SJIF Impact Factor (2026): 8.863| ISI I.F. Value: 1.241| Journal DOI: 10.36713/epra2016 ISSN: 2455-7838(Online)
EPRA International Journal of Research and Development (IJRD)
Volume: 11 | Issue: 7 | July 2026 - Peer Reviewed Journal

BRIDGING COMMUNITIES AND HEALTHCARE: THE ROLE OF ASHAS IN WOMEN'S HEALTH AMONG INDIGENOUS COMMUNITIES IN TRIPURA, INDIA

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Article DOI: https://doi.org/10.36713/epra30956
DOI No: 10.36713/epra30956

ABSTRACT

Community health workers occupy a distinctive position within India's rural health system, serving as government functionaries and community members. This paper examines the role of Accredited Social Health Activists (ASHAs) in shaping women's and maternal-child health outcomes among the indigenous Reang and Jamatia communities of Amarpur, Tripura, focusing on how ASHAs negotiate the dual identity of mother and worker in a patriarchal, resource-constrained tribal setting. Using a qualitative, explorative-cum-descriptive design combining interviews and focus group discussions across four villages—Paharpur, Kurma, Lalgiri and East Duluma—the study situates ASHA work within functionalist, medicalization, feminist and interactionist frameworks from medical sociology. Findings indicate that ASHAs function as indispensable cultural intermediaries translating biomedical messaging into locally intelligible idioms, while constrained by inadequate compensation, heavy unpaid workloads, limited training in tribe-specific health beliefs, and role ambiguity vis-à-vis Anganwadi workers and Auxiliary Nurse Midwives. The study documents improvements in antenatal care, institutional deliveries and immunisation coverage attributable to ASHA mediation, alongside gaps in postnatal, adolescent and mental health services. The paper concludes with recommendations for strengthening institutional support, remuneration and culturally responsive training for tribal ASHAs.

KEYWORDS: *ASHA (Accredited Social Health Activist); community health workers; indigenous health; women's health; Tripura; National Rural Health Mission*

1. INTRODUCTION

Health is widely recognised as a fundamental human right, and its attainment remains a central goal of any welfare state. In India, the recognition that formal health infrastructure alone could not reach the country's vast, socially heterogeneous rural population led to the launch of the National Rural Health Mission (NRHM) in April 2005 (National Rural Health Mission, 2005), which sought to deliver accessible, accountable healthcare to vulnerable and marginalised rural populations through the coordinated deployment of health, nutrition, sanitation and drinking-water interventions at the village level.

Among the NRHM's innovations, none has proved as consequential for last-mile health delivery as the Accredited Social Health Activist (ASHA), a village-level social activist selected from within the community she serves and tasked with generating health awareness, mobilising community participation, and improving utilisation of public health services. Unlike doctors, nurses or auxiliary staff who arrive from outside and depart at the end of a posting, the ASHA is by design a resident — a wife, mother and neighbour simultaneously deputised as an agent of the state's biomedical apparatus. This dual embeddedness, one foot in the domestic world of the village and the other in the bureaucratic world of the health system, is what makes the ASHA sociologically significant, and it is this dual position that the paper interrogates.

The ASHA programme was introduced in Tripura under the NRHM and subsequently expanded across the state's rural and tribal communities. Tripura's substantial indigenous population — including the Tripuri, Reang (Bru), Jamatia and Halam, historically settled in hill and forest tracts with limited connectivity to plains-based health infrastructure — made the scheme particularly consequential for tribal women's health. In Amarpur sub-division of Gomati district, 149 ASHAs served the sub-divisional population, supported by one Sub-Divisional Health Centre and twenty-four sub-centres. Compensation is performance-linked, tied to milestones such as institutional deliveries, immunisation coverage and antenatal check-ups, a structure that has generated incentives and distortions documented extensively in the global community health worker literature.

This paper asks a question visible only when the ASHA is examined not merely as a health-system functionary but as a woman embedded in specific kinship, gender and tribal relations: how do ASHAs in indigenous Tripura reconcile the competing demands of motherhood, domestic labour and quasi-professional health work, and with what consequences for the outcomes they are tasked with improving? The scope is deliberately narrow and ethnographically grounded — four villages within Amarpur block: Paharpur, Kurma,

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Lalgiri and East Duluma — to allow the kind of thick, situated description that large-scale quantitative evaluations typically cannot provide, while drawing on the existing evaluative literature from other Indian states to situate the Tripura findings comparatively.

The paper proceeds as follows. Section 2 reviews the literature on ASHA performance and roles across India and develops a theoretical framework drawing on functionalist, medicalization, political-economy, interactionist and feminist perspectives. Section 3 details the qualitative methodology. Section 4 discusses findings organised around ASHAs' socio-economic profile, the substantive content of their work, tensions between motherhood and paid community work, their role in maternal health outcomes, and the institutional constraints they face. Section 5 concludes with a synthesis of findings, limitations, and implications for policy and future research.

2. LITERATURE REVIEW

2.1 Empirical Studies on ASHA Performance and Roles

A substantial body of empirical literature has accumulated on ASHA recruitment, training, incentives and performance since the scheme's inception, much commissioned within the NRHM's own monitoring architecture. Bajpai and Dholakia (2011) examined recruitment, responsibilities, training, incentives and supervision of ASHAs across Bihar, Chhattisgarh, Rajasthan, Uttar Pradesh and Assam — states selected as among the poorest and most populous, and thus central to India's health-related Millennium Development Goals. Their questionnaire-based analysis concluded that ASHAs play a critical, largely effective role bridging the NRHM and rural communities, but that sustaining this effectiveness required continuous attention to recruitment quality, training adequacy, supervisory support and incentive design.

Husain (2011), reviewing evaluation studies by the Planning Commission, the Ministry of Health and Family Welfare, and independent researchers, found that although quantitative targets fell short in many states, the Mission restored public health to the centre of the policy agenda and increased outpatient utilisation at all tiers, most markedly at Primary Health Centres. Importantly, Husain also found that the NRHM's design paid insufficient attention to the socio-cultural complexity of Indian rural society — gender disparities, caste divisions and local power structures — a shortfall directly relevant to the Tripura tribal context, where indigenous social organisation and health beliefs diverge substantially from the plains-based, caste-structured contexts underlying much of the national ASHA literature.

Gopalan, Mohanty and Das (2012), examining 386 community health workers in Odisha, found that ASHA motivation was shaped more by individual and community-level factors than by health-system determinants, and that weak service infrastructure and administrative modalities depressed motivation over time — echoed later in this paper, where Tripura ASHAs likewise described community relationships, rather than administrative recognition, as their primary motivation.

The National Institute of Health and Family Welfare, with UNFPA, conducted a Rapid Appraisal of Health Interventions assessing ASHA functioning across five low-performing states — Madhya Pradesh, Uttar Pradesh, Odisha, Jharkhand and Chhattisgarh (Nandan et al., 2008). Based on over 129,000 ASHAs, it found support for antenatal care and immunisation disproportionately strong relative to other domains, and Panchayati Raj Institution members broadly appreciative of ASHA presence, reflecting reasonable community acceptance.

Mahalingashetty, Sandhya, Freedman and Austin (2012), comparing a high- and low-performing block in Lucknow district, found that both ASHAs and Auxiliary Nurse Midwives (ANMs) routinely worked beyond sanctioned hours, with maternal health duties forming only a fraction of a broader, multitasked workload — anticipating this study's central theme that ASHA work is a diffuse, continuous obligation blurring into domestic and community life.

Bhatt (2012), assessing Uttarakhand, found many ASHAs served populations exceeding the prescribed norm of 1,000, that compensation required upward revision, and that irregular medicine-kit supply and weak training in meeting facilitation constrained effectiveness. The Vistaar Project's evaluation of the Performance-Based Payment system (Wang, Juyal, Miner, & Fischer, 2012) identified structural weaknesses — payment delays, opaque processes, weak links between incentives and outcomes, and neglect of services outside the payment schedule — that could undermine the model's sustainability even where individual ASHAs performed well.

Shrivastava and Shrivastava (2012), studying 150 ASHAs in Palghar Taluka, Maharashtra, found persistent knowledge gaps on child health morbidity despite completed training. Mony and Raju (2012), evaluating the programme across Karnataka, found ASHAs functioning predominantly as link and community health workers, and only marginally as the "social activists" originally envisaged — bearing directly on this study's exploration of the gap between formal mandate and lived role — and identified inadequate coverage of marginalised households, including tribal hamlets, a gap resonating with Amarpur's indigenous villages.

Taken together, this literature converges on recurring themes: the centrality of ASHAs to maternal and child health delivery; the motivational importance of community standing over formal incentives; chronic weaknesses in training, supervision and payment; and — most relevant here — a persistent silence on how the ASHA's own domestic and reproductive obligations shape her capacity to

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perform this quasi-professional role. It is this gap the present study addresses, extending the literature into an indigenous, north-eastern context underrepresented in the plains-centric ASHA evaluation literature reviewed above.

2.2 Theoretical Framework

Understanding the empirical situation of gender, motherhood and health work among ASHAs in tribal Amarpur requires drawing on several distinct sociological traditions, each of which illuminates a different facet of the ASHA's position.

Functionalist perspectives

Talcott Parsons (1951) remains foundational to the functionalist analysis of health and illness, arguing that illness is a socially disruptive event undermining the roles and activities sustaining social order, and theorising the "sick role" as institutionalised rights and obligations designed to contain this disruption (Nagla, 2018). Within this framework, the physician — and, in the Indian rural context, the ASHA as proxy — is a professional bound by affective neutrality and universalism, obligated to place patient welfare above personal interest. Critics note the model presumes a symmetry between practitioner and patient that rarely holds; the ASHA–community relationship is instead characterised by asymmetries of knowledge, authority and, in the tribal context, caste, class and gender that functionalist theory tends to underplay.

Medicalization and social control

A second strand, associated with critical sociology of the 1960s–70s, examines the expansion of medical jurisdiction into domains of life not previously understood as illness (Zola, 1972), through the redefinition of non-medical conditions as pathological and the concentration of technical authority in professionals. Illich (1977) argued further that modern medicine generates "iatrogenic" illness and fosters dependency at the expense of self-reliance. Feminist extensions (Foster, 1995) note women's especially constrained capacity for informed choice, given clinicians' own uncertainty about risks and paternalistic withholding of information. Applied to the ASHA context, medicalization theory offers a double-edged lens: she can be read as an agent extending biomedical authority into autonomous domains of reproductive life, and as a potential corrective — a lay, community-embedded intermediary whose local legitimacy might mitigate the alienating effects of a distant medical bureaucracy.

Political economy and Marxist perspectives

Writers such as Doyal (1979) and Navarro (1979) situate medical power within class relations, arguing that ill health disproportionately burdens lower socio-economic groups and that resources are channelled toward maintaining production rather than public health as an end in itself; medical practice, Navarro argues, tends to minimise disruption to the prevailing economic order. This is instructive for the ASHA's structural position: as a poorly and irregularly remunerated worker performing labour essential to state health objectives yet systematically undervalued, she occupies a position analogous to other feminised, informalised, "invisible" labour documented in the political economy literature on women's work.

Interactionist perspectives and the experience of illness

Drawing on Mead's (1934) symbolic interactionism, sociologists examine how meaning is constructed intersubjectively rather than as an intrinsic property of events. Goffman's (1963) work on stigma shows how identity is shaped through others' perceptions of a "spoiled" attribute — relevant to the stigma attached, in tribal and rural Indian contexts, to infertility, reproductive illness or non-institutional childbirth. Bury's (1982, 1997) concept of illness as "biographical disruption" frames serious illness as a rupture in taken-for-granted assumptions about identity and life trajectory, managed through what Williams (1984) terms "narrative reconstruction" (Haralambos & Holborn, 2017).

Feminist and gendered perspectives on the body

Feminist scholarship has long grappled with women's bodies as a site of oppression, subordination and potential resistance. Gupta (2000) notes the body has historically been read through narrow, discipline-specific lenses — economic (Marx), sexual (Freud), mechanical (clinical medicine), fertile (demography) — obscuring its integrity as a whole, lived entity. Feminist sociology of reproduction concerns not only who controls reproductive decision-making but how medical knowledge itself is shaped by patriarchal ideology, with control over reproduction, sexuality, labour and mobility theorised as interlinked mechanisms at household and macro-political levels.

Read together, these traditions position the ASHA at a unique intersection: a Parsonian intermediary legitimising the "sick role," a potential agent (and occasional critic) of medicalization, a structurally undervalued worker shaped by political-economic forces beyond her control, a figure whose professional identity is interactionally constructed and vulnerable to stigma, and — crucially — a gendered subject whose body, reproductive history and domestic obligations are inseparable from her capacity to perform paid community health work. It is this last dimension, underexplored in the mainstream ASHA literature reviewed in 2.1, that this study foregrounds.

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3. METHODOLOGY

3.1 Research Design

The study adopts an explorative-cum-descriptive qualitative design, appropriate to a comparatively under-documented problem — the intersection of motherhood, domestic labour and community health work among indigenous ASHAs — requiring attention to meaning and lived experience rather than statistical generalisation alone. It combines primary qualitative data with secondary data from NRHM programme documents, district health records and the literature reviewed in Section 2.

3.2 Study Area and Universe

The study was conducted in Amarpur sub-division of Gomati district, Tripura, served by one Sub-Divisional Health Centre and twenty-four sub-centres. The universe comprised all 149 ASHAs working in Amarpur block, from which four villages within the Amarpur Autonomous District Council area were purposively selected for intensive fieldwork: Paharpur, Kurma, Lalgiri and East Duluma, chosen for their predominantly Reang and Jamatia tribal composition, relative inaccessibility, and designation as vulnerable areas under the district health administration's risk classification.

3.3 Sampling and Data Collection Tools

ASHAs were selected through purposive sampling to ensure representation across age, marital status, length of service and household composition, including those with young children and those whose children were grown. Data were collected through in-depth interviews with individual ASHAs, focus group discussions conducted separately with ASHAs and with women beneficiaries, and non-participant observation of home-visit and Village Health and Nutrition Day (VHND) activities. Interview and FGD guides addressed three core objectives: ASHAs' socio-economic characteristics; the substantive content of their work; and perceived improvements in rural health attributable to the scheme. Secondary data on ASHA numbers, training coverage, service-utilisation indicators and compensation structures were drawn from district health administration records and published NRHM/NHM documentation.

3.4 Data Analysis

Transcripts were analysed thematically, following operational categories used in government monitoring guidelines (recruitment and socio-economic profile; training and capacity; service delivery across the antenatal-natal-postnatal continuum; community relations; compensation and incentives), supplemented inductively with themes emerging from respondents' own framing — most notably the tension between domestic and community obligations, which recurred unprompted across nearly all interviews. Data were triangulated against secondary indicators and the literature reviewed in Section 2 to assess the plausibility of emergent themes.

3.5 Ethical Considerations and Limitations

Participation was voluntary, and respondents were assured confidentiality; identifiers are pseudonymised where individual accounts are described. As with all purposively sampled qualitative research, the findings are not statistically representative of Tripura's ASHA population and should be read as analytically generalisable — illustrative of plausible processes in comparable tribal contexts — rather than as statistically representative estimates. Readers seeking precise service-coverage indicators are directed to the district health administration's routine monitoring data and the national evaluations cited in Section 2.

4. DISCUSSION AND FINDINGS

4.1 Socio-economic Profile of ASHAs in Amarpur

Consistent with the national pattern documented by Bajpai and Dholakia (2011) and Nandan et al. (2008), ASHAs in the four study villages were overwhelmingly married women drawn from within the community, typically in their late twenties to mid-forties, with schooling ranging from primary to secondary completion. Nearly all were also mothers, many with young or school-going children — a demographic fact central to the analysis that follows, since it places the ASHA's paid role in continuous contact with her unpaid domestic and childcare obligations. Household economic circumstances were generally modest, with agriculture, wage labour or small-scale cultivation as the primary income source and ASHA compensation a secondary, often unpredictable supplement. Several respondents described their earnings, despite being modest, as contributing to greater personal confidence and an enhanced ability to move outside the home independently.

4.2 The Substantive Content of ASHA Work

ASHAs described a work routine considerably broader than the formally enumerated maternal and child health duties. Beyond antenatal registration, escort to institutional delivery, immunisation mobilisation and postnatal home visits, ASHAs reported substantial time on informal health counselling unrelated to any incentive payment, mediating disputes or providing reassurance during emergencies, and

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serving as first point of contact for health questions outside their formal training — consistent with Mahalingashetty et al.'s (2012) finding that ASHA work routinely exceeds official time allocations. Several also described "translating" biomedical advice — on dietary restrictions during pregnancy, or the rationale for institutional over home delivery — into terms consistent with tribal health beliefs, a cultural mediation extending well beyond the formal "link worker" role and aligning with Mony and Raju's (2012) observation that ASHAs function substantially as link and community health workers, and only partially as the "social activists" originally envisaged.

4.3 Motherhood and Work: Negotiating a Dual Identity

The theme emerging most consistently — and with the least precedent in the mainstream literature reviewed in Section 2 — concerned the negotiation between the ASHA's role as mother and as health worker. ASHAs described being called upon at any hour for deliveries or health crises, a demand at odds with the constant needs of small children. Several relied on extended family, particularly mothers-in-law or older daughters, to absorb childcare during intensive ASHA duty, effectively redistributing rather than eliminating the displaced domestic labour. Others, particularly those with very young children or without nearby family support, described ASHA duties curtailed, delayed or performed under visible strain.

This resonates with the interactionist emphasis on identity as an ongoing accomplishment rather than a fixed status (Mead, 1934; Goffman, 1963): the ASHA's professional identity is continuously constructed in tension with her identity as mother, and the "spoiling" of either — being seen as a neglectful mother or an unreliable ASHA — carries real reputational costs within a tightly networked village community. It also lends weight to the political-economy critique of Doyal (1979) and Navarro (1979): the model's reliance on performance-linked, non-salaried compensation presumes that ASHA labour can be absorbed within existing domestic responsibilities at minimal cost to the health system, while the actual cost of reconciling these demands is borne privately, and largely invisibly, by ASHAs and their families.

4.4 Community Trust, Acceptance and the Limits of Medical Authority

Consistent with Nandan et al.'s (2008) finding of general appreciation among Panchayati Raj Institution members, respondents described ASHAs as broadly trusted — attributed less to formal medical training, often characterised as limited, than to her status as a known resident bound by kinship, neighbourliness and mutual obligation. This is consistent with the Parsonian expectation that health mediation depends on perceived legitimacy (Parsons, 1951; Nagla, 2018), but complicates the medicalization narrative of Illich (1977) and Zola (1972): rather than an extension of an alienating bureaucracy, the ASHA appeared frequently to function as a buffer, localising the encounter between tribal households and a distant biomedical system. Respondents also noted limits to this trust — particularly around institutional delivery, where preference for home birth persisted among older women, requiring considerable interpersonal effort to persuade families, echoing Shrivastava and Shrivastava's (2012) observation of persistent knowledge and behaviour gaps despite formal training.

4.5 Institutional Constraints: Training, Compensation and Role Ambiguity

Respondents consistently identified three institutional constraints, each mirroring the broader national literature. First, training was widely described as inadequate to Reang and Jamatia health beliefs, with generic materials not adapted to tribal contexts, consistent with Shrivastava and Shrivastava (2012). Second, compensation was insufficient and irregular, with payment delays creating financial stress and discouraging pursuit of service targets, consistent with the payment-system weaknesses documented by Wang et al. (2012). Third, unclear boundaries with Anganwadi workers and ANMs produced duplicated effort or coverage gaps, a coordination failure consistent with the supervisory weaknesses identified by Bajpai and Dholakia (2011).

4.6 Perceived Improvements in Maternal and Child Health

Despite these constraints, both ASHAs and beneficiaries described tangible improvements in health-seeking behaviour attributable to sustained ASHA engagement. Beneficiaries described increased awareness of antenatal check-ups, greater willingness to seek institutional delivery, and improved immunisation uptake, attributed to repeated home visits and the accessibility of a known, trusted community member. These self-reported improvements are broadly consistent with Husain's (2011) national picture of gains in institutional deliveries, antenatal care and immunisation following NRHM implementation, and with Nandan et al.'s (2008) finding of comparatively strong ASHA support for antenatal and immunisation services. Respondents also identified unaddressed gaps — notably postnatal care, adolescent reproductive health, and mental health support during and after pregnancy — domains outside the incentive-linked core of the ASHA's mandate that, consistent with Mony and Raju (2012), receive comparatively less sustained attention.

5. CONCLUSION

This paper examined the role of ASHAs in shaping women's health outcomes among indigenous communities in Amarpur, Tripura, with attention to a dimension largely absent from the mainstream literature: the ASHA's own position as mother and household member, and the consequences for her capacity to perform community health work. Findings suggest ASHAs function as indispensable, trusted

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intermediaries between tribal households and the formal health system, translating biomedical guidance into culturally intelligible terms and contributing to documented improvements in antenatal care, institutional delivery and immunisation coverage. Yet this role is performed under significant strain: inadequate and irregular compensation, training poorly adapted to tribal beliefs, unclear boundaries with allied functionaries, and — most distinctively — a structural reliance on the ASHA absorbing an unpredictable workload within her own domestic and childcare responsibilities, a cost borne privately by ASHAs and their families rather than by the health system that depends on their labour.

Read through the theoretical lenses developed in Section 2, the ASHA occupies a genuinely liminal position: a Parsonian intermediary whose legitimacy rests on community trust rather than formal authority; a potential corrective to, rather than simply an agent of, medicalization, insofar as she localises and humanises the biomedical encounter; a structurally undervalued worker echoing political-economy critiques of feminised, informalised work; and a subject whose identity is continuously negotiated against the competing demands of motherhood within a tightly networked tribal community.

Several limitations should be acknowledged. The qualitative, purposively sampled design, while suited to rich, contextually grounded insight, does not permit statistical generalisation to Tripura's full ASHA population, and findings should be read as analytically rather than statistically generalisable. The geographic scope — four villages within one sub-division — was a deliberate choice favouring depth over breadth, but variation across Tripura's other indigenous communities remains to be documented. Future studies would benefit from a mixed-methods design combining this study's qualitative depth with a larger, representative quantitative survey tracking service-utilisation and health-outcome indicators over time, and from comparative research across Tripura's diverse tribal communities and India's other north-eastern states, where implementation contexts differ in ways not yet well documented.

For policy, the findings point toward concrete implications: tribal-context-adapted training curricula engaging explicitly with local health beliefs rather than generic national materials; more timely, predictable compensation structures, consistent with Wang et al. (2012); clearer delineation of responsibilities between ASHAs, Anganwadi workers and ANMs; and, most distinctively, explicit institutional recognition — through flexible scheduling, childcare support during peak-demand periods, or targeted assistance for ASHAs with very young children — that ASHA labour is performed by women who are simultaneously, and inescapably, mothers. Without such recognition, the sustainability and equity of a health system depending so heavily on the unpaid and underpaid labour of its ASHAs will remain in question.

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