

Intimate Labor at Biomedical Frontlines: Situated Knowledges of Female Community Health Workers in the Management of COVID-19 in India

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Abstract

Media reports of the COVID-19 pandemic in India have highlighted the important role that India's female community health workers, the Accredited Social Health Activists (ASHAs), have played in managing COVID infections in India. This paper explores the epistemic basis of ASHA work to understand the significance of their role. Through a discourse analysis of textual media articles, we show that the ASHAs' routine and COVID-related caregiving practices are a form of embodied, intimate labor rooted in their situated, community-oriented knowledge. This labor is devalued as emotional and feminized care work, which denies the ASHAs professional status in the public healthcare system of India and, in turn, reflects a hierarchy among health practitioners that stems from the status of objectivity/disembodiment in biomedicine. We find that, despite their low status in the public health system, ASHA workers develop a self-concept that enables them to self-identify as healthcare professionals, motivating them to continue providing essential healthcare services during the pandemic. We argue that an official recognition of the epistemic value of ASHA work would help to overcome the age-old nature/culture dichotomy that informs what counts as valuable, legitimate, formal medical knowledge. Furthermore, our analysis provides a

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critique of the gendered devaluation of care work within a political economy of health increasingly dictated by a neoliberal logic.

Introduction

In several parts of rural India, the figure of a local community woman draped in a pink *saree* (traditional Indian attire) has become representative of the public healthcare system. These women in their pink *saree* uniforms are part of a large pool of approximately 1 million female community health workers designated as the Accredited Social Health Activists (ASHAs). The ASHAs have come to play a pivotal role in the management of the novel coronavirus (COVID-19) pandemic in India. ASHA workers were first recruited in April 2005 as a central component of a flagship scheme called the National Rural Health Mission (NRHM) (Hota 2006). This scheme was developed to address the vast disparities between rural and urban health infrastructures in India (Leslie 1985). The initial objective of NRHM was to make healthcare accessible to India's rural population (Karol and Pattanaik 2014). The remarkable success of ASHA workers in rural regions prompted the government of India to extend the ASHAs' services to urban areas, thus transforming the NRHM into the National Health Mission in 2012 (Sharma 2014). This experience of the ASHAs as preliminary healthcare providers bridging the gaps in the national medical infrastructure has led to their emerging as a critical workforce for managing the COVID-19 pandemic in India.

The health services that the ASHAs provide, the necessity of these services, and their valuations are shaped profoundly by the ASHAs' identity. The initial thrust of the ASHA program was to address maternal and infant mortality in India (Joshi and George 2012). To facilitate cultural acceptance among communities, certain selection criteria were imposed for recruiting the ASHAs: ASHA workers must be local community women who are married, widowed, or divorced; preferably between the ages of twenty-five to forty-five years; and they must have completed primary education of up to eighth standard (Abhay and Khandekar 2014). Thus, an ASHA's gender and social status is inextricable from her profession. An ASHA's work environment is also impacted by her caste identity, which emanates from the socio-religious hierarchy of the caste system and determines her relationship with the communities she serves. In other words, ASHA work is quintessentially embodied. We explore the role that this embodiment has played in managing COVID infections in India. We discuss the intersections between three approaches in the literature on embodiment to inform our analysis of ASHA work: embodied medical practice (Mol 2002), intimate labor (Boris and Parreñas 2010), and situated knowledges (Haraway 1988). The analysis itself is carried out through a discourse analysis (Lupton 1992) of textual media articles, including interviews of several ASHA workers conducted

during the pandemic. Through a discussion of the key themes that emerge in this media coverage, we demonstrate the link between the embodied nature of ASHA work and a trenchant process of devaluation that is rooted in the feminization and voluntarism of care work.

In writing this paper, we are also cognizant of the co-existence of modern medicine with traditional medical systems in India—a reality explicated by the term *medical pluralism*. Nevertheless, sociological and anthropological analyses have revealed biomedicine's dominance over alternative medical systems (Cant and Sharma 1999; Lambert 2012). It is common knowledge that the biologically reductionist approach of biomedicine has increasingly replaced more holistic medical systems in India that incorporate the social, the environmental, and the moral in healthcare practices. In this paper, we argue that the recruitment of ASHA workers in the public health system of India, however, pushes the epistemic frontiers of biomedicine towards acknowledging the importance of the social for the biological. Yet it has been shown that, despite their contribution to expanding the reach of India's public health institutions, ASHA workers occupy a marginal professional position within the healthcare system (Sharma 2014, 296–97). This marginality has become starker during the pandemic. To understand this marginalization, it is essential to explore the conditions of ASHA work that are shaped by larger epistemic and socioeconomic structures. An attention to the discourse surrounding ASHA workers in the public sphere reveals the underlying ideologies that structure ASHA work and shape its perception in society (LeGreco and Tracy 2009). This paper contextualizes the embodied healthcare practices of the ASHA, both prior to and during the pandemic, with respect to these broader social processes.

The structure of the paper is as follows. In the first section, we begin with a discussion on embodiment to situate our study within the broader discourse on epistemic practices and women's labor. In the following section, we discuss the four key themes that emerge from our analysis: the situatedness of the practices of ASHA work; the othering of ASHA workers both within the healthcare system and within the communities they serve—what we call “twice othering”; the ASHAs' social and professional self-awareness; and finally, the ASHAs' demands for reforming their status. We conclude with a discussion of the significance of the ASHAs' standpoint in critiquing the reductionist tendencies of biomedicine that reify a hierarchy of both medical knowledge systems and care providers. Our analysis also indicates that gendered devaluations of care work are made possible through an increasing privatization of the healthcare system in India.

Practices, Intimacies, and the Situatedness of Biomedicine

In her influential book *The Body Multiple: Ontology in Medical Practice*, Annemarie Mol (2002) discusses her ethnographic work of investigating the medical practices of treating atherosclerosis, an arterial condition that causes pain in the legs while walking. This ethnographic study challenges the settled boundary between nature and culture that informs what ought to count as formal medical knowledge. Mol compares the practices of diagnosing atherosclerosis in two specialist departments in a Dutch hospital: the outpatient clinic and the pathology division (Mol 2002, 29–52). While pathology focuses exclusively on biological principles to explain disease ontology, in the clinic, on the other hand, physicians rely on patients' narratives to diagnose atherosclerosis. Mol demonstrates how physicians' documentation of their patients' narrative is ultimately key to diagnosing the affliction. The central thesis of this ethnographic study is that a pathologist's practice of observing sections of leg arteries under a microscope to detect signs of disease and a physician's attention to patients' accounts of suffering are different ways in which atherosclerosis gets "enacted" in the hospital (Mol 2002, 32–36). We build upon this ethnographic insight to argue that ASHA work is a form of healthcare practice that also enacts disease differently through a documentation of patient narratives and an incorporation the ASHAs' knowledge of patients' intimate medical and social realities.

Such multiplicity of disease ontologies is particularly relevant for medical practices in India where traditional and modern medicines co-exist and often complement one another. In a seminal article on Indian medical practice, R.S. Khare (1996) discusses medical pluralism in India through the concept of "practiced medicine." Khare explains how practiced medicine in India is generated together by patients and doctors to find the "best treatment." Doctors and caregivers approach medicine and healthcare as being concerned with more than just the biological being. Practitioners—traditional and modern—combine their social knowledge about patient backgrounds to provide a model of care that addresses the physical, social, as well as the spiritual aspects of the well-being of their patients, sometimes encompassing more than one medical system (Khare 1996, 840–43). In India, socioeconomic complexity and the strategies employed by caregivers to navigate these complexities are therefore embedded in practiced medicine. In other words, the social situations of India necessitate an acknowledgement of diverse approaches to managing diseases.

Since the formation of the NRHM in 2005, ASHA workers are officially included in the category of caregivers in India. The health services that ASHA workers provide thus belong to the multiplicity of healthcare practices within India's public health system. However, the nature of work that the ASHAs perform is not formally recognized as healthcare practice and gets subsumed under care work

(Kammowanee 2019). Care work comprises occupations that enhance the “human capabilities” of those receiving care, such as mental and physical health, and cognitive and emotional development (England, Budig, and Folbre 2002). These care professions are considered distinct from medical practice. Paula England (2005) theorizes this distinction through the framework of the devaluation of care work, arguing that care work is devalued because it is deemed a public good that accrues indirect societal benefits. In other words, the provision of care is secondary to the medical management of afflictions in biomedicine.

Such analyses, therefore, allude to a generalization of care work as feminized work that fails to secure social recognition and state support owing to such labor being deemed as feminine, intrinsically motivated—that is, voluntary—and hence requires lesser skills (England 2005, 395). Padmini Swaminathan (2015) locates this characterization of care work within the context of “doing development” through women, as opposed to doing development for women. She argues that the Indian state has developed welfare programs that feminize responsibilities under the banner of women’s empowerment, employing local women as “honorary volunteers” for developmental projects. These programs nevertheless categorize these women as informal care workers or social activists whose labor is devalued as self-interested work directed towards the betterment of their communities (Swaminathan 2015). The voluntarism of “poor women’s work,” largely unpaid and disguised as performances of communitarian “solidarity,” has been theorized as a feature of the receding welfare state in India (Banerjea 2011). Similarly, ASHA workers are depicted by the state as voluntary actors taking charge of their communities’ healthcare needs. Voluntarism, therefore, not only represents the politics of establishing ASHA workers as neoliberal agents but also demonstrates a neoliberalization of the healthcare system in India as a whole. Some scholars have argued that public health has ceased to be a public good in India post liberalization in the 1990s (Ghosh and Qadeer 2020). Within this neoliberal framework, voluntary care work is emotive work, and therefore not formal work that merits professional recognition. As we discuss below, this assumption has been refuted by the realities of the COVID-19 pandemic, where workers in low-paid and low-status positions such as community health workers, janitors, and agricultural workers have emerged as essential workers.

The devaluation of care work as emotive and voluntary work can be understood through Sara Ahmed’s (2004) “cultural politics of emotions” that reveals how emotions are simultaneously associated with femininity and primitivity. The presence of emotions is seen as limiting the capacity to make fair judgments and to act autonomously, constructing the emotive individual as a less-than-civilized “other.” Ahmed challenges this notion and argues that emotions are sensations of the body involved in the act of perceiving the world formed not only through individual consciousness but also as a collective conscience contingent on historical knowledge and social memory (Ahmed 2004, 9). Emotions are thus

intentional and underlie the foundations of knowledge systems that determine everyday practices in societies (Ahmed 2004, 7). Drawing upon Ahmed, we argue that ASHA work as emotionally driven, voluntary healthcare provision is a form of indispensable health service that enables the mitigation of infrastructural inadequacies on the ground and is therefore of high epistemic and social value.

However, ASHA work cannot be characterized as solely emotive linkage care work. We argue that ASHA work is a form of "intimate labor" that sustains "the day-to-day work that individuals and societies require to survive" (Boris and Parreñas 2010, 2). Intimate labor is concerned with the most private aspects of an individual's life and involves knowledge of personal information and intimate needs such as bodily upkeep and care, the sustaining of social and emotional ties, and the maintenance of health and hygiene. Despite its emotive dimensions, intimate labor is first and foremost an economic activity, "a primary source of livelihood" for socioeconomically marginalized women exchanged in the marketplace rather than performed within the atomistic context of the family (Boris and Parreñas 2010, 7–8). This form of labor includes the know-how or embodied knowledge of the objects, instruments, or situations that surround a worker, embedding them in their environment (Ducey 2010). The knowledge acquired through intimate labor, such as shared secrets, interpersonal rituals, bodily information, personal vulnerability, and embarrassing situations, are rarely accessible to an outsider (Boris and Parreñas 2010, 3). In the developed world such intimate labor is also devalued by its historical association with workers who belong to ethnic minority or marginalized communities. The devaluation of intimate care work is therefore not a contingency, but a global reality rooted in the larger political economy of care work that enables "poor women's work" from the Global South to circulate internationally in the industrialized social circuits of the Global North (Mahon and Robinson 2011). Similarly in the case of the ASHAs in India, the local circulation of poor women's work is mediated by social identities based on gender, class, and caste, as we demonstrate below.

The status of objectivity in scientific knowledge systems and epistemic practices also contributes to the devaluation care work like ASHA work. Objectivity relies on a distancing of the observed from the observer—that is, a distancing from the embodied reality of the observed in favor of abstractions that give rise to universal truths. This objectivity is foundational for biomedicine. Michel Foucault (1973), in *The Birth of the Clinic*, characterizes the significance of the "medical gaze" in modern medicine. Medical knowledge is produced through an objective gaze that is capable of penetrating beyond the surface of the skin, illuminating even the dark recesses of the body (Foucault 1973). This medical gaze is an unembodied position of power/dominance over the observed. Feminist theory challenges this disembodied notion of objectivity through an emphasis on embodiment. In one of the foundational essays on feminist objectivity, Donna Haraway (1988) writes about the positionality of the objective gaze: "This gaze

signifies the unmarked position of Man and White” (Haraway 1998, 581). Haraway calls, instead, for the development of an objectivity that is cognizant of the “standpoint” of the observer and acknowledges the observer’s gender, geographical location, culture, and social situation. Feminist objectivity is thus embodied, and embodied objectivity is situated knowledges (Haraway 1988, 581).

Scholars have used the concept of situated knowledges for understanding knowledge practices in the Global South. A recent study in Ghana has drawn upon the lived experiences of members of a Ghanaian gold mining community to understand emergence and transmission of Buruli ulcer, a neglected tropical disease (Tschakert et al. 2016). An older study on bio-prospecting for drug discovery in the Chiapas Highlands discusses how the perspectives derived from the situated knowledges of Mayan healers inform the critique of the reductionism of the “biomedical gaze” (Nigh 2002). Both these studies demonstrate the multiplicity of ways of knowing in different societies that make up medical knowledge systems determining how ontologies of disease/illness and treatment/healing are formulated. Likewise, the healthcare practices of ASHA workers are an alternative way of knowing about the health issues and medical belief systems of communities. An attention to their situated knowledges is thus essential for comprehending how biomedicine operates in contemporary India. Our analysis of the public discourse on ASHA work during the pandemic lends to this argument by demonstrating how the knowledge acquired by these “poor women” through their embodied voluntary labor has generated crucial biological data for the medical and political management of COVID-19 India.

Embodied Management of COVID-19 in India

In our discussion thus far, we have situated ASHA workers in the literature on embodiment. In this section, we characterize and contextualize the work that the ASHAs perform both as a part of their routine healthcare responsibilities and as part of preliminary healthcare provision during the pandemic. There is a growing body of literature that enumerates, assesses, and evaluates the caregiving roles that these female healthcare workers perform. We utilize this literature to place the media coverage of ASHA work during the pandemic in conversation with the broader epistemic, sociopolitical, and economic contexts that shape public perceptions of ASHA work. Four themes emerge consistently in the media discourse on the ASHAs’ role in pandemic management. While being attentive to nuances, we arrange these dominant themes into the following conceptual schema that allows us to provide an account of the everyday realities, challenges, and hopes of the ASHA workers.

Situating ASHA Work: Practices and Perceptions

Since the early stages of the pandemic in India, two terms have come to be frequently associated with the ASHAs in the media discourse: ASHA workers are being described as the “foot soldiers” (Changoiwala 2020) at the “frontlines” of the fight against COVID-19 in India (Singh 2020). The analogy with war is immediately evident. “Foot soldiers” are the first line of defense in war strategies, placed at the “frontlines” of battle. Indeed, ASHA workers have been the first line of defense in India’s COVID management strategies. The ASHAs have worked with minimal or no protective equipment in locales that are ubiquitous but nonetheless inaccessible to Indian biomedicine—the villages and slums of India. Some ASHA workers have also contracted the virus in their line of duty (Agrawal 2020). This predicament of the ASHA workers represents a dual politics of the body wherein the biopolitical (Foucault 1990) management of COVID-afflicted individuals is accompanied by a necropolitics (Mbembe 2008) of risking the health and lives of “frontline” ASHA workers. ASHA workers work at the very grassroots level of India, bartering information about a highly contagious virus that disrupts everyday life as much at the hinterlands as in the urban centers of the country. In amassing biological information about coronavirus infections and extending biopolitical surveillance to remote villages, it can thus be argued that, through its failure to ensure the safety of ASHA workers, the Indian state is imbricated with a necropolitics that renders the ASHAs a dispensable workforce.

The routine responsibilities of ASHAs as health activists include the following: connecting residents in rural areas to healthcare facilities; monitoring pregnancies and educating about bringing the health benefits of delivering babies in medical institutions; neonatal care and immunizations; the dispensing of basic medical provisions like contraceptives and medicines, among others (Sharma, Webster, and Bhattacharyya 2014). Our analysis of media articles shows that, in addition to these routine responsibilities, managing the pandemic requires the ASHAs to perform the following work: creating awareness among the rural population about the pandemic; informing about precautionary measures against COVID infections; tracing the travel histories of people; collecting information about COVID symptoms; daily monitoring for these symptoms, especially among vulnerable populations like the elderly and people with underlying conditions; visiting quarantine centers; assisting in testing; and conducting door-to-door surveys. Incidentally, the work performed by these “foot soldiers” is not unlike the practices of a physician diagnosing atherosclerosis in a Dutch hospital. The patient’s narratives of their symptoms, or the lack thereof, is instrumental in determining whether a COVID test is required for the patient—much like how a physician would determine from her the patient’s account whether he may have the symptoms of atherosclerosis. Only when the ASHA worker has diligently monitored and inscribed the bodily symptoms of the members of all the households in her community can a comprehensive biomedical and statistical estimate of the pandemic be generated. The preliminary healthcare services

provided by the ASHAs are, therefore, instrumental for the biopolitics of COVID management in India.

The health services that ASHA workers provide require intimate knowledge of their patients' bodily conditions. However, performing this intimate work also requires deep situated understandings of the social relations and environments of the communities. ASHA workers are often members of their own communities, and their knowledge about the health practices of their communities is instrumental for fulfilling their healthcare responsibilities. This includes de-escalating potential hostile situations, especially in an atmosphere of anxiety due to the pandemic. Performing routine ASHA work has its challenges (Sarin and Lunsford 2017). However, one of the factors that have proved to be a bigger challenge during the pandemic is the ambiguity of the role of ASHAs. They are not perceived as professionals by the state, the healthcare system, or the communities that they serve. This lack of professional status adds to their vulnerability as is evident from accounts of many ASHAs being attacked while collecting data about COVID symptoms in their communities (Bhanupriya and Tewari 2020). Although physicians have also been attacked while providing COVID-related care, the ambiguity of the ASHAs' professional status diminishes their legibility as healthcare workers, which makes them more vulnerable to such attacks by community members who fear discrimination in the event of a positive detection. For these reasons, the ASHAs have now long been fighting for recognition as formal healthcare professionals. But the pandemic has brought into stark relief their plight rooted in the informality of their professional designation (Mutha 2020).

Facing and managing conflict situations is not a secondary function of ASHA work; it is, indeed, a part of her professional practice. In a recent incident, ASHA workers had to intervene in a relatively rural district called Koppal in Southern India where villagers had turned against one of their own members who had returned from a pilgrimage to Saudi Arabia (Bhat 2020). The pilgrim was not being allowed by the villagers to enter the village for fear of being a carrier of coronavirus. The ASHAs managed this conflict by clarifying misconceptions that the villagers harboured about the infection. This incidence demonstrates how the social know-how of the ASHA workers, in terms of their communities' beliefs and levels of awareness, is an integral part of managing the realities of healthcare provision during the pandemic at the grassroot level. Such embodied practices therefore need institutional recognition for mediating the health needs of rural and marginalized communities. However, any institutional support extended to the ASHAs must account for the fact that how ASHA workers are designated influences how her labor is valued both socially and economically.

The Twice Othering of the ASHAs

The door-to-door surveys that ASHA workers have conducted during the pandemic have deferred the requirement for mass testing programs to detect coronavirus infections in India (Mutha 2020). Nevertheless, as we have discussed above, ASHA work is regarded as care work rather than healthcare practices that generate medical value. Most of the media accounts we have analyzed highlight how ASHA workers continue to deliver primary healthcare services during the pandemic despite infrastructural disadvantages (such as dearth of protective equipment, masks, and sanitizers) and threats to their own lives and the lives of their families. These narratives seem to suggest that the most critical role of ASHA workers has been to sensitize communities and enhance awareness about healthcare services among rural and marginalized populations (Gupta 2020). Such media reports reflect the dominant perception that ASHA work is voluntary care work carried out by local community women employed as activists and not as public professionals (Ratho 2020).

Furthermore, ASHA workers are also made to perceive their own work as an extension of household care (Chatterjee 2020), or are made to view themselves as a “samajsevika” (in Hindi, female social worker) (Kammowanee 2019, 2). This devaluation constructs ASHA work as non-economic activity. Such social practices limit ASHA workers' earnings to Rs. 33 per day/0.9 paise per hour (about US\$0.44 per day) (The Tribune News Service 2020). ASHAs are paid an honorarium amount of only Rs. 2000 to 3000 per month (about \$35–\$40) for their “voluntary” work. The remainder of their income comes in the form of incentives conferred for completing individual tasks. During the pandemic, some regional state governments have given an additional amount of Rs. 1000 (about \$13.55) for COVID-related additional work (Mutha 2020). However, such increases are inconsistent, and reports have shown that some ASHAs have not been paid for over fifteen months (Kajal 2020). Numerous policies such as accident and life insurances of up to Rs. 5 million (\$67,000) have been offered to the ASHA workers (Singh 2020). But they are of little value in the face of their ongoing financial crisis due to either delays in the disbursement of salaries or the inadequacy of their income. An ASHA worker named Ujjawala says, “What money is better after death when survival is in trouble?” (Mutha 2020). Another ASHA worker expressed her hopes of becoming a full-time government worker: “I live in hope that someday, this [ASHA work] will turn into full-time employment” (Ramaprasad and Chakraborty 2020). This meager salary of the ASHA workers was determined during the conception of the NHRM when a “no salary employment model” was advocated for, arguing that the ASHA workers would underperform once they receive fixed salaries (Ved et al. 2019, 6). It is, therefore, a conscious decision on the part of policymakers to maintain the ASHA program as a voluntary community institution and to not assimilate it into the public health system (Ved et al. 2019, 7). In this way, the ASHA worker has been reduced to an

underpaid “cultural broker” (Leslie 1985, 923) who nevertheless provides essential healthcare services.

A consequence of such devaluation of their work is that these “frontline” workers do not share the spotlight with the doctors and nurses fighting COVID-19 in India (Ramesh 2020), which has resulted in the ASHAs being systematically marginalized and made to feel insignificant. An ASHA expresses her distress as follows: “The PHC (primary health centers) staff asked us why we needed masks at all. ‘Are you touching COVID positive patients?’” (Bhanupriya and Tewari 2020). This marginalization is further cemented when doctors visit affected communities fully equipped with personal protective equipment while ASHA workers use only their *duppattas* (in Hindi, scarves) as masks. The negligent attitude of the Indian state towards the working conditions and financial issues faced by ASHA workers insinuates a mechanism of othering (Canales 2000). As we have discussed above, this othering happens due to several factors working in conjunction: describing ASHA work as emotional care work, feminizing developmental programs, and ascribing a low-skill status to ASHA work. This othering also happens for instrumental economic reasons, such as the state’s intention to avoid creating a fresh cadre of government employees who will be entitled to lifelong employment and pension benefits (Ved et al. 2019, 9).

The practices of othering the ASHAs is not only limited to the state and its bureaucratic regimes. ASHA workers are also othered by their own communities. These state-recruited “cultural brokers” have been held accountable for governmental failures and policy inadequacies. In one instance, during their door-to-door surveys for COVID-related work, ASHA workers were questioned in the following manner by community members: “You come to ask about fever and cold, but has your government ever come to ask if we have food in our homes, if our stoves are burning?” (Bisht and Menon 2020). ASHA workers are continually regarded with suspicion among certain communities. In the aftermath of the alleged marginalization of India’s Muslim population through recent policy amendments to Indian citizenship (such as the Citizenship Amendment Act), the fear of data appropriation and surveillance by the current regime have fueled non-compliance with the ASHAs among Muslim communities (Mutha 2020). Thus, ASHA workers endure the risk of representing governmental lapses without securing appropriate acknowledgement from the state. This is what we have termed as the “twice othering” of the ASHA workers. The indifference of the Indian state is translated into systemic oppression mediated by the processes of devaluation and othering. This oppression is compounded by the overburdening of ASHA workers charged with managing the pandemic at the grassroots level.

Overburdened ASHAs and their “Self-Concept”

The media articles we analyzed reiterated the seriousness of the escalating workload of the ASHAs due to the pandemic (Outlook India 2020). Before the

pandemic, each ASHA worker was required to monitor 1,000 individuals in rural areas, and between 1,000 and 2,500 individuals in urban areas. But with the onset of the pandemic, this number has significantly risen as ASHA workers were also made to work in neighboring areas. An ASHA worker is required to reach up to 30 to 50 households a day (Prakash 2020). During these long hours of work, they hardly get a chance to eat, rest, or use restrooms (Gupta 2020). ASHA workers have been reported to work for more than 12 hours a day during the pandemic, visiting not only households but also quarantine centers twice a day to check on quarantined individuals (Bhanupriya and Tewari 2020). In the city of Bengaluru, ASHA workers were also forced to perform the duties of municipal health officials, who remain mostly absent (Mishra and Mandyam 2020). In addition to this, in the dearth of adequate information about COVID-19, ASHA workers were also made to acquire knowledge about the virus through personal efforts from online and television sources (Srinivasan et al. 2020).

The arduous documentation work done by the ASHAs gives the Indian state access to ground-level data to be utilized in policymaking. The government of India thus extracts critical biological information through the ASHAs' labor without substantially investing in them. This indifference on the part of the India state has led to a mental health crisis among the ASHA workers, intensified by anxieties and fears about the virus and physical exhaustion (Kajal 2020). This crisis is further aggravated by the discrimination that the ASHAs face from family and community members, owing to the mobile nature of their work (Editorial Staff 2020). For instance, in a tragic episode an ASHA worker attempted to commit suicide after she was verbally abused by a village leader for visiting a home-quarantined individual in another district (P 2020). An ASHA's distress is also rooted in her identity shaped by gender, caste, and religion (Scott et al. 2017). An ASHA worker's position within patriarchal socio-cultural settings requires her to negotiate prevalent norms and customs. For instance, a recently published study has found that ASHA workers belonging to "lower caste" communities have faced caste-based discrimination while performing COVID-related service in villages belonging to "higher caste" communities (Niyati and Mandela 2020). Media accounts of such caste-based discrimination of the ASHAs are few and far between, reflecting a non-acknowledgement of caste hierarchy in the Indian public sphere. Even as the ASHAs grapple with these stresses of their work, they continue to perform their gendered domestic roles, such as that of a "good daughter-in-law" who fulfills household chores and attends to the needs of her family (Saprii et al. 2015, 8). This pressure to fulfill traditional domestic responsibilities limits their ability to perform professionally and adds to mental distress. Inability to adhere to gendered roles as well as infrequent pay (Ramesh 2020) instigate families to encourage the ASHAs to quit their work, further devaluing their contributions. ASHA workers have, in this way, come to embody an "inner role conflict" when their profession as healthcare worker conflicts with their social identities (Pandey et al. 2019).

However, despite these challenges, ASHA workers have shown continued dedication to their work. They interpret these challenges as a fight against the system and not against the communities they serve (Ramesh 2020). They understand that the community members rely heavily on their services and they do not wish to abandon their duties. This dedication is commonly understood as being motivated by altruistic intentions. However, the ASHAs' dedication to their profession can be better understood through the notion of "self-concept" (Pandey et al. 2019, 232). The self-concept of the ASHA workers is a psychological self-understanding based on a sense of identity that originates in the roles and responsibilities associated with their jobs. A quote by an ASHA worker demonstrates this aptly: "I am not bothered about the safety gear, honorarium or benefits. I have been working amidst these people for 14 years. They are at risk now, and I must tend to them" (Changoiwala 2020). Such articulations show that the ASHA workers' self-concept has become more defined in the face of the harsh realities of the pandemic. Their contributions to the health and social well-being of their communities are becoming self-evident. For instance, a women's rights organization working in the states of northeast India roped in ASHA workers to intervene in the alarming rise in the cases of domestic violence due to the lockdown imposed during the pandemic (Ramesh 2020). These instances demonstrate the ASHA workers' relevance to social problems that have accompanied the pandemic. Such accounts also illustrate how the ASHA workers' situated intimate practices attend to the most private aspects of community members' lives. The ASHA workers' awareness of their own value to the medical system and community social relations shapes their self-construction, and they begin to identify themselves as "healthcare professionals" who emulate medical doctors (Pandey et al. 2019, 232).

Recognition, Remuneration, Respect: Understanding the Demands of ASHA Workers

Understanding the embodied labor that ASHA workers perform and its contribution to the management of the pandemic in India necessitates paying close attention to the demands of the ASHAs for reforming the conditions of their work. The media articles that we have analyzed thus far present first-hand experiences of the challenges that the ASHAs face as health workers. At the same time, they enumerate the ASHAs' demands for addressing these challenges. As we have discussed above, the first obstacle that the ASHAs face stems from their very designation—*activists* and not *workers*—which leads to a devaluation of their labor. To overcome this devaluation, ASHA workers have sought the assistance of trade unions and have been staging several demonstrations demanding an improvement in their status (B.P. 2020). Ranjana Nirula (2015), the convenor and member of the All India Coordination Committee on ASHA Workers, has published an online statement listing the demands of ASHA workers, including becoming "regularized as government health workers"; "paid (a) minimum wage

of Rs. 15000 per month (about \$200 per month)”; given access to “social security benefits like pension, gratuity, maternity benefits, etc.”; and being provided with a designated “uniform, ID cards, bus passes” (Nirula 2015). These demands are a definitive assertion for recognition by the ASHA workers. ASHAs not only have a self-concept of being health professionals but due to their identification as members of the public health system, they also feel a sense of entitlement (Scott and Shanker 2010). This sense of entitlement is reflected in their specific demand for being provided with better training to perform their duties. The issue of inadequate training for the ASHAs (Wagner et al. 2018) has become especially important during the pandemic, as most ASHAs feel that the training that they have received from the state is insufficient for dealing with the pandemic (Bhanupriya and Tewari 2020).

These accounts show that what is at stake for the ASHA workers are questions of dignity and respect in their everyday lives, intertwined with the issues of recognition and remuneration. In the wake of the overburdening of ASHA workers during the pandemic, some state governments have chosen to provide additional incentives to the ASHAs. In the state of Maharashtra, ASHA workers are being paid a meagre additional amount of Rs. 1000 (about \$13.24) for a month of COVID-related work (Ramaprasad and Chakraborty 2020). In the absence of protective equipment and with the persistent risk of contracting the virus themselves, the ASHAs feel that this additional incentive is not only inadequate but also insensitive. As one ASHA worker has expressed, “That’s how little our lives are worth” (Ramaprasad and Chakraborty 2020). The issue of remuneration then is also about “worth.” As one ASHA put it, “We want respect” (Ramesh 2020). These instances of devaluation and discrimination of community health workers have prompted the World Health Organization to call upon all national governments and stakeholders to ensure the health, safety, and, hence, the dignity of frontline health workers (Raman 2020).

The pandemic has proven beyond a doubt that ASHA workers play a critical role in filling the gaps of the medical infrastructure in the public health system of India (Berman 2015; Sharma 2015). Based on this realization, some academics have argued that the focus of the Indian government must now shift from recruiting ASHAs as healthcare activists to retaining these essential workers in the public health system (Bisht and Menon 2020). Ensuring the retention of ASHA workers in the system requires addressing the question of remuneration in conjunction with the issues of recognition and respect. This recognition ought to estimate the worth of ASHA workers’ lives as equal to the lives that they have been made to assume the responsibility of caring for during the current pandemic.

Discussion

The central focus of our paper is the significance of the embodied healthcare practices of the all-female community health workers of India, the ASHAs. We have demonstrated how the situated knowledges of ASHA workers are embedded in the healthcare practices they have performed, both prior to and during the pandemic. Nevertheless, ASHA work is continued to be devalued owing to its embodied nature. The ASHAs' labor is perceived as emotional voluntary work motivated by "psychological altruism and empathy" and is regarded as contributing to the larger "public good" (Pandey et al. 2019, 232). Our discourse analysis finds that this devaluation has been challenged by the indispensability of the ASHA workers in managing the pandemic. Despite this instrumental role, however, the ASHAs' embodied labor does not meet the demands of objectivity in biomedicine. Historically, Western medicine became successfully implanted in diverse geographical locations and cultures through colonization (Baer, Singer, and Susser 1994). With this, the objective but disembodied approach to medicine, health, and well-being became dominant in diverse societies. Today, biomedicine flourishes in postcolonial countries as a prestigious institution together with traditional forms of medicine. Nevertheless, ethnographic accounts have documented the prevalence of biomedicine's hegemony over other medical systems (Nichter and Nitcher 1996). The devaluation of the ASHAs' embodied labor takes place in the context of this historicity of biomedicine.

The growth of biomedicine is also linked to the rise of capitalism, with biomedicine being one of the major contributors to the development of the global economy (Baer, Singer, and Susser 1994, 329). This growth is accompanied by a professionalization and commoditization of caregiving roles (Freund, McGuire, and Podhurst 2003). Due to this professionalization, Western allopathic doctors have achieved a status that subordinates all other health practitioners, thus forming a rigid hierarchical structure among different medical knowledge systems and practitioners. Within this structure, ASHA workers occupy the lowest rung, which means that their intimate wisdom about the health issues of the communities they serve go unheard (Scott and Shanker 2010, 1610–11). Further reifying this hierarchy is the political economy of an increasingly privatized healthcare system that substitutes voluntarism for state expenditure on public health. These structural conditions maintain voluntary healthcare provision as informal work that lacks expertise. Nevertheless, scholars have shown that in India well-informed health policies have failed due to cultural oversights and the inability to incorporate meanings of diseases that originate in local cultural contexts (Jain and Jadhav 2009). These observations reveal the fallacies of denying the epistemic value and adequate recognition of embodied care work like that performed by the ASHAs in India's public health system. Here, it is worth noting that at the heart of this conundrum is the definition of what counts as

technical expertise, revealing the inadequacy of a nature/culture dichotomy in explaining contemporary realities (Balsamo 1996).

Our analysis finds that, despite the ambiguity in their designation, the ASHA workers' self-concept enables them to identify and assert their rights as community health workers (Bhatia 2014, 280–82). They are aware of their importance to the communities they work in and invest in building relationships of trust with them (Mishra 2014). An ASHA worker as a healthcare provider thus has a unique standpoint that transcends the nature/culture binary. The standard of objectivity in biomedicine relegates an ASHA's profession to an extension of her everyday life. However, viewing ASHA work through the lens of feminist objectivity—that is, situated knowledges—makes it clear that the embodiment of the ASHAs' practices is critical for biomedical knowledge production. This is clearly demonstrated by the reliance of the Indian state on the data collected by the ASHAs during the pandemic. Community health workers elsewhere face similar devaluations and seek legitimacy either through their community-specific knowledge or through the acquisition of technical knowledge and skills (Swartz 2013). The case of ASHA workers in India is no different. But the ASHAs have developed additional skills of comfortably accommodating both traditional healing rituals prevalent among communities and biomedicine caregiving practices (Mishra 2014, 965–68) They have developed the capability of traversing radically different medical knowledge systems to ensure “best treatment” for their communities.

Throughout this paper, we have emphasized the indispensability of the embodied knowledge of the ASHA workers for the public health system of India, especially during the pandemic. As we have shown, this indispensability is due not only to their role as linkage workers in scenarios of inadequate medical infrastructures but also to their community-oriented knowledge. In a country like India, which has diverse medical systems, the standpoint of ASHA workers unsettles the reductionist dichotomies between nature/culture, objectivity/embodiment, biomedical practice/care work. A recognition of the epistemic importance of the ASHAs' healthcare practices in a post-pandemic public health system of India would be a step away from such ideological dichotomies and towards a more holistic form of medicine untethered from the colonial and gendered hierarchies of medical systems and healthcare practitioners. Moreover, we argue that the recognition of the ASHAs as formal healthcare professionals would be a step towards an alternative political economy of healthcare that values care work as essential work in a post-pandemic world.

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