

## **Urban Community Health Workers in Punjab, India: A Qualitative Study of ASHAs' Roles in the Health System**

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1 **ABSTRACT**

2 **Background:** The Accredited Social Health Activist (ASHA) program is the worlds' largest all-female  
3 community health worker (CHW) initiative. While most CHW programs have been extensively studied  
4 in rural contexts, little is known about how ASHAs and CHWs operate in urban settings. Research on  
5 urban programs globally remains limited with a primary focus on single-disease interventions. A  
6 more holistic understanding of urban ASHAs' roles is needed to more comprehensively understand  
7 urban health delivery. This study explores the experiences, challenges, support systems, and  
8 systemic barriers faced by urban ASHAs in Punjab, India.

9 **Methods:** This qualitative study was conducted in one urban and one peri-urban site. Data collection  
10 included 25 in-depth interviews, participant observation with 28 ASHAs over three months, and  
11 community-level focus group discussions. Data were analyzed using thematic coding with MAXQDA  
12 software. A half-day financial participatory session was implemented to document the financial  
13 aspects of urban ASHAs' work.

14 **Results:** Urban ASHAs play a vital role in connecting vulnerable populations to healthcare and  
15 promoting government health services. Despite this, they face challenges including overseeing  
16 populations that far exceed the limits set by guidelines, limited training opportunities, low  
17 community engagement, and insufficient financial compensation. Systemic barriers, such as  
18 unfilled supervisory positions and minimal collaboration with community engagement structures  
19 exacerbate these issues.

20 **Discussion:** To maximize the impact of the urban ASHA program, policy makers and implementers  
21 may consider strengthening governance, refining ASHA selection processes, enhancing community  
22 engagement, addressing staff shortages, providing targeted training, and revising financial  
23 incentives. Implementing these recommendations may strengthen urban ASHAs' ability to deliver  
24 equitable healthcare in Punjab and provide a model for improving urban health delivery across India.

## 25 INTRODUCTION

26 Over the past several decades, the Government of India has committed to improving public  
27 health, enhancing health indicators, and responding to emerging health challenges through  
28 transformative policy changes. A key component of these efforts was the launch of the Accredited  
29 Social Health Activist (ASHA) program in 2005 (1). Over one million ASHAs, a cadre of community  
30 health workers (CHWs), operate across 27 of India's 28 states, forming the world's largest all-female  
31 community health workforce(2).

32 The ASHA program was initially designed to support marginalized rural areas, as these  
33 populations face significant barriers to care (1). Over the last two decades, the rural ASHA program  
34 has made substantial strides, with access to ASHA services being associated with a 17% increase in  
35 first antenatal care visits, a 5% increase in four or more antenatal visits, a 26% increase in having a  
36 skilled birth attendant at delivery, and a 28% increase in facility-based deliveries (3). Despite these  
37 impressive strides in rural India, marginalized populations in urban India faced distinct healthcare  
38 access challenges, often without comparable government intervention. To address these growing  
39 disparities, the Indian Government launched the National Urban Health Mission (NUHM) in 2013,  
40 expanding the ASHA program to support urban populations (4,5). Despite the urban ASHA program  
41 being active for over a decade, research on this program is limited. This mirrors the global literature  
42 gap on CHWs' contributions to urban health systems (6).

43 Globally, most research on CHW program implementation and effectiveness has focused on  
44 rural programs (7), despite the rapid urbanization of many countries (8). Studies on urban CHWs have  
45 largely examined their role in specific health issues (9,10) or evaluated their effectiveness in  
46 delivering single-disease interventions (11,12). However, there is little evidence on the broader  
47 design, management, and administration of urban CHW programs, including payment structures,  
48 supervision, and recruitment policies (9). Although the urban poor can be as vulnerable to health

49 risks as the rural poor (13), identifying solutions to address growing urban health disparities has not  
50 been extensively documented in the global health literature (14). This gap is particularly pronounced  
51 in the ASHA program; while there has been extensive research examining the functioning of rural  
52 ASHAs, little is known about how the program operates in urban settings.

53 The existing literature on urban ASHAs has primarily focused on specific health campaigns,  
54 such as eye health education and at-home breast exams (15,16), or more recently, on evaluating their  
55 effectiveness in achieving health outcomes based on select performance metrics (17). A systematic  
56 review of 122 studies published between 2005 and 2016 on India's ASHA program found that only  
57 two focused on urban settings (18). As India's urban population grows, understanding how ASHAs  
58 navigate healthcare delivery for marginalized populations in these settings is crucial. Without a  
59 deeper understanding of how urban CHWs, including ASHAs, function within complex health  
60 systems, efforts to support urban healthcare delivery risk being misaligned with the realities on the  
61 ground.

62 In this study we examined how urban ASHAs' roles, challenges, and support structures align  
63 – or fail to align – with the evolving health needs of urban communities in two sites in urban Punjab,  
64 India. This was guided by the CHW-health systems interface framework which explores CHW social  
65 profile and agencies, CHW program inputs, CHW-community interface, the health services context,  
66 program governance, program outcomes, and program impact (18). This specific framework was  
67 selected as we aimed to understand the urban ASHA program on a broader level, which required a  
68 detailed understanding of elements of the frameworks' broad domains. We found that while ASHAs  
69 are expected to support the most vulnerable populations, inadequate support, socioeconomically  
70 diverse populations, limited compensation for transportation, and difficulties with community  
71 engagement limit ASHAs' ability to ensure that they are most effectively supporting vulnerable  
72 populations. By addressing these gaps through policy and programmatic change, we believe that the

73 ASHA program can be strengthened to better support urban populations access and use health  
74 services in India.

75 By developing a more nuanced understanding of the urban ASHA program, this work aims to  
76 provide an essential window to begin to understand these broad, complex issues of health delivery  
77 among marginalized urban populations, both in India and on a global setting. This research is an  
78 essential initial contribution to strengthening global urban community health delivery by focusing on  
79 CHW program design, management, and sustainability in India's ASHA program.

## 80 **BACKGROUND: THE ASHA PROGRAM**

81 Launched under the National Rural Health Mission in 2005 – and under the National Urban  
82 Health Mission in 2013 – the ASHA program broadly aims to improve equitable access to healthcare  
83 and strengthen health delivery systems for marginalized populations in rural and urban areas. The  
84 urban mission was designed to improve the health status of urban populations by providing care  
85 through a network of Urban Primary Health Centers, Urban Community Health Centers, and urban  
86 ASHAs (4,5). Grounded in the belief that community-based workers drive health behavior change,  
87 ASHAs were implemented to leverage local bonds to enhance outreach (19). An ASHA is expected to  
88 receive at least 23 days of training on basic health topics before she is assigned a population of  
89 approximately 1000 people to provide care to (1,20).

90 ASHAs are responsible for raising awareness about health-related social determinants, such  
91 as nutrition, sanitation, and hygiene, and providing support to marginalized groups. They also  
92 facilitate continuity of care through home visits, facility escorts, and outreach activities like Health  
93 and Nutrition Days. ASHAs are also expected to facilitate coordination with community-based  
94 organizations, such as Mahila Arogya Samitis (MAS) – or women's collectives – to strengthen  
95 community ownership of health interventions and empower women as active health advocates (4,5).  
96 Although ASHAs receive a modest honorarium which varies by state, most of their earnings come

97 from task-based incentives tied to specific maternal and child health services. ANM (Auxiliary Nurse  
98 Midwife) workers, who complete a two-year certification program for this role, serve as the primary  
99 supervisors for ASHAs within a structured, hierarchical health system. Positioned as intermediaries  
100 between ASHAs and higher-level health officials, ANMs oversee ASHA activities, ensure task  
101 completion, and provide guidance on maternal and child health initiatives.

## 102 **METHODS**

103 This qualitative study draws on several data sources: (i) in-depth interviews (IDIs) and community-  
104 level focus group discussions (FGDs), (ii) participant observation, (iii) case studies, and (iv) a finance  
105 participatory session. This work was conducted by the first author (referred to as “BD” and “I”)  
106 between September-December 2023, with rapport building in late September and initial participant  
107 recruitment starting on 04/10/2023 and ending on 07/12/2023.

### 108 Ethical Considerations

109 The research team obtained approvals from the Johns Hopkins Bloomberg School of Public Health  
110 (IRB #25369), Panjab University (ECR-2308-162), and the Punjab National Health Mission  
111 (NMH/PB/CCP/2023/106613-16). BD took written consent from all participants, explaining the  
112 purpose of the research, the voluntary nature, and any risks and benefits using an informed consent  
113 form and participant information sheet in Punjabi or English. Moreover, in accordance with the  
114 American Anthropological Association's Statement on Ethics and Principles of Professional  
115 Responsibility, BD emphasized ongoing informed consent as a part of the study design to promote  
116 participant agency and engagement (21). As ethnography has the potential to blur lines between  
117 research and friendship (22), BD engaged in ongoing discussions to clarify whether participants  
118 intended their shared experiences to be treated as research data or as personal exchanges; data not  
119 considered as research by participants was excluded from field notes.

### 120 Field Sites

121 The study was conducted in two sites in Punjab, India which were selected by the National Health  
122 Mission, Punjab. The site referred to as the “urban site” in this text was an urban city of roughly 1  
123 million people that has seen rapid development in recent years. The area is characterized by a  
124 growing number of shopping malls, business centers, and newly constructed residential apartment  
125 complexes, reflecting its transition to an urban hub. This city is undergoing significant economic and  
126 infrastructural expansion, attracting a population of wealthy individuals seeking to relocate, as well  
127 as the migrant workers who are facilitating this transition. Migrants often lived in sprawling slum  
128 settlements where homes were pieced together from available materials – discarded construction  
129 debris, tarps, and rusting sheets of metal. Some of these settlements have stood for years, while  
130 others emerge overnight near construction sites, quickly assembled as temporary shelters for  
131 migrant workers. The roads within these settings are typically uneven dirt paths, at times pooling with  
132 wastewater. Access to water typically comes from a shared hand pump, where women gather daily  
133 to fill containers. With limited sanitation infrastructure, open defecation is common. Income is  
134 unstable with most women finding work as domestic helpers in nearby homes, while men take on  
135 day labor in construction, drive rickshaws, or engage in other forms of informal, low-wage work. The  
136 site referred to as the “peri-urban site” in this paper was an area with a population of approximately  
137 500,000 people. The peri-urban site is characterized by its unique blend of rural and emerging urban  
138 elements, attracting a significant number of migrants for agricultural work and employment in local  
139 industrial positions. While some neighborhoods resemble organized areas with concrete homes and  
140 small shops, others resemble the slums of the urban site. Both areas have a complex socio-  
141 economic environment, where long-term residents and new arrivals navigate shifting job  
142 opportunities, infrastructure challenges, and access to basic services.

#### 143 Data Collection

144 The research team and public health experts introduced BD to ASHA supervisors in-person across  
145 both field sites, who in turn facilitated introductions to ASHAs. Following these initial meetings, BD  
146 began study activities, meeting ASHAs at their convenience and accompanying them in their daily  
147 routines. BD conducted participant observation with 28 ASHA workers across the two field sites,  
148 spending several hours a day, six days a week, shadowing their routine activities such as door-to-  
149 door community outreach, vaccination sessions, hospital visits, survey work, ad-hoc tasks,  
150 meetings, and interactions with community members and other health workers. As an "active  
151 observer," BD participated in ASHA activities, conducted informal and formal interviews during this  
152 time, and built rapport through social engagement.

### 153 In-Depth Interviews

154 BD conducted 25 formal in-depth interviews until thematic saturation was reached: 13 with ASHAs  
155 and 12 with policymakers and health program administrators. All participants were initially recruited  
156 through the research team and local health system contacts, followed by snowball sampling to  
157 identify additional stakeholders; participants were purposively selected based on their knowledge of  
158 the ASHA program. Interviews with ASHAs largely explored their motivations for remaining in their  
159 roles, their expected responsibilities and tasks assigned to them, their interactions within the  
160 community and health system, and alternative opportunities available to them. Interviews with  
161 policymakers and administrators focused on program design, management, and administration.  
162 Interviews ranged from 20 minutes and two hours. I continued to facilitate recruitment and conduct  
163 interviews until I reached thematic saturation, or no additional data were found (23). Since the  
164 concept of 'saturation' in qualitative research lacks a structured framework, I assessed saturation  
165 using 'conceptual depth criteria' to provide a systematic approach (24). In line with these criteria, I  
166 determined that saturation was reached when the data contained multiple instances illustrating key  
167 insights, demonstrated subtlety to convey deeper meaning, and exhibited validity through

168 confirmation of results from individuals within the context. Most interviews were conducted by BD in  
169 Punjabi, with two stakeholder interviews in English. Interviews were audio recorded; two  
170 stakeholders declined to be recorded, and detailed field notes were taken for those interviews  
171 instead.

#### 172 Financial Data Collection Exercise

173 We conducted a half-day participatory session in the urban site to document the financial aspects  
174 of urban ASHAs' work. Twenty-five ASHAs attended the session and completed a hand-written  
175 spreadsheet to record the time they spent on each work-related task, the financial costs they incur  
176 when completing tasks, and the incentive amounts they earn for completing each task. ASHAs were  
177 monetarily compensated for their participation, both in recognition of their time and to offset any  
178 potential loss of incentives.

#### 179 Data Management and Analysis

180 While in the field, I took jottings during interactions subtly, which were later expanded into detailed  
181 field notes on a regular basis. These notes captured reflections on daily activities and helped identify  
182 emerging questions for further exploration (25). I transcribed and translated all interview recordings.  
183 Each week, I systematically revisited my research questions and study aims and conducted a rapid  
184 analysis of field notes and transcripts to assess whether key aspects had been sufficiently explored  
185 or if gaps remained. Based on these reflections, I adapted my data collection approach by refining  
186 my data collection tools – adding new questions to probe emerging themes, modifying prompts to  
187 ensure richer responses, and removing questions that were ineffective. This iterative process  
188 ensured that the research remained dynamic and responsive, allowing me to delve deeper into areas.  
189 After completing data collection, I began thematic analysis with a close reading of the data and  
190 development of a coding framework (list of codes with their definitions, grouped by topic) (23,26).  
191 After developing and refining the coding framework, I applied it to all the transcripts using the

192 qualitative data management software MAXQDA (27). I then read coded outputs to identify higher-  
193 level themes, such as “ASHA Payment” or “ASHA Community Benefits”, with subcodes that fell into  
194 these categories. These themes were developed and substantiated with descriptive quotes from the  
195 data to form a codebook. This codebook was applied to all transcripts and field notes. I also analyzed  
196 the completed spreadsheets from the finance session to calculate averages for time, costs, and  
197 incentives across groups, providing a descriptive understanding of ASHAs' financial experiences.

## 198 **RESULTS\***

199 **\*All names in the results are pseudonyms and all identities have been anonymized \***

200 This section provides a structured account of the urban ASHA experience across two study sites,  
201 addressing knowledge gaps in how the program functions on the ground. We offer a descriptive  
202 overview of key aspects of the ASHA role – capturing the complexities of their daily work and the  
203 structural factors that shape their effectiveness. Our findings begin with a short case study that  
204 highlights day-to-day realities of urban ASHAs. We then discuss experiences during the ASHA  
205 selection process, health system support structures, initial training processes, the community  
206 context and engagement within the community, their financial incentives, and perceived benefits of  
207 ASHA work.

### 208 ***Sabita's Story***

209 One sunny morning, Sabita (*pseudonym*), an ASHA, and I met at 10am in the urban site. She  
210 was in her late 20's and she had been an ASHA for three years. As her husband was recovering from  
211 medical issues and was unable to work, she was eager to support her family. We started our morning  
212 cautiously navigating *kothis* (mansions) of wealthy residents to make progress on her population  
213 survey – something she is expected to complete monthly for everyone in her area, regardless of their  
214 financial background. She carefully documented the number of people in each household – noting if

215 any of them suffered from a non-communicable disease – and checked for any unvaccinated  
216 children in the house.

217 *“I’m still nervous to go to kothis alone,” she said as we walked. “The people are educated and*  
218 *get mad at me for coming because they think I’m talking to them about government services. They*  
219 *say they don’t need them.”*

220 Many doors were shut in our faces, and several people shouted at us, refusing to share their  
221 ‘*biodata*’. Frustrated, Sabita decided to switch to her maternal and child health (MCH) tasks. “*This*  
222 *survey work doesn’t even give me an incentive,” she said as we waited for a rickshaw. “At least my*  
223 *MCH work does.”*

224 Ten minutes – and 40 rupees of rickshaw fees later – we were in a more modest neighborhood.  
225 We navigated the streets to a smaller home where a family rented the first floor of a three-story  
226 house. A family member welcomed us in, recognizing Sabita. He led us to a bedroom where a woman  
227 lay resting with a newborn baby nearby. Her questions came out rapidly, checking on both the family  
228 and child, “*Has she been feeding? You’re going to bring her for vaccines in two weeks, right? Come*  
229 *on Tuesday to the clinic and bring her card. Are you having any pain after delivery?”*

230 After ensuring everything was in order, Sabita took a quick picture with the parent and baby –  
231 evidence for her supervisor that she had completed this task – and we prepared to leave. A family  
232 member stood nearby with a plate of pink ‘*ladoo*’, a treat that often signifies the birth of a new baby;  
233 he smiled and insisted we take one to welcome the baby.

234 With our mouths still sweet from the *ladoo*, we took another rickshaw to a small settlement  
235 which also fell in her area. She was most at ease in this settlement, considering her own family lived  
236 nearby in a similar – but slightly more established – setting. In just 20 minutes we (1) sought out and  
237 checked on a woman who was badly injured in a road accident; (2) conducted a wellness check on a  
238 woman who had suffered a miscarriage; (3) guided a woman on how to obtain an *Aadhaar*

239 (identification and social security) card after hers was lost to flooding; (4) made a plan to take a  
240 woman to the district hospital to get a new birth certificate for her child; (5) completed a postnatal  
241 visit for a newborn; and – while walking between these tasks – (6) encouraged parents of small  
242 children to attend the upcoming immunization session. Although these tasks clearly bridged  
243 community members to the health system, only one of these tasks provided Sabita with a financial  
244 incentive.

245 As Sabita and I carefully stepped around ‘*nallahs*’ –small streams of rainwater, wastewater,  
246 and sewage – and swatted away mosquitoes, I reflected on the words of a senior ASHA supervisor  
247 who had shared during an interview, “*The people in slums are totally dependent on the ASHAs. They*  
248 *see them as doctors because they are the only ones who can help them.”*

249 By the time we reached the health clinic at 4 PM, Sabita’s day had already spanned three  
250 neighborhoods, multiple health-related tasks, and countless interactions with community members  
251 – yet much of her work remained invisible and unpaid. From navigating the *kothis* of the wealthy,  
252 where her presence was met with resistance, to the informal settlements, where she was the first  
253 point of contact for healthcare and social support, her role adapted to the needs of each setting.  
254 While she was tasked with bridging vulnerable populations to essential health services, the burden  
255 of unpaid tasks, out-of-pocket costs for transportation, and community resistance in wealthier areas  
256 highlight the challenges ASHAs face in fulfilling their mandate.

257 While ASHAs are expected to support the most vulnerable populations, inadequate support,  
258 socioeconomically diverse populations, limited compensation for transportation, and difficulties  
259 with community engagement limit ASHAs’ ability to meet the mandate put on them by the health  
260 system.

261 ***“I thought why don’t I just put in an application?”: The ASHA Selection Process***

262 Like other CHWs globally, ASHAs are intended to be selected by and from the communities  
263 they serve, ensuring stronger community ties and engagement. This participatory selection process  
264 is designed to allow ASHAs to be recognized as trusted intermediaries, fostering deeper relationships  
265 with local families and improving health outcomes. However, participants in both sites reported that  
266 the ASHA selection process lacked community-driven initiatives.

267 When asked about recruitment, ASHAs consistently mentioned a connection who informed  
268 them of a vacancy and encouraged them to apply. An ASHA in the urban site, Bhavna (*pseudonym*),  
269 explained how she just applied to her role. *“I used to go to the doctor here [at the dispensary] to get  
270 medicine,”* Bhavna explained during an interview. *“When I told the doctor that I do stitching, I started  
271 working for them a bit. Through these dispensary visits [dropping off and picking up stitching], I got to  
272 know the lady who worked here a little. She came to my house one time and said, ‘we need some  
273 ASHAs for this area if you’re interested’. I thought why don’t I just put in an application?”* Bhavna  
274 started her role as an ASHA soon after, and she had been working for the past four months.

275 ASHAs in the urban site were initially recruited mid-2020 to address pressing COVID-  
276 19 needs. While the urgent need for ASHAs explains the lack of community engagement in their  
277 selection processes, ASHAs in the peri-urban site – who began in 2016 – also reported finding their  
278 roles in a similar way.

279 *“When my family member was sick, he was in the hospital for about a month,”* an ASHA  
280 of seven years told me as we navigated her area in the peri-urban site. *“I would go every day and help  
281 take care of him, and then I also took care of the other patients as well. While I was there, the hospital  
282 said, ‘you know, we’re starting to look for urban ASHAs in the area that you’re from, would you be  
283 interested in being an ASHA?’”*

284 She laughed at the memory. *“I didn’t know what an ASHA was then. I said, ‘I don’t know. What  
285 is an ASHA? What do they do?’. They said ‘it’s basically the same thing that you’ve been doing. You*

286 *take care of sick people, and you help them, you bring them to the hospital. You're in the community,*  
287 *people already know you, and you're already here helping people. You may as well do it for money'."*

288 Although this hiring process may have been more straightforward, it may have reinforced the  
289 perception of ASHAs as extensions of the health system rather than embedded community  
290 representatives.

### 291 **Health System Level Support for ASHAs**

292 ASHAs rely on system-level support to effectively carry out their work. The health guidelines  
293 outline a structured framework of supervision and mentorship with Medical Officers, Auxiliary Nurse  
294 Midwives (ANMs), and Lady Health Visitors (LHV) providing oversight, training, and problem-solving  
295 support. Although this framework should ensure that ASHAs can navigate their responsibilities and  
296 challenges, across both urban sites ASHAs reported that these structures offered varying levels of  
297 support.

298 A newer ASHA, Ananya (*pseudonym*) – who had been in her role for six months – painstakingly  
299 noted which households refused to answer her survey questions and took their signature as evidence  
300 that they didn't want to answer. "*When I leave the page blank, I get in trouble,*" Ananya explained.  
301 "*Even when I tell the Medical Officer that people refuse to give me their information, sometimes she*  
302 *still goes and checks with them to see if that's true.*"

303 In both sites, the absence of a designated city-level community mobilizer further exacerbated  
304 these challenges. This position, intended to provide targeted community engagement support,  
305 remained unfilled, creating a critical gap in the chain of supervision and mentorship. As a result,  
306 much of the day-to-day management of ASHAs fell to the ANM workers – who often acted as a direct  
307 supervisor for ASHAs.

308 ANM workers reported being systematically overburdened, with Rani (*pseudonym*)– an ANM  
309 worker of over five years – reporting that there were only three working in an area with 150,000 people.

310 “According to the guidelines, there should be 15 ANMs,” she told me. Rani was frustrated by this  
311 asking, “How can we be expected to give high quality care this way?” Despite this burden of care, and  
312 their limited time, ANM workers like Rani had taken on mentoring and supporting ASHAs.

313 When Anjali (*pseudonym*) – an ASHA worker of three years – was detailing her frustrations  
314 with the health system, she emphasized the support Rani offered her. “A few days ago someone  
315 working at the hospital was saying to me ‘you don’t do work, so you don’t need to come to the  
316 hospital’. Then I went to Rani Mam crying, and she said ‘no child, it’s not like that. Just keep working  
317 hard, and people will stop [saying these things]’. Our ANM mam is so supportive. If I have any issues,  
318 the seniors listen and help me,” highlighting the supportive role of ANM workers and others in the  
319 health system.

320 Further, ANMs were generally beloved by the ASHAs, constantly encouraging and guiding  
321 them despite the overwhelming workload. During an interview, an ASHA at the peri-urban site  
322 explained how much they appreciated the ANM worker saying, “This ANM who you just met is our  
323 mam – but we call her *didi* (big sister)!”

324 Despite the limitations of formal support structures, ASHAs built their own networks of  
325 solidarity, relying on trusted ANM workers and each other for guidance, encouragement, and  
326 problem-solving within the broader health system.

### 327 **“When a new ASHA joins, we teach each other”: ASHA Training Procedures**

328 ASHAs are expected to undergo structured training to equip them with the knowledge and  
329 skills needed to support maternal and child health, conduct community outreach, and facilitate  
330 access to health services. However, ASHAs across both sites reported that formal training was often  
331 delayed – or in some cases, never conducted – leaving them to rely on peer learning and on-the-job  
332 mentorship to navigate their roles.

333 One ASHA who started in her role a year prior, explained that the expectation is that they  
334 support each other, *“Well, didi (big sister) taught me this because we don’t have a formal training*  
335 *session. When a new ASHA joins, we teach each other [like didi taught me]. The ANM Ma’am helps at*  
336 *first, but we mostly rely on each other.”*

337 ASHAs reported that their ANM provided initial practical training, guiding them through their  
338 assigned areas, explaining their responsibilities, demonstrating how to communicate with people in  
339 their community, and instructing them on how to approach households for survey work. An ASHA  
340 explained in an interview, *“They [ANM workers] explain everything and go with us over 2-3 days, and*  
341 *then the other ASHAs train us. Then we can always go back and ask more questions.”*

342 An ANM worker of ten years elaborated on this, explaining, *“A formal training is later after*  
343 *starting because we expect the ASHAs to learn in the field. There is an expectation that they pick*  
344 *things up and teach each other.”*

345 A district officer confirmed that there were occasionally delays in the training process, so this  
346 ASHA-led training was used in the meantime: *“When any new ASHA starts, they all get an 8-day*  
347 *training. But it’s true it might not happen right away. So, in a month or two we might have 2-3 ASHAs*  
348 *join. We can’t train them all as one-offs. We have to make a batch with a minimum of 40 ASHAs, and*  
349 *they should get this 8-day induction training – maybe not immediately but it happens within the year.”*

350 This occasionally did not happen, with one ASHA who had been in her role at the urban site for three  
351 years, reporting, *“Fine. I understand that I started during COVID and there weren't staff. There weren't*  
352 *people who were offering the training. But there's still nothing now.”*

353 Despite the absence of formal onboarding training for ASHAs, there were consistent training  
354 sessions for new tasks and responsibilities. One ASHA reported, *“I had one day of training with the*  
355 *ANM worker. In this session they went over everything at a basic level like area and responsibilities.*  
356 *Other than this, I’ve only had trainings for schemes (programs) or when issues – like checking dengue*

357 *hotspots – come up.”* A LHV confirmed this explaining, *“As work comes up, we do training. When we*  
358 *get instructions from the hospital, we bring them all to the district hospital and have their training*  
359 *there.”*

360 Through informal peer-led learning networks, ASHAs ensured that essential training was  
361 passed down through experience and collective support, even in areas where structured instruction  
362 was lacking.

### 363 ***“How can one single ASHA manage?”: The Community Context***

364 The urban ASHA program was designed to focus on the most vulnerable populations,  
365 ensuring that those with the greatest health needs receive dedicated support. In practice, however,  
366 ASHAs found themselves responsible for entire neighborhoods, often without clear guidelines on  
367 how to differentiate or prioritize vulnerabilities among residents. Administrative demands, such as  
368 mandatory survey work and additional assignments from health officials, further expanded their  
369 scope, requiring them to engage with all households – regardless of need.

370 As I sat in an office interviewing an ANM worker about the design of the ASHA program, a  
371 frazzled ASHA ran into her office, filled her bag with folic acid packets, and darted back out. *“That*  
372 *ASHA who just came in,”* the ANM started. *“Her entire population is 13,000. How can one single ASHA*  
373 *manage? The workload is so high they can’t do good work.”* However, these 13,000 people were not  
374 all vulnerable and varied widely from a socio-economic perspective. Sabita’s story was not an  
375 isolated incident, and most ASHAs navigated complex socio-economic landscapes, balancing their  
376 intended role as community health connectors with a growing burden of administrative and outreach  
377 tasks that extended far beyond the most vulnerable populations. ASHAs were required to visit every  
378 household, including affluent families – who neither rely on nor welcome government healthcare  
379 services – to complete survey work, while still being expected to support vulnerable populations in  
380 need of health assistance.

381           This varying socio-economic context among community members was also common in the  
382 peri-urban site. During participant observation with Aditi (*pseudonym*), an ASHA of eight years, we  
383 walked through a temporary settlement. Aditi would call out to women who had recently moved to  
384 the settlement, “*Hello di (sister)! Is that your child? How old are they? Do they have a vaccine card?*”  
385 None of them did. “*Bring them to the vaccine clinic at the health center today. We’ll help you make*  
386 *sure your child is caught up.*” They usually agreed.

387           The setting and population rapidly changed as we walked. The homes began to look more  
388 established, each with multiple rooms, courtyards, and fenced in areas where they parked their  
389 motorbikes or, for some, their cars. Seeing my confusion, Aditi explained. “*These people have been*  
390 *here for 10-15 years now. They’ve been able to send their kids out. A lot of their kids are now in the*  
391 *army, and they have good jobs. Some even have government jobs! They’re all doing well, and they’ve*  
392 *built themselves up from what they used to be. But when they first came, they were like the people*  
393 *on the other side.*”

394           In this more developed area, Aditi’s visits took on a different tone. Residents often invited us  
395 in for tea and snacks, warmly welcoming her survey questions, even though they no longer required  
396 her MCH services. Many women had already consulted private doctors for their pregnancies and  
397 taken their children to private doctors for vaccines. However, unlike in the urban site – no doors were  
398 shut in our faces, and no one was offended by the idea of government services. While these  
399 interactions showcased Aditi’s valued community presence, like the ASHAs in the urban site, she  
400 was spending time supporting populations that were no longer the most vulnerable.

401           The role of ASHAs in the community raises a critical tension in the vision of primary  
402 healthcare. Ideally, government health services should be accessible and utilized by all, fostering  
403 trust and engagement across socio-economic groups. In reality, ASHAs are often compelled to focus  
404 their health-related efforts on the most vulnerable and forced to target wealthier populations with

405 administrative tasks with wealthier populations. This dynamic not only limits ASHAs' ability to  
406 navigate wealthier communities but also perpetuates the notion that public healthcare is inferior and  
407 designed for the poor. While prioritizing the most underserved populations is a practical necessity in  
408 a resource-limited system, it also risks deepening existing inequalities in healthcare access and  
409 perception.

#### 410 ***“They felt they didn’t get anything out of it”: Difficulties with Community Engagement***

411 ASHAs play a crucial role in bridging the gap between communities and the health system,  
412 fostering trust and encouraging participation in government health programs. Although ASHAs are  
413 supposed to be supported through coordination with local leaders and structured platforms, in  
414 practice, ASHAs struggled to gain community trust and engagement, facing limited coordination  
415 from community leaders, skepticism from residents, and declining participation in formal  
416 community meetings.

417 The urban site was split into different neighborhoods, each with a distinct community council  
418 referred to as a Municipal Corporation (MC). Each council was led by an elected man or woman, a  
419 person who was simply referred to as ‘*the MC*’. While the MC was known and respected within the  
420 community, most ASHAs reported that these leaders were not actively involved in supporting their  
421 work or integration into the community. As I walked through an area with Sapna (*pseudonym*), an  
422 ASHA of four months, she was frustrated by this limited interaction. *“The MC should tell people the  
423 ASHAs are coming. He should tell them our names so they know – this way they would have no  
424 problem with us coming,”* she frustratedly said as we’d had yet another door shut on our face. *“The  
425 MC has the authority to do it – but no one has done this. Sometimes people say to us ‘the MC has not  
426 informed us you are coming’, so people don’t want to give their details. Then we have problems.”*

427 However, in the more vulnerable parts of an ASHAs area, community members felt that the  
428 ASHA was their key connection to healthcare and the health system. *“She is the only one who comes*

429 *and checks on all of us, checks our kids are okay, checks that we're okay,"* a FGD participant from a  
430 slum reported. *"It doesn't matter if someone has older or younger kids, she asks about everyone. No*  
431 *one has health issues with her here."*

432 Across slums and peri-urban sites ASHAs are expected to facilitate community engagement  
433 through the MAS; however, the MAS was often simply used for community education, as opposed to  
434 a community-driven engagement platform. An interview with a district-level stakeholder confirmed  
435 this. *"In the village they have Village Health Sanitation and Nutrition Days. These [MAS meetings]*  
436 *basically have the same function. They do the same things, but the name is different."*

437 An older ASHA in the peri-urban site explained that while there used to be engagement with  
438 the MAS, it eventually stopped. *"Over time, people stopped showing up to the MAS meetings,"* she  
439 said. *"There was frustration because they felt they didn't get anything out of it."* Among newer ASHAs,  
440 most had no idea about MAS meetings, gently responding, *"I don't think we have this in my area,"*  
441 when asked.

442 Without strong institutional backing or meaningful community incentives, ASHAs struggled  
443 to engage residents, leaving many community platforms underutilized and reinforcing their position  
444 as peripheral rather than central actors in local health governance.

#### 445 ***Payments and Incentives***

446 Although ASHAs play a critical role in delivering community healthcare, their compensation  
447 remains low, unpredictable, and often insufficient to cover the costs of their work. ASHAs across  
448 both sites reported that they received a guaranteed honorarium of 2500 rupees per month (less than  
449 \$30 USD), and they earned incentives for additional tasks. However, as transportation costs  
450 associated with traveling to complete their tasks are not reimbursed, ASHA workers explained that  
451 this honorarium – something they often referred to as their 'salary' – typically only covered  
452 transportation expenses.

453 One ASHA reported, *“The [guaranteed payment] is almost fully lost in the coming and going.*  
454 *The late-night rickshaws I take when a community member goes into labor in the middle of the night,*  
455 *the back and forth to hospitals with pregnant women for visits and going between areas.”*

456 Another ASHA expressed her frustration as we walked towards a house to drop off a maternal  
457 immunization card. *“We only get one incentive, but how many rounds does it take? I went there to*  
458 *get the card made – 20 rupees there, 20 rupees back – and that’s one of my many visits for her, all to*  
459 *get a 150-rupee incentive [when she] delivers the baby.”*

460 In addition to the maternal and child health work outlined in their guidelines, ASHAs are  
461 regularly assigned ad-hoc work, such as outbreak investigation, registration for government  
462 programs, and survey work. Occasionally, ASHAs reported being promised incentives for ad-hoc  
463 work – such as election work – that did not materialize. One ASHA shared her experiences saying,  
464 *“The last election we worked from 7am-7pm because they told us they would give us 500 rupees to*  
465 *work all day. We told them that we needed it up front because they never pay us after,”* she said, her  
466 words coming out faster the angrier she became. *“They told us they would give it to us at the end of*  
467 *the day – then you know what happened? They left right after the election ended. They told us it should*  
468 *be on in our pay this month.”* Her tone changed, and she sounded defeated. *“Will it happen? Who*  
469 *knows?”*

470 During the financial participatory session ASHAs provided an in-depth look at many of the  
471 tasks they are responsible for (Table 1). In addition to their base honorarium, ASHAs earn incentives  
472 for select tasks; however, ASHAs reported that the time dedicated to these tasks varied significantly,  
473 from under an hour for certain postnatal care visits to nearly ten hours for overnight stays following a  
474 child delivery. Further, ASHAs reported a sharp disconnect between the costs incurred to complete  
475 the task and the incentives provided. For instance, antenatal care visits consistently resulted in a  
476 financial loss, as the expenses associated with transportation and other necessary resources

477 outweighed the modest incentives. Only a few activities, such as child delivery, overnight stays after  
 478 delivery, certain vaccines (1-month and 9-month doses), and specific well-child visits (6-month),  
 479 generate a positive net profit. Even tasks that yielded a profit – such as child deliveries and overnight  
 480 stays – provided minimal returns considering the time required.

481 **Table 1: Workload and Earnings of ASHAs in Maternal and Child Health**

482

| Task Category   | Time Commitment                | Financial Outcome   |
|---|--------------------------------|---|
| Antenatal Maternal Health ( <i>Four Care Visits</i> )           | 2+ hours per visit             | ASHAs report losing between 11 and 56 rupees ( <i>less than \$1 USD</i> ) per antenatal care visit after factoring in transportation expenses.  |
| Childbirth and Post-Delivery Support                            | 8 – 10 hours per case          | After accounting for travel costs, ASHAs report a net gain of 15 – 22 rupees ( <i>less than \$0.50 USD</i> ) for supporting through childbirth.   |
| Newborn and Child Health Visits ( <i>Ten Visits per Child</i> ) | Approximately 1 hour per visit | ASHAs visit children at 3, 7, 14, 28, 42 days, as well as 3, 6, 9, 12, and 15 months. Each visit was reported to result in losses of 2.5 – 25 rupees ( <i>less than \$0.50 USD</i> ) after accounting for transportation expenses.  |
| Immunization Support ( <i>Eight Visits per Child</i> )          | 1.5 – 2 hours per visit        | Although ASHAs support caregivers with vaccinating their children for all required doses they report most vaccination visits result in losses of 10 – 63 rupees ( <i>less than \$1 USD</i> ) after accounting for travel costs. However, 1-month and 9-months vaccine visits resulted in net benefits for ASHAs, ranging from 28 – 33 rupees ( <i>less than \$0.50 USD</i> ). |

483

484 ***‘ASHA work brings me out of the dark’: Perceived Community, Health System, and Personal***

485 ***Benefits of the ASHA Program***

486 Although urban ASHAs were introduced to the health system relatively recently, their impact  
 487 extends far beyond their immediate responsibilities. By increasing awareness of government  
 488 healthcare services and strengthening trust between communities and the health system, ASHAs  
 489 have become essential health intermediaries while also finding personal fulfillment and a sense of  
 490 purpose in their work.

491 One stakeholder explained how one of the most valuable contributions the ASHAs have  
 492 made is in educating the public about the benefits of government healthcare in an interview, saying,

493 *“The government puts so much work and effort into launching these good schemes (government*  
494 *programs) – when the ASHA goes door to door then they talk about these schemes. They come here*  
495 *[dispensary] once, and then they won’t even try to go to private again. An ASHA will educate them*  
496 *that they can get treatment for TB free for 6 months. If they go private, one month of medicine is 40,000*  
497 *rupees – a poor family could not afford this! The government has so many schemes – the ASHA*  
498 *explains it, and then they come to the government sector.”*

499 ASHAs also took pride in educating the public about government healthcare options. A newer  
500 ASHA in the urban site reported, *“I like to motivate people that they can get everything that they are*  
501 *getting in the private sector in the government for free. They tell me that they went and got these*  
502 *injections for 5000 or 6000 in the private sector, and I like telling them that they can get these*  
503 *injections for free from the government. I like that I am learning, and then in turn I am teaching.”*

504 The health system also benefited greatly from the ASHAs, as stakeholders reported that  
505 ASHAs were instrumental in reducing maternal mortality rates (MMR) among migrant populations in  
506 the peri-urban site. One ANM worker reported, *“Initially the migrant populations didn’t want to come*  
507 *or listen. They never agreed to anything. Now they know the ASHA is there to help them. They even*  
508 *motivate each other! They tell others, ‘Oh she [ASHA] is helpful. She took me to the hospital to deliver*  
509 *my baby’, and now home deliveries in the slums have gone way down.”* This improvement was  
510 supported by a district-level stakeholder, who shared, *“Last year our district did commendable work.*  
511 *In the entire country, [our] district had one of the highest reductions in MMR. The ASHAs did a lot for*  
512 *this – they registered women in a timely manner, they sent high-risk pregnancies to the hospital and*  
513 *helped anemic women.”*

514 ASHAs themselves felt that they got mental health benefits from ASHA work. *“At home we*  
515 *have our own tensions – we are just thinking and thinking, and nothing comes of that. Now we go out*  
516 *and we meet so many people – 100 or 200 people a day sometimes! We leave all the stresses of home*

517 *behind, and we meet new people, learn new things. It's nice.*" Many other ASHAs also reported that  
518 this job gave them purpose, allowing them to leave their homes, and improve their mental health.  
519 *"When you stay home you feel depressed,"* an ASHA told me as we stood in her kitchen carefully  
520 watching the *chai* (tea) boil. *"When I go out into the field – I meet the doctors, patients, and I*  
521 *understand the hospital. It's good for me."* An ASHA who had moved from a rural community to the  
522 peri-urban site after marriage explained that the isolation and adjustments to motherhood made her  
523 lapse into a depression for three years. Since starting her ASHA work, she's *'come out of the dark'* by  
524 talking to people and not *'sitting at home all day.'*

525 Their relationships with each other and others in the health system also motivated them to  
526 stay in their roles. An ASHA responded to my question about relationships eagerly and without  
527 needing to be probed. *"Oh, we are like family members,"* she said with a smile. Another told me, *"Yes,*  
528 *we can't live without them, and they can't live without us."*

529 The impact of ASHAs extends beyond healthcare delivery – they have become essential links  
530 to the health system and sources of support for one another. Despite the challenges of their work,  
531 many ASHAs remain motivated by the relationships they build, the lives they improve, and the  
532 personal sense of purpose their roles provide.

533 After a particularly long and difficult day with an ASHA, I asked her why she didn't leave this  
534 work when her hours were so long, and her pay was so low. She smiled and her words radiated with  
535 the love she feels for the community: *"You've seen how much love people have for us. You can't bring*  
536 *yourself to leave when you see all that love."*

## 537 **DISCUSSION**

538 This study contributes to the growing but still limited global literature on urban CHW  
539 programs by offering a nuanced analysis of how urban ASHAs navigate healthcare delivery in  
540 complex and under-resourced settings. While rural CHW programs have been extensively studied

541 (7,18), urban CHWs operate in environments characterized by greater socioeconomic diversity,  
542 fragmented health systems, and rapidly shifting community needs – underexplored challenges in  
543 global health research (9). Existing studies on urban CHWs have largely focused on the role of CHWs  
544 in disease-specific interventions or health education campaigns (9,10), rather than examining the  
545 broader structural and governance challenges shaping their work. By addressing gaps in program  
546 design, supervision, financial sustainability, and community engagement, this study not only  
547 enhances understanding of India’s urban ASHA program but also provides critical insights for  
548 exploring CHW programs in other urban contexts globally, particularly as countries work toward  
549 achieving universal health coverage in increasingly urbanized health landscapes (8). My work offers  
550 a grounded analysis of the gaps and opportunities within the urban ASHA program, emphasizing the  
551 need for reforms that are evidence-based but also responsive to the lived realities of CHWs and the  
552 communities they serve.

553 We found that ASHAs experience issues including few formalized recruitment and training  
554 processes, insufficient system-level support from dedicated program management staff, and  
555 financial burdens. At the core of these challenges are governance-related issues which impact the  
556 overall management of Punjab’s urban ASHA program to make it more challenging to achieve  
557 intended outcomes. Evaluations of the ASHA program in rural settings suggest that greater political  
558 and administrative commitment – through institutional structure development, community-led  
559 selection processes, robust training, innovative management strategies, and grassroots-level  
560 leadership – are essential for a more effective and well-supported ASHA program (2,28). These  
561 lessons are just as – if not more – relevant for urban ASHAs, as urban populations are projected to  
562 grow significantly over the next decade (29).

563 Recommendations to address the identified challenges are summarized below. While the  
564 tailored recommendations may address localized challenges, they are grounded in the

565 understanding that improving overall governance is a critical step to enhance the overall  
566 effectiveness of the urban ASHA program.

567 **Recommendation 1: Enhance Community Engagement in Urban Health Programs to Improve**  
568 **ASHA Effectiveness**

569 ASHA guidelines emphasize community participation through involvement in selection, engagement  
570 with the MAS, and community group activities (5,30). Globally, however, community participation in  
571 CHW programs is often tokenistic or absent, limiting long-term connections (31,32). Further,  
572 evidence from rural settings in India, where community engagement has historically been stronger,  
573 shows that efforts to sustain community engagement structures have tapered off due to unclear  
574 objectives, inequitable participation, and weak alignment with local governance structures (33–35);  
575 similar issues exist in urban settings. To overcome this tokenistic engagement, and difficulties with  
576 long-term engagement, community engagement should ideally be independently driven, as  
577 community engagement that is organized, shaped, and at the discretion of the state often raises  
578 questions of robustness and effectiveness (36,37). In urban settings – comprised of transient and  
579 diverse populations – it may not be practical to select ASHAs in the same way as rural communities  
580 do (1). Districts could implement community-driven selection processes tailored to urban needs by  
581 ensuring active participation from the MCs and other local leaders. Urban local bodies, such as MCs,  
582 also could benefit from training to effectively engage with ASHAs – ensuring that they are  
583 coordinating with and sensitizing the community to the existence and role of the ASHA. Establishing  
584 formal collaboration protocols between ASHAs and MCs, including regular interactions and joint  
585 planning, could also further strengthen community engagement and align urban ASHA programs  
586 with their mandate.

587 **Recommendation 2: Strengthen Mentorship Structures to Ensure ASHAs Receive Adequate**  
588 **Support**

589 ASHA guidelines specify staffing ratios, including Public Health Managers or Mobilization Officers,  
590 and adequate ANM-to-population ratios (30). However, many of these positions remain vacant,  
591 limiting the support available to ASHAs. In the absence of formal training, ANMs have stepped in as  
592 informal mentors, leveraging their rapport with ASHAs to provide guidance. To address gaps in the  
593 system, the state could consider filling vacant positions or formalizing mentorship roles for ANMs,  
594 ensuring they are adequately supported and incentivized. Training ANM workers on aspects of ASHA  
595 performance monitoring and supervisory functions, as well as institutionalizing mentorship as a  
596 formal component of these roles, could enhance sustainability and build on their existing strong  
597 relationships to better support ASHAs.

598 **Recommendation 3: Implement Targeted Training for Improved System Functioning and Reduce**  
599 **ASHA Workload**

600 Comprehensive training for health workers and community engagement structures may address  
601 coordination gaps. ASHAs frequently perform tasks outside their intended scope – often at the  
602 direction of their supervisors – highlighting training gaps across all levels. Training senior health  
603 workers on vulnerability mapping, as outlined in existing guidelines(5), could help ensure ASHAs  
604 focus on populations most in need, reducing their workload. Ongoing, targeted training for ASHAs,  
605 senior health workers, MCs, and community structures is critical to improving coordination and  
606 service delivery.

607 **Recommendation 4: Adjust ASHAs' Financial Compensation to Reflect Urban Realities**

608 Urban ASHAs are often assigned non-health-related duties, often without compensation, detracting  
609 from their primary responsibilities. Policymakers could consider establishing clear guidelines to limit  
610 these assignments or ensure ASHAs are compensated for such work. States could also revise  
611 incentive structures to better reflect urban realities, including accounting for transportation costs

612 through higher base honorariums or transportation allowances. Addressing financial burdens could  
613 reduce strain on ASHAs and improve their effectiveness in delivering healthcare services.

614 The recommendations presented are based on research conducted in two specific urban  
615 sites in Punjab. While these findings offer valuable insights into the factors shaping urban ASHAs'  
616 experiences and provide guidance for programmatic and policy improvements, they are not  
617 universally representative. ASHAs' experiences may vary across districts in Punjab and India due to  
618 differences in socioeconomic, cultural, and administrative conditions. The study was intentionally  
619 structured as a snapshot of the urban ASHA experience rather than a long-term analysis of ASHA  
620 roles, community engagement, or health system dynamics. Further, the ethnographic approach and  
621 the inclusion of a finance participatory session were designed to provide more nuanced insights into  
622 urban ASHAs' experiences. However, we note that the financial session cannot be taken as  
623 conclusive or generalizable, given that the data were generated by ASHAs and not triangulated with  
624 bank statements, receipts, or external assessment of time spent per task. This workshop  
625 nonetheless highlights the lived experiences and perceptions of ASHAs, showcasing that these  
626 ASHAs spend more out-of-pocket than they receive in incentives for most tasks – without accounting  
627 for time spent. Moreover, the study's focus was on the urban ASHA experience in specific sites,  
628 acknowledging that variability in ASHA roles across other contexts may present additional  
629 complexities beyond the scope of this research.

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