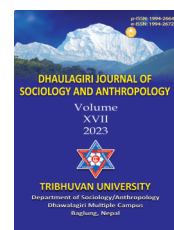


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Dhaulagiri Journal of Sociology and Anthropology



Payment and Motivation: Female Community Health Volunteers in Nepal

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Article Info

Received: December 10, 2021

Revised received: December 2, 2023

Accepted: December 15, 2023

Available online: December 27, 2023

DOI: <https://doi.org/10.3126/dsaj.v17i01.61143>

Abstract

The paper attempts to critically discuss the payment issue among Female Community Health Volunteers (FCHV) in Nepal. It examines how the Female Community Health Volunteers experience such issues and the impact on them. The payment issues among Community Health Workers are very contentious, particularly in developing countries. The prevalence of this issue in Nepal merits critical attention. The paper further examines Female Community Health Volunteers' motivation to work despite the numerous challenges. The paper is based on fieldwork in the Bardiya District of Nepal where most respondents expect to receive some basic remuneration for their service regularly. The question, therefore, arises for examination as to why they are unwilling to leave their position even though they do not receive any financial rewards for community service. Social status, mobility, gaining new knowledge, participating in various programs, and building relationships with others are some of the motivating factors for FCHVs.

Keywords: female community health volunteer, motivation, payment, Nepal, volunteerism

Introduction

Payment of Community Health Workers (CHW) is a contentious issue, particularly in developing countries. Many developing countries' delivery of health care services relies heavily upon volunteer labor (Maes, 2012). Generally, volunteers receive outcome-based payments for activities, including promoting immunization, facilities delivery, etc. They are also compensated for time spent in training and meetings. However, CHWs differ within and across countries in terms of their recruitment, training, supervision, type and amount of work, and remuneration (Ormel et al., 2019). Indeed, the importance of community health workers is increasing because of the shortage of professional health care workers, which is clearly stated in the WHO 2006 report.

There is a chronic shortage of well-trained health workers. The shortage is global but most acutely felt in the countries that need them most. For a variety of reasons, such as the migration, illness or death of health

workers, countries are unable to educate and sustain the health workforce that could improve people's chances of survival and their well-being. (WHO, 2006).

WHO estimates that 4.3 million health workers are needed to fill the gap. Fifty-seven countries, mostly in Africa and Asia, face a severe health workforce crisis (WHO, 2006). Community Health Workers (CHWs) are filling this gap in many countries, including Nepal. Task shifting is recommended by WHO for this process (WHO, 2006). Task shifting is the strategic reallocation of responsibilities within healthcare teams. This involves transferring certain tasks from highly skilled healthcare workers to those with less training and qualifications to optimize the use of available human resources for health. There are different types (Paid and Volunteer) of Community health workers within countries (USAID, 2017). The paper focuses on unpaid and Female Community Health Volunteers of Nepal who have no fixed working hours. Many public health institutions and donors use several economic and



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moral arguments to justify the minimal compensation of CHWs and volunteers (Glenton et al., 2010; Maes, Kohrt, & Closser, 2010). They argue that CHWs should not be interested in salary and should have a “volunteer spirit” to serve others (Maes, 2012). This article contextualizes this background to understand what motivates volunteers to work in resource-poor settings full of dedication and also tries to explore their views on the question of payment.

Methodology

This paper is based on qualitative data from the fieldwork carried out in the Bardiya District. In-depth interviews (25), non-participant observation, and life history methods were used to collect data from the field. The researchers also interviewed key informants (10) Primary Health in-charge, other health staffs of Primary Health Center, School Principle, Village District Committee chairperson, under five children mother, pregnant mother, policy maker, women activist and district health office staff, local women leader, community head, and local NGO. An attempt was made to get access to some basic data (Full list of FCHV With Name and Age) of FCHV from the district health office. Health center staffs were also helpful as far as introduction to some of the FCHV is concerned. The purposive sampling method has been utilized to select participants based on specific criteria such as age, education, ethnicity, and caste. A field study was carried out from February 2018 to January 2019.

Background of Female Community Health Volunteer Programme in Nepal

The Female Community Health Volunteer (FCHV) Program in Nepal was started in 1988 by the Ministry of Health and Population to improve community participation and enhance the outreach of health services through local women working voluntarily. FCHV's primary assigned role is to empower community members, with a particular focus on women, to enhance the health of mothers and children and the overall well-being of the family and community. The FCHV program believes that the impact of FCHVs starts at the ward level and gradually cascades to the VDC level (now at the local level). Ultimately, these efforts will reach and benefit the entire nation.

In the mid-1990s, a strategy was adopted to allocate FCHVs by population, leading to the recruitment of additional FCHVs. Over 50,000 FCHVs are currently working in Nepal (National Demographic Health Survey, 2022). Basic maternal and child healthcare services used to be provided by community health leaders before the FCHV. The Community Health Leader Programme has involved both men and women. However, the female service users were reluctant to avail of service provision by male community health volunteers. This is perhaps one reason female community health volunteers took over the male community health leaders (Pandey et al., 2017). FCHVs are part of Primary Health Care (PHC), which has

been praised as the key to “Health for All by the year 2000”. Alma-Ata conference in 1976 declared that PHC is a means of providing “essential health care to all individuals through their first level of contact with national health services (Stone, 1986). Community health workers and the PHC are the two sides of a coin (Mulareedharan & Prasad, 2007). WHO and other agencies have promoted PHC as a more equitable alternative to an earlier medical development that was primarily curative, urban, and hospital-based. The later model was unable to provide services to the majority of the poor people in many countries and bypass the underlying issues of socio-cultural aspects of health.

PHC follows the public health model which prioritizes health education over curative services, lays greater emphasis on paramedical workers than doctors, and adopts a strategy of ‘community participation’ whereby communities identify their own health needs and assume responsibility for improving their health within this framework. (Stone, 1986, p. 293)

Nepal has adopted an Integrated Community Health Programme (ICPH) that was designed to combine existing “Vertical” (disease-specific) health programmes. International policymakers were approaching Primary health care to serve rural areas, which resulted from the Alma-Ata conference. During the late 1970s, ICPH was gradually transformed into primary health care. The key objective of PHC is to provide essential health care to all individuals through their first level of contact with national health services. Commonly, this first level of contact is the rural health workers (Stone, 1986).

Role and Responsibilities of Female Community Health Volunteers in Nepal

FCHVs play crucial role in contributing to a variety of key public health programs, including family planning, maternal care, sick childcare, vitamin A supplementation/de-worming and immunization coverage (FCHV Program Strategy, Government of Nepal, 2010). Maternal and child health is improving in Nepal. Maternal Mortality has declined to 151 per 100,000 live births in 2021 from 850 in 1991 (National Population and Housing Census 2021). Under-five, mortality has declined from 142 to 27 per 1000 live births between 1991 and 2021 (Nepal Demographic and Health Survey, 2022). The use of maternal health services has improved since 1996, with the increase in the coverage and number of Anti Natal Care visits (50% for four ANC visits), rates of institutional deliveries, and deliveries attended by a SBA.

FCHVs actively work at the community level by undertaking door-to-door visits to offer promotive, preventive, and curative services. They visit all newborns within 24 hours of birth (New Era, 2007). They record births and counsel caretakers on essential newborn care. FCHVs undertake bi-monthly follow-up visits to all infants to determine survival status. Services provided by FCHVs represent the central pillar of CB-MNC (Community-

based maternal and Neonatal care) activities. Their primary tasks in CB-MNC are to identify PW (registering them in the CB-MNC Register) and counsel them and their family members on key topics, including antenatal care, maternal and newborn danger signs, birth preparedness, postpartum and newborn care, and family planning. The study clearly stated that CB-MNC achievements are primarily the result of the dedicated services provided by FCHVs and also mentioned that FCHVs are saving the lives of many women and children across Nepal every day (Jennie 1999, New Era, 2007). A comparison of results and experiences across the three CB-MNC districts suggests that the districts most likely to achieve maximum benefit from CB-MNC are less prosperous districts with high levels of newborn mortality. FCHVs' major activities can be summarized as follows: Education and promotion regarding all family planning methods, provision of pills and condoms, education in pregnancy and promotion of antenatal care, iron supplements and tetanus toxoid, provision of iron supplements in selected districts, promotion of birth preparedness including use of a skilled birth attendant and/or emergency preparations (particularly in selected districts), promotion of good newborn care practices, provision of vitamin A to post-partum mothers, promotion of good nutrition, hygienic and healthy behaviors, treatment of simple pneumonia with cotrim and referral of serious cases, treatment of diarrhea with Oral Rehydration Solution (ORS), treatment of diarrhea with zinc (pilot districts), distribution of high dose vitamin A and de-worming tablets twice a year to targeted children under age five, support for childhood immunizations and provision of polio drops during national immunization days, Provide education and promotional services for other diseases (e.g., HIV/AIDS), provision of limited first aid/treatment of minor illnesses, activate and serve as the secretary for the local mother's group, report to the local health facility monthly using the ward register through their local supervisor (Analytical report on FCHV, 2007).

They often have to do other work that gets assigned to them besides the aforementioned workload. FCHV's role was noticeable during emergencies such as the 2015 earthquake and COVID-19 (Horton et al., 2020; Prajwal et al., 2020). Various research shows the scope of FCHV is to prevent noncommunicable diseases (Basnet et al., 2021; Rawal et al., 2022). Their title as volunteers renders them speechless against misuse. Ultimately, the continuous burden of workload affects FCHV's dedication and determination. FCHV's payment needs have remained unaddressed despite increased workloads over the years. Various factors motivate them, but inadequate pay, lack of job security, and poor communication are some of the major factors that affect CHW motivation (Cathrine 2012).

Motivation of Female Community Health Volunteers and Payment Issue

Motivators are often categorized as either intrinsic

or extrinsic. Intrinsic motivators exist without regard to external rewards and align with personal motives and values. These motivators include empathy, altruism, pride, and a desire for self-fulfillment. Extrinsic motivators are generated from external rewards, including money and employment opportunities, non-monetary material rewards (such as bicycles and uniforms), and other non-material rewards, such as heightened social status and increased knowledge. Studies recommend using a combination of intrinsic and extrinsic motivators to prevent CHW attrition (Ahmed, 2008; Khan et al., 1998; Rahman & Tasneem, 2008). Perhaps the most contentious debate surrounding CHW motivation involves the financial remuneration of CHWs.

FCHV gets NRS 400 for the polio and Vitamin A program, held twice a year, and a dress allowance of NRS 12,000 per year. Tea and snacks are available for them at the time of the meeting in PHC. Remuneration is absent except for tea and snacks during the polio and Vitamin A program under NGO and INGO training.

We often have to work for several other institutions where we do not get anything because they know that we, as volunteers, are bound to work for everybody for free. Since most of them come through the contact of the village head, we cannot ask for anything (28 years, FCHV).

Sometimes, they get non-monetary incentives such as dresses, bicycles, torches, umbrellas, etc., but of poor quality. In this regard, one FCHV recounted her experience.

Last year, we were very happy to get torches and umbrellas from VDC and PHC. As we often walked at night and in rainy times, these were necessary for us. Unfortunately, torches stopped functioning after one month, and umbrellas broke in two months owing to poor quality. When we informed PHC in charge about this, he replied that it is difficult to give good quality items from a meager amount of funds provided by the government (40-year FCHV)

FCHVs are motivated by other intrinsic factors

I am motivated to work when I see all the mothers with their children assembling at the instructed place on capsule distribution days. People, including local medical attendants, come to me for advice. This encourages me to work harder even if I do not get paid (43 years, FCHV).

I feel so happy and motivated when I successfully cure pregnant women and children in their difficult situations. Many incidents motivated me to do this work, but one I can share with you. One woman had a third pregnancy; she had one daughter. Her second pregnancy had failed due to miscarriage. It was a critical case of delay in delivery, but her family members did not pay any heed to her health. Upon reception of the call, I informed them about her critical situation. In the event of their refusal to get help from anybody, I carried her to Sorahawa Health Center by bicycle. After four hours, PHC referred her to Nepalgunj Hospital. I called her husband, who was a driver and was

staying in Nepalgunj. He came by vehicle and carried her to the zonal hospital, where the doctor had to conduct a cesarean because of her critical condition, and she needed blood, which her husband donated. She remained under observation for 14 days. When she returned home with a baby child in good condition, all family members seemed happy. When they saw the son, family members appreciated me so much. It was with my help as the savior of mother and child that my real happiness lay rather than the family's appreciation. (28 years, FCHV).

Despite all this, some of the incidents de-motivated them

I sometimes wonder why I am doing this work without getting anything when community people spread rumors that we are salary workers (50 Years FCHV).

These people are of the opinion that we do all this for a good sum of money. Why should we listen to them? Anyway, they are not giving us (community women) anything.

Most of the FCHVs are illiterate and from poor economic conditions. All of them have families with two or more children. Gender inequality affects their work. They would have gotten free time if they had a daughter and daughter-in-law.

I could become FCHV because I had three daughters and one daughter-in-law at home to do housework. Family, especially my daughters, allows me space for this work. The committee has chosen me as FCHV because of my suitability to give time for community service. I had interest but was denied first. When my family allowed me, I became so happy. I have always desired to go out, meet people, talk with them, and learn something new (73 years FCHV).

It is not that women were not interested, but rooted patriarchy and gender roles stopped them from becoming FCHV. One of the respondents said

I had interest, but without my family's consensus, how could I do? Society held a skeptical view about women who went out, advised people, and walked from village to village at that time. Society labeled her as a characterless and bad woman. People did not like utterances from women. They said "pothibaseko suhaidaina" means it is inappropriate to hear women's voices (Community Women).

Community people's perception towards them is very important for their motivation. They get respect from community people. People address them as doctors in many remote areas that motivates them to do more and more work. If FCHVs cannot provide curative medicine, they have to face negative responses from community people, which Linda Stone has also revealed in her research.

In most communities of Nepal, villagers feel they already know how to promote good health, how to feed babies and what pregnant women should eat..... Thus, it is not only that the PHC package fails to deliver what the people really want by way of modern

health services, but also that the package itself runs the risk of being perceived as largely unneeded and irrelevant to the majority of people it is intended to serve. (Stone, 1986, p. 296)

Community people expect more curative services from them. They have limited medicines, but villagers come to them for all kinds of diseases and ask for medicines.

Once, I gave cough medicine to my neighbor to cure her cough. Next time, she came to ask for the same medicine, but I did not have it because that was a medicine that I had bought for my cough and cold. She thought that I was provided with all sorts of medicines for the community people and was not distributing them. I wish for their health and happiness, but what can I do in my poor economic condition (53 years, FCHV)

There is also debate on FCHV education level and the ability of semi-literate volunteer women to correctly diagnose and treat the disease like pneumonia. Hence programme implemented two intervention arms: "treatment" and "referral". FCHVs were trained to assess children for danger signs. They also used a timer to count respiratory rate and to classify sick children (0–59 months of age) with cough or difficulty breathing as having pneumonia or not. In the "treatment" children aged 2–59 months with only fast breathing (50 breaths or more per minute) were treated at home with co-trimoxazole and reassessed on the third day. Children whose condition deteriorated or did not improve were, then referred. Pneumonia is very common among children in rural areas. FCHVs are treating it so well, which is evident from this research. Old FCHVs are mostly illiterate, whereas new FCHVs are educated. Most of the researches show that altruism is one of the most motivating factors for volunteer work. The difference in motivation is also determined by age and education. For most old-age FCHVs, altruism is a major motivation for their dedication and determination toward volunteer work. Young and educated¹ FCHVs add other factors such as career opportunities, networks, and mobility.

Gita finished her intermediate-level education and joined an FCHV. It appealed to her to see some FCHVs' engagement with NGO's for earning. She views this work as a platform for a better future. She hopes to get a better opportunity. However, only a few FCHVs are getting this opportunity.

Interestingly, there is a category of Female Community Health Volunteers who do not expect much but a minimum payment. It provides them freedom from home, hence they prefer volunteering. They very often face ill-treatment from family members, which dampens their spirit.

Attending a training organized by PHC fetches us just \$2. Since the time of such training is mostly during harvest

1. According to New Era et.al 2007 data shows that Forty-two percent of FCHVs have completed primary school or gone up to secondary education, 16 percent have attended but not completed primary school and 42 percent have never been to school.

season, it compels us to hire labor for harvesting for 400 rupees. In this difficult situation, our family members scolded us. We thus feel de-motivated (39 Years, FCHV).

I know all the trouble which is pressing in my heart. The wife goes out wearing a saree in between work. I have to manage everything. I cannot ask her to resign from work because now everywhere is the time for women Other people come to threaten me if I do that. Hence, I keep quiet and do whatever I can. If she gets money to fulfill her necessities, it would be ok. Nevertheless, there is nothing but a disadvantage for the family (Husband of FCHV).

For the Poor FCHVs, the money they get from training, polio, and Vitamin A is used to buy daily essentials like tea, sugar, oil, and salt. So, the question arises whether volunteer work is suitable for poor? The earlier definition of volunteers was middle-aged, highly educated, with a secure income, who attend church regularly and are altruistically motivated (Wardel et al., 2000). The same definition was articulated by medical anthropologist Paul Farmer. However, the recent demographic and employment shifts have challenged this definition.

To motivate FCHVs, the government created Female Community Health Volunteer Fund with around 50,000 Nepali Rupees to enhance skills and welfare of Female Community Health Volunteers in 2008 (2064BC)². Theoretically, FCHVs should invest this money for micro-credit activities, but women use it for household purposes, pay children's school fees, for treatment of their family members, and for pilgrimage. FCHVs get 20,000 Nepali Rupees on their retirement time as prestige³. Sometimes they have to pay tax using the money. Since the promulgation of the federal system, some local-level governments appear to be showing a bit of recognition towards FCHVs by providing financial support compared to earlier times⁴.

Conclusion

More than 50,000 women are working as Female Community Health Volunteers in Nepal. The contribution of FCHVs is noticeable in a variety of key public health programs like family planning, maternal and child care, vitamin A supplementation/de-worming, and immunization coverage. Payment to community health workers is a very contentious issue till now, particularly in developing countries. Motivators are classified into intrinsic and extrinsic. Intrinsic motivators exist without regard to external rewards and align with personal motives and values. These motivators include empathy, altruism,

2. [https://mohp.gov.np/program/female-community-health-programme/en#:~:text=Government%20of%20Nepal%20\(GoN\)%20is,50%2C000%20to%20each%20VDC.](https://mohp.gov.np/program/female-community-health-programme/en#:~:text=Government%20of%20Nepal%20(GoN)%20is,50%2C000%20to%20each%20VDC.)

3. <https://publicservices.international/resources/videos/female-community-health-workers-in-nepal-talk-about-labor-exploitation?id=13272&lang=en>

4. <https://shorturl.at/mxzHT>

pride, and a desire for self-fulfillment. Extrinsic motivators are generated from external rewards and include money and opportunities for employment and non-monetary material rewards (such as bicycles, uniforms, heightened social status, and increased knowledge. However, the attrition rate is very low (4%) in Nepal. Altruism is one of the major motivating factors among FCHVs in Nepal, particularly for old age FCHVs, whereas career opportunity, network, and mobility motivate young, educated FCHVs. Female community health volunteers do not have any big expectations. They demand a minimum level of payment. In this regard, one of FCHVs mentioned "we are asking for regular instead of more for strengthening our capacity to do more work". Most of the respondents expected something basic but did not specify in financial or non-financial terms. They are asking for a little beyond the existing status. Young FCHVs insist on financial incentives, and they also raise their voice at the time of the meetings, but stakeholders often silence them with the argument of volunteerism. It is unfair to compel poor people to do volunteer work for a very long time. Their average working hours can be summed up between 5-6 hours per week but their health service cannot be quantified. They are available all the time for their community people. Although they do not complain about volunteerism, they are facing challenges at the family and community levels. Aspiration for a better future among young FCHVs tends to render them less active than older and illiterate FCHVs. Community respect, mobility, gaining new knowledge, participation in various programs, relation to other health staff, supervision, and family are some of the motivating factors for FCHVs.

Declarations

Ethics approval and consent to participate:

This study was conducted as part of my PhD research at Jawaharlal Nehru University, India. The research committee at the university approved the study, and consent was obtained from participants before conducting interviews.

Consent for publication from participants:

Not Applicable.

Availability of data and materials:

Data can be shared.

Competing interests:

There are no competing interests in this study.

Funding:

No funding.

Acknowledgments:

I would like to express sincere gratitude to all the participants who generously gave their time during

this study. I would also like to thanks to all the faculty members of the Center for the Study of Social System, Jawaharlal Nehru University for approving this study. Special thanks to supervisor Prof. Renuka Singh for her support throughout the study.

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