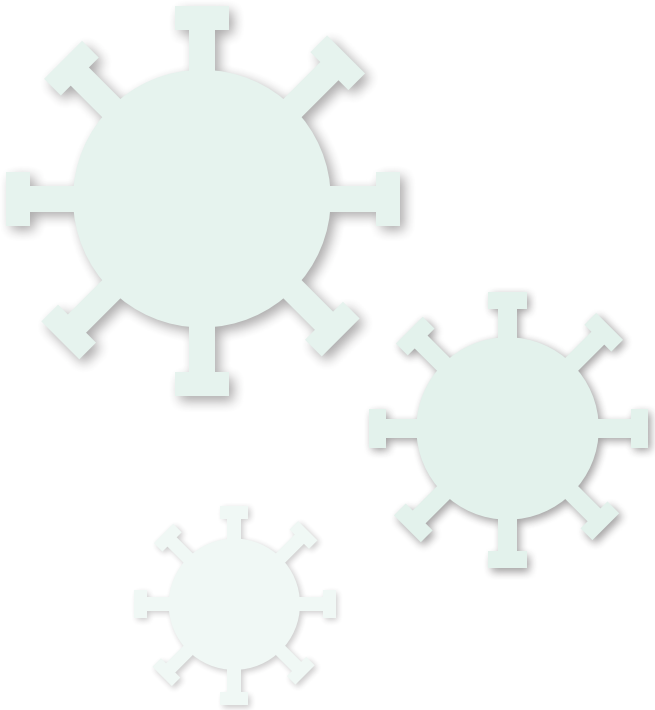
LOCAL GOVERNANCE DURING THE COVID 19 PANDEMIC

KERALA INSTITUTE OF LOCAL ADMINISTRATION (KILA)
2019-2020



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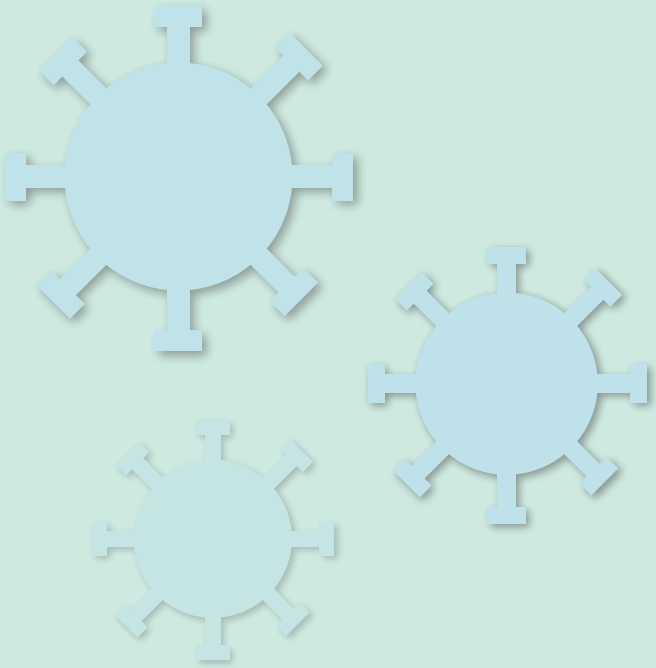

Local Governance During The Covid 19 Pandemic

Lessons on the emergent role of LSGs in Kerala in community-centric Disaster Management

Ethnographic study focused on ASHA workers from 14 districts in Kerala

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Suggested Citation:

Elamon, J., George, N. S., Amrutharaj, R.M., Kurian, N.M. (2020).
Local Governance during the COVID-19 Pandemic Times.
Kerala Institute of Local Administration.

LOCAL GOVERNANCE DURING THE COVID 19 PANDEMIC

EXECUTIVE SUMMARY

After the news of Coronavirus emerged from China and the World Health Organisation declared the COVID 19 a pandemic on March 11th, countries across the world have dealt with the crisis differently. While many identified this as a law and order or health- related problem, many identified it as a social problem. Kerala's early response to the pandemic had caught national and international attention including that of the World Health Organisation for its community-centric nature. And in that, the roles of Kerala's local Self-governments (LSGs) as well as its front-line workers, the Accredited Social Health Activists (ASHA) workers have not been small. This short study has two parts: one looks at the role donned by LSGs in Kerala in the COVID response as a community-centric disaster management model that offers lessons for further strengthening in Kerala as well as replication in other settings. The other is an ethnographic study looking at the specific, intersectional and gendered issues covering various health, social, financial and familial issues of front-line health workers, the ASHAs in order to suggest measures for improvement.

The study has shown that the LSGs in Kerala took contextualised, community-centric action building on the State's social capital and making use of their Constitutional mandate and powers under the overall guidance of the State Government Departments. The decades of concerted strengthening of LSGs through regular capacity building, transfer of funds, functions and functionaries as well as recent formal recognition of LSG's role in disaster management and associated trainings and tools saw the LSGs upholding ideals of social justice and equity during

the COVID response. The operation of the framework further saw overall conformity with the principles of devolution of functions, namely subsidiarity, autonomy, role clarity, complementarity, people's participation, accountability and transparency propounded by the Sen Committee. Going ahead this stands testament to the need for further strengthening and formal recognition of the role of LSGs in building long-term community resilience in other states in India as well, through regulatory as well as financial and other means after conducting focused studies.

As far as ASHA workers are concerned, their role as front-line workers in the COVID pandemic has been deeply appreciated. However, the study showed that many ASHA workers have been doing their service on inadequate remuneration and inconsistent income. It also showed that considering the social and financial background that many of them come from, they are not in a position to bargain with the authorities for better working conditions. That said, they are all committed to their work and state that their work has gained recognition among the general public post COVID. The study found the need to better the condition of ASHA workers through measures including fixing a line of control and reducing hierarchy, ensuring job security and a decent income as well as providing regular training to them. There is also a need for enhancing their risk allowance and providing them with insurance coverage and protective gears.

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ACKNOWLEDGEMENTS

The Research study is the fruit of the untiring efforts of many persons in the Kerala Institute of Local Administration as well as the whole-hearted support from many individuals in our partner institutions. The research has been funded by the Azim Premji University as part of the COVID 19 Research Funding Programme 2020. We place on record our immense gratitude to the University and concerned authorities for giving an opportunity to be part of such a prestigious and timely work of research.

We would like to express our sincere gratitude to various individuals who supported us whole-heartedly during this endeavour, especially Dr. Monish Jose, Mr. Mathew Andrews, Mr K. B. Madanmohan, and Dr. Malu Mohan, Ms. Sumitha T.S. and Dr. Divya C.S. for their support and guidance.

We would like to thank Mrs. D. Sudha, Director of KILA-CHRD and the experts in our Gender for Local Governance at KILA, Dr. Amrutha K.P.N. and Mrs. Rismiya R I. for their valuable support and contribution towards the research. We would also like to thank our Administration and Finance wings in KILA, especially Mrs. Girija Devi and Mr. Kiran. We would like to place on record our sincere gratitude towards our Nerkazcha documentation team for their help in organising and gathering data about the presentations done by the LSGs. And this includes the IT team led by Mr. O. Mirash.

We like to extend our gratitude to the field researchers and especially our interns, Ms. Niharika Jacob, Ms. Rebecca Barry and Mr. Aravind J. Nampoothiry who helped us during data collection and analysis.

The whole Research Project Team carried out extensive field work for collecting the data from the selected LSGs, and this was possible due to the co-operation of the

participants of the study. We would like to extend our gratitude to the LSG functionaries which did the presentations and especially to all the amazing ASHA workers who have been Kerala's army on the ground, carrying the burden of front-line work in COVID response. They spared their precious time to be part of our study. Words are not enough to thank them.

Research Team

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ABBREVIATIONS

ASHA	Accredited Social Health Activist
B.Ed	Bachelor of Education
B.Tech	Bachelor of Technology
CDS	Community Development Society
CHC	Community Health Centre
CHIM	Controlled Human Infection Model
CHIP	Children's Health Insurance Programme
DMO	District Medical Officer
DOTS	Directly Observed Treatment
FHC	Family Health Centre
HI	Health Inspector
IFA	Iron and Folic Acid
JHI	Junior Health Inspector
JPHN	Junior Primary Health Nurse
JSY	Janani Sureksha Yojana
LHI	Lady Health Inspector
LIFE	Livelihood, Inclusion and Financial Empowerment
LSG	Local Self-Government
LSGI	Local Self-Government Institution
M.Sc	Master of Science
MAA	Mothers' Absolute Affection
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MSS	Mahila Swasthya Sangham
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organization
NHM	National Health Mission
NRHM	National Rural Health Mission
OP	Out Patient
ORS	Oral Rehydration Solutions
PDC	Pre Degree Course
PHC	Primary Health Centre
PPE	Personal Protective Equipment

RCH	Reproductive Child Health
RTI	Reproductive Tract Infections
SSLC	Secondary School Leaving Certificate
STI	Sexually Transmitted Infections
TA	Travelling Allowance
TB	Tuberculosis
TTC	Teacher Training Certificate
TTI	Teacher Training Institute
UAE	United Arab Emirates
UP	Upper Primary
VHSS	Vocational Higher Secondary School
WHO	World Health Organisation

INTRODUCTION

INTRODUCTION

World-wide the challenges posed by the COVID pandemic have been multi-dimensional. After the news of Coronavirus emerged from China, the World Health Organisation declared the COVID 19 a pandemic on March 11th. Post this, countries across the world imposed different forms of lockdowns or restrictions on travel. Borders were closed and air travel suspended. India declared it as a national disaster. By the end of 2020, restrictions have been eased and international borders have been partially opened. A few countries have seen their number of positive cases coming down while in others the situation is yet to let up. But as we reach the end of the year, there is a perceivable need for countries and regions across the world to analyse their respective COVID responses, and not just in terms of the response by their health systems, but also in terms of the social dimensions of their disaster response. This gains even more significance in light of the fact that in many parts of the world, the pandemic which emerged as a health crisis has metamorphized into a humanitarian crisis with many sections of the population facing a much higher threat than others not just to the disease but also to the economic and social fallout of the pandemic and pandemic response.

In light of this there is a need for studying Kerala's response to the pandemic. Backed by the gains of decades of concerted investment in social development, participatory democracy and public health infrastructure, Kerala's response to the pandemic had caught national and international attention including that of the World Health Organisation (WHO) for its community-centric nature[1].The Accredited Social Health Activists or the ASHAs, one of Kerala's front-line

[1] *World Health Organisation, 'Responding to COVID 19- Learnings from Kerala' (2 July 2020) https://www.who.int/india/news/feature-stories/detail/responding-to-covid-19---learnings-from-kerala accessed 29 December 2020.*

workers acting as crucial links between the community and the government had also garnered attention for their commitment and hard-work.

This study is in two parts: the first is an attempt to study and trace the main steps in disaster-preparedness and disaster response that were taken by Kerala through its decentralised governance framework as part of COVID response. Set against the context of decentralised governance, this study we hope will help build a case for increased recognition of the role of LSGs in enabling community-centric disaster response and mitigation. The second part focuses on the specific, intersectional and gendered issues covering various health, social, financial and familial issues of front-line health workers, the ASHAs in order to suggest measures for improvement.

PART I

LESSONS ON THE EMERGENT ROLE OF LSGs IN COMMUNIT`Y-CENTRIC DISASTER MANAGEMENT

INTRODUCTION

1.1. BACKGROUND

> ***"The greater the power of the Panchayats the better for the people"***
>
> ***Mahatma Gandhi***

1.1.1. WHY LOCAL SELF-GOVERNMENTS IN DISASTER MANAGEMENT?

The United Nations Office for Disaster Risk Reduction (UNISDR) defines resilience as: "The ability of a system, community or society exposed to hazards to resist, absorb, accommodate to and recover from the effects of a hazard in a timely and efficient manner, including through the preservation and restoration of its essential basic structures and functions"[2]. Both the Hyogo Framework for Action 2005-2015[3] and the Sendai Framework on Disaster Risk Reduction 2015-2030[4] drive attention to the need for people-centric, inclusive disaster risk reduction strategies which position local authorities[5] as key stakeholders in

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[2] *United Nations Office for Disaster Risk Reduction (UNISDR), 2009 UNISDR Terminology on Disaster Risk Reduction (Geneva, May 2009) <http://www.unisdr. org/we/inform/terminology> accessed 28 December 2020.*

[3] *International Strategy for Disaster Reduction, Hyogo Framework for Action 2005- 2015, Extract from the final report of the World Conference on Disaster Reduction(A/CONE206/6)*

[4] *United Nations Office for Disaster Risk Reduction (UNISDR), Sendai Framework for Disaster Risk Reduction 2015 - 2030.*

[5] *In India, local authorities can be equated with the elected local governments or the Panchayats in the rural and the Municipalities and Corporations in the urban areas. The National Disaster Management Act, 2005, Section 2(h) defines local authorities to include panchayati raj institutions, municipalities, a district board, cantonment board, town planning authority or Zila Parishad or any other body or authority, by whatever name called, for the time being invested by law, for rendering essential services or, with the control and management of civic services, within a specified local area.*

building such resilience through disaster risk reduction. The Sendai framework especially calls for the need for empowering local authorities and local communities to reduce disaster risk including through resources, incentives and decision-making responsibilities as appropriate, while maintaining the role of the national and federal state governments as an enabling, guiding and coordinating one.[6] This also appears to be closely linked to the principle of subsidiarity as an element of democratic decentralisation as it is understood in India, which suggests that what can be done at a particular level of governance should be done there and not at higher levels.[7] In effect the upper levels of government retain their role of coordination and guidance while the government closest to the people take contextualised action in accordance with specific needs pre-disaster, at the time of a disaster and post-disaster.

1.1.1.1. 73RD AND 74TH CONSTITUTIONAL AMENDMENTS

In India, with a constitutional mandate of implementing social justice and economic development through participatory democracy, the local self-governments are in a position to aid communities in building long term resilience through disaster risk reduction. The 73rd and 74th Constitutional Amendments in 1993 which gave formal recognition to the decentralised regime introduced as well the idea of Gram Sabhas or village assemblies comprising all the adult voters in a village or group of villages, giving citizens the direct right to engage in their own governance. This in effect provided not just for a multi-tier governance system which took governance close to the doorsteps of the people, but it also rendered space for autonomy, role-clarity between the different tiers of local self-government as well as transparency and accountability.[8]

When the need for a central framework to handle disaster management in the country became evident post the Indian tsunami in 2004 and as a result of international developments, the subject was allotted to the Union under its residuary powers and the National Disaster Management Act, 2005 was enacted.[9] That said, on the basis of operational dynamics, even today most subjects with implications on disaster management including mitigation and adaptation fall within the scope of the state governments and post the 73rd, 74th Amendments under the powers of the 3rd tier of government or the local governments. Agriculture, water supply, construction of roads and bridges, rural housing, upkeep of schools, health centres and most importantly welfare of vulnerable populations- subjects which have been transferred to the rural local governments have bearing upon pre-disaster management and post-disaster recovery; and subjects transferred to urban governments including regulation of land use and construction of buildings, urban planning, town planning and urban forestry, protection of environment, promotion of ecological aspects all have similar implications as well.[10]

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[6] *United Nations Office for Disaster Risk Reduction (UNISDR), Sendai Framework for Disaster Risk Reduction 2015 - 2030.*

[7] *Democratic decentralisation in India can be defined as the process of devolving the functions and resources of the state from the centre to the elected representatives at the lower levels so as to facilitate greater direct participation by the citizens in governance; see TM Thomas Isaac, 'Campaign for Democratic Decentralisation in Kerala' [2001] 29 Social Scientist 8.*

[8] *S B Sen Committee, Report of the Committee on Decentralisation of Powers: Suggestions for amending Kerala Panchayat Raj Act (1997)*

[9] *Article 248, Constitution of India, 1950. See also Second Administrative Reforms Commission, Third Report- Crisis Management- From Despair to Hope (New Delhi: Government of India, 2006); Rajendra Kumar Pandey, 'Legal Framework of Disaster Management in India' (2016) ILI Law Review, pp 172 to 190*

[10] *Government of Kerala, Kerala Floods and Landslides: Post Disaster Needs Assessment (October 2018)*

That said, at the national level the recognition of the role of said local governments in disaster risk reduction has still been very limited. The National Disaster Management Act, 2005 states that local authorities have to create local level disaster management plans.[11] But unlike the other tiers of disaster management plans that are defined under the legislation, such a clear explanation is lacking in the case of local level disaster management plans.[12] The legislation also states that the local authorities have to be consulted on the making of the district disaster management plans.[13] But as has been argued, instead of mainstreaming and emphasising their role in disaster management, their role has been relegated to perfunctory bodies obliged to perform under the command and control of other agencies.[14]

In reality, this approach has seen some change after the COVID pandemic struck. In many places the mere inaccessibility of rural areas for the state machinery has meant that the local self-governments have been roped in to carry out various COVID response measures on the ground, including awareness generation, contact tracing, monitoring etc. And the LSGs have carried out these response measures effectively with the departmental staff merely giving instructions and monitoring programmes and plans.[15]

1.1.2. WHY KERALA?

The situation in Kerala has been different opposed to the rest of the country. Following the 73rd and 74th Amendments to the Constitution, Kerala enacted the Kerala Panchayat Raj Act, 1994 and the Kerala Municipality Act, 1994. Following this, there was a massive exercise of transfer of powers and functions to local governments, along with institutions, offices and functionaries. This was followed by the People's Plan Campaign in mid-August 1996 through which it was decided to devolve 25-40 percent plan funds to local governments. Ever since then the local governments have always known in advance the resources they are going to have as it is included in the state budget. In Kerala, the local self-governments not only have the powers to collect taxes; around 90% of the plan funds is given in a practically untied form with which they can prepare their own schemes and implement them within certain broad policy framework which stipulates that at least 40% of the funds (10% in urban areas) should be invested in productive sectors, not more than 30% (50% in urban areas) should be invested on roads and at least 10% should be earmarked as Women Component Plan.[16] Post this, the Kerala Panchayat Raj Act and the Kerala Municipality Act were also restructured and in 2000, amendments were brought about in 35 Allied Acts having relevance to local government functioning. All this has garnered Kerala's LSGs much attention for their role in

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[11] *National Disaster Management Act 2005, s 32*

[12] *The National Disaster Management Act, 2005 under sections 11, 23 and 31 lay out in detail the constituents of the National, State and District Disaster Management Plans respectively. Section 32 briefly mentions that local authorities shall subject to the supervision of the District Authority prepare disaster management plans.*

[13] *National Disaster Management Act 2005, s 30*

[14] *Rajendra Kumar Pandey, 'Legal Framework of Disaster Management in India' (2016) ILI Law Review, pp 172 to 190*

[15] *T. R Raghunandan, 'Kerala and Karnataka have shown how democratic decentralisation has worked in their favour' (The Hindu, 11 May 2020) https://www.thehindu.com/opinion/op-ed/responding-to-covid-19-at-the-grassroots/article31552359.ece accessed 2 January 2021*

[16] *Mariamma Sanu George, An introduction to Local Self Governments in Kerala (first published 2007, SDC CapDecK)*

strengthening social democracy[17] as well as the State's performance in many sectors, especially in health,[18] education and in ensuring social justice and local level economic development.[19]

Over the past three years, the state and its LSGs have had to confront challenges of a different kind. The state was faced with multiple disasters, both localised and regional leading to public health and other governance emergencies (drought and cyclone Okhi in 2017, August 2018 floods, August 2019 floods, Nipah virus outbreak in 2018 and the present Covid-19 pandemic), which critically tested and challenged its governance system.

The disaster response during all these emergencies saw the general public working in close coordination with different authorities including the local self-governments on the ground.[20] And it was very well articulated during this period that Kerala's rebuilding vision post the August 2018 floods[21] as well as disaster risk reduction into the future[22] should position LSGs as a major stakeholder and actor.

And the Kerala Government post the floods in August 2018 accorded formal recognition to the role of local self-governments in disaster management. Delegated legislations which refer to the process involved in local level disaster management,[23] as well as how to incorporate it into the state's overall planning process were brought about.[24] Necessary capacity building was also provided during this time through specialised agencies such as the Kerala Institute of Local Administration (KILA) and Kerala State Disaster Management Authority (KSDMA) in association with the various other agencies and line departments of the Kerala Government.

1.1.2.1. LOCAL LEVEL DISASTER MANAGEMENT IN KERALA

Before August 2018 floods, at the time of a disaster the state witnessed a command-and-control situation strictly under the Kerala State Revenue Department.[25] Though there had

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[17] *Patrick Heller, 'A virus, social democracy, and dividends for Kerala' (The Hindu, 18 April 2020)https://www.thehindu.com/opinion/lead/a-virus-social-democracy-and-dividends-for-kerala/article31370554.ece accessed 27 December 2020*

[18] *Isaac TMT, Franke RW, Local Democracy and Development: The Kerala People's Campaign for Decentralized Planning (Rowman & Littlefield; 2002) 272*

[19] *Mariamma Sanu George, An introduction to Local Self Governments in Kerala (first published 2007, SDC CapDeck)*

[20] *Institute of Sustainable Development and Governance, Towards Disaster Risk Reduction in Kerala (Report, 2018); Rahim A, Chacko T, 'Nipah outbreak in North Kerala – What worked? Insights for future response and recovery based on examination of various existing frameworks' (2019) Indian J Public Health < http://www.ijph.in/text.asp?2019/63/3/261/267208> accessed 29 November 2020*

[21] *M. A Oommen, 'Rebuilding Kerala, policy choices and the Way forward: Developing an Approach' in Institute of Sustainable Development and Governance, Towards Disaster Risk Reduction in Kerala (June 2019) pp 39 to 43*

[22] *Government of Kerala, Kerala Floods and Landslides: Post Disaster Needs Assessment (October 2018) pp 261 -262. See also Muralee T and Peter B, Leaving No One Behind Lessons from the Kerala Disasters (Centre for Migration and Inclusive Development, 2019); Singh A, Reddy S, Kamthan M, et al., 2018 Kerala floods, Report on Governance and Legal Compliance (Special Centre for disaster Research, Jawaharlal Nehru University, 2018)*

[23] *G.O (Ms.) No. 156/2019/LSGD dated 4.12.2019. see also G.O (Ms.) No. 14/2020/LSGD dated 14.01.2020*

[24] *G.O (Ms.) No.157/2019/LSGD dated 05.12.2019*

[25] *The Kerala State Disaster Management Plan was drafted in 2016 in line with the Sendai Framework and other national guidelines. It identified 39 hazards categorised under two broad heads, namely Naturally Triggered Hazards (Natural Hazards) and Anthropogenically Triggered Hazards (Anthropogenic Hazards). See Kerala State Disaster Management Authority, Government of Kerala, Kerala State Disaster Management Plan (Plan, 2016)*

been efforts at community-based disaster risk reduction planning in certain LSGs, these were for a few selected LSG alone on a pilot basis and led directly by the Kerala State Disaster Management Authority through the District Disaster Management Authorities.[26] Post the floods however there has been a shift in this practice in Kerala. Unlike earlier situations where the impact of the disaster was primarily localised, the August 2018 floods saw a situation where the entire state was affected and there was a need for prompt action to be taken by those on the ground. The local leaders or elected representatives who were more familiar with the lay of the land, the people and the immediate needs were the authorities closest at hand when the disaster struck. And post the floods, the Kerala Government has taken steps to formally recognise and acknowledge the importance of local self-governments in community- centric disaster management- in terms of steps for disaster risk reduction, preparedness and response.[27]

The first in these steps was the creation of a working group in every local self-government exclusively on Biodiversity, Disaster Management, Environment and Climate Change in September 2018. The Working Group was primarily set up for the purpose of preparing projects to be included in the Annual Plan, aimed at long-term resilience of the LSG.[28] In January 2020 the Kerala government issued a government order which laid down a specific Disaster Management Plan (hereafter referred to as DMP) guidance template for formulating projects aimed at disaster risk reduction and preparedness as well as disaster response plans, all through participatory planning. Broadly keeping in line with the National Disaster Management Guidelines issued in the context of the State Disaster Management Plans, the template followed the main guiding principle of participatory, community-based planning taking into consideration local vulnerabilities and resources.[29] The Working Group was made responsible for the coordination of said DMP planning process. They were to gather the project ideas from the other Working Groups and incorporate them into the DMPs as well. [30] KILA in association with the Kerala State Disaster Management Authority and other line departments thereafter gave extensive training to the functionaries and elected representatives at the local level on the DMP process reaching almost 3 lakh people over January and February 2020. Though the process itself had to be cut short due to COVID restrictions, all 1034 LSGs in Kerala prepared the local level disaster management plans just before the COVID pandemic struck.[31]

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[26] *Village level disaster management plans were prepared for Munroethuruthe and Peringara villages of Kollam and Pathanamthitta villages in 2015. Disaster Management Plan was also prepared by the Trivandrum Corporation in 2015. The Plan also made a recommendation for making local level disaster management plans in all LSGs. See Kerala State Disaster Management Authority, Government of Kerala, Kerala State Disaster Management Plan (Plan, 2016)*

[27] *G.O (Rt) No. 14/2020/LSGD dated 14.01.2020*

[28] *G.O (Rt) No. 2462/2018/LSGD dated 19.09.2018*

[29] *The English translation of the template is available on KILA's website at the following link: https://www.kila.ac.in/sitedoc/documents/misc/NammalNamukkai/Presentation/Local%20Governemnt%20Diaster%20Management%20Plan%20Guidelines%20and%20Template.pdf. See also G.O (Ms.) No. 14/2020/LSGD dated 14.01.2020; National Disaster Management Guidelines, Preparation of State Disaster Management Plans 2007*

[30] *G.O (Ms.) No. 156/2019/LSGD dated 04.12.2019*

[31] *The DMPs created by all the LSGs have been uploaded district-wise on KILA's website. Available @ https://dmp.kila.ac.in/#details*

As far as the incident response system at the time of a disaster is concerned, the legal framework places the Steering Committee of an LSG consisting of the President, Vice-President and Standing Committee Chairpersons with the President as the Chairperson in charge at the time of a disaster. Trained Emergency Response teams – one each for Early Warning, Search, Rescue and Evacuation, Camp Management and Basic Life Support are also to be formed to assist the executive authority at the time of a disaster, preferably with representation from all the wards in the LSG.[32] Training and capacity building activities were organised for these specialised teams by the Kerala Institute of Local Administration with the technical support of the Kerala State Disaster Management Authority.

These steps taken at the State level have provided Kerala's LSGs with a newly strengthened, formal mandate in disaster management.

1.2. SIGNIFICANCE OF THE STUDY

World over, the increasing frequency of disasters is exacerbating inequalities, and causing increased social deprivation of marginalised populations. During the COVID crisis, countries across the world have shown a complete failure on their ability to deliver last mile services. There have also been instances where the crisis has been seen entirely as a law and order problem with the state enforcing strict measures without clear communication to the people. This has shown the need for more community-centric, participatory approaches to disaster management in line with the Sendai framework.

Set against the backdrop of the concerted investments which Kerala has made in decentralised governance over the last 25 years, the COVID response measures undertaken by Kerala's LSGs offer valuable lessons in terms of how such community-centric decentralised disaster management can take place. This being a short study, an in-depth analysis of quality of services delivered has not been done; rather broad aspects of the work undertaken by LSGs during the COVID pandemic have been analysed.

1.3. RESEARCH QUESTIONS AND OBJECTIVES

1.3.1. TO ANALYSE THE RESPONSE STRATEGIES ADOPTED BY KERALA'S LSGs DURING THE COVID 19 PANDEMIC

1.3.2. TO CRITICALLY ANALYSE THE EMERGENT ROLE OF LSGs IN COMMUNITY-CENTRIC DISASTER MANAGEMENT

1.3.3. TO CRITICALLY STUDY WAYS AND MEANS TO FURTHER STRENGTHEN SUCH ROLE

[32] *G.O (Ms.) No. 156/2019/LSGD dated 04.12.2019*

LITERATURE REVIEW

The literature on role of Local Self Governments in Disaster Management is limited due to the emergent nature of the subject. However there has been some literature which has emerged in this context post the August 2018 floods in Kerala. The authors have done a brief literature review of all such pertinent literature as well as some general literature on Local Self-Governance in the context of Kerala.

POTENTIAL OF LOCAL SELF-GOVERNMENTS IN DISASTER MANAGEMENT NEEDS TO BE TAPPED

The Post Disaster Needs Assessment done after the August 2018 floods was led by certain United Nations Agencies, the World Bank and the European Union. The PDNA Report noted that the bottom-top approach coupled with implementation of appropriate technology and adherence to science could ensure effective risk governance in the State. The PDNA also noted the significance of the transferred subjects to the rural and urban local governments in terms of disaster risk reduction and noted that Kerala's LSGs have the capacity to handle disaster management work due to intensive capacity building trainings, experience, personnel as well as financial autonomy. But it also noted with regret that this potential was yet to be tapped properly. It also made very significant recommendations with regard to need for creation of a Panchayat level Disaster Management Committee (DMC) under the leadership of the President of the Gram Panchayat to co-ordinate, monitor and supervise the disaster management activities. It recommended that KSDMA along with the National

Institute of Disaster Management and other State Institutions build capacity of local self-governments in preparing High Risk Vulnerability Assessments and Gram Panchayat level plans. It also recommended that each LSG may prepare environmentally friendly Disaster Management Plan (DMP) inclusive of both pre-disaster and post-disaster components with the help of experts engaged at this level since the time of decentralisation planning or the People's Plan Campaign.[33]

THE DECENTRALIZED PLANNING AND GOVERNANCE HAVE HELPED THE STATE'S OVERALL PERFORMANCE IN MANY SECTORS, ESPECIALLY IN HEALTH

The Kerala People's Campaign for Decentralized Planning, a study by Isaac and Franke showed that through the decentralisation process, healthcare institutions in Kerala were transferred to the Local Self Governments (LSGs). Public participation being a key feature of such decentralisation, the planning itself involved mass participation of elected representatives, voluntary agencies, ordinary people, non-official experts etc. This process involved giving maximum autonomy to LSGs in their planning formulation and micro level planning methodology. With the People's Planning Campaign which was launched in 1996, issues such as declining quality in the service sectors- education and health were also given much-needed attention. The Campaign which enabled the implementation of a new set of guidelines for smooth functioning of Local Government Plans helped tackle delay and helped simplify the process. With the implementation of the Campaign, 35-40 % budget allocation was reserved for LSG and LSGs were directed to use 40% of budget allocation for the improvement in the health and education sector. The decentralisation has been made possible through the involvement of varied institutions under the LSGs such as the Ward level Committees, Anganwadi Committees, Women Self Help Groups etc. All the investments made in this has contributed towards the overall improvement in public health and associated indicators including women and child welfare, family planning, reduction of water borne diseases through provision of clean and safe drinking water, better waste management etc.[34]

PRINCIPLES OF DEVOLUTION OF FUNCTIONS

Laying down that Local Self-Government is essentially the empowerment of the people by giving them not only the voice, but the power of power of choice as well in order to shape the development which they feel is appropriate to their situation, the Sen Committee held that this needs maximum decentralisation powers to enable the elected bodies to function as autonomous units with adequate power, authority and resources to discharge the basic responsibility of bringing about "economic development and social justice". It was held that rather than mere formal transfer of powers and responsibilities there was a need for vesting of authority in the LSGs in order to allow them to exercise them fully including changes in conventions and practices alongside the change in the legal or institutional framework.

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[33] *Government of Kerala, Kerala Floods and Landslides: Post Disaster Needs Assessment (October 2018)2015 - 2030.*

[34] *Isaac TMT, Franke RW, Local Democracy and Development: The Kerala People's Campaign for Decentralized Planning (Rowman & Littlefield; 2002) 272*

The Committee identified principles of devolution of powers which the decentralisation framework has to abide by.

AUTONOMY

The committee held that there was to be three types of autonomy, functional, financial and administrative. The basic proposition is that the LSGs should be able to function freely and independently and that government supervision should be limited. And that as far as developmental matters are concerned, national and state priorities and general guidelines alone need to be indicated to them to help them to take their own decisions.

SUBSIDIARITY

This principle essentially suggests that what can be done at a particular level should be done at that level and not at a higher level. This goes for a bottom-up approach of power transfer, essentially suggesting that residuary functions along need to be given to higher authorities.

ROLE- CLARITY

This principle essentially goes hand in hand with the principle of autonomy implying that each level of administration should have clear perception of their role in the developmental process that they support each othr without working at cross-purposes. Functional clarity without rigidity is what is desirable.

COMPLEMENTARITY

Again related to role clarity this suggests that functions should not be overlapping and repetitive and that they should merge into an overall unity through a process of horizontal integration. It also means that the work done by higher levels should complement those of lowers levels and the programmes implemented by all agencies in a given LSG would be consistent with local needs and priorities and would converge into an integrated local plan.

UNIFORMITY

This suggests that the norms and criteria for the selection of beneficiaries, sites of prioritisation of activities and pattern of assistance within an LSG should be same for all programmes implemented there irrespective of the agency sponsoring such programme.

PEOPLE'S PARTICIPATION

Rather than being mere passive beneficiaries of the developmental measures being initiated by the LSGs, the people especially those excluded from the developmental process should have an active role and ownership of the activities being taken up at the local level.

ACCOUNTABILITY

The LSGS are accountable to the people in the sense they are answerable to the people not merely through elections but also through formal means such as social audit.

TRANSPARENCY

Decisions taken by the LSGs have to be transparent and have to based on norms and criteria

evolved on the basis of social consensus. The rationale behind each decision has to be made public as well, especially as to how money is getting spent.[35]

DECENTRALISATION WAS SUCCESSFUL IN IMPROVING THE HEALTH INFRASTRUCTURE AND EQUIPMENT IN THE PRIMARY AND SECONDARY HEALTH CARE FACILITIES INFRASTRUCTURE FACILITIES.

A study done in 2011 by Thomas and Rakesh aimed at analysing the transition in the healthcare sector during the two decades (1996-2011) linking it to the interventions of the local governance found that the decentralisation process was successful in improving the health infrastructure and equipment in the health infrastructure at the grass-root level. It also found that the network of health care delivery was widened. Another crucial finding was regarding improvement in provision of safe drinking water and sanitation. However, shortcomings were noticed in the form of issues of nutritional imbalance, elderly health care, lifestyle diseases and the changing morbidity pattern in the state. This the authors found needed more attention, which they were of the opinion could be settled through greater functional autonomy for LSGs to do more contextual adaptation in accordance with the changing pattern of health care needs and diseases.[36]

[35] *Report of the Committee on Decentralisation of Powers (S B Sen Committee) Suggestions for amending Kerala Panchayat Raj Act, Government of Kerala, 19972018)2015 - 2030.*

[36] *Thomas MB, Rajesh K, 'Decentralisation and interventions in health sector: a critical inquiry into the experience of local self-governments in Kerala' (Working paper, 2011)*

ANALYTICAL FRAMEWORK

This study was done over a short period of time from October to December 2020. The study has been done through a blended approach employing both normative and empirical research methods.

The existing legal and policy framework with regard to general disaster management in the state was analysed briefly- both primary and secondary sources through a doctrinaire approach, followed by an analysis of the executive instruments which were enacted in the context of the COVID pandemic.

During the COVID pandemic, there were health-related protocols to be followed across the world. These were protocols from the state and the central governments, which were in turn guided by advisories from the international level, mostly the WHO. These were available in the public domain and at different levels of government, instructions were issued on how to follow them. The instructions from the central government were issued to the states and the states in turn issued them to the LSGs and other departments and institutions under them through executive orders.

As far as the LSGs in Kerala are concerned, their primary instructions were issued by the Local Self Government Department. KILA had prepared IEC materials on all these government orders (GO) and advisories and provided them to the LSGs and associated functionaries through online platforms. For the sake of this study, all the executive orders that were issued by the LSG Department during this period which had been collated into a repository by KILA during this period have been analysed to identify the type of activities which were entrusted formally by the State government with the LSGs to carry out. This was a total of 70 government orders which were collated

by KILA and uploaded on KILA's repository. The list of the government orders and the translated titles in English is attached as Appendix I.

Parallelly, we also did an analysis of the actions that were taken up by LSGs on the ground as reflected in presentations that were carried out by the LSGs on their work during the time; these were showcased on KILA's website and YouTube channel. The presentations which were done during May and June, 2020 saw the LSGs (both rural and urban) explain with the help of visual aids the work that was being taken up by them on the ground, along with specific contextual action they had to take due to challenges unique to them. These videos which are in Malayalam are uploaded on KILA's website https://cblsgi.kila.ac.in/facebookPremiere.html. Transcripts of these webinars were prepared by KILA at the time itself and were uploaded on the official website of Kerala Institute of Local Administration (https://cblsgi.kila.ac.in/facebookPremiere.html). There was a total of 91 LSGs which did presentations. These were subjected to deductive qualitative content analysis using a Semi-structured Analysis Matrix. The table showing the district wise list of LSGs is attached as Appendix 2. This was further supplemented by data consolidated from the LSGs by the Divisions under the Local Self-Government Department on aspects relating to funding. These have been provided as figures within the analysis Chapter of the study.

The analysis from this was thereafter briefly tested against an adapted version of the principles of devolution of functions as was laid down by the Committee on Decentralisation popularly known as the Sen Committee, an expert Committee appointed by the Government of Kerala in 1997 to study and make recommendations for effective decentralisation of power to the LSGs in the state.

ANALYSIS OF THE MEASURES TAKEN UP BY LSGs AS COVID RESPONSE

A BRIEF TIMELINE

While going through the actions taken by the LSGs in Kerala as part of COVID 19 response, it was seen that activities undertaken by them were under the overall guidance as incorporated in protocols issued at the state, national and international levels. Contextual adaptations were made by them according to their particular LSG's requirement. Another aspect was that in accordance with the changing scenarios of the pandemic, clear stages were recognisable in the COVID response and activities undertaken by the LSGs could also be seen through that prism.

A brief timeline of pertinent events is being explained here to give context to these main steps that were taken by Kerala's LSGs during the COVID response. Some of them were external events whereas others were triggered by executive action through notifications.

TABLE 1: LIST OF EVENTS

Sl No.	Date	Event details
1	January 22nd	The Kerala Health Department issued an alert and stepped up surveillance at 4 airports. Instructions were issued that anyone coming from China would have to inform district medical officers.[37]
2	January 31st	COVID in Kerala- students arriving from Wuhan test positive for the Virus
3	February 1st	Preliminary guidelines on what LSGs should do were issued by the Local Self Government Department focusing on the Break the Chain Campaign[38]
4	March 20th	Detailed instructions on Break the Chain Campaign issued.[39] Instructions also on home isolation, inventorisation and details to be collected from the grassroot level[40]
5	March 23rd	Lockdown declared in Kerala till 31st March declaring exemption for essential services and for relevant Departments. Urban local bodies, Panchayat institutions, Municipal Corporations included in it.[41]
6	March 24th	Central Government declares a nation-wide lockdown from March 25th for 21 days[42]
7	March 26th	Orders issued on setting up community kitchens with the help of Kudumbashree/ Volunteers by the Local Self-government Department[43]
8	March 27th	LSGs directed to collect data on home isolation by the Local Self-government Department[44]
9	April 14th	Central Government extends the national lockdown upto May 3rd
10	April 30th	LSGs directed to provide life-saving medicines for critically ill people by the Local Self-Government Department[45]
11	May 1st	Central government extends the lockdown measures for two weeks from 4.5.20[46]
12	May 5th	Central government directs the continuation of the previous order Return of Indian Nationals stranded outside the country start through Vande Bharat[47]

[37] *Press Trust of India, 'Kerala Health dept issues alert, surveillance at 4 airports' (BusinessStandard, 22 Januray 2020) <https://www.business-standard.com/article/pti-stories/kerala-health-dept-issues-alert-surveillance-at-4-airports-120012201653_1.html>*

[38] *DC1/ 71/2020 / LSGD dated 01.02.2020*

[39] *GO (Rt) 620/2020/LSGD dated 14.03.2020*

[40] *G.O (Ms) No.55 / 2020 dated 20.03.2020*

[41] *G.O (Ms) No. 49/2020/GAD dated 23.03.2020*

[42] *Ministry of Home Affairs, Government of India, Order No.40-3/2020-DM-I (A) dated 24.03.2020*

[43] *G.O (Rt) No.713/2020 dated 26.03.2020*

[44] *Circular No: LDC1 / 71/2020 dated 27.03.2020*

[45] *G.O (Rt) No. 69/2020 / LSGD dated 30.04.2020*

[46] *Order no. 1-29/2020-PP dated 01.05.2020*

[47] *No.40-3/2020-DM-I(A) dated 05.05.2020*

13	May 20th	Subhiksha Keralam Order issued by the Local Self Government Department to utilise plan funds for increasing food security and to take up projects aimed at that[48]
14	May 25th	LSGs directed to start preparing Covid First Line Treatment Centres in consultation with the District Disaster Management Authorities[49]
15	May 30th	Central government issues order to reopen prohibited activities in a phased manner in areas outside Containment Zones[50]
16	July 16th	Detailed instructions given on how to run Covid First Line Treatment Centres[51]

The COVID response by the LSGs has been divided into stages based on the timeline for better understanding and contextualising of specific activities that were taken up by the LSGs during this period.

STAGE I- PRIMARY FOCUS ON PREVENTIVE MEASURES AND SPREADING AWARENESS

This is the first stage when news came of COVID 19 spreading in Wuhan, China. The Kerala Health Department issued an alert and stepped-up surveillance at 4 airports on January 22nd and instructed that anyone coming from China would have to inform District Medical Officers.[52] The first reported case of COVID 19 in India on 30th January 2020 was a medical student studying in Wuhan in China returning to Kerala.

It is clear that during this time, the primary focus of the COVID response was on spreading awareness about the disease itself and about taking pre-emptive precautionary steps. From February 1st itself, preliminary instructions on the Break the Chain campaign were issued.[53] On February 4th, 2020 the Disaster Management Department of the Kerala Government declared the Corona virus outbreak as a State Specific Disaster.[54] Later as a pre-emptive measure for stopping the spread of the disease the Kerala government declared a state-wide lockdown, imposing restriction upon movement of people. So, the first stage is taken as the time from when the government stepped up surveillance at the airports after issuing a press release to when the lockdown was imposed, and the primary area of focus here is the activities that were taken up under the Break the Chain Campaign.

STAGE II- STRUCTURAL MEASURES SUCH AS COMMUNITY KITCHENS AND UPSCALING OF HEALTH INFRASTRUCTURE

On March 23rd 2020, taking into consideration the need for stemming the spread of the disease, Kerala declared a state-wide lockdown till 31st March.[55] On March 24th 2020, the

[48] *G.O. (R.T) No. 928/2020/LSGD dated 20.05.2020*

[49] *G.O. (R.T) No. 955/2020/LSGD dated 25.05.2020*

[50] *Ministry of Home Affairs, Government of India, Order No. 40-3/2020-DM-I (A) dated 30.05.2020*

[51] *G.O. (R.T) No. 1364/2020/LSGD dated 16.07.2020*

[52] *Press Trust of India, 'Kerala Health dept issues alert, surveillance at 4 airports' (BusinessStandard, 22 Januray 2020) <https://www.business-standard.com/article/pti-stories/kerala-health-dept-issues-alert-surveillance-at-4-airports-120012201653_1.html>*

[53] *DC1/ 71/2020 / LSGD dated 01.02.2020*

[54] *G.O.(Ms)No.3/2020/DMD dated 04.02.2020*

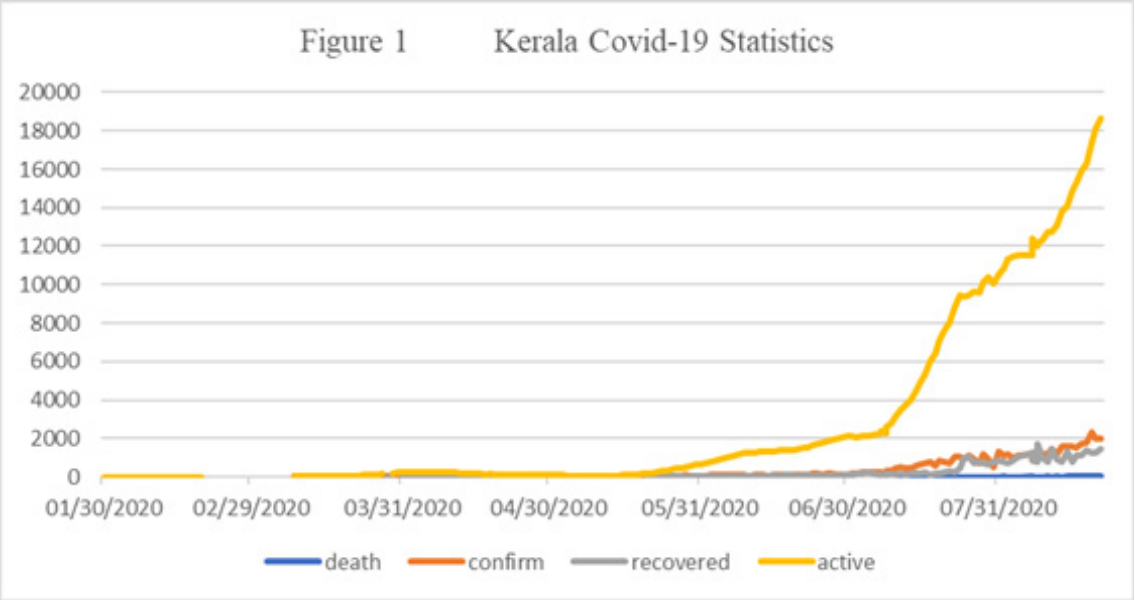
[54] *G.O (Ms) No. 49-2020-GAD dated 23.03.2020*

Central Government declared a nation-wide lockdown from the next day for 21 days with the intention of controlling the spread of the disease. All intra-state borders were closed.[56] During this time, since most people were staying inside their homes the primary challenge for the people was to meet basic needs due to the restrictions caused by lockdown. Meanwhile the first train carrying migrant labourers from Kerala plied on 1st May 2020.[57] Then the Central Government allowed non-resident Indians to come into India via the special flights called Vande Bharat from 5th May 2020. During this time another effort was to prepare for the arrival and subsequent quarantine of Non-Resident Indians. This stage is from when Kerala imposed lockdown to when the NRIs came to the state. The primary focus during this period was on the community kitchens set up in association with the Kudumbashree mechanism. Another emphasis was on large scale upscaling and reorienting of local level health systems towards adequate quarantine and associated facilities once the non-resident Keralites would return to the state.

STAGE III- STRUCTURAL MEASURES SUCH AS FACILITATION OF THE COVID FIRST LINE TREATMENT CENTRES

From 5th May 2020, the Central Government allowed non-resident Indians to come into India via the special flights called Vande Bharat. This was a period which saw intense preparations for the persons coming from abroad. This period also saw an exponential rise in the number of Covid positive cases.

FIGURE 1: KERALA COVID 19 STATISTICS



Source: Government of Kerala Database 21.08.2020

[56] *This lockdown was later extended three times upto 31st May 2020.*

[57] *S Anil Radhakrishnan and MP Praveen, 'First Train for Migrant Labourers from Aluva' The Hindu (Thiruvananthapuram, May 1 2020)*

From 1st June, 2020 onwards, the concept of total lockdown imposed by the Central Government was lifted and restrictions were placed on 'containment zones'. Activities were thereafter allowed to be resumed in a phased manner outside containment zones in accordance with the requirements of individual states. This is the third and final stage which has been analysed. During this period, the primary work carried on by the LSGs was to take up the work of setting up and facilitation of Covid First Line Treatment Centres (hereafter referred to as CFLTC).

The analysis has been carried out in two parts. The points 3.1 to 3.5 analyses some broad features of the work by the LSGs in the COVID disaster response process. The points 3.6 to 3.10 traces the structural and non-structural measures that were performed by the LSGs during the COVID response based on the stages of the COVID response. 3.11 dives into the funding aspects of the COVID response measures.

4.1. PRE-EMPTIVE MEASURES

Many of the LSGs examined confirmed that they had acted before instructions were issued by the State authorities. During the first stage of the COVID response, it was stated by many LSGs that even before advisories were formally issued by the Kerala State Health Department, they were entrusted with the task of quarantining persons who returned from COVID infected places such as Wuhan, as well as ensuring quarantine of persons who had come into contact with these persons. The LSGs confirmed the role of ASHA workers on the ground who were made responsible for drawing up critical links for contact tracing for the purpose of moving persons into quarantine during this period.

During the first stage of the COVID response, the LSGs were also making use of existing institutional frameworks for taking timely action, especially the Grama Sabhas and Ward Sabhas. Many LSGs were quick to facilitate classes by the Health Department for the Health Workers in the Primary Health Centres as well as ASHA and Kudumbashree workers through the Grama Sabhas and Ward Sabhas. One such example was evident from the New Mahi Panchayat in Kannur.

> *"It was in February that the Grama Sabhas started. After that- in every grama sabha that was organised, the health department officials were made to take awareness classes. In addition to this all the teachers, ASHA workers, other officers, Anganawadi teachers were all called in to attend classes and then to spread the awareness to other nooks and corners as well"*

Another aspect was the massive use of already existing online platforms for awareness generation and communication. Many LSGs confirmed that they had used social media platforms and groups, many of which were formed during the time of earlier disasters and disaster training processes. This helped them to communicate with volunteers, youth, political parties, arts and sports clubs especially who had taken part in many of these disaster response activities in the past as well.

The LSGs had also gone through a rigorous two-month training activity through January and February 2020 as part of the local level disaster management pprocess. Many of the LSGs pointed out that they were able to utilise resources prepared during that time in the COVID planning process, especially in resource mapping and inventorisation. They reported as having

been able to complete such inventorisation process before the lockdown was imposed itself, giving them a detailed idea of vulnerable populations etc living within their LSG area who would later on require assistance. They also appreciated the support provided by already trained members of the Emergency Response teams in the COVID response.

Tourist places faced a specific challenge during this time due to the influx of people from other places and difficulty in controlling numbers. It was reported by one such tourist hot spot in Kerala, the Kumily Grama Panchayat in Idukki how even before the lockdown came into effect, they were quick to restrict influx of tourists.

> *"Our panchayat is one which sees a lot of tourist footfall. Before the lockdown was imposed itself, restrictions were imposed on the entry of such tourists. They were not permitted to enter and for those who entered, detailed instructions were given and they were requested to go back as early as possible."*

4.2. CONTEXTUAL ADAPTATION

Most of the LSGs taken as part of our study reported that they had made contextual adaptations to the instructions that were issued to them. They reported that the guidelines issued by the State Government and the Health Department had to be changed according to the specific needs of their people, and also often in accordance with specific features of their local self-government. This was a practice seen across all stages of the COVID response, but especially in the first stage before major restrictions were imposed by the higher levels of government itself.

One Grama Panchayat, Kumily in Idukki for instance noted how because they were a border Panchayat, how they had to carry out extensive sanitation activities of all the bus stations and other public places in these areas. They also noted how they had to carry out COVID symptomatic screening of passengers at the bus stations post the lifting of the inter-state border control.

Another challenge was reported as having been faced by LSGs with specific categories of vulnerable persons. For instance, there were LSGs that reported how they had to take specific steps to engage with the migrant population or the guest labourers in their language itself. So, the awareness material brought out by the Health and other Departments were translated by them with the help of translators in different languages for the sake of the guest labourers. The Neeleshwaram Municipality for instance gathered data on the guest labourers early on itself by entrusting councillors who were fluent in Hindi.

> *"Another problem that was faced was the loss of jobs during the lockdown period. For that, in order to mitigate the problems of those who had lost their jobs, and to study the situation, we gathered details of the guest labourers early on. We entrusted this task to three Councillors of whom two could speak Hindi very fluently."*

As regards guest labourers many of the LSGs were quick to note that the guest labourers did not prefer Kerala style food from the community kitchens. They were provided grains and other cooking materials which they could prepare on their own.

Steps such as giving masks for specific category of persons was another specific preventive activity which many LSGs stated as having done. This was during the second stage of the

lockdown primarily when restrictions on movement was not imposed on certain services deemed as "essential" by the state government. Taxi drivers, goods lorry drivers etc were in this manner aided by the LSGs who did targeted distribution of masks and other preventive materials among these categories of persons. Many LSGs also reported having manufactured masks and hand sanitisers anticipating a shortage in supply at a later stage.

4.3. INTER-DEPARTMENTAL COORDINATION ACTIVITIES

It is important to note that an analysis of the various executive instruments issued during this time give different roles to different departments. In every local self-government, LSG level committees were formed followed by Rapid Response Teams (RRTs) or Ward committees under the leadership of ward elected representatives. These had personnel from various departments as well as volunteers. On the ground, many LSGs reported active coordination with the other departments during the entire COVID response, especially the Health, the Revenue Department, the Police and the Fire Force. This was mainly reported in the activities around the Break the Chain, Home Isolation, Sanitation activities, running of the COVID First Line Treatment Centres etc.

Many of the LSGs reported working with the Kudumbashree workers or the women self-help groups on the ground to take up many activities including preventive measures during this time, especially for the Break the Chain Campaign, community kitchen and the Subhiksha Keralam scheme. During the first stage, the manufacture of masks and hand sanitiser was taken up by the LSGs conjointly with the Kudumbashree. During the second stage of the COVID response, all LSGs took up activities related to community kitchen- to provide food to needy people during the lockdown. During this time, engagement with the Kudumbashree was directed by the Local Self-Government Department itself through clear instructions on roles to be donned by the different agencies. During the last stage of the COVID response, the main activity taken up with the Kudumbashree was the Subhiksha Keralam programme where the coordinated activities with various departments and agencies under the leadership of LSGs in ensuring long term food security through massive intervention in agriculture and allied activities.

The Perinthalmanna Municipality reported:

> *"To encourage vegetable gardening in the Municipality, 2760 Kudumbashree volunteers distributed vegetable seeds and plants to 13800 houses."*

The LSGs also showed initiative in procuring materials from other Departments in order to solve non-availability in their LSG. The New Mahi Panchayat for instance reported having obtained spirit from the Excise Department in order to settle the problem of non-availability of hand sanitiser in their LSG.

They were also able to actively engage with specialised agencies and institutions of the government to implement special schemes and projects during this time. The Madakkathara Panchayat in Thrissur District reported working with the Central Plantation Crops Research Institute in Kasargod for getting high yielding varieties for distribution during this time.

> *"The Panchayat in association with CPCRI, Kasargod established a coconut plant nursery of 3000 higher yielding varieties of coconut plants."*

They also reported dovetailing operations undertaken by community health workers, Kudumbashree, trained members of rapid response teams and emergency response teams, experts from various fields and vast number of volunteers. With active support from volunteers, political parties, religious institutions and other groups, LSGs are credited with gathering funds for the community kitchens on a large scale.

Multi-department committees were stated to have been formed at the ward level by the LSGs incorporating personnel from Health Department, Kudumbashree, Angwanawadi teachers, ASHA workers to take up preventive measures. Other committees such as the Village Health, Nutrition, Sanitation committee, Jagratha Samithi and Rapid Response Teams were also reported to have been formed or activated by LSGs to serve on the ground, many of whom had received specialised training under the guidance of other line departments such as the Health Department and the Kerala State Disaster Management Authority.

4.4. CARE OF VULNERABLE AND MARGINALISED SECTIONS

Mostly all the LSGs involved in the study reported that they gave specific focus to the needs of the marginalised and vulnerable sections and those needing special attention during the COVID period. Specialised care of the most vulnerable can be stated as one of the main focuses of the COVID response showcased by the LSGs in Kerala. Many LSGs reported having made lists of the marginalised sections in their LSGs as early as February itself in order to ensure that specialised attention could be given to them later. Some of them also reported making use of lists already prepared as a part of the local level disaster management planning process.

Many guest laborers in Kerala for instance were stranded without contractors and without jobs or means of getting home; many of them in very cramped living conditions. The Neeleshwaram Municipality reported having engaged with their contractors to ensure that they were taken care of. The Municipality also reported having provided them with Vishu kits comprising atta for them to cook during this period.

The help was extended to such guest labourers; surveys were conducted to find out their needs and leaders were selected from among them to coordinate activities. They were also provided counselling.

While many LSGs stated that they helped marginalised sections especially guest labourers, others were keen to note the presence of elderly citizens living alone, patients with comorbidity issues, persons with disability, pregnant women etc who required help at a later stage of the COVID response. LSGs also reported having identified poverty-stricken families including those who did not hold ration cards for distribution of food from the community kitchens.

4.5. SUPPORT DURING LOCKDOWN

The LSGs were quick to realise the difficulties faced by the people during this time due to loss of income and other such issues. They took steps such as waiving rent for LSG owned buildings, giving instructions to building owners to waive rent etc. Some LSGs reported giving interest free loans to persons who lost jobs. Financial support was also given for Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) and Ayyankali Urban Employment Guarantee Scheme (AUEGS) workers. Time for filing applications for services,

for seeking renewal of licenses etc was extended.

LSGs took up various functions as part of COVID preparedness for the benefit of the people. Help desks to communicate the government COVID protocols and to provide other updates were set up.

> *"Medicines available only in far-off places were procured by us and supplied to the patients within 24 hours by associating with the police force and health department. This was done under the leadership of the Ward Samitis."*
>
> *- Nenmara Panchayat President*

Measures were taken by the LSGs to ensure that regular functions were not disrupted. Mobile clinics were started to ensure that regular medical services did not suffer due to the pandemic. Telemedicine facilities were arranged for those in quarantine. Medicines were distributed free of cost to patients with cancer and kidney problems, to severe alcoholics etc. Many LSGs made sure that medical support available to elderly patients was not hampered. Support was provided for pregnant women, as well as emotional support through counselling.

Activities to reduce stress such as book distribution, online engagement between citizens was encouraged; as well as online competitions for children. Online education through whatsapp groups was encouraged.

4.6. PREVENTIVE MEASURES

Detailed advisories on preventive measures were issued by the Health Department as early as February itself based on WHO advisories. Many LSGs were keen to note that they had taken steps in this regard even before such instructions were issued utilising their already existing health infrastructure, including the Jagratha Samitis. This they did during the first stage of the COVID response and it was continued well into the third stage of the COVID response.

A State-wide campaign called the "Break the Chain" campaign was launched in March which emphasised the need for physical distancing and hand hygiene.[58] The LSGs were tasked with the duty to spread awareness regarding social distancing and hand hygiene, as well as to set up hand sanitiser and hand washing kiosks in all public places including government offices, bus stations and shop clusters.

Many LSGs reported having taken up the tasks that were given to them whole-heatedly, but many LSGs went further and adapted them accordingly. For instance, noting that there would not be availability of masks and sanitisers as also price-rise due to non-availability, many LSGs reported taking up production and distribution of these items at the LSG level promptly by engaging with the Kudumbashree workers. They reportedly distributed masks, hand sanitisers and disinfectants to the people free of cost in the LSGs. LSGs noted that this had considerably helped them in controlling the rise in the number of cases in the first stage.

Already existing whatsapp groups, social media pages etc were all used for spreading awareness regarding COVID. Mic announcements, notice distributions, banners, rallies etc were all carried out. Voluntary groups were roped in to assist with the awareness generation

[58] *Special Correspondent, 'Minister launches 'Break the Chain' campaign' The Hindu (Thiruvananthapuram, 16 March 2020)*

activities, especially the National Cadet Corps and other youth groups, arts, sports, cultural clubs etc. During this time, the State government announced the formation of Volunteer Force (Sannaddha Sena), members of which became very supportive for all these activities.

Many LSGs also designed their own innovative campaign slogans to ensure participation by the people. It is clear that the LSGs detected resistance from the people in the initial stages and chose to find attractive and innovative ways to spread the word. For instance, an LSG, the Thanneermukkam Grama Panchayat promoted an innovative measure of using an umbrella to ensure physical distance. The campaign was called "Akalam Paalikkan Kuda Choodam" which asked people to hold open umbrellas in order to maintain physical distance.

> *"Akalam Paalikkam Kuda Choodam" campaign was carried out by us to encourage people to maintain physical distance, an idea that was widely taken up at the international level. We distributed 10,000 umbrellas on subsidised rates for this. It got a lot of national and international attention."*

"Thoovala Viplavam" or handkerchief revolution was another campaign designed by the Thanneermukkam Grama Panchayat in the context of schools in the LSGs which was started before the Break the Chain Campaign by the State government.

> *"Being a Panchayat which is often afflicted by different types of outbreaks like Chikungunya , we have been conducting weekly meeting of health workers for a long time. During one such meeting on January 29th we discussed the COVID outbreak and under the guidance of the steering committee we decided to start a campaign starting with the school children called "thoovala viplavam".*

Competitions and other rewards were conducted to encourage people to stay at home. The LSGs noted that in this manner they were able to engage the people and make use of public trust to carry out these steps effectively.

4.7. MEDICAL FACILITIES

Throughout the different stages of the COVID response in Kerala, the health workers under the local self-governments- the ASHA workers, the Junior Health Inspectors, the Junior Public Health Nurses along with the respective ward members were handling the primary task of coordination and house-to-house monitoring of contact tracing, isolation and quarantine. It is important to note that this was guided by COVID guidelines released by the Health Department. Throughout all the stages this involved quarantine of all those who had come in touch with positive cases as well as those who had travelled abroad. This involved contact tracing and strict monitoring of those in quarantine.[59] Different innovative mechanisms were used by the LSGs for ensuring clear communication channels with those in quarantine ranging from whatsapp groups to other smart quorum voice messaging system for monitoring and communication. When entire homes would have to go into quarantine due to one positive case emerging in the household, they would take quick steps to ensure that the positive case was moved to the hospitals on ambulances. Thereafter many LSGs took up the task of ensuring that all the basic needs of such homes in quarantine would be

[59] *The terms "quarantine" and "isolation" have been used interchangeably due to interchangeable use of the terms in guidelines.*

met. A notice would be stuck outside such houses, but at the same time the LSGs under the leadership of the ward members took up the huge task of ensuring that this family would not be stigmatised. There was constant engagement and house-to-house follow-up, both through phone and through visits.

During these different stages, though guidelines were issued by the Government of India on how to carry out quarantine, these were contextually adapted by the state government to suit the imminent threats. For instance, the Government of India directed that 14 days institutional quarantine be carried out for those coming from abroad through Vande Bharat flights. But Kerala permitted home quarantine for those who had facilities at home. The monitoring of the facilities and the quarantine would be carried out by the health workers under the LSGs. But for those who could not use home quarantine due to other factors such as any high-risk group residing in their household etc the LSGs were to make arrangements for institutional quarantine. All facilities for such quarantine centres were arranged by the LSGs especially food, sanitation, waste management etc.

Later, in anticipation of rise in number of positive cases, the State Government also asked the LSGs with arranging COVID First Line Treatment Centres (CFLTC), primary health care centres were positive cases with mild symptoms of COVID could be housed and monitored. The responsibility of identifying and arranging infrastructure in suitable buildings within the LSGs for such purpose was given to the LSGs. Most LSGs set up these CFLTCs in both public-owned and private-owned buildings. Many educational institutions, community halls, hostels, auditoriums, even indoor stadiums were identified as CFLTCs in the concerned LSG. It is important to note that this activity was started during the second stage of the COVID response itself, though the primary operation of such CFLTCs were in the third stage. Though most of the LSGs did identify multiple CFLTCs, especially in urban areas, many LSGs did not have to bring into operation the identified CFLTCs.

All the LSGs set up management committee headed by the Chairperson of the LSG for the administration of such CFLTC. This committee was tasked with managing the daily activities of the CFLTCs. A nodal officer was appointed to manage the CFLTCs. Necessary requisites such as beds, toilets, food, water, waste management, compost pit for biodegradable waste, incinerator, semi-permanent toilets (if needed) and sufficient human resources were arranged in the CFLTCs according to a pre-set checklist. Here again, the facilitation including physical infrastructure, food, sanitation etc was done by the LSGs while other medical issues would be handled by the Health Department. The LSGs were also responsible for ensuring adequate human personnel to serve in these quarantine facilities. Nurses and cleaning personnel were engaged on ad-hoc basis to serve in CFLTCs and other COVID related institutional care centres. The District Disaster Management Authority was the authority to give final permission for starting a CFLTC. Funds were also to be allotted from the District Disaster Relief Fund.

4.8. SANITATION AND WASTE MANAGEMENT WORK

Most of the LSGs studied reported the heightened challenge of waste management during the COVID period. They reported not only the increased use of plastic and other disposables but also the added task of handling the bio-medical waste carefully. The Thanneermukkam

Grama Panchayat realising the issue of COVID bio-medical waste mixing with other waste came up with an innovative measure of providing airtight PVC and Bamboo pipes to dispose off contaminated masks and gloves.

LSGs reported having given specialised training for their regular staff, primarily Haritha Karma Sena members to carry out the disposal and management of such waste carefully. Protocols on how to handle the bio-medical waste were issued to be followed by the LSGs.

General sanitation was also carried out during this period extensively by the LSGs. For sanitation of public spaces, the LSGs engaged with many different departments including the Fire Force and Health Department. Many also reported volunteer groups at the ward level who came out to carry out sanitation activities of the public places. Labour camps and the hygiene there was a major concern for many LSGs. They attempted to ensure proper hygiene in these labour camps by distributing disinfectants.

The LSGs also reported hiring extra cleaning staff for this period for carrying out sanitation and other waste management activities.

The Thanneermukkam grama panchayat reported having conducted innovative competitions to encourage waste management.

> *"We provided 'Clean House' awards to wards which successfully completed waste management at the ward level itself."*

4.9. COMMUNITY KITCHENS

During the second stage of the COVID response after the lockdown was imposed, even before receiving any form of instruction from the government a few LSGs in Kerala set up community kitchens. Within a week of the lockdown, all LSGs set up community kitchens to provide food to the people within their LSGs. Detailed instructions were issued in this regard by the LSG Department itself during this time instructing LSGs to take up this task in association with the Kudumbashree Mission workers.

All the infrastructure as well as funding was gathered by the LSGs themselves. The cooking itself was led by Kudumbashree members and other youth volunteers, members from various political parties, religious institutions – all pitched in to support including to gather funds and to manage the kitchens. The kitchens aimed at providing food to persons who could not cook for themselves at their homes, for those engaged in COVID work and for supply to COVID care institutions.

Many LSGs took up the task of identification of vulnerable sections within their LSGs who were in need of free or subsidised food. Then efforts were made to provide food to them. This included destitutes, poverty-stricken families and other marginalized sections. Many LSGs also made sure that certain sections of the population engaged in COVID essential services got food during this period such as goods transport vehicle drivers etc. Food was also supplied from the Community Kitchens to households which were in COVID quarantine. All such identification was taken up by the Kudumashree members, ASHA workers and teams under the leadership of the Ward Members or RRTs. Volunteers and Kudumbashree members also engaged in delivering food directly to the houses for people.

Many LSGs during this time took it upon themselves to use modern technology to reach out to the community. Using their own funds, they designed mobile applications to carry out home delivery of food as well as of other items so that persons would not have to leave their homes.

> *"We created the "aye auto" app to supply food and other items directly to the homes. We consider it a great victory that this was used extensively by the people due to which they didn't get out of their homes to buy things."*
>
> *- Kottakkal Municipality Chairperson*

4.10. AGRICULTURAL ACTIVITIES

The study showed that many LSGs had distributed seeds as a means for people to engage in agricultural activities during the lockdown period. Then during the second stage of the COVID response, the state government anticipating a shortfall in supply of vegetables and other food materials, introduced the Subhiksha Keralam scheme to ensure food security. A list of subsidy modifications was fixed and released by the State Government. There were many LSGs which took up tharishe rahitha or fallow land-less panchayat objectives. Dairy sector was also improved. Cultivation of tuber crops were also taken up on a massive scale. Inland fisheries was also done in natural and artificial ponds.

The LSGs were encouraged to conduct this scheme by pooling all possible funds towards it. LSGs during this time carried out distribution and sale of vegetable seeds, kits, plants and agricultural equipment through the Krishi Bhavan and through Kudumbashree workers. Some LSGs conducted competitions to encourage the participation of the people.

The LSGs took other measures to actively support the people. For instance, spoiled fish stock that was captured was converted to manure and distributed to the people. Also, to avoid a fodder shortage due to the lockdown, fodder was delivered to dairy farmers.

LSGs also took steps to assist farmers with sale of products during this period.

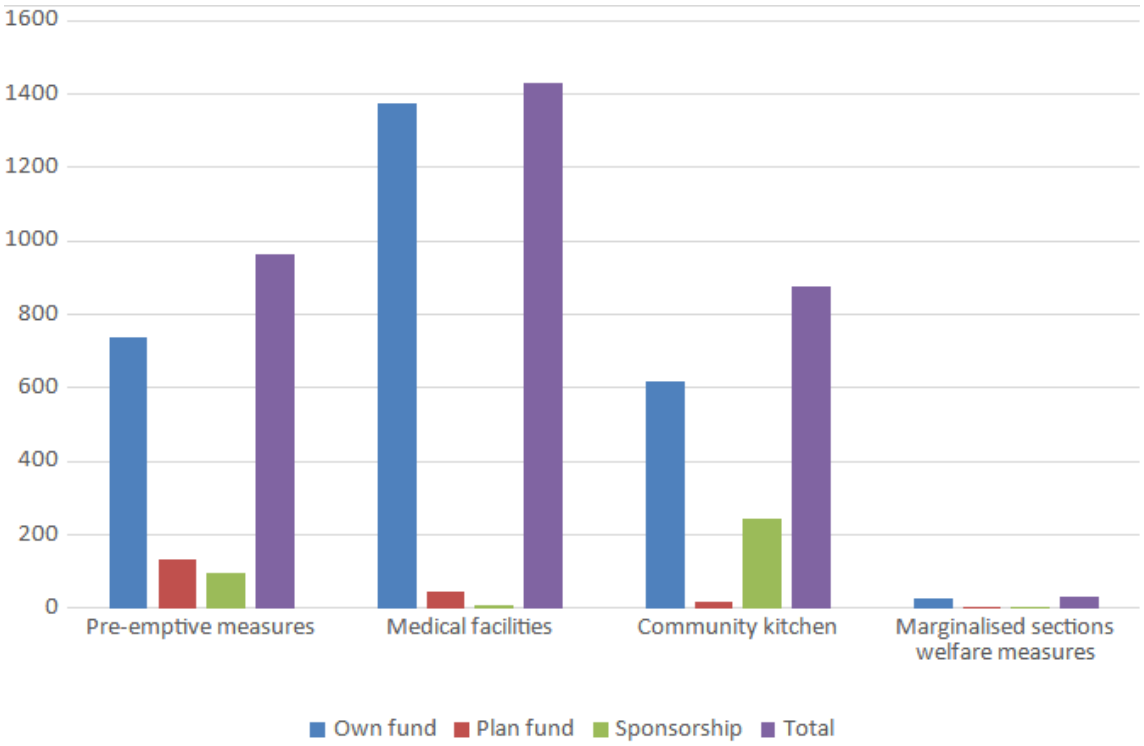
> *"During the 1st phase of the lockdown, there was a serious crisis for our farmers including our dairy farmers. Problems due to not being able to sell their products and lack of public transport were there. Under the leadership of the Kalpetta MLA Mr. Shashidharan necessary steps are being taken for arranging facilities for the farmers to sell their products. Steps were taken for selling the crops through Horticorp. Steps were also taken for "Milma" to procure the milk from the dairy farmers."*
>
> *- Vengapally Grama Panchayat President*

4.11. FUNDING

During the COVID response, the LSGs were able to handle the activities mainly through their own funds, plan funds and through sponsorships. Many LSGs reported carrying out much of their Community Kitchen related work through sponsorships and voluntary contribution. Instructions were issued by the Local Self-Government from time to time to utilise funds in this manner, though many LSGs reported having taken initiative in this regard from funds at their disposal otherwise itself. Volunteer groups, political parties, civil society organsiations

and religious institutions worked together to gather funds for these activities. For the work towards the COVID First Line Treatment Centres, the State Government further gave instructions that funds from the District Disaster Relief Fund should be made available, though this was not required in all LSGs due to the lesser number of COVID cases.

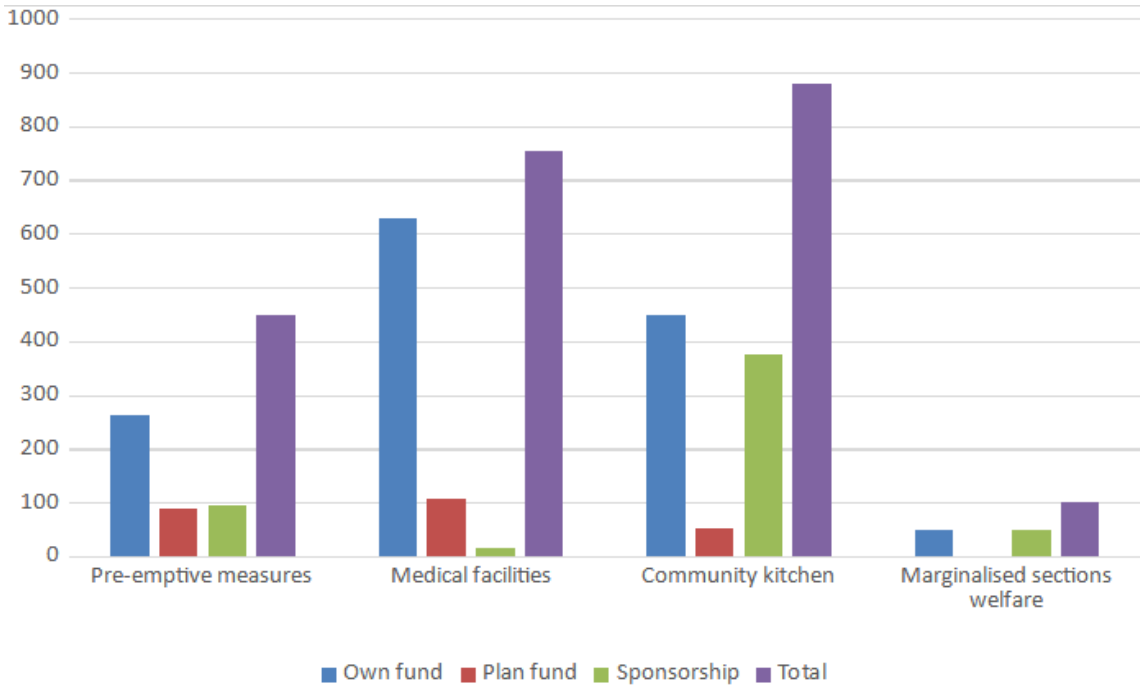
FIGURE 2: GRAMA PANCHAYATS- FUND UTILISATION IN LAKHS



For this tabular analysis, we have gathered details made available by the Local Self-Government Department. An analysis of the fund utilisation by the Grama Panchayats for the period until June 2020 shows that their maximum fund was utilised for medical facilities including upscaling of hospital infrastructure, for running the various specialised institutions for COVID care including the COVID care centres, the institutional quarantine centres and the COVID First Line Treatment Centres as also for temporary appointments of medical personnel.

The pre-emptive measures studied here looks at the expenditure incurred under the Break the Chain Campaign including setting up of hand sanitiser counters as well as awareness generation campaigns. The data shows that the LSGs were making use of their own funds for running these activities. For community kitchen alone it is clear that a substantial contribution came through sponsorships from the public. It appears that they had to spent the least amount of money on providing assistance to marginalised sections (guest labourers, destitutes) including for the running of camps. We can understand that this was because the number of destitutes is very small and mostly limited to certain urban and semi urban areas. Moreover, food, medicines and other facilities for them too have been included in the respective figures. With regard to the guest labourers, they had started moving back to their home states during the beginning of the third stage of the response.

FIGURE 3: URBAN LSGs- FUND UTILISATION IN LAKHS



An analysis of the fund utilisation by the Urban LSGs, the Municipalities and the Corporations for the period until June 2020 shows that their maximum fund was utilised for running of the community kitchens. Even for urban LSGs the maximum fund has been utilised from the own fund itself by LSGs with a smaller part coming from plan funds and sponsorships. Here again it is evident that for running of community kitchens a substantial contribution came through sponsorships from the public.

DISCUSSION ON THE EMERGENT ROLE OF LSGs IN DISASTER MANAGEMENT

"Tackling a social calamity is not like fighting a war which works best when a leader can use top-down power to order everyone to do what the leader wants – with no need for consultation. In contrast, what is needed for dealing with a social calamity is participatory governance and alert public discussion"

Dr. Amartya Sen

For the discussion in this study, we have attempted to map the major aspects regarding the work of the LSGs during the COVID response, to identify the role of LSGs in a disaster scenario. Set against a larger scenario of an emergent role of LSGs as prominent stakeholders in disaster management, this has further been tested briefly against the principles of devolution of functions,

namely subsidiarity, autonomy, role clarity and complementarity, people's participation, accountability and transparency as propounded by the Committee on Decentralisation of Powers, popularly known as the Sen Committee.[60] This being a brief and quick study, in-depth exhaustive analysis has not been done. Instead, the major elements emanating from the role donned by LSGs during the COVID response have been mapped thematically.

5.1. OVERALL GUIDANCE OF THE STATE GOVERNMENT

The COVID pandemic saw the need for concerted action across the globe involving action from the international level all the way to the ground level. It saw a need for flow of instructions and guidance from the global level such as the World Health Organisation all the way to the local level; therefore, there was an overall framework within which every player operated. As far as Kerala is concerned, the Health Department of the State government was quick to act and issued protocols based on WHO guidelines and advisories from the beginning itself through government orders and continued that through all stages of the COVID response. During this COVID pandemic, they have been serving as the nodal agency based on which other departments including the Local Self Government Department have been issuing their steps as far as the technical aspects of disease containment is concerned. They acted as the coordinating department which tied together actions happening across the state as far as disease containment was concerned.

Hence protocols on how quarantine was to be done, upgrades in health infrastructure, treatment protocols etc were all issued by them which had to be largely followed by all the instrumentalities in the State including the primary health system under the LSGs. Regarding the "Break the Chain" campaign, the operation of COVID First Line Treatment Centres etc the protocols were laid out by the Health Department and Local Self-Government department which were followed by the LSGs. However, considering it as a disaster, the State Government under the leadership of the Chief Minister, being the Chairman of the State Disaster Management Authority steered the action. The government had to bring together various departments, agencies and systems, all of which had to be converged at the local level through the local governments. In the meantime, the District Disaster Management Authority acted as the district level coordinating agency.

As far as other activities such as welfare and social measures were concerned, such as Community Kitchens, care of marginalised sections etc, the LSG Department issued guidelines to the LSGs. It could be noted that in all these activities, the State Government Departments operated in coordinating roles. The LSGs operated as the final authority and umbrella platform through which all COVID activities were routed in accordance with the specific needs of that particular area keeping in line with the principles of autonomy and subsidiarity. Kudumbashree, the women's neighbourhood group federation, played a key role. Its existence and experience as an autonomous community-based organisation, but under the overall guidance and umbrella of the local government system made the major difference. Similar is the case with anganwadi workers, ASHA workers, health system staff

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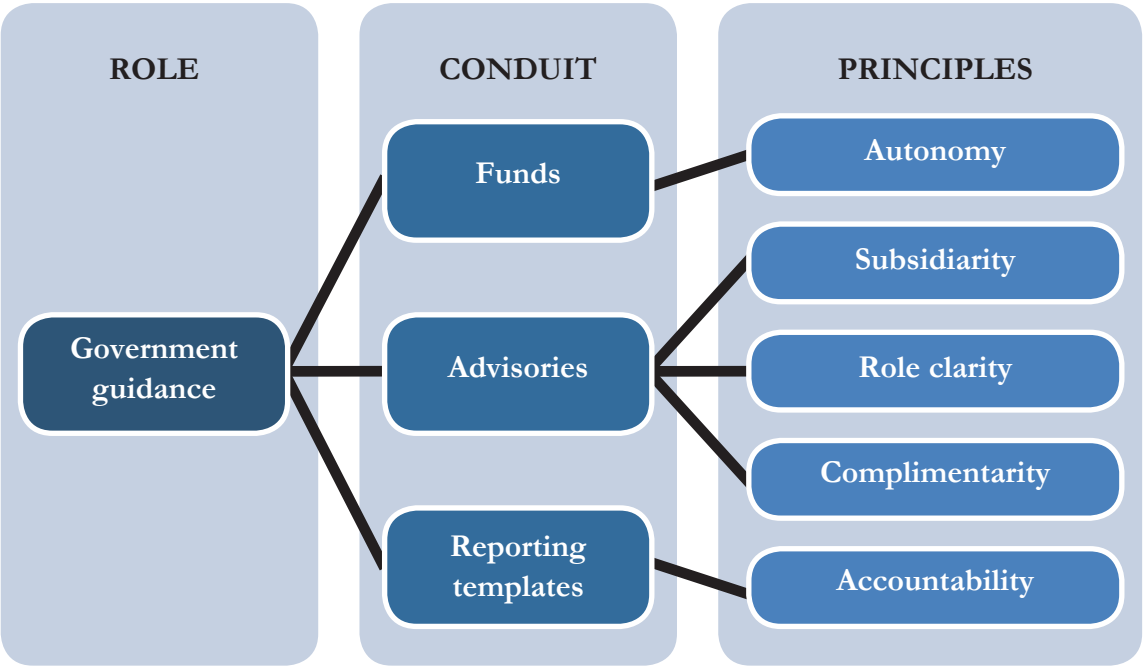
[60] *Report of the Committee on Decentralisation of Powers (S B Sen Committee) Suggestions for amending Kerala Panchayat Raj Act, Government of Kerala, 1997. See also S. M. Vijayanand, Kerala-A Case Study of Classical Democratic Decentralization (KILA 2009) 87*

and many other filed level functionaries. In order to help LSGs with their work during this period, KILA as the primary training and capacity building institute for LSGs in the state had also prepared IEC materials in Malayalam, English and in other Indian languages on all the advisories and guidelines given by all these departments. KILA also facilitated the exchange of experiences of local self-governments through regular webinars and other media.

The devolution of power to the LSGs during this period was not merely deconcentration or administrative reorganization but rather the transfer of political power to the LSGs to make value judgments on the steps that were needed as part of COVID response through clear instructions and through transfer of power and funds.[61] Especially towards the second stage of the COVID response, ie, when community kitchens were started, there was a clearer recognition of the role of the LSGs and role clarity and complementarity also evolved as a result. Each entity was clearer about their roles and worked in tandem with the LSGs complementing the work of the various responsible departments on the ground.

While this downward flow of power was clear, there was also upward reporting and subsequent monitoring of actions by the different Departments. Templates were given to the LSGs to collate information so that overall coordination could be made possible at the higher levels. This ensured accountability as well, both towards the populace as well as towards the State government.

FIGURE 4: THEMATIC REPRESENTATION: GOVERNMENTAL GUIDANCE



5.2. FIRST RESPONDENTS

It is critical to note that the Kerala State Disaster Management Rules, 2007 defines local authority as the authority invested by law for rendering essential services or the authority which holds the control and management of civic services within a specified local area.[62]

[61] *Government of Kerala, Report of the Committee for Evaluation of Decentralised Planning and Development' (Report, 2009)*

[62] *The Kerala Disaster Management Rules, 2007, rule 2(e)*

Whereas the Rules themselves did not elaborate what the specific functions of the LSGs are on the ground at the time of a disaster, the definition suggests that their primary function has been to provide a supporting role through civic services such as food and shelter and not other critical front-line services. That said, from the period post the August 2018 floods, the role of LSGs in front-line services during a disaster itself has gained recognition through legislative changes as well as through transfer of power.[63]

Traditionally a command and control, top-down scenario has been followed during the time of a disaster with the uniformed forces and revenue authorities taking over fully at the time of a disaster. But being the government closest to the people and accountable to the people, they were directly serving as the front line of defence during the devastating August 2018 floods in Kerala. They exercised their autonomy and served on the mandate of the people, utilising existing resources, institutions and familiarity with the topography and the local demography. They served alongside officials from the Revenue Department during the August 2018 floods. And even in places where the uniformed forces were in action, they worked in close coordination with the LSGs who were from the area and familiar with the land.

Realising the need for formal recognition of the role of LSGs in disaster management, such role has been granted formal recognition post August 2018 through changes in institutional frameworks by the State Government as emphasised by the Sendai framework.

During the COVID response, their role has become even more prominent due to the social nature of the disaster. The humanitarian aspect of the disaster saw the need for welfare measures more than search and rescue as with certain sudden onset disasters like floods where uniformed forces have a prominent role.

Here though there were instructions from the State government, it is noteworthy that many LSGs took steps prior to such instruction as part of their already existing mandate and powers itself. This is in clear testament to their capacity to take such critical action due to the autonomy they enjoy through existing powers and institutions itself. The manner in which LSGs were able to utilise existing institutional frameworks for taking timely action during the first stages of the disaster proved very critical in the early disaster response and containment. Grama Sabhas, Ward Sabhas, various committees, the local level Disaster Management Planning process were all LSG mechanisms that were readily available. The LSGs were able to fruitfully engage these platforms to strategise and carry out disaster response measures engaging the local community.

Furthermore, one of the primary needs for engaging critical frameworks at the grassroot level for disaster response is in the perceptible need for contextualisation. Such quick, contextual adaptation is critical to meeting specific challenges and vulnerabilities and for ensuring inclusive egalitarian action. This is furthermore important for ensuring people's participation and people's support during such crisis situations. One size fits all approaches rarely gain the support and trust of the people. Where the people take ownership and participate, the LSGs would also be able to make such adaptation as per the needs.

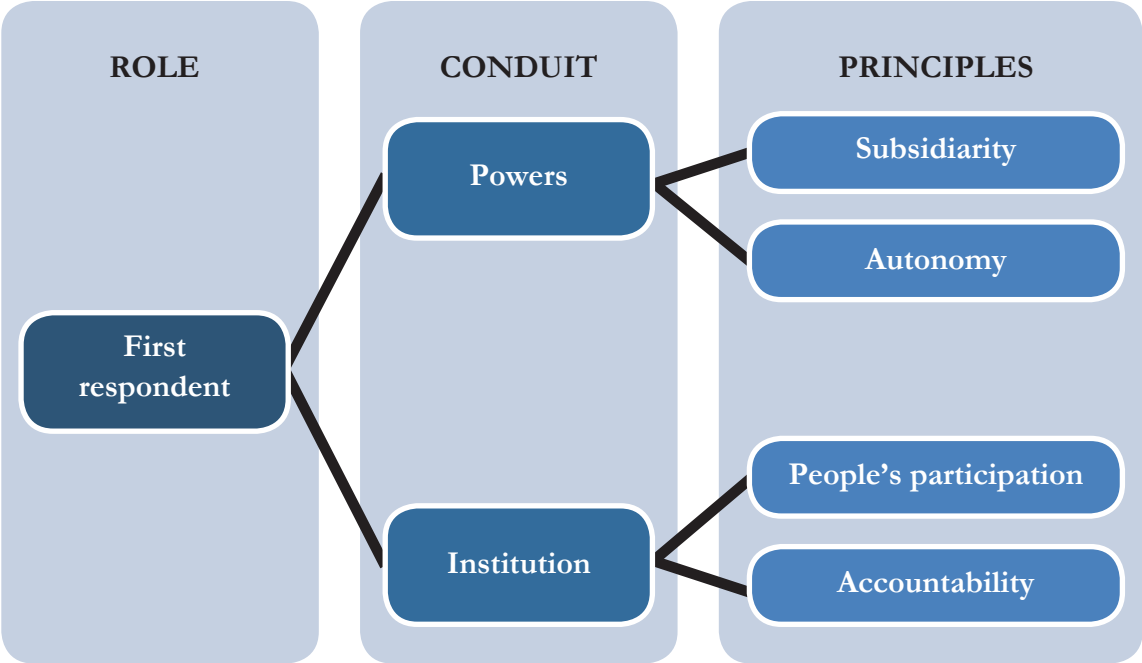
Presently Kerala has 941 Grama Panchayats, 87 Municipalities and 6 Corporations which are all further divided into wards. During the COVID pandemic, the steering committees

[63] *G.O (Ms.) No. 156/2019/LSGD dated 04.12.2019*

of the LSGs operated as the Incidence Response System, with further action being taken at the ward level through Ward Committees / Rapid Response Teams under the leadership of the respective ward members. With such an extensive network of LSGs operating on the ground, it is important to utilise the strengths and autonomy enjoyed by these elected representatives as those closest to the people to take individualised action through people's participation and community-centric approach.

The benefits of such contextual adaptation were evident in many LSGs during the COVID response, especially ones with marginalised sections residing. By taking steps such as issuing pamphlets in the local languages of the guest labourers as well as engaging translators to converse with them effectively, they were able to gain their support and participation. Steps were taken to provide guest labourers with ration and other cooking materials as opposed to cooked food from the community kitchens, so that they could cook and eat food of their preferred choice. The LSGs were able to take such steps only because of their in-depth understanding of its citizenry.

FIGURE 5: THEMATIC REPRESENTATION: LSGs AS FIRST RESPONDENTS



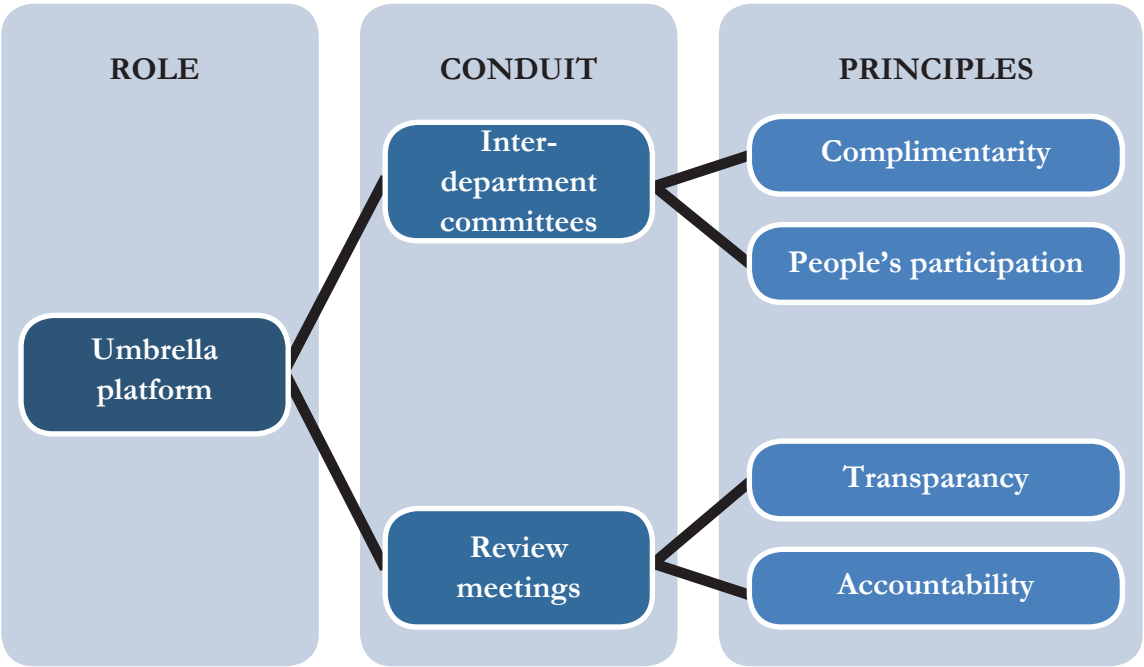
5.3. UMBRELLA PLATFORM FOR INTER-SECTORAL CO-ORDINATION AND VOLUNTEER TEAMS

The COVID pandemic saw a need for sustained integrated operations both vertically and horizontally involving different levels of government departments, volunteer organisations and civil society groups. This was especially significant due to the nature of the emergency. In Kerala the LSGs are the platforms for disbursement of social welfare pensions, schemes and for ensuring critical service delivery, which has served as the backbone of the welfare democratic state. This has been possible due to the nature of their role as an umbrella platform for coordination of activities on the ground level through the transferred institutions such as the Primary Health Centres, Krishi Bhavans, Anganawadis etc.

During recent years, their capacity to channelise the spirit of volunteerism among the youth and other organisations in their respective LSGs has also garnered attention. Critical services were provided at the ground level by the local self-governments including through dovetailing operations undertaken by community health workers, self-help groups like the Kudumbashree, trained members of rapid response teams and emergency response teams, experts from various fields and vast number of volunteers, all in a community-centric manner through people's participation. Through this, the LSGs have become the mobilisers of social capital in the state.

Furthermore, during the initial stages of the COVID response itself, multi-department committees were formed at the ward level by the LSGs incorporating personnel from the Health Department, Kudumbashree, Angwanawadi teachers, ASHA workers, police etc to take up preventive measures. Many other committees such as the Sanitation committee, Jagratha Samithi, Rapid Response Teams were formed by LSGs to serve on the ground as well. Regular review meetings which were conducted also enabled accountability and transparency, and modalities for reporting not just to the people but also to the upper echelons of government. All these instrumentalities reporting vertically to different departments were further able to complement each other's work under the coordination of the LSGs. It was important to note that many of these teams had received specialised training under the guidance of the Kerala Institute of Local Administration and line departments including the Health Department and the Kerala State Disaster Management Authority under various specialised programmes.

FIGURE 6: THEMATIC REPRESENTATION SHOWING LSGs AS AN UMBRELLA PLATFORM



5.4. HUMANITARIAN APPROACH

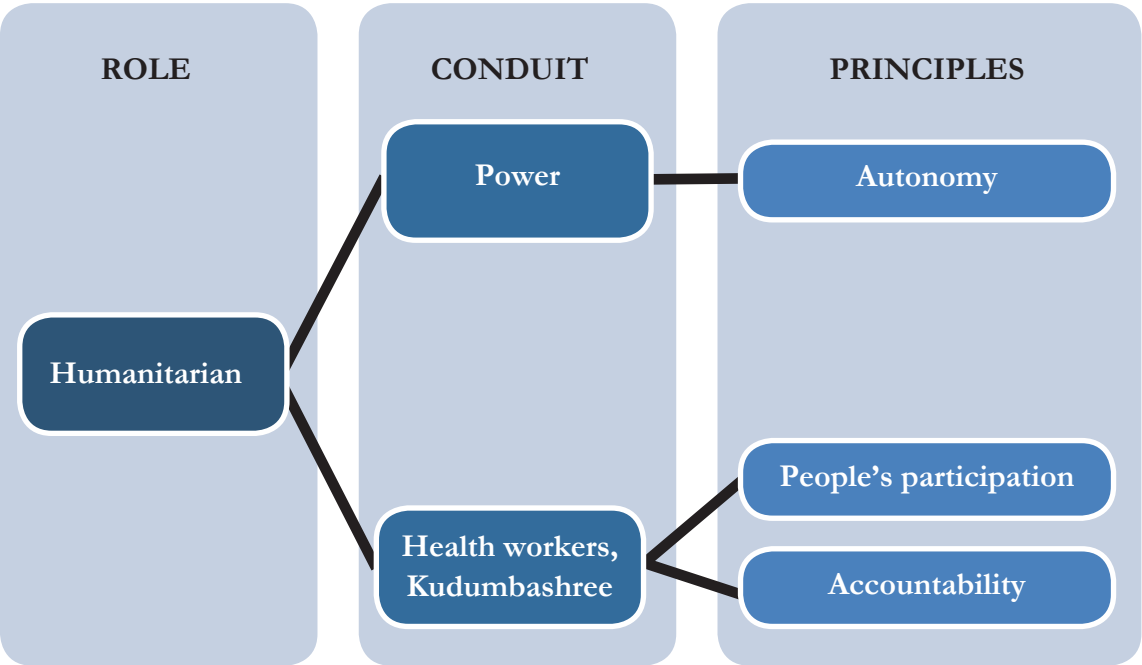
During the COVID pandemic, world over the biggest challenge for nations have been to deal with the disaster in a humane manner. In many places, the issue was seen as a law-and-

order problem with the state imposing restrictions on the people using very brutal means. In Kerala, the involvement of ASHA workers, health workers, Kudumbashree members, Anganwadi workers as well as vast number of volunteers under the Sannaddha Sena and others on the ground, who were already familiar with the community meant that the people were ready to repose trust in the system. As far as home quarantine and contract tracing were concerned, this participatory approach meant that people in general cooperated with the system and voluntarily offered information on where they had been and who they had interacted with etc.

The same was also evident in the manner the LSGs provided financial support to those facing financial difficulty as a result of losing jobs during the lockdown. The LSGs were quick to realise the difficulties faced by the people during this time due to loss of income and livelihood means. They took steps such as waiving rent for LSG owned buildings, giving instructions to building owners to waive rent and similar steps. Interest free loans were given to persons who lost jobs. Financial support was also given for MGNREGS and AUEGS workers. Extension of time was given for filing applications for services, for seeking renewal of licenses etc. These steps were all taken by the LSGs using their existing powers.

It is evident that this approach was humanitarian and empathetic. All this was possible primarily because of the participation of the community itself in the operations. One of the prominent tasks taken up by Ward level committees under the leadership of the Ward members was to ensure that households which were directed to go into quarantine were provided all needed support. Teams would visit such houses to ask whether they were in need of anything as well as to ensure that no stigma was attached to them by the neighbouring houses. Such type of crucial interventions were done by many LSGs with the whole hearted support and awareness of the community.

FIGURE 7: THEMATIC REPRESENTATION SHOWING THE HUMANITARIAN APPROACH BY LSGs



5.5. PERFORMING CRITICAL FUNCTIONS ON THE GROUND

There was a double role for LSGs as far as the COVID response was concerned. On the one hand, there were the new tasks to be done as part of COVID response, while on the other there was also the existing functions which they needed to ensure went on uninterrupted.

There were major challenges faced by the LSGs in carrying out both of these. Some of the basic functions such as waste management, sanitation, agricultural activities, medical facilities, education etc that are carried out by local self-governments in Kerala became challenging as well; considering that much of their personnel and resources were being diverted to serve the disaster situation. Funding was also an issue, due to the additional expenses as a result of the COVID response measures which had to be taken. These regular functions performed by local self-governments in Kerala gained renewed significance in the context of the COVID pandemic. It could be seen though that LSGs were able to ensure that these services were not disrupted. They were carried out effectively by the LSGs at all stages of the COVID response, and taking into account COVID specific requirements as well.

The manner in which the funds were utilised during the COVID pandemic also showed that they had the autonomy to manage their funds for this purpose.

5.5.1. HEALTH CARE FACILITIES RELATED TO COVID

Throughout the different stages of the COVID response in Kerala, the health workers at the local level were tasked with coordination and monitoring of isolation and quarantine. It is important to note that this was taken up almost entirely on the basis of COVID guidelines released by the Health Department. Throughout all the stages this involved quarantine of all those who had come in touch with positive cases as well as those who had travelled abroad. This involved contact tracing and strict monitoring. The task of strict monitoring of those in home isolation and in case of violation- reporting to the District COVID cell was assigned to LSGs by the State Government. These government orders and instructions helped bring role-clarity in an otherwise emergency situation.

During these different stages, though guidelines were issued by the Government of India on how to carry out quarantine, these were contextually adapted by the state government to suit the imminent threats taking into consideration the autonomy that vests in the LSGs. For instance, the Government of India directed that 14 days institutional quarantine be carried out for those coming from abroad through Vande Bharat flights. But Kerala permitted home quarantine for those who had facilities at home. The monitoring of the facilities and the quarantine would be carried out by the health workers under the LSGs. But for those who could not use home quarantine due to other factors such as any high-risk group residing in their household the LSGs were to make arrangements for institutional quarantine. All facilities for such quarantine centres were to be arranged by the LSGs especially food, sanitation and waste management.

Later, in anticipation of the rise in number of positive cases, the State Government also tasked the LSGs with the responsibility of finding suitable buildings within their LSGs for the purpose of converting into COVID First Line Treatment Centres where patients with mild symptoms could be housed. Here again, the facilitation including physical infrastructure, food and sanitation was to be done by the LSGs while other medical issues would be handled

by the Health Department. The LSGs were also responsible for ensuring adequate personnel to serve in these quarantine facilities. Nurses and cleaning personnel were engaged on ad-hoc basis by LSGs to serve in CFLTCs and other COVID related institutional care centres.

In all these it was clear that the LSGs had the financial, functional as well as administrative autonomy to ensure that prompt action could be taken.

5.5.2. SANITATION AND WASTE MANAGEMENT WORK

Waste Management is carried out in Kerala by the LSGs. This task became all the more challenging during the COVID pandemic due to increased use of disposables due to the emergency nature of the pandemic. There was waste being generated by the COVID related institutions as well, especially bio-medical waste. Bio medical waste was managed through an existing system of the Health department. LSGs provided support through their Haritha Karma Senas. The LSGs were also able to provide specialised training at the time for handling of such waste.

General sanitation was also a major task during this period. For sanitation of public spaces, the state government engaged many different departments including the Fire Force and Health Department during the COVID times. But it is pertinent that they too worked under the coordination of the LSGs at the local level. And for all other regular cleaning of public places such as KSRTC bus stands, labour camps, community health centres, schools, anganawadis etc, and for the regular pre-monsoon cleaning activities, the LSGs were able to ensure uninterrupted services. Further they were able to appoint extra cleaning staff as required also. Cleaning of wells were also carried out to ensure clean drinking water supply.

Realising the need for ensuring public trust and cooperation, some LSGs had even come out with innovative measures to ensure better waste management. For instance, conducting competitions to encourage waste management at the ward level.

5.5.3. PROVIDING FOOD THROUGH COMMUNITY KITCHENS FOR THE NEEDY

Providing food was also a major function taken up by the LSGs during the lockdown period with the aim of ensuring that no one went hungry. Realising that post lock-down declaration many would face difficulty in obtaining food, community kitchens were started immediately after lockdown was declared in March. Basic instructions were given as to how to conduct community kitchens, but all the infrastructure as well as funding was gathered by the LSGs themselves. The cooking itself was led by Kudumbashree members and other youth volunteers, members from various political parties – all pitched in to support including to gather funds and to manage the kitchens.

All 1034 LSGs in Kerala started community kitchens within three days of the lockdown, many of them at the ward level also. Apart from cooking itself, one of the other crucial features of the community kitchen was to ensure that the deserving got the food. With the help of anganawadi teachers, Kudumbashree workers and ASHA workers, many LSGs had managed to find out exactly who was in dire need of food. The kitchens were primarily aimed at providing food to persons who could not cook for themselves at their houses, for those engaged in COVID work, those housed in COVID institutions and for needy persons who might have gone hungry otherwise. For the last category of persons, ie, destitutes, poverty-stricken families, marginalized sections, the food was provided free of cost. After such

specialised lists were prepared, focused attention was given. This was possible only due to the extensive network the LSGs already have working on the ground and among the people.

5.5.4. AGRICULTURAL ACTIVITIES FOR ATTAINING FOOD SECURITY

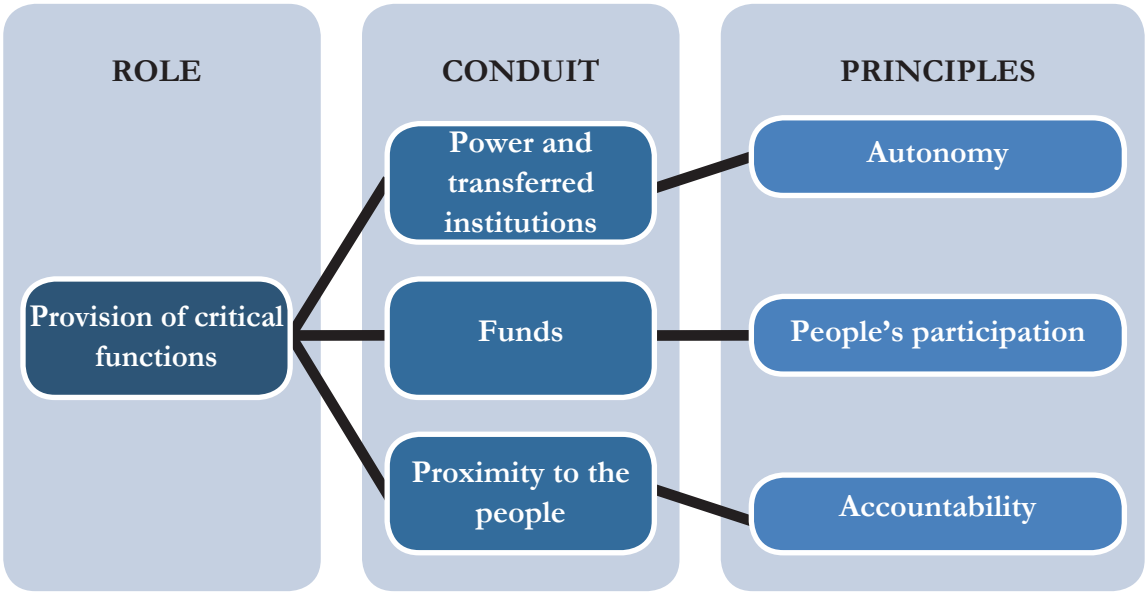
During the second stage of the COVID response, the state government anticipated a shortfall in supply of vegetables and food materials in the long run and introduced the Subhiksha Keralam scheme to ensure food security. A list of subsidy modifications was fixed and released by the State Government. The LSGs were encouraged to carry out this scheme by using all possible funds towards it. They carried out distribution and sale of vegetable seeds, kits, plants and agricultural equipment during this period through the Krishi Bhavan and through Kudumbashree workers. To encourage the participation of the people, competitions in agricultural activities were encouraged.

To avoid a fodder shortage due to the lockdown, fodder was delivered to dairy farmers. Steps were also taken to assist farmers with sale of products during this period.

5.5.5. MEDICINES AND REGULAR HEALTH FACILITIES

It is critical to note that the LSGs were able to ensure a continued supply of medicines and other critical supplies to the people. For instance, anticipating a shortfall in availability of medicines, medicines not available in the LSG were obtained and distributed from other LSGs by some LSGs. Understanding that many patients with co-morbidity issues would not be able to travel to hospitals during this time, mobile clinics were started. Telemedicine facilities were arranged for those in quarantine. Realising that many people may be facing financial difficulty during this time, medicines were distributed free of cost to patients with cancer and kidney problems. Many LSGs made sure that medical support available to elderly patients was not hampered. Support was provided for pregnant women, as well as emotional support through counselling. These were all critical tasks that LSGs took up to carry on the welfare approach

FIGURE 8: THEMATIC REPRESENTATION SHOWING PERFORMANCE OF CRITICAL FUNCTIONS BY LSGS



PART II

ROLE OF ASHA WORKERS IN COMBATING COVID-19 - SHORT ETHNOGRAPHIC STUDIES

INTRODUCTION

6.1. BACKGROUND

People and governments started recognizing and valuing the contribution of health workers more than ever before. During the coronavirus pandemic, in India ASHA workers have served as a critical link between community and state health service delivery and have been at the frontline of COVID-19 response system, conducting door-to-door surveys and identifying those with symptoms. The perception and attitude of the general public towards ASHA workers has also changed remarkably. The words of Chandrika (name changed), an ASHA worker from Thiruvananthapuram, Kerala bears much better testimony to it. "Before COVID- 19, when we approach people, a sarcastic smile would appear and they used to call us mosquito catchers, in open or in secret. But, now things have changed". But did things really change? Did our people and system really value and reward this 'Corona warriors', what they deserve?

ASHA workers face multiple challenges being a woman health worker on low wages in high risk conditions and without any adequate training. The issues of ASHAs who are women from the same community, facing similar socio-economic struggle, and continue to expose themselves to the harsh consequences of the pandemic demand a thorough and detailed investigation. ASHA workers have always acted as a 'stopgap' in the country's public health care system. Now the health and security of these frontline health workers, who keep rural populations, particularly women and children, healthy and safe, are at stake. Complete focus on the pandemic have doubled their duties and often their regular duties have taken a backseat as health services deemed nonemergency have been put on hold. Though the responsibilities of the ASHA

workers were expanded, little was done in the country to strengthen their deteriorating social and physical protection. The plight of these frontline health workers is an issue of serious concern since it not only threatens India's virus containment effort but also impacts other essential public health services they provide.

6.2. SIGNIFICANCE OF THE STUDY

Kerala has taken a coordinated and structured effort in containing the pandemic. The service of frontline workers including ASHAs under the effective leadership of the strong Local Self Governments has proven effective in contact tracing and tracking down of transmission chains. This need to be sustained and have to be developed as a model for the whole country to emulate. It is imperative that multifaceted issues of ASHAs should be understood and taken care of. More than numerical evidences it is important to delve under the skin of these issues to tackle the situation. We do think one should ask them about their lives before making assumptions and proceed to make policy decisions for them. The researchers believe that the findings of the ethnographic studies will help in truly understanding the problem and therefore design better solutions.

6.3. RESEARCH QUESTION

6.3.1. TO ANALYSE THE SPECIFIC, INTERSECTIONAL AND GENDERED ISSUES COVERING VARIOUS HEALTH, SOCIAL, FINANCIAL AND FAMILIAL ISSUES OF ASHA WORKERS DURING THE COVID-19 PANDEMIC

6.4. LITERATURE REVIEW

ASHA WORKERS AT THE COMMUNITY LEVEL, ARE AT THE CENTRE OF THE PUBLIC HEALTH SYSTEM, BUT FACE NEGLECT; THEIR ROLE NEEDS TO BE FURTHER RECOGNISED

According to a study done by Aswathi Warrier in 2020 over 90,000 women, the ASHA workers at the community level, are at the centre of the public health system especially in the rural areas have been working non-stop during this pandemic. But they are not only invisible to the nation at large, they are also the most neglected, with no protection equipment with the government classifying them as low risk. In the time of an unprecedented pandemic, ASHA workers have proven to be indispensable. But they cannot sustain themselves without proper support from administration and society.[64]

ASHA WORKERS PLAY AN IMPORTANT ROLE IN EXTENDING THE ARM OF PRIMARY HEALTH IN THE RURAL AREAS

Study by Abhay and Sanjay (2014) attributes the success of India's National Rural Health

[64] *Aswati Warrier, 'The Women Warriors Fighting COVID-19 at the Frontline: ASHA Workers Left Without Hope' (Working Paper, 2020) eSocialSciences*

Mission to Accredited Social Health Activists (ASHA). A primary health care-based health system should ensure universal coverage and access to services that are both equity-enhanced and acceptable to the population. Accredited Social Health Activist being the grass root level worker, the success of National Rural Health Mission in India depends on how efficiently is ASHA able to perform. ASHA plays an important role in reaching primary health to rural areas. She is an inevitable component in bringing health services to the grass root level by creating awareness on health and mobilizing the community towards local health planning. This has resulted into increased utilization of maternal and child health services. She has an important role in motivating people to use existing health care services and acts as a link between community and the health care system. She collaborates with local self-governments in addressing the health needs of the society. After implementation of the programme, some health indicators have shown decline like Maternal Mortality Ratio, Infant Mortality Rate and Total Fertility Rate. With the involvement of ASHA, the country has been making remarkable strides in the improvement of maternal health. ASHAs have become the backbone of National Rural Health Mission and have become an integral part of social life in the villages of India. From the perspective of the shortage of human resources for primary health care in the country, ASHAs are a important resource complementing the health system and facilitating efforts to achieve the Millennium Development Goals.[65]

COMMUNITY HEALTH WORKERS PROGRAMME COULD MOTIVATE AND EMPOWER LOCAL WOMEN ON COMMUNITY HEALTH

Study done by Gopalan and Mohanty in 2012 examined the performance motivation of community health workers (CHWs) and its determinants on India's Accredited Social Health Activist (ASHA) programme in the state of Odisha. This is a Cross-sectional study employing mixed-methods approach involved survey and focus group discussions. One of the main findings is gender mainstreaming in the community health approach, especially on the demand-side and community participation were the positive externalities of the community health workers programme. The conclusion of the study is that the community health workers programme could motivate and empower local lay women on community health largely. The desire to gain social recognition, a sense of social responsibility and self-efficacy motivated them to perform. The healthcare delivery system improvements might further motivate and enable them to gain the community trust. The CHW management needs amendments to ensure adequate supportive supervision, skill and knowledge enhancement and enabling working modalities.[66]

ASHA WORKERS PLAY A PIVOTAL ROLE IN INCLUSIVE DEVELOPMENT

A study done by Bajpai and Dholakia (2011) found that the Accredited Social Health Activist (ASHA) represents the pivotal part in the whole design and strategy of the National Rural Health Mission (NRHM), which, in turn, is a critical initiative of the central government to fulfil its promise on inclusive growth. The performance of ASHAs is, therefore, crucial for the success of NRHM and hence of the inclusive growth strategy of the government in India.

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[65] *Mane Abhay B, Khandekar Sanjay V, 'Strengthening Primary Health Care Through Asha Workers: A Novel Approach in India.Primary Health Care' (2014)*

[65] *Gopalan SS, Mohanty S, Das A, 'Assessing community health workers' performance motivation: a mixed-methods approach on India's Accredited Social Health Activists (ASHA) programme' (BMJ Open 2, 2012)*

In the primary healthcare sector, NRHM is the principal programme of the government to achieve the health related millennium development goals such as infant mortality rate (IMR), maternal mortality rate (MMR); as well as control of specific diseases, and improvement of nutrition status of children and mothers. The paper is devoted to identifying and suggesting ways in the short to medium term to improve performance of ASHAs under NRHM in India. The purpose of this investigation is not to question the strategy based on ASHAs in the rural setting but to explore and evaluate alternatives. The paper examines current and potential provisions of the recruitment, training and deployment of ASHAs in India. The paper is based on data collected through written questionnaires with ASHAs in Bihar, Chhattisgarh, Rajasthan, and UP. Where appropriate, the study has also provided key qualitative insights from the state of Assam through focus group discussion with 25 ASHAs and 4 ASHA facilitators.[67] It is in this context the present study is undertaken, an ethnographic search on the roles played by ASHAs in the times of COVID.

6.5. METHODOLOGY

The ASHAs are women from within the community. Ethnographic research is proven effective in order to develop a richer understanding of people and social phenomena from the 'inside' by observing and participating in social activities, and talking to people in their 'natural' settings. For the present study short ethnographic studies are done among 28 purposively selected ASHA workers from all the 14 districts of Kerala.

Ethnography is a research method that provides an alternative to traditional quantitative research. Ethnographers study people, social groups, ethnic populations and religious groups using qualitative research tools--e.g., observation, interview, and analysis. For the present study participant observation, non-participant observation, semi-structured and unstructured interview were employed. The field investigators visited the subjects' home, observed their life and interacted with family members; they have also accompanied ASHA workers to the field. A Common broad guidelines and semi structured schedule to satisfy the general objective of the study is developed after informal discussions with ASHA coordinators and other officials. After the field investigators' preliminary interaction with subjects, tools were finalised. Series of online meetings were held with field investigators regarding the methodology and progress of the study.

The selection of these 28 ASHA workers is not randomly done; it was altogether purposive. Our purpose was to collect the stories of ASHA workers as different as possible from each other. The major common point, of course, remained role of ASHA workers in combatting the COVID-19 pandemic. We have made a conscious effort to make it representative as far as possible. We have collected biographies of ASHA workers from all the 14 districts of Kerala. Each one who told us her story is special and unique in her own way. There are ASHAs belonging to different religion, caste, community and class. While some of them belong to tribal communities some come from fisher folk. Some work as daily labourers while some of them are members of Local Self Government. There are ASHAs who are new comers to best ASHA award winners and union leaders. Some of who work in remote tribal village and others who work in bustling towns and cities. The stories are presented as

[67] *Bajpai N, Dholakia RH 'Improving the Performance of Accredited Social Health Activists in India' (Columbia University, 2011)*

reported by our field investigators from 14 districts (names and places are changed due to ethical concerns). Narrations haven't followed a uniform pattern but each story throws light to specific, intersectional and gendered issues covering various health, social, financial and family issues of ASHA workers and their life and work during the pandemic. The profiles are arranged district wise from the south to the north.

6.6. ANALYSIS AND DISCUSSION ON THE HEALTH, SOCIAL, FINANCIAL AND FAMILIAL ISSUES OF ASHA WORKERS

THIRUVANANTHAPURAM

Thiruvananthapuram District is the southernmost district in the Indian state of Kerala. The district was created in 1949, with its headquarters in the city of Thiruvananthapuram, which is also Kerala's capital. The present district was created in 1956 by separating the four southernmost Taluks of the erstwhile district to form Kanyakumari district. The district is home to more than 9% of total population of the state. Its population density is the highest in Kerala, with 1,509 inhabitants per square kilometre.

PROFILE 1: CHANDRALEKHA

Chandralekha is the leader of 33 ASHA workers at Pulluvila Grama Panchayat, a coastal village in Thiruvananthapuram district. She learned type writing and sewing after completing pre-degree. She got married at the age of 23 to a daily wage worker whose educational qualification is only SSLC. Chandralekha has a daughter and a son. Her daughter, a final year degree student got married last year. Her son is studying for plus two.

She had been appearing for competitive examinations after her studies as she always longed for a job in her life. She joined in the Mahila Swasthya Sangham, a programme under Ministry of Health and Family Welfare in the year 2000 in the vacancy of her relative who resigned the job after marriage. The nature of work in MSS was to conduct chlorination and Pulse Polio immunisation in the area. In 2007, when NRHM notified for the post of ASHA worker, she put in her application. Appreciating her dedication in work, she was persuaded by the Medical Officer and other staff at Pulluvila PHC to apply for the post. The interview was on June 27th, 2007 and on the next day itself she had to attend the 7-day residential training. Being the mother of a ten year old girl and 5 year old boy at that time, she was able to attend the training only because of the support of her husband and his mother. Since husband shifted to her place after marriage she had the convenience to work in her own village and among the people she was familiar with.

In the initial stage, she had to face various challenges such as persuading people to take immunisation for their children, create awareness about Cholera in the early years. It had been a period when people did not even know about an ASHA worker. They did not heed to the words of an ASHA worker and kept them at a distance. Later the scenario changed and many appreciated the dedicated work of ASHA workers in the Panchayat. She tells the people that she would get incentives only if they come to PHC for immunisation. That trick yields result to her surprise. She has to visit 261 houses in a month. Since ASHA worker is a

woman, the women in the houses are ready to open their hearts on various problems. They shed their inhibitions to ask their doubts on family planning methods and even discuss sexual issues. Earlier they asked for 'Nirodh' or Copper-T in secret only. But now they are not shy to ask in front of other family members also. (I was sceptical about this claim. But for my surprise, during field visit, one woman asked about remedies for her daughter's issues in front of her husband. Her daughter also described the details without any hesitation in front of her father.)

Chandralekha had a phase in her life when she did not have any remuneration for the extensive work she had been doing. The incentive received for selected activities was a maximum of Rs.1500/- per month, and that too cumulatively once in four to six months. Now the situation is far better comparing to those earlier years. Now she gets Rs.5000/- per month as remuneration. If she could register a pregnant woman in the list and report her delivery, she would get Rs.300/- and if that delivery happens to be in a government hospital she gets an incentive of another Rs. 300/. Registration of pregnant women, support work for delivery and immunisation of children contribute to the major part of Chandralekhas's incentives. She gets a total of Rs.9000/- as remuneration and through various incentives including COVID-19 incentive. But she does not think that this is a fair amount for her strenuous work. At the same time, she is not complaining like many other ASHA workers, because it was clearly stated in the beginning itself that their work would be in nature of service only. Having suffered the hardships in life, she can not turn a blind eye to people's sufferings and doles out monetary help occasionally during household visits. She describes such an experience. One woman was bedridden and her husband could not go for work leaving her alone at home. The single room house, which has only tin walls was in a very poor condition and used to leak during rains. Since none was there to help them out, Chandralekha took initiatives to provide assistance from the Grama Panchayat. She was successful in getting the family included in the LIFE mission scheme for a good house and aided the hapless woman with her registration in palliative scheme. She feels contented when looks back at such kind acts of her own.

Chandralekha got trainings containing 8 modules over these 13 years. She also got periodical training with classes on seasonal diseases and precautions to be followed. Moreover, Medical officer, Health Inspector and JPHN always stood by her side with all possible help. Chandralekha's reporting officer is the JPHN of Pulluvila Community Health Centre (CHC). She attends all the monthly meetings and submits report in time. Chandralekha says that all the staff at the PHC is generally cooperative with ASHA workers. At the same time there are people who treat them as 'secondary' citizens. She has been invited for all celebrations and feasts organised in the PHC as she is the leader of ASHA workers. But other workers have not been invited. Meanwhile the staff members in the CHC have always been invited by ASHA workers when they organise a celebration. When the PHC staff invited Chandralekha alone for their staff tour, she did not attend it expressing her solidarity with other ASHA workers who were not invited for the same. Though she wished to organise a tour solely for ASHA workers they are yet to realise it owing to financial constraints. Since ASHA workers undergo much physical and mental strain all through their work, Chandralekha feels it will be good to arrange such recreational activities once in a year.

Chandralekha's day starts early morning at 3.30 as she has to prepare and pack food for her husband who is working 10 kilo meters away at his native village. She has to take care of her

mother–in law who has been bed ridden for some years. But for her relief her sister-in law who is living next door takes care of the food requirements of her mother-in law. Husband also helps her in household chores like scrapping coconut and washing clothes. She proudly told that her husband never asks for her salary at any cost. She has the full freedom for utilising it. But she saves the major part of her income in the local chit funds and to repay the debt in banks. Also, the husband does not have any bad habits including alcoholism. They became indebted for constructing a house and buying gold for the marriage of their daughter. They spent 5lakh rupees to fulfil the dream of her daughter to wear gold ornaments in her marriage just like the models of advertisements in Gold showrooms. Chandralekha accepts that it was her dream too to adorn her daughter with new fashion gold ornament during her marriage because she herself could wear only five sovereigns of gold.

She usually starts her field visits at 7am as she completes her household chores by the time. Then she goes to the PHC also if there is anything to be done there. She returns home by 3 O'clock in the evening. She visits approximately 35 houses a day. On other days of the month she has duty at the CHC, antenatal clinic, NCD clinic, visit to palliative patients, visit to lactating mothers and those who need antenatal care, Chlorination on the third Monday of every month, source reduction campaign etc.

Chandralekha thinks that the COVID-19 pandemic drastically increased the work load of ASHA workers. At the same time, it brings recognition to their work from common people.

She gets trainings regarding COVID-19 through online and at the CHC also. She has been working with the Panchayat staff and elected members and the CHC staff all through these days to set up quarantine centres, monitor it, monitor the COVID positive people in the field, help the CHC staff in conducting COVID-19 tests. She is also engaged in distributing sanitizer to the students and teachers while examinations are going on in the school. According to her the staff in CHC is giving utmost care regarding the safety of ASHA workers who are engaged in COVID-19 duty. When she went to a quarantine centre for the first time in a late evening, her anxious husband, worried of her safety accompanied her. But after he witnessed the care given by her colleagues, he too acknowledged the same. After the first lockdown since July, her duty was always in high-risk areas such as quarantine centres or COVID-19 test camps. She believes that she might have been prone to corona virus without symptoms and got through it. Since her mother-in law is a palliative care patient, Chandralekha had shifted her to sister-in law's house for safety in June 2020 itself.

She resumed her routine field work in October after the outbreak of COVID-19 in March. People had a bad feeling towards her in the initial days because they knew that she was in the duty of COVID-19 tests. And she herself is taking utmost care while visiting high risk category people like pregnant women, elderly people etc. "as informed people about COVID -19, we should not make issues" she is clear in her stand. She wore PPE kit once she visited a palliative patient. But it was a very difficult experience for her. She could not urinate or even drink water till afternoon.

Chandralekha observes that the attitude towards the pandemic among common people has changed a lot after the first phase. There had been issues of isolating even the family members of a COVID-19 positive patient in the village and people were reluctant to undergo quarantine. But continuous awareness among people made changes in the attitude. Now they call us before their relatives reach from foreign countries.

The risk allowance for a JHI is Rs.9000/- per month. But for the ASHA workers who are doing the most risky work among the health workers are getting only Rs.1000/- per month and that too months later. The remuneration and incentives of each month should be credited to their accounts in the next month itself based on the report they submit in the portal. These are the two important matters that Chandralekha wish to highlight.

PROFILE 2: CHANDRIKA

COVID-19 pandemic has changed the lives of people in Muttada ward (name changed), Thiruvananthapuram also drastically as in the rest of the world, in their attitudes, perception, and implementation, a much real paradigm shift. The words of Ambika, an ASHA worker at the ward level bear much better testimony to it.

"Before COVID-19, when we approach people, a sarcastic smile would appear and they used to call us mosquito catchers in open or in secret. But, now things have changed". Now people start asking "My son is coming back from UAE next week. What all precautions should we take". This is what I understand from the words of Ms. Chandrika, who is working as ASHA worker in the Muttada ward of Thiruvananthapuram Corporation. She is one among the four ASHA workers in the much affluent ward of Thiruvananthapuram.

Having not being able to complete the pre-degree course, Chandrika, learned type writing and short hand just like many in those days. Before marriage, she used to take tuition classes for school children. She got married at the age of 24 to a man who works as a construction labourer. They were blessed with a baby girl on the 8th year of their marriage.

Chandrika started her career as ASHA worker in her own ward, in 2010 under the Primary Health Centre (PHC). Although she applied for this post in 2009, she could not make it, since there was a seven-day residential training at Kovalam, for which she had to leave her daughter at home. In the next year she made it as the training went off as non- residential one. Eight women including Chandrika joined the job from her ward. Though it was non-residential, she had to put in great efforts to attend the training. The classes usually started at 9 am. So she woke up early morning to complete the household chores and entrusted a relative to send her daughter to school, who was studying in second standard at that time. She had to travel around 50 kilometres changing two buses daily for attending the training. She reached home at 7 pm after the training and then had to cook dinner and do cleaning works.

The very first activity after the training was to conduct a survey. The objective was to collect information regarding the health of each family member under her jurisdiction, which was around 250 households or 1000 of the population. She had to spend minimum half an hour in a house to collect data with a remuneration of Rs5/- fixed per house. She remembers that the data collected was very helpful in the later activities in many ways; she got acquainted with the people in her area, got information about which household should be followed up for immunisation or pregnancy related matters.

The next activity was source reduction. The reason for the nick name 'mosquito catchers' comes from nowhere else but from this activity of emptying water filled waste pots or coconut shells from the premises of the houses. Earlier people had a belief that emptying such pots were the responsibility of ASHA workers only and not at all their concern. But gradual changes occurred after six months of intense field work and much to their delight

people started cooperating very much.

Muttada is considered to be an elite ward of Thiruvananthapuram Corporation and many ASHA workers shunned working there. Chandrika got an opportunity to work at Muttada when one of the ASHA workers resigned and authorities decided to fill the vacancy. Majority families in the ward belong to upper class category and it was a common complaint that they treated ASHA workers' advices with scorn. Two ASHA workers were appointed by drawing a lot and Ambika was one among the chosen. Later the number was raised to four as per the decision of the authority that there should be four ASHA workers in a ward. Chandrika started working at Muttada ward from September 1st 2018 onwards.

Apart from the seven days training in the beginning, 4 day training of 3 modules and 3 day training of 3 modules were also conducted over the years. Thus a total of 7 modules were completed so far. Text books, notes, activities and field practical were the methods used in the trainings.

Travel allowance was provided during the trainings. But there was no remuneration or T.A for the field work in the beginning of her career. Since it was clearly stated in the interview itself that the job would be purely in the nature of service, she accepted the reality. In 2012 they started getting remuneration. It was Rs.300/- per month and that too, a cumulative amount once in six months or so. Even though it was a small amount, it meant lot for the ASHA workers as the government recognition meant a lot. After strenuous work all these years, the remuneration per month has gradually reached up to Rs.5000/-. Apart from this they get incentives for various activities like registration of pregnant women before 3rd month of gestation, immunisation at PHC etc. They have to submit a monthly report during every month. Incentives are fixed based on this report. Chandrika gets a total amount of Rs.10000/- per month. But the foremost issue she faces is that this amount is transferred to her account only once in three- four months. Arrears pending during lockdown were credited to the account in May and until September it was credited at the middle of next month. But after October, the same story again. Not any credits till the date (beginning of December). Though ASHA workers conducted online protests, solution is yet to come.

Chandrika says that her expenses always cross her income. During house visits, sometimes she has to help people who are in distress. "I could not turn my back towards their difficult situations" she told. Like other ASHA workers, she is not working in the same ward where she resides. So the travel expense is high. She has to spent Rs.130/- per day to travel between her home and work place. She has to change two buses and hire auto rickshaw for one and a half kilometres to reach Muttada. When she raised this difficulty in a monthly meeting she was asked why not she could save the money by walking that extra one and a half kilometre. But she prefers saving energy for field visits as she usually walks during field visits. Sometimes her husband helps with drop offs or pick-ups. But it would be difficult if her husband has to go for work early or gets no income because of lack of work, especially during this COVID-19 period. Chandrika says that she continues in this field only because of the support of her husband. He helps her in doing household chores such as scraping coconut and washing cloths of all family members. Still she has to wake up in the early morning at 4 O'clock to do the household chores and leave for work in time.

Registration of pregnant women within 3 months of gestation, insist timely vaccination of infants and children, bring people who have life style diseases to the NCD clinic conducted

in the PHCs on all Wednesdays and Fridays, visit the palliative patients, ensure pre-monsoon hygiene protocols etc. are the routine activities of ASHA workers. They also have to collect the details of women who live alone and newly wedded girls who come from outside their jurisdiction. There are 3000 households in Muttada now. So the number of households of each ASHA worker has been increased from 250 to 750 over the years. They have to do field duty for 15 to 20 days a month to cover these 750 houses. Apart from field duty, they have to join the palliative team on one day, visit women who live alone and pregnant women and children who are below one year on one day each. They have 3 days duty in the PHC also. The responsibility at PHC is to help the nurses and patients. They do not have cleaning duty at PHC as there is strict instruction from NHM that ASHA workers must not be assigned such works. In her experience, she has to visit at least 3 times a family to get acquainted with them and to get proper information about them. After that they would call her for anything and everything related to their health needs. Even the upper class people are also visiting PHC for NCD clinic and immunisation of children. People are cooperating in the registration of pregnant women also. But only economically backward people are coming for regular check-ups of pregnant women and palliative needs in the PHC.

Fortunately, Chandrika, 52 year old, does not have much health problems. But since she has to walk daily to visit homes she has been suffering from knee pain and if walks under the Sun she feels headache in the evening. She does not feel any stress or pressure at workplace as the JPHN, Medical Officer and other staff of the PHC are very helpful in doing her duty.

The COVID-19 affected Chandrika in different ways. The most significant impact is the increase in workload. In the earlier days during lock down there was no field duty. But she got a number of phone calls even at midnight from panic people about COVID-19. An empathetic Chandrika replies to those calls calmly, even though she never got training for counselling. She feels elated to hear them say "Now I am so much relieved, sister". After the three months lockdown, when people from outside the State and Country started coming, she had to be in the field on all time no matter whether it is day time or night. Ensuring quarantine, monitoring of people who are under quarantine, paste quarantine or COVID-19 positive sticker in front of such houses etc. were their duties. It was a rich and at the same time tedious experience for Chandrika to go pasting stickers in front of houses. They had to paste the sticker in the front gate itself. In the beginning the neighbours isolated such houses and no support were given to the family. Therefore people opposed and disrupted the activity. But she managed to convince the people about the need of sticker. "Would you like to hear news that the post man/woman, who came here unsuspectingly to deliver an appointment letter for your job, becomes COVID-19 positive?" That question itself was more than enough to make them rethink and comply with the rules.

She has been using two masks, gloves, face shield and sanitizer while she is on duty. When visiting a house of COVID-19 positive person, she has been using two gloves instead of one and removes it once she comes out from the house. The residents' association representatives used to accompany her in the pre COVID-19 time when she visits households for source reduction and other campaigns. But after the COVID- 19 outbreak she receives no such support and one cannot expect such warm gestures during a pandemic.

"People appreciate our work more during the COVID-19 Pandemic, and the government has rewarded it with an incentive of Rs.1000/-" Chandrika concludes.

According to Dr. Meenu, the Medical Officer of Muttada PHC, ASHA workers are the backbone of COVID-19 related field works. Without the dedicated support of ASHA workers, the health department would not have been able to contain this infectious disease effectively. But the remuneration they are getting is not at all proportional to the work they are doing. "People like Chandrika may not complaint about the remuneration as they had joined when there was no remuneration. But the newly appointed workers are very much concerned about remuneration".

The reports of ASHA workers have to be uploaded between 5th and 10th of every month by the JPHN. They would be entitled to get their remuneration and incentives only after this filing of reports. The reports from Muttada PHC have been duly uploaded and updated. But there is a delay in payments of two-three months. In contrast, the salary of all other staff of the PHC is credited the very next month beginning itself. Dr. Meenu says that she feels sorry when the ASHA workers complain about their low remuneration and the delay in payment. She also referred to the negative attitude of common people towards the ASHA workers. "You don't need to visit our house", "we don't need the government service" etc are common feedback from the field. Some complain about ASHA workers not visiting their houses. It happens so because while ASHA workers reach out to the houses during daytime, only elderly members would be there who usually forget to report their visits.

KOLLAM

Kollam (erstwhile Quilon) is a southern district of Kerala, located 70 km north of the state's capital Thiruvananthapuram. It is flanked by the Arabian sea on the west, Tamil Nadu on the east, Alapuzha and Pathanamthitta districts on the north and Thiruvananthapuram district on the south. Housing a population of over 2.6 million, Kollam is one of the more densely peopled districts of India.

PROFILE 3: GEETHA

Geetha belongs to a poor family. She earns her daily bread with her effort as a co-worker of her husband who is a blacksmith. They have two children. According to Radhamany her husband is good natured and hard working. Her father's home was at Karunagapally. She is the second daughter of Krishnan Achary and Radhamma. Krishnan also was a blacksmith. When she arrived her husband's house at Kadavoor, she had new dreams but know the limitations of blacksmith's earnings. She tried to improve her life with the small earnings of her husband. When her family extended with two children she focused her attention to give them proper education. She also works hard to construct a small house for them in the midst of all financial crisis, she successfully built a small terrace house.

Years later Geetha joined as a member of Kudumbashree neighbourhood group. From that organisation she got new knowledge and courage to lead a better social life and economic stability. Because of her hard working nature, punctuality and truthful nature she won the support of team members and gradually she was selected as the Area Development Committee Member. At that time, she got many group and individual training sessions. These awareness classes were conducted by Grama Panchayath, Suchithwa Mission, Kudumbashree district mission units, Agriculture Department etc. From those training programmes she got new ideas. She was inspired by the new waste management plans, composting and kitchen

gardening. She started pipe composting and Bio Gas Plant in her house. She had only three and a half cents land but she started farming in her terrace .there she arranged step by step log benches and grow plants in broken buckets, tins, carry bags, grow bags, helmets and shoes. In her terrace farm she cultivated tapioca, Lady's finger, tomato, peas, potato, cauliflower, plantain trees, chilly brinjal etc. Geetha's farming methods were very successful. She distribute seeds and plants of vegetables to her neighbours. Her good deeds were appreciated by the local self-government. One of the notable NGOs, the Quilon Social Service Society, honoured Geetha as a good farmer. She is known to all as a good farmer and social worker.

At the same time Geetha acted as a better Health Volunteer under NRHM. In the beginning she got only Rs 500/-as remuneration. She is very hard working and stubborn. With a limited period of time she won the heart of natives. She successfully worked to get proper immunisation for children and pregnant women. As part of ASHA Worker's duty she worked among old age people and palliative patients, attend monthly review meetings, participate in OP duty and house visits.

When COVID-19 spread in all parts of the world Geetha take it as a challenge. She got full support from her family and nearby people. She was inspired by the slogans of Kerala Government "Break the Chain" and "Jeevante Vilayulla Jagratha". She got training from Local Self Government and NRHM. All the councillors and officials joined together to face the situation. She taught her area members to keep social distancing, wear mask properly, the need of frequent hand washing with soap and water or using sanitizer. Thus, she successfully supports the community to reduce virus infection rate.

Geetha faced the critical situations of COVID- 19. She served the COVID-19 affected people. She herself distributed food materials, drinking water, milk, groceries, medicines etc. She supported the aged people to attain reverse quarantine, people who come from abroad were given support for home quarantine facilities. COVID-19 patients who suffered other emergency needs or difficulties were given support to get oxygen, hospitalization or ambulance services, for these she got support from HI ,JHI, JPHN, Ward Councillors and other Government authorities.

She told us that she had now so many who consider her as a relative and love her as their own daughter. The elderly people and palliative members are eagerly waiting to hear her footsteps. They want somebody to hear them and want someone to understand their feelings they found these qualities in this health worker. So she decided to live her life to give happiness, physical and mental health to the needy in her area and beyond limit.

As an ASHA worker, Geetha is very satisfied and happy. Now she is a popular figure in her locality. Now she is able to attend online training courses. She herself practices exercises and teach others to practice exercises and yoga, change their food habits and takes effort to teach others whole heartedly.

PROFILE 4: GRACY

ASHA worker Gracy resides near the shore of Ashtamudy Lake. She belongs to a family of fishers. She is born as the second daughter of Nicholas and Mable. She completed her Pre-degree from a private college. She liked to lead a life of a common house wife. Her parents arranged her marriage with Varghese Joseph who was from Vellimon, Kollam. She does

all the household chores and looks after her parents and husband. Her main aim is to give sufficient education to her only daughter. When life went smoothly her financial need also increased, to make ends meet she went outside for work as a care giver.

At this time Panchayat member informed her about the health volunteer work. She at first did not understand the importance of that, but joined it in the hope of getting remuneration. In the beginning she got only Rs 500/-. Then gradually her duties increased and she came to know about the importance of a health worker. Her daughter completed her BSC Nursing and her husband got pump operator's job in Ceramics Company. She managed to build a double storied house with the support of her husband. Her family members gave her full support to work as an ASHA worker. All the forms related to work and field meetings were prepared with the support of daughter .From 2008 to 2020 she gradually developed as an efficient health worker.

Immunization programme, source reduction programme and verification, chlorination palliative care etc. were her primary duties. Now the whole situation has changed with the arrival of COVID-19. Financial crisis, health issues, fear and distress prevailed among the people. The spread of COVID-19 and its after effects caused many tragic incidents. As a health worker she boldly faced the situation and continued her work more effectively. For this she got support from her family and local self-government. NHM team members gave frequent trainings and support to all ASHA workers. She got OP work as part of ASHA Worker duty. People belong to her service area gave whole hearted love and support.

As an ASHA worker, she joined the Neeravil Cluster Unit, organised by Local Self Government and Health Mission. She attended the monthly review meeting, informed the cluster leader regarding all details of her work in the area, supported the COVID-19 affected members, distributed food supplements, medicines, milk grocery items and drinking water to the needy people and helped the infected people to avail ambulance service. She frequently visited the service area and gave palliative care support. She also visits elderly people and gives them mental and health support.

She is very happy as an ASHA worker. Her most important happiness lays in the eagerly waiting eyes of old people and palliative bed ridden patients. These people welcome her as their own and discuss all their tragic life events and share happiness and love. She also cares them as her own grandparents and related ones. She decided to live her life for the wellbeing of these people. She is now very bold and satisfied with her health and social work. She has made up her mind to work for her entire life as a health volunteer

ALAPPUZHA

Alappuzha is the smallest district in Kerala. It was formed as Alleppey District on 17 August 1957. The name of the district was officially changed to Alappuzha in 1990. Alappuzha is a landmark between the broad Arabian Sea and a network of rivers flowing into it. Kuttanadu, the rice bowl of Kerala is in the district. It is also the most important centre in the state for Coir industry.

PROFILE 5: NEENA KUMARI

Neena Kumari is an ASHA worker from the 8th ward of Chambakulam Panchayat in Kuttanad area of Alapuzha district. She is also the Panchayat Member representing the ward.

She is working as an ASHA worker for the last fifteen years. Neena regrets that though she was interested in studies she was able to study only till SSLC due to the poor financial condition of her family. She lives with her husband, mother in law and two sons. Neena's husband is a farmer. She says that she is getting full support from her family for her work as an ASHA and elected representative. Her whole family shares the responsibility of the domestic chores, so that she can happily engage in her social and political activities.

As a ward member and ASHA worker she took the leadership of all the activities related to COVID-19 in her ward. She had the dual duty as an ASHA worker and elected representative. She coordinated all COVID-19 prevention and control activities with the help of local self-government, health department and police. Awareness campaigns, quarantine activities, contact tracing, providing soaps, sanitizers, protective gears etc. were done under her leadership.

Two Panchayat members were tested COVID-19 positive and all other Panchayat members and officials including herself were on quarantine for two weeks. The Panchayat office was also closed in the mean time. But by taking proper precautionary measures they were able to check the spread.

In another incident a priest in the church of her ward was tested COVID-19 positive. Contact tracing confirmed that the priest had attended the last rites of an old woman, who tested COVID-19 positive later. Immediate contacts of the priest were asked for self-isolation and quarantine in the building in the premises of the church. She says that there was apprehension and resistance from the public in keeping people in quarantine in the premises of the church. But she along with concerned authorities convinced and pacified the people.

She also recounts the incident of cremating two people who died due to COVID-19 by following COVID-19 protocol and not by abiding to religious belief after getting the support from their relatives. She believes her role as an elected representative and ASHA worker are complementing each other and so she is able to get recognition and support from the people and authorities. She feels satisfied and happy with her as an ASHA worker.

PROFILE 6: UMA

Uma, ASHA worker from the 6th ward of Chambakulam Panchayat, Alapuzha district successfully contested the recently concluded local self-government election as a Block Panchayat member. She is representing the intermediary Panchayat from her division for the second consecutive term. Uma's husband is an Ex-Service man, now he is working as a security officer in a private company. Uma had completed Pre-Degree. They have two sons; the elder one is working in a mall owned by a multinational company, the younger one is working as an engineer in Bangalore after completing B.Tech.

She joined as an ASHA worker in 2008. For the last 12 years she is engaged in antenatal care, palliative care, immunisation of children, diseases prevention activities during rainy season etc. She herself has initiated fundraising for transplant of a Kidney patient. She was awarded the best ASHA worker. She conducts frequent home visits to check on the welfare of old citizens and people living alone.

From 2019 March onwards her life and work had a drastic change, due to COVID-19 outbreak. Since then she is engaged in awareness raising contact tracing and quarantine activities. She

says she confronted such a situation only during floods. At a point of time her ward was declared as containment zone. More than 400 people were tested in her ward among them 10 people tested COVID-19 positive. In the initial days she herself was panicky. She had to seek medical aid to de-stress herself. The doctor advised her some therapeutic exercises and thus she overcame the situation. By wearing PPE kits she accompanied COVID-19 patients to hospital in ambulance. She collects address of people returning from gulf countries and other foreign countries and makes arrangements for quarantine and COVID-19 testing.

She says that the JPHN also assists her in all the activities. She is getting all the support from the health department and PHC. She proudly says that she is able to do all her assigned duty without any complaint from the public and as per the direction of the health department.

PATHANAMTHITTA

Pathanamthitta District is a district in the southern part of Kerala, India. A hilly province of pristine splendour, the district of Pathanamthitta is hailed as the headquarters of pilgrim worship in Kerala. Three rivers course through its prosperous terrains comprising natural divisions of the lowlands, the midlands and the highlands. Interspersed with temples, rivers, mountain ranges and coconut groves, more than fifty per cent of the total area of this region is covered by forests. Pathanamthitta is one of the richest districts in India with just 1.17% poverty as of 2013, which places the district among top 5 districts in India with least poverty.

PROFILE 7: SAJANA

Sajana, is the youngest of the eleven children of Muhammed Ravuthar and Aiysha. Her father died when she was very young. Her mother had to bear the burden of the family including the education of the children. Her mother however succeeded in providing good education to all her children. Sajana completed her Pre-Degree. She got married in 1997 to Mr. Shajahan. She has three sons, all of them are students. Her family went through a lot of financial crisis; she took up the job of ASHA worker in 2009.

After her household duties she concentrates on her job. Though she has a lot of responsibilities as a wife and mother she carries on her ASHA worker duties happily and sincerely.

Their normal duties including providing benefits of JSY, MAA, providing vitamin supplements, immunization, vaccination for different age groups, sterilization, palliative care, conducting yoga class, cookery show, physical exercises, referring to mental health programmes, visit to houses of vulnerable groups, duties related to Ardram mission, support for cataract surgery etc.

As an ASHA worker she has to fulfil all the above mentioned activities to receive their honorarium and incentives. From a meagre amount of salary it has now been hiked at a very low pace to Rs.5000. They can get only this small income and they do not get time for any other activities or work.

They have to conduct survey during their duty hours. The ASHA workers get good support from JPHN and JHI of the PHC and they work together as a team. ASHA workers have proved themselves to be a part of the team. Two days in a month they have duty at PHC to help the nurse and patients. According to her most people who depend on PHC are from poor and weaker sections of the society. One ASHA worker per 1000 population is the ratio.

Therefore one ASHA worker has to take responsibility of a ward in the Gram Panchayat. In the initial stage the honorarium was meagre, from Rs 200 per month it was hiked to Rs 300. This amount was not regularly paid. They usually get it once in two months. But still they carried out their responsibilities whole heartedly.

Their responsibilities include registering pregnant women of their respective wards in their first trimester, promoting vaccinations of the children of the ward according to the national immunization schedule, attending to the palliative patients with the palliative staff, also house visit to make sure that all are following the proper measures to keep up the hygiene as part of pre-monsoon sanitation activities. They have to attend to the field work at least 15 -20 day in a month. In addition, they have to visit the palliative care patients with the palliative team.

COVID -19 pandemic added to the hardships of every ASHA worker. They had to arrange quarantine including putting up stickers and providing maximum needs to the people from abroad and those who came from other states. Thus, they had to spend more time in the field. When all were safe at home during COVID- 19 the ASHA workers were at the field which was really a threatening situation for them. But it was during this time they were regularly paid. There had been cases where an ASHA worker had to face the outburst of people who are in quarantine. They also had the responsibility to prevent these people from becoming socially isolated. They were to give them proper advice regarding the importance of quarantine in preventing the spread of COVID- 19. Preparing the contact list of COVID-19 positive cases were also their job. During the COVID-19 times, she used to provide medicine to the aged (above 60) to their homes.

According to Sajana the services that an ASHA worker rendered to the society during the COVID-19 days gave them a good position in the society. Considering their activities, the government hiked their incentive to Rs 1000. Considering the risk of the job they under take the amount is too meagre, she feels.

They used all the protective measures like masks, sanitizers, gloves, face shields for their field work. Considering their hardships during these difficult times of COVID- 19 they hope that the Government would take proper measures to give them a deserving remuneration.

PROFILE 8: SANTHI

Santhi is the youngest of the 6 children of the Late Chandraswami Chettiyar and Gowri Amma Her father was in police service. She is married to Ramdas, in 1986. He runs a petty shop selling unniyappam, cakes and tea. They face a lot of hardships financially. Despite these hardships they succeeded in providing good education to their two daughters. Eldest daughter is an M.Sc, B.Ed degree holder. Youngest one passed TTC. Both are married. Santhi has a lot of responsibilities including helping her husband, looking after her in-laws in addition to her household duties in the joint family. She complains that she does not get time for any other activities.

She took the job of ASHA worker when she was formerly working at MSS. She passed SSLC. She is very happy to work as an ASHA worker. She is always there to help the needy. Santhi, lists the people whom she renders her service, like newborns, children, newly married couples, pregnant women, breast feeding mothers, people with life style diseases, senior citizens, differently abled, palliative patients. Thus, she touches all the people of her locality.

To get honorarium and incentives an ASHA worker should fulfil activities like Health Activity Assessment Report, Report on ward health activities, review ward matters, attend review meeting at the sub-center, hospital duties as part of the Ardram Mission, Immunization duties, clinic for pregnant women and palliative care for all patients. Apart from this they have to do the listed duties also like on health, nutrition, basic sanitation, hygienic practices, healthy living and working conditions, providing information on existing health services and need for timely utilization of health and family welfare services. Birth preparedness, importance of safe and institutional delivery, breast-feeding, immunization, contraception, prevention of RTI/STI other RCH issues. Facilitate the access and availability of health services in the public health system at the sub center, PHC, CHC and district hospitals. Work with the Village Health and Sanitation Committee to develop the Village Health Plan.

Santhi opines that in her panchayat, ASHA workers get good support from JPHN and JHI. One ASHA works for a population of 1000 people. Their responsibilities include registering pregnant women of their respective wards in their first trimester, promoting vaccinations of children in the ward according to the national immunization schedule, attending to the palliative patients along with the palliative staff and pre-monsoon sanitation activities.

COVID-19 pandemic has increased the responsibilities of ASHA workers. They had to arrange quarantine to the people from abroad and those who came from other states. They were in fore front of government's "Break the chain campaign", sensitizing people regarding personal hygiene and physical distancing. They have worked along with health team, Local Self-Governments and police. They used all the protective measures like masks, sanitizers, gloves, face shields for their field work.

KOTTAYAM

Kottayam is the land of letters, lakes and latex. Flanked by the Western Ghats on the east and the Vembanad Lake and paddy fields of Kuttanad on the west. The district shares borders with Ernakulam district in the north, Pathanamthitta in the south, Idukki on east and Alappuzha on the west. The area's geographic features include paddy fields, highlands, and hills. It is a central Travancore district with 2,208 sq. Kilometres area and a population of 19,52,901. Moovattupuzhayar, Meenachil Lake and Manimala Lake are the three rivers that pass through the district. Kumarakom, which lies a few feet below sea level, is situated in the western border of the district. It is the first city in India to achieve 100% literacy also the first tobacco free city of India.

PROFILE 9: RUPA

Rupa was born in Kalamboor, a village in Piravom Municipality, Ernakulam district. She is the eldest child of Chandran and Shyama and has a younger sister. Her father is no more, and mother works as a house maid at a house in Thripunithura.

Rupa did her bachelor's degree but did not clear all the exams as English papers were tough for her. When she was learning typewriting, she fell in love with John, a tailor from Mulakkulam. Despite the objection of the families, they got married and have 2 kids now. Eldest son is Nithin, who is now 20 and is a trainee at OEN Company. Youngest son Naveen is a 9th standard student. John had plenty of tailoring work before COVID-19 and used to stich school uniforms for students as well. However, schools being closed due to

the pandemic affected his income. They depend more on Rupa's small income of around Rs. 8000 nowadays. Nithin earns around Rs. 7,000 a month but they are content with what they earn. They have some debts and their house was built with Rs. 1.5 lakhs allotted from the Panchayat. Even though the construction is not yet completed, it is secure and it is their home.

Rupa's family was happy with her working as an ASHA. Her in-laws worked in paddy fields doing sowing, reaping etc. This was not a familiar job for Rupa and it was a challenge for her in the beginning. Once husband's brother got married and his wife became close with Rupa, a lot changed for her. They became best friends very soon and started going everywhere together. She helped Rupa in overcoming the challenges she faced with household chores and work in the paddy fields. Two years back her brother-in-law passed away. Rupa supported and took care of his wife and kid as they were very dear to her.

Rupa became an ASHA worker in 2009. During training, she had to stay away from home for 7 days. Her second child was only 2 years old at the time and Rupa's mother Shyama came to her home to take care of the kid during those days.

First year on job, it felt more like a service as she hardly earned anything during this time. After that she started earning Rs. 600 per month. Still she stayed committed to her work. Now she is earning Rs. 8000 per month and keep collecting health related data and other details from 220 families under her responsibility, which includes:-

- Children
- Newly Married couples
- Pregnant women
- People with lifestyle diseases
- Senior citizen
- Differently abled and other patients
- Bedridden patients
- Breast feeding mothers

And now additional COVID-19 related data like

- New COVID-19 patients
- People in Quarantine/Observation
- People who came from outside State/Country
- Recovered COVID-19 cases

She collects these details at the panchayat level, and the consolidated report is sent to the district authority daily as she is the leader for the ASHA workers in the whole panchayat.

The following are the day-to-day activities of Rupa: -

- Registration for the patients at O P counter

- Helping the palliative care team
- House visits to monitor the condition of bedridden patients
- Activities related to Vaccination
- Supply the preventive medicines for Leptospirosis and Filariasis to all the families
- Supply bleaching powder for the needy and help them with the chlorination of drinking water.
- Collect the details regarding people with lifestyle diseases.

COVID-19 related special duties.

- Assist during the COVID-19 test ensuring the test sample does not get mixed up
- Collecting the details of the COVID-19 patients
- Collecting the details for the people who are in isolation and ensuring they get enough support regarding their health
- Supplying necessary medicines for people with lifestyle diseases at their home during COVID-19 times.
- Supplying preventive medicines for Leptospirosis for people who are working as per National Rural Employment Guarantee Scheme, people who forage for cattle and people who cowherd at their homes.
- Collecting the names and phone number of people who come to hospitals in relation with COVID-19 (Before and after quarantine, testing etc.) and providing them sanitizers and ensuring they have enough facility for sanitizing hands at hospitals
- Collecting all COVID-19 related details from all the ASHA workers in the Panchayat, consolidate the data and reporting to the district authority.

Personal information on Rupa

Health: She feels unwell and faces mental stress during menstruation. She was unable to discuss this with her kids. When she acts differently during these times, her kids usually ask casually if mom has gone insane. She faces severe headache and physical unrest. She had gone through two abortions, one before her eldest child and one after that. She suffers from the difficulties due to Rheumatoid Arthritis as well. However, her husband and kids usually share her household chores like cleaning, which is really helpful for her.

When she started as an ASHA worker, her husband was strict regarding the time she reaches home. Due to this she used to get worried that she had to get home before 12.30 in the noon during any programs. This was very stressful for her and her husband used to call multiple times to check on her. Finally, her friends started answering the call explaining they were also working like her and they also have a family to take care of like her. They explained to him that it was stressful for her if he keeps calling her every minute preventing her to work peacefully. After a few instances like this, Jose understood her situation and changed. She justifies it as over possessiveness of her husband that caused this behaviour.

Financial condition: Husband is a tailor and elder son is a trainee at a privete Company earning Rs. 7000 a month. Younger son is a 9th standard student. They have moved out from husband's house and make their own home with the 1.5 lakhs allocated from Panchayat for building their house. Even though the house is not yet completed, it is their home. Their house is located in a low-lying area which is affected by flood every year. So, every year they have to shift to relief camps during flood season. They have some debts including money borrowed from Kudumbashree and a private finance company.

Education: She did her degree course in Hindi. She was not able to clear three papers of English. She has learnt typewriting.

Social life: She is very 'social' with everyone and well-mannered with people. She is very committed to her profession. Everyone including the doctors at the PHC, Health inspector, other ASHA workers in the panchayat, JPHN etc. have excellent impression on her. JPHN have seen her house and the situation during flood in 2018 and has helped them by supplying whatever was necessary there. During special occasions like Onam and Christmas, they make sure they celebrate it with everyone without any discrimination. They make sure to celebrate with other ASHA workers as well as the health workers together. ASHA workers have a financial scheme that they set up, where 17 people will collect Rs. 17,000 and in case anyone is in need, the amount is used.

PROFILE 10: JANAKI

Janaki was born as the third daughter of Sreedhari and Ganesan at Thonnalloor. She passed SSLC but could not pursue higher studies due to financial problems. Her parents were farmers in leased land. She had two brothers and two sisters. Janaki was working as a helper in a pre-primary school near to her home and was earning Rs. 300 per month. She married Gopi and settled in Mulakkulam panchayat. She could not continue her job after marriage because of distance. Her husband used to work as a casual labourer in a Newsprint Factory. As company has shut down, he is now going for other casual work. Her house is not completely built. But they had no debts. So, they are living a peaceful life in that house with their only son. She joined the duty of ASHA worker in 2009. She had gone through 8 module training and is doing her duties sincerely so far.

Her normal duties: -

- She has to do the OP-counter registration of patients in Public Health Centre
- She accompanies the palliative care team for house visit of bed ridden patients and she will talk to them about their children and other things to distract their attention while the nurse changes the tube which helps to reduce their pain.
- They should give report to district authorities about various health issues like life style diseases in their area.
- She does regular house visits and distributes preventive medicine for Leptospirosis and Filariasis.
- During house visits she gives bleaching powder for chlorination of wells and water tanks.
- She is the ASHA worker in charge of 270 families
- She was very active in organising flood relief camps during 2018 and 2019.

Other duties she is rendering during COVID-19:

- In PHC she has duty of registration of people who visit the PHC with their phone number.
- She has the duty in OP-counter registration of patients.
- She delivers medicines for patients with life style disease to their home.
- She visits the people in quarantine keeping distance and enquires their health issues and needs.
- She is supporting the health inspector during the COVID-19 test procedure, ensuring the test sample does not get mixed up.
- When people come from outside the state/country she should give them enough information about their facilities in quarantine centres and their procedures.
- She reports daily to district authorities about the number of newly infected people how many they have there in quarantine/observation, how many got recovered from infections etc.
- She attends online meeting and classes concerned to COVID-19 precautions and preparations at intervals from district authorities.

Janaki's personal details

Health Problems: She is suffering from severe rheumatic pain in joints. She had undergone surgery in the breasts for removing 'growth'. Despite all these problems she is very active in her duties. Her husband, knowing her health condition do share the house hold work.

Education: She has passed SSLC in 1987, but couldn't continue higher studies. Now at the age of 50, she is trying to appear for Higher Secondary exam through Saksharatha Mission.

Social: Janaki is a jovial person by nature. She greets everyone with a pleasant smile while in the registration duty in PHC. She helps her co-workers and neighbours by bringing medicine and bleaching powder for their families on her way to home after work.

IDUKKI

Idukki district of Kerala is known for its landscape; mountains, hills, forests and spice gardens. It is one of the 14 districts of Kerala and was created on 26 January 1972. Idukki which lies amidst the Western Ghats of Kerala is the second largest district and has the lowest population density in the state. It has a vast forest reserve area; more than a half of the district is covered by forests. Idukki is also known as the spice garden of Kerala.

Kumily Panchayat of Idukki district comes under Azhutha Block Panchayat. Kumily is the largest Gram Panchayat of Idukki. Kumily is also a doorway to Tamil Nadu. Five ethnically different tribal communities; the Mannans, the Paliyas, the Uralis, the Mala-arayas and the Malampandarams have settled in Kumily panchayat, mainly on the outskirts of the Periyar Tiger Reserve. Though they used to earn their living through traditional occupations like fishing and agriculture, with the advent of eco-tourism initiatives, they have found alternative jobs. They actively take part in the tourism-related programmes and serve as guides for

tourists or as forest guards to prevent poaching and other illegal activities.

PROFILE 11: LEKSHMI

Lekshmi is a resident of Paliyakudi and belongs to the Scheduled tribes. She is now 53 years old and healthy. She doesn't own or have a motor vehicle and the means of transportation are pretty limited in these areas. It is not a bus route and is really close to the forests. You would have to either get a taxi; auto-rickshaws or walk if you do not own a vehicle. We would pass the Government VHSS TTI which is also known as the Kumily Tribal School, PHC and an Anganwadi before reaching her home. The houses are not nearby, but the community is well connected.

Lekshmi lives with her son Sunil and daughter in law Sangeetha. She was married to Gopalan in 1987, when she was 19 years old. Her native place is Thamarakulam, Alapuzha district. Lekshmi was the only daughter of Saraswathi and Karuththakunj. She has four elder brothers. She completed her schooling in Kayamkulam. Education was not given much importance at that time and she discontinued after 10th standard. But she is very glad that she could learn so much about public health and serve her community being an ASHA. She has completed all the 8 modules of training and is actively participating in current trainings. Her husband passed away in 2011. He has been very supportive in her role as an ASHA. She also has a daughter, Chandrika, who now resides in Kattappana with her husband and family. Sunil stopped his studies after 10th and is currently working in an automobile workshop in Kumily. Both Ambili and Sangeetha have completed degree. Sangeetha has been going for vocational training; tailoring and hopes to find a living through it. Whereas Chandrika has been trying for a government job and is in the rank list for Health Inspector. Lekshmi was very concerned about her children getting a good job. She feels that it is really hard for indigenous people to get a "good" job. She also says that this is a pattern among the people, boys tend to stop studying after 10th or 12th, but girls try to earn a degree. Most men employed by the government, among the tribals are working as forest protection officers/watchers in the forests. Apart from that most of them struggle for a living or does cheap labour.

Lekshmi works in the 11th ward of Kumily Panchayat. She has been an ASHA since 2007 and has worked with the MSS before that; from 1994. She has worked in Mannarkudy, Thekady and Valakadav, among the Paliyans, Mannans and Malampandarangal tribes.

Lekshmi has worked mostly with tribals and feels that, it is one of the main reasons why she is being treated with respect, in comparison to her ASHA colleagues who works in other parts of the Panchayat. She works in Mannarkudy and takes care of around 320 houses. She explains how the people look up to her and listens to her instructions. Though in some places there is still a problem with the livelihood and cultural gaps.

In 2007 she has worked the whole year without any kind of remuneration; it was from 2008 they started to get an honorarium of Rs. 500. It has been increased over the years and has reached Rs. 5000 by April 2020. She says that she came into this work so that she can be helpful to her community and saw it as a service. Even now when she talks about a year of work without remuneration, she does not complain about it. But she also opines that it would be better if they could get a decent wage for their sincere work. She visits all the 320 houses monthly, and visits those in need more than once. She responsibly checks on elderly citizens, pregnant women, new born babies, children who are in the age for different

vaccines, people with lifestyle diseases etc.

One of the challenges that she faces in her area is that there is a lack of education and awareness about health and hygiene. Some of them have been forced out of their dwellings and are still finding it hard to live outside it, in concrete houses built for them. They would still prefer to sleep in their yards and rely on forest resources for food. She shared the story of Kamala (name changed) who had a miscarriage at 5th month and was not coping well. Even though Lekshmi have tried her best to support her, her husband is a drunkard. They don't even have their caste certificates, without which it is very hard for getting any kind of government services under various schemes.

While sharing her experience with the JPHN, Lekshmi said that there are no conflicts with her and that they treat her with respect and care. When asked, whether they respect her work and sincerity, she said that more than that they stand as inspiration and have the responsibility of two wards, where as we as ASHA only have to take care of one ward. She said that, they are very cooperative and considerate.

On the day of field visit, Lekshmi would get up early, as usual, finish all the household works, including preparing lunch and would leave home by 9 in the morning. She has to walk around 6-8 Kms to visit houses in Mannarkudi. Even after the COVID-19 outbreak, Mannarkudi has not changed much. She says that people would always listen to her and mostly follow the instructions responsibly. She would continue her visits till 2.30-3.00pm and return home. It is in December, 2020, Mannarkudi reported its first case of Corona. It was a young man who had travelled to Ernakulum for work. The patient had sufficient facilities at home and was instructed to be on home quarantine. Lekshmi says she was initially worried whether it would spread. But the patient and family strictly followed precautionary measures. They would call Lekshmi in case of any doubt and she was always ready to help.

Lekshmi does not have a smart phone; she uses an old model phone. Even though she does not consider it as a problem at all, smart phones have turned to be a necessary gadget, particularly for a person whose timely communication is so valuable for the area. Most of the trainings are conducted in Zoom or other digital platforms. In order to access these trainings, Lekshmi, along with two other ASHAs would choose one of their houses and borrow their children's smart phones for that duration. When these Zoom meetings are turning into essential training platforms, the state has the responsibility to ensure that its frontline workers can access such means. There is no allowance to recharge their phones; which they use to keep everyone updated and check on them. Whenever I was with Lekshmi, I have noticed that she got calls over calls, asking about all kinds of doubts regarding Diabetes medicine, iron tablets for mothers to updated quarantine guidelines. When phone is an important tool in their work, it should be considered as such and there should be provisions made for the same.

The main problem that she faces during these tough times is the lack of decent wage. With all added up, considering the honorarium, incentives and COVID-19 allowance, the maximum that she would receive is Rs. 7000. It is only recently that the payments got regular. There are still so many terms under which ASHAs receive this amount. They have to submit a very detailed monthly report. It is on the basis of this report the incentives are calculated, so it had to be well managed. She thinks that unions can bring changes to the existing conditions. Though she is happy with the way people treat her, she is very well aware of her fellow

ASHAs' problems and how some people treat them badly. She also said that there is no union in Kumily, because it would be hard for a close knitted group like theirs to go into different parties and blame each other. But still she hopes that the unions would be able to pressurize the government and create better conditions. There are no provisions for leave, travel allowance or any other security.

PROFILE 12: CHINNAMMA

Chinnamma is a 52 year old ASHA from Kollampattada. Her place is just 2 Kms from Kumily town. But the road to her place is so steep and uphill. It is not a bus route and is comparatively a smaller road where only one car could go at a time. It is also near to the forests and the houses are not nearby.

She has two daughters and their education has always been a priority for her and her family. Before becoming an ASHA, her children were in school and she concentrated on taking care of them. Chinnama is very proud of her daughters and is really happy that she spent time on them in their childhood. Her eldest daughter, Chinjuumol is 28 years old and is currently pursuing Phd in Physics in Mumbai, with a Junior Research Fellowship. Her youngest daughter, Dalmia is 25 and has been preparing for the Mains, she is a civil service aspirant. Her husband, Sajan is a postman and has been supportive in Chiinamma's decisions. Chinamma is the daughter of Ajitha and Kunjachan. She could not continue her education after 10th; later on she studied to be a lab technician, but has not taken it up for career. In her perspective, being an ASHA has helped her learn more and more about public health; vaccines, lifestyle diseases, palliative care, antenatal and post- partum care etc. She has completed all the 8 modules of training and has taken various other trainings. She is very enthusiastic about these and considers them as a very good opportunity to learn and explore more. Even in the times of this pandemic, she is attending all the online and offline trainings.

Chinamma works in the 7th ward of Kumily Panchayat. She has been an ASHA for 11 years. Walking up the road to her place, my first concern was how she visited houses. Though it is just 2 Kms, it is very steep and a hard walk. She does not own a vehicle and usually walks. At times her husband would drop her on their motorbike. She is diabetic and has problems because of it. In her 11 years of service, she worked the most in Kollampattada (9 years), but now she works in Kumily and some parts of Mannarkudi.

Chinamma is responsible for 428 houses, among which 123 are tribal households. She works mostly in Kumily town and Mannarkudi. She says that she has had incidents where people do not welcome her, when they know that she is an ASHA. They would look down on her, would say things like "we know about our health" and "we are always clean, we are educated" and ask her to leave. She does not take offence in it, rather says that she can spent more time on people in need, people who would need help in accessing health care or any other related schemes.

As of now she gets an honorarium of Rs. 5000 and incentives in addition to that. Until November 2020 she has received the COVID-19 allowance, but it has stopped now. Irregularities in payment were a reality of this work until April 2020, but the government started acknowledging our work and its importance, in midst of a pandemic, says Chinamma. She strongly argues that, ASHAs are not given due respect or remuneration and working conditions. There is no ASHA- workers union in Kumily Panchayat and even if there are

unions in nearby Panchayats, it is of not much use.

While explaining about her routine, Chinamma shared a few stories, which she thought was very important to let the world know. One of the main points she said was "we are humans," people should realize that we are human beings just like them, some people treat us like we are their servants. "There would be very healthy, able bodied, young people, who would be going for all the functions, let it be engagements, weddings, house warming, baby shower, what not? And they would easily give the prescription slip to us, we would have to take OP tickets for each person, consult the doctor, go to the pharmacy and collect medicines. If it is for one or two people daily, it would not be much of a problem. But when it becomes 15-16 people per day from different areas, it is very hard for me to do it alone. It would take me a day to consult the doctor and collect the medicines. I would go and distribute it the next day, by then there would be another group calling me for their medicines. And it is very risky as we carry all these medicines together and there are chances for misplacement. I am not a pharmacist or doctor to understand all these medicines. If there are healthy, low risk people at home, they should reach out to the PHC themselves".

Another story that she shared is her experience with palliative care. She would talk on and on about the Nurse who is in charge of palliative in Kumily. "She is an inspiration for all of us, with her sincere work and kind behaviour". Chinamma further continued to share how some of the people treat their elderly parents or in laws. She says that, it is only because we visit their homes and question the conditions; otherwise they would be treating this people very badly. "I am sad for the parents, they would have done so much for their children and then, when they need them so much, they treat them without basic dignity". The case of Manaiyan, a 55 year old man, who is half paralyzed and needs help for everything was lying in his own excreta, in an open terrace, with roofing only. These aluminium sheets are the only thing preventing him from being drenched in rain. "When we asked him, why aren't you insisting on sleeping inside, he said 'what can I do?' Then we had to talk to his son and daughter in law and threaten them with legal action before they agreed to move him down stairs. It is very obvious that they won't treat them with the basic necessities, if ASHAs didn't visit houses regularly".

She was so keen to talk about the problems people in her area faced, more than her own problems. She shared the case of Kochumon (50) and Aliya (42) from Range Officemedu, who were HIV positive and is struggling without a proper house. Chinamma has tried so much to ensure that they get a house, but it hasn't happened yet. She explains how Aliya recently underwent a surgery and is now on wheel chair. This has affected their lives even more. They live in a small hut, with a single room. They have food, sleep and use the commode in the same small space. It is heart wrenching to see their lives in that small hut.

The JPHN for the ward, who Chinamma fondly refers to as Sini sister, is about to be transferred from the PHC. Chinamma is anxious about how things will be afterwards. With Mini sister, she has a good connection and space to express her concerns. She feels respected and heard, but is anxious about her transfer, as problems with JPHNs are quite common. "It would be really hard to work under someone who wouldn't respect you, your work and boundaries. Most JPHNs do not have a good relation with ASHAs, as they think our work is inferior; of no particular value".

In the initial days of the pandemic, people would listen and acted responsibly. Chinamma

says that there is indifference now. "The shop owners and shopkeepers of Kumily town are the most uncooperative among all. They wouldn't wear masks properly, or keep sanitizers in front of the shops, wouldn't responsibly follow social distancing, nor ask their costumers to do so. As of now there have been a total of around 40 cases in 11th ward alone. Still people don't take us seriously. One of the biggest concerns is people breaking quarantine and putting others in risk". Some people would agree to follow all the instructions and would break them as soon as we leave, complains Chinamma. She further explains that there are people, who are afraid of us, as we visit houses and PHC, they are afraid that we would expose them to the virus. But we take all necessary precautions and are ourselves very cautious about everyone's health. We would never put another person at risk.

Another problem that Chinamma faces is the status associated with the job and the nature of it. "People think of ASHAs as some unskilled, untrained poor women with means for no other job. She says that, I would never drink a glass of water from any house that I visit, because, if I do so, they would judge me as someone who is looking for their mercy rather than someone who is providing service. Whenever people ask me about the remuneration, I would lie. If I say the real benefits, people usually look down on me and asks me why I do this. I am doing this work considering it as a service, but I should be able to provide this service and also benefit from it. There is no travel allowance. There are no proper guidelines for leave. There is no guarantee that we would receive the incentives or the honorarium, we would be at the mercy of the HI and others who could always choose to reduce the remuneration. All we want is apposite remuneration for the work we do. If the state acknowledges us as essential workers, it has the responsibility to treat us as such".

ERNAKULUM

Ernakulum is a district of Kerala, India. Situated in the central part of the state and spanning an area of about 3,000 square kilometres. Ernakulum district is home to over 9% of Kerala's population. Ernakulum bordering the district of Thrissur in the north, Idukki in the East, Alappuzha and Kottayam in the south, Lakshadweep Sea in the west is an amalgam of a hoary heritage and global growth of industry and commerce. For the outside world, Ernakulam is part of Kochi referred to in the history of Kerala as the Queen of Arabian Sea.

PROFILE 13: VIJAYAMBIKA

Vijayambika hails from Kodanad, a green pasture famous hub for taming Elephants. She moved to Nayathod twenty-eight years ago as the wife and homemaker to a dream maker and painter by profession. The Nayathod was otherwise important globally due to its hard-line communism, and it is recorded that Late E.M.Sankaran Namboothiripad well known as EMS, the first Chief Minister of the state of Kerala and the communist supremo's hideout during the period of freedom fight was there. Now it is an Aircraft hub. This Cochin International Airport Ltd,(CIAL). The Airport is globally known for its Public Private Partnership (PPP) constitution and noted for its unique method of energy generation from solar panels (Green Energy) for the entire operation of the hub.

Vijayambika was persuaded to enrol as ASHA worker twelve years ago by a seasoned social worker and Ward Councillor. Six days of training at a faraway institution in the company of total strangers transformed her fully. Vijayambika is allocated with prefixed

established programmes designed for ASHA workers across Kerala. Her duty is comprised of counselling, awareness classes, monitoring COVID- 19 patients, surveying the state of quarantined patients, management of vaccination, palliative care, distribution of medicines etc. Yet another task of Vijayambika is the Non Communicable Diseases (NCD) Programmes designed for the urbanized areas, a significant long term project envisaged to ensure a healthy living of people. This programme is formulated for the people aged above 35. Their blood pressure and sugar levels are examined periodically to ensure that they are not in the bracket of NCD.

Vijayambika carries out the additional duty of distributing social welfare pensions. She is also a CDS member of Kudumbashree. She is a unique person, matured and empathetic, loving, respected and very much compassionate. All these observations are true to the heart.

I accompanied Vijayambika to Government Taluk Hospital, Angamaly, where she is attached to. The Taluk Hospital, Angamaly is situated in the heart of Angamaly Muncipality. There are 30-ASHA workers for 30-divisions. This is indeed an appreciable ratio and reflects the significance and virtue of their contribution. This learned force has now become an integral partner of the health sector as well as in the social welfare field. We have all observed their relentless services when the entire area witnessed drastic flood situation twice and now it is in the emergence and fierce spread of COVID-19. This fearless team is in the forefront to combat this invisible enemy. To be honest to say at this juncture, that their contributions were not recognised appropriately.

The entire ASHA workers are trained and regularly work well to confront COVID-19 and any forthcoming mishap. Some members of this team with Vijayambika's status are experiencing a difficulty on multilingual communication. Her proximity to the Airport required interaction with floating and settled multilingual group from the northeast and north of the nation apart from foreigners. 'However, all instructions, directly connected to COVID-19 and accountability as quarantine watchdog, were translated to generous pubic through numerous voice messages on behalf of Vijayambika.' A wonderful experience Vijayambika would like to narrate.

There is one thing I would like to highlight now is related to the Government Taluk Hospital Angamaly. Their protocol compliance is appreciable, the coordination among doctors and staff fraternity including ASHA's is a rare phenomenon in a government organisation.

As part of the duty, she should visit 50 houses of her domain weekly once to earmark 5 members expected to attend the month-end appraisal meeting participated by Anganwady worker (AW), Junior Primary Health Nurse (JPHN) and ASHA worker. It seems like a varied protocol when compared with "Grama panchayat." The other duties are the same to all across the state.

PROFILE 14: SREEJA

Puthenvellikkara is an isolated hamlet inhabited mostly by the lower and lowest classes. Sreeja's foot set on this land seventeen years ago as a newly married daughter in law of this beautiful village, it was indeed an auspicious moment in her life and a good omen for the village.

Now she is the mother of two daughters, who are students and she is a respectable ASHA

worker of 9-years standing. Presently she is in charge of 220-houses Her assignments include registration of expectant women, care for baby kids & children, management of vaccine at a regular interval, palliative care, medicine distribution, organising awareness classes etc.

Sreeja also attends PHC duty 4 days every month. At Primary Health Centre (PHC) she was provided with a mask, hand gloves and mandatory preventive tools. Her duties comprise of maintenance of patients register, the responsibility of asking series of questions to authenticate whether COVID-19 symptoms are there, counselling, awareness classes, appraising patients with the preventive protocols like how to cover face and nose properly and familiarising hygienic cleaning ways.

I accompanied her 4 days to appraise and absorb aspects affiliated to her assignment. Her home was visited on the first day itself, a tidy one designed for minimum comfort. Neighbourhood houses were also similar. We visited twenty neighbourhood houses of her domain. There were issues of irregular supply of drinking water, delayed issuance of various government welfare pensions etc. Interacted with numerous bedridden sick elderly people and those impacted by terminal diseases like cancer. Pregnant women and children having vitamin deficiency were also there. Sreeja always gave thoughtful hearing to their disturbed sufferings and she responds quickly to ensure it is solved and known as a skilled trouble-shooter.

Sreeja briefed me the stories of her childhood, adolescence, youth and married life. She was the youngest and the seventh child of her parents. Her dreams were grey coloured then. She hoped for a nursing degree but couldn't achieve due to economic backwardness, Sreeja was so scared of attending ASHA workers' training sessions because then she was only a homemaker in a village . However, she completed the training successfully and now she organises numerous meetings and presides over teaching and awareness classes.

In the beginning, she was paid only Rs. 500/- per month as honorarium and later enhanced to Rs. 5000/- and again enhanced in the recent past to Rs.7000/-. She had several embarrassing moments in life because she failed at times in discharging the homemaker commitments due to shortage of money.

THRISSUR

Thrissur is a district situated in the central part of Kerala covering a total area of 3032 square kilometre. It is popularly known as the cultural capital of Kerala and is home to 9% of the Kerala's population.

PROFILE 15: LIYLA

Liyla is a 54 year old ASHA worker who works at the 44th division of the Thrissur Corporation. She was born in Nagappuzha, (Muvattupuzha, Ernakulam district) as the daughter of lorry driver Bhadran, who delivered timber to the nearby factories and Narayani, a housewife. Liyla is the eldest of the 2 children of her parents, her sibling being a sister. Shyla and her sister lost their father in an accident in the initial years of childhood and hence the family was fully taken care of by her mother. Liyla doesn't even remember her father, but as life moved on she realised the hardships borne by her mother to take care of the entire family by engaging in farming along with the household works.

Liyla completed her 10th standard and is forced to stop her education at that stage. She remembers that she used to be the class leader while at school and always wished to bring positive changes in the society. It was in the year 1987 that she got married to a mechanic and from then on she started living with her husband at his ancestral home in Thrissur. With the husband working at his workshop and dealing the external chores and Liyla engaging herself in the household chores, life went on smoothly during the initial years. But as years passed by, S understood that she too needed to work outside the home in order to give herself and her family a better life. With this aim she started working as an agent in a private insurance company. But Liyla's dream was to work for the society. So she quit her existing job and looked for jobs that would satisfy her dream as well as provide her with money for a better living. It was at this time that she noticed a press release stating the need for ASHA workers in Thrissur Corporation under the National Rural Health Mission. The very next day she filled the application for the post of ASHA worker and submitted it in the local body. Even though the benefits of or remuneration for the job were not clear while applying, Liyla believed that it was the perfect job to fulfil her wish and also to take care of the needs of her family. Thus, in the year 2007-08, Liyla started working as an ASHA worker under the National Rural Health Mission. It was in the year 2005 that the government started appointing ASHA workers. By the year of 2007, even though the applications were being called for the post of ASHA worker, response was very low.

Liyla remembers how hard her initial days of work as an ASHA worker were. Since it was a new initiative, the beneficiaries never understood who an ASHA worker was and was never ready to cooperate. Hence the first task was to explain in detail to the citizens of her division about the mission of NRHM and the scope of work of an ASHA worker. Since it is a mission under the Central Government, the remuneration was fixed in the form of incentives. For example, if an ASHA worker arranges for a vaccination in her division, she receives Rs. 20. This incentive increases and decreases based on the number of cases and along with it a monthly honorarium of Rs100/- is given by the State Government, which reaches the ASHA worker once in every few months. This was the way in which ASHA workers receive the wages for their daily work.

Even though the income was inadequate, the workload was very high. Liyla travelled to each and every household in her division explaining about her role, till the people understood who she really was and the reason for which she was appointed for the work. The next major task was to explain and make people understand about the various aspects of public health, necessities of vaccination, importance of maternal welfare, importance of clean surroundings and so on. Since the scope of mobile and online communication was very limited, she tried her best to visit every home in order to bring the benefit of the public health system to the people.

Life became miserable when very few people cooperated initially, and when the superior health officials started making suspicious arguments on whether the duties performed by the ASHA workers were sincere and true. Along with this, there were no proper allotted leave for ASHA workers and in case she didn't attend the monthly meeting for any reason, the total incentives and honorarium for that particular month would be completely cancelled. Tears rolled down her eyes when she explained the efforts she took for her work even after less remuneration, just for her wish to do something good for the society and people around her.

As years passed by, the duties of the ASHA worker included, proper chlorination of water used in the households and checking the surroundings for cleanliness, ensuring safe maternal and infant health, ensuring timely vaccinations, palliative care, offering mental support to needy women as well as referring cases to government cells and much more. Even though the roles performed by the ASHA worker developed extensively, there wasn't a proper increase in their remuneration. The Central Incentive remained same throughout all the years. In the year 2010 the state incentive was Rs 300/-per month but it was never paid accurately in the concerned months. Liyla remembers how she had to walk long distances without being able to afford refreshment in between due to lack of money. With huge strikes between 2011 and 2016, however the honorarium amount was increased to Rupees 900, but this amount was never paid monthly and was also inadequate for livelihood. Liyla explains that it was after 2016, under the leadership of the present health minister of Kerala that their monthly honorarium was raised in stages. Between the years 2016 and 2018, the honorarium amount became Rs 2000/-. In the year 2018-2019 it was increased to Rs 4000/- and at present it is Rs 5000/- and an extra of Rs 2000/- subject to terms and conditions, making the total honorarium amount to Rs7000/-. Along with this the older incentives were also added, but everything is subject to many terms and conditions related to home visits, number of vaccinations and many more. With the outbreak of COVID-19 pandemic, an extra of Rs 1000/- is also allowed for carrying out necessary works at the COVID-19 camps. At present the funds are supplied either in the same month or the next month without causing much delay from the part of the government. But how much amount an ASHA worker must get is decided mostly by her superior health authorities and there are cases where the funds are not accurately provided even after the work is correctly performed.

At the initial stage of service, ASHA workers had to brief all her duties and roles to the beneficiaries in her division in order to familiarise them. But as years went by, whether people are fully aware of the role of an ASHA worker or not, they understand that the ASHA worker is someone who is helping them out in the field of public health. Liyla remembers that during the initial phase, work was mainly for maternal care and vaccination. She made sure that each and every household with a pregnant woman was identified and reported. Early registration of these mothers had to be conducted before the first trimester so that all the detailed analysis is carefully done and the ASHA worker also receives the appropriate incentives. As years passed by the maternal care and vaccination care areas got advanced. Now, weekly and monthly meetings are conducted with pregnant women, offering them essential instructions to be followed regarding diet, personal hygiene etc. Also regular home visits are arranged in order to help them and to offer mental support if they face any difficulties. The ASHA worker explained a few cases in which she has even took some mothers for delivery at government hospitals and had to stay with them for support in the respective hospitals. There were a few cases where mothers had no one to stay with them in the hospitals and thus ASHA worker chose to stay. Other than that, if necessary she stays with the family of the pregnant woman in order to help them buy medicine, settle the bills and so on.

Another area of work of the ASHA Worker includes that of Family Planning. For the purpose of effective family planning, condoms are provided by the ASHA worker. Also, other methods of family planning like the use of Copper T etc. are explained and proper support extended. Also ASHA worker helps by referring couples to health officials for sterilisation surgeries. ASHA worker also takes classes for adolescent boys and girls about

changes in their body and about menstruation and menstrual hygiene thus helping a lot in removing stigma about the same.

Liyla explains that equal importance is given to the proper timely vaccination of the child along with maternal health care. She also checks into palliative care, welfare of old people and of people living alone. She frequently visits the homes of old people, supplying them with adequate medicines, ensuring that they regularly attend the medical camps, and also helps them with their household chores if necessary. Mental health of all the people in her division is also her concern. She tries to talk in detail with everyone, especially women, kids and old aged people in her division. In this regard also she elaborated a few incidents.

In her division, there is a family consisting of father, mother and 2 children. It is a middle class family. The father in the family is differently abled. A few years after the birth of the children, they started developing symptoms of mental illness and later it was confirmed. The mother of the household who is a housewife was highly traumatised by the happenings and started expressing suicidal tendencies to the ASHA worker. Liyla explains how she regularly started speaking with the lady from then on, making her feel that she is never alone and always providing essential mental health support to her with help of the authorities and by constant interaction.

Another noted incident in which she got involved was regarding the drug and alcohol use among youngsters. By identifying the few youngsters in her area prone to drug and alcohol use, she organised conversations with their families and informed about the same to higher health officials, thus helping them to recover and return to normal life with proper counselling from the appropriate platforms offered by the government.

Liyla elaborates that it was when life was already in a very busy schedule that Kerala got affected with 2 floods in two consecutive years and a pandemic at the present. Her division was not deeply affected by the 2 floods that occurred in Kerala. But as part of the duty assigned, she worked at various flood relief camps, participated in cleaning and chlorinating flood affected homes and ensured hygiene throughout her division. She says that other than all such emergency duties, ASHA workers are sometimes asked to work at election booths and once in a week they work at PHCs in cases of vaccination; check-up etc. to record details of beneficiaries who are present and also to help them in case of necessities.

It was while all these activities were going on that by the end of January 2020 the health department was alerted about the COVID 19 pandemic, with the first case in India that was reported being a medical student based in Thrissur Corporation, who had come from Huwan in China. With effective training and measures advised to ASHA workers, Liyla remembers how she visited every household, concentrating more on the homes with pregnant women, children and old aged people, asking them to wash hands frequently in the proper manner before going outside and on returning home. Also, even in the initial stage of spread of the Virus, based on the instructions provided to her, she asked the pregnant women to stay away from the working members of their home when they return from work and to try using face mask while at public places.

She explains how the people in her ward were initially worried by the news of the outbreak of the pandemic and that the virus didn't have any kind of vaccinations so that it can be treated. But her timely interactions with people helped them to gain mental strength says a lady from

her division. As time moved on, government regulations got tightened and she received timely instructions about the spread of the virus and thus she started requesting the people to inform her in case they showcased any symptoms. Also, she requested them to report in cases of any family members arriving from outside the state or country, or if the authorities are already aware of such arrivals she helps the authorities to locate their home and to check whether provisions for quarantine could be provided at home or whether the person had to be shifted to the camp. Despite this, she makes frequent visits to the locality of her work in order to check whether any one has developed any of the symptoms or if anyone needs any kind of support.

Other duties at the time of pandemic included providing old aged people and people living alone with essential food, medicines and helping them in case of any necessities. Extra care is provided to pregnant women and children.

Liyla also works at the PHC in providing sanitizer and to check temperature and also in doing the weekly duties. Similarly, services also have to be provided at the COVID-19 camps in basic health care, food preparation, cleaning, sanitisation and so on. It was while working at the health centre that she got into a primary contact with COVID -19 affected people and got affected by COVID- 19 herself, this October. She stayed in the health camp and took an extra week of quarantine before returning to work, and she continues to provide her service at camps along with her regular responsibilities.

It was while elaborating about these on-going works that Liyla explained about the hierarchical issues she faces at work. She says that while working in PHC she is often not provided by gloves by the superior health officials. ASHA worker often needs to beg in order to use gloves in the centre, which is actually provided for the safety of all health workers regardless of the posts. As per the rule the superior health officials in few posts must conduct frequent and proper home visits. But they rarely make such visits and most of the times the details as are being taken from the data collected by ASHA worker and the report made by her.

She further elaborates an incident which occurred a few years back. Every month, a meeting is conducted at the PHC with all the health officials. Due to a very hectic day before the day of the meeting, Liyla fell sick and couldn't attend the monthly meeting. Even though she was on leave with adequate reason, her honorarium for the complete month was cancelled, which she says was the most painful experience for her. This issue happened to many other ASHA workers and after repeated requests, officials conveyed that if the monthly meeting is not attended only Rs 500/- would be deducted from the honorarium.

Liyla explains that she has always experienced clear inequality in the field of work. When all other staff of PHC is provided with refreshment, she was always asked whether she needs that, rather than just providing her with the same facilities that all the others enjoy. Similarly she is usually excluded from the celebrations and excursions conducted in the PHC, in which all others participate.

Despite of all these, Liyla is committed to social change and says that she has the support of her husband, kids and the people of her division. Her daughter was the former councillor of one of the divisions in the corporation. She always provides moral support for her. Liyla explains that for her, in her mid 50s, monetary benefits are just part of the job she is doing, but considering her co-work mates, she, who was earlier leader of ASHA workers, winner

of the Best ASHA award and also presently the Thrissur Area Secretary of ASHA Workers Federation CITU thinks that the honorarium system must be replaced with proper salary and the status of the job must be made permanent. She thinks this will motivate the ASHA workers to work efficiently. Also, there must be a proper mechanism to address the problems faced by the ASHA workers and to offer them effective solutions.

Committed in the development of effective public health system, Liyla firmly believes that the future of health system of Kerala is brighter and she promises her service for the welfare of the people regardless of all the difficulties that she faces.

PROFILE 16: SUKANIYA

Born in the year 1970 at a village known as Vaaka in Thrissur district, Sukaniya (ASHA worker of 11th ward at Elavally Gram Panchayat) is the second eldest among the 5 children of Chandran and Thankama. She has an elder sister, a younger sister and 2 brothers as her siblings. Her father was a farmer and a daily wage labourer. Mother also got engaged in daily wage works at households and fields.

Sukaniya completed her elementary education from UP school Vaaka. Later she joined Mattom High School. She finished her PDC from a private institute and later joined a College in Thrissur for her Bachelor's Degree in the field of Commerce. Sukaniya couldn't clear all the papers in her Bachelor's Degree. Thus her journey of formal educational ended there.

From a very young age, Sukaniya started engaging herself in farming and other works with her parents along with her studies. As years passed by, she understood the financial difficulties faced by her family and hence started conducting tuition classes for children at her home. In the year 1995 she got married to Sunil Kumar, who was working at a private firm in the Middle East. Ever since the confirmation of the marriage proposal, he expressed to Sukaniya that he doesn't expect his wife to go out of the home and work, therefore she could either continue to take tuitions at home or lead her life as a home maker. After marriage, Sukaniya started living in her husband's home in the nearby village. She continued to take tuitions and life moved on. However, she was never fully happy with the kind of life she was leading. Soon after the birth of her 2 sons, her family shifted to an independent house, her husband was still working in the Middle East during these times. The financial difficulties of the family slowly increased as years passed by. The earnings from tuition were not enough for Sukaniya to offer quality living conditions for her kids. She also had thoughts to join for a job, but the restrictions set by her husband stopped her from doing so.

It was during this particular time that Sukaniya's elder sister committed suicide along with her little one. Her sister had faced issues of domestic violence and being a homemaker the lady lacked money to start her own life independently, all of which compelled her to consume poison and end her life. Even though the lady gave poison to both of the children, the elder one survived. This was a very shocking and depressing incident for Sukaniya and her family. With the passing away of the mother, the responsibility of the child was taken over by Sukaniya and her siblings. Also, the thought that her sister would have survived if she had a proper source of income, disturbed Sukaniya a lot.

It was in the later few years that her younger sister (who was herself an ASHA worker), mentioned about the vacancies to the post of ASHA worker in Elavally Panchayat. When Sukaniya came to know about the work, she realised that this will be a golden opportunity

for her to step out of home and explore the outside world, interact with people and earn for her family. But the fact that her husband would disagree to this decision brought fear in her mind.

But this time with all the strength, she applied to the post of ASHA worker and submitted the applications in the local body. Thus, in the year 2010, Sukaniya officially started working as an ASHA worker. She didn't disclose about her job to husband till the final day of her training. At the last day of the 8 module training, she called her husband who was in the Middle East and informed him that she had decided to join for the job. Thus began her journey as an ASHA worker.

But the journey was not at all easy. The people in her ward had no information regarding the duties and responsibilities of an ASHA worker and thus were reluctant to cooperate with her. Also, there was no monetary benefit other than the few incentives provided by the Central Government. Life became disheartening for Sukaniya, as her family and relatives blamed her for getting into a job which gave her no benefits. But she was firm in her decision. She knew that this was the kind of work she always wanted to do and she always wished to interact with the people around her.

Sukaniya visited each and every house in her locality, explaining about her job and duties as an ASHA worker. The initial work she was asked to perform was to engage in the process of chlorination of the homes, ensuring that the surroundings are clean, checking if there is any water logging and reporting the details to the authorities. ASHA worker participated actively in the Monsoon season disease prevention initiatives and always inspected that all the people were following the instructions. She explains that while engaging in the process of chlorination, their dress often gets damaged and there would also be rashes on the skin. These rashes stays up for weeks and since it is necessary to chlorinate and see to it that the surroundings are clean, often the personal discomforts are not taken into consideration.

Another important duty is the early registration of the pregnant women and various programmes that must be conducted for them. Weekly and monthly meetings are conducted with pregnant women to discuss various aspects of pregnancy such as nutrition, mental health support, maternal care, details on exercises to be performed and so on. The ASHA worker is provided with timely trainings in the areas of palliative care, seasonal diseases, life style diseases and care of pregnant women and children. She conducts frequent home visits to check on the welfare of aged citizens, people living alone and those who need palliative care. In some cases, she even purchases medicines and groceries for needy families.

While the initial response of the people and relatives were negative, as time passed they all were very impressed with the kind of efficient service she offered. But still the lack of proper monetary benefits remained a serious concern. In the initial stages of her service, she worked without any remuneration. After one year, she started receiving the incentives for vaccination, maternal health and for the selected works subject to terms and conditions. She had to make detailed reports on vaccination, monthly classes, chlorination, palliative care to avail these incentives (Rs.20 per vaccination for example) and these were received in hand once in every few months. Thus the workload was very high but the monetary benefit was too low to survive. She says that after a few years Rs 500/- was given per month as honorarium that too was subject to various terms and conditions. This amount was also never paid monthly and was not adequate for survival. It was after 2016 that the honorarium

was increased in stages and at present it is Rs 5000/- by the state government, Rs 2000/- as an incentive jointly by state and central governments and other regular incentives. But this amount is subject to various terms. But while comparing with the initial stage Sukaniya feels that situation has changed a bit. Sukaniya explains that sometime even after her hard work, she didn't get the full honorarium as a few superior health officials denied it showcasing irrelevant and false reasons. However in recent months honorarium is being received either at the exact month or the month after, without any further delay. Sukaniya has the view that despite all the difficulties she faced, there was one specific incident which made her aware about the advantage she received because of the training and work as an ASHA worker. She further explains the incident-

A few years back one morning, Sukaniya was working in her kitchen which has a window facing towards her neighbour's home. There was a differently abled kid in that particular house. She saw the mother of the child coming out of the home and searching for the child. Initially Sukaniya didn't take it seriously. But within a few seconds, she heard the mother crying out aloud and an elderly man came running out of the house. This made the ASHA worker understand that there was an issue and thus she ran towards the mother. It was then that she noticed that the kid had slipped and fallen into the well in front of the house and the elderly man was trying to get inside the well. With no delay Sukaniya called in the Police helpline number and also ran towards the road asking the people to gather for help without panicking. Even though the police came and rescued the child, it didn't survive. She says that it was a very shocking and depressing incident in her life, but it was only because she received adequate training as an ASHA worker that she thought of calling police and the local people in that situation without any trauma or panic. Sukaniya had received the best ASHA worker award of her Panchayat in the years 2013-14 & 2016-17 in consideration of her contributions aiming at social change.

It was when life was moving on that disasters came along. Sukaniya's ward in Elavally Gram Panchayat is a flood prone area. The 2 consecutive floods in Kerala affected her area very badly. Her husband had returned from the Middle East and started working as an auto driver in the locality. She also owns 2 cows at home. At the time of both of the floods her locality (including her home) and the entire ward was negatively affected. She had to vacate the flooded home along with her cattle and move to the nearby camp. After making sure that her family is comfortable in the camp, she returned to her work as an ASHA worker and joined the team to clean houses, do proper chlorination, provide people with necessary medicines and to cook food at various camps. This repeatedly happened in 2 consecutive years. The financial loss and heavy workload were too much to be managed well.. But for Sukaniya, it was her dedication towards the work that kept her moving forward.

It took a long time after both the floods for life to return to normalcy and that was when emergency came up in the form of COVID- 19 pandemic. Being located in the interior part of Thrissur, her village and ward were comparatively less affected by the COVID- 19 pandemic. But the duties were still high. The ASHA worker works at Primary Health Centre providing Sanitizer, checking the temperature, registering the names, helping people to follow social distancing measures and soon. She also had duties at various medical camps. The worst part was that the ASHA workers are not given the PPE kits and sometimes not even gloves, which make them more prone to COVID-19 contact. The ASHA worker had to repeatedly ask for masks and gloves to the officials and it depends on the officials whether to provide

such necessities during a health emergency. ASHA worker also checks on the number of quarantine cases in her ward and offers them with effective mental support. She also creates awareness about the pandemic among the people in her ward. At the initial phase, during the outbreak of the pandemic, her panchayat had kept an effective hand wash challenge and she ensured that all the people in her ward were aware of it and understood about the proper technique to wash hands during the pandemic. Often there are many misconceptions and stigma related to the COVID-19 pandemic. The ASHA worker sees to it that such stigma doesn't exist and people could contact her for any physical or mental problem. She talks to everyone and refer the cases to higher health officials if necessary. Along with all these duties she sees to it that her normal works are carried out satisfactorily. There is no compromise in frequent home visits and routine work even in the time of the pandemic.

For Sukaniya every person in her ward is like her family member. It was with extreme sadness that she explained an incident which caused her utmost pain in the time of COVID- 19 pandemic. Leelamma (the original name has been changed due to ethical concerns) was an elderly lady in this ASHA worker's ward. She lives alone in her small house. Since a few months before COVID-19 outbreak, Leelamma developed the habit of wandering through streets and visiting each and every household in the locality. People were initially very fond of how friendly the old lady was. But as time passed, the mental state of Leelamma began to deteriorate. She started speaking matters which are not connected and slowly forgot to dress properly. Sukaniya used to visit Leelamma at home, but due to her recent wandering nature, she couldn't find Leelamma at home during home visits. With the outbreak of COVID-19, people in the locality started fearing the presence of Leelamma as she wanders through streets and many houses hence creating a chance for spreading COVID- 19. Realising the situation, Sukaniya started searching for Leelamma in the streets in order to persuade her to stay inside her home, but she was missing. ASHA worker visited the lady's home but with doors closed and no one responding she returned. But one day somehow Sukaniya felt that the lady was inside the home and she tried to open the door and to her surprise it was open. ASHA worker stepped inside the home and saw that it was filled with rotten food waste. Waste water was logging in the floor and foul smell was present. Since the electricity bill was not paid correctly there was no electricity in the house. She was frightened and disheartened to see Leelamma lying in one of the rooms in the house. With no proper clothes, Leelamma lacked the energy to get up. Understanding the situation, Sukaniya tried to enter the kitchen and boil some hot water. But, the kitchen was filled with rotten groceries, dead insects and foul smell making it difficult to use. Thus she contacted the neighbours and asked them to provide hot water, tea and necessary food. Sukaniya informed the higher authorities about the incident and they came out to help. With the help of palliative unit Leelamma was given a bath, her dress was changed and she was given food. The authorities informed her relatives about the incident and asked them to take her to their home. Even though the relatives arrived and took the custody of Leelamma after few weeks she came back and the relatives informed the concerned authorities that they could no more take the responsibility of Leelamma. Thus the old lady was shifted to care home and within a few days she passed away. Her mortal remains were brought to her home once again for the last time. ASHA worker broke into tears while explaining the incident and she says she feels the same pain when any member of her ward passes away.

With the outbreak of COVID-19 the financial burden has been doubled for ASHA worker

and her family. She had taken educational loan for her sons. Both of them completed their higher education this year, but with the outbreak of the pandemic job opportunities decreased. ASHA worker says that she rarely takes leave from her job as she would not receive her full honorarium. There are no proper leaves or medical insurance facility available to the ASHA worker. It was only by end of November 2020 that her son got enrolled for a job that too for a very less salary. Thus the financial difficulties caused due to COVID-19 are too hard for Sukaniya and her family.

While talking about the future of her work as an ASHA worker, she explains that what she needs is a peaceful workplace and not one where there is hierarchy and inequality among the officials. Every person has the right to be treated equally with humanitarian conditions. But an ASHA worker never receives that concern from part of their higher officials. She says that the ASHA workers including her needs an office where people of their ward can come and meet them for discussing their personal problems as during home visits often detailed talks are limited by the people due to privacy concerns. She wishes for a proper leave system and respect from the part of authorities for the work performed by ASHA workers.

At the initial stage of her work, she didn't have the support of her family but as years passed by her family, especially the husband have come to terms with her choice to work. The people in her ward supports her in all her duties and it is that intimacy with the people that keeps her moving forward despite all the difficulties she faces.

PALAKKAD

Palakkad is one of the fourteen districts of Kerala and has no coastal line. The district opens the state to the rest of the country through the Palakkad Gap with a width of 32 to 40 Kms. The district is one of the main granaries of Kerala and its economy is primarily agricultural. The district is also the land of Palmyras. Also, it is the largest district in Kerala from 2006.

PROFILE 17: GREESHMA

Greeshma ASHA worker of 17th ward at Lakkidi-Perur Grama Panchayth was born in the year 1971 at Akaloor, a village of Palakkad district. She is the second one among the 3 children of her parents. She has an elder sister and a younger brother. Her parents were both farmers and daily wage workers.

She studied till 10th standard. After that, she joined for tailoring and started earning money from that. In the year 1996 she got married to Unni, who was then working in a factory in Kanjikode, Palakkad district, who was also a political activist. After marriage she moved to her husband's home in Mulanjur, another village of Palakkad district. They have two sons. Elder son completed B.tech and the younger one is in college. Their life was going smoothly until her husband was forced to leave his job due to severe health issues. After this incident they started facing financial crisis and they struggled a lot to meet the ends. So Greeshma started her tailoring job again in order to provide for her family. From then for about 5-6 years that was the only income for their family. During that time her mother in law also fell sick and it became difficult for her to manage the household chores, tailoring, looking after her mother in law and her children at the same time. So she dropped tailoring there and her husband started a small stationary shop near their home with the little savings they had. But it was not very successful back then, they earned very little income from the shop. By then her

mother in law died two years after falling ill. And when her children entered upper primary classes, she restarted her tailoring.

During 2009 she learned about vacancies to the post of ASHA worker in her Panchayath. And she was interested in this work and also had some experience by volunteering in health related activities in the same panchayath. Greeshma says that she was always interested in doing social service and she thought then why can't she choose this as a job which will also help to earn for her family.

So she applied to the post of ASHA worker and submitted the application in the local body. After passing the interview and after successfully completing the residential training in the year 2010, Greeshma officially started working as an ASHA worker.

But she got posted in another ward which is 3kms away from where she lives. She daily walks about 6-8kms a day. With the experience she had while doing volunteering activities across the panchayth, she is somewhat familiar with the locality where she is posted as an ASHA worker. Greeshma says that it was a difficult task for her to make people understand about who an ASHA worker is in order to cooperate with her. The total population of the ward where she works as an ASHA worker is 1433. The total number of houses is 437 and this ward consists of 3 SC colonies. Majority of the population comes under General and OBC categories.

Greeshma says that she was a bit disappointed in the beginning after learning that there won't be any monetary benefit for the work they were doing. In 2011 she started getting Rs. 900/- as honorarium and gradually it has been increased over the years and that too was irregularly. She also says that during the time of training it was said to them that they could also engage in any other job apart from being an ASHA worker and their duty would only be for 4 days a week. But gradually this scenario changed and some strict regulations have been implemented like they have to work every day in a week, that too without taking a day off. In short it meant that an ASHA worker should be available 24X7hrs. She manages to do all the household works before going to the field or after coming back. She also added, if they failed to attend any meetings conducted in the ward level, block or district level they will cut certain amount from the incentives that is been provided and sometimes it maybe Rs.500- or more. Due to lack of time she is not able to do tailoring also. The financial burden is still there and they had taken educational loan for her son. Her elder son completed his higher education this year, but with the outbreak of the pandemic job opportunities are less.

She says, their job responsibilities are three-fold, including the role of a link-worker (facilitating access to healthcare facilities and accompanying women and children), that of a community health worker (depot-holder for selected essential medicines and responsible for treatment of minor ailments), and of a health activist (creating health awareness and mobilizing the community for change in health status. She conducts frequent home visits to check on the welfare of old citizens, people living alone and for palliative care. They have to supply medicines especially for expecting mothers, and have been assigned the responsibility of taking medicines from the dispensary and dropping them off at patients' doorsteps when needed. Greeshma says, one of the major challenges she faces from the beginning till now is that a major part of the population in her ward is the Muslim community who are very orthodox. They will not agree to take vaccination or take birth control measures. The explanation they give for this is that those things are against their religious views and it is very

difficult to make them understand the importance of all of this. But now this situation had changed quite a bit while compared to the starting period, she says.

Greeshma sounds very happy while saying, "one good thing that the COVID-19 has done for the ASHA workers is, now everyone recognises our importance like never before". She says, while many of them have shifted to work-from-home during the lockdown, not much has changed for ASHA workers. If anything, they have additional COVID-19 duties over and above their regular tasks. Their core responsibilities such as distributing iron tablets, checking on immunisation schedules of babies and pregnant women, undertaking periodic checks on tuberculosis (TB) patients, among others, have been supplemented with additional duties of contact tracing, spreading awareness on prevention of COVID-19, keeping a close watch on incoming migrant workers to ensure whether they follow quarantine protocols and reporting suspected cases. They are getting sanitizer, mask and gloves from the PHC as per their request.

So far there have been 39 COVID-19 positive cases reported in this ward where most of of the cases belong to the 20-50yrs age group and majority of the cases happened due to contact with other positive cases. During the initial period of the pandemic the people were in a panic and she used to visit each and every house on a rolling basis and sensitise them about the importance of washing their hands frequently, usage of mask and sanitizer and to keep distance while going outside etc. There have been situations in her ward where some people didn't follow quarantine protocols. She also added that some of the positive cases households would not allow to stick the COVID-19 positive case notice in front of their house because they didn't want others to know that positive case have been reported in their house and thinks others will discriminate them in the name of this. Due to this there even have been situations where people who do not inform ASHA workers if any migrant worker comes back and even started showing symptoms, Greeshma says.

She says, despite the lockdown and other curbs on movement, ASHA workers were performing their duties to the fullest. They are working tirelessly to prevent COVID-19 transmission while also ensuring that the delivery of other health services remains uninterrupted. Her suggestion is that the government and their communities recognise and reward their work through financial and non-financial incentives. They have to be considered as government staffs and a proper retirement age as well pension shall also be provided. They should not discriminate from the frontline health workers and have to get equal recognition.

PROFILE 18: RADHAMANI

Radhamani ASHA worker of 6th ward at Peringottukurissi Grama Panchayat, (Palakkad district) was born in the year 1967 at a village known as Aayakurissi in Palakkad district. She was the 4th child among the 6 children of her parents. She has 2 elder sisters and 3 younger brothers as her siblings. Her parents were farmers.

She studied till 10th standard. She got married at 1987 to Sankaran who is a farmer and she started living with her husband and in-laws at his ancestral home. It was a joint family which consisted of 15 members. Gradually the siblings of her husband got married and everyone started living separately. She now lives with her husband. They have two children. The daughter is married & their son is working abroad. They were raising cattle for a living. She and her husband were looking after them but now they had to sell them due to time

constraints. Their daughter's child lived with them, so even after the field visit days; they had to help the child with homework, along with the rest of the household works. After all this work is done, they sit at night and prepare all the field visit reports. She says that she has never faced much financial crisis from the very beginning itself. They have thyroid and asthma and regularly take medication for it. And now she suffers from leg pain too as a result of walking long distances to and from the field, so she now regularly goes to the field with a crepe bandage on her leg.

She has been working as an ASHA worker since 2008. Prior to this, she was not working but she was doing some voluntary works in the ward level through the panchayath so they are somewhat familiar to the locals. So she never had much trouble approaching people. She had already completed the 8 module training and still attending all the meetings and trainings without any backups. The total population in the ward is 1653. There are a total of 472 houses. 4 SC colonies are there in this ward. Since it is a new initiative, the local people never had an idea about who an ASHA worker is and the first task was to explain in detail to them about the mission of National Rural Health Mission (NRHM) and the duties of an ASHA worker. They walk 4-5 km a day on the field. They say that they and the locals have known each other well in advance and that there has been good cooperation from them from the very beginning. Economically and socially backward and middle class people are always ready to cooperate with them but this is not the case with those people who are financially advanced. They often do not even allow her to enter the premises of their house. Now as an ASHA worker, her duties includes making people understand about the various aspects of public health, necessities of vaccination, importance of maternal welfare and importance of clean surroundings, proper chlorination of the households, ensuring safe maternal and infant health, ensure timely vaccinations, palliative care, offering mental support to women in need and referring cases to government cells and many more. Most of the days, the nurse and she goes to the field together. The nurse on duty in their ward is treating them very well and they have never had a bad experience. They said there is no such hierarchical issue between them. Initially they did not get any honorarium for 2 years. Their work is considered as social service. After that they got Rs. 900 for the first time and then it gradually increased and now they get Rs 5000/- and an extra of Rs 2000/-, making the total Rs 7000/-. Along with this,some other incentives are also there, but everything is subject to many terms and conditions related to home visits, number of vaccinations, delivery, etc. After the outbreak of COVID- 19 an additional Rs 1000/-has been provided.

When the pandemic had started, the government bought certain strict regulations and according to the instructions she received from higher authorities she started informing the people to inform her in case any of them showed any symptoms. Also, she asked them to inform her if any family members were arriving from outside the state & country. She also helps the concerned to locate the homes of those people. She visits those houses where people are in quarantine and check whether any one has developed any symptoms. Now they have COVID-19 duty at the PHC, but initially she didn't go for this duty because she has asthma and now she had started doing COVID-19 duty too and the duties include recording the details of the people coming over there, giving sanitizer, checking temperature, etc. She says that safety kits including sanitizer, mask and gloves are provided from the PHC whenever they ask for it. So far 17 COVID-19 positive cases have been reported in this ward and most of them are between 40-70 years of age. This includes cases with or without

contact. They say that most people who are in the quarantine often do not co-operate with them. There have been situations where people in quarantine often go out and when they go to inquire about this she said that their reaction was really bad. They say that for the first time since they started working as ASHA, they have had their worst experience during this COVID-19 period, when a COVID-19 patient insulted them, questioned, humiliated and threatened them about the work they were doing. They said the incident caused them severe mental distress.

The roles performed by the ASHA worker developed extensively over the years and there wasn't a proper increase in their remuneration. Radamani says that even though the income is too little, the workload is very much heavy. She says that whatever the amount is, they needed to receive it on specified date every month. She says that most of her friends from the same field are dependent only on this income so when there is lag in getting their remuneration it is really difficult for them to make the ends meet. But in her case she thinks that even if it is little she is happy with it because it was made by her own effort and hard work and at least she doesn't need to be dependent on anyone in order to fulfil her own needs. Radamani also reminds that there have been cases were many of them are unwilling to join as ASHA worker or do not stay for long in the job because of the low payment they receive. She also says that the Government should fix minimum wages for ASHA worker according to today's standard of living.

MALAPPURAM

Malappuram is a district in the state of Kerala, India. It is the most populous district of Kerala, which is home to around 13% of the total population of the state. The District was formed on 16 June 1969. It was formed by incorporating southern parts of the erstwhile district of Kozhikode with north-western parts of the erstwhile Palakkad. It is bound by the Western Ghats and Arabian Sea on the eastern and the western borders respectively.

Profile 19: Sumitha

Sumitha P.P is an ASHA worker from 8th ward of Thenhippalam Panchayath in Malappuram District. She was born as the third child amongst the four children of Venu-Tanga Couple on May 28, 1978. She was born to a middleclass family and got married at the age of 18. Along with her husband Shankaran and two children she is leading a very normal life. There is a block for the ASHA workers under NHM in Malappuram District. In that Thenhippalam belongs to Neduva block. 10th grade is her educational qualification. Later on, after her marriage she attended classes and passed 12th grade. Being an ASHA worker she is playing a great role in Thenhippalam panchayath. She is the leader of ASHA workers in Thenhippalam. She has won the best ASHA worker award in Panchayath level in 2015. Presently she is a candidate for the election at the block level.

Sumitha started working as ASHA worker from February 2008. Hence, she has been working for the past 12 years. In the initial stage ASHA workers were selected by the health and ward members. The only criterion for the selection was that the person should know how to read and write. The selected person would undergo 7days training to become the ASHA worker. Presently the ASHA workers are selected by the Panchayath and ward members. The main criterion is that the person should pass 10th grade. When Sumitha started working as an ASHA worker her only aim was service; she was not paid. Later ASHAs were given

honorarium and incentives. Her main responsibility was to share health related information to all people irrespective of their class. Even though she started working as a service she started to get Rs.500 as honorarium from 2010 onwards. Later on, it started to increase each year as Rs.1000 and Rs 2000. After 2016, honorarium increased and in 2019 they were paid Rs. 4000 each month based on their work.

She is assigned to undertake various responsibilities as an ASHA worker. A monthly report should be submitted to the sub centre. The 7th ward of Thenjipalam belongs to Devathiyal sub center. There are four sub- centers in a panchayath. 6, 7, 8, 9, 10 wards of Thenjipalam panchayath came under Devathiyal sub-centre. There are 327 houses under ward 7.

There will be an ASHA review meeting on monthly basis at a primary health centre. Those who participate in it will get 100 rupees. There are lot of responsibilities and duties for an ASHA worker. They should maintain details regarding the vaccination of children. They will get 20 rupees for the vaccination of each child. When a woman who belongs to BPL category gave birth in government hospitals and private hospitals, she would get 600 and 300 rupees respectively. They must ensure that the carrying woman gets enough medicine like folic acid, calcium and iron tablets and they should also visit them five times. They have to register the details of a pregnant woman early on. The ASHA workers get incentives if only they registered their details early. Their registration is done at health center. Many of them do not register properly. The reason for not registering within three months is because it is assumed that it can be confirmed after 3 months. Also, early registration is not done due to reluctance to speak out about it. Many people are reluctant to register as they have to register within the first 3 months.

ASHA Workers have a government diary to record annual matters. The activity done each day should be accurately recorded. The diary for ASHA activists is provided by NHM. As an activist, they have many responsibilities.

- Antenatal registration of pregnant women should be done
- Immunization of children
- Vaccination activities
- RCH (Reproductive Child Health) Registration
- Prevention activities during rainy season
- Cleaning work
- Chlorination

There is a different duty in the afternoon each day of the week. They must attend a health class on Monday. They have to do their duty at the geriatric clinic on Tuesday. The clinic will also have a health inspector. They have a check-up for children under the age of 5 on Wednesday. They will check sugar and pressure on Thursday. The health inspector will also be present at that time. Pregnancy check-up is done on Friday in the presence of the JPHN.

On Saturday a class of adolescent age group is conducted at Devathiyal Sub Center. Class is at 2 p.m. There will be a health inspector in the boys 'class and a sister in the girls' class. There is also an incentive apart from the honorarium. 2000 fixed incentives are received from

the centre. 50 houses should be surveyed continuously. Survey report should be submitted to the sub centre. The sub-centre sends the report to the PHC and PHC to the block and from block report is submitted to the panchayath. There are a total of 26 ASHA activists in Thenjipalam.

ASHA workers had a lot of responsibilities including surveying of each house, restriction of use of plastic, cleaning, enquiring about the diseases and recording all these details. COVID-19 situation led to increase in the duties of ASHA workers. These duties were done by ASHA workers in Thenjipalam. They have to record the details of people who had come from gulf and other state and these had to be informed to the NHI and JPHN. ASHA workers also must visit these houses 3 or 4 times and enquire about their problems. In this area, 74 COVID cases were reported on November 1. In this ward 38 cases were registered. People who are in quarantine should be called regularly and asked about their problems. They also need to find out if they are having any difficult in food and other basic needs. They have to check the sugar level and blood pressure levels of the patients properly and gave them medicines properly. They should also buy medicines and give them to quarantined persons who are regularly taking medicines for other ailments. Facilities are being set up to test the oxygen in the homes of needy people. ASHA workers also needed to do palliative care works. They have two duties as per palliative care:

1. Secondary palliative - 3 or 4 days duty at panchayath.
2. Pariraksha Mission of panchayath

The sub centre has home care duty on Tuesdays. Home care duty is done during COVID -19 pandemic times. PHC duty does not have to be done due to COVID-19 situation. Clinical activities other than PHC duty should be done. Vaccination and field work should be done regularly. They had many different experiences while doing field work. People look at them in different ways.

Rarely do some people recognize us when we go down to the field. Pregnant women keep information secret. Some do not say details of children's vaccination. Many people behave badly when going for a home survey during COVID-19. They ask whether we came to spread Corona. It may be sad to hear these words, but our efforts are well received by some. Many of them see us as members of their own family. They usually used to communicate freely with others. When they didn't see them for a short period, they will enquire about the reasons. Because they treat people well, people also cooperate in a positive way. Therefore, ASHA work can be done with 100% responsibility. They get hundred percentage satisfactions both as an ASHA worker and a woman. They work mainly in the health sector. ASHA activists work in collaboration with Anganwadi. Some people, especially the 20%, consider their work without much seriousness. There have been a lot of changes since the beginning of my work as an ASHA worker. Despite the low income, they are able to live self-sufficiently.

Even in this pandemic time they get honorarium and incentives without delay. She is able to live on her income even when her husband has to stay at home for months without a job. No matter how hard they worked in the earlier period, they were not paid regularly. Before 31st of every month they should prepare the report. They earn good recognition in the society. Therefore as an ASHA worker she is able to maintain good relations with others. As an

ASHA worker she had worked in many emergency situations. When a small child dies in a house, she immediately goes there and inquires about things. She goes out and works during the COVID-19, collecting and surveying the information of those in the quarantine. Her family members also support her work. She started working as a public servant; therefore, every task is done with complete satisfaction. Activities are very risky but they do not shirk responsibilities.

The risk is high, especially during COVID-19. The risk of getting sick is very high also. She has many memories as an ASHA worker. There were both good memories and painful memories. Initially she has no idea about this field. People would ask her why she was visiting their houses and asking about their son. She had to convince many of them to take vaccine properly. A woman told her that she would take vaccine only if she said so. The child had an accident at that time. The boy survived only because he was vaccinated. So she felt very happy on hearing this. But there was another painful experience during the corona period. In her neighbourhood two people got COVID-19 positive. When the old man suddenly fell ill, no one helped them. When they were taken to the hospital at night, the medical officer also treated them badly. They suffered very badly later also. Sometimes people would say bad things if the drugs didn't arrive early. They will forget all the good things they did up to that point.

Although they do a lot of work as ASHA worker, they faced many kinds of problems. The most important of these is the salary issue. It is a very risky job but they do not get paid accordingly. They also face problems institutionally. They usually didn't get much recognition as ASHA and no significant consideration is received from PHCs. No problem with PHCs here. But when she goes to some offices or hospitals, she would not get due consideration from other health staff. Only our sub centre's JPHI, JHI, LHI and doctor provide enough consideration towards our needs. In the early days, ASHA workers were not allowed to attend festivals like Onam and Vishu in PHCs. Sometimes, even well-educated people give us recognition. Some even call her madam.

ASHA Workers have faced trouble since the Citizen Amendment Bill came out. When she went down to the fieldwork, she had to get a signature as proof of each visit. Only then they would get incentive. After the Citizen Amendment Bill came, many were afraid to sign it. Due to COVID-19 related work she can't even visit her own mother. During field work she is able to visit her mother only after 14 days. She had to do both the duties including household work and field work. So, it is very difficult to manage both duties. She had to spend a lot of time in each house doing field work. Therefore, it is possible to visit only 10 houses a day. Even then she feels that she is able to balance her life both as a woman and as an ASHA worker.

PROFILE 20: SHASHIKALA

Shashikala is an ASHA worker from the 17th ward of Pallikkal panchayat in Malappuram district. She was born on 2 April 1982. She got married when she was 21. She leads a normal life with her husband and two children. Her husband is a politician, and her income is the only source of income for her family. The eldest son is doing +1 and the youngest daughter is 2 years old. She started working as an ASHA worker in 2008 and has been working for 12 years. She covers 546 houses in the 19th ward. As an activist, Shashikala has a lot of responsibilities

and duties in the ward. Especially in the COVID-19 context she has been doing other duties in addition to her current assignments. Their view is that no matter how hard they worked the work of ASHA activists would not be exposed to the outside. Unlike other jobs, ASHA workers have a responsibility to get out and work during COVID-19. Along with ASHA work she was running Calicut University Kudumbasree Mess, which is not functioning now. In 2008, it was through the party that she came to know that ASHA workers are needed in health department. In that selection, 36 people were selected. Shashikala was one of them. Shashikala studied till 10th standard and she could not study further. Although her husband Unni krishnan is a politician, she has a lot of support. At that time, a person who could read, write and could work could attend the interview. Educational qualification is 10th standard today.

As an ASHA worker, Shashikala has many responsibilities. The most important of these are with regard to pregnant women, children and bedridden people. There are many activities such as registering pregnant women, vaccinating children and so on. In addition, there is the task of pulse polio. During this COVID-19 situation, she has to identity foreigners and workers from other states in order to provide them with the necessary facilities and assistance collect their information, call and visit from time to time to know their needs and difficulties, and submit their report to the Health Department. If they need to see a doctor in case of any critical situation, they could call them and hand over the doctor's number. And deliver the medicine they need.

There are 8 modules of training prior to the ASHA activity. It also had a 1 week residential class. That was the first thing to do. Through that training she got to know what is ASHA work, it's role, and what to do in the ward. There is a class in every year related to this. It is conducted by JPHI from each district. The class is held at the main center from Kondotty CHC. That is where the ward separates. ASHAs do not have to be able to work in the same ward where they live. Shashikala had got class from CHC and in 2019 from Kunoormad PHC.

As an ASHA worker, she had a variety of experiences while on the field as an activist. Mainly people don't remember the dates of immunisation. People will only come for the injection if they are told many times and reminded the day before the injection.

She has an old mother and a 2 - year - old child at home. Yet even during this dangerous COVID-19 situation she is doing a lot of work. She visits people who are in quarantine. People would come to the window and say if they needed anything. There are currently 2 people in COVID-19 quarantine. The reaction of the people is positive. People love to see them because ASHA workers are the few who stand for their welfare.

She must visit 50 houses every month. It was not enough to just visit and get signatures from them. In addition to 50 houses, 20 houses should be visited - homes of pregnant women and children. Thereafter 20 Home visits to those who are bedridden or living alone. Therefore, in addition to his work, she must visit 90 houses. It is not necessary to collect signatures from COVID-19 patient's home. But the house must be visited. The incentive is based on the work she does. If a child is vaccinated, she gets Rs10. Thereafter Rs. 100 per child for vaccination at the age of 10 months and Rs. 50 per child for vaccination at the age of one and a half years. Thus a total of Rs.3000 is given as incentive and Rs.5000 as honorarium. Jobs started at Rs.500 and increased to Rs.1000, 2000, 4000, 5000. This requires a lot of work; only

then did she get the money. It can only be rewarded by conducting an Anganwadi meeting, conducting classes for children, mothers and pregnant women, and conducting a class at the Anganwadi. Classes were initially taken by the concerned JPHN. The class is about each subject. But it has not been necessary to take the class in the context of COVID-19.

She faced some shocking events during COVID-19 time. It was, in particular, a bad experience on the part of the ward member. The member went to the PHC doctor and asked him to terminate her; then took a lot of efforts to get rid of her by saying bad things about her. But the doctor supported her. Later, during COVID-19, she and the panchayat member would have been able to collect information from the quarantine people only if they had stood together. Aside from the bad reaction on the part of the member, there was no bad reaction from the people.

The area comprising the 17th ward of Pallikkal panchayath is a large area. The University is one boundary while the other boundary is by Devathiyal. In the meanwhile many areas are coming under their area of her work. Surveys and other meetings are held between their jobs. She is in a state of not being able to go for other work along with this job. Her husband is a politician and has no fixed income. The eldest daughter is studying at +1 at home. Because all the classes are conducted online, there is only one phone for the total online class at home. Information related to ASHA's activities is done through WhatsApp. Since her daughter has a class, she goes to work leaving her phone at home. Through this, one can see the difficulty of the person who is unable to meet the basic needs of her home. As an ASHA worker who works outside during COVID-19, she is getting support from home but also experiences the pain of a mother who has left her 2-year-old baby at home. Many times, the meeting would go on until the evening. Until then, the baby is left alone at home.

The sister at the subcentre is very supportive. There would be a meeting once a month at Kunurmad PHC. The meeting was not held under COVID-19 circumstances. The meeting took place last month, a few months later than originally planned. The report should be prepared every month. Information on those who have been vaccinated, information on pregnant women and birth surveys should be written in a diary and white paper and taken to the Puthur sub-centre once a month.

Life has changed a lot for her since ASHA work started. The most important thing in life is to be able to have good relationships with people. She was the person who was generally confined to not even talking to outsiders and who had no contact with the outside world. She was later able to talk to people and establish good relationships with them when she started ASHA activity. She is even happier to be able to earn an income on her own. She earns a very small salary but that is why she and her family make a living in this COVID-19 situation; things are going very well for ASHA worker.

Although a lot of people are forcing her to contest in politics, she wants to go ahead only as an activist. Shashikala says that her job has great tension. Tension would remain until a child is born and goes home. There is a great deal of tension over whether something will happen to the child. Such cases have been reported here. She often goes to the home of the deceased even at 12 o'clock at night and immediately inquires about the cause of death and reports to the JPHIs. There is no risk at work. They can do it at any time for their convenience. But in addition to risk, there is tension.

People in the Nineteenth Ward are behaving well. There is a great deal of acceptance because

she has been bringing every single thing to the people there, looking after pregnant women and delivering the medicine they need. She does not face any caste discrimination. However, they face some other problems in life. With this ASHA worker, she cannot do any other work. Similarly, when it comes to home and family work, she faces a dual task.

As an ASHA worker, she has faced many problems institutionally as well. She is entitled to 500ml of sanitizer, mask and gloves, but she did not get it. However, she must go down to the field and investigate things and gather information of the people who are in the quarantine. Despite being provided with such basic facilities at Kunurrmad PHC, she did not get it. It caused great distress.

Along with regular ASHA worker's duties she also works for under Aardram Mission. As part of this she must be at the OP from 9 am to 6 pm. She is now on duty once a month. From there, Shashikala was not given any mask, sanitizer or gloves. In addition to the Aadram duty, there is also the duty of Pariraksha. The duty of care is to go to the home of the bedridden patient one day. She complained to the DMO when she could not get a sanitizer. It was dispensed after being transferred to a 500 ML small bottle in a bottle that someone had already used. Due to this a complaint was given and later the sanitizer was received.

There were 38 ASHA activists in Pallikkal panchayath. There are currently 34 ASHAs. Institutionally, there are a lot of problems. No matter how hard they work, high officials are not satisfied. They do not cooperate with them or support them.

As an ASHA worker, she has been involved in a number of areas as an activist, mainly in the health sector. She would also attend the Aganawadi and panchayath level meetings. When the disease was high, the panchayat and the health department met frequently and when they went on care duty, they were given lunch in the afternoon and no fare was charged. The things changed. A job can start at Rs. 500 and reach Rs.5000.

Actually she does what she loves to do. There are some who oppose but the rest are very supportive. As a party worker she finds it easy to work and attends meetings at any time. But her husband Unnikrishnan is very supportive. There are no barriers to going out and working anywhere. Her husband could come with her when it was late. She does not get TA when she goes to a meeting and also she has to use her own money to take photocopies.

Due to COVID-19 she has a lot of work related to COVID-19. This also involves a lot of risky work. However, Shashikala suggests that they need insurance coverage. She says that as an ASHA worker she is getting her own space and wide range of social acceptance.

KOZHIKODE

Kozhikode is a district of Kerala state on the southwest coast of India. It is the central part of the former Malabar district. Kozhikode is also known as Calicut. Kozhikode District was the capital of the erstwhile kingdom of the mighty Zamorins and once a renowned commercial center. Kozhikode district is bordered by the districts of Kannur and Mahé (Puducherry) to the north, Wayanad to the east, and Malappuram to the south. The Arabian Sea lies to the west and Western Ghats stretches towards east.

PROFILE 21: FAZINA

Born in Kinassery, Kozhikode district, Fazina was brought up as Uppa and Umma's darling

child. She had started studying in Kinassery High School with high hopes and dreams, but had to get married at the age of 15. Her husband was an alcoholic and did not care about family matters. Even when three children were born, he refused to care for them. A few years later they got divorced and Fazina with her three girls, moved into her own home and she joined Kudumbasree. She did all kinds of works for the family, and earned a living and raised her children. She continued her studies up to Pre-Degree but there were many obstacles to move forward.

In 2007 she joined as an ASHA worker. Although it was a little difficult at first, Fazina was not ready to give up. When Fazina became an active ASHA worker, she was strengthened by the knowledge and experience that there were people around her who were suffering and overcoming serious life situations more than she ever faced. By being a part of their journey, Fazina was able to be satisfied with her work as a community service provider even when her low income was not enough. Still, life remained a question mark. She continued to serve as a visitor to 634 homes in the 23rd Ward, as a relief to the helpless people, as a daughter to the elderly, a sister to pregnant women, and a companion to children.

It is a common practice to deduct Rs.500 each time from the total income of Rs.5000 /- if one takes leave or do not attend any duty or attend any meeting. Yet Fazina became the strength for everyone. Fazina was chosen as the leader of the 40 ASHA activists in Olavanna Panchayat because of her dedication and good performance. She received a total of 64 trainings and also received 6 trainings according to the 7-training module.

Fazina was assigned to prepare ward health register, conduct review meeting, attend sub-centre review meeting, attend panchayat review meeting, preventive immunization clinic duty, palliative clinic, home visit, and giving heath and yoga class for mothers and adolescents in Anganwadis and in addition to that, Fazina has been able to bring relief and hope to the lonely, the bedridden, the tuberculosis patients, the kidney patients, the cancer patients and the mentally ill.

During the COVID-19 period, Fazina was very proud to be able to deliver the Break the chain message to all households and to allay people's concerns, in addition to the assigned duty. She is an unwavering service provider with a kind heart who has been able to go to the field and test COVID-19 patients for coughs and fevers, clean the homes of the patients and deliver medicine, food and other necessities to them without any fear.

She was active in collecting the information of COVID-19 positive people, including the phone numbers of all the members of the household who were COVID-19 positive, taking them to the health centre and calling them every day. Enquiring about their needs and meeting their needs brought her utmost satisfaction. She was well-recognized by the public as an activist and for her services during the COVID-19 Period. Officers also praised Fazina's work.

Not only is the honorarium of Rs 5,000 not enough for anything, but it is sad that higher paid health workers sometimes underestimate the value of the ASHA workers.

As a woman, she does not usually have big problems, but sometimes her relatives and superiors become judgemental and Fazina finds that annoying. However, Fazina's sees her financial insecurity as her biggest challenge. She believes that her humble life is blessed when she sees the relief, the grateful look, and the smile on the patients' face as she heals their

wounds.

Fazina noticed that some families stayed away from interacting with TB patients. But later when she went to visit those families she was happy to find out that the fear they had initially, gradually started decreasing.

PROFILE 22: SUNITHA

Sunitha took over as an ASHA worker at a time when the COVID-19 epidemic was sweeping the world.

Born in Olavanna Panchayat, Kozhikode district, she studied at Panteerankavu High School and Campus Higher Secondary. Later, while studying TTC, she got married at the age of 18 to Thottummaram house in Kozhikode Corporation. Yet, she completed TTC after marriage.

It was difficult for them to live with her 2 girls on the small income of her husband who is a workshop worker. At that time Sunitha wanted to help her husband by earning a living by doing something. In February 2020, when she saw an advertisement in the Kozhikode Corporation inviting ASHA workers, she applied and got selected. 125 ASHA workers were selected in the first phase, but in the case of COVID-19 many were unwilling to take charge. Despite these challenges, Sunitha started working in March.

Sunitha, an ASHA activist, is the ray of hope and comfort of about 3000 people in 500 houses in the 32nd ward. There are 2 other ASHA activists in the 32nd ward. They are also in charge of 500 houses each. Sunitha's first mission was to go to all the houses when COVID-19 started and spread the message of Break the chain and then, to accompany the patients in ambulance to the Covid Care Centre, decontaminating their homes etc. Wearing a PPE kit, she endured the unbearable heat every day. When 4 people over the age of 50 in the ward died due to COVID-19, Sunitha was at the forefront front to help with their funeral.

In those days she could not even visit or see her own parents because her parents are heart patients. The children were also moved to her sister's house for safety. Sunitha was ready to serve with all her heart if needed, remembering the many faces that awaited her help even though her relatives forbade her to do such hard work on a small income.

Wearing a PPE kit and working with the volunteer boys in the area, she had to face many accusations and mocking from all quarters. But that did not discourage Sunitha. She carried out her duty more vigorously than ever before. However, she later began to receive more support and applause from the community. And she began to look on with pride as everyone began to approach their needs faster than before.

Sunitha was also able to deliver rations and medicines to the needy and chlorinate the wells. Often, she had to spend her own money for such expenses but, her undying dedication never stopped her from doing so.

Sunitha is also able to visit 50 homes a month and meet their needs. She would sit at the counter from 1 pm to 6 pm two days a week to give OP sheets at Kinassery sub centre. After becoming an ASHA worker, she was able to understand the real situation in the area. Even before the survey was conducted, she could identify and assist the patients, who were suffering from loneliness, those who do not get food on time, and those with lifestyle diseases. She helped those who did not have a ration card by providing them necessary assistance to get the ration card. She delivered Vayomitra's medicine to bedridden patients. The number

of cancer patients in the ward is relatively low; and Sunitha was ready to visit them and provide them with the necessary medication and palliative care. Despite all this work, Sunitha is preparing to conduct a survey of TB patients.

The Rs.2000 given by the government to the ASHA workers as an incentive during the COVID-19 period was a temporary relief to them.

Sunitha did not face much challenge other than the fact that some people did not like the fact that a woman wearing a PPE kit was working for COVID-19 patients. But her husband and parents gave her full support.

Sunitha says that ASHA workers became the most needed people in the society during this COVID-19 period; she also saw a tendency among people to call ASHA workers for all their needs. Working in this field, she could meet more people and establish loving relationships. Sunitha is very satisfied that she has become the hope of those who are suffering.

More than anything else, Sunitha is proud to be known as an ASHA worker and to be able to organize awareness campaigns and stand with the community in the war against COVID-19, that is spreading in this entire world.

WAYANAD

Wayanad is a district in the north-east of Kerala state with administrative headquarters in the Municipality of Kalpetta. It is set high on the Western Ghats with altitudes ranging from 700 to 2100 meters. The district was formed on 1 November 1980 as the 12th district in Kerala by carving out areas from Kozhikode and Kannur districts. About 885.92 sq.km of area of the district is under forest. Wayanad has three municipal towns Kalpetta, Mananthavady and Sulthan Bathery. There are many indigenous tribals in this area. In 2006 the Ministry of Panchayati Raj named Wayanad one of the country's 250 most backward districts out of a total of 640.

PROFILE 23: JAINNAMMA

Jainnamma was born on at Noolpuzha Panchayat, Wayanad and she was the third daughter of Dany and Mary. They belonged to a typical Christian farming family. Her father died when she was seven. Later, her mother took care of the children and household, by going to work as a laborer and she farmed without remarrying. Jainnamma completed pre- primary and upper primary education from Kallur School which is located near their home and her Pre-Degree studies at St. Mary's College, Bathery. Although Jainnamma excelled in her studies, she couldn't complete her Pre-Degree. She had to undergo surgery due to her heart condition and she missed classes. She could not continue her studies after Pre-Degree. She got married at the age of 20 to Koshy from Thottamoola. Koshy used to work as an auto driver in Meenangadi. Meanwhile, he has been in the Gulf for 12 years from 2007. Since then, she has been looking after the children alone. They have been living in Choothupara for 24 years and have two children. Eldest son Jinu is 28 years old and has been working abroad after electronics engineering. Her daughter Meenu, is a nurse. In the early days after the marriage, she did not go to work. She later started working as ADS in Kudumbashree and MGNREGA.

It is said that Mahila Swast Sangh or MSS was the reason for her joining work as an ASHA

worker. They worked as volunteers in the sub-centre under the Health Department. They did not have any particular job but attended monthly meetings, organized events, and arranged classes. At that time in 2007, the NHM conducted an interview inviting women interested in social work. Its criteria were that the general category should be SSLC qualified and the tribal people should have 8th standard qualification. This is the criteria that existed in 2007. This is said to have changed in 2008.The panchayat committee, health supervisor and doctor were also present at the interview held in Meenangadi Panchayat in 2007. She remembers answering all the questions correctly and the doctor praising her. It was on the next seven-day training that they were told about their work and its nature.

The guidelines provided by NHM were like this: At present, you are doing this as a service, you won't receive salary or any allowance. If there is any chance, NHM will provide. However, the main reason for her continuing the job was because she felt there might be a chance of getting good salary later because it is runs by NHM which is government-run. She says she opted for the job because of her good knowledge and ability to socialize. This is the instruction they were initially given by NHM. "You don't have to be on duty every day. You can work three or four hours a day, three or four days a week. In the meantime, you can do other works," she said. She got her ASHA worker job in the same year when her husband went to work in the gulf, so her husband had no objection to her going to work. Initially their work was to find pregnant women among the tribals, locate the children for vaccination and take them to the nearest health centre and register the pregnant women. They had to do the work of entire colony in the two wards. In 2007, only 9 ASHA workers were selected for 18 wards, so they had the task of looking after two wards. All the information in each family was collected from the beginning itself; nevertheless, the health department and the panchayat did not tell them how to conduct the survey or what its format was. However, they went to each house and told them about themselves and explained their work to them. The data was then collected according to the wish of the ASHA worker. They collected data of children of all ages, pregnant women, in-patients, elderly cancer patients, married people, people living in rented houses and recorded it in a diary and changed it when they go back to the field. By this they say that they have become able to tell the exact details of every household in their ward, no matter who asks. She said that the first time they received a salary was in 2012.

They were allowed a salary of Rs 300 but received Rs 500. Prior to that, the incentive received was only a small amount. For this reason alone, doing this job alone was a hassle for them as they needed money to look after things at home and to be active like this. She was told that she could do other work in addition to this job, so she went for MGNREGA work. She also knew how to sew, so she sewed outside and started a sewing shop with her sister. It is said that other jobs were done after ASHA's duty but the priority was given to this ASHA worker job. Accredited Social Health Activists (ASHA) or ASHA workers are those who works under the NHM and work in the field at the grassroots level. The success of the NHM lies in the fact that it's a work in progress. The people who work with ASHA workers are the Junior Public Health Nurses, The Junior Health Inspector and the nurse. ASHAs are seen as mere field workers.

JHIs also need to be in the field to raise awareness and take classes on infectious diseases, but often ASHA workers alone are seen as working as slaves at the grassroot level. In the early days, even if they did not receive a salary, they would get an incentive; but if they

want to get an incentive, they have to inform their activities to JHI regarding what they did and send it to higher officials. It is said that when the work was first received, they did not receive an incentive commensurate with the work done. They still have a complaint that many things have been withheld and says that the activities in Wayanad district are not being carried out in a unified manner. As an example, they mentioned well chlorination. Every ward has public wells and own wells which are funded for chlorination. But some JHIs pay the required wages to ASHAs and others do not. This is the work assigned by the panchayat and there is a ward sanitation committee for this. JHIs have to come to the meetings but they would not come. A fixed salary has not been determined so far. An amount of Rs.5000 from state government and Rs.2000 from the Central Government can be obtained only if they work properly which includes preparing Health Activity Assessment Report, Report on ward health activities, reviewing ward matters, attending review meetings at the sub-center, performing hospital duties as part of the Ardram Mission, Immunization duties, doing clinic for pregnant women, providing palliative care for all patients.

Apart from this they have to do listed duties also on Health, Nutrition, basic sanitation, hygienic practices, healthy living and working conditions, providing information on existing health services and need for timely utilization of health and family welfare services. Birth preparedness, importance of safe and institutional delivery, breast-feeding, immunization, contraception, prevention of RTI/STI, other RCH issues, facilitate the access and availability of health services in the public health system at the sub center, PHC, CHC and district hospitals, work with the village Health and Sanitation Committee to develop the village health plan, escort the needy patients to the institution for care and treatment etc. She would accompany the woman in labor to the institution and promote institutional delivery. For Minor ailments such as fever, first aid for minor injuries, diarrhoea etc, a drug kit has been provided to the ASHAs.

ASHAs are also providers for DOTS, act as the Depot Holder for ORS, IFA, DDK, chloroquine, oral pills and condoms. They take care of new born children and manage a range of common ailments, inform births, deaths and unusual health problem or disease outbreak, promote construction of household toilets etc. That amount will be received only if ASHA workers do it properly. Apart from this, there are conditions to get Rs.2000 sanctioned by the Central Government. These are 50 consecutive home visits, 20 homes for pregnant women and children under the age of one, and 20 homes for single and bedridden patients. Accurate figures for all this are given to the JHI and sent to their senior officials. Often, they are not even paid for what they do. It is said that there are ASHA workers who earn less than a limited amount a month. It has been four years since they started getting their own salary to their bank account. Before that the salary was first sent to higher officials hands and they would transfer it to ASHA workers as per their wish.

ASHA worker, JHI and JPHN are above HI, HS, LHI and LHS. The Medical Officer, District Program Manager, the District Medical Officer are the higher officials. District Coordinator coordinates the work of codifying the activities of the ASHA workers. But higher officials do not even look at whether ASHA workers are getting salary or not, say Jainnamma. Although JHI and JPHN should go to the field, they will not go to the field and fill the data. This is one of the issues told by Jainnamma. JHI, JPHN and ASHA worker are volunteers who have to go for palliative work but JHI and JPHN often says they are not with them. For many things,

they are forced to work for a minimal Travel Allowance. At one time their duty was to collect sputum from people with tuberculosis and take them to Mananthavady Hospital for TB nat test. Mananthavady is at a distance of 45 km from Meenangadi and all they got for returning was 50 rupees.

There are many barriers for getting incentive amount. They said that it is very difficult to get an incentive amount. Pregnancy care is something that pays less than Rs. 300 for maternity and early registration in government institutions. If you register three months in advance, you will get Rs 300. In many cases, early registration may not take place. The reasons for this are many. Pregnant women in one ward are sometimes from another state. Some people do not disclose without pregnancy confirmation. Tribals often conceal pregnancy information. Because of all this, early registration does not take place. Secondly, pregnant women get an additional Rs 300 when they give birth in a government hospital. Sometimes that amount is not received. Those admitted to a government hospital for childbirth are referred to a private hospital when there are any complications. At that time the benefit is lost. If a child is still-born, no money is given. They have had two such experiences where they did not get paid when the child died despite doing everything for so long. They said they did not receive a single rupee at that time.

ASHA workers have to do all jobs told by the panchayat. The CHIM and CHIP is the main program of Meenangadi panchayat; the work under CHIM is to find underweight children under the age of 12 in the tribal population and CHIP is to find the underweight girl child under the age of 6. In addition to this, there is a duty to be performed by the ASHA workers every week as per the instructions of the health department. The clinic for pregnant women is on Thursdays and the clinic for lifestyle patients was initially on Friday and now it is on Tuesday. This is the work they have to do in their sub centre and they perform the same duty in the hospital once a month. On the day of the Life style Diseases Center functioning clinic. Some times JPHN was absent she had to look at the BP of the patient. In such a situation it is said that she was not able to give proper guidance to that patient. In addition to this duty the children have to be vaccinated on the second Friday of the month. She also has to organize a class focusing on one area once a month as part of Nutrition Day, make two visits to pain and palliative patients. She also has to attend meetings and visit 90 homes per month on non-working days. She says she can't even take leave because of the duty involved. It is said that if you have to take leave, your salary will be cut. The ASHA workers had such an experience. She had to take leave for her daughter's wedding in September last year. Even though she was on leave, the arrangements for the children's immunization had been made. She says she did not get paid for the day despite doing everything in advance.

ASHA workers are forced to do many jobs because they are not financially well off. She also started a tailoring shop. Her sister also works in the shop with her. But with the arrival of a new order, it is not possible to go for any other work. The ASHA workers did not agree to work and say they could not move forward on this salary. COVID-19 has burdened them with additional responsibilities and risks. Although the number of positive people was low in the district, it's harder to look at people who are in surveillance than it is to monitor those who are positive. The exact details of those under surveillance, those who have gone abroad and neighbouring states, should be traced. At first such people were under surveillance in government institutions when they came but now they are in their homes and places they

find on their own. In this case, whether they have accommodation, facilities, adequate food, or bathroom facilities available, the medicines they need etc have to be checked. ASHA workers say it is up to them to do all this.

Many people from the Karnataka region are said to have come in this way. In addition, during the COVID-19 period, they were given OP duty of the Meenangadi Government Hospital. She had to provide people with lifestyle ailments medicines to their homes. All this time they couldn't give precise instructions except to look at the pressure. Even in this COVID-19 situation, she can't stay at her own home instead. If someone is dead, she has to go to the place and stands there until the body is buried, making a list of people who came and see if the COVID-19 protocol is being followed. If a person dies at night, she has to get there at night. During the Lock Down, no vehicles were there, but there were situations where she had to call an auto and deliver medicine to their homes.

Now another problem the ASHAs face is that they are worried about how the polio vaccination will work during the COVID-19 period. All children up to the age of five should be prepared to do so. All households should be visited and told about this. But under the current circumstances, they say, ASHA workers cannot do that too. Many jobs need to be coordinated by JHI, JPHN and ASHA workers but there is no proper cooperation on their part. Wages are not paid for the work they do. Often wages are withheld. The hardships of the ASHA workers are mentioned in review meetings but often the blame falls on ASHA workers themselves. Their demand is to get their salary paid every month regularly and the incentive amount received monthly during Onam, Christmas and Vishu. ASHAs hope all these circumstances will change and everyone is waiting for that day when they will be paid and honoured according to their service.

PROFILE 24: KALYANI

Kalyani, was born in 1974 as the third daughter of Madhu and Shankini. They belong to the Kuruma section and were born at home. They were staying at Mukkath Colony in Poothadi Panchayath in Panamaram block of Wayanad. Her father worked as a labourer, and her mother stayed at home looking after the children. In addition to her, there were ten children. The mother gave birth to all the children at home. Three of the children had sickle cell anaemia. As the eldest child in the family, Kalyani looked after the house and the younger children. Kalyani, who excelled in her studies, was not able to concentrate well in her studies due to her early home duties. After class, there was still housework and paddy threshing. LP and UP studies were at a nearby school. Father took care of his children's education and sent them to school, despite the lack of facilities to study. Therefore, she did her high school studies at St. Mary's Hostel Bathery at St. Marys College. Although she wanted to study Pre- Degree, at the age of nineteen her cousin Rajan S/o Pichen and Madhu from Kolampatta Colony, Kakkavayal married her and came to their house.

They were married in 1993. In 1992 Kalyani's father died. She got married and went home with her husband, but did all the household chores and sibling's affairs as well. Omana's husband is a laborer. The eldest daughter Reeja works as a mentor teacher in a private School. She is married. Youngest daughter Shreesha has completed her PG and is studying for PSC. Kalyani cared to teach both children according to their wishes. Kalyani was ready to provide her children with facilities and education that she did not have. It was decided to

marry them off only after they had completed their studies and obtained a job. The youngest daughter said that it is with great pride that we get to be known in our places through our mother. Although her husband worked as a laborer, she never went to work until her children grew up. They also had small scale paddy cultivation. Kalyani wanted to work and look after the family at that time.

In 1999, the Tribal Department and the Panchayat conducted an interview for ST promoters in the tribal areas and Kalyani participated in it and got selected. Their only responsibility was to take care of the affairs of the tribal people as they were in that field for about five years. It was an easy job and at the beginning she had a salary of 1000 and later the amount was increased to 2500. But when the next administration took charge their term ended and they lost their jobs. Next time she applied for this post but she did not get it. Then for a year or two she stayed at home without going for another job. It was then that in 2007 a meeting was held with the panchayat under the NRHM inviting women interested in the field of social service. This was also an activity among the tribals. The main task was to take care of pregnant, lactating mothers, and children and to care for their health.

At that time the duty was for about ten colonies in two wards. It was said that in the early days activities would be incentive based but incentive was not received. If pregnant women were found and registered and they gave birth, they would get Rs.600. They say the process of registering such people has been completed but that the amount lapsed. She got the job after working in the tribal department. During the time of her resignation she received an amount of Rs 2,500. During her tenure as ST promoter, she was involved in social work and public works. She saw this job as a good opportunity to deal with the hardships of losing a job and interacting with people again. She was sure that the experience of working in the tribal areas would also help in this work. She was able to make a difference in the tribal colonies in five years. When they were selected in 2007, the Department of Health's recommendation was to stop deliveries at home. It was also a time when there were a lot of home deliveries among the adivasis. When asked what the disadvantages of home deliveries are, they said: One is the possibility of bleeding, second one is that the umbilical cord of child may not be cut or may be cut using an object available to them, resulting in infection. The first seven days of training included such topics. So after they became more aware, they carried out precise interventions and awareness programs and eliminated home delivery. The delivery date of each women is known to the ASHA worker, during this period they do things in advance to get them to the hospital.

In 2008, the ASHA workers were given new rules and responsibilities. It was rearranged in a manner that one ASHA for 1000 people. She had to look at the things of the general people as well. The emphasis was on pregnant women, lactating mothers, and children. Later it was changed from a thousand people to a whole ward. There are currently 438 families in their ward and they have accurate data of these 438 families. It contains accurate information on all categories of people, including children, children under the age of five, pregnant and lactating mothers, the elderly, inpatients, and lifestyle and cancer patients. In the early days it was a house-to-house survey. All homes must be visited at least once every three months. Accurate data should be taken. Only then can the pregnant woman be registered three months in advance following which she can receive an incentive. If not followed properly, the pregnant woman will not be informed and the ASHAs will not receive the incentive

amount. ASHA workers receive only incentives in addition to honorarium. It also has a lot of criteria. Therefore, after two or three years, they receive an honorarium of Rs. 500. Although it increased in subsequent years and increased to 4000 in 2018 and 5000 to 2020-21, this amount is not always accurate.

There are certain rules for getting incentive and getting honorarium. Preparing Health Activity Assessment Report, Report on ward health activities, reviewing ward matters, attending review meetings at the sub-center, following hospital duties as part of the Ardram Mission, performing immunization duties, clinic for pregnant women, palliative care for all patients through camps. Apart from this they have to do the listed duties also on Health, Nutrition, basic sanitation, hygienic practices, healthy living and working conditions, providing information on existing health services and need for timely utilization of health and family welfare services, birth preparedness, importance of safe and institutional delivery, breast-feeding, immunization, contraception, prevention of RTI/STI other RCH issues, facilitating the access and availability of health services in the public health system at the sub center, PHC, CHC and district hospitals, work with the village Health and sanitation Committee to develop the village health plan, escorting the needy patients to the institution for care and treatment. She will accompany the woman in labor to the institution and promote institutional delivery. For minor ailments such as fever, first aid for minor injuries, diarrhoea a drug kit has been provided to ASHA. She is also the provider for DOTS, and act as the Depot Holder for ORS, IFA, DDK, chloroquine, oral pills and condoms. She also takes care of new born babies and manages a range of common ailments, inform about births, deaths and unusual health problem or disease outbreak, promote construction of household toilets etc. Honorarium can be obtained only if all these are done correctly. Apart from this, there are conditions to get Rs.2000 sanctioned by the Central Government. These are 50 consecutive home visits, 20 homes for pregnant women and children under the age of one, and 20 homes for single and bedridden patients.

They got their salary very slowly. Initially it was not said that this work alone should be done. But now that is what they have to do. After entering the job, they cannot go for any other job. She is working in Cheeramkunnu sub center under Meenangadi Government Hospital. They do the work as a team. In addition to these, there are two ASHA workers, JHI (junior health inspector) and JPHN (junior public health nurse). They are going well with everyone. In the working field, they say, there is no difficulty from the bosses now. Every day there is a fixed duty work; clinic for pregnant women on every Thursday, clinic for lifestyle patients on Fridays, immunization on the second Thursday of every month. The responsibility of ASHA workers also includes taking the pregnant women to the anti-natal clinic for check-up, taking care of the elderly and taking people with lifestyle diseases to the NCD clinic. It is the responsibility of the ASHA worker to take the children for the immunization program. ASHA workers must attend the day's duty. When the need arises to take leave, others help by taking over the duty. In addition to this they have to visit Pain and Palliative Home two days in a month. Nutrition Day should be held once a month and classes were taken for children on different topics. They can also enlist the help of an Anganwadi teacher. The class will be taken by JHI.

They have received 8 modules training to cope with each and every need. In spite of these difficulties there is a reason why they continue in this job, it is because of the care which they

can provide for pain and palliative patients by going to their homes and talking with them and listening to their concerns. Patients often feel sad if ASHAs don't visit their home. She also says that by interacting with such patients she knows how to tackle such situations. An example of this is that when her sister-in-law's husband fell down and became bedridden, she was able to take care of and pacify her sister-in-law.

While she was still an ASHA worker, in the early days she tried for another job and tried twice for ST promoters' post but did not get it. She later said she never tried for an interview for the position. She was elected as the UDF candidate in the last election due to their acceptance among the people and because of working among all people. She lost her seat by a very small margin. On return, she continued as an ASHA worker. Asked what else she wants to work on, she said she wishes to continue as an ASHA worker. She said that she loved the job so much that after entering the job she was able to maintain good relationships with most people in the community including common people and other dignitaries. People share all their problems with them because they have good relationship with people. They started working without a salary and now earn at least a small income. They says that the income which was not received properly before started to come on time after COVID-19.

But after COVID -19, the duty schedule changed and she got more jobs. The daily information of the people who were positive, information of the quarantined people, the preparation of the contact list of the people who were positive, the OP duty of the Meenangadi Government Hospital, the delivery of medicine to the home of the lifestyle disease patients, and the inquiries of the pregnant women and children- all this came to her. It is said that due to the low number of positive cases reported so far in Wayanad district and the low number of reported cases in Meenangadi, she has less works to do but this increased the use of WhatsApp and phone calls.

To get the complete details of every person in a region the officials have to seek the help of ASHA workers. For example, during elections, they are asked about the number of members of a household and the details of people whose names are on the voters list. The monthly review meeting is a platform to open up about ASHAs problems. In this the activities of ASHAs are evaluated and their problems are told to higher officials. They get salary and incentives occasionally. It is said that the salary and incentives were received correctly during this COVID-19 period. If it is not received at the right time, those who lead a normal life are not able to repay the loan in a month. That is why they want the exact salary at the right time. The hardest part of their job is the annual pulse polio vaccination. For making this program success they have to give their 100 percentage commitments ie, children should be brought from home and accommodated with them until they are vaccinated. But for this they get only gets Rs 75 per day. ASHA workers too anticipate better treatment for themselves and a day when COVID-19 is wiped off from the face of the world.

KANNUR

Kannur is one of the 14 districts along the west coast in the state of Kerala. Kannur is most renowned for its Theyyam Performances and this magnificent art form plays an integral part in the culture of Northern Kerala. Kannur has, since time immemorial, been hailed as an influential sea port.

PROFILE 25: BEENA

Beena is a 42 year old ASHA Worker of Mangattidom Grama Panchayath of Kannur district. She was born as the daughter of a farmer Gopi and house wife Vimala. She had 2 brothers and one sister. The main income of her family was agriculture. They did cultivation of paddy, pepper, banana, tapioca and vegetables. Beena's parents were very hard working and earned income from all these for their survival. Her family atmosphere was really good. They were not rich, but her father was able to meet all the necessities of his children through the income from agriculture. The children also helped the parents in farming. Parents gave freedom for children to express their views about life. Her parents were not that much educated, but they had a vision about their children. Beena remembers that there were no tension and problems in those days.

Beena was average in her studies and completed SSLC from Aralam Higher Secondary School and did Pre-degree from a Private College. She didn't continue her studies after that. She started helping her parents in farming. After 2-3 years her parents decided to get her married. In 1998 she got married with a timber business man named Jayan who was residing at Mangattidom Grama Panchayath. When the marriage was fixed, she got a job in District co-operative Bank as a collection agent. She went for job 2 months before marriage. After marriage, she continued her job only for 2 months. Her husband's house was in a remote area and no bus services were available. Her office was too far away from husband's house. Beena had a plan to stay at her own house and continue her job for at least one year. If she did so, that would have been a solution for her travel difficulties.

Husband's family was very orthodox and reserved. They had no contact with neighbours and society. Husband had a sister and a brother. His parents didn't like to send her for a job. But she continued the job. After 2 months, she became pregnant and became unconscious while doing her job. After this incident, husband's parents refused to let her continue the job. Her husband had no voice to oppose his parent's decision. At everyone's urging, she resigned her job and she didn't go for any job for 7 years. She became the mother of 2 children. After 5 years, they moved away from family home to their new home. Husband's brother and sister got married by that time. After 2 years, husband's parents died.

Beena's husband was very progressive. He did not want her to be only a house wife. After 8 years of marriage, she joined kudumbasree and started to become active in public. She also joined the National Employment Guarantee scheme and started to earn a small income. For the last 13 years, she has been active in politics. She became the Secretary of her Kudumbasree Ayalkootam.

Beena really likes to mingle and work for public welfare. During this time, she came to know that applications for the post of ASHA workers were invited in the Panchayat under the National Rural Health Mission (NRHM). So she applied for that and got selection. In 2009, she started a new career as an ASHA Worker. At that time she had 3 days of work in a week and got Rs. 300 as honorarium. Remuneration was very low at that time, but for Reena, work among the public was the main reason to select this job. In 2009, 34 ASHA workers were selected.

She says that in the initial stage, the job was really difficult. ASHA Workers had to travel to

each and every house in their concerned wards to explain the aim of NRHM, roles and duties of ASHA Workers. Since Reena's area was very hilly it was very difficult to reach every house. In her ward 2 ASHA Workers were appointed. It was really difficult to convince people about ASHAs. In her ward, majority of population is from minority community and they were not ready to vaccinate their children. For Reena, convincing the minority community of the importance of Vaccination was a Himalayan task. There were 270 houses under her. In those days, people were also not ready to cooperate with her. But she visited each and every house many times. At the beginning there were only some duties to perform. But later, duties of ASHAs increased. Among 34 ASHAs, 15 resigned their job due to the strain of the work. So, the strain of remaining ASHAs increased immensely.

Beena gave a short note on their duties.

1. Making the people aware about the importance of Pulse Polio, other vaccinations, personal and environment hygiene.
2. Enrolling pregnant women in PHC in first 3 months and providing them with Folic and iron tablets. Reena visits the pregnant women every month and make them aware abut T T, monthly check-up, good food and exercises.
3. She gives MCP cards to the pregnant ladies and encourages child birth in Government hospitals.
4. She takes all the details of new-born babies like date of birth, weight etc and gives report to junior public Health Nurse (JPHN) within 7 days.
5. She explains in detail about family planning methods and about the health of children up to 5 years.
6. Finds and registers bed ridden patients and arranges things for their assistance (water bed, wheel chair, walking stick) in association with the PHC and the Panchayat. Visits palliative care patients every month.
7. Finds out about infectious diseases and chicken pox and reports it in the PHC.
8. Chlorinates the wells and performs source destruction activities.
9. Visits cancer and dialysis patients, organizes nutrition day and sanitation committee at Anganwadis and discusses about the issues related to local health.
10. Participate in Grama sabha, Panchayat level meetings, Aardram and NCD duty in the PHC, conducts Survey and finds out about TB patients and gives the report to the PHC.
11. Conduct awareness classes for adolescent girls and boys.
12. Reena takes care of old and critically ill people, and visits their houses regularly. Sometimes Reena has to go to the hospitals with the patients, because there are no responsible person with the patients.
13. She attends all ADS meetings regularly.

Beena has many more additional works to perform. Beena shared an experience of a bed-ridden patient. The patient's children were not ready to take care of them or cleanse the patient's body. The patient was lying as if bathed in urine and faeces. One could not go

into the room without holding one's nose. A palliative care nurse was also with Beena. They could not bear to see the situation of the patient. They also spent a long time cleaning the patient's room. The next time they visited the patient, it was very clean; but the most amazing thing was that it was not the children but the neighbours who cleaned the patient. They said, if you have come somewhere to clean, then why not we do it since we are nearby. After this incident, whenever Beena went to visit the house, the patient looked clean. That was as unforgettable experience for her.

Beena has had to deal with children who are addicted to Alcohol, Panparag and Hans. She informed these matters to the concerned authorities and took necessary actions. As a result of this, the use of intoxicants by school children has been brought to the attention of the authorities. It was seen as a great achievement.

Works during COVID -19

People have been panicking since they came to know about the pandemic. ASHA workers' work-load doubled during this period. Beena visited all the houses and made people aware of the disease. At first people were not aware of the importance of quarantine, social distance, use of masks and sanitizers. Beena had to visit the persons who were in quarantine and if needed gave them medicines and other things they needed.

She also had to check whether the person in quarantine violates quarantine or not. She says there was an unforgettable incident during COVID-19 period. A person had come from the Gulf and he was not ready to go into quarantine. He came and got out of his vehicle and fled without going to the quarantine centre. Beena reported this to the officials. That person (Rajeev) reached his home and shut the door. All officials including the Police, the Panchayat President, Doctor went there and asked him to go to the quarantine centre. Rajeev refused to go. He climbed on top of the house and threatened that he would commit suicide. After several conciliations, he was brought down and placed in the quarantine centre. Beena was able to return home only after completing all these procedures. Next day this news came in the newspaper, but Beena's name was not mentioned anywhere. Despite all this, she was very upset that she did not even get any recognition for it.

During the COVID period she had to work without any time limit. She has to identify the persons who were in quarantine and submit the report to higher authorities. She had to visit these persons daily and report whether they had any symptoms. Beena delivered medicines and other essentials to the people who were in quarantine. She went to the PHC and bought medicines and delivered them to the COVID patients. Beena had to relieve patient's mental stress and misconceptions among the people.

Challenges and problems facing by ASHA Workers.

1. Over burdening due to work; at the time of any pandemic and other infectious diseases, they have to work not only in their own ward but in other wards too.
2. At first, they were called upon for PHC cleaning, but later ASHA workers said it was not possible. She said that higher authorities do not understand ASHA Workers' difficulties.
3. ASHA Workers submit their work report to JPHN and she is the concerned person who has to submit this to the higher authority. ASHAs will get their salary only if JPHN submits the report accurately. Due to the mistake of JPHN, some ASHA Workers didn't

get their salary in Lock down period.

4. ASHA Workers are underpaid in comparison to the work done by them. They do not get sufficient salary.
5. Though the ASHA get support from the public, they do not get that from the officials. They have to do field work which has to be done actually by the JPHN. This doubles their workload.
6. ASHAs want to be paid for the work they do every month. They are also worried that their Superiors see them as inferior.

Despite all these problems Beena likes her job very much. She considers this job as a privilege; to be among the people and to know their comforts and sorrows. She is happy to be able to do what she can do for others. She wants to do this job as long as she can. When I visited houses with Beena, I could see the affection of people towards her. When we went to the homes where the elderly lived, they were lovingly embracing Beena. From this we can understand, how passionate and sincere is Beena in her job. She has an opinion that the authorities need to understand the problems and work load of ASHA workers and take necessary actions to solve this. They need recognition from the authorities and should be paid sufficient salary in accordance with their work.

PROFILE 26: LALITHA

Lalitha is the ASHA worker of ward 10 of Pinarayi Grama Panchayat, Kannur. She was born in 1966 at Kappummal, Panakimetta as the third daughter of Rajan and Layila. She has 2 elder brothers and 2 younger sisters. Her parents were daily-wage workers. Her father was a stone mason and her mother was a beedi worker. Theirs was a life of poverty. Her parents worked hard to make both ends meet. Lalitha completed her studies from Kozhur UP School, Kappammal and Kathiroor High School. After SSLC, though she joined Pre-Degree she did not pass the final examination. After that she started doing beedi work to help her parents. According to her, the situation of her house was very pathetic and that at times there was even not enough food to eat. Due to poverty all her siblings stopped studying and started going for wage labour. She worked as a beedi maker for about 5 years. In 1988 she got married to Dineshan from Pattenpara of Pinarayi Panchayat, He was a stone mason in Kappana. According to Lalitha, though he used to drink alcohol, he is a good person. Lalitha recollects that she always had issues with her in-laws. After 12 years, they built a house of their own and shifted to the new house. They have a daughter, who is now married and with her husband.

In 2009, when Lalitha found that ASHA workers' applications were invited, she did not even know what an ASHA Worker was. Any way she applied for the job at the age of 44. 45 years was the age limit. Once she was selected she had crossed the age limit. Because of this there were many obstacles to get appointment and she got job after a lot of problems. It was only after training that she realized what an ASHA Workers' Job was. At that time 265 houses were under Lalitha's supervision. In the beginning she was not well received among the community and many acted badly towards her. People asked her who gave her the power to collect their household details. It was very difficult to convince them and make them aware about the roles and responsibilities of ASHA workers. At first, she did not have a lot of work, but gradually the workload increased. After the ASHA Worker who worked with Lalitha

resigned, she was given that responsibility too. She had the total responsibility of the ward and she had about 560 houses in the ward. It was very difficult for her to complete the full house visit. Her ward was in a remote area with fields and slopping areas. There was no bus service available. So, she had to walk long distances every day.

Lalitha is residing in the 10th ward and working as an ASHA worker of the 11th ward. So, in the initial stages of work people didn't co-operate with her, so she had a hard time. The main thing was the lack of co-operation from the people. Once she went to a mentally challenged man's house and he held Letha in his arms. She cried for help and neighbours came and rescued her from that man. That was a terrifying event. Similarly, while walking through an uninhabited field to visit a distant house, a mongoose bit her. The blood flowed non-stop but no one was willing to take Letha to the hospital or accompany her. That was a shocking moment for her. Lalitha was crying when she described this incident to me. This incident shows the clear picture of non-cooperation and rude attitude of people towards her. Later, circumstances changed and people began to co-operate with her.

Lalitha has to go through many difficult and challenging tasks as part of her job. Initially there was little co-operation from JPHN and the authorities and the work done was not approved or their report were not forwarded to the superiors in a timely manner. As a result Lalitha and another ASHA worker didn't receive a month's salary. Lalitha complained about this and there were orders to pay the amount due from JPHN's salary as it was due to fault on the part of the JPHN. This incident angered the JPHN. The JPHN always tries to find fault with Lalitha though she had done things honestly. So there were many who were against her because she was a person who spoke things openly. Often most difficult jobs are given to Lalitha. Though there were many difficulties she enjoys her job. The JPHN got transferred and a new JPHN joined. Thereafter she has felt that there is a change in the working atmosphere.

Lalitha says that COVID-19 time was a time of fear and that people were really panicking about the pandemic. People were terrified of how they would survive the disease. Also, there were many misconceptions about the disease among the people. People were not aware about the precautions and proper use of mask and sanitizer. Some people consider COVID-19 as just a fever. Lalitha fears that this will worsen the situation. Lalitha visited each and every house of her ward many times and tried her maximum to make the people aware of the situation. For her visiting more than 500 houses during this difficult time was a huge task. She sincerely wishes that the world should be rid of this disease. Till now she had dealt with 30 COVID-19 positive cases and more than 100 people who were in quarantine. She lists her duties as an ASHA worker during COVID-19 thus:

- Buying medicines for COVID-19 patients from the PHC in a timely manner and delivering them.
- Collecting declaration from the patient and submitting it to the PHC.
- Visiting the houses of people who are in quarantine and finding whether they are having any symptoms or not and giving the report to PHC.
- Delivering medicines and other necessities to the people in quarantine.
- Providing informal counselling to alleviate the stress of people who are under stress related to COVID-19.

- Spreading awareness to the people regarding the pandemic and the need for practicing social distancing, proper use of mask and sanitizer and washing hand with soap and personal hygiene.

Lalitha described the difficulties she faced. One patient who was in quarantine in her ward committed suicide, because he could not bear the mental stress. He was unmarried and had no close relatives. That was an unforgettable incident for her. She says COVID-19 Kits with necessary medicines were supplied in some Panchayats to ASHA workers. She complains that such kits were not provided in her panchayat. So she had to procure for each patient as required through PHC and distribute it. Some people in quarantine used to call for every little need every day. Not all ASHA workers were given masks and sanitizers from the PHC. They were given only if asked several times.

Lalitha has been facing difficulties from her previous JPHN. She says if for any reason, any ASHA worker was on leave on the day of submission of monthly report JPHN would cancel the payment for that month. No matter how much work ASHA workers do, they are nor treated decently. She feels the current JPHN is sensible and more empathetic towards these issues.

During these adversities she wishes to continue this job since is her only source of income. She also loves this job so much because she can help people at least a little bit through this work.

KASARAGOD

Kasaragod or Kasargod is the northernmost district of Kerala and is included in the North Malabar region. It is also known as Saptha Bhasha Sangama Bhoomi (The land of seven languages), as seven languages namely Malayalam, Tulu, Kannada, Marathi, Konkani, Beary, and Urdu are spoken, unlike the other districts of Kerala. It was a part of the Kannur district of Kerala until 24 May 1984. The district is bounded by Dakshina Kannada district to the north, Western Ghats to the northeast, Kodagu district to the southeast, Kannur district to the south, and Arabian Sea to the west. Kasargod district has the maximum number of rivers in Kerala.

PROFILE 27: RAGINI

Ragini, an ASHA worker from ward 7 of Bedadukka Grama Panchayat in Kasaragod district is a gifted folk singer. Her strong personality is reflected in her voice and smile.

Amidst the hardships of the pandemic and the rush of heated election campaigns, she sat down for a few minutes to tell her story, about her desires and her anxieties as a social worker and health activist.

Ragini had a completely transformational journey. Her journey began as a Kudumbashree volunteer; later on she became the ASHA worker of ward no 6. At the age of 43, with just an SSLC qualification from the government school of her village, she became the local body elected member of ward number 6 in the year 2016 - 20. This transformational journey from being a volunteer to becoming a democratically elected local body member is worth listening to.

On being questioned about her source of confidence and encouragement for her people centric activities, she says that her household is the source of her inspiration. Her close-knit household consists of her husband who is a temporary forest watcher for the village in the hilly forest area which suffers from the encroachment of dangerous wild animals, her son who is a research scholar at the central university and her daughter who is pursuing post-graduation in Carnatic music from the Kerala Kalamandalam. Her musical family enjoys performing beautiful folk songs for patients during the palliative care unit activities. She believes her biggest asset as a people's representative was the happiness they brought to the people.

Her daily schedule is unimaginably hectic. The remoteness of her village is felt in her daily journey to the Panchayat office, which includes trekking a steep mountain and then interchanging two buses. Unlike an adventure activity, this is her routine as an ASHA worker. Also, her work as a peoples' representative and other multiple political ventures consumes her whole day. On being asked, whether her work as an ASHA worker or an elected representative is the bigger responsibility, she replied that the latter is the bigger responsibility.

Her perspective about village development as a whole was very insightful. She claims that the health of an individual and the health of the village is of equal importance for overall development. The local inhabitants also look forward with many expectations towards this development. She says that addressing these expectations is a very difficult task.

The only dissatisfaction she pointed out with a smile regarding her candidature was the realization that "the crowd would forget you no matter how revolutionary your work is, with time." With a curious laugh, she explains how unexpected it was for her to be elected in ward 7. Her journey as the ward 7 member and the ASHA worker of ward 6 would be taking her all over the place, with a lot of responsibilities ahead.

Ragini talks about how ASHA workers weren't given much consideration in her early days. She says that the gradual increase in incentives and the salary along with the responsibilities was a great relief. She was working at the forefront in coordination to achieve collective resistance during COVID-19 pandemic. She managed her responsibilities in COVID duty, at the testing centres and the Out Patient facility in the hospital. Her presence was significant in the monitoring committee and the monitoring of the quarantine centres.

During this chaotic period with over burdening responsibilities, she said her biggest relief was the allowances. During this situation, carrying out the election campaigns and the ASHA worker's responsibilities were very difficult. Despite the difficulties, she devoted her major time in the field only. While she was a ward member, she didn't receive the honorarium as an ASHA worker due to some policy issues. She says that the ASHA workers union had to intervene to find a solution.

With much pride she described the achievements of her ward. The palliative care unit of her remote village in the hilly terrains of Kasaragod along with the supportive local body representatives and other officials were rewarded at the Maha Panchayat organized by a prominent news channel. She emphasized the importance of ASHA workers in her ward, they were part and parcel of everything happening in the ward.

She says that as field workers, the health department officials do get the opportunity to work

along with the palliative volunteer team. At first, it is a bit difficult to confront the sorrows and hardships of the people. But with time, according to Rajani she changed to a more empathetic person, who could console people. She said that writing down the details about her visits in the diary enlisting her works as ASHA worker was very much helpful for her social and political activities.

On some days she feels as if there's no one to help. There's no proper road leading to her house. But the moment she leaves her house she will be busy in her responsibilities as an ASHA worker and elected representative of the ward. She is always in the midst of people where she is heard, valued, needed and appreciated.

PROFILE 28: PONNAMA

Ponnama is an ASHA worker of ward 3 of Bedadukka Panchayat. She lives near the banks of river Payaswini near the Bavikkara dam. It is the source of water for Kasaragod town. Her small house is near the suspension bridge. Thankamani's husband is a farmer. They have two daughters and a son. All of them are married. Their son got married to a Srilankan girl last year.

Ponnama was forced to stop her studies after SSLC due to financial difficulties of her family. She joined as an ASHA in 2010. Since she was a Mahila Samastha Sangham Volunteer she had an opportunity to join as an ASHA at the time of its inception itself. But due to some family responsibilities and other difficulties she was not able to join at that time. She is also engaged in Kudumbashree and Women's associations of her panchayat. Currently her work revolves around the 322 houses of the 2nd ward. She actively participates in all the jobs assigned to her. Once when her pregnant neighbour who was crossing a bridge underwent sudden labour contractions, Ponnama without any hesitation carried the lady to the nearest vehicle. The road was not in a good condition and the women delivered the baby inside the vehicle itself. Ponnamma stood by the lady during the delivery. She shares this as one of her most memorable experiences.

While the world was gripped in the fear of the pandemic, she had to leave for Abu Dhabi in August 2020 to take care of her pregnant daughter-in-law. Her daughter in law, who is from Srilanka had lost her mother in an accident few months ago. Her visit was only possible because of the grants she received to care of her daughter in law, even during those restrictive times. Even during her absence, she was able to stay up to date regarding her work through WhatsApp with the help of two Anganwadi teachers from whom she had sought help prior to her visit. For her 2 months leave, an anxious Ponnama was ready to take her first flight. She was perplexed and scared about the strict COVID-19 protocol, rules and regulations especially the security check. All of this was a new lesson for her.

Ponnama recalls that the incentives provided to ASHA workers are very low. Later on, with the intervention of the ASHA workers union there has been a rise in the honorarium. Although there was an increase of Rs 2000 during the pandemic, the workload was much bigger compared to that amount. There has been a relief with new guidelines to conduct meetings and classes. Ponamma says that, the bus fare alone in this hilly area empties her savings. She is looking forward to the newly built road so that she can learn to ride a Scooty.

Ponnama is very active in the palliative care activities of the Panchayat. The palliative care unit along with the health workers and local body representatives organizes palliative day

by sharing food and organising cultural programs. Ponnama says that due to her timely intervention many needy people in her ward was able to avail of the government's pension scheme.

She says that during the initial days, first aid kits were provided. Nowadays, even a Blood Pressure monitor isn't available. Ponnama said that while returning from Abu Dhabi she brought a Blood Pressure machine with her, which is very useful for the patients. She used to check blood pressure during Kudumbasree meetings. Ponnama says that providing primary health care workers with basic medical equipment would be good. With immense difficulties and a meagre amount as honorarium Ponnama finds it difficult to meet both ends. Still, due to the support of her family and the satisfaction she gains by serving people she moves forward.

FINDINGS AND CONCLUSION

From this study tracing Kerala's LSGs' response during the COVID pandemic including the ethnographic study on ASHA workers, there are many findings that are clearly evolving with regard to the emergent role of LSGs and LSG functionaries in community-centric disaster management. While some of them can be clearly linked to the strong decentralised governance framework that Kerala has evolved the last 25 years, some of them can be linked, albeit not as clearly to the changes in policy brought forth after the devastating floods of August 2018 as well as the COVID pandemic response itself.

The main findings and suggestions from the first part of this study are:

- Set against the backdrop of the need for ensuring autonomy to LSGs in-order to facilitate individualised, contextualised action, there is a need for overall guidance and coordination from the upper echelons of government considering the federal nature of government during a disaster. This can be in the form of advisories, guidelines and similar instruments, but they have to retain decision-making power with the LSGs so that they can make value judgments instead of merely acting on the instruction of the State government. Such an approach has surely helped Kerala's LSGs to serve effectively during the COVID response, especially after the lockdown started during the second stage of the COVID response.
- The Incident Response System on the ground consisting of the LSG steering committee and associated teams needs to be strengthened with adequate resources including information and capacity building. Government advisories should provide role clarity, and enable departments and institutions on the

ground to work under the IRS in a complementary manner. Such an approach will surely enable to Kerala's LSGs to serve effectively during disasters.

- Training and capacity-building that has been provided as part of the local level disaster management planning process by KILA and the State Disaster Management Authority, tools such as the local level-disaster management plans and the recognition of the Steering committee as an umbrella body for coordinating action at the ground level has proven well during the COVID response including in disaster preparedness. More focused training through training needs analysis can be done.
- During peace time as well as during a disaster period, there is a need for abiding by the principle of subsidiarity in order to simplify delivery of services to the people. Therefore, the government closest to the power should be given the autonomy through necessary conduits including executive instruments, existing frameworks and funds to do this. In Kerala, this has been done to a certain extent during the COVID response ensuring that maximum activities and service delivery and welfare measures are taken by the LSGs itself through their existing mandate. This also ensured that the LSGs could continue to perform their regular functions and delivery of services even during the COVID response period. However, there is much scope for improving this, especially in light of more long-term consideration of different categories of disasters.
- A system of monitoring evolved from the within the decentralised governance framework itself would make overall coordination simpler. This would also help in building accountability of the LSGs, not just towards the State government but also towards the people. This can be done using reporting templates and as was done during the COVID response; however more emphasis needs to be given to regular review meetings allowing for exchange of information on both vertical and horizontal channels. These will help in integration between different authorities but also provide opportunities for clarification of concerns and apprehensions of everyone concerned, especially the LSGs.
- The LSGs have the capacity to ensure a humanitarian approach at the time of a disaster due to their existing mandate itself. But this can be achieved in the long run only through the active involvement of the people, not just through consultation and flow of information but through active participation, interaction and ownership. Only such relationship can help in efforts for instance to ensure no stigma towards COVID positive cases and to ensure all support – emotional and financial to such households, something which the LSGs took up actively under the leadership of their ward members.
- Most LSGs in Kerala were able to coordinate and work with volunteer groups during recent disasters and especially COVID; however, this needs to be strengthened through further inclusion of civil society and volunteers in committees not just at the time of a disaster but during regular time as well especially utilising the Grama Sabha and other forums including working groups and specialised committees and response teams.
- The integration with the Health Department and the Kudumbashree workers during the COVID response helped the LSGs to work effectively during the COVID response. More in-depth studies are required to study possibilities for such integration further. Such studies should be targeted on reducing issues arising out of dual control on functionaries operating under the LSGs, especially with regard to their roles with regard to disaster management.

FINDINGS REGARDING ASHA WORKERS

In an ethnographic research we have large set of other data including detailed description presented in narrative. In the present study the purpose of description is to allow the reader, be it a researcher or policymaker for a very detailed micro-analysis and interpret it accordingly. But for the purpose of answering research questions the researchers are trying to answer, the data is reduced and analysed to come up with the following findings:

- Despite all the odds they face the ASHA workers are highly motivated and expressed satisfaction about their work.
- Barring three, all the ASHA workers opined that they are getting support from their family members. Even then all of them face double burden of shouldering domestic roles and public role.
- ASHA workers do their service on inadequate remuneration, irregular payment and inconsistent income.
- Majority of the ASHA worker's husbands or other family members are daily wage earners or work in unorganized sector with minimum job security and irregular source of income. So these women can't afford to leave this job or have the courage to bargain for their needs and demands with the authorities.
- There are no fixed guidelines for leave, travelling allowances, job definition and proper coordination of work or line of control. They are answerable to many and under multiple controls. The job of an ASHA worker reinforces the stereotypical gender role of care work as unpaid and undervalued women's role.
- Most of the ASHA workers reported that they are healthy without many ailments, three of them who complained regarding joint pain, one, who is having difficulties due to Asthma and another one who has undergone severe stress due to panic over COVID-19.
- All the ASHA workers unanimously stated that their service during COVID-19 have enhanced their reputation and acceptance among people. They also reported that they started receiving their payments regularly after the pandemic.

SUGGESTIONS

There is a need to fix a line of control and reduce hierarchy, ensure job security and a decent income as well as to provide regular training to the ASHA workers. There is also a need to enhance risk allowance and provide insurance coverage and protective gears to the ASHA workers.

CONCLUSION

In Kerala, the role taken up by LSGs in the COVID response speaks about the capacity of LSGs to serve in a pivotal position at all stages in disaster management. Kerala's approach, brought on by years of concerted investment in LSGs including through regular capacity building, transfer of funds, functions and functionaries saw an overall attempt to ensure conformity by the principles of social justice and equity during the COVID response. During the COVID response, most LSGs were able to take contextualised, community-centric action building on existing social capital and making use of their Constitutional mandate and powers with only overall coordination and guidance from the State government line Departments. From running awareness campaigns to taking care of their vulnerable sections to running community kitchens to something as simple as working actively against stigma towards COVID positive cases, most LSGs showed a very strong commitment to the task at hand, integrating activities across the board with different stakeholders especially the community.

Going ahead this clearly indicates that LSGs in Kerala are indeed the pivotal umbrella platforms through which community centric, participatory, empathetic form of disaster management integrating different departments as recommended by the Sendai Framework could be carried out. Being the government closest to the people, they have indeed been able to gain the trust of the people, as well as act as links between the community and the state government. Their capacity to mobilise social capital and the volunteerism spirit in Kerala since the August 2018 floods is truly remarkable. That said, this stands testament to the need for further strengthening and recognising the role of LSGs beyond perfunctory bodies in building long-term community resilience in other states in India as well.

It also marks the need for further devolution of powers, including regulatory and funds to the LSGs through proper studies and analysis once the COVID crisis is over.

The study being a short one, we have not been able to do a more in-depth quality assessment of the services offered across the state by the LSGs, but from the working of LSGs during the COVID response, and from the overall disaster management framework emerging in the state, it is evident that the principles of devolution of functions, subsidiarity, autonomy, role clarity and complementarity, people's participation, accountability and transparency as propounded by the Sen Committee[68] have been abided by to a considerable extent. A more rigorous analysis of the overall decentralisation framework including systemic issues would be required to identify specific failures and weaknesses in the system, especially the LSGs' capacity to deal with different categories of disaster, especially sudden onset for instance, those induced by climate change.

During any disaster situation, the response of a state is only as strong as the state's front-line workers. Their work is indispensable and more importantly, one which needs to be recognised and strengthened. As far as our front-line workers during COVID, the ASHAs workers are concerned, their role in community resilience building and overall public health is profound. As their name suggests, during the COVID pandemic they have been spreading hope, going from home to home, often without adequate protective gear or risk coverage. It can be rightly said that an otherwise invisible role merely gained scant recognition during this COVID period. This surely has to change, both from the side of the administration, as well as from the side of society. Through this short ethnographic study on the ASHA workers, we have made an attempt to throw light on their contribution during an unprecedented pandemic as also uncover the multifaceted challenges they face, not just during the pandemic but also in general times. As frontline workers, ASHA workers have proven to be indispensable. The study highlights the crucial need for enhanced support from administration and society based on further in-depth, focused studies.

[68] *S B Sen Committee, Report of the Committee on Decentralisation of Powers: Suggestions for amending Kerala Panchayat Raj Act (1997). See also S. M. Vijayanand, Kerala-A Case Study of Classical Democratic Decentralization (KILA 2009) 87*

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APPENDIX 1

LIST OF GOVERNMENT ORDERS

LIST of GOVERNMENT ORDERS/CIRCULARS ISSUED BY THE LSGD during COVID 19 as on 30.11.20				
Sl no.	Date	GO/ Circular number	Subject	
			Malayalam	English
1	01.02.2020	No. DC1/2020/ LSGD	സംസ്ഥാനത്ത് കോവിഡ്-19 പ്രതിരോധ നടപടികളുമായി ബന്ധപ്പെട്ട് തദ്ദേശസ്വയംഭരണ സ്ഥാപനങ്ങളുടെ നേതൃത്വത്തിൽ സ്വീകരിക്കേണ്ട നടപടികൾ	Actions to be taken by the Local Self Government Institutions in connection with COVID 19 Preventive Measures.
2	05.02.2020	No. 46/ DC1/2020/ LSGD	ആരോഗ്യജാഗ്രത - പകർച്ച വ്യാധി പ്രതിരോധയജ്ഞം 2020 - ആരോഗ്യ സുരക്ഷയ്ക്ക് മാലിന്യമുക്ത പരിസരം - മാർഗ നിർദ്ദേശങ്ങൾ	Health Awareness - Prevention of Infectious Disease 2020 - Pollution free Premises for Health Safety - Guidelines
3	14.03.2020	G.O (Rt) No. 620/2020/ LSGD	സംസ്ഥാനത്ത് കോവിഡ്-19 പ്രതിരോധ നടപടികളുമായി ബന്ധപ്പെട്ട് തദ്ദേശസ്വയംഭരണ സ്ഥാപനങ്ങളുടെ നേതൃത്വത്തിൽ സ്വീകരിക്കേണ്ട നടപടികൾ	Actions to be taken by the Local Self Government Institutions in connection with COVID 19 Preventive Measures.
4	20/03/20	G.O (Rt) No. 695/2020/ LSGD	കോവിഡ്-19 പ്രത്യേക സാഹചര്യം പരിഗണിച്ച് തദ്ദേശസ്വയംഭരണ സ്ഥാപനങ്ങളിൽ വസ്തു നികുതി പിഴകൂടാതെ അടയ്ക്കുന്നതിനും വ്യാപാര ലൈസൻസ് ഉൾപ്പെടെയുള്ള വിവിധ ലൈസൻസുകൾ പുതുക്കുന്നതിനും, വിനോദ നികുതി അടയ്ക്കുന്നതിനുള്ള അവസാന തിയ്യതി 30/04/2020 വരെ ദീർഘിപ്പിച്ചിരിക്കുന്നു.	Extension of the last date for payment of property tax without penalty and renewal of various licenses, including trade licenses and payment of entertainment tax to 30/04/2020, because of the special circumstances of COVID 19.
5	20.03.2020	G.O (Rt) No. 686/2020/ LSGD	സംസ്ഥാനത്ത് കോവിഡ്-19 പ്രതിരോധ നടപടികളുമായി ബന്ധപ്പെട്ട് തദ്ദേശസ്വയംഭരണ വകുപ്പിൽ 'കോവിഡ് - 19 സെൽ' രൂപീകരിച്ചു	Setting up of COVID-19 Cells in the Local Self Government Departments in connection with COVID-19 preventive measures in the State

6	20.03.2020	G.O (Ms) No. 55/2020/ LSGD	സംസ്ഥാനത്ത് കോവിഡ്-19 പ്രതിരോധ നടപടികളുമായി ബന്ധപ്പെട്ട് തദ്ദേശസ്വയംഭരണ സ്ഥാപനങ്ങൾ ഏറ്റെടുക്കേണ്ട പ്രവർത്തനങ്ങളും ഉത്തരവാദിത്വങ്ങളും	Activities and responsibilities to be undertaken by the Local Self Government Departments in connection with the COVID-19 preventive measures in the State
7	25.03.2020	G.O (Rt) No. 710/2020/ LSGD	സംസ്ഥാനത്ത് കോവിഡ്-19 പ്രതിരോധങ്ങളുമായി ബന്ധപ്പെട്ട് തദ്ദേശസ്വയംഭരണ സ്ഥാപനങ്ങളുടെ നേതൃത്വത്തിൽ സ്വീകരിക്കേണ്ട നടപടികൾ സംബന്ധിച്ച തുടർ നിർദ്ദേശങ്ങൾ	Additional instructions on the steps to be taken by the Local Self Government Departments in connection with the COVID-19 defenses in the State
8	26.03.2020	No. DC1/71/2020/ LSGD	സംസ്ഥാനത്ത് കോവിഡ്-19 പടർന്നു പിടിക്കുവാനുള്ള സാധ്യത - പ്രതിരോധ നടപടികൾ - പരിസര ശുചിത്വ പ്രവർത്തനങ്ങൾ സംബന്ധിച്ച്	Risk of outbreak of COVID-19 in the State - Preventive measures - with regard to environmental sanitation activities
9	26.03.2020	G.O (Rt) No. 713/2020/ LSGD	കോവിഡ്-19 പ്രതിരോധ നടപടികൾ - തദ്ദേശസ്വയംഭരണ സ്ഥാപനങ്ങളുമായി ഒത്തുചേർന്ന് കുടുംബശ്രീയുടെ ആഭിമുഖ്യത്തിലുള്ള കമ്യൂണിറ്റി കിച്ചൺ രൂപീകരണം - മാർഗ നിർദ്ദേശങ്ങൾ	COVID-19 Preventive Measures - Establishment of Kudumbasree Community Kitchens in collaboration with the Local Self Government Institutions - Guidelines
10	27.03.2020	No. DC1/71/2020/ LSGD	സംസ്ഥാനത്ത് കോവിഡ്-19 പ്രവർത്തനങ്ങൾ കൂടുതൽ ഉർജ്ജപ്പെടുത്തുന്നതിലേക്കായി ഹോം എസൈസൊലേഷനിൽ ഉള്ളവരുടെ വിവരശേഖരണം സംബന്ധിച്ച്	Regarding collection of data on people under Home Isolation to further strengthen COVID-19 prevention activities in the State
11	27.03.2020	G.O (Rt) No 715/2020/ LSGD	കുടുബശ്രീ - 2019-2020 സാമ്പത്തിക വർഷത്തെ പ്ളാൻ ഫണ്ടിൽ നിന്നും 23.64 കോടി രൂപ പിൻവലിക്കുന്നതിനും സംസ്ഥാനത്ത് കോവിഡ് - 19 വ്യാപനത്തിന്റെ പശ്ചാത്തലത്തിൽ ബഹു.മുഖ്യമന്ത്രി പ്രഖ്യാപിച്ച ആശ്വാസ നടപടികളുടെ ഭാഗമായ 20 രൂപയ്ക്ക് ഉച്ചയൂണ് വിതരണം നടത്തുന്നതിന്	Order for withdrawing Rs 23.64 Crores from the Kudumbasree Plan Fund 2019-2020 and utilizing the same for the initial expenses of setting up 1000 Community Kitchens ("Corpus Fund to Kudumbashree for setting up of 1000 Community

			വേണ്ടി "Corpus Fund to Kudumbashree for setting up of 1000 Community Kitchens" – ന്റെ പ്രാരംഭ ചിലവുകൾക്കായി പ്രസ്തുത തുക വിനിയോഗിക്കുന്നതിനും ഉള്ള ഉത്തരവ്	Kitchens") for distributing mid day meals at Rs 20/- as part of the relief measures announced by the Chief Minister in the context of COVID 19.
12	28.03.2020	No. DC1/71/2020/ LSGD	കോവിഡ്–19 പ്രതിരോധ പ്രവർത്തനങ്ങൾ – തദ്ദേശ സ്വയംഭരണ സ്ഥാപനങ്ങളുടേയും കുടുംബശ്രീയുടേയുംആഭിമുഖ്യത്തിലുള്ള കമ്യൂണിറ്റി കിച്ചൺ – പ്രവർത്തന മാർഗരേഖ	COVID–19 Preventive Measures – Guidelines for the functioning of the Community Kitchens under the auspices of Local Self Government Institutions and Kudumbasree.
13	28.03.2020	No. DC1/71/2020/ LSGD	കോവിഡ്–19 പ്രതിരോധ പ്രവർത്തനങ്ങൾ – വോളണ്ടിയർമ്മാരുടെ സേവനം – മാർഗ്ഗനിർദ്ദേശങ്ങൾ	COVID 19 Preventive Measures – Guidelines for Voluntary Services.
14	03.04.2020	G.O (Rt) No 733/2020/ LSGD	സംസ്ഥാനത്ത് കോവിഡ്–19 പ്രതിരോധ നടപടികൾ – കുടുംബശ്രീയുടെ ആഭിമുഖ്യത്തിലുള്ള കമ്മ്യൂണിറ്റി കിച്ചൺ രൂപീകരണം – സ്പഷ്ടീകരണം നൽകി ഉത്തരവ് പുറപ്പെടുവിക്കുന്നു	COVID–19 Preventive Measures in the State – Establishment of Community Kitchen under the auspices of Kudumbasree – Explanatory Order issued
15	04.04.2020	G.O (Rt) No. 736/2020/ LSGD	കുടുബശ്രീ – കോവിഡ് 19 വ്യാപനത്തിന്റെ പശ്ചാത്തലത്തിൽ ബഹു.മുഖ്യമന്ത്രി പ്രഖ്യാപിച്ച പ്രത്യേക പാക്കേജിൽ ഉൾപ്പെട്ട കുടുംബശ്രീ മുഖേനയുള്ള 2000/- കോടി രൂപയുടെ"മുഖ്യമന്ത്രിയുടെ സഹായ ഹസ്തം വായ്പാ പദ്ധതി" (CMs Helping Hand Loan Scheme – CMHLS) – കുടുബശ്രീ അയൽക്കൂട്ടങ്ങൾ വഴി നടപ്പിലാക്കുന്നതിന് അനുമതി നൽകുന്നു	Permission for implementation of CM's Helping Hand Loan Scheme – CMHLS (The special package of Rs 2000/- Crores announced by the Chief Minister in the context of COVID 19) through the neighborhood groups of Kudumbasree.
16	08.04.2020	No–103/ FM3/2020/ LSGD	LSGD–Utilization of 14th Finance Commission's (FFC) Grants for tackling COVID–19 pandemic in Gram Panchayats–Extension of time limit for utilizing FFC grants up to 31/3/2021–instruction	

17	08.04.2020	G.O (Rt) No 746/2020/ LSGD	കോവിഡ്–19 വ്യാപനം തടയുന്നതിന് ലോക്ക്ഡൗൺ ഏർപ്പെടുത്തിയ സാഹചര്യത്തിൽ ഒരു അർദ്ധ വർഷത്തേക്ക് അറുപതു ദിവസമോ അതിൽ കൂടുതലോ ആയ കാലയളവിലേക്ക് തുടർച്ചയായി ഒരു ആവശ്യത്തിനും ഉപയോഗിക്കാതെ ഒഴിഞ്ഞു കിടക്കുന്ന കെട്ടിടങ്ങൾക്ക് വസ്തുനികുതിയിളവ് (വേക്കൻസി റെമിഷൻ) അനുവധിക്കുന്നതിനുള്ള അപേക്ഷ ബന്ധപ്പെട്ട തദ്ദേശ സ്വയംഭരണ സ്ഥാപനത്തിൽ സമർപ്പിക്കാനുള്ള കാലാവധി 2020 ജൂൺ വരെ ദീർഘിപ്പിക്കുന്നു	Deadline for submitting application for vacancy remission of buildings that have remained vacant for a continuous period of 60 days or more at the concerned local body extended up to June 2020 in view of the lockdown imposed to prevent the spread of COVID–19.
18	11.04.2020	G.O (Ms) No. 62/2020/ LSGD	തദ്ദേശസ്വയംഭരണ സ്ഥാപനങ്ങളുടെ 2020–21 വാർഷിക പദ്ധതി – അംഗീകാര നടപടികൾ പൂർത്തിയാക്കുവാനുള്ള മാർഗ നിർദ്ദേശങ്ങൾ	2020–21 Annual Plan of Local Self Governments – Guidelines for the Completion of Approval Procedures
19	18.04.2020	G.O(Rt) No. 762/2020/ LSGD	കോവിഡ് 19 പ്രതിരോധങ്ങളുമായി ഏകോപിച്ച് നഗരസഭയിലെ ശുചീകരണ പ്രവർത്തനങ്ങളും മഴക്കാല പൂർവ്വ ശുചീകരണ പ്രവർത്തനങ്ങളും നടപ്പിലാക്കുന്നത്	Sanitization activities and pre–monsoon clean–up operations in Municipalities in coordination with COVID 19 defenses
20	20.04.2020	No. DC1/188/ 2020/LSGD	കോവിഡ് 19 വിവിധ സ്രോതസ്സുകളിൽ നിന്നും ബയോമെഡിക്കൽ മാലിന്യവും ഖരമാലിന്യവും ശേഖരിച്ച് സംസ്കരിക്കുന്നത് സംബന്ധിച്ച്	COVID 19 – Collection and disposal of biomedical waste and solid waste from various sources, regarding
21	20.04.2020	No. DB4/531/20/ C.E/LSGD	സാങ്കേതിക വിഭാഗം – "മുഖ്യമന്ത്രിയുടെ തദ്ദേശ റോഡ് പുനരുദ്ധാരണ പദ്ധതി" [Chief Minister's Local Roads Rebuild Project (CMLRRP)] യുടെ പ്രവർത്തികൾ – നിർവഹണം സംബന്ധിച്ച്	Technical Section – Implementation of the Chief Minister's Local Roads Rebuild Project (CMLRRP), regarding.
22	20.04.2020	G.O(Rt) No. 765/2020/ LSGD	കോവിഡ്–19 പ്രതിരോധ ആശ്വാസനടപടികളുടെ ഭാഗമായി തദ്ദേശസ്വയംഭരണ സ്ഥാപനങ്ങളുടേയും കുടുംബശ്രീകളുടേയും നേതൃത്വത്തിൽ നടത്തുന്ന കമ്മ്യൂണിറ്റി കിച്ചനുകളിൽ നിയോഗിക്കുന്ന പാചക	Order for Issuance of Honorarium to workers employed in the Community Kitchens run by the Local Self Governments and

			ജോലിക്കാർക്ക് ഹോണറേറിയം നിശ്ചയിച്ച് ഉത്തരവ് പുറപ്പെടുവിക്കുന്നു	Kudumbasree Units as part of COVID-19 preventive relief measures
23	21.04.2020	G.O (Rt) No. 771/2020/ LSGD	മഹാത്മാഗാന്ധി ദേശീയ തൊഴിലുറപ്പു പദ്ധതി – കോവിഡ് 19 പശ്ചാത്തലത്തിൽ പ്രവർത്തി എടുക്കുന്ന തൊഴിലാളികൾക്ക് ആവശ്യമായ ഫെയിസ് മാസ്ക്കും കൈയുറകളും നൽകുന്നതിന് ഗ്രാമപഞ്ചായത്തുകളുടെ തനത് / ജനറൽ പർപ്പസ്സ് ഫണ്ട് വിനിയോഗിക്കുന്നതിന് അനുമതി നൽകി ഉത്തരവാകുന്നു	Mahatma Gandhi National Employment Guarantee Scheme – Order granting permission for utilization of Gram Panchayats' own / General Purpose Fund to provide necessary face masks and gloves to workers in the context of COVID 19.
24	22.04.2020	G.O (Ms) No 65/2020/ LSGD	മഹാത്മാഗാന്ധി ദേശീയ ഗ്രാമീണ തൊഴിലുറപ്പ് പദ്ധതി – കോവിഡ് 19 പശ്ചാത്തലത്തിൽ തൊഴിലുറപ്പ് പദ്ധതിക്ക് കീഴിൽ പ്രവർത്തികൾ ആരംഭിക്കുന്നത് – മാർഗ്ഗനിർദ്ദേശങ്ങൾ	Mahatma Gandhi National Rural Employment Guarantee Scheme – Commencement of activities under the Employment Guarantee Scheme in the context of COVID 19 – Guidelines
25	25.04.2020	G.O (Rt) No 782/2020/ LSGD	സംസ്ഥാനത്ത് കോവിഡ് 19 പ്രതിരോധ ആശ്വാസ നടപടികളുടെ ഭാഗമായി നടത്തുന്ന കമ്മ്യൂണിറ്റി കിച്ചണുകളുടെ സുഗമമായ പ്രവർത്തനത്തിന് കുടുമബശ്രീവനിതകളെകൂടാതെ പാചക തൊഴിലാളികളെ കൂടി നിയോഗിക്കുന്നതിന് അനുമതി നൽകി ഉത്തരവാകുന്നു	Order granting permission to deploy other workers in addition to the Kudumbasree women for the smooth functioning of community kitchens operating as part of the COVID 19 preventive relief measures in the State.
26	29.04.2020	G.O (Rt) No. 802/2020/ LSGD	തദ്ദേശസ്വയംഭരണ സ്ഥാപനങ്ങളുടെ ഉടമസ്ഥതയിലുള്ള കെട്ടിടങ്ങളുടെ വാടക കുടിശ്ശിക, പിഴയും പിഴ പലിശയും ഒഴിവാക്കി ഒടുക്കുന്നതിന് സമയ പരിധി ദീർഘിപ്പിച്ചു നൽകി ഉത്തരവാകുന്നു	Order extending the time limit for payment of rent arrears without penalty and penalty interest, for buildings owned by Local Self Government Institutions
27	30.04.2020	G.O (Rt) No. 69/2020/ LSGD	കോവിഡ് 19 പ്രതിരോധ, ആശ്വാസ നടപടികൾ – ഗുരുതര രോഗം ബാധിച്ചവർക്ക് ജീവൻ രക്ഷാ മരുന്നുകൾ ലഭ്യമാക്കുവാൻ തദ്ദേശഭരണ സ്ഥാപനങ്ങൾക്ക് മാർഗ്ഗനിർദ്ദേശങ്ങൾ നൽകി ഉത്തരവു പുറപ്പെടുവിക്കുന്നു	COVID 19 Prevention and Relief Measures – Issuing guidelines to local bodies for providing life-saving medicines to the critically ill

28	04-05-2020	No.D.C.1/191/2020/LSGD	മഴക്കാല പൂർവ്വ ശുചീകരണം - പകർച്ചവ്യാധി പ്രതിരോധ പ്രവർത്തനങ്ങൾ , വരൾച്ചയും കുടിവെള്ള വിതരണവുമായി ബന്ധപ്പെട്ട വിഷയങ്ങൾ തുടങ്ങിയവ സംബന്ധിച്ച മാർഗ്ഗനിർദ്ദേശങ്ങൾ	Pre-Monsoon Sanitation - Guidelines on Prevention of Infectious Diseases, and issues relating to Drought and Drinking Water Supply.
29	04-05-2020	G.O. (R.T) No. 818/2020/LSGD	മുഖ്യമന്ത്രിയുടെ തദ്ദേശ റോഡ് പുനരുദ്ധാരണ പദ്ധതി - മാർഗ്ഗ നിർദ്ദേശങ്ങൾ	Chief Minister's Local Road Reconstruction Project - Guidelines
30	04-05-2020	G.O. (M.S) No. 71/2020/LSGD	മുഖ്യമന്ത്രിയുടെ തദ്ദേശ റോഡ് പുനരുദ്ധാരണ പദ്ധതി യുടെ രണ്ടാം ഘട്ടത്തിൽ 2018 പ്രവർത്തികൾക്കായി ഭരണാനുമതി നൽകുന്നു	Administrative clearance for works in the second phase 2018 of the Chief Minister's Local Road Reconstruction Project
31	04-05-2020	G.O. (R.T) No. 820/2020/LSGD	അടയ്ക്കുന്നതിനും വ്യാപാര ലൈസൻസ് ഉൾപ്പെടെയുള്ള വിവിധ ലൈസൻസുകൾ പുതുക്കുന്നതും വിനോദ നികുതി അടയ്ക്കുന്നതിനുമുള്ള അവസാന തിയ്യതി 31.05.2020 വരെ ദീർഘിപ്പിച്ചു നൽകുന്നു	Extending last date for payment of fees and renewal of various licenses including trade license and payment of entertainment tax till 31.05.2020
32	05-05-2020	No.DA1/130/2020/LSGD	കോവിഡ് പ്രതിരോധ പ്രവർത്തനം - ഭക്ഷ്യവസ്തുക്കളുടെ ലഭ്യതയും ഉല്പാദനവും വർദ്ധിപ്പിക്കാനുള്ള വിവിധ പദ്ധതികൾ - ബഹു. മുഖ്യമന്ത്രി നടത്തുന്ന വീഡിയോ കോൺഫറൻസ് - സംബന്ധിച്ച്	COVID Prevention Activities - Various schemes to increase the production and availability of food items - Video Conference by the Honourable Chief Minister - Reg.
33	05-05-2020	G.O. (M.S) No. 73/2020/LSGD	കോവിഡ് പകർച്ച വ്യാധിയുടെ പശ്ചാത്തലത്തിൽ തദ്ദേശ സ്വയം ഭരണ സ്ഥാപനങ്ങളിലെ ജന പ്രതിനിധികളുടെഹോണറേറിയം കുറവ് ചെയ്യുന്നത് സംബന്ധിച്ച്	Reduction in the honorarium of the people's representatives in the Local Self Government Institutions in the context of the COVID epidemic, reg.
34	06-05-2020	G.O. (R.T) No. 831/2020/LSGD	കോവിഡ് 19 - നിർവ്യാപന / പ്രതിരോധ പ്രവർത്തനങ്ങൾ - പ്രവാസികളുടേയും മറ്റ് സംസ്ഥാനങ്ങളിൽ നിന്നുള്ള മലയാളികളുടേയും തിരിച്ചുവരവ് കണക്കിലെടുത്ത് നടത്തുന്ന ക്രമീകരണങ്ങൾ - വാർഡുതല	COVID 19 - Containment / Prevention Activities - Arrangements for Return of Expatriates and Malayalees from Other States - Orders for constituting Ward

			മോണിറ്ററിഗ് കമ്മറ്റികളും തദ്ദേശ സ്ഥാപനതല കമ്മറ്റികളും രൂപീകരിച്ച് ഉത്തരവ് പുറപ്പെടുവിക്കുന്നു	Level Monitoring Committees and Local Body Level Committees.
35	07-05-2020	G.O. (R.T) No. 836/2020/ LSGD	സംസ്ഥാനത്തെ മൈക്രോ സ്മാൾ ആൻറ് മീഡിയം എൻറെർപ്രൈസസ്സ്(MSME) യൂണിറ്റുകൾക്ക് ലൈസൻസ് പുതുക്കുന്നതിനുള്ള കാലാവധി 31.10.2020 വരേ ദീർഘിപ്പിച്ച് ഉത്തരവ് പുറപ്പെടുവിക്കുന്നു.	Order extending the license renewal period for Micro Small and Medium Enterprises (MSME) units in the State till 31.10.2020.
36	07-05-2020	No. R.A. 1/168/2020/ LSGD	ലോക്കഡൗൺ കാലയളവിൽ നിർമ്മാണാനുമതിയുടെ കാലാവധി അവസാനിച്ച കെട്ടിടങ്ങൾക്ക് നിർമ്മാണാനുമതി ദീർഘിപ്പിച്ചു നൽകുന്നു	Order extending the construction permit for buildings whose building permit has expired during the lockdown period.
37	09-05-2020	G.O. (R.T) No. 849/2020/ LSGD	കോവിഡ് 19 നിർവ്യാപന / പ്രതിരോധ പ്രവർത്തനങ്ങൾ – വിദേശത്തു നിന്നും മറ്റു സംസ്ഥാനങ്ങളിൽ നിന്നും എത്തുന്ന കേരളീയരുടെ ക്വാരൻറയിൻ സംവിധാനം – തദ്ദേശ സ്വയംഭരണ സ്ഥാപനങ്ങൾ നിർവഹിക്കേണ്ട ചുമതലകളും പ്രവർത്തനങ്ങളും നിശ്ചയിച്ച് ഉത്തരവ് പുറപ്പെടുവിക്കുന്നു	COVID 19 Containment / Preventive Measures – Quarantine Arrangements for Keralites Arriving from Abroad and Other States – Orders regarding the duties and functions of the Local Self Government Institutions
38	20-05-2020	G.O. (R.T) No. 928/2020/ LSGD	"സുഭിക്ഷ കേരളം" പദ്ധതി വാർഷിക പദ്ധതിയുടെ ഭാഗമാക്കുന്നതിനുള്ള മാർഗ്ഗ നിർദ്ദേശങ്ങൾ	Guidelines for integrating the Subhiksha Kerala Project with Annual Plan for the State.
39	25-05-2020	G.O. (R.T) No. 955/2020/ LSGD	കോവിഡ് 19 – കോവിഡ് ഫസ്റ്റ് ലൈൻ ട്രീറ്റ്മെന്റ് സെന്റർ (CFTC) രൂപീകരണവും നടത്തിപ്പും സംബന്ധിച്ച മാർഗ്ഗനിർദ്ദേശങ്ങൾ	Guidelines for the formation and operation of the COVID First Line Treatment Centers (CFTC)
40	27-05-2020	No.232/ DC1/20/ LSGD	സ്കൂളുകളുടെ ശുചിത്വം , പരിസര ശുചിത്വം എന്നിവ ഉറപ്പാക്കുന്നതിന് തദ്ദേശസ്വയംഭരണ സ്ഥാപനങ്ങളുടെ മേൽനോട്ടത്തിൽ നടപടികൾ സ്വീകരിക്കുന്നത് സംബന്ധിച്ച്	Order regarding actions to be taken by under the supervision of the local self-government institutions to ensure cleanliness in schools and the cleanliness of the environment.

41	29-05-2020	G.O. (R.T) No. 1009/2020/ LSGD	സുഭിക്ഷ കേരളം - സബ്സിഡി മാർഗ്ഗരേഖയിൽ ഭേദഗതികളും കൂട്ടിച്ചേർക്കലുകളും	Subhiksha Kerala - Amendments and additions to the Subsidy Guidelines
42	01-06-2020	No.I.A 1/116/2020/ LSGD	കമ്യൂണിറ്റി കിച്ചൻ - നിർത്തലാക്കിയ കമ്യൂണിറ്റി കിച്ചനുകളിൽ ലഭ്യമായ ഭക്ഷ്യവസ്തുക്കളുടെ വിതരണം - സംബന്ധിച്ച്	Community Kitchen - Distribution of food items available in discontinued community kitchens, reg
43	05-06-2020	G.O. (R.T) No. 1065/2020/ LSGD	കോവിഡ് 19 - നിർവ്യാപന / പ്രതിരോധ പ്രവർത്തനങ്ങൾ - വിദേശത്ത് നിന്നും മറ്റ് സംസ്ഥാനങ്ങളിൽ നിന്നും എത്തുന്ന കേരളീയരുടെ ക്വാരൻറൈൻ സംവിധാനം - ശുചീകരണ പ്രവർത്തനങ്ങൾക്കായി ദിവസ വേതന അടിസ്ഥാനത്തിൽ ജോലിക്കാരെ (Paid Worker) നിയോഗിക്കുന്നതിന് അനുമതി നൽകി ഉത്തരവാക്കുന്നു	COVID 19 - Containment and Preventive Measures - Quarantine System of Keralites Arriving from Abroad and Other States - Order regarding appointment of paid workers for cleaning operations on daily wages
44	05-06-2020	G.O. (R.T) No. 1062/2020/ LSGD	കോവിഡ് 19 - പ്രത്യേക സാഹചര്യം പരിഗണിച്ച് തദ്ദേശസ്വയംഭരണ സ്ഥാപനങ്ങളിലെ വസ്തു നികുതി പിഴകൂടാതെ അടയ്ക്കുന്നതിനും വ്യാപാര ലൈസൻസ് ഉൾപ്പെടെയുള്ള വിവിധ ലൈസൻസുകൾ പുതുക്കുന്നതിനും വിനോദ നികുതി അടയ്ക്കുന്നതിനുമുള്ള അവസാന തിയ്യതി 30.06.2020 വരെ ദീർഘിപ്പിച്ച് നൽകിയും തദ്ദേശസ്വയംഭരണസ്ഥാപനങ്ങളുടെ ഉടമസ്ഥസയിലുള്ള കെട്ടിടങ്ങളുടെ വാടക കുടിശ്ശിക പിഴ ഒഴിവാക്കി അടയ്ക്കുന്നതിനുള്ള സമയ പരിധി 05.07.2020 വരേ ദീർഘിപ്പിച്ച് നൽകിയും ഉത്തരവ് പുറപ്പെടുവിക്കുന്നു	Order regarding extension of last date of payment of property tax in local bodies without penalty, renewal of various licenses including business licenses and payment of entertainment tax to 30.06.2020 in the context of COVID19 and extending the time limit for payment of rent arrears of buildings owned by Local Self Government Institutions till 05.07.2020
45	10-06-2020	No.DC1/222/ 2020/LSGD	കോവിഡ് 19 - മാലിന്യ സംസ്കരണവുമായി ബന്ധപ്പെട്ട് തദ്ദേശ സ്വയംഭരണ സ്ഥാപനങ്ങളുടെയും സെക്രട്ടറിമാരുടെയും ചുമതലകൾ	COVID 19 - Duties of the Secretary and Local Self Government Institutions in connection with waste management

46	11-06-2020	G.O. (R.T) No. 1101/2020/ LSGD	കോവിഡ് 19 പ്രതിരോധത്തിൻറെ ഭാഗമായി കേരള ആഗ്രോ മെഷിനറി കോർപ്പറേഷൻ ലിമിറ്റഡ് (KAMCO) വികസിപ്പിച്ച പെഡൽ ഓപ്പറേറ്റഡ് സാനിറ്റൈസർ തദ്ദേശസ്വയംഭരണ വകുപ്പിന് കീഴിലുള്ള സ്ഥാപനങ്ങളിൽ ഉപയോഗിക്കുന്നതിന് അനുമതി നൽകി ഉത്തരവ് പുറപ്പെടുവിക്കുന്നു	Order regarding permission for use of Pedal Operated Sanitizer developed by Kerala Agro Machinery Corporation Limited (KAMCO) in the Local Self Government Departments as part of COVID 19 defense
47	12-06-2020	G.O. (R.T) No. 1114/2020/ LSGD	ഓൺലൈൻ പഠന സൗകര്യത്തിനായി വിദ്യാർത്ഥികൾക്ക് ടെലിവിഷൻ /ലാപ്ടോപ് / കമ്പ്യൂട്ടർ എന്നിവ വാങ്ങുന്നതിന് തദ്ദേശ സ്ഥാപനങ്ങളുടെ ഫണ്ട് ഉപയോഗിക്കുന്നതിന് അനുമതി നൽകി ഉത്തരവ് പുറപ്പെടുവിക്കുന്നു.	Order granting permission to use funds of the Local Self Government Institutions for purchase of television / laptop / computer for students for online study facility.
48	13-06-2020	G.O. (R.T) No. 1131/2020/ LSGD	COVID -19 വ്യപനത്തിൻറെ പശ്ചാത്തലത്തിൽ തിരുവനന്തപുരം വികസന അതോറിറ്റിയുടെ ഉടമസ്ഥതയിലുള്ള കെട്ടിടങ്ങൾക്ക് പലിശ, പിഴ പലിശ എന്നിനവ ഇല്ലാതെ വാടക അടയ്ക്കുന്നതിന് 05/07/2020 വരെ സമയം അനുവദിച്ച് ഉത്തരവ് പുറപ്പെടുവിക്കുന്നു	Order issued in the light of the spread of COVID-19, extending payment date till 05/07/2020 to pay rent without interest or penalty interest for buildings owned by Thiruvananthapuram Development Authority.
49	15-06-2020	No.DA1/113/ 2020/LSGD	കോവിഡ് പ്രതിരോധ പ്രവർത്തമനങ്ങൾ - ആർ. ആർ.ടി വാർഡ് സമിതികൾ - റൊട്ടേഷനും തുടർ പരിശീലനവും സംബന്ധിച്ച്	COVID Defense Activities - RRT Ward Committees - rotation and continuing Training
50	16-06-2020	No. D.C.1/258/ 2020/LSGD	കോവിഡ് 19 - വ്യാപനം തടയുന്നതിനുള്ളപ്രവർത്തനങ്ങൾ-വിവധ ആവശ്യങ്ങൾക്കായി തദ്ദേശ സ്വയംഭരണ സ്ഥാപനങ്ങളിൽ എത്തുന്ന പൊതുജനങ്ങൾക്കുള്ള നിർദ്ദേശങ്ങൾ	COVID 19 - Instructions to public visiting Local Self Government Offices for various purposes to control spread of the pandemic.
51	23-06-2020	G.O. (R.T) No. 1241/2020/ LSGD	കോവിഡ് 19 പശ്ചാത്തലത്തിൽ ഓരോ സ്റ്റാഫ് നേഴ്സിനെ എല്ലാ പി.എച്.സി കളിലും , സി.എച്ച്.സി കളിലും നിയമിക്കുന്നതിന് അനുമതി നൽകി ഉത്തരവ് പുറപ്പെടുവിക്കുന്നു	Order is issued authorizing the appointment of one staff nurse in each PHCs and CHCs in the context of COVID 19.

52	25-06-2020	G.O. (R.T) No. 1266/2020/ LSGD	അയ്യൻകാളി നഗരതൊഴിലുറപ്പ് പദ്ധതിക്ക് കീഴിൽ 2018-19 സാമ്പത്തിക വർഷത്തിൽ 100 ദിവസം തൊഴിലെടുത്ത കുടുംബങ്ങൾക്ക് കോവിഡ് മഹാമാരിയുടെ പ്രത്യേക സാഹചര്യം കണക്കിലെടുത്ത് പ്രത്യേക സഹായധനം അനുവദിച്ച് ഉത്തരവാകുന്നു.	Special assistance extended to the families of those who have worked for 100 days under the Ayyankali Urban Employment Guarantee Scheme during the financial year 2018-19 in view of the special circumstances of the COVID epidemic.
53	29-06-2020	G.O. (R.T) No. 1278/2020/ LSGD	കോവിഡ് 19 - വ്യാപനം തടയുന്നതിന് സംസ്ഥാനത്ത് ലോക്ക്ഡൗൺ ഏർപ്പെടുത്തിയ കാലയളവിൽ തദ്ദേശസ്വയം ഭരണ സ്ഥാപനങ്ങളുടേയും വിക,ന അതോറിറ്റികളുടേയും ഉടമസ്ഥതയിലുള്ളതും ലോക്ക്ഡൗൺ കാരണം തുറന്ന് പ്രവർത്തിക്കാൻ സാധിക്കാത്തതുമായ സ്ഥാപനങ്ങളുടെ വാടക ഇളവ് നൽകുന്നതിന് തീരുമാനമെടുക്കാൻ തദ്ദേശസ്വയംഭരണ സ്ഥാപനങ്ങളെയും വികസന അതോറിറ്റികളേയും അനുവധിച്ചുകൊണ്ട് ഉത്തരവ് പുറപ്പെടുവിക്കുന്നു	COVID 19 - Order allowing Local Self Government Institutions and Development Authorities to decide on extending rent exemption to establishments working in buildings owned by them, but unable to open and operate during the period of lockdown that was imposed to prevent the spread of the pandemic.
54	16-07-2020	G.O. (R.T) No. 1364/2020/ LSGD	കോവിഡ് ഫസ്റ്റ് ലൈൻ ട്രീറ്റ്മെൻറ് സെൻറെർ(CFLTC) രൂപീകരണവും നടത്തിപ്പും സംബന്ധിച്ച പുതുക്കിയ വിശദമായ മാർഗ്ഗനിർദ്ദേശങ്ങൾ പുറപ്പെടുവിക്കുന്നു	Revised and detailed guidelines on the formation and operation of the First Line Treatment Centers (CFLTC).
55	21-07-2020	G.O. (R.T) No. 1379/2020/ LSGD	കോവിഡ് പ്രതിരോധ പ്രവർത്തനങ്ങളുടെ ഭാഗമായി Foot Operated Sanitizer / Dispenser എന്നിവ സിഡ്കോ-യിൽ നിന്നും വാങ്ങുന്നതിന് തദ്ദേശസ്വയം ഭരണ സ്ഥാപനങ്ങൾക്ക് യഥേഷ്ടാനുമതി നൽകി ഉത്തരവാകുന്നു	Order authorizing Local Self Governments to purchase Foot Operated Sanitizer / Dispenser from CIDCO as part of COVID prevention activities.

56	21-07-2020	G.O. (R.T) No. 1382/2020/ LSGD	2020-21 വാർഷിക പദ്ധതി – കോവിഡ് പ്രതിരോധത്തിൻറെ മൂന്നാം ഘട്ട പ്രവർത്തനങ്ങളുടെ ഭാഗമായി അടിയന്തിര പ്രോജക്ട്കൾ ഏറ്റെടുക്കുന്നതിന് അനുമതി നൽകി ഉത്തരവ് പുറപ്പെടുവിക്കുന്നു	2020-21 Annual Plan – Order granting permission to undertake urgent projects as part of the third phase of COVID Defense activities.
57	27-07-2020	G.O. (R.T) No. 1409/2020/ LSGD	തദ്ദേശ സ്വയംഭരണ വകുപ്പ് – കേരളത്തിലെ എല്ലാ പഞ്ചായത്തുകളിലും First Line Treatment Centre കളിൽ ആവശ്യമായ എണ്ണം കിടക്കകൾ വാങ്ങുന്നതിന് തദ്ദേശ ഭരണ സ്ഥാപനങ്ങൾക്ക് യഥേഷ്ടാനുമതി നൽകി ഉത്തരവ് പുറപ്പെടുവിക്കുന്നു	Local Self Government Department – Order granting permission to Local Bodies to purchase the required number of beds in First Line Treatment Centers in all Panchayats in
58	04-08-2020	G.O. (R.T) No. 1453/2020/ LSGD	LSGD – COVID 19 – Prevention activities – Expert Data Management Team constituted – Order Issued	
59	04-08-2020	G.O. (R.T) No. 1450/2020/ LSGD	തദ്ദേശ സ്വയംഭരണ വകുപ്പ് – 2020-21 വാർഷിക പദ്ധതി – കോവിഡ് മഹാമാരിയുടെ പശ്ചാത്തലത്തിൽ ഉത്പാദന മേഖലയിലെ ഗുണഭോക്താക്കളെ തെരഞ്ഞെടുക്കുന്നതിന് നിശ്ചയിച്ചിരുന്ന നടപടിക്രമങ്ങൾ സേവന മേഖലയ്ക്ക് കൂടി ബാധകമാക്കി – ഉത്തരവ് പുറപ്പെടുവിക്കുന്നു.	Department of Local Self Government – 2020-21 Annual Plan – In the context of the COVID Epidemic, the procedure for selecting beneficiaries in the manufacturing sector has been extended to the service sector – the order is issued.
60	05-08-2020	G.O. (R.T) No. 1458/2020/ LSGD	തദ്ദേശ സ്വയംഭരണ വകുപ്പ് – കോവിഡ്-19 പ്രതിരോധ നടപടികളുടെ ഭാഗമായി കേരള അഗ്രോ മെഷീനറി കോർപ്പറേഷൻ ലിമിറ്റഡ് (KAMCO) വികസിപ്പിച്ച പെഡൽ ഓപ്പറേറ്റഡ് സാനിറ്റൈസർ തദ്ദേശ സ്വയംഭരണ വകുപ്പിന് കീഴിലുള്ള സ്ഥാപനങ്ങളിൽ ഉപയോഗിക്കുന്നതിന് അനുമതി നൽകിക്കൊണ്ടുള്ള ഉത്തരവ് – ഭേദഗതി ചെയ്ത് ഉത്തരവ് പുറപ്പെടുവിക്കുന്നു.	The Local Self Government Department – Order issued in amendment of earlier order permitting the use of pedal operated sanitizer developed by the Kerala Agro Machinery Corporation Limited (KAMCO) in institutions under the Local Self Government Department as part of COVID preventive measures.

61	05-08-2020	G.O. (R.T) No. 1456/2020/ LSGD	തദ്ദേശ സ്വയംഭരണ വകുപ്പ് – കോവിഡ് മഹാമാരിയുടെ പശ്ചാത്തലത്തിൽ തദ്ദേശ ഭരണ സ്ഥാപനങ്ങളിലെ യോഗങ്ങൾ ഓൺലൈൻ ഉൾപ്പെടെയുള്ള മാർഗ്ഗങ്ങളിൽ ചേരുന്നതിന് അനുമതി നൽകി ഉത്തരവ് പുറപ്പെടുവിക്കുന്നു.	The Local Self Government Department- Order issued permitting local bodies to conduct meetings including online in the wake of The COVID Pandemic.
62	07-09-2020	G.O. (R.T) No. 1615/2020/ LSGD	തദ്ദേശ സ്വയം ഭരണ വകുപ്പ് – ജീവനക്കാര്യം – കോവിഡ് 19-കാലഘട്ടത്തില്പ്രവര്ത്തിച്ച് വരുന്ന പാലിയേറ്റീവി കെയര് നഴ്സുമാര്ക്ക് ഇന്സെന്റീവ് അനുവദിച്ച് ഉത്തരവ് പുറപ്പെടുവിക്കുന്നു	Local Self Government Department- Order granting incentive to Palliative Care Nurses serving during COVID 19 period.
63	14-09-2020	G.O. (R.T) No. 1649/2020/ LSGD	തദ്ദേശ സ്വയംഭരണ വകുപ്പ് – കോവിഡ് 19 – പ്രതിരോധ പ്രവർത്തനങ്ങളുമായി ബന്ധപ്പെട്ട് പ്രവർത്തിക്കുന്ന ശുചീകരണ തൊഴിലാളികൾക്ക് അവർ ഏർപ്പെടുന്ന തൊഴിലിലെ Risk Factor പരിഗണിച്ച് 750/- രൂപ ദിവസ വേതനം അനുവദിക്കുന്നതിന് അനുമതി നൽകി ഉത്തരവ് പുറപ്പെടുവിക്കുന്നു .	The Local Self Government Department – Orders sanctioning daily wages of Rs.750/- to the cleaning workers involved in COVID prevention activities in view of the Risk Factor in their occupation.
64	18-09-2020	G.O. (R.T) No. 1688/2020/ LSGD	തദ്ദശ സ്വയം ഭരണ വകുപ്പ് – കോവിഡ് 19 – പ്രത്യേക സാഹചര്യം പരിഗണിച്ച് തദ്ദേശ സ്വയം ഭരണ സ്ഥാപനങ്ങളില് നിന്നും നല്കി വരുന്ന വ്യാപാര ലൈന്സ് ഉള്പ്പെടെയുള്ള വിവിധ ലൈസന്സുകള് പുതുക്കുന്നതിനുള്ള അവസാന തീയ്യതി 30.09.2020 വരെ ദീര്ഘിപ്പിച്ച് നല്കി ഉത്തരവ് പുറപ്പെടുവിക്കുന്നു	Local Self Government Department – Order extending the last date for renewal of various licenses including trade lines issued from local bodies till 30.09.2020 under the special circumstances prevailing because of COVID 19.
65	22-09-2020	G.O. (R.T) No. 1704/2020/ LSGD	തദ്ദേശ സ്വയംഭരണ വകുപ്പ് – ലൈഫ് മിഷൻ – ഗുണഭോക്തൃ പട്ടികയിൽ ഉൾപ്പെടാൻ കഴിയാതെ പോയ അർഹരായ ഗുണഭോക്താകളുടെ പട്ടിക തയ്യാറാക്കൽ – അപേക്ഷ സമർപ്പിക്കുന്നതിനുള്ള സമയം ദീർഘിപ്പിച്ച് ഉത്തരവ് പുറപ്പെടുവിക്കുന്നു .	The Local Self Government Department –Order extending the time for submission of application for inclusion in the list of eligible beneficiaries of LIFE MISSION for those who have not been included earlier.

66	04-10-2020	G.O. (R.T) No. 1815/2020/ LSGD	Local Self Government Department – Strategy to be adopted to handle COVID-19 pandemic during the time when the elected representatives will be out of action on account of election campaign, and further in case of delay in conducting the elections, from 2020 November 11 onwards – 3 member team constituted – Orders Issued.	
67	14-10-2020	G.O. (R.T) No. 1903/2020/ LSGD	Local Self Government Department – COVID 19: Standard Operating Procedure on Dead Body Management and guidelines for relatives of the deceased and Local Bodies in the State – Order Issued	
68	22-10-2020	DD2/205/ 2020/LSGD	ത.സ്വ.ഭ.വ – മഹാത്മ ഗാന്ധി ദേശീയ ഗ്രാമീണ തൊഴിലുറപ്പ് പദ്ധതി – കോവിഡ് 19 വ്യാപനത്തിൻറെ പശ്ചാത്തലത്തിൽ 65 വയസ്സിന് മുകളിൽ പ്രായമുള്ള തൊഴിലാളികൾക്ക് തൊഴിലെടുക്കുന്നതിന് ഏർപ്പെടുത്തിയ വിലക്ക് പിൻവലിക്കുന്നത് സംബന്ധിച്ച്	Local Self Government Department – Order withdrawing the ban on employment to workers above 65 years of age under the Mahatma Gandhi National Rural Employment Guarantee Scheme in the wake of the spread of COVID19.
69	04-11-2020	G.O. (R.T) No. 2073/2020/ LSGD	തദ്ദേശ സ്വയംഭരണ വകുപ്പ് – കോവിഡ് 19 – പ്രത്യേക സാഹചര്യം പരിഗണിച്ച് തദ്ദേശ സ്വയംഭരണ സ്ഥാപനങ്ങളിൽ നിന്നും നൽകി വരുന്ന വ്യാപാര ലൈസൻസ് ഉൾപ്പെടെയുള്ള വിവിധ ലൈസൻസുകൾ പുതുക്കുന്നതിനുള്ള അവസാന തീയ്യതി 30.11.2020 വരെ ദീർഘിപ്പിച്ച് നൽകി ഉത്തരവ് പുറപ്പെടുവിക്കുന്നു.	The Department of Local Self Government– Order extending the last date for renewal of various licenses including trade licenses issued from local bodies till 30.11.2020 considering the special circumstances of COVID 19.

70	11-11-2020	G.O. (R.T) No. 2125/2020/ LSGD	തദ്ദേശ സ്വയംഭരണ വകുപ്പ് - നിലവിൽ കോവിഡ് ഫസ്റ്റ് ലൈൻ ട്രീറ്റ്മെന്റ് സെൻററുകളുടെ (CFLTC) മാനേജ്മെൻറ് കമ്മിറ്റി അധ്യക്ഷ സ്ഥാനത്ത് 12.11.2020 മുതൽ തദ്ദേശ സ്വയംഭരണ സ്ഥാപന അദ്ധ്യക്ഷനു പകരം അതത് തദ്ദേശ സ്വയംഭരണ സ്ഥാപന സെക്രട്ടറിയെ ഉൾപ്പെടുത്തിക്കൊണ്ട് ഉത്തരവ് പുറപ്പെടുവിക്കുന്നു.	LSG Department - Orders replacing the Chairman of the LSG with the Secretary of LSG from 12.11.2020 in the post of Chairman of the Management Committee of the CFLTC.

APPENDIX 2

DISTRICT WISE LIST OF LSGS

LIST OF LOCAL SELF-GOVERNMENTS- DISTRICT WISE		
Sl. No	**Name of Local Self-Government**	**District**
1	Pattanakkad Grama Panchayat	Alappuzha
2	Mavelikkara Municipality	Alappuzha
3	Thanneermukkam Grama Panchayat	Alapuzha
4	Chenampallipuram Grama Panchayat	Alapuzha
5	Mulakuzha Grama Panchayat	Alapuzha
6	Piravom Municipality	Ernakulam
7	Mulanthuruthy Grama Panchayat	Ernakulam
8	Vadavucode Grama Panchayat	Ernakulam
9	Edavanakkad Grama Panchayat	Ernakulam
10	Varappetty Grama Panchayat	Ernakulam
11	Njarakkal Grama Panchayat	Ernakulam
12	Pallipuram Grama Panchayat	Ernakulam
13	Rayamangalam Grama Panchayat	Ernakulam
14	Chotanikkara Grama Panchayat	Ernakulam
15	Kadungaloor Grama Panchayat	Ernakulam
16	Nayarambalam Grama Panchayat	Ernakulam
17	Eloor Municipality	Ernakulam
18	Vazhakulam Grama Panchayat	Ernakulam
19	Kunnakara Grama Panchayat	Ernakulam
20	Kuzhuppilly Grama Panchayat	Ernakulam
21	Kumali Grama Panchayat	Idukki
22	Peravoor Grama Panchayat	Kannur
23	Pariyaram Grama Panchayat	Kannur
24	Eranholi Grama Panchayat	Kannur
25	Payam Grama Panchayat	Kannur
26	Kannapuram Grama Panchayat	Kannur
27	Anthoor Municipality	Kannur
28	Kadambur Grama Panchayat	Kannur
29	Thalassery Municipality	Kannur
30	Pappinisseri Grama Panchayat	Kannur
31	Padiyoor Grama Panchayat	Kannur
32	Aralam Grama Panchayat	Kannur

33	Chittariparamba Grama Panchayat	Kannur
34	New Mahi Grama Panchayat	Kannur
35	Cherukunnu Grama Panchayat	Kannur
36	Mattanoor Muncipality	Kannur
37	Kurumathoor Grama Panchayat	Kannur
38	Kottayam Grama Panchayat	Kannur
39	Koothuparambu Municipality	Kannur
40	Cheruvathoor Grama Panchayat	Kasargod
41	Neeleswaram Municipality	Kasargod
42	East Eleri Grama Panchayat	Kasargod
43	Bedadka Grama Panchayat	Kasargod
44	Kinanoor Grama Panchayat	Kasargod
45	Dhelampadi Grama Panchayat	Kasargod
46	Pulloor- Periye Grama Panchayat	Kasargod
47	Karadukka Grama Panchayat	Kasargod
48	Alappad Grama Panchayat	Kollam
49	Chirakkara Grama Panchayat	Kollam
50	Aadhichannalur Grama Panchayat	Kollam
51	Kuravilangad Grama Panchayat	Kottayam
52	Kaduthuruthy Grama Panchayat	Kottayam
53	Kavilumpara Grama Panchayat	Kozhikode
54	Chengettukovu Grama Panchayat	Kozhikode
55	Karasheri Grama Panchayat	Kozhikode
56	Arikulam Grama Panchayat	Kozhikode
57	Chelembra, Grama Panchayat	Malappuram
58	Cheriyamundam Grama Panchayat	Malappuram
59	Perinthalmanna Municipality	Malappuram
60	Thazhekode Grama Panchayat	Malappuram
61	Urangattiri Grama Panchayat	Malappuram
62	Kottakkal Municipality	Malappuram
63	Tirur Municipality	Malappuram
64	Malappuram Municipality	Malappuram
65	Ponnani Municipality	Malappuram
66	Perumbadappu Grama Panchayat	Malappuram
67	Puzhakattiri Grama Panchayat	Malappuram
68	Vilayur Grama Panchayat	Palakkad
69	Thrithala Grama Panchayat	Palakkad
70	Patambi Municipality	Palakkad
71	Nenmara Grama Panchayat	Palakkad
72	Kappur Grama Panchayat	Palakkad
73	Malayalapuzha Grama Panchayat	Pathanamthitta
74	Ranni Grama Panchayat	Pathanamthitta
75	Vallikode Grama Panchayat	Pathanamthitta

76	Seethathodu Grama Panchayat	Pathanamthitta
77	Pramadam Grama Panchayat	Pathanamthitta
78	Chittar Grama Panchayat	Pathanamthitta
79	Elanthur Grama Panchayat	Pathanamthitta
80	Cherunniyoor Grama Panchayat	Thiruvananthapuram
81	Thiruvananthapuram Corporation	Thiruvananthapuram
82	Karakulam Grama Panchayat	Thiruvananthapuram
83	Neyattinkara Muncipality	Thiruvananthapuram
84	Kodakara Grama Panchayat	Thrissur
85	Madakkathara Grama Panchayat	Thrissur
86	Perinjanam Grama Panchayat	Thrissur
87	Mulankunnathukavu Grama Panchayat	Thrissur
88	Paralam Grama Panchayat	Thrissur
89	Meenangadi Grama Panchayat	Wayanad
90	Vengapally Grama Panchayat	Wayanad
91	Vythiri Grama Panchayat	Wayanad

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