

Feminised Frontline Governance in Public Health Services: A Mixed-Methods Study of PMMVY Implementation in North-Eastern Rajasthan

¹. Dr Shruti Rawal, ². Dr. Happy Agrawal, ³. Dr. Megha Choudhary

¹Assistant Professor, Department of English St. Xavier's College Jaipur, Email ID: shrutivipul@gmail.com, ORCID: 0000-0002-2354-5631

²Assistant Professor, Department of Business Administration St. Xavier's College Jaipur, Email ID: guptahappy29@gmail.com ORCID: 0000-0001-7247-668X

³Lecturer, Department of English, Government Polytechnic College, Bhilwara, Email ID: meghachoudhary@gmail.com

HOW TO CITE:

Shruti Rawal, Happy Agrawal,
Megha Choudhary (2026).
Feminised Frontline Governance
in Public Health Services: A
Mixed-Methods Study of PMMVY
Implementation in North-Eastern
Rajasthan.
International Journal of Special
Education, 41(2), 213-232

ABSTRACT:

This study examines the role of frontline women workers in mediating the implementation of the Pradhan Mantri Matru Vandana Yojana (PMMVY) in four districts of North-Eastern Rajasthan. It addresses gaps in existing scholarship that overlook everyday implementation practices, gendered frontline labour, and the links between maternal welfare, early childhood support, and inclusive developmental opportunities. Using a qualitative-dominant mixed-methods design, the study conducted thematic analysis of 15 interviews with ASHA and Anganwadi workers and triangulated the findings with descriptive statistics from questionnaires administered to 300 beneficiaries. Three themes emerged: labour-mediated governance of health services, feminisation of frontline care labour, and structural and digital barriers in policy implementation. Drawing on feminist political economy, street-level governance, and intersectionality, the study shows that PMMVY implementation depends on continuous, adaptive, and labour-intensive practices by frontline workers who manage gender expectations, technological requirements, documentation demands, and administrative bottlenecks. The study further argues that Anganwadi-based welfare interactions have relevance for special and inclusive education because maternal nutrition, early childhood monitoring, documentation support, and frontline counselling shape the conditions through which children from marginalised households access early learning and developmental services. The findings recommend formal recognition, social security, digital support, context-sensitive administrative flexibility, and stronger convergence between health, ICDS, and inclusive early childhood systems, thereby offering policy-relevant insights into gendered governance, welfare access, and the early welfare conditions that may support educational inclusion in India.

COPYRIGHT STATEMENT:

Copyright: © 2026 Authors.
Open access publication under the
terms and conditions
of the Creative Commons Attribution
(CC BY)
license (<http://creativecommons.org/licenses/by/4.0/>).

Keywords: PMMVY; frontline labour; Anganwadi workers; inclusive early childhood support; special education; maternal welfare governance; developmental inclusion; policy implementation.

1. Introduction

Gender, as a social construct, plays an important role in distributing work, authority, and responsibility in institutions, households and communities. According to feminist theorists, labour is not distributed equally, rather, it is influenced by gender norms, situating women in caregiving roles from an early age. These expectations are influenced by social and institutional structures that reinforce the idea of caregiving being “women’s work.” Women are often expected to manage it along with their education, employment, and other economic responsibilities. Despite its contribution to social and institutional systems, this feminisation of care work, including unpaid, underpaid and affective labour, is often unrecognized. These dynamics are clearly visible in the Indian health systems, especially in the area of maternal health governance. Maternal and child health systems depend heavily on women’s labour extending beyond formal hospital settings into households and communities. While government policies have created a positive impact, such as reduced maternal mortality and increased institutional deliveries, the everyday practices producing these health outcomes depend on labour that remains mostly invisible. Feminist political economy perspectives show that such labour is mostly from marginalized communities and their contribution to health systems is often not acknowledged in policy practice (Elson, 1999; Federici, 2004; Folbre, 1994).

The Indian government has implemented many policies to incentivize reproductive behaviour and increase the use of maternal health services. One such mechanism is the Conditional Cash Transfer (CCT) schemes, which links financial assistance to compliance with certain prescribed health behaviours. This is the approach and one such key initiative was taken by Pradhan Mantri Matru Vandana Yojana (PMMVY) introduced from 1 January 2017. The scheme offers some amount of compensation for the loss of wages during pregnancy and encourages good health behaviour including early registration of a pregnancy, regular visits to antenatal care and institutional birth

(Department of Women and Child Development, 2026). PMMVY ties cash transfers to behaviour change in line with the recommended maternal health behaviour, thus tying health support to behaviour control. These policy interventions depend on a frontline worker network that makes them a reality in day-to-day practice. Accredited Social Health Activists (ASHAs) and Anganwadi Workers (AWWs) are the key players in this in India. ASHAs: They are community health workers associated with National Health Mission, handle counseling of women, pregnancy registration and assist in the facilitation of institutional services, while Anganwadi workers are associated with Integrated Child Development Services (ICDS) and deal with the nutritional provision, early childhood services and documentation process related to these schemes. They serve as the backbone of maternal health service delivery, working as mediators between the state institutions and pregnant women.

Although PMMVY is primarily a maternal welfare scheme, its implementation has implications for inclusive and special education because maternal health, nutrition, antenatal care, early childhood monitoring, and household-level counselling shape the developmental conditions within which children enter early learning systems. In India, Anganwadi centres are not only sites of nutrition and welfare delivery but also important community-level spaces for early childhood care, preschool exposure, developmental monitoring, and referral-based support. For children from marginalised households, early access to such services can influence school readiness, developmental inclusion, and future participation in inclusive education systems. Therefore, the labour of ASHAs and Anganwadi workers is relevant not only to public health governance but also to the broader early childhood support structure that precedes formal and special education.

The role of ASHAs and AWWs in health governance brings attention to the feminisation of frontline public service delivery. Maternal and

child welfare schemes are implemented through women workers from local communities, often working under contractual or honorarium-based roles. Their work moves beyond formal job descriptions, including emotional support, community discussions, bureaucratic documentation, digital entries, and conflict management within families. This feminised structure of healthcare governance indicates the state's dependency on socially constructed gender roles in care, altruism, and community responsibility. Though this kind of structure increases outreach and trust, it also reinforces labour conditions, low remuneration, and limited social protection for these workers. This study uses data gathered from frontline workers and beneficiaries of PMMVY to examine how gendered labour operates in the implementation of maternal welfare policy. It focuses on the role of ASHAs and Anganwadi workers in mediating PMMVY while also analysing the social, structural, administrative, and digital challenges within which they operate. By linking maternal welfare governance with Anganwadi-based early childhood support, the study contributes to discussions on gendered governance, public welfare delivery, developmental inclusion, and the institutional foundations that shape access to inclusive education for children from marginalised communities.

Research Problem

While interventions like PMMVY are designed to increase maternal health and well-being through conditional cash transfers, their implementation is dependent on frontline women staff whose work is often undervalued and under-researched. Existing literature focuses mostly on beneficiary coverage, fund distribution, or health outcomes, with limited focus on how gendered frontline staff shapes these outcomes through everyday mediation. This gap is significant for special and inclusive education because maternal welfare, nutrition, documentation support, health monitoring, and Anganwadi-based services influence the developmental conditions through which children from marginalised households enter early learning and care systems. The

feminisation of frontline labour, along with structural, administrative, and digital barriers, therefore affects not only the delivery of maternal health services but also the early welfare interface that supports developmental inclusion. Hence, the central research problem lies in understanding how feminised frontline labour mediates PMMVY implementation and how these barriers create gaps between policy design, maternal welfare access, and inclusive early childhood support.

Research Objectives

The study seeks to:

1. Analyze the role of frontline workers in mediating the implementation of PMMVY.
2. Examine the impact of feminisation of frontline labour in PMMVY governance.
3. Identify structural, administrative, and digital constraints affecting service delivery.

While these objectives focus on PMMVY implementation, the study also discusses its implications for inclusive early childhood support because Anganwadi-based maternal welfare services shape children's access to nutrition, developmental monitoring, early care, and future educational inclusion.

Research Questions

The study is guided by the following questions:

1. How is PMMVY implementation operationalized through the labour of ASHA and Anganwadi Workers?
2. In what ways does the feminisation of frontline welfare labour influence PMMVY implementation and service delivery?
3. What structural, institutional, and digital barriers shape the working conditions of frontline women workers?
4. How does frontline-mediated PMMVY implementation contribute to or constrain inclusive early childhood support for children and families from marginalised communities?

2. Literature Review

Government welfare systems, especially in developing countries like India, are heavily dependent on gendered labour structures. A

growing body of literature has shown that the majority of women are involved in domestic and caregiving work (Mehta & Mehta, 2025), which is usually overlooked in formal economic accounting (Chowdhuri & Chowdhury, 2025). Scholars have also shown the intersection of feminisation of care labour with social structures like caste and class, as many frontline workers are recruited from socially and economically marginalized groups with limited employment opportunities, conceptualized as “feminine caste contract” (Monteiro, 2022). Studies focusing on elder care (Ramanathan & Kochuvilayil, 2025) and urban women (Mazumdar et al., 2021) have found how gender norms contribute to women’s domestic workload, and limit economic opportunities, as seen in higher job losses among women during pandemic (Nikore et al., 2023). The frontline health workers such as ASHA and Anganwadi workers are usually categorized as honorary or voluntary workers rather than formal employees, with limited job security, low wages, and performance-based incentives, reflecting their informal and precarious employment (Marwah, 2022; Mehta & Mehta, 2025; Palriwala & Neetha, 2010). The relevance of this labour also extends to inclusive and special education because early childhood support systems influence children’s later access to learning, developmental monitoring, and educational inclusion. In India, Anganwadi centres operate at the intersection of maternal welfare, nutrition, preschool exposure, child development monitoring, and community-based referral support. For children from marginalised households, these early welfare interactions may shape school readiness, developmental inclusion, and access to institutional support before formal schooling begins. Therefore, the work of ASHA and Anganwadi workers should not be understood only as health-service delivery, but also as part of the wider early childhood support structure that influences inclusive educational opportunities.

Frontline workers function as street-level bureaucrats, mediating between policy and local communities. Literature shows that multiple actors, like frontline workers, administrative

staff, community workers, and beneficiaries, along with their negotiations, power relations, and institutional dynamics, influence service delivery and policy implementation (Parashar et al., 2020). Workers’ compensation and performance-related incentives influence their motivation and willingness to get involved in such tasks, indicating the impact of behavioural motivation on policy implementation (Srinivasan & Sarin, 2023). A study conducted on the ASHA programme shows that frontline workers practice discretion and negotiate with families, maintaining a balance between their roles in government and community (Ved et al., 2019). Structural challenges such as heavy workload, irregular wages, and limited recognition influence how they prioritize their work or use community networks to meet the goals of a policy (Shrivastava et al., 2023).

The importance of frontline workers is also seen when administrative process, socioeconomic status, and regional contexts create barriers in beneficiaries’ accessibility to the scheme. Research has shown that administrative bottlenecks such as incomplete documentation, identification errors, delays in fund disbursement, and poor monitoring system cause delays in enrolment and service delivery, making beneficiaries visit health or administrative offices multiple times (Banerjee et al., 2025; Kumar et al., 2024; Shukla et al., 2023). Limited access to information and poor health infrastructure also lead to barriers in rural areas, reducing the effectiveness of the scheme (Kumar & Shobana, 2023). All these challenges increase the workload on frontline labour, reinforcing their importance as mediators between the government and citizens. These findings also reveal how the gendered nature of these frontline workers, along with structural and administrative barriers, not just influence the effectiveness of maternal health interventions like PMMVY, but also the daily experiences, decision-making power, and workload of the women implementing them.

These barriers are also important from the perspective of inclusive education because delays in maternal welfare access,

documentation problems, weak follow-up, and limited frontline support may affect the early welfare environment available to mothers and children. Although PMMVY does not directly function as a special education programme, its implementation is connected to early childhood conditions through nutrition, health monitoring, Anganwadi contact, counselling, and household-level support. When frontline workers are overburdened or digitally constrained, marginalised families may experience weaker access to early services that are foundational for later developmental and educational inclusion.

Research Gap

Although the current literature on frontline service delivery explains the importance of ASHA and Anganwadi workers, it mainly focuses on the policy outcomes, instead of the everyday practices of these frontline workers. The perspectives of frontline workers as interpreters and negotiators are still not explored adequately. Though the feminisation of frontline workers has been acknowledged, the influence of gender norms on expectations, authority, and remuneration should also be examined. Moreover, while the existing studies have analysed administrative challenges like work load and payment delays, very few studies focus on their combined effects on the delivery of health services. With increasing digitalisation in government systems, the influence of technological burdens and surveillance on frontline labour should also be explored. The agency and daily experiences of frontline workers are also not studied sufficiently in policy studies. Another gap lies in the limited attention given to the relationship between maternal welfare governance and inclusive early childhood support. Special education literature often focuses on school-based inclusion, disability support, classroom practices, and formal educational interventions, while less attention is given to welfare systems that shape children's developmental conditions before school entry. In the Indian context, Anganwadi-based services connect maternal health, nutrition, preschool exposure, documentation, and referral support. However, the role of

frontline women workers in mediating this early support environment remains insufficiently examined. There is also a lack of integrated approaches that examine how gender, labour, governance, and implementation barriers connect to influence maternal welfare, early childhood support, and inclusive developmental opportunities for children from marginalised communities.

Theoretical Framework

This study uses three theoretical perspectives to understand the gendered nature of frontline health workers in maternal and child welfare. These theories help in explaining how the workforce of community health workers like ASHAs and Anganwadi workers is positioned, perceived, and enacted within government health systems. These frameworks give an understanding of how frontline health workers are situated within debates on labour, gender, and governance.

Feminist political economy provides a framework to understand the reliance of economic systems on gendered forms of labour that remains unrecognized in formal policy frameworks. According to scholars, economic systems rely heavily on unpaid or underpaid care work, most of which is performed by women in families and communities (Elson, 1999; Federici, 2004; Folbre, 1994). This labour is often denoted as part of social reproduction, and includes childcare, elder care, and community health work. It plays a major role in societies and labour markets, but still, is often overlooked in traditional economic accounting. In health interventions, this pattern is seen in the role of ASHAs and Anganwadi workers, who work as mediators delivering maternal and child health services to local citizens. They perform a range of work, from health counselling to mobilizing beneficiaries, and are often named voluntary or honorarium-based workers rather than formally employed people. Feminist political economy shows how such kind of arrangements reinforce gender inequalities by depending on women for care work and providing them low wages, limited protection, or institutional recognition.

This study also draws on the theory of intersectionality to complement the feminist political economy. Intersectionality theory explains how multiple factors, such as gender, caste, and class, intersect and together determine the experiences of people belonging to marginalized communities. According to this framework, social identities are not separate categories, instead, they interact to produce differences in the experiences of various groups (Crenshaw, 1989). The experiences of ASHAs and Anganwadi Workers in India are influenced by gender, class, caste, and geographical region. According to scholars, these social structures determine access to authority, resources, and institutional recognition (Agarwal, 1997; Kabeer, 2016). Most of the frontline workers are recruited from marginalized communities. While this can increase the trust of beneficiaries in health systems, it may also expose these health workers to social barriers in local communities. An intersectional perspective helps in examining how these overlapping inequalities shape the working situations, authority, and daily experiences of these frontline women workers.

The implementation of public health policies by frontline workers can be explained through street-level governance theory. According to the theory, frontline workers, such as teachers, police officers, and social workers, play an active role in shaping policy outcomes because of their interaction with local citizens (Lipsky, 2010). These workers are intermediaries between the local communities and government and are responsible for putting the policy goals into practice. One of the important concepts in this theory is 'discretion' – namely the capacity of frontline staff to make interpretations and adaptations in the policies in the context of the situation. ASHAs and Anganwadi workers' work pressure, prioritisation of beneficiaries and community needs often lead to exercising their discretion. It has been found that frontline staff, in addition to enacting policies, have a profound impact on what local communities actually experience (Brodkin, 2012). But these are affected by the bureaucracy, reporting and resources. Street-level governance theory shows

how these frontline workers mediate between government institutions and local challenges in delivery of health services.

In addition to these three perspectives, the study situates PMMVY implementation within the broader framework of inclusive early childhood support. Educational inclusion begins before formal schooling, through access to maternal health, nutrition, early care, developmental monitoring, documentation, and referral services. Anganwadi centres and frontline workers form part of this pre-school support structure, particularly for children from marginalised households who may face developmental vulnerability or delayed access to services. This perspective helps connect feminist political economy, intersectionality, and street-level governance with debates in special and inclusive education by showing how welfare implementation shapes the early conditions of educational inclusion.

3. Methodology

Research Design

This study employs a qualitative-dominant mixed-methods research design to understand gendered frontline labour in PMMVY implementation and maternal welfare governance. The qualitative component captures the complex, process-oriented, and context-specific experiences of frontline workers involved in the delivery of maternal and child welfare services. The study follows an interpretivist paradigm, focusing on how frontline workers perceive and make sense of their everyday roles, responsibilities, negotiations, and challenges. Quantitative data were obtained from PMMVY beneficiaries to triangulate and support the qualitative findings. Although the beneficiary questionnaire was not designed to directly measure special education outcomes, items related to Anganwadi access, frontline-worker support, home visits, communication, and trust were treated as indicators of families' access to early childhood welfare support. These indicators are relevant to inclusive and special education because early institutional contact, nutrition support,

developmental monitoring, and frontline mediation can shape children's access to later learning and developmental services. The research design therefore helps in understanding how gendered expectations, institutional arrangements, digital systems, and frontline labour influence PMMVY implementation and the broader early support environment for marginalised families.

Study Area

The study covers four districts of Rajasthan namely Alwar, Bharatpur, Dausa and Jhunjhunu. The districts represent the wide range of socio-economic compositions of Rajasthan such as levels of rurality, maternal health indicators, level of poverty and access to health institutions etc. The socio-economic indicators are comparatively low in the districts of Bharatpur and Dausa with high level of vulnerability among the marginalized communities, while the education and social development indicators are comparatively high in the districts of Jhunjhunu and Alwar. The different development profiles of these districts enabled the study to look at the role that local socio-economic contexts play on working conditions, expectations and performance of frontline health workers. Anganwadi centres are tied up to nutrition, early childhood care, exposure in the preschool period and access to welfare at the community level, hence these districts serve as a context for exploring the intersection of support for early childhood and inclusiveness in developmental opportunities.

Sampling

Stratified sampling method and purposive sampling method were used in collecting data. Stratified sampling was used to represent all the study districts and administrative units. Frontline workers who participated in maternal health interventions were identified using purposive sampling. Semi-structured one-to-one interviews were held with the existing ASHA workers and Anganwadi workers. These frontline workers worked in a variety of contexts and for different years, offering unique perspectives. In qualitative research, the principle of

saturation was used, whereafter 15 interviews were conducted, no new data were collected. The beneficiaries were randomly selected from the rural and urban areas in the selected districts of Rajasthan and 300 beneficiaries were selected for quantitative data collection. To gain insights into the experience of women and families in regard to frontline support, access to Anganwadi under PMMVY and service mediation, the beneficiary sample was used.

Data Collection Tools

An in-depth semi-structured interview technique was used to collect qualitative data with ASHA and Anganwadi workers who participated in the implementation of PMMVY. The semi-structured interviews enabled them to be flexible and detailed in their explorations of their work responsibilities, training experiences, documentation practices, digital challenges, infrastructure constraints, and interactions with beneficiaries. Interviews were all conducted in participants' preferred language, and recorded with their permission. Verbatim transcripts were prepared and used for thematic analysis. A structured questionnaire with seven items was prepared in English and Hindi and used for the quantitative component and administered to the beneficiaries of PMMVY. The questionnaire captured beneficiary experiences related to Anganwadi visits, home visits by frontline workers, ease of access to Anganwadi centres, help received from frontline workers, ease of communication, approachability and trust, and politeness of frontline workers. These items were used to assess the nature of frontline-mediated service access and the early welfare interface available to mothers and children.

4. Analytical Techniques

Data obtained from interviews were analysed using the thematic analysis approach proposed by Braun and Clarke (2006). The process involved familiarisation with the data, generation of initial codes, searching for themes, reviewing themes, and defining and naming themes. Interview transcripts were systematically coded, and recurring patterns related to gendered frontline labour, institutional expectations,

digital and administrative barriers, and everyday implementation practices were identified. The analysis followed an inductive approach, allowing themes to emerge from participants' narratives rather than from pre-defined categories. Descriptive statistics were used to analyse quantitative data obtained from PMMVY beneficiaries. These results were used

to triangulate the qualitative findings by showing how beneficiaries experienced access, communication, trust, and support from frontline workers. The integration of qualitative and quantitative findings helped connect frontline workers' experiences with beneficiary-level service access and early welfare support.

Table 1: Phases in the Analysis and a Description of the Processes Involved

Phase	Description of Process	
1.Data Preparation	The researcher transcribed all interviews and cleaned the responses obtained from the questionnaire.	
2.Familiarization with data	with	The researcher read and reviewed the transcripts obtained from frontline workers multiple times to understand the context of data.
3.Generating codes	initial	The researcher generated codes directly from the verbatim without any pre-defined categories. Codes were reviewed and consolidated iteratively, with similar codes merged.
4.Developing naming themes	and	The researcher grouped similar codes into themes, clearly defined each theme, linking them to relevant research questions of the study.
5.Integration synthesis of data	and	The researcher analysed patterns and relationships between themes and descriptive statistics results to synthesize key insights.

Ethical Considerations

This study followed all the established ethical standards for conducting social science research. Informed consent was obtained from all the respondents before collecting data. The participants were clearly informed about the research purpose and their right to withdraw at any stage of the study. Personal identifiers were removed from transcripts and datasets at the time of analysis, maintaining confidentiality and anonymity. Special precautions were taken while conducting interviews with frontline workers, considering their position in the government welfare schemes, so that their participation in the study does not affect their work status. The vulnerability of the beneficiaries' population was also considered to avoid any discomfort while administering questionnaires. Given the

hierarchical employment position of frontline workers and the vulnerability of beneficiary participants, care was taken to ensure that participation was voluntary and that responses could not be linked to individual identities or work locations. All the data collected were stored securely and used only for research purposes.

5. Results

The analysis revealed three superordinate themes: Labour-Mediated Governance of Health Services, Feminisation of Frontline Care Labour, and Structural and Digital Barriers in Policy Implementation. These themes were developed through an inductive approach and represent the implementation of PMMVY by frontline workers. While the findings primarily explain maternal welfare governance, they also

show how frontline-mediated PMMVY implementation contributes to the early welfare environment within which mothers and children access Anganwadi-based services, nutrition support, documentation assistance, and household-level counselling. These dimensions are relevant to inclusive and special education because early childhood support systems shape children's developmental access before formal schooling.

Theme 1: Labour-Mediated Governance of Health Services

Theme 1 describes how maternal health governance emerges through the work of frontline workers who act as mediators by turning policy into practice, through continuous engagement, procedural tasks, and interpersonal interactions. Many frontline workers described learning through peer interaction and experiential adaptation, and not just formal systems. A gradual learning trajectory is seen, where skills and competence are developed through practice in the field, rather than structured training alone.

P2: "Our Ma'am gives this information... LSP Ma'am and our CDPO Sir... When there is something new or any new update... LSP Ma'am explains to us... CDPO Sir also tells us what has to be done... how it has to be done... They tell us step by step procedure about all the schemes."

Participants described that institutional training and hierarchical communication shape their knowledge and awareness of different government schemes. Supervisors serve as major sources of information, making workers dependent on the formal authority for implementation.

P3: "The CDPO sir also comes from outside... to check our work and guide us... Sometimes the SDM madam also takes it... She comes and reviews the work that we have done... She also takes sessions on what we are doing... She tells us where we should focus more on."

The authority figures visit regularly to oversee and monitor the performance of frontline

workers. These interactions show accountability on the part of frontline workers while also conveying the expectations of the government.

P5: "Training is conducted four to five times a year... regularly... they tell us how to identify women... how to fill forms... what changes have occurred... we also share our doubts... they tell us everything."

Participants revealed the periodic occurrence of their training, increasing their knowledge on policy changes. These interactions also provide a space where frontline workers can share their doubts and enhance their learning.

P10: "Madam explains... during our training sessions... and we also ask other workers... if there is any doubt... we discuss among ourselves... if someone has placed similar problem earlier so they tell us... so we are able to complete our work... we help each other."

The workers also expressed accounts on peer-based learning and collective problem solving in maternal health governance. While the supervisory authorities remain key sources of information exchange, workers also depend on horizontal information sharing to solve their everyday problems.

P14: "First we go to the houses in our area... we identify the pregnant women at her home... then we tell her about vaccination... about the scheme... what benefits they will get... why is it important... and after that we bring her to Anganwadi... then we fill their PMMVY form."

Participants also described the continuity and responsibility in their work. Their role includes spreading awareness, persuading beneficiaries, and filling their documents, bringing policy into practice.

P14: "We meet women regularly... around 5-6 times in a month... sometimes we go at their homes... and sometimes we call them at the Anganwadi center... we tell them about the scheme... about vaccination... we also ask them if they have received the amount in their bank account."

These repeated contacts also indicate the role of frontline workers in sustaining early institutional engagement with families, which is important for children's later access to nutrition, preschool exposure, developmental monitoring, and inclusive early childhood support.

Participants perceived the implementation of PMMVY as a sequential and labour-intensive process. Frontline workers have to engage frequently and repeatedly with the beneficiaries of the scheme.

P6: "The scheme has been running since 2017... Since then... we have been working... we have filled 20-25 forms... we identify the women in our area... explain the scheme to them... then ask for their documents... and then we fill their form."

These repeated interactions show that building trust in beneficiaries is an important aspect of the implementation of government schemes, influencing their enrolment and compliance.

P1: "It is only beneficial... If a pregnant woman gets Rs. 5000 to 6000... then the money should be given for her nutrition... The child should be nourished and the pregnant woman should remain healthy... Right now, if someone is poor, then the government scheme is giving money so that the pregnant woman can eat."

Participants also expressed the perceived benefits of the scheme. The scheme is considered as helpful in improving maternal nutrition, child health, and is found to be especially useful for poor households.

P7: "WhatsApp will be sent when the training will take place... so WhatsApp groups are being added... we also send WhatsApp messages... WhatsApp groups have been set up so that when you join the group, the training can continue."

P8: "We're benefiting from this, ma'am... We can see everything... If we have any problems, we can call and get it resolved... all details are available on our phones... information is easily available... Earlier, it was very difficult to fill out the form... but now, we just open the PMMVY app on our phone and fill it out ourselves..."

Earlier, we had to face a lot of problems... Beneficiaries were sent there... E-mitra also charged a fee... but now we fill it out ourselves on our phones."

Participants also talked about the use of digital tools in their everyday practices. The use of mobile phones has helped them in coordinating with beneficiaries, as well as, managing their own training.

P2: "Ma'am... there will be problems when you work... everything cannot take place easily... sometimes we face some challenges... sometimes documents are not complete... other times connectivity issues occur... there are some problems."

P6: "It's good ma'am... There is no problem... It's just that... right now the Anganwadi is in the school... If a separate office is made, then it is fine... We hear voices from school... students come and sit inside the Anganwadi... Space is also limited."

Another important finding was the normalisation of work challenges by frontline workers. The interviews reflect how systemic inefficiencies, such as, distant training centres and poor infrastructure, have been internalized by participants as routine aspects of their work. This also shapes their expectations and responses to different work-related challenges.

Theme 2: Feminisation of Frontline Care Labour

Theme 2 describes how PMMVY implementation is carried out through feminised frontline labour, shaped by gendered expectations, economic precarity, and dependency on male family members, especially for managing the digital process. This dependency can also be seen in documentation requirements during enrolment.

P4: "It gets done easily... I take my husband's help... he is able to use the phone and upload all the documents... he knows how to fill the form online... he can do it quickly... then it becomes easy."

The interviews revealed that though participants considered the digital processes as manageable, they were mostly dependent on the assistance of male family members. This shows that digital access is not individual, but is mediated through interpersonal relationships, reinforcing gendered dependency in domestic settings.

P12: “We ask them for their documents... their Aadhar Card, Bank Passbook, and husband’s Aadhar Card... these documents have to be uploaded online... then the form gets filled... if all the details are correct... they are enrolled in PMMVY.”

The requirement of husband’s documents shows that women’s accessibility to the scheme is mediated by the presence of male identity and authority. This also reinforces patriarchal norms where verification is linked to male documents.

P15: “We tell men to do this work... for example, to help us with some tasks... but if they feel lazy... or don’t want to go... then they don’t go... so we have to wait for them... and our work gets delayed.”

Participants have also expressed male disengagement, creating barriers in implementation. This creates a situation where women are dependent on their male family members, and are constrained by their absence, increasing the burden on frontline workers.

P10: “We meet the women in our area 4-5 times in a month... we check their health condition... we follow-up on their vaccination... if they have got their child vaccinated or not... we also ask them if they have received the money from the government.”

Participants also expressed how their work also involves social and emotional labour. The frontline workers are involved in continuous follow-ups, persuasion, and problem-solving within households. This shows that their roles extend beyond formal work responsibilities. Such relational and emotional labour is significant for inclusive early childhood support because marginalised families often depend on trusted frontline workers to understand welfare procedures, attend Anganwadi centres, and

remain connected with early care and developmental services.

P12: “When instalments are delayed... people blame us... They think we have made some mistakes... while filling their documents... or we have not paid attention... but these issues are not under our control.”

Participants also expressed experiencing accountability without any authority. Since they work as mediators between the government and the local communities, they are often held accountable for systemic delays.

P13: “We have been working for so many years for Rs. 5000... There are no facilities for us... Nothing is provided on retirement... we should also get something... some financial support... for working for the government for all these years.”

Economic precarity also increases the burden on women working as frontline labour in implementation of health services. They often have to work under low wages, without any benefits and social security.

P3: “Yes, ma'am... if we get more help... we can fill out better forms... By making this online, we can also inform all the women... so they can fill out their forms themselves.”

However, participants also expressed that they want to have greater autonomy and digital independence. They also aspire to empower beneficiaries by making them self-sufficient so they can enrol on their own.

Theme 3: Structural and Digital Barriers in Policy Implementation

Theme 3 describes how structural, infrastructural, and digital barriers work together to influence the implementation of government policies, affecting accessibility and delivery. Participants reflected on the use of digital tools in everyday life, expressing initial challenges and then gradual adaptation. The workers also adapted to these systems by experiential learning, rather than relying on formal training. While the participants perceive digitalisation to

have a positive impact, some technological challenges have also been revealed.

P5: “Ma'am, when LSD ma'am told us about the form... about doing it online... initially we had some problems... we did not have any knowledge about technology... how to use these apps... but when ma'am guided us... she taught us everything... how to use the app... how to fill the forms online... then we started filling forms online... with practice, we learned... then now we do not have any problem.”

Participants have to adapt to the use of technology in everyday life, despite lacking initial skills. It shows the increase in their responsibilities and their dependence on higher authorities to manage digital tasks.

P7: “There is a problem with the face capture system... the government has introduced the face verification system... without capturing their face, the portal does not open... sometimes beneficiaries could not reach Anganwadi... so that creates problems for us... we couldn't track the status of their fund disbursement.”

Participants expressed concerns over digitalisation in maternal health governance. Workers are required to handle both digital barriers and the mobility of beneficiaries, creating delays in their work.

P11: “Aadhar is not updated.... we ask them for their birth certificate or marriage certificate... They are unable to provide those documents... Sometimes the beneficiaries are not aware about their documents... then we talk to their husbands... they also don't have the documents... these documents are necessary... we have to upload them online to fill their PMMVY form.”

P3: “Even after completing everything... and submitting the forms... sometimes the instalments are delayed... the beneficiaries get confused and dissatisfied... they do not receive the money on time... when they require it the most.”

Documentation requirements also create bureaucratic hurdles in the implementation of the scheme. Participants express delays in disbursement of funds, creating additional barriers. From the perspective of inclusive early childhood support, such documentation barriers are important because they can delay families' connection with welfare systems that support maternal nutrition, child monitoring, Anganwadi contact, and later access to educational inclusion.

P5: “The training center is 40 kilometres away from our place... It takes a lot of time to travel such a long distance... there are also no proper transportation facilities for us... We have to wait for private transport... it is not regular.”

The workers also described limitations in infrastructure and training. Training centres are located far away, and the workers are dependent on public transport to reach them.

P14: “There are some problems... Transportation is not available... We wait for private buses... Five to six people go together... We coordinate among ourselves... They arrange transport... This is how we manage... It becomes easy for us then.”

Interviews also revealed how frontline workers use collective coping mechanisms, by organizing transportation resources in the absence of institutional support. This shows that while digitalisation and structural systems are being used to increase the efficiency of schemes, they also create barriers related to exclusion, delay, and additional labour, requiring these frontline workers to continuously adapt themselves. To support these findings from the thematic analysis, data was collected from the beneficiaries to assess their interaction with the frontline workers.

Figure 1 presents the percentage distribution of beneficiary responses across seven items related to Anganwadi access and interaction with frontline workers. These items capture beneficiary experiences of early welfare access, including Anganwadi visits, home visits, communication, assistance, trust, and politeness.

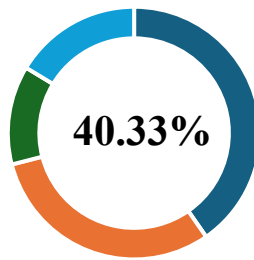
In the context of this study, these indicators are treated as measures of frontline-mediated access to maternal and early childhood support systems rather than as direct measures of special education outcomes. The findings show positive experiences of beneficiaries with frontline workers involved in the implementation of PMMVY. Majority of the beneficiaries have received assistance from frontline workers, and expressed high levels of approachability, trust, and ease of communication with ASHA and Anganwadi workers. Almost all of the beneficiaries perceive frontline workers as polite, reflecting the importance of interpersonal relationships in policy implementation. Variations are seen in the number of Anganwadi visits by beneficiaries, showing the impact of procedural challenges in enrolment of the scheme. A majority of beneficiaries agreed to receive multiple home visits by ASHA and Anganwadi workers, but the unequal distribution in outreach reflects gaps in delivery of health services. Moreover, while thematic analysis revealed challenges faced by frontline workers in travelling to distant training centres, beneficiaries' responses indicate that they find it convenient to reach at the Anganwadi centres in their area. This shows the differences in experiences of different stakeholders involved in the effective implementation of PMMVY.

PMMVY, Anganwadi Access, and Inclusive Early Childhood Support

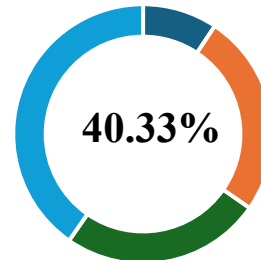
The beneficiary data also indicate that PMMVY implementation is connected to a wider early

childhood support environment. The questionnaire items captured beneficiaries' experiences of Anganwadi visits, home visits by frontline workers, ease of access to Anganwadi centres, help received from frontline workers, ease of communication, approachability and trust, and politeness of frontline workers. These indicators are important because Anganwadi centres function not only as points of maternal welfare delivery but also as community-level spaces linked with nutrition, early childhood care, preschool exposure, and developmental monitoring.

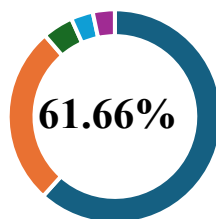
The findings suggest that frontline workers help reduce procedural and social barriers for beneficiaries. A majority of beneficiaries reported receiving assistance from frontline workers and expressed positive experiences regarding communication, trust, and approachability. Almost all beneficiaries perceived frontline workers as polite, indicating the importance of relational accessibility in welfare delivery. Although these findings do not directly measure special education outcomes, they show that ASHA and Anganwadi workers contribute to an early support interface through which marginalised mothers and children access welfare, nutrition, documentation, and institutional contact. This early support interface is relevant to inclusive and special education because educational inclusion begins before formal schooling, through systems that identify vulnerability, support families, and connect children with developmental and learning-related services.

Number of Visits to Anganwadi Centers

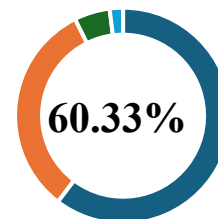
■ One ■ Two ■ Three ■ More than four

Home Visits by Frontline Workers

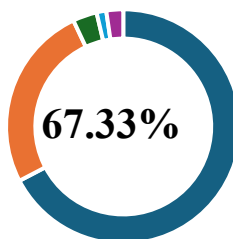
■ Never ■ Once ■ 2-4 times ■ Multiple times

Ease of Access to Anganwadi Centres

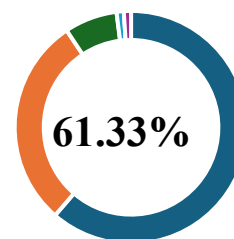
■ Strongly Agree ■ Agree
■ Neutral ■ Disagree
■ Strongly Disagree

Help Received from Frontline Workers

■ Strongly Agree ■ Agree
■ Neutral ■ Disagree
■ Strongly Disagree

Ease of Communication

■ Strongly Agree ■ Agree
■ Neutral ■ Disagree
■ Strongly Disagree

Approachability & Trust

■ Strongly Agree ■ Agree
■ Neutral ■ Disagree
■ Strongly Disagree

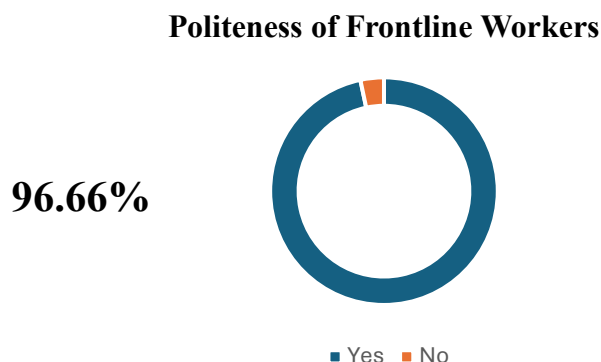


Figure 1: Beneficiary Responses on Anganwadi Access and Frontline Support under PMMVY

6. Discussion

PMMVY implementation is not merely an administrative process but a labour-mediated form of welfare governance. ASHA and Anganwadi workers translate policy into practice through counselling, documentation, digital work, household negotiation, and follow-up. These practices make frontline women workers central to maternal welfare delivery and to the welfare interface through which marginalised mothers and children access nutrition, Anganwadi contact, monitoring, and support. Read through feminist political economy, intersectionality, and street-level governance, PMMVY depends on feminised, adaptive, and undervalued labour.

6.1 Labour-Mediated Governance of Health Services

The first research question is addressed by the study, which demonstrates that PMMVY is implemented at the ground level through the daily work of the frontline workers. In accordance with the theory of street-level governance that posits that actors on the street are not just passive implementers of policy but also interpreters of it (Lipsky, 2010). ASHA and Anganwadi workers find eligible women, counsel them about the benefits of the scheme, gather documents, fill out forms, follow-up payments and keep in touch. It is their work that requires discretion, but that's not enough to explain implementation. Relational practices, translating policy rules into accessible services, are also crucial for PMMVY delivery.

The results indicate that the frontline knowledge is generated by trainers and learning in practice. Supervisory guidance gives workers procedural information and peer discussion and field based problem solving helps them to address difficulties. This builds upon the previous studies on frontline governance where it has been indicated that implementation capacity is achieved not just through institutional instruction but also through adaptation (Parashar et al., 2020; Ved et al., 2019). The repeated contact with beneficiaries also builds trust and compliance, and research has shown that when frontline engagements lead to better usage of maternal and child health services, the outcomes are positive (Lyngdoh et al., 2018; Rammohan et al., 2021). The interactions are important for inclusive early childhood support because the home visits, Anganwadi contact, counselling, documentation and follow-up are institutional relationships.

6.2 Feminisation of Frontline Care Labour

The results presented in response to the second research question indicate that feminised care labour influences the implementation of PMMVY. While ASHA and Anganwadi workers undertake administrative, emotional, relational and digital functions, they are inadequately compensated and protected from their work. With reference to the welfare system, this is explained by feminist political economy, which suggests that welfare systems are based on women's paid or unpaid care labour, and that only a few of the women doing the care receive recognition, security or even authority (Elson,

1999; Federici, 2004; Folbre, 1994). Decision making authority is retained at a higher level while responsibility is delegated to frontline workers.

This disconnect exists when beneficiaries complain about slow disbursement of instalments, issues with documentation, or failed disbursements by the frontline worker, even if these are not under the frontline worker's control. This is a form of accountability without authority, which shows the fragile position of women workers in governance of welfare. Intersectionality also indicates that gender, caste and class influence workers' power and institutional protection (Crenshaw, 1989; Kabear, 2016). The results also show that there is gendered digital dependency, with women depending on men for online forms and uploading documents. Autonomy is not, thus, a self-evident outcome of digitalisation. In some instances, it further strengthens gender dynamics at home and provides unpaid labour. This is important for inclusive early childhood support because they are based on under-recognised workers working in the Anganwadi who assist families to access care, nutrition, documentation and services.

6.3 Structural and Digital Barriers in Policy Implementation

Structural, administrative, and digital barriers all play a part in the implementation of PMMVY in addressing the third research question. Issues with documentation, Aadhaar related, delayed payments, verification issues, network failures, and limited transport block the beneficiaries and add extra work to the frontline workers. These findings corroborate with the study that demonstrates how underdeveloped administrative and digital systems exacerbate the frontline work under a lack of infrastructure and training (Banerjee et al., 2025; Falcao, 2025; Shukla et al., 2023). While digitalisation can help streamline processes, it also shifts technical accountability to the workers who may not have access to the devices, internet or support.

Other factors influencing implementation are infrastructural barriers, such as remote training centres and transportation problems. Informal

coping mechanisms like peer support, shared travel, shared problem solving are the responses shown by workers, showing institutional gaps. From the perspective of inclusive and special education, such barriers matter because early childhood support depends on families' ability to remain connected with welfare institutions. Documentation failures, delayed payments, and digital exclusion can weaken access to nutrition, Anganwadi services, counselling, monitoring, and referral pathways. For marginalised households, weakened welfare contact may affect school readiness and future educational inclusion.

6.4 Implications for Special and Inclusive Education

The findings have policy implications for special and inclusive education because they suggest that some conditions for educational inclusion are shaped before formal schooling. PMMVY is not a special education programme, but its implementation intersects with Anganwadi-based early childhood support through maternal nutrition, counselling, documentation, institutional contact, and referral possibilities. These processes may influence whether marginalised families remain connected to systems that support health, development, and learning.

The study therefore invites a broader policy discussion on inclusive education beyond school-based interventions. It shows that frontline women workers help create early welfare conditions through which children access care, monitoring, and developmental support. Strengthening their training, remuneration, social security, digital support, and authority is therefore relevant not only for PMMVY implementation, but also for building inclusive foundations for educational participation.

7. Policy Implications

The results indicate a number of policy options. First, the formal recognition of frontline workers must be strengthened, along with timely remuneration and provision of basic social

security, such as health insurance and pension support. The implementation of PMMVY is also dependent on the women workers and, therefore, improving their working conditions is also pertinent to gender equality and worker retention.

Second, digital infrastructure must be improved with reliable devices, internet connectivity, regular training and technical support. Information technology should not impose extra workload on ASHA and Anganwadi workers in terms of paperwork.

Third, there should be some degree of administrative flexibility to deal with documentation errors, delayed registrations and fund-disbursement issues. The blame should not fall on frontline workers for any delays which are not within their control.

Lastly, there is a need to tie in the implementation of PMMVY to early childhood support systems. Frontline workers need basic developmental milestone and developmental delay training and awareness of disabilities and referrals. The Anganwadi centres should be reinforced as child inclusive early childhood support centres particularly for children who may be marginalized and may experience delayed access to nutrition, documentation, monitoring or preschool exposure.

8. Limitations

While the study provides an in-depth understanding of feminised frontline governance in the implementation of PMMVY, it has some limitations that must be acknowledged. Since the study is based on a small sample of ASHA and Anganwadi workers in four districts of Rajasthan, the findings cannot be generalised to all regions and contexts. The qualitative analysis is based on self-reported data from frontline workers, which may be influenced by social desirability bias, recall bias, or perceived power dynamics, considering their position within hierarchical government structures. The use of thematic analysis involves some degree of subjectivity, and the researcher's positionality may have

influenced the interpretation of data. The study focuses on PMMVY within a particular socio-cultural context, and the findings may not represent the experiences of frontline labour in other maternal health or welfare policies. In addition, the study does not directly measure child developmental outcomes, disability identification, school readiness, or access to special education services. Therefore, its relevance to special and inclusive education is interpretive and policy-oriented, based on the relationship between PMMVY implementation, Anganwadi-based early childhood support, and the early welfare conditions that may shape later educational inclusion. Another limitation is that the study draws mainly on maternal welfare, frontline governance, and gendered labour literature; therefore, its engagement with special and inclusive education is limited to the policy implications of early childhood support rather than a direct review of special education scholarship.

9. Conclusion

The study analysed the governance at the frontline of maternal health services, based on the experiences of ASHA and Anganwadi workers in implementing PMMVY in North-Eastern Rajasthan. The analysis identified three themes – firstly, labour-mediated governance of health services, secondly, feminisation of frontline labour, and thirdly, structural and digital barriers in the implementation of policies. The findings indicate that frontline workers serve as mediators who help to put government provisions into practice by counselling, documenting, going on home visits, entering into digital records and maintaining follow-up with beneficiaries. The study highlights that the feminisation of frontline governance leads to high expectations of women workers who are undervalued, underpaid and under-supported. They solve administrative, infrastructural, relational and technological issues, but their power in the implementation system is constrained. The implementation of PMMVY, therefore, requires not only institutional design but also continuous adaptive labouring at the frontline level which is gendered. The results

indicate that the impacts of PMMVY are not limited to maternal health. The scheme helps to create the early welfare environment of marginalised mothers and children through Anganwadi access, nutrition support, documentation assistance, household counselling and the repeated interaction with the frontline workers. The conditions could be applicable to inclusive and special education, as early involvement in formal education starts before school and is through systems that promote health, development, family engagement, and access to institutions. The empowerment of frontline workers is therefore critical to the well-being of mothers,

References

- Abrar, D., & Malik, A. (2025). Assessing challenges and sources of dissatisfaction among accredited social health activists employees. *International Review of Management and Marketing*, 15(1), 91. <https://doi.org/10.32479/irmm.17570>
- Agarwal, B. (1997). "Bargaining" and gender relations: Within and beyond the household. *Feminist economics*, 3(1), 1-51. <https://doi.org/10.1080/135457097338799>
- Banerjee, R., Singh, B. S., Sahrawat, N., Mehrotra, A., Swain, S., Mishra, R. M., Antony, P., Aparna, U., Jain, B. K., & Neogi, S. B. (2025). Effect of India's flagship conditional maternity benefit scheme on utilization of maternal and child health services: evidence from a statewide evaluation study. *BMC Pregnancy and Childbirth*, 25(1), 294. <https://doi.org/10.1186/s12884-025-07416-3>
- Braun V., & Clarke V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. <https://doi.org/10.1191/1478088706qp063oa>
- Brodkin, E.Z. (2012). Reflections on Street-Level Bureaucracy: Past, Present, and Future. *Public Administration Review*, 72(6), 940-949. <https://doi.org/10.1111/j.1540-6210.2012.02657.x>
- Chowdhuri, J. G., & Chowdhury, S. (2025). The Invisible Backbone: The Unrecognized Political Economy of Women's Unpaid Care Work in India. *International Journal of Multidisciplinary*, 10(8), 31-47. <https://doi.org/10.31305/rrijm.2025.v10.n8.005>
- Crenshaw, K. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. *University of Chicago Legal Forum*, 1989(1), 139-167. <https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8>
- Department of Women and Child Development. (2026). Pradhan Mantri Matru Vandana Yojana. Government of India. <https://wcd.delhi.gov.in/wcd/pradhan-mantri-matru-vandana-yojana-pmmvy>
- Deshpande, S., Gadapani P, B., & Manapurath, R. M. (2019). Analysing the challenges and demotivating factors faced by accredited social health activist workers in tribal India in implementing their roles. *International Journal of Medical Science and Public Health*, 9(2), 117-120. <https://doi.org/10.5455/IJMSPH.2020.1131025112019>
- Elson, D. (1999). Labor Markets as Gendered Institutions: Equality, Efficiency and Empowerment Issues. *World Development*, 27(3), 611-627. [https://doi.org/10.1016/S0305-750X\(98\)00147-8](https://doi.org/10.1016/S0305-750X(98)00147-8)
- Falcao, V. L. (2025). The 'Digitalwashing' of India's Public Welfare: Evidence from the Pradhan Mantri Matru Vandana Yojana. *Information Technology for Development*, 32(1), 263-283. <http://dx.doi.org/10.2139/ssrn.5795444>
- Federici, S. (2004). *Caliban and the Witch: Women, the Body and Primitive Accumulation*.
- developmental inclusion and equitable service provision.

Acknowledgment

This research paper is part of the project titled "Assessing the Multidimensional Efficacy of the Pradhan Mantri Matru Vandana Yojana (PMMVY) among Marginalised Women: A Socio-Spatial Analysis of Rural and Urban Intersections in North-Eastern Rajasthan", funded by the Indian Council of Social Science Research (ICSSR) under the Special Call for "Punyashloka Devi Ahilyabai Holkar Scheme for Women-Led Research on Women-Led Development."

- Folbre, N. (1994). *Who Pays for the Kids?: Gender and the Structures of Constraint* (1st ed.). Routledge. <https://doi.org/10.4324/9780203168295>
- Kabeer, N. (2016). Gender Equality, Economic Growth, and Women's Agency: the "Endless Variety" and "Monotonous Similarity" of Patriarchal Constraints. *Feminist Economics*, 22(1), 295-321. <https://doi.org/10.1080/13545701.2015.1090009>
- Kumar, D. S., Jain, D. P., & Garg, D. U. (2024). Impact, Challenges, Opportunities: A Literature Review of the Pradhan Mantri Matru Vandana Yojana in addressing Maternal, Child Health and Nutrition in India. *Educational Administration: Theory and Practice*, 30(3), 2419–2424. <https://doi.org/10.53555/kuey.v30i3.6077>
- Kumar, J. S., & Shobana, D. (2023). Awareness and Utilization of the PMMVY Scheme of Lactating Mothers and Pregnant Women in Nagaland. *International Journal of Social Science & Management Studies*, 9(3), 81-87.
- Kurapati, J., & Thippaiah, A. (2025). Exploring the Digital Challenges Faced by Community Health Workers in a District of Telangana, India: A Qualitative Study. *Journal of Community Medicine and Primary Health Care*, 37(2), 49-63. <https://dx.doi.org/10.4314/jcmphc.v37i2.5>
- Laloo, M. N., & Parveen, N. (2025). Digital transformation of work practices among ASHAs in Meghalaya. *International Journal of Sociology and Humanities*, 7(2), 114-118. <https://doi.org/10.33545/26648679.2025.v7.i2b.189>
- Lipsky, M. (2010). *Street-level bureaucracy: Dilemmas of the individual in public service*. Russell sage foundation.
- Lyngdoh, T., Neogi, S. B., Ahmad, D., Soundararajan, S., & Mavalankar, D. (2018). Intensity of contact with frontline workers and its influence on maternal and newborn health behaviours: cross-sectional survey in rural Uttar Pradesh, India. *Journal of Health, Population, and Nutrition*, 37(1), 2. <https://doi.org/10.1186/s41043-017-0129-6>
- Marwah, V. (2022). Liminality as wage penalty for India's women community health workers. *Gender, Work & Organization*, 30(2), 412-430. <https://doi.org/10.1111/gwao.12938>
- Mazumdar, K., Sen, I., & Parekh, S. (2021). The invisible frontline workers: lived experiences of urban Indian mothers during COVID-19 in India. *Journal of Gender Studies*, 31(5), 623-638. <https://doi.org/10.1080/09589236.2021.2007472>
- Meena, S., Rathore, M., Kumawat, P., & Singh, A. (2020). Challenges Faced by ASHAs during their Field Works: A Cross Sectional Observational Study in Rural Area of Jaipur, Rajasthan. *International Journal of Medicine and Public Health*, 10(3), 97-99. <https://doi.org/10.5530/ijmedph.2020.3.20>
- Mehta, B. S., & Mehta, A. K. (2025). Paid and Unpaid Care Work: Gender Inequities and Policy Pathways. *Indian Journal of Human Development*, 19(1), 50-67. <https://doi.org/10.1177/09737030251357106>
- Monteiro, T. S. (2022). Intersections of caste, class, and gender in healthcare sanitation work in India: Social work imperatives for restructuring marginalized women's care work. *Asian Social Work and Policy Review*, 16(3), 254-264. <https://doi.org/10.1111/aswp.12264>
- Nikore, M., Deshmukh, A. S., Sharma, M., & Mahant, T. (2023). Chronicling the observed gendered effects in India's labor markets during COVID-19. In *Contextualizing the COVID pandemic in India: A development perspective* (pp. 169-197). Singapore: Springer Nature Singapore.
- Palriwala, R., & Neetha, N. (2010). Care arrangements and bargains: Anganwadi and paid domestic workers in India. *International Labour Review*, 149(4), 511-527. <https://doi.org/10.1111/j.1564-913x.2010.00101.x>
- Parashar, R., Gawde, N., Gupta, A., & Gilson, L. (2020). Unpacking the implementation blackbox using "actor interface analysis": how did actor relations and practices of power influence delivery of a free entitlement health policy in India?. *Health Policy and Planning*, 35(2), 74-83. <https://doi.org/10.1093/heapol/czaa125>
- Ramanathan, M., & Kochuvilayil, A. (2025). Gendered care work for the elderly: an examination using the longitudinal aging survey of India, 2018-19. *Journal of Social and Economic Development*. <https://doi.org/10.1007/s40847-024-00415-8>

-
- Rammohan, A., Goli, S., Saroj, S. K., & Jaleel, C. P. A. (2021). Does engagement with frontline health workers improve maternal and child healthcare utilisation and outcomes in India?. *Human Resources for Health*, 19(1), 45. <https://doi.org/10.1186/s12960-021-00592-1>
- S. R., S. (2025). Challenges and Problems Faced By Anganwadi Workers in Their Daily Life. *Journal of Research and Development*, 17(1), 51-54. <https://doi.org/10.5281/zenodo.14948722>
- Sharma, S., Mall, A., & Pardeshi, G. (2024). Exploring the Challenges Faced by Accredited Social Health Activist Workers while Delivering Healthcare Services in a Tribal District of Maharashtra: A Qualitative Study. *Indian Journal of Applied Research*, 14(7), 19-21. <https://doi.org/10.36106/ijar/8900963>
- Shrivastava, R., Sharma, L., Jolly, M., Ahuja, R., Sharma, R., Naslund, J. A., Agrawal, J., Shidhaye, R., Mehrotra, S., Hollon, S. D., Patel, V., Tugnawat, D., Kumar, A., Bhan, A., & Bondre, A. P. (2023). "We are everyone's ASHAs but who's there for us?" a qualitative exploration of perceptions of work stress and coping among rural frontline workers in Madhya Pradesh, India. *Social Science & Medicine*, 336, 116234. <https://doi.org/10.1016/j.socscimed.2023.116234>
- Shukla, V., Ray, K., & Basu, M. (2023). Barriers and Solutions Pertaining to Pradhan Mantri Matru Vandana Yojana (PMMVY) Implementation in A Block of West Bengal: A Mixed-Methods Approach. *Healthline*, 14(1), 9-16. https://doi.org/10.51957/healthline_467_2022
- Srinivasan, S., & Sarin, A. (2023). Frontline workers' performance in prosocial tasks: evidence from a Lab-in-the-Field in Western India. *International Journal of Public Sector Management*, 36(6/7), 546-562. <https://doi.org/10.1108/ijpsm-01-2023-0027>
- Ved, R., Scott, K., Gupta, G., Ummer, O., Singh, S., Srivastava, A., & George, A. S. (2019). How are gender inequalities facing India's one million ASHAs being addressed? Policy origins and adaptations for the world's largest all-female community health worker programme. *Human Resources for Health*, 17(3). <https://doi.org/10.1186/s12960-018-0338-0>