.

National Health Mission:Ministry of Health & Family Welfare. Mobilising for action on violence against women: a handbook for ASHAs. New Delhi.

National Rural Health Mission (2005–2012): Mission Document. Government of India: National Health Mission.

NHSRC India. ASHA INCENTIVES-APRIL 2024. 2024.

Nieder, C., Muck, C., Kärtner, J., 2019. Sexual violence against women in India: daily life and coping strategies of young women in Delhi. Violence Women 25, 1717–1738. https://doi.org/10.1177/1077801218824056.

Parimal A.Dabhi. 1st conviction: Man gets 3-year jail for sexually harassing ASHA worker. 2023.

Perova, E., Reynolds, S.A., 2017. Women's police stations and intimate partner violence: Evidence from Brazil. Soc. Sci. Med 174, 188–196. https://doi.org/10.1016/j.socscimed.2016.12.008.

Prevention of Violence Against Healthcare Professionals and Clinical Establishments Bill, 2022.

Protection of healthcare service personnel. PRS Legis. Serv. 2020. 〈https://prsindia.org/covid-19/covid-blogs/protection-of-healthcare-service-personnel〉 (accessed 26 September 2024).

Rao, L., Prakash, R., Rai, P., et al., 2021. Investigating violence against *Accredited Social Health Activists* (ASHAs): a mixed methods study from rural North Karnataka, India. J. Glob. Health Rep. 5. https://doi.org/10.29392/001c.24351.

Rukmini, S., 2021. India officially undercounts all crimes including rape. The Hindu.

Saaliq, Sheikh, 2024. India's top court creates Task Force on workplace safety after doctor was raped and killed. PBS N.

Saprii, L., Richards, E., Kokho, P., et al., 2015. Community health workers in rural India: analysing the opportunities and challenges Accredited Social Health Activists

(ASHAs) face in realising their multiple roles. Hum. Resour. Health 13, 95. https://doi.org/10.1186/s12960-015-0094-3.
Satyanarayana, V.A., Chandra, P.S., Vaddiparti, K., 2015. Mental health consequences of violence against women and girls. Curr. Opin. Psychiatry 28, 350–356. https://doi.org/10.1097/YCO.0000000000000182.
Scott, K., Shanker, S., 2010. Tying their hands? Institutional obstacles to the success of the ASHA community health worker programme in rural north India. AIDS Care 22, 1606–1612. https://doi.org/10.1080/09540121.2010.507751.
Shalini Singh, Baldeep Dhaliwal, Arpana Kullu, *et al.* The ASHA program in times of universal health coverage: Old tensions in a new context. Right Health Resour. 2024. ⟨https://rthresources.in/conversations-on-health-policy/the-asha-program-in-times-of-universal-health-coverage-old-tensions-in-a-new-context/⟩ (accessed 6 October 2024).
Sriram, V., Topp, S.M., Schaaf, M., et al., 2018. 10 best resources on power in health policy and systems in low- and middle-income countries. Health Policy Plan 33, 611–621. https://doi.org/10.1093/heapol/czy008.
Steege, R., Taegtmeyer, M., McCollum, R., et al., 2018. How do gender relations affect the working lives of close to community health service providers? Empirical research, a review and conceptual framework. Soc. Sci. Med. 209, 1–13. https://doi.org/10.1016/j.socscimed.2018.05.002.
The Epidemics Disease Act. 1987.
Unheard and Uncounted Violence against Women in India. India Armed Violence Assessment 2025.
Unnithan, N.P., Nalla, M.K. (Eds.), 2019. Violence against Women in India, 1st ed. Routledge.
Ved, R., Scott, K., Gupta, G., et al., 2019. How are gender inequalities facing India's one million ASHAs being addressed? Policy origins and adaptations for the world's largest all-female community health worker programme. Hum. Resour. Health 17, 3. https://doi.org/10.1186/s12960-018-0338-0.
Verma, J.S., Seth, L., Subramanium, G., 2013. Report of the committee on amendments to criminal law. New Delhi.
Walsh, P.P., Banerjee, A., Murphy, E., 2022. The UN 2030 Agenda for Sustainable Development. In: Murphy, E., Banerjee, A., Walsh, P.P. (Eds.), Partnerships and the Sustainable Development Goals. Springer International Publishing, Cham, pp. 1–12.
WHO multi-country study study on women's health and domestic violence against women, 2005. summary report: initial results on prevalence, health outcomes and women's responses. World Health Organization, Geneva, Switzerland.
Zabiliūtė, E., 2020. Claiming status and contesting sexual violence and harassment among community health activists in Delhi. Gend. Place Cult. 27, 52–68. https://doi.org/10.1080/0966369X.2019.1586651.