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Wichterich, Christa

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Christa Wichterich:

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Protection and Protest by "Voluntary" Community Health Workers: COVID-19 Authoritarianism in India

Christa Wichterich *

Abstract: *»Schutz und Protest von ‚freiwilligen' kommunalen Gesundheitshelfern: COVID-19 Autoritarismus in Indien«.* During the COVID-19 crisis, the Indian state assigned an outstanding role in the containment of the pandemic to ASHAs, "voluntary" community healthcare workers. Local women were recruited as "honorary" workers receiving only a small honorarium or piece rate "incentives." The feminisation, casualisation, and informalisation of work in state-funded social welfare schemes are examples of care extractivism. ASHAs had to spearhead awareness-raising, identify infections, and organise vaccinations in rural areas, often without proper protective equipment and always without fair payment. Despite such care extractivism, these caregivers were celebrated by the middle classes as frontline fighters of the nation amidst a masculinist discourse of "war," "warriors," "heroes," and "sacrifice." Yet, at the height of the crisis in 2020 when thousands of ASHAs contracted COVID-19, they went on strike. Having gained confidence in earlier struggles, they complained about extreme exhaustion, increased vulnerability, and the depletion of caring capacities. Their efforts reflect a feminisation of labour struggles that focuses on care work with an emphasis on both the care-recognition-gap and the care-pay-gap.

Keywords: COVID-19, pandemic, volunteering, India, care, social reproduction, extractivism, labour struggles.

1. Introduction[1]

During the COVID-19 crisis, the Indian state assigned an outstanding role to accredited social health activists (ASHAs), who are "voluntary" community

* Christa Wichterich, former guest professor for gender politics at the University of Kassel, Department of Political Sciences and International Centre for Development and Decent Work (ICDD), Kleine Rosenstraße 1-3, 34117 Kassel, Germany. In 2018/19 fellow of ICAS-MP, Max Weber Stiftung, New Delhi, India; wichterich@femme-global.de.

[1] This article is dedicated to Ranjana Nirula. Ranjana Nirula died of COVID-19 in May 2021. As a CITU trade unionist and leading figure in the All India Democratic Women's Association (AIDWA),

healthcare workers, to contain the transmission of the virus. Current feminist–political analyses of care during the pandemic have emphasised how the crisis impacted women's unpaid care work in private households and their paid care work in the labour market (Kabeer, Razavi, and Meulen Rodgers 2021). Notably, however, this work tends to neglect intersectionality and voluntary work. This article uses India as an example to fill these two gaps by accounting for how categories of social inequality like gender, class, caste, and race or ethnicity help structure the division between productive and reproductive labour, as well as other societal divisions of labour in everyday life and crises (Rao 2021). Thus, the article uses an intersectional approach to analyse the work currently performed by ASHAs, many of whom are Dalits – or "untouchables"[2] – as a case for voluntarism during the COVID-19 pandemic. After contextualising voluntarism within India's social development, neoliberal policies, and its healthcare system, the article turns its interests towards the ongoing pandemic to explore a) how biopolitical strategies use voluntarism during the COVID-19 crisis, b) what relevance voluntarism has for the state, and c) which role unpaid/underpaid community health workers perform to manage the pandemic nationally and locally. The assignment of very challenging tasks during the COVID-19 pandemic raises the question of whether this changed the low esteem attributed to care work and voluntary care workers in India. In state-sponsored social welfare schemes, the feminisation and voluntarisation of work are striking examples of care extractivism, intersectionality, and the continuous devaluation of care capacities (Wichterich 2019). The term care extractivism is used to map out, systematise, and theorise the recent scope of strategies that revise, intensify, or extend the devaluation and exploitation of care work in the context of the neoliberal welfare regime and privatisation of the public sector. Analogous to resource extractivism (Burchardt and Dietz 2014), care extractivism marks the intensified commodification and exploitation of care as a resource that shifts the burden of managing crises, including its costs and responsibilities, away from the state or the health industry. Extractivism is a development strategy and a mode of accumulation; it provides resources to the market at cheap prices and results in their depletion, whether in the environment or social reproduction.

The first part of the article analyses the interplay between the political economy of care in terms of the neoliberalisation of public policies and informalisation of labour, and the sociocultural economy of care in light of its norms, values, and the intersections of various power regimes. As social

she spent decades fighting for the rights of scheme workers and ASHAs. During my research in India in 2018 and 2019, she was one of my favourite informants, interviewees, and dialogue partners.

[2] In the Indian caste hierarchy, Dalits represent the lowest caste groups and must perform the most polluting and impure work.

reproduction and care are highly gendered, ethnicised, and racialised work, issues of how work is recognised, respected, and valorised as unskilled or skilled labour are fundamental and are intersectionally intertwined with caste and class categories.[3]

The second part of the article highlights how the Modi regime used the first wave of the COVID-19 crisis as an opportunity for the reckless extractivism of care work from these extremely low-paid, local women workers. In an authoritarian move, one million ASHAs, who were responsible for mother and childcare, as well as immunisation, were transformed into "frontline fighters" against the disease – often without proper protection or fair payment. Like in many other countries, healthcare workers were celebrated as fearless "heroines" by the Indian middle classes, giving previously unseen visibility to this traditionally invisible, low-valued care work.

The third part of the article focuses on nationwide organising and protests by ASHAs, whose key demand was for the regularisation of their labour. This mirrors the agency of the powerless and subalterns, and a feminisation of labour struggles. In July 2020, 600,000 ASHAs went on strike and demanded better payment and more recognition as well as appropriate social and physical protection. This became a model for the mobilisation of "honorary" and essential workers against the state's "structural carelessness" (Aulenbacher 2021).

The COVID-19 pandemic also determined the article's research methodology; the author initially established the empirical and theoretical groundwork for this article during a fellowship in 2018 and 2019. However, during the pandemic, Indian co-researchers were unable to travel to the countryside to support the empirical research. Therefore, the article partly relies on printed reports, newspapers, and journals rather than topical academic sources. The writing process was overshadowed by heart-breaking news about the pandemic's second wave in India, where many friends and colleagues struggled for oxygen and for their lives. The worsening situation led to a lack of communication and contact, which made the geographical distance between Europe and India and the involuntary mode of home research very painful.

[3] The groundwork for this study was done during a fellowship in 2018/19 based at the M.S. Merian-R. Tagore International Centre of Advanced Studies "Metamorphoses of the Political" (ICAS:MP), an Indo–German research cooperation funded by the German Federal Ministry of Education and Research (BMBF). All views expressed here are solely that of the author.

2. Voluntarism from Community Development to Neoliberal Welfare

> We have so many tasks to do. It is our duty to serve the community. But the government thinks it is just the same we do at home – now in the community. As we are not paid at home, the government doesn't want to pay us. They say: no job, no salary. But my family and the community believe it is a government job and we should bring home a salary. (Interview with USHA in Old Delhi, February 2019)[4]

In order to improve access to rural healthcare, the Indian government launched the National Rural Health Mission (NRHM) in 2005, which now has over one million ASHAs (*asha* means "hope" in Hindi). More recently, the government extended these services to urban areas using *urban social health activists* (USHAs). The NRHM is a scheme, or a state-sponsored temporary programme, which must be renewed after a certain number of years.

Presently, more than six million scheme workers, called *volunteers* or *activists*, run government schemes in India including kindergartens, school lunches, local midwiferies called *auxiliary nurse midwives* (ANMs), and the NRHM. These schemes are jointly financed by the state and one of the 28 states or eight union territories and provide care for the social reproduction of rural communities as "managers of poverty" (John 1996, 3071). Throughout the 45-year history of community development and anti-poverty schemes in India, top-down ordered voluntarism has functioned as the backbone of these schemes, while female workers' caring capacities has been their most valuable asset (Mane and Kandhekar 2014).

India's Integrated Child Development Scheme (ICDS) was conceptualised in 1975 with Anganwadi[5] workers, nursery teachers, as key actors. They were deemed as voluntary social workers in an imagined community solidarity economy, wherein scheme work is honorary. This voluntariness largely comprises unpaid work that is not considered employment in the public sector, but rather a gendered community service (*seva*). It denotes that women's caring for others is merely an extension of housework (Roychawdhury 2018; Sreerekha 2017; Chaudhary 2018[6]), while the stipulated honorarium is purported to be a gift from the state. Women are recruited from their communities, typically come from deprived households, are above 25 years old, and may be married, widowed, deserted, or divorced. The approach intentionally and positively discriminates against low-caste and low-class women. Basic

[4] Interview by the author in February 2019 in Old Delhi.

[5] *Anganwadi* is the Hindi word for "kindergarten" or "childcare centre."

[6] Manira Chaudhary, "'Taken for Granted and Ignored', Anganwadi Workers Demand Better Pay, Conditions," *The Wire*, 10 September 2018, https://thewire.in/labour/anganwadi-icds-child-development-ministry.

recruitment requirements are at least partial primary education, good communication skills, and an aptitude for social services, all of which imply existing social capital in the community. Thus, poor women in these villages are eager to become scheme workers, which they hope may lead to permanent and secure government employment (Sreerekha 2017, 168).

In Indian political thinking, voluntary social work at the grassroots level stands as a continuation of Gandhi's village self-rule and self-sufficiency (*gram swaraj*). Within the context of the 1970s JP Movement,[7] it also represents democracy from below and against corruption in the Indira Gandhi government. Democratic institutions like the local self-governance system, *panchayat,* expect the community to govern and control development programmes itself. From this Gandhian perspective, social development and care provision in, for, and by the community imply the sovereign organisation of solidarity and of a social common supported by a caring welfare state. However, considering that the Indian caste system is an impediment to community participation and development, communities are not homogeneous entities. Rather, they are determined by complex relations of power, privileges, exclusion, and dependencies linked to caste, class, gender, ethnicity, and religious biases (Sreerekha 2017, 190; Rao 2021).

Another catalyst for establishing the schemes in the communities was India's coercive family planning programme from the 1970s. In particular, the country's violent forced male sterilisation campaign created a deep mistrust against public health work in rural communities. Health workers were feared as government agents of population control, while people avoided health activities at rural primary health centres out of the fear of being captured and taken to sterilisation camps (Nair, Kirbat, and Sexton 2004, 27). This public resistance precipitated the political strategy to identify people from within the community who could act as mediators to implement government schemes. Deploying community-based grassroots workers was conceptualised as a bridge between people and the government to improve national programme outreach (Zafar 2021).

Given India's widespread rural poverty and its monetarised labour market, voluntarism is a paradigmatic form of care extractivism. However, the myth of honour and the narrative of women's empowerment obscures the financial and care extraction that arises through voluntarism. Because these workers are welfare beneficiaries themselves, community participation and solidarity are assumed to ensure low costs alongside high efficacy, accountability, and acceptance at the grassroots level (Sreerekha 2017, 253). Meanwhile, state practices are a mode of appropriating freely available care resources in the community. For example, not paying women scheme workers a regular wage is rooted in the assumption of a male breadwinner model that presumes

[7] This political movement was started in the Indian state of Bihar in 1974 and was led by the Gandhian socialist, Jayaprakash Narayan, who was known as JP.

women can afford to do honorary work, which Palriwala and Neetha (2012a, 175) call "gendered familialism." While the political and social contexts differ in India and Europe, the articles in this HSR Forum on Greece (Markantonatou 2021) and Turkey (Akkan 2021) point to similar gendered familistic assumptions in the context of the pandemic, which structured government measures. Thus, voluntarism must be explored as an ambivalent process between solidarity and coercion.

Current community development schemes are emblematic of the piecemeal, patchwork, and stratified way that India provides assistance to needy and deserving groups as a residual welfare state instead of having a comprehensive, citizen-oriented, and rights-based social policy (Palriwala and Neetha 2012a, 2012b). The country's economic liberalisation involved an immense drive for state-sponsored privatisation, while economic corporatisation changed the discourses and programmes related to development, welfare, and social justice. The neoliberal development path stipulates the state's withdrawal from welfare measures while giving preference to market forces. The Modi government made this neoliberal strategy clear in its first union budget, which reduced its allocation for ICDS by nearly 60 percent. This stood in contrast to the ruling party's earlier pledge in its election manifesto to increase scheme worker wages (Drèze 2016, 15). Despite the state's attempts to maintain its reputation of providing adequate welfare by introducing additional schemes, cost efficiency became the guiding imperative for how Indian public service reforms could overcome the fiscal crisis – a kind of neoliberal welfarism.

Manoeuvring between India's old gender norms of female service (*seva*) and modern gender norms of women's empowerment through wage labour, the neoliberal state's priority is to construct a cheap and docile care labour force available at the grassroots level while creating political legitimacy as a welfarist and developmentalist state. At the same time, the deeply patriarchal Indian state linked social and anti-poverty programmes to international development partnerships that depicted women's empowerment as a priority issue. Gender is inscribed into the state's structure, culture, and policies as well as into its development schemes. The state navigates between its neoliberal interests in cost-saving and austerity, and international development agencies, such as USAID, the World Bank, UNICEF, and Care, who support India's welfare schemes and care extraction through voluntarism. In other words, these agencies build their ostensible women's empowerment programmes upon women's unpaid work. For example, between 1994 and 2002, USAID invested $623 million US in ICDS, of which a portion went towards family planning (USAID/INDIA 2002).

3. ASHAs: Community Health Workers at Piece-Rate Wages

> What do we tell our family about our earnings when they are so low and don't even come on time? My in-laws are always taunting me on what work I do when I don't even get a decent income. There is no respect for us – neither in our own homes, nor at dispensaries, or in the community. This is injustice. (Interview with ASHA Workers by Seemi Zafar 2021)

In 2005, the NRHM was launched in response to concerns about the Indian public health system and enlisted ASHAs as a new type of local healthcare worker. The programme was developed within the context of an ongoing rural health crisis that was characterised by high maternal and child mortality as well as low immunisation rates against diseases like polio and the measles. ASHAs initially handled three main tasks under the NHRM: immunisation, promoting hospital births – which included accompanying pregnant women to the hospital – and reducing child and maternal mortality. In order to provide a minimum level of professionalism and quality care work, ASHAs receive training to ensure basic knowledge and skills and obtain drug kits (Saprii et al. 2015). The female *seva* stereotype also led to the government's decision to replace male *village health guides* with women under the Rural Health Scheme, thereby reinforcing India's strict gendered division of labour where poor women villagers are ideal worker-volunteers.

Under the auspices of neoliberalism, voluntarism took an extractivist turn from its community development and participatory orientation to an efficiency and cost-optimisation focus. Like industrial workers, ASHAs were constructed as voluntary piece-rate workers in a Taylorised way: They receive "incentives," but only collect their substandard payment after completing all the tasks related to institutional childbirth and pre- and ante-natal mother-and-child care and after meeting the targets for immunisation. Piece-rate payment introduced a market logic to Indian schemes, which coincided with the Anganwadi workers' organisation and struggle for recognition as workers and for adequate remuneration.

In total, these small honoraria and incentives translate into average monthly earnings of ₹2,000 to ₹4,500 (€22 to €50) for ASHAs, which is a significant contribution to their family income and survival strategies (National Health Mission 2018, 25). However, as with other scheme workers, ASHAs work without job security, career opportunities, and social benefits. Furthermore, scheme workers frequently experience pay delays that range between three and nine months, demonstrating their low value to the state and its bureaucratic indifference (Saprii et al. 2015). Likewise, these delays discourage women and make them feel exploited. Hence, these precarious, informal

labour relations make them highly vulnerable workers and constitute the framework of care extractivism.

In rural areas, one ASHA worker is expected to provide essential services to between 1,000 and 2,500 people; four to five ASHAs report to one supervising ANM at a *Primary Health Centre*. Each ANM is assigned to a population of 15,000 to 20,000, compared to the 1:5,000 norm advocated for by the World Health Organisation (WHO). In addition to these initial three main tasks, ASHAs' scope of work was extended to include administering family planning devices and administering medications to tuberculosis patients, and ultimately comprised 66 defined tasks (Sreerekha 2017, 159, 190; Prasad and Arathi 2020). Hence, the patient-to-health worker ratio and the overburden of numerous tasks are extraction strategies that further contradict voluntarism in the context of neoliberal governance and shrinking welfarism.

As ASHA responsibilities expanded, their control and monitoring intensified. Methods of institutionalised surveillance and discipline towards ASHAs that facilitate care extraction include permanent documentation and maintaining several registers as well as control through GPS and daily *WhatsApp* selfies (Bathia 2017, 40). From a Foucauldian perspective, these surveillance mechanisms operate as governance techniques and teach women self-governance and discipline. While these management methods purport to professionalise care work – and professionalisation can operate as a component of upgrading and recognition – they are intimidating to scheme workers and often accompanied by threats of dismissal for noncompliance. In his study on the ICDS, Gupta (2012) concludes that "the implementation of this program demonstrates that the affective dimension of state power has as much to do with care as with patrolling, exercising surveillance, and punishment" (Gupta 2012, 38).

This growing control and monitoring necessitate care workers to both accelerate and work overtime, while their extension of duties contradicts principles of voluntarism. This suggests that unpaid and underpaid care work in India's public schemes is being progressively steered towards neoliberal market principles of competition, efficiency, and increased productivity. At the same time, the emotional components of care work are typically ignored and devalued, which intensifies care extraction and leads to community workers feeling overburdened by tasks and expectations, which depletes their capacity for caring (Rai, Hoskyns, and Thomas 2011). The emotional and affective dimensions of governing the COVID-19 pandemic are also addressed in the articles on Austria (Dursun, Kettner, and Sauer 2021) and on Mali (Hasenöhrl 2021) in this HSR Forum.

When fulfilling their tasks, scheme workers construct a subjectivity of being workers, which is supported by the community's prevailing perception that they *are* government employees. Thus, scheme workers are proud to earn at least some money for their families; many enjoy breaking away from

the patriarchal confinement of the home and feel that they achieve a lot at work. This is a vital component of identity formation, which is reflected by their rejection of being described as volunteers or social activists (Sreerekha 2017, 199), and how they sometimes call themselves "teachers" (Gupta 2012, 269). Hence, these women integrate the hegemonic female ascription of caring and mothering into their identity as community workers, accepting the gendered division of labour.

When payments or programme funds fail to arrive, committed scheme workers often use their own money and proactively subsidise the programme's implementation – e.g., by covering pregnant women's transportation costs to a clinic. This points to a calculated financial extraction by the state in addition to care extraction from these women, who are categorised as poor. Thus, costs and pressure are transferred from the fiscal squeeze of the welfare state to the individual welfare providers.

Scheme workers are wedged between competing interests and expectations, namely from the state and local bureaucracy, the local community, and their own families. They are expected to function as intermediaries between villagers and the Indian public health system. Thus, conflicts inevitably arise between scheme workers and communities when public administration fails to provide food or medications, for which the communities blame the scheme workers. These voluntary workers are channelled through a form of bureaucracy, which acts as a machine that produces indifference towards the poor. Such indifference encourages individual officials to appropriate funds for personal gain through clientelism and systems of extra and non-material benefits (Gupta 2012, 6). From this bureaucratic perspective, welfare provisions to the poor are therefore distributed as charity rather than as citizens' rights.

While religious sentiments and motherly affection are often mobilised in India, the ideology of honour attributed to voluntarism lacks monetary benefits and does not lead to recognition. The imagined culture of honour contributes to an idiosyncratic condition that violates women's dignity and labour rights by a "state without honour," as stressed by Sreerekha (2017). For example, the state does not provide welfare to its welfare workers, and ASHAs have no right to maternity leave. Likewise, the state did not include female scheme workers in the 2010 Bill on Protection of Women against Sexual Harassment, despite frequent complaints from ASHAs about sexual abuse during home visits and when accompanying expecting women to hospitals at night.

Statistics imply that ASHAs achieved increased rural immunisation rates, hospital deliveries, and the reduction of malnutrition (NITI 2017, 126). Honorary work is a pillar of the haphazard mode of delivering social services in a neoliberal context and of externalising the state's welfare responsibility to one of the most vulnerable groups in society. Therefore, the combination of voluntarism and the continuing devaluation of work and workers are an effective method of cost optimisation. However, scheme workers are also

empowered by the social capital and prestige they maintain in the community and have a reputation for being gatekeepers (Pattenden 2016, 149). During elections, their public power as influencers becomes apparent and all party-affiliated trade unions try to mobilise scheme workers due to their local popularity.

4. Stereotyping and Stigmatisation: The Sociocultural Economy of Healthcare Work

The work performed by ASHAs shares many similarities with nursing, whose sociocultural and political economy remains deeply rooted in the Indian gendered division of labour, the female connotation of care work, and *seva*. Brahminic norms derived from concepts of purity and impurity attribute a low status and invisibility to healthcare work. Besides gender, the intersections of caste, class, ethnicity, and religion have been decisive for status issues since colonial concepts of nursing first emerged in India. Work that involves direct contact with bodies and bodily fluids is assigned close to midwifery and cleaning, untouchability, and pollution (Healey 2013).[8] Hence, by being considered women's work first and polluting second, nursing and healthcare work was ascribed very low value and esteem in India.

The female body and female morality are central to nursing and discourses surrounding the subjectivities of nurses. Enduring prejudices persist about ASHAs' morality because they must visit pregnant women's homes, meet their husbands, and accompany these women to the hospital – (often) at night – which evoke connotations of liberal sexual behaviour. This sexualised image was overtly assigned to ASHAs when the condoms they were expected to freely distribute throughout communities were marked with "ASHA," insinuating their permissiveness. In response, ASHAs successfully protested against distributing the labelled condoms.[9]

To counter stereotypes of impurity and permissiveness, Christian missions added nobleness and discipline to nursing through concepts of self-sacrifice and de-sexualisation, like nuns, who were symbolised in starched white *sister* uniforms (Nair and Healey 2006, 4). However, ASHAs insisted on a pink sari uniform to construct a collective identity and dignity in response to their discrimination and humiliation as impure workers at hospitals and

[8] For high-caste women, practicing polluting midwifery work was taboo, and most midwives were *Dalits* – so-called *untouchables*.

[9] Shruti Tomar, "Word 'Asha' dropped from govt-supplied condom packets following protest," *Hindustan Times*, 16 July 2018, https://www.hindustantimes.com/india-news/word-asha-dropped-from-govt-supplied-condom-packets-following-protest/story-tlJQnzNoNUOyO83LkYf8LI.html.

dispensaries; for example, when they are not permitted to sit, use a toilet, or when they are requested to wait outside.

The unsympathetic regime of superiority and subordination within the Indian health system mirrors and interacts with the country's societal scope of discrimination and hierarchisation. Skilled health personnel transfer polluting tasks, bodily work, and prejudices about morality to nursing aides, trainees, unskilled casual nurses, and cleaners. In doing so, the former promotes and supports the healthcare extraction of *others* throughout the entire health system. Ray observes that "the feminine is relegated to a new other" (Ray 2016, 65) in which professional upgrading at the top segment of the healthcare hierarchy leans towards administrative, managerial, and medical tasks. This corresponds to the downgrading and devalorisation of the health system's lower segments, which are linked to caste, class, and ethnicity. For example, doctors are valued as mostly masculine, upper-caste curers who are associated with scientific knowledge and technology, while nurses are portrayed as feminine, lower-caste carers. This entanglement of traditional norms and economic principles of unequal exchange thus contributes to structural discrimination and hierarchisation that legitimises care extraction in the health sector (Valiani 2012).

Furthermore, despite their *seva* ethos and successful programme implementation, ASHAs have also been ascribed a stigmatising counter narrative of petty corruption and irregularities like other scheme workers (Saxena and Srivastava 2009). While reports about widespread resource misallocation claim that up to 30 percent of allotted resources are siphoned away by politicians and bureaucrats, scheme workers are also included in the narrative of corruption. As a result, they face allegations of resource misuse like absenteeism, poor attention to core responsibilities, a lack of accountability, and a poor quality of services. Women are often enticed into corrupt – but usually petty – practices as part of a larger social network, e.g., because officials demand bribes for selecting scheme workers (Gupta 2012, 259; Dasgupta and Sandhya 2019, 51). However, ASHAs tend to engage in petty corruption to offset their insufficient and irregular remuneration, reflecting how voluntarism itself produces this form of petty corruption. This includes selling biscuits meant for children at the market as well as faking the number of children at Anganwadi centres or hospital deliveries to increase their income. Hence, these caregivers are caught in a structural flaw: Even if petty corruption is part of their survival strategy and an outcome of not being paid for their work, this kind of discourse is instrumental to perpetuating the little respect and recognition received by ASHAs and their work. Stigmatisation articulates how people are devalorised, which means ASHAs' image and esteem are caught in the dilemma between care ethics and petty corruption, nobleness and impurity, empowerment and humiliation.

5. Warriors for People's Health: Left Alone in the Pandemic

> During the lockdown, when everyone was at home, we were going out like a warrior and spreading awareness among people. Simultaneously, we were also constantly worried about our families. After a day's work, we would come home but stay away from the family. Staying away from children was especially challenging. However, these times have made us more confident, we can work in any situation now! (ASHA worker in Bhopal, Madhya Pradesh; cited from Accountability Initiative 2020)[10]

Since the onset of the COVID-19 pandemic, a narrative of community health workers has portrayed them as "forefront warriors" (Deccan Herald, 10 October 2020), "foot soldiers of the battle,"[11] "frontline health soldier[s],"[12] the "first line of defense" (Prasad 2020), and "unsung heroes."[13] This rhetoric spread across the media amidst a militaristic discourse of a "war" against the virus (Ray 2020). Prime Minister Modi, employing a gesture of symbolic populism, instructed Indian citizens to clap, ring bells, or beat plates for healthcare workers "to boost their morale and salute their service."[14]

The reason for presenting the work performed by ASHAs and other scheme workers as heroic and self-sacrificing was paradoxical in that the riskiest healthcare labour was shifted to the least-paid and most-neglected health workers (Shanmugham 2020). Similar processes of devaluating so-called "essential workers" are described by Maria Markantonatou (2021) in the Greek context in her contribution to this HSR Forum. However, the orchestrated applause for health workers could not compensate for the state's indifference towards the dignity, rights, and well-being of informal, vulnerable workers. When the government introduced a nationwide lockdown in 2020 after a large-scale COVID-19 outbreak that forced millions of migrant workers to return to the countryside from cities, ASHAs were tasked with village home visits and placing migrant workers under mandatory quarantine. After receiving

[10] Accountability Initiative. "After The Pandemic, This ASHA Worker Says She Can Work Any Serious Situation," *Feminism India*, 08 December 2020, https://feminisminindia.com/2020/12/08/after-the-pandemic-asha-worker-says-work-any-serious-situation/.

[11] Mythreyee Ramesh, "9 Lakh ASHA Women Fight COVID-19, With Just Dupattas as Protection," *The Quint*, 07 April 2020, https://www.thequint.com/voices/women/asha-workers-in-fighting-coronavirus-in-india.

[12] Puja Awasthi, "The life of ASHA workers in the time of COVID-19," *The Week*, 10 April 2020, https://www.theweek.in/news/india/2020/04/10/the-life-of-asha-workers-in-the-time-of-covid-19.html.

[13] Manu Balachandran, "Unsung heroes: ASHA workers, the foot soldiers of battle against Covid-19," *Forbes India*, 8 January 2021, https://www.forbesindia.com/article/the-unsung-heroes-of-covid19/unsung-heroes-asha-workers-the-foot-soldiers-of-battle-against-covid19/65579/1.

[14] "Full text of PM Modi's speech on coronavirus pandemic," Sify, last modified 20 March 2021, https://www.sify.com/news/full-text-of-pm-modis-speech-on-coronavirus-pandemic-news-topnews-udubeVcbagcdb.html.

a short phone training session from their supervisors,[15] ASHAs typically had to visit 25 to 50 households daily, walking up to 20 km door-to-door each day while carrying a large number of documents; others had to travel to another part of their district without being provided proper means of transportation by the government. Additionally, they were required to check family members for influenza-like symptoms and educate them about precautionary measures like social distancing and hygiene. In case of infection, ASHAs had to quarantine patients by putting a sticker on their door or referring them to the nearest subdistrict hospital (Prasad 2020). During shifts, which lasted more than 12 hours, they were also expected to log extensive details in survey reports and quarantine schedules.

In the South Indian state of Karnataka, 42,000 ASHAs conducted a vulnerability mapping survey of 159 million households.[16] Teams of ASHAs and ANMs were transported from the outskirts of Delhi and deployed to the urban area to screen and map how the virus was spreading.[17] Others were transported to nearby airports to screen travellers' temperatures and symptoms, for which they did not receive additional payment.[18] These strategies of externalisation and care extractivism capitalised on the cheapest resource in the Indian health system and shifted risks to its most vulnerable workers for the sake of the nation – in particular, the middle classes.

Initially, the Indian state government knowingly put ASHAs at a high risk of contracting COVID-19 by failing to provide proper protective equipment like masks or gloves. Instead, ASHAs were asked to pull their saris over their noses and mouths, or to buy their own hand sanitisers and masks,[19] meaning the state shifted both risks and costs to the most precarious actors at the bottom of the healthcare chain. While working, ASHAs often could not access safe drinking water, toilets, or proper food, and did not receive transportation (Muhta 2020). Thus, they were forced to use their own means to purchase protective kits, masks, and gloves. Furthermore, some ASHAs who lacked childcare had to bring their small children with them, while others worked

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[15] Puja Awasthi, "The life of ASHA workers in the time of COVID-19," *The Week,* 10 April 2020, https://www.theweek.in/news/india/2020/04/10/the-life-of-asha-workers-in-the-time-of-covid-19.html.

[16] "42,000 Asha workers map 1.59 crore homes in Karnataka for coronavirus," newstribe, accessed 11 November 2021, https://www.newstribe.in/42000-asha-workers-map-1-59-crore-homes-in-karnataka-for-coronavirus/.

[17] Risha Chitlangia, "Asha workers fight on 2 fronts: Against Covid-19, for better pay," *Hindustan Times*, 28 June 2020, https://www.hindustantimes.com/delhi-news/asha-workers-continue-to-fight-for-better-salaries/story-tF1HakHmfxfJeBZpEtMTiO.html.

[18] Deepanshu Mohan, Jignesh Mistry, Advaita Singh, Sunanda Mishra and Shivani Agarwal, "Travails of ASHA Workers During COVID-19 Call for Renewed Focus on Public Health," *The Wire*, 12 January 2021, https://thewire.in/health/covid-19-frontline-workers-public-health.

[19] Mythreyee Ramesh, "9 Lakh ASHA Women Fight COVID-19, With Just Dupattas as Protection," The Quint, 07 April 2020, https://www.thequint.com/voices/women/asha-workers-in-fighting-coronavirus-in-india.

while pregnant. In a formidable act of indifference, government officials paradoxically recommended ASHAs to follow social distancing guidelines despite requiring them to collect information from members of their communities. Seeing how the state arguably sacrificed ASHAs and treated them as a disposable and renewable resource, it is unsurprising that such a high number were infected by COVID-19 and died during the pandemic's first wave.[20]

Social distancing was a controversial concept in India due to the nature of casteism. For example, Dalit activists refused the notion that it was a mode of social protection from the virus's spread after having spent their entire lives engaging in practices of social distancing and exclusion. In this sense, distancing risks officially reenforcing concepts of untouchability and the low esteem ascribed to Dalits and their labour (Patil 2021). In partial response to this debate over terminology, the WHO switched to describing "physical distancing."

During the first wave of the COVID-19 pandemic, the Indian government announced that it would pay ASHAs a monthly COVID-19 allowance of ₹1,000 (€11 Euro) on top of their average monthly honorarium. This translated into about ₹33 (€0.37) per day and less than ₹1 per household.[21] Like regular payments, this small COVID-19 allowance was delayed. Some state governments pledged to double basic pay for doctors, laboratory technicians, and ambulance drivers – but not ASHAs. Additionally, the incentives ASHAs normally receive for each institutional childbirth delivery or full immunisation was waived during the pandemic. Thus, by being controlled and devalued, ASHAs' voluntary work represents a neoliberal form of forced labour.

COVID-19 testing and tracing duties meant ASHAs had either had little or no time to perform their regular duties like attending to pregnant women, providing family planning counselling, and supplying contraceptives. However, they sometimes attended late-night childbirth deliveries because the health crisis created dysfunction at public district hospitals. Therefore, ASHAs went against their training and recommended that expecting mothers give birth at home. Furthermore, contraceptive demand increased when migrant workers returned home to their villages during lockdown, but contraceptives were only available from the market at high prices. Due to this shortage, women desperately asked ASHAs to provide condoms (Priyadarshini and Chaudhary 2020). However, ASHAs had not been supplied condoms, nor nutritional supplements nor even iron tablets for expecting and lactating mothers.

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[20] "Covid-19: Centre puts number of doctor deaths at 162, medical body says over 700 have died," *Scroll.in*, 04 February 2021, https://scroll.in/latest/985921/covid-19-centre-puts-number-of-doctor-deaths-at-162-medical-body-says-over-700-have-died.

[21] "Paid Rs 33 a day, ASHA workers protest govt 'apathy'," *The Tribune*, 30 April 2020, https://www.tribuneindia.com/news/patiala/paid-rs-33-a-day-asha-workers-protest-govt-apathy-78193.

Despite being essential to their communities, health workers found themselves wedged between the two disapproving forces: their villages and their own families. Villagers mistrusted them because of being asked for their travel and health histories. Suspicious community members attacked and chased ASHAs away, while higher-caste and upper-class people, like the landowner caste, abused Dalit ASHAs as a form of "caste supremacy" (Shanmugham 2020). Workers also faced gendered harassment from male migrant workers who returned from cities and did not want to disclose their health, travel, and contact data (Prasad 2020). This issue must be considered within the context of India's 2019 Citizen Amendment Act and its new citizen register, which defined who illegal migrants and non-Hindus were, depriving their right to Indian citizenship. Furthermore, ASHAs were accused of transmitting COVID-19 infections and not wearing protective gear.

ASHAs' own families frequently replicated this community reproach. For example, husbands often feared being infected by their wives and tried to persuade them to not work for such little remuneration.[22] The women were also accused of neglecting household chores while being additionally burdened by expectations to support their husbands during the harvest season.[23] In some cases, husbands refused to let their wives continue their ASHA jobs; others resigned to avoid infecting their children. Nevertheless, most ASHAs remained at work because they considered it a social duty. As India's entire health infrastructure was collapsing, some ASHAs also forwarded money to cover medication costs for COVID-19 patients.[24]

The situation created a dilemma that confronted ASHAs with competing expectations from the state, the community, and their own families, yet they received no protection from others, even as they struggled with multiple burdens and risks. Although many were exhausted after the first wave of the COVID-19 pandemic, they resumed their pre-pandemic maternal-and-newborn care routine. Notably, many ASHAs later worked extra shifts to compensate for the lack of service provision during the pandemic's initial peak.[25]

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[22] Pratichi Research Team, "COVID-19 and India's Unsung Frontline Health and Childcare Workers," *The Hindu*, 15 October 2020, https://thewire.in/society/covid-19-india-frontline-health-workers.

[23] "ASHAs pillars of COVID-19 response, reached out to 39 cr. people, says Health ministry," *The Hindu,* 05 July 2020, https://www.thehindu.com/news/national/ashas-pillars-of-covid-19-response-reached-out-to-39-cr-people-says-health-ministry/article31994318.ece.

[24] Manu Balachandran, "Unsung heroes: ASHA workers, the foot soldiers of battle against Covid-19," *Forbes India*, 8 January 2021, https://www.forbesindia.com/article/the-unsung-heroes-of-covid19/unsung-heroes-asha-workers-the-foot-soldiers-of-battle-against-covid19/65579/1.

[25] Deepanshu Mohan, Jignesh Mistry, Advaita Singh, Sunanda Mishra and Shivani Agarwal, "Travails of ASHA Workers During COVID-19 Call for Renewed Focus on Public Health," *The Wire*, 12 January 2021, https://thewire.in/health/covid-19-frontline-workers-public-health.

6. Biopolitics of the Responsibilisation of the Weakest

> We help the state so much. (ASHA worker at a rally in New Delhi; cited from timesnownews 2019)[26]
>
> We are paying the price in our community for the government's inability to keep us safe. (ASHA worker in Assam; cited from Rao 2020)[27]

How do these women persevere against all odds, harassment, and hostility? How do they negotiate multiple dilemmas and rumours? It is clear that their motivation goes beyond neoclassical economic notions of rationality, since their commitment is driven by a care ethos for the community, a self-affirming awareness of their social responsibility, and the importance of their work – as well as the desire to become "professionals."[28] Eventually, ASHAs' experiences during the pandemic contributed to improved self-esteem and self-appreciation, while many villagers who received their support expressed appreciation.

Due to casteism, India's millions of sanitation workers faced a similar dilemma as the ASHAs, due to being trapped by poverty, a lack of job alternatives, and the responsibility they felt towards people's well-being while being immersed in a constant site of conflict between appreciation and condemnation. Although not explicitly defined as such, these sanitation jobs are arguably another form of healthcare work for society (Karpagam and Dsouza 2021).

Manual scavenging, possibly the dirtiest and most hazardous work performed in India, is ascribed with disrespect and contempt towards Dalit people. Sanitation work – which includes collecting garbage as well as cleaning drains, sewage systems, and waste from hospitals and corpses – downloads health risks to the worker. At the same time, being denied protective gear and technical equipment helps construct workers' low status and vulnerability. Toxic sewage system gases have been responsible for the deaths of many sanitation workers, reflecting their treatment as a disposable resource or an extension of human waste.

Half of India's garbage collectors and street sweepers are women. Even before the COVID-19 pandemic, female sanitation workers experienced low renumeration and lacked maternity leave (Salve and Jungari 2020). Unlike all

[26] "Delhi Chalo Agitation: Women government workers demand labour act implementation," *timesnownews*, accessed 11 November 2021, https://www.timesnownews.com/videos/mirror-now/society/delhi-chalo-agitation-women-government-workers-demand-labour-act-implementation/21959.

[27] Bhanupriya Rao, "Anger, Distress Among India's Frontline Workers In Fight Against Covid-19," *Behanbox*, accessed 11 November 2021, https://behanbox.com/2020/06/12/anger-distress-among-indias-frontline-workers-in-fight-against-covid-19/.

[28] Deepanshu Mohan, Jignesh Mistry, Advaita Singh, Sunanda Mishra and Shivani Agarwal, "Travails of ASHA Workers During COVID-19 Call for Renewed Focus on Public Health," *The Wire*, 12 January 2021, https://thewire.in/health/covid-19-frontline-workers-public-health.

other migrant workers, who were driven out of cities during the 2020 lockdown, sanitation workers were forced to stay. Like ASHAs, they insisted on maintaining their community service through this essential but high-risk work. Some municipalities paid workers a risk premium during the COVID-19 crisis, although it was markedly gendered at ₹250 per day for women and ₹500 for men (Shanmugham 2020).

Due to few reported infections, the South Indian state of Kerala stood out as a unique exception during the first wave of the COVID-19 pandemic and served as a model for managing the crisis. The state has a long history of high social development that arose from the 1996 People's Plan Campaign for decentralised governance. The plan built on community participation and a network of grassroots solidarity groups and includes a prominent community-based health structure run by *Kudumbashree*, a large grassroots women's organisation. ASHAs became integrated into this self-organised, voluntary community governance and were asked by political parties to run as candidates for elected positions in local governance institutions. In 2018, ASHAs became key actors during the Nipah virus outbreak for their role in a local test-trace-isolate-support strategy. This experience helped them prepare to monitor and control the eventual spread of COVID-19 in a broader context of village solidarity work. Therefore, ASHAs in Kerala work with a strong sense of solidarity are well-trusted by their communities. Unlike ASHAs in other parts of India, they did not share the feeling of being abandoned by the state. However, they echoed the common demand from ASHAs elsewhere to receive treatment as a regularised workforce (Prasad and Arathi 2020).

When India's COVID-19 vaccination campaign began in January 2021, health workers, including community mother-and-child-care-workers, were amongst the first offered vaccinations because of being COVID-19 "warriors" (Saikia 2021).[29] However, widespread vaccine hesitancy in India left ASHAs and other health workers conflicted over their personal safety and the efficacy of the two Indian vaccines offered. These vaccinations only received weak approval from the scientific community due to the observed risk of adverse effects and a lack of large-scale trial data. While the government defined health workers as the campaign's first beneficiaries, many felt like they were being used as test subjects – especially after one ASHA died following her vaccination (ibid.). Hence, this ostensible prioritisation of healthcare workers reveals another way that health risks are externalised to lower classes and castes in Indian society and reflects their treatment as subalterns and others who must sacrifice themselves for society.

During the COVID-19 vaccination campaign, ANMs and ASHAs were mobilised as a vaccination "army" because of their previous success in organising

[29] Arunabh Saikia, "First to get Covid-19 vaccine, India's healthcare workers are torn between duty and personal safety," *Scroll.in*, 13 January 2021, https://scroll.in/article/983764/first-to-get-covid-19-vaccine-indias-healthcare-workers-are-torn-between-duty-and-personal-safety.

child immunisations throughout in the country.[30] By contrast, the 2021 vaccination campaign was contingent on workers' efforts in their own communities, including persuading vaccine-hesitant people.

These pandemic policies must be considered in light of India's notoriously low health budget. At 1.15 percent of the GDP, and average healthcare spending costs of ₹6,044 per person (€66), India ranks 184th out of 191 countries according to the WHO.[31] By comparison, neighbouring countries like Sri Lanka, China, and Thailand spend three to four times more per capita. India's rural healthcare is impaired by a severe medical professional shortage, with only a quarter of Indian doctors working in the countryside. Although India has pledged to increase healthcare spending to 2.5 percent of its GDP by 2025, it is an unrealistic goal given the insufficient health budget allocation announced for 2020–2021, which does not include an increase for centrally sponsored schemes or the NHM.[32] Consequently, despite the pandemic's role in magnifying the deficiencies in the Indian public healthcare system, this trend of underfunding is expected to persist.

The Indian government justified its heavy-handed approach to the March 2020 lockdown by arguing that it was necessary to buy time while building up its capacity to treat the large number of expected COVID-19 patients. These efforts were concentrated on public hospitals and involved converting secondary and tertiary hospitals into COVID-19 centres by discharging low-income patients who had no alternative options to remain hospitalised. Public hospitals, labs, and health facilities were primarily tasked with testing, caring for, and curing COVID-19 patients. Meanwhile, because other important health services were suspended to increase COVID-19 capacities, patients suffering from chronic illnesses or life-threatening conditions like cancer experienced significant complications due to the sudden discontinuity of care (AISPN 2020).

In violation of the Essential Services Maintenance Act, many private hospitals reduced their services or closed down altogether by refusing to provide critical care. Those that experienced financial losses requested government tax relief, while others overcharged and earned extra profits from their services. Unlike other countries, the Indian government did not regulate or control corporate hospitals before or during the COVID-19 crisis. In her

[30] Manavi Kapur, "Behind India's coronavirus vaccine plan is an army of poorly paid female health workers," *Quartz India,* 15 January 2021, https://qz.com/india/1957664/asha-workers-midwives-key-for-indias-coronavirus-vaccine-plan/.

[31] "Budget 2020 Expectations for Indian Health Care Sector", Financial Express, accessed 11 November 2021, https://www.financialexpress.com/budget/budget-2020-expectations-for-indias-healthcare-sector/1842519/.

[32] Rajeev Ahuja and Amit Kumar,"Health budget: blessing in disguise," Healthworld, accessed 11 November 2021, https://health.economictimes.indiatimes.com/news/industry/health-budget-blessing-in-disguise/73895586.

contribution to this HSR Forum, Beverley Skeggs (2021) labels this economy of carelessness in the UK "necroeconomics."

The violations of human rights and dignity during the COVID-19 pandemic are a form of biopolitics that, according to Foucault (2008), govern, survey, administer, and control populations in order to control their lives. During the pandemic, India's governance that concerns people's health, housing, and mobility led to reckless decisions about the life and death of certain groups of citizens. Thus, in an emergency contextualised by neoliberalism, the activating and mobilising state became more demanding and more extractivist for the sake of its primary constituency – the middle-class. By reducing public funds, the state withdrew from its responsibilities for social commons, and shifted costs, risks, and work burdens to precarious workers such as scheme workers.

Regarding unpaid women's work, feminist political economist Diane Elson describes the "downloading of risk to the kitchen" to depict a typical pattern during shocks like structural adjustment measures and financial crises (Elson 2002). During emergencies, women's unpaid work is used as a shock absorber, wherein voluntary scheme workers subsidise public welfare expenditure (Barria et al. 2018) while welfare becomes workfare (Gupta 2012, 276; Sreerekha 2017, 252). Transferring responsibility to the individual community worker coincided with other methods of discipline and control that resulted in the non-provision of protection and increased documentation during India's COVID-19 crisis. Responsibilisation means shifting the work burden from the formal public health sector to informal and grassroots voluntary work, which is assumed to be too docile and weak to stand up for itself.

7. Labour Conflicts and Boundary Struggles

> We are no longer the ASHA workers of 2005 [...] We have learnt to raise our voices for our demands. (ASHA worker in Madhya Pradesh; cited from Chowdhury 2020)[33]

Over time, India's scheme workers have developed an identity of being *real* workers. Demanding sari uniforms shows their ambition to shape their identity as a particular class of working women. By opposing an ideology of voluntarism and honour, their core demand is for regularisation or being entitled to labour rights. The struggle for better remuneration is situated within a comprehensive agenda for improved labour rights, social protection, and respect that reflects ongoing frustration about scheme workers' persistent degradation, lack of payment or social security, and career opportunities.

[33] Shreya Dutta Chowdhury, "ASHA Workers Criminalised For Fighting For Their Rights," Behanbox, accessed 11 November 2021, https://behanbox.com/2020/10/21/3-states-wage-war-against-indias-corona-warriors/.

The state's failure to recognise their work and achievements is seen as humiliating and a violation of their dignity as well as a catalyst for worker protests and struggles.

By collectively challenging their honorary status and actively engaging in protests over the past 20 years, scheme workers have challenged the prevailing perception in India that female workers are docile and submissive. In many states, scheme workers have formed *sanghas*/*sangathans* (associations, assemblies) at the rural bloc level to develop collective agency and associational power. These are sometimes supported by NGOs like women's rights organisations and larger movements like health or human rights movements and are occasionally linked to (party-affiliated) trade unions. India's trade unions have long argued that it is a "matter of national shame" that the workforce charged with combatting community-based poverty is impoverished itself (CITU December 2018, 26). Hence, these unions promise to both help scheme workers improve their economic standing and help them gain dignity.

In 2006, India's Supreme Court rejected an application from the Anganwadi Workers Union to be recognised and paid as workers. The Court insisted that these workers do not hold civil posts, meaning they are volunteers rather than public servants (Sreerekha 2012, 224). Following this legal setback, scheme workers intensified their direct confrontations, protests, and strikes at the state and national levels. By challenging what society and the state define as normal and natural, the protest movement became a political school of civil disobedience for scheme workers. For ASHAs, their successful campaign for dignity against condoms labelled "ASHA" was paradigmatic.[34]

Anganwadi workers are considered the best-organised group of informal workers in India, while ASHAs are seen as less organised. However, scheme-based organising promotes a highly fragmented topography of organisations and unions. For example, scheme workers have started unions along caste lines in Haryana (Workshop Report 2016, 7). While this may help connect with Dalit sections of the workforce, fragmentation tends to weaken bargaining power.

After long strikes in 2018, the Indian government pledged to increase payments for ASHAs and Anganwadi workers. Although this success was the result of a long-fought battle waged by care workers, the pledge only constituted an incremental increase and failed to address necessary structural changes to the work paradigm in government schemes or ongoing forms of care extraction like voluntarism.

In response to being exposed to hazardous conditions and their lack of protection, the state's marked disrespect and recklessness towards ASHAs

[34] Shivani Azad, "Accredited Social Health Activist workers protest against 'Asha Condom'," *Times of India*, 14 July 2016, https://timesofindia.indiatimes.com/city/dehradun/Accredited-Social-Health-Activist-workers-protest-against-ASHA-Condom/articleshow/53212912.cms.

encouraged them to protest and strike during the COVID-19 pandemic. ASHAs mobilised the associational power that they had gradually achieved in terms of numbers and collective agency over time. When rumours began to spread that hundreds of ASHAs tested positive for COVID-19, were hospitalised, or died in 2020, ASHA workers unions and associations blamed state governments for structural negligence and apathy and amplified their demand for personal protective kits.[35] ASHAs boycotted working in several states over a lack of protective gear and payment. In response, some states criminalised workers for their advocacy, including by filing police charges, threatening dismissal, or removing them from their jobs until the massive protests ended.

By elevating their systemic relevance as essential service providers, the COVID-19 pandemic introduced better opportunities for structural power through bargaining power. Nearly 600,000 ASHAs participated in a two-day nationwide protest to demand a minimum wage of ₹12,000 (€134), a ₹10,000 (€111) lockdown allowance, protection kits, immediate arrear payments, and assurance that their families would receive compensation in the event that ASHAs were injured, infected, or died as a result of their work.[36] In Karnataka 42,000 ASHAs went on strike for over two weeks and were sometimes joined by 17,000 sanitation workers.[37] These protests represented a fight against unpaid care extractivism and deploying ASHAs as shock absorbers for the COVID-19 pandemic. Although ASHAs appeared to have gained bargaining power from state and community dependence on their services, they were unable to change the structures of care extractivism or the risk externalisation outside the formal public health sector. However, the power resources approach suggests these workers lacked the institutional power to afford them opportunities where they could influence institutional arrangements or change existing structures (Schmalz, Ludwig, and Webster 2018).

The division of paid and unpaid work, formal and informal work, and production and social reproduction is at once a bread-and-butter conflict and – drawing on Nancy Fraser – a "boundary struggle" (Fraser 2016, 116). This boundary struggle challenged the docility ascribed to the voluntary healthcare workforce, who empowered themselves through their resistance. Hence, this situation mirrors a new type of labour struggle and organising –

[35] Divya Goyal and Kamaldeep Singh Brar, "After four test positive, Punjab ASHA workers ask: 'Why should we put our lives in danger?'," *The Indian Express*, 4 May 2020, https://indianexpress.com/article/india/after-four-test-positive-asha-workers-ask-why-should-we-put-our-lives-in-danger-6392288/.

[36] Nalini Ravichandran, "As COVID-19 Sweeps Karnataka, ASHA Workers, AYUSH Doctors Strike for Better Pay," *The Wire*, 14 July 2020, https://thewire.in/rights/covid-19-karnataka-asha-workers-ayush-doctors-strike-pay.

[37] Ronak Chhabra, "Karnataka: ASHA, Sanitation Workers Battle Govt Neglect Amid Pandemic," *Newsclick*, 24 July 2020, https://www.newsclick.in/karnataka-ASHA-sanitation-workers-battle-govt-neglect-pandemic.

namely the feminisation of protests – an emphasis on care work, and the implied care-recognition gap and care-pay gap.

8. Conclusions

When describing "coronacapitalism" in India, Nivedita Menon (2020) declared that forced labour exists at the lower end of authoritarianism, while digital surveillance – which was spearheaded during the COVID-19 pandemic – exists at the higher end. Healthcare work performed by ASHAs is paradigmatic to both ends of this spectrum, as demonstrated by how the authoritarian Indian governance regime intensified care extractivism from voluntary community health workers. Care extraction is a systematic manner of colonising women's unpaid and underpaid reproductive work, and an expropriation of care energies for the sake of crisis management and cost reduction. Analysing these extractivist strategies helps clarify and politicise India's ongoing low social and monetary valorisation of care work in public schemes within the context of shrinking welfarism. Here, the core mechanism is voluntarisation as a gendered, modernised form of bonded labour and a state strategy to shift responsibility and risks to the individual community worker. This individualisation and communitarisation under the banner of solidarity and honour represents a neoliberal manner of relieving the state of social duties and costs. Likewise, digitalised documentation, stereotyping, and the stigmatisation of women, as well as the indifference towards their safety needs and health risks, characterises well the low value assigned to this essential work by the Indian state – even at a time when ASHAs are celebrated as heroines by the urban, middle-class public.

The neoliberal welfare state downloads costs and risks to community workers, thereby diminishing its own health and welfare responsibilities. The activating state mobilises community and solidarity resources while ignoring labour rights, which included voluntary informal labour during the COVID-19 pandemic in India. Additionally, the reckless and careless state curtailed general labour rights through a labour law amendment, which enabled, for example, extending daily working time to 12 hours. Extracting care from female grassroots workers is a strategy that externalises risks and costs outside of public welfare and health policies to the community area, and outside of the formal labour market to informal, feminised, reproductive labour.

However, during the COVID-19 pandemic, scheme workers started organising massive protests against old and new strategies of devaluation and care extraction. Their key regularisation demand is demonstrated through their fight for labour rights (Nirula 2015) and the boundary struggle over who pays for the costs of social reproduction, both in general and during the pandemic. The strikes indicate ASHAs' changing subjectivities and identities as workers,

and a feminisation of labour struggles in sectors where the indispensability of essential services made strikes previously unthinkable because of care ethics and the assumed docility of female workers.

Transferring responsibility, risks, and workloads to ASHAs during the COVID-19 pandemic reflected political practices of doing vulnerability at the intersection of gender and caste. This intensified the stratified reproduction and reinforcement of India's caste system and casteism at the expense of an already vulnerable and poor group of healthcare workers. However, the ASHA protests and strikes show that rejecting this form of constructing caste- and gender-specific vulnerability and disposability is achievable, as is their fight for empowerment as regular workers who are entitled to labour rights as well as social and physical protection.

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