

RESEARCH ARTICLE

"I pray to God that greed never sets in": Community health workers' reflections on "care" during the Covid-19 pandemic

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Abstract

Background: Care provision received renewed attention during the Covid-19 pandemic as several healthcare providers vied for the coveted title of "frontline warrior" while they struggled to provide care efficiently under varying health system constraints. While several studies on the health workforce during the pandemic highlighted their difficulties, there is little reflection on what "care" or "caring" itself meant specifically for community health workers (CHWs) as they navigated different community and health systems settings. The aim of the study was to examine CHWs' care-giving experiences during the pandemic.

Methods: Twenty narrative interviews with CHWs including ASHAs (Accredited Social Health Activists) and ANMs (Auxiliary Nurse Midwives) were conducted in different states between July and December 2020.

Results: Our findings highlight the moral, affectual, and relational dimensions of care in the CHWs' engagement with their routine and Covid-19 related services, as well as the "technical" aspects of it. In this article, we argue that these two aspects are, in fact, enmeshed in complex ways. CHWs extend this moral understanding not just to their work, but also to their relationship with the health system and the government, as they express a deep sense of neglect and the lack of "being cared for" by the health system.

Conclusion: CHWs' experiences demand a more nuanced understanding of the ethics of care or caring that challenges the binaries between the "technical" and moral aspects of care.

Keywords: community health workers, care, health workforce, Covid-19 pandemic, India

Introduction

"The global spread of Covid-19 has been accompanied by a grand-scale 'call to care'" [1], drawing renewed attention to the value of caregiving. Care became important in all spaces, including family, community, and clinical practice, as well as policy ecosystems. The health workforce was at centre stage not merely because of the applause and display of gratitude they received but also because they bore the brunt of fragile health systems. The health system constraints in dealing with the pandemic were distinctly visible and the range of protests by health workers on the streets exposed them further. The pivotal role of Community Health Workers (CHWs) in fighting the pandemic was acknowledged worldwide [2,3]. In India, CHWs including Accredited Social Health Activists (ASHAs) and Auxiliary Nurse Midwives (ANMs) played a significant role in curbing the spread of the virus in rural and urban areas amidst massive migration from cities to rural areas during the national lockdown in March-April 2020. The role of CHWs, particularly ASHAs, during the pandemic, gained global attention when the World Health Organization conferred the Global Health Leaders' Award-2022 on the ASHAs for their leadership and commitment to advancing global health issues, and their contributions during the pandemic. While this recognition is important, ASHAs' contributions during the pandemic bred numerous stories of struggle, survival, hope, and despair that needed to be understood in the larger context of care provision. Navuluri et al caution against the discourse of heroism among the health workforce as it is "likely to miss how Covid-19 has transformed the foundations of public health that attract healthcare workers in the first place: human interaction, communication, and education" [4: p 212]. It is important to ask "what kind of logic of care is at stake during the pandemic? What can be done to protect the labour that care?" [4].

Several studies emerged during the pandemic that highlighted the experiences of CHWs in India and globally. These studies identified varied concerns including inadequate training, poor and delayed payments, lack of adequate safety gear and insurance cover, lack of proper information and grievance redressal channels, increase in disrespect and abuse within the community, experiences of mental and physical stress, and experiences of gendered negotiations with their own families [5-11]. While many of these stressors are not new, the pandemic aggravated

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them; ironically it also reinforced the critical role played by CHWs at the community level.

The pandemic imposed new demands on CHWs. For example, they had to navigate vaccination services while following social distancing norms and managing monitoring and quarantine services. They did this along with, and often at the expense of, routine health services. The effects of these demands unfolded through complex community and health system level dynamics, revealing how CHWs engaged in “caring” for the communities they were embedded in during the pandemic.

Though care, caring and caregiving are intrinsic to medicine and healthcare, recent medical anthropological literature as well as the medical humanities call for a renewed engagement with the “care” in healthcare. This is specifically in response to the understanding that the practice of biomedicine is increasingly driven by market logic, even as the epidemiological transition to chronic and long-term illnesses necessitates that “caring” goes beyond quick-fix cures in a clinical setting. Kleinman [12] and Kleinman and van der Geest [13] argue for reclaiming the moral world of medicine by demonstrating why caregiving is essentially a moral experience. This moral face of caregiving entails, at the core, “acknowledgment of the personhood of the sufferers and affirmation of their conditions and struggles” [12: p 1551]. The authors expand on their theme, arguing that terms like “taking care” and “caring” imply affirmation of the person cared for and their relationship through the practices of attending, empathetic listening, being there, supporting, and collaborating [12-13]. These echo Gilligan’s argument that the ethics of care “starts from the premise that as humans we are inherently relational, responsive beings and the human condition is one of connectedness or inter-dependence.” [14]

Furthering this line of thought, political theorists Joan Tronto and Berenice Fischer lay out the moral qualities integral to care provision in four phases [15]. The first phase, “*Caring about*,” involves noticing someone’s unmet caring needs, and requires the moral quality of *attentiveness* towards the other’s needs. The second phase of “*Caring for*” involves *taking the responsibility* of caring for others once these needs have been noticed. The third phase of “*Caregiving*” requires the moral quality of *competence*. To be competent, the authors argue, given one’s caregiving responsibilities, is not simply a technical issue but also a moral one. The fourth phase of “*Care receiving*” involves observing the caregiver’s response to the care receiver and evaluating whether it was adequate and complete. This requires the moral quality of *responsiveness* [15]. These discussions question two important facets of care:

- the binaries of the technical/clinical (eg providing clinical services) and the moral/relational dimensions (being empathetic, trusting), and
- the relegating of most caring activities to professions like nurses, counsellors, social workers, and even patient support networks [16].

Drawing on these theoretical discussions of caring, in this paper we explore and analyse what it means to provide “care” in a community health setting wherein the values, culture, and beliefs of the community are enmeshed with the idea of providing and receiving care. We argue that the moral aspects involve the moralities not just of the caregiver and the care receiver but also of the community, and the social contexts in which it is provided.

Methods

The paper draws on a small exploratory research study conducted between July and December 2020. The study was triggered by insights shared during a webinar co-organised by the authors in May 2020. This webinar was attended by close to 100 health workers and led by CHWs who were invited as panellists [7]. The webinar focused on understanding how grassroots-level healthcare workers prepared themselves to combat the pandemic, how they had been supported by the government, and their experiences while providing Covid-19 related as well as other routine services. The webinar made us realise the need for a forum for CHWs to voice their concerns and experiences, as many of them felt unheard. With this objective in mind, our exploratory study was conceptualised to capture the everyday experiences of CHWs during the pandemic. We followed up the webinar with narrative interviews with CHWs in order to understand, in detail, their experiences of working during the pandemic. We identified ASHAs, *Mitanins*, *Sahiyas*, ASHA facilitators, Mitanin trainers, and ANMs from different geographies, broadly constituting the cadre of CHWs.

We used the narrative enquiry method in which participants’ personal stories and life experiences are examined during specific events, in this case, the pandemic. Given the study’s exploratory objective, the interviews focused on Covid-19 related responsibilities, personal and professional preparedness, experiences of working during the pandemic, specific challenges (community, family, health system) and how participants navigated these challenges, including what kept them going, and any specific learnings. We identified the participants through the COPASAH-Theme 5 network^a. We began by approaching and interviewing a few of those who had participated as panellists and participants in the webinar. Later by use of the snowballing method, the health workers led us to other CHWs in their associations and networks. The health workers were drawn from 10 states. We approached 23 health workers and a total of 20 interviews were conducted. Three of the CHWs withdrew their participation at different stages due to discomfort with the medium of conversation (WhatsApp) and due to availability issues. Given the study’s exploratory nature, we followed the rule of saturation and found 20 interviews to be adequate and satisfactory for analysis.

The interviews were conducted by both the authors mostly

in Hindi, and a few were conducted in Odia. The excerpts quoted in the findings are translations into English. The CHWs were approached beforehand and explained the purpose of the study in detail, the nature of information sought and the mode of its dissemination before consent was taken. Given the logistical constraints during the pandemic, we conducted telephonic interviews with the CHWs at a day and time convenient to them. Consent was sought for the audio recording of the interviews and these recordings were transcribed and stored with unique codes. In cases where the participant refused to be audio recorded, we made detailed notes and shared an oral summary of the interview with the participant at the end of it. The transcripts and audio recordings were stripped of important identifiers and stored on a shared drive accessible only to the researchers involved. The study received ethical approval from the Institutional Review Board at Azim Premji University.

Each transcript was first read individually and then by both authors to validate insights emerging from each of the interviews. While analysing the data, the transcripts were coded first under four broad themes. These four themes followed our broad set of interview questions covering a) the professional context of the CHW, b) Covid-19 related responsibilities, c) experiences with facilitating and providing care for both Covid-19 and routine services, and d) challenges and learnings of being a CHW. The data were coded inductively, and sub-themes were identified which led us to discern specific notions of caregiving and receiving, reflections on what it means to be a CHW, and experiences of managing relationships with the community, with other health personnel, and with the health system itself during the pandemic. The sub-themes also pertained to different experiences based on the CHWs' contractual or permanent employment status. We recorded each such sub-theme and kept a close ear and eye on who was speaking and how and categorised these sub-themes accordingly. We then triangulated the data at multiple levels: a) across transcripts; b) with existing literature and webinars by academics on CHWs' experiences during the pandemic; c) the health system context of the specific states, and d) literature on care or caregiving. The meta-narrative that emerged from this layered analysis focused on CHWs' experiences and understandings of what caregiving entails, which we discuss below in our findings.

Reflexivity

Despite having done extensive qualitative research in community health, we found doing telephonic narrative interviews was a new experience as the "field" moved to a remote space (telephone, online) [17,18]. We had to be very mindful, not merely of the larger context of the pandemic, which had unsettled our personal and professional lives in many ways, but also of the norms of collecting "thick data" as is typical of qualitative research and even more of the narrative interview method. The CHWs were comfortable with WhatsApp audio call interviews as most of them were familiar

with the App. As researchers, this required more effort and close observation to sense the participants' tone, their emotional expressions of anger, neglect, confusion, fear as well as elation on being approached for interviews, and also other non-verbal cues. Communicating via WhatsApp allowed many CHWs to share images and additional information about their work sites after the interviews, thus confirming the tone and spirit of the trust-building exercise and the non-threatening mode of conversations. The authors are deeply conscious of the time given and grateful for the stories shared by the participants during the course of the study, especially in the context of the pandemic. The foremost intention of the study was to produce research outputs that can be fed back into the CHW ecosystem in the form of usable insights for health system advocacy. Therefore, the first research output was a publicly available compendium of health workers' stories in English and Hindi [8], and the second research output is this article which contributes to existing academic literature on "care" in the healthcare context.

Results

"They know that if there is a health problem, I will take responsibility": Caregiving as a moral responsibility

During the interviews, CHWs did not describe their work merely in terms of tasks (contact tracing, surveying those who returned to the villages, facilitating testing, etc) but also in terms of a moral duty and responsibility. They located their work in a relational space of what it means to trace contacts, how community members respond to such contact tracing, how feasible/not feasible social distancing is among certain communities, and how a different style of communication is required in such settings. CHWs' descriptions of their work resonated with the theoretical discussion above which highlights the qualities of trust building, attentiveness, responsibility, competence, and responsiveness as essential elements of the moral dimension of care provision.

In the community healthcare setting, these qualities and relational aspects of care provision become more complex for three reasons. First, the gendered social location of the CHWs, most of them being women, leads to the assumption that CHWs have natural caregiving qualities, unfairly burdening women. Further, due to such an assumption, the moral and relational aspects of care are not really valued by the health system or on occasion by the communities themselves. Second, in a community setting (unlike a clinical space) there is no strict separation of care and cure. CHWs themselves may not be providing the "technical" part of the services. Or they may be doing that in a limited way, as the ANMs in India do at the community level. But CHWs are critical to facilitating care. Third, the hierarchy between caregivers and receivers (as in the case of patients and doctors) is not strictly defined, as CHWs are supposed to be, and often are, from the community. They therefore operate

in an ambiguous space wherein their roles and duties are defined by the health system, but the performance of their tasks unfolds in a very social and morally loaded space. This requires CHWs to negotiate the moral standards required for care provision. Their competencies are judged by the community members not just on their technical abilities but also on their ability to adhere to and understand social and moral codes. The sense of responsibility in such a case is also not just a product of being a “government” health worker (though ASHA workers are not regularised government health workers); it is also because the caregiver is a moral being connected to the people she is serving. The nature of responsiveness then becomes a deeply personal project, especially during a time such as the pandemic, when preventive care services were prioritised as much as curative services, and physical isolation hindered the usual processes of care provision.

The experience of giving care as a moral duty operates in fragile community and health system settings. Health workers described instances when they faced the community's distrust and scepticism and were considered to be “carriers of diseases” or “agents” of the government, forcing social and physical restrictions on them. Some CHWs explained that the community's distrust of the health system was translated into distrust towards them as individuals, shifting the onus of accountability from the health system to CHWs. The CHWs felt morally responsible for ensuring clear communication and provision of health services to the community.

When I tracked them and visited their house to do the survey and collect their name and contact number, people came to my house angrily after knowing that I had collected their information. I assured them that if anything happened in the village then I would be the first person to get caught. I am living in the village and I'm from the same community, so I am always available if some harm comes to people. When people accused me of killing their children from vaccination, I said to them I would kill myself first before the death of their children if anything harmful happened. It took a lot of effort to win the trust of people. (ASHA, Bihar)

The CHWs placed a lot of importance on their ability to be seen as trustworthy within the community to which they provided care. One of the ANMs explained how she tried to convince the community where she was recently deployed that she was “one of them” and that she would take responsibility for their health.

The villages are inhabited by the Warli Adivasi (indigenous) community. They had asked me, in my initial days as an ANM, if I was from their caste, I had said “yes.” They have a lot of trust in me. They know that if there is a problem, I will take responsibility.” (ANM, Maharashtra)

Health workers explained in different ways how important they considered community healthcare work to be and said that their motivation remained despite delayed and

inadequate payments. CHWs portrayed their work to be beyond designated tasks and incentives and attached strong moral values to their work.

We are not getting extra money to work for Covid-19. Our salaries were also delayed. Despite this, I consider it my duty to protect the lives of the people in the village. I worked with dedication to protect our people from Covid-19. (Mitanin trainer, Chhattisgarh)

Some of them also explained that the monetary incentives were secondary motivations and it was important that one did not focus on earning more in this line of work.

I take pride in my work. When the people of the village are healthy, what else can I ask for? I love what I do. I pray to God that greed (yearning for more money) does not set in. You (the researcher) also pray for me. If we become greedy and think of money only, we cannot do this work. This work is not meant for earning more money but to serve people. The fact that I have met so many “big” people, that is a great thing. I get a lot of respect from everyone in the health system. They trust me and I can also rely on their support. (ASHA, Odisha)

Thus, CHWs in their descriptions of how they built trust, bonded with community members, and took responsibility for providing care during the pandemic highlight the moral, affectual, and relational dimensions of “care/caring” in community health work.

“I escort the woman back to her house after the quarantine period.”: The importance of tacit knowledge in caring

CHWs are often selected or appointed from their own community because it is assumed that being part of the community allows them to have unique information about the community due to their lived experiences, in other words have tacit knowledge. This prior bond and information allows them to be better health workers and caregivers. While the logic of the CHW programme itself relies on them having this tacit knowledge, the exercise or use of this knowledge is underappreciated and undervalued, and is assumed to be an unchallenging task. CHWs' efforts to bind the rational and clinical aspects of health programmes with the moralities of the care-receiving community — especially when communities are not monolithic — are underestimated by the health system, including by policymakers. CHWs narrated how the official Covid-19 protocols to maintain social distancing, sanitising, and quarantining measures were difficult to follow. Even though they were “technically” correct, these protocols did not seem appropriate in the community settings, impelling CHWs to devise creative ways to ensure that community members were protected. Enforcing Covid-related measures and safety protocols in the community required tacit knowledge about the socioeconomic conditions and moral codes of the villagers. The practice of public health measures was thus

continuously negotiated and enforced in collaboration with the community members by CHWs, and not in a mechanical manner oblivious to the local contexts.

CHWs highlighted the importance of tacit knowledge in different ways. For example, while quarantining appeared to be a simple and effective measure to prevent the spread of coronavirus, this measure had to be navigated through cultural and gender norms. As one of the ASHA workers explained:

Many pregnant women travelled back to their natal home for the delivery. Since they travelled from other places, they had to be isolated. I visited them, isolated them in their house in a separate room. If they did not have a separate space, I would take the woman to another place [the community centre in the village, Anganwadi centre] and get the Covid test done. The women often had to spend two days for the results to come. If the result was negative, I used to escort the women back to their houses. You know, in villages people would otherwise say bad things about the women spending time outside the house. If I go with the woman and assure the family that the result is negative and I took responsibility during the isolation period, the family would be reassured.” (ASHA worker, Odisha)

Thus, the ASHA, by understanding the cultural connotations, could help the pregnant woman quarantine safely as per public health standards but also ‘safely’ as per community gender norms. CHWs also narrated how they leveraged their relationships within the community to find new ways to disseminate Covid-19 related information.

It is not easy to convince people to wash hands frequently and follow social distancing norms. I took my daughter (who works in the Red Cross Society), the Anganwadi worker, the Mitanin, the village head and members of the youth organisation in the village to form a team. We went together to the village and discussed what Covid-19 is, its symptoms and why prevention and protection are the best measures. Since many people visit the local shop, I suggested they form circles outside for people to stand, put a bucket of water with soap and asked the shopkeeper to be aware that before and after giving any items everyone should wash their hands with soap. Similarly, at the handpump, we suggested to women that they should not go all together to fetch water; they should go one by one to maintain social distancing. Because of teamwork, such communication and ensuring rules that are easier for people to follow became possible.” (ANM, Chhattisgarh)

Community health workers shared many such experiences of drawing on their tacit knowledge to communicate about Covid-19 and operationalising protection and prevention measures suitable to the local contexts. The active drawing upon this tacit knowledge is particularly important as communities are seldom homogenous, and this kind of localised understanding allowed CHWs to navigate caste,

gender, and tribal differences within their communities.

CHWs also highlighted how the usual ways of caring, through touching hands, face-to-face conversations, or just being there and listening became tough in the wake of social distancing norms, specifically during the lockdown. This posed an additional burden of finding creative and effective ways to provide care.

“We feel like the stepchildren of the health department”: Who cares for us?

Parallel to the narrative that care given by CHWs is a moral and emotional exercise instead of just several designated tasks, was the narrative that CHWs were not being adequately cared for, recognised, valued, and compensated. CHWs, especially the ASHAs who are the lowest rung of CHWs, felt unheard and ignored by the health department. They expressed these missing elements of “care” which involved supporting CHWs through the provision of additional information on facilities, treatments, symptoms, adequate training, provision of safety gear, support and encouragement from senior staff, timely payments, and space for grievance redressal by highlighting the inadequate training related to Covid-19, lack of adequate masks, sanitisers, testing facilities for CHWs and delayed payments. In addition to this, they drew attention to the overall absence of support in handling people’s fears, rumours, and myths in the community, often leaving CHWs to deal with all these on their own. In many cases, they did not have a forum to share their grievances and were forced to be out on the streets protesting or frantically writing to senior officials and even state ministers. The process of bringing attention to their grievances reminded them of their dispensability. One of the ASHAs working in urban areas said,

I raised the issue of delayed payment with the senior official. I was immediately told, ‘If you are not satisfied with your job, you can leave. We can give it to someone else’. I have worked for 12 years and feel that I have wasted these years of my life, as there is neither money, nor additional skill set, nor any recognition of my work. (ASHA, Uttar Pradesh)

Another ASHA facilitator from Madhya Pradesh said ASHA workers were treated like the “stepchildren of the health department”, easily blamed for all problems, and not considered with empathy. In many government circulars, their names or signatures were not mentioned or required which, according to them, implied “no signatures means that we don’t exist”. Those ASHA workers who shared experiences of being supported and cared for had positive experiences of providing care in the communities. These were also the instances where the health system had been functioning well even before the pandemic, enabling health workers to capitalise on the existing bonds among the health staff and with the communities [6].

CHWs were deeply aware that their value came from both the health department and the community they served. They felt rewarded emotionally when people recognised their efforts and were cognisant of how the lack of recognition from the department influenced their status within the community.

Among the CHWs, in addition to the ASHAs, those ANMs who were on contract had a different experience to share compared to those who were in regular positions. The employment status of ANMs also determined whether their work received any acknowledgment or appreciation during the pandemic. While all permanent ANMs were provided (or, at least, promised) health insurance and additional incentives during Covid-19, contractual ANMs did not receive any extra payment or social security benefits [8]. The contract-based ANMs said they did not receive regular training, timely payment, and any Covid-19 related incentives while being expected to do all the work that a regular ANM does. Many of those on contract felt overworked, underpaid, unsupported by the health staff (health officials did not visit field sites to provide guidance), and emotionally drained. Some of the ANMs asked if their lives were valued by the health system at all.

I have been working for 14 years. I have not been paid for the last six months. This is the situation for many other ANMs in the block. I am the sole earning member in the family. I have been staying away from the family as I wish to protect them from the infection. While payment is delayed and irregular, none of the targets set can be delayed. In fact, my work has doubled and follows irregular hours. Even while dejected and demotivated, I continue with my daily work of looking after 10 villages — Covid-related work as well as routine health services. [We] often [work] without adequate gear, which adds to the uncertainty about my own life — we can protect people only when we ourselves are alive.” (ANM, Uttar Pradesh)

Thus, CHWs pointed towards the damaging effects of the lack of trust, responsiveness, and empathy by the health system on their efforts to provide care, and on their morale. While the material aspects of monetary incentives, PPE kits, and insurance cover are important, feelings of being supported — by the health system dealing with rumours, acknowledging the efforts of health workers, and listening to their concerns — are all critical elements of care.

Discussion

The work of CHWs is usually assessed through the outcomes of their designated tasks (number of children vaccinated, number of women counselled on family planning, number of incentives disbursed etc). This disregards the complex processes, interfaces and relationships in community settings that shape the carrying out of these tasks [19]. The CHWs' narratives in our study highlight how providing care is deeply embedded in a moral framing. Such a framing does not distinguish between “technical” aspects and “moral/relational”

aspects of care. Schneider and Lehman rightly argue that “systemic approaches that would foreground the key relationships surrounding CHWs are inadequately developed. Of these relationships, the interface with communities and community embeddedness are poorly understood” [20: p 113]. The CHWs' narratives draw our attention to these relationships and what it means to provide care in a community setting given the vulnerability of these communities and the drawbacks of the health system — both of which became more apparent during the global health crisis. During the pandemic, CHWs also worked to ensure that their bonds with the communities were not broken due to rumours, myths and fears in the community, and failure of routine health services.

We see CHWs not only spelling out the moral aspects of the care they provide to communities but also speaking of the responsibilities of the state and the health system in moral terms when they say they “do not feel cared for”, or they “feel like the stepchildren of the department”.

Maintaining a moral dimension is also very important, not just for care receivers but also for CHWs, because it is the domain from which they draw their legitimacy and try to keep themselves relevant despite their weak location in the health system. However, in a gendered and health system context, maintaining this moral dimension, though crucial for the nature of the work, it is also used against CHWs to reinforce that they must work for the moral good and not for financial incentives. The narratives show the struggle of CHWs as they try to demand both respect and financial recognition for their work, while managing the moral, emotional, and intangible aspects of community health practice. We see CHWs expressing their moral motivations and distancing themselves from the connotations of greed while they protest and demand accountability and better wages. This struggle arises because clinical care is understood as a more professional service than care provision that involves affectual, moral, and emotional dealings. Therefore, it is important that the tacit knowledge and the moral and emotional aspects of community health workers' labour be recognised as an indispensable part of community health practice and acknowledged as “competence” rather than as personal or gendered behaviour that is taken for granted.

By locating the CHWs' experiences in the ambit of ethics of care, we urge health practitioners and health policy makers to see the moralities and technicalities of community health provision from a holistic perspective. For community health policy and practice, such a perspective would help reimagine CHWs' training by including, in their core competencies, aspects of rapport building, trust-building, understanding local social norms, and other softer aspects of care work that many CHWs already perform. This would also mean recognising these competencies as professional capabilities worthy of fair and formal compensation and

enabling the workforce to create strong linkages between the community and the health system. Understanding the moralities of the care provided by CHWs will allow holistic planning of community health practice and better care provision by CHWs in the Indian context. This also emphasises why evaluation of CHWs' performance needs to consider the processes through which they implement a programme rather than just counting the output indicators.

Notes: Community of Practitioners on Accountability and Social Action in Health (COPASAH) is an international network of community health practitioners. In its last symposium in 2019, COPASAH included the additional theme of "Community and health care workers: Forging alliances". This was jointly curated by the first author in Azim Premji University with the Health, Ethics and Law Institute- Forum for Medical Ethics Society, Innovative Alliance for Public Health, and Seher -Centre for Health and Social Justice.

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Statement of Similar Work: This paper is the second research output of the original study conducted by the authors. Here is [the link](#) to the first research output — a compendium of CHW stories was published prior to this paper. This has been referenced in the paper and mentioned in the methodology.

Author Contribution:

First Author: Study concept, data collection, transcription, conceptualising theoretical framework, writing and reviewing of the manuscript.

Second Author: Data collection, transcription, conceptualising theoretical framework, writing and reviewing of the manuscript.

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