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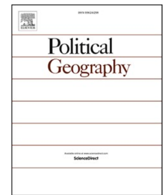

Full Length Article

The “Corona Warriors”? Community health workers in the governance of India’s COVID-19 response

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ABSTRACT

India’s nearly 1-million strong band of quasi-volunteer accredited social health activists (ASHAs) have been key actors in government efforts to control COVID-19. Utilizing a nationalist rhetoric of war, ASHAs were swiftly mobilized by the government in March 2020 as ‘COVID warriors’ engaged in tracking illness, disseminating information, and caring for quarantined individuals. The speed at which ASHAs were mobilized into mentally and physically grueling labor was all the more stunning given these minimally paid community health workers have long been seen to have low morale given their precarious, informalized work arrangements. Building on work examining the spatialities of global health governance alongside literature on geographic contingency, this paper explores the ways that nationalist COVID-19 war rhetoric promulgated from Delhi worked as a technology of health governance to propel ASHAs into certain forms of action, yet also opened up spaces of potentiality for them to reimagine their relationship to both the state and the communities they serve. In particular, in our analysis of in-depth telephone interviews with ASHA workers in the state of Himachal Pradesh, we find that their hailing as COVID warriors inspired patriotic calls to duty and legitimized their (long over-looked) roles as critical governance actors, yet also was subject to resistance and reworking due to a combination of institutional histories, local politics, as well as happenstantial everyday encounters of ASHA work. The precarious employment of ASHAs – in terms of basic remuneration as well as the great on-the-job risks that they have faced – underscores both the fragile nature of India’s health governance system as well as possible political movements for its renewal. We conclude by calling for geographers to give greater attention to community health care workers as a key window into understanding the uneven ways in which health systems are made manifest on the ground, and their ability to respond to citizens’ healthcare needs – both in the COVID-19 pandemic and beyond.

> The fight against Corona is one between life and death itself … we have to win ….[And] We are able to fight a battle on such a massive scale, only on account of the zeal and grit of frontline warriors like you … Be you a Doctor, a nurse, a paramedic, ASHA, an ANM worker, sanitation worker ….
>
> -India’s Prime Minister Narendra Modi’s Address to the Nation, March 24, 2020

> India was first to respond to COVID -19 and stands on a better footing then the rest of the world because of the valuable and sincere services of our Corona warriors ….We know the enemy and its whereabouts. We are able to check this enemy through community surveillance, issuance of various advisories, cluster containment and dynamic strategy.
>
> India Minister of Health, Harsh Vardhan, April 16, 2020

> “No ASHA worker said No to venture into the field.
>
> ASHA Worker, Himachal Pradesh, Kamla October 8, 2020

1. Introduction

As the SARS COV-2 virus swept across the world in spring 2020, India’s Prime Minister (PM) Narendra Modi – like many other world leaders – started drumming up a nationalist rhetoric of war that used

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metaphor as a means to mobilize the population into particular forms of action. Central to his rhetoric were the 'selfless' 'COVID Warriors' comprised of healthcare and essential workers who he celebrated as "defenders of the nation … stand[ing] firmly between us and the Corona pandemic." This included the million-strong band of female Accredited Social Health Activists (ASHAs), India's national force of 'quasi-voluntary' community health workers, who in late March were tasked with conducting door-to-door surveys to monitor citizen movement, report symptomatic individuals, enforce quarantines, and spread information on virus containment. As India's Minister of Health made clear in the opening quote, the decentralized infrastructure of community-embedded ASHAs were central to disease surveillance during India's initial six-week lockdown. Moreover, as Kamla indicated in the third opening quote, among her colleagues in Himachal Pradesh, "*no ASHA said no*" to their call to service. The ambivalence in Kamla's statement, phrased in the negative, is something that permeated the 18 in-depth telephone interviews with Himachal Pradesh ASHA workers conducted in 2020. Thus, this paper works to unpack the sentiment of Kamla and colleagues through investigating COVID-19 war metaphors as a technique of power that both shaped the ways that ASHAs fulfilled their duties in North India and also allowed them to reimagine their relationship to the state and communities they serve.

This exploration is necessary because, in many ways, ASHAs' prominence in the COVID response strategy was remarkable, given that these unsalaried 'quasi-employees' have long expressed low morale as the lowest rung in India's health hierarchy (e.g. see Bhatia, 2014; Ved et al., 2019). Established in 2005 as key actors in India's National Rural Health Mission (later, National Health Mission), ASHAs are selected from villages across India to serve as 'links' between marginalized communities and the formal health system while also providing basic preventative and curative services and public health information (MOHFW, 2022). As such, ASHAs occupy a unique space in overlapping nexuses of 'health governance' in that they are an intimate extension of state power designed to govern population through statistical surveillance and health promotion, yet they are also subject to a system of governance that is often described as "neoliberal" in that they are not regularized employees with monthly salaries but paid only when they complete certain tasks as a means to maximize their accountability and minimize the cost to the state (Roalkvam, 2014; Swaminathan, 2015). ASHAs' precarious, unsalaried spot in India's health-system hierarchy has led them to unionize and agitate the government to make them regularized employees and provide more secure working conditions (e.g. see Bhatia, 2014; Ved et al., 2019). Given this institutional history, the government's move to hail ASHAs as COVID-warriors responsible for disease surveillance and containment was a notable governance gamble, and also fertile ground to explore the ways that state discursive strategies are negotiated by their ostensible protagonists.

Our analysis builds on scholars who trace how global health has deployed gendered and securitized tropes that legitimate particular policy actions (Brown et al., 2012, Mitchell and Sparke 2015), and brings it into conversation with scholarship that is attentive to the ways global health policy is subject to contingencies that arise across geographic space due to both local politics and as well as the encounters of everyday life (Herrick, 2016, Roalkvam, 2014; Gupta & Sharma, 2006). In particular, our analysis examines how nationalist COVID-19 war metaphors promulgated from Delhi produced certain atmospheres of urgency that propelled ASHAs into particular forms of action, yet also formed spaces of potentiality for them to reconsider their relations to the state and the communities they serve. Drawing on in-depth interviews with ASHAs in the state of Himachal Pradesh alongside textual analysis of Prime Minister Narendra Modi's COVID-19 communications, our analysis shows how the public pronouncement of ASHAs as 'COVID warriors' central to state security increased their governance roles and further legitimized their authority as extensions of the state. We find that their acceptance of greater responsibility, however, was rooted in a mix of patriotic duty, commitment to service work, and calculated decision-making motivated by beliefs that their loyalty and service as warriors would be rewarded through regularized governmental employment. Thus, we find while war metaphors served as an effective means to mobilize swift action over the short-term, ASHAs' responses suggest such rhetoric may produce longer term consequences if 'warriors' are not properly compensated for their sacrifices.

Our work has several implications. While emergent literature discusses the social implications of state discursive strategies framing COVID-19 in terms of war (Bates, 2020; Chapman & Miller, 2020; Pfrimer & Barbosa, 2020), little published work has examined how these discourses actually shape the subjectivities and actions of the ostensible protagonists of such rhetoric. We contend examining how ASHAs negotiated these new demands on their self-hood is crucial to understanding not just the implications of COVID's war framing, but also the fragile nature of India's public healthcare system that rests on the underpaid, tenuous work of ASHAs (Ashtekar, 2008). It is in conversation with political geographic analysis of how disinvestment in state-run health care has produced new forms of vulnerability and precarity increasingly shouldered by gendered and raced bodies (Rose-Redwood et al., 2020; Sparke & Anguelov, 2020). Our empirical analysis reaffirm the harms produced through a neoliberal state and precarious employment, yet also calls geographers to attend to the micro-level dynamics of the governance tactics used to manage health care workers, as well as the ways these actors embrace, resist, and adapt dominant narratives. We contend such research is central to understanding how health governance operates in practice in the context of the present pandemic and beyond (Bhaumik et al., 2020). In making this argument, we seek to extend calls from geographers for a greater focus on the 'workers' in healthcare systems (Connell & Walton-Roberts, 2016), through urging research to move beyond a preoccupation with trained professionals (e.g. doctors, nurses) to improve understanding of community health workers who form the underpaid, and often unseen, backbone of health systems in the global South and beyond (World Health Organization, 2018).

The paper continues in 5 parts. Section 2 outlines relevant literature. Section 3 overviews our study sites and methods. Section 4 presents our analysis and section 5 concludes.

2. Literature review

This section outlines the main debates around community health workers (CHW) from both mainstream and critical perspectives, highlighting the unique position CHWs hold as critical nodes in health governance regimes themselves, and also as subject to material and discursive governance techniques designed to ensure accountability. We bring this work into conversation with the literature theorizing the socio-spatial implications of war metaphors and argue that the concept of geographic contingency holds potential for understanding the ways such rhetorical moves come to matter across space and bodies.

2.1. Community health worker motivation and ethnographies of health governance

Since the early 2000s, low- and mid-income countries – including India-have increasingly employed bands of largely female community health workers as a key strategy to ensure 'universal' health care access to populations (Scott et al., 2019; World Health Organization, 2018). The strive to ensure 'good health at low cost' has been pitched as a win-win in 'empowering' women to become leaders of community health, while also 'linking' hard-to-reach populations to the formal health system and providing basic preventative or curative health services (Closser et al., 2019; Maes, 2015). An expansive literature has emerged examining factors that maximize CHW motivation and accountability, yet there remain debates over the role financial incentives should play. While some argue providing CHWs minimal financial incentive means that women will not be money-driven, but

'intrinsically' motivated by a commitment to social service or increased knowledge (Gopalan et al., 2012; Roalkvam, 2014), others argue low-pay leads to high levels of CHW attrition and low morale (Bhatia, 2014, Mishra. 2014). While recent WHO guidance suggests that all CHWs should receive some type of financial incentive for their work, debates linger over what this should look like in different contexts (Ormel and De Koning, 2019). This remains especially true in India, where ASHAs' task-based systems of payments have gradually been revised to give them regular tasks attempting to 'simulate' a monthly salary and opportunity to apply for government benefits (Ved et al., 2019). While mainstream health systems research has increasingly called for more work to examine the rights of CHWs to decent work (e.g. Scott et al., 2019), this literature has mostly focused on how to maximize the efficacy of CHWs through reducing attrition and maximizing motivation for the least cost.

However, a more critical literature of CHWs has focused on their roles at overlapping nexuses of health governance and pointed to the complex gendered neoliberal ideologies that inform these positions. While the concept of "health governance" has been used by health systems research to discuss bureaucratic arrangements and institutional strategies to govern complex systems (Barbazza & Tello, 2014), more critical scholars have used the term to refer to a Foucauldian notion of governmentality where populations are governed through 'nimble' and efficient campaigns that seek to produce citizen-subjects responsible for practicing normative behaviors to manage health 'risks' (Brown et al., 2012, Kickbusch, 2007; Sparke, 2014). Although ASHAs – as extensions of the formal state system – *enact* a type of intimate gendered governance through being instructed to share tea and casual conversation with households to build trust in formal healthcare services such as institutional birth delivery and childhood vaccinations (Roalkvam, 2014), they are also *subject* to technologies of neoliberal health governance. This is because state rhetoric and bureaucratic procedures (e.g. task-based payments) aim to produce ASHAs that are dutiful, accountable actors that require less top-down supervision (e.g. see Gupta, 2001 and the analysis of the 'surprise inspection' of ICDS clinics, also Kane et al. 2020, Swaminathan, 2015).

There is a strongly gendered trope traversing these health governance regimes where CHW programs, including the ASHA program, pitch themselves as "empowering" women who possess an "inherently altruistic, acquiescent, and apolitical nature." (Ved et al., 2019:8, see also Roalkvam, 2014; Maes, 2012; Mitchell and Sparke 2015; Closser et al., 2019). Mitchell and Sparke (2015) draw attention to how these new iterations of global health focus on the gendered and racialized bodies that were the 'losers' of structural adjustment and selective primary healthcare approaches, and work to 'empower' them as responsible citizen-subjects that can manage the health of themselves and communities. CHWs are undoubtedly an outcome of these broader socio-spatial restructurings of health networks to be decentralized, 'locally accountable', and efficient. Thus, in many ways, the task-based ASHA position is an exemplar of neoliberal health governance, designed to ensure accountability and limit the need for district officials to monitor ASHA activities.

Yet, while neoliberal technologies govern the ASHA position, Gupta and Sharma (2006) contend that India as a whole has only partially exhibited a 'neoliberal' character given the state's continued presence in rural areas through individuals such as ASHAs and other village health infrastructure. The spate of 'rights-based' legislation in India – focused on enshrining legal rights to health, education, and welfare – are exemplified by the Rural Health Mission from which the ASHA position was born continues to work to produce rural citizens who demand accountability from the state (Li, 2010). Thus, Gupta (2001) argues a central task for analyzing these new modalities of enacting governance – and the contradictions that bely them - is to identify and understand the way certain subjectivities are forged (as well as resisted or reworked) through both state discourse and everyday practices. Roalkvam (2014) builds on Gupta's theorization through ethnographically studying ASHAs in Rajasthan to find that although ASHAs are constructed as 'activists' to mobilize populations to demand state accountability, they remain unduly beholden to state imperatives thereby limiting their more radical potential to engender change. Moreover, while the decentralized governance ASHAs are embedded in is designed for local accountability and trust, this often papers over the complex local caste and class hierarchies that ASHAs (and other frontline health workers) must negotiate and may actually further entrench through their everyday actions (Gupta, 2012; Mishra, 2014; Roalkvam, 2014). Yet, as Foucault (1990) urges us to look at the interstitial ways that disciplinary power is reworked through everyday practice, Roalkvam (2014), too, contends that more work is needed to parse apart the ways that ASHAs negotiate their contradictory roles, particularly given the vast differences in politics, culture, and caste relations across India.

We build on Roalkvam's (2014) work through examining the ways that state rhetoric shapes the way ASHAs envision their roles and relationships to the state. In particular, while Roalkvam (2014) finds that ASHAs remain beholden to the state, we argue the dramatically reconfigured role ASHAs played in COVID-19 is fertile territory to see how emergent conditions of pandemic work opened up new spaces for ASHAs to envision themselves. Moreover, while much work has examined the specifically gendered discourses that seek to produce dutiful ASHAs, this present paper is in conversation with political geographic analyses of COVID-19 that contend the discourses of securitization present in COVID-19 war metaphors are a categorically different type of rhetoric that has potential to shape subjectivities in novel ways (Pfrimer and Barbosa, 2020).

2.2. *Metaphors of war and atmospheres of urgency*

Although the analysis of war metaphors within public speech and health communication has a long history (Flusberg et al., 2018), COVID-19 unleashed a global upsurge among political leaders in invoking notions of war to communicate information, mobilize populations in particular ways, and legitimate certain policy actions (Bates, 2020; Horton, 2020; Wagener, 2020). The goals of metaphor in public speech are to make a complex, unfamiliar topic such as COVID-19 understandable through an established mental structure that the audience is more familiar with, such as war. The metaphor presents a structural domain that is developed through drawing on specific elements (known as entailments) associated with a notion of war – such as enemy, soldiers, home front, front line, and victory or defeat (Flusberg et al., 2018). By elaborating on these entailments in logical ways the metaphor becomes a flexible vehicle that not only communicates information but legitimates or constrains specific policy actions (Bates, 2020). Thus, per Foucault, war metaphors can be understood as a technique of disciplinary power – or governmentality - where discursive strategies work to produce particular imaginaries of state authority and obedient citizen-subjects.

Flusberg et al. (2018) also note that war metaphors are laced with a particular emotional valence that can engender atmospheres of urgency, threat, and fear. In particular, the war framing conjures up a battle of good versus evil, and often serves a unifying function that motivates action and sacrifice in the quest for victory against a sometimes ill-defined 'enemy' (Flusberg et al., 2018). Scholars also have suggested that COVID-19 war metaphors may imply the pandemic will end with a simple 'victory' and create an atmosphere where health care workers are cast as soldiers who must comply with orders from above (Bates, 2020; Horton, 2020; Lohmeyer & Taylor, 2020, Rohela et al., 2020). Within this there is also a necessary implication of the potential for collateral damage and for loss of life on the 'frontlines' (Rohela et al., 2020), that may legitimate the death of some to preserve the life of others (Lohmeyer & Taylor, 2020; Wagener, 2020). These seemingly dramatic sacrifices are rendered less exceptional within the affective atmospheres of urgency that imaginaries of war produce.

While these socio-spatial implications of war metaphors are far-

reaching, Bates (2020) contends that framing policy action in terms of 'war' carries significant political risk if elements of the event and policy response do not align with common understandings of war's entailments. Though Bates (2020) is discussing the stakes in terms of broad sweeping national 'sentiment', we bring this work into conversation with the health worker ethnographies reviewed above to investigate the impacts of war metaphors on the subjectivities and everyday actions of community health workers. Moreover, we turn to geographers theorizing contingency in relation to global health who alerts us to the ways that seemingly airtight global health policy may have 'unintended impacts' that go beyond oppression and suffering and open up "junctures of sociospatial conditions of possibility" as subjects negotiate discursive and material forms of power (Herrick, 2016, p. 676). Here, Herrick is interested in more than local cultural and political 'context' and asserts that the happenstantial emergence of everyday life under policy directives open up spaces of potentiality. In taking this notion of contingency seriously within the context of India's variegated neoliberal health governance, we aim to understand the ways that COVID-19 war metaphors unfolded across space and time and came to matter in the lives of ASHAs.

3. Methodology and study site

This qualitative project was nested within a larger mixed-methods study focused on decentralized governance within the mid-Himalayan state Himachal Pradesh (HP) (see redacted et al., 2020, redacted et al., 2020, for more details). HP has relatively high levels of human development compared to other parts of India, with literacy rates nearing 90%, near universal access to electricity (99.5%) and improved drinking water (96.2%) (NFHS-5 2021, see Table 1 for demongraphics).

Notably, these achievements are the outcome of decades' progress in improving state services, made possible by a responsive bureaucratic structure and support for decentralized governance structures, including the *gram panchayat* (village council) (Drèze & Sen, 2002; Fischer, 2016; Mangla, 2015). HP has also been a high-focus state of the Rural Health Mission since its advent in 2005 (Sharma, 2009), and has slowly seen an increase of registered ASHAs to their present level of 7,787 (MOHFW, 2022). These factors suggest that HP is likely to be particularly conducive to coordinate and support ASHAs in their roles, thus provides a particularly interesting case to explore some of the possibilities and contradictions that ASHAs face within their currently envisioned roles.

At the time of data collection (July–December 2020), the COVID-19 case count in HP was relatively low compared to harder hit states like Maharashtra and Delhi. The particular district of this study, Denali[1] is located in the southern portion of HP, and has levels of development and demographic indicators almost equivalent to the all-state averages. While Denali boasts high levels of development, the topography is quite hilly, which makes transit between villages and within villages challenging. COVID cases counts in Denali were similarly low compared to hard-hit areas elsewhere in India, yet in the context of HP it was one of the harder hit areas.

Table 1
Social demographics of Himachal Pradesh (Census of India, 2011).

	Himachal Pradesh
Total Population	6,864,602
General category castes (not historically marginalized)	4,743,224 (69%)
Scheduled castes	1,729,252 (25%)
Schedule tribes (indigenous ethic groups)	392,126 (6%)
Religion – Hindu	95%
Religion – Muslim	2%
Religion – Sikh	1%

At the outset of the pandemic, the HP government had instituted an additional 2,000 INR (USD 28) for ASHAs to compensate for labor in the 'Active Case Survey' (ACS) surveillance they conducted in June and July 2020 (Hindustan Times, 2020). The stipend was supplemented with training and the provision of personal protective equipment (PPE). The ACS required ASHAs to visit every household in their field to provide basic information on COVID-19 and to collect data on COVID-19 symptoms. If an individual was suspected of COVID exposure or returned from an urban area, ASHAs were responsible for assisting them in home-quarantine or taking them to a quarantine center (Fig. 1). While the responsibilities of ASHA workers varied somewhat across different states, ASHAs' role in health monitoring and information dissemination were a central part of COVID-19 response across India – and explicitly recognized for this role within national-level policy action (PMO, 2020e).

3.1. Methods

As the pandemic unfolded, our research team reorganized to collect data remotely. The primary data collector for this study, an Indian woman, consulted with HP field staff to develop a list of contacts for village women willing to participate in telephone interviews focusing on the gendered aspects of the COVID lockdown. The village ASHA was contacted and a snowball sampling methodology was used to recruit other ASHAs working under the same supervisor. While some initial

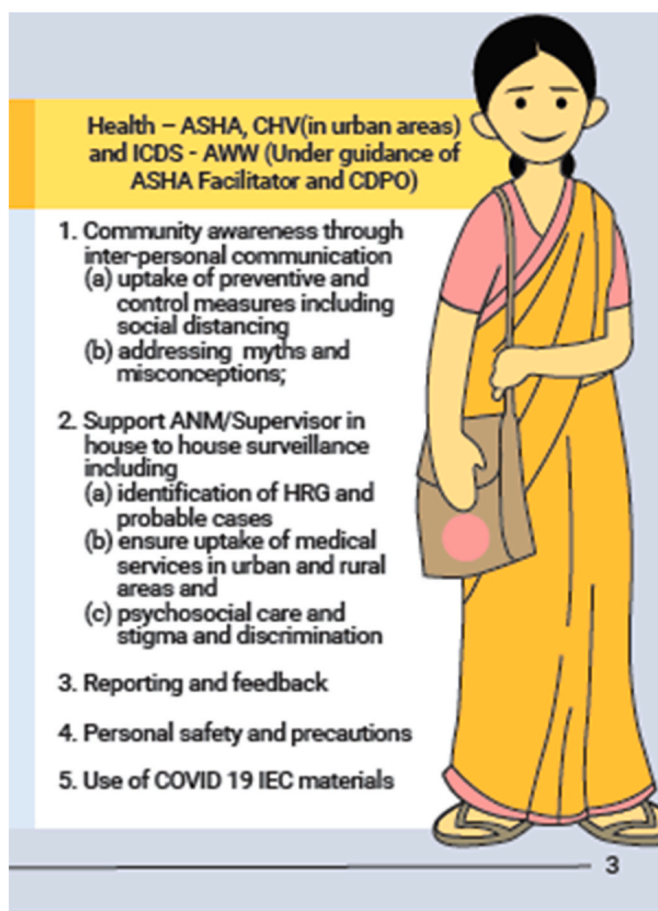

Fig. 1. *'Role of Frontline worker'* Infographic from COVID-19 Facilitator Guide: Response and Containment Measures Training Toolkit for ANM, ASHA, AWW. Produced by Ministry of Health and Family Welfare, https://ayushportal.nic.in/pdf/Covid_19_facilitator_guide.pdf.

[1] The district name is a pseudonym to protect the identities of ASHA respondents.

interviews with ASHA workers took place in July 2020, the majority took place between October and December 2020, with some additional data collection in July 2021. We interviewed a total of 19 ASHAs and conducted follow-up interviews with 11 of them. We also interviewed the male trainer who directly supervised the ASHAs.

The interview aim was to understand the phenomenological experience of being an ASHA during the initial period of COVID-19, and to elicit a broader history of their engagement in ASHA work. Phenomenology attempts to capture the lived, subjective experiences of research participants. And interviews were designed to center participants' experiences as women living in rural HP before discussing their roles as ASHAs. Interviews consisted of questions on socioeconomics, motivations for taking the ASHA role, experience as an ASHA pre-COVID-19, and detailed accounts of ASHA work post-COVID-19. Rapport building through phone calls and WhatsApp helped to build trust with participants. The telephone served as a unique platform, and the informality and intimacy of frequent phone conversation were integral to eliciting candid narratives from our participants. After initial rapport-building, interviews were conducted over several 30–45-min phone calls. That women did not have enough time to engage in conversations over 30 min was testament to their immense workloads. Interviews often took place as women were engaged in other activities (e.g. walking to work, cooking, stitching), which also enabled the interviewer to observe the types of interpersonal interaction women had with others. While remote interviews presented limitations in restricting our embodied observations of ASHA workers in the village, they also provided unique opportunities for intimacy.

The analysis was conducted iteratively. Interviews were transcribed and uploaded to MaxQDA software for analysis. We used inductive *in-vivo* coding, which uses the respondent's own words to capture the contextualized meanings embedded in certain phrases or words. In coding the data, we paid close attention to the tone and non-verbal cues (e.g. laughter) present in the narrative to better understand the affect enfolded within women's speech. During analysis, we were struck by respondents' invocation of the war metaphor in their description of events and their motivations/justifications for doing COVID labor. As such, we also downloaded and analyzed seven key governmental communications from March–May 2020 when the government outlined the COVID strategy for the Indian public. We focused our efforts on Prime Minister Narendra Modi's four addresses to the nation in this time period, as well as three episodes of his more informal monthly radio show *Mann ki Baat* (roughly translated to 'inner thoughts'), broadcast across the nation on All India Radio.

Following a similar methodology as described in Bates (2020), the seven Modi transcripts were read to identify the metaphorical entailments used to make the threat of COVID-19 cognitively accessible to the public and to legitimate a certain set of policy actions. We focused our analysis on the particular points directly discussing the healthcare work force of the country. After all relevant elements of text were selected, we read them to analyze particular thematic patterns. We note several themes emerge around ideas of (i.) national unity, (ii.) the importance of service in Indian society, and (iii.) the need for sacrifice, determination, and patience in battling the coronavirus. The following empirical section outlines these discursive themes, then presents data from Himachali ASHA workers to understand how rhetoric from Delhi impacted these women and their understandings of their relationship to the Indian state.

This study has several limitations. First, remote interviews and snowball sampling invariably restricted our sample to individuals with time and confidence to speak with a researcher they had never met, and made it difficult to diversify our sample in terms of caste, class, or religion. Our respondents were relatively financially secure, and all belonged to the General Caste communities (e.g. from non-marginalized castes). Moreover, our use of telephone interviews meant we had to rely on perceptions of ASHAs rather than take a more holistic approach to interviewing multiple stakeholders. Thus, the accounts below are not representative of ASHA workers across diverse contexts in India or meant to be a positivistic assessment of India's COVID-19 response. Nevertheless, our data provides a unique opportunity to explore how community health care workers engaged with state discourse in the early days of the pandemic, from the eyes of ASHA workers themselves.

4. Findings

4.1. Mobilizing the frontline warriors

As COVID-19 began to force lockdowns globally in March 2020, the Indian government moved quickly to institute a set of protocols to mobilize forces to respond to COVID-19 outbreaks and enforce one of the world's strictest lockdowns. While the institutional infrastructure surrounding ASHAs was already in place, there was a need to mobilize this quasi-voluntary workforce to immediately engage in novel, uncertain, and dangerous work.

This challenge of governing the world's largest force of community health workers was partially addressed through PM Modi's rhetorical strategy of invoking notions of war within all public-facing COVID communication. The metaphor of war is featured in several sentences of his first national address on COVID-19, when he asserts the severity of the crisis caused by coronavirus "exceeds that of World Wars I and II" (PMO 2020a). This is echoed in his March 24th address where he announces the beginning of a strict 21-day national lockdown, arguing that "discipline and patience" and "collective sacrifice" makes him "confident that every Indian will not only combat this difficult situation successfully, but also emerge victorious" (PMO, 2020b). The following day, Modi addresses the nation from the city of Varanasi and likens the 21-day lockdown to the epic Hindu battle of Mahabharata, continuing his prediction of a quick and decisive victory. He says:

> Remember, the victory in the battle of Mahabharata came after 18 days. Today, the entire country is battling the Corona crisis. It is our endeavour to win this battle in 21 days. (PMO, 2020c)

Central to Modi's rhetoric in March was the notion of unity and that all "*130 crore countrymen*" (1.3 billion people) are collectively waging war against *"Corona"* (PMO, 2020c). Although he continuously emphasizes "*that the nation can unite in one in the battle against Corona*" (PMO, 2020d), he also frequently calls attention to frontline workers.

On March 19th he declares, "*as defenders of the nation, [healthcare and essential workers] stand firmly between us and the Corona pandemic*" and asserts the broader public must signal their gratitude for these individuals who "*have lived by our value-system of 'Seva Parmo Dharma', that is Service being the highest Duty*." (PMO 2020a) Again, in his March 29th address he invokes wartime language declaring,

> In this war, there are many soldiers who are fighting the Corona virus, not in the confines of their homes but outside their homes. These are our front-line soldiers-especially our brothers and sisters on duty as nurses, doctors and paramedical staff. (PMO, 2020d).

ASHAs were implicated early on in these calls as the Ministry of Health and Family Welfare in Delhi quickly organized a set of webinars for ASHAs and other frontline workers on their roles in the COVID-19 response. In mid-April the rhetoric of soldiers shifted to that of "warriors," and the government created a "COVID Warriors" website as a centralized information platform where even everyday citizens could sign up to volunteer in disease mitigation. Modi also frequently urged the public to signal gratitude for such "warriors" selflessly protecting the nation from Corona through symbolic acts such as lighting candles or praying from balconies (PMO, 2020d).

Throughout these addresses, he weaves together an argument that both celebrates the extraordinary efforts of these citizens, and also legitimates it as nothing more than living up to one's national duty, arguing *"the notion of service and sacrifice is not just our ideal; it is a way of life in India"* (PMO 2020f). We see that ASHAs' personal accounts largely reflected these narratives in both feeling that their work was

extraordinary (and deserving of additional governmental reward), yet at the same time argued there was a duty to perform the work despite potentially significant risks.

4.2. Traveling metaphors: the corona battle in Himachal Pradesh

The war metaphor was not confined to high-level speeches, but trickled down to governance tactics in local and regional governance structures throughout the country (e.g. see Datta, 2020; Dutta and Fischer, 2020). In our study site, the war metaphor refracted through local geographies and gendered politics to become palpably present in both the ways the local male ASHA supervisor from a General Caste motivated the workforce, and in the ways ASHAs responded to the call to duty.

In particular, the Himachal health supervisor for ASHAs reported raising morale was crucial since budget cuts at the district level over the past several years had left the health workforce severely understaffed including the postings for Auxiliary Nurse Midwife. Thus, while central and state directives defined ASHAs' role for managing the COVID-19 pandemic, the district-level supervisor indicated this was inevitable as ASHAs were the only labor force available.[2] The COVID-centered tasks of conducting door-to-door surveys and assisting with quarantine were significant departures from their traditional tasks that mostly focus on maternal and child health (c.f. Scott et al., 2019). As such, the educator emphasized morale raising was the crucial task at hand, saying

> ASHA workers were morally boosted up and told that they have a very crucial role to play. I told them [Coronavirus] will be contained because of them and they should ensure their personal protection …. We gave them some guidelines and told them not to be fearful. (Health Educator, September 2)

This new set of responsibilities and power produced conflicting feelings among respondents. Whereas many expressed pride that they were given new 'powers' and responsibilities in this crisis period, all respondents also reported deep fear in 'battling' COVID-19. Most notably, there was a strong sentiment among ASHAs that throughout the early pandemic, they were risking their lives on a daily basis in the 'battle' against COVID. Little was known about the lethality of COVID-19, however the government's rhetoric led ASHAs and others to fear the worst. One ASHA recounted the atmosphere of fear and uncertainty that permeated the early days of work:

> In the beginning I would go to [a bigger town] to get medicines, and people would say 'you would bring Corona in the house!' I used to think if the whole world will come to end then I will also die, what is to be done about that? I thought the world is in such great tension so I should do whatever I am capable of. When I would think that I may die then I consoled myself that one day everyone has to die. (Nari, November 4)

Nari's feelings were broadly reflected across the interviews, as women recounted the intense uncertainty and risk permeating the first several weeks of lockdown. These perceptions of risk and potentially imminent harm were exacerbated by the lack of PPE and training initially given to them. One ASHA reported the PPE scenario, which was also echoed in every other interview. She said,

> In the beginning the ASHA workers demanded safety, we did not have sanitiser, gloves or masks …. The Corona thing happened so suddenly, that we did not understand what to do? How to do? We just had to jump onto it, so lots of challenges came. (Manju, August 28)

While ASHAs felt unsupported due to lack of PPE, as poorer women living in hilly regions, they also struggled to report survey data via an online portal accessed through smartphones. Many ASHAs did not own smartphones and had to borrow them from relatives, and often had network issues that made uploading data arduous. Thus, while technologies of digital surveillance dominated urban India (Datta, 2020), the technological reach into the countryside was more tenuous. Moreover, because all education was being carried out via WhatsApp messaging, those with children had to choose between leaving the phone with their children for their studies or take it to the field with them. In these cases, women would stay up late into the night entering data when they returned. One ASHA recalled,

> It was the third day of the Corona-survey that we were asked to enter data online. I would sleep at 11 pm then wake up in the morning to finish household chores then run to the field and again sleep late. During the initial days we were in a bad shape! We had to enter things online and not everyone had a phone, …. In those days, day and night were the same for us. There was no time to eat, drink or sleep …. (Sarita, November 10)

Thus, as Sarita makes clear, women were not just burdened with increased stress around potential COVID exposures, but the sheer scale of the work was exhausting. This was especially true in Himachal, where the terrain is hilly and houses are sometimes at a great distance from one another with expanses of forest between village hamlets. As transport was completely shut down, women had to walk through forests where many reported they worried about potential threats from strangers or wildlife. Thus, the top-down policy for ASHAs to conduct door-to-door surveys across the nation became considerably more difficult due to local topographies and infrastructure.

4.3. Novel threats, novel responsibilities

In addition to being physically and mentally grueling, COVID-19 presented a set of new responsibilities and powers entrusted to ASHAs to govern. To be sure, ASHAs have always had to exercise high levels of discernment in their roles (Kane et al. 2020; Mishra, 2014; Scott & Shanker, 2010), with many recounting the creative strategies they have used to influence families to permit institutional child delivery for daughters-in-law or childhood vaccination, such as befriending newly married woman or meeting skeptical mothers-in-law every day for tea to build trust. However, COVID-19 intensified the responsibility over health governance in novel ways as ASHAs were charged with regulating movement and enforcing quarantine protocols. As one ASHA said, *"everyone was locked up in their houses but ASHAs were made to run in such a way as if they had extra power"* (Manju, August 8).

Although some women were proud of their increased 'power' and the respect it brought, others felt that by hailing ASHAs as COVID-warriors, it inadvertently absolved others from taking collective responsibility for actions such as enforcing mobility restrictions. While government rhetoric pitched the battle against COVID-19 as a *collective* effort where dutiful citizens would all contribute, several ASHAs felt that in practice they were singled out to regulate movement in the village. For example, one ASHA exasperatedly reported,

> Earlier there were a lot of [outside] people who had returned from cities, and the villagers would breathe down my neck, and push me to speak to them to ask them to be home-quarantined. For example, there was some timber work going on in the village and I had to ask the workers how they got permission. They replied, 'we have permission, we are from Himachal!!' The villagers were afraid to ask! And so I have to ask and be the bad person in the village! (Sarita, November 10)

Thus, while the war metaphor effectively mobilized ASHA 'warriors', it also introduced an implicit 'us'/'them' binary where certain bodies were seen as sacrificial in order to save others. Moreover, it was through these happenstantial encounters with outside bodies that Neema became

[2] While anganwadi workers were also tasked to undertake this labor, they are managed by the Department for Mother and Child Welfare, not the Health department.

particularly angered at the role she was placed in. Several other ASHAs expressed resentment that the community did not help regulating traffic in the village, which would turn to cynicism that they were doing more dangerous work than their superiors, while also being paid less. One ASHA narrated

> There is a lot of praise everywhere that ASHA bhenji (sisters) have done a lot during Corona, we fought bravely. …. [In April/May] no one else was going into peoples' houses to give them support. The big staff workers were also not going. ASHA would go even if she is sick or if she has young children. [speaking jestingly as if to imitate superiors] 'Sacrifice her for everything. ASHA is always prepared for death' (Kamla, November 18)

Kamla's narrative is broadly reflected in many of our respondent's sentiments that ASHAs – as the lowest 'rung' in India's health system – were asked to perform work while their supervisors remained in their homes. Others also explicitly stated they felt like they were being asked to sacrifice the safety of themselves and their families in service to their country. Within Modi's war metaphors there are strong themes of national unity but also the sanctity of *sewa* or service for one's nation. Within the notion of service there is a recognition that wars bring collateral damage, which ASHAs – somewhat cynically-were aware directly implicated them and their families. Thus, most ASHA narratives strongly critiqued the sentiment that Corona has pulled the country into a collective battle. Another ASHA lamented,

> ASHA workers have sacrificed the most. Those in high positions never step foot in the field. They take information from us. Even the people who have tested positive, we are the ones visiting their homes. All the reporting goes through us be it patwari, secretary, and Pradhan [local government officials]. People know that we are the most hardworking ones. (Diya, December 22)

Diya's account broadly foreshadows the findings in the next section, where she, and many others, began to see themselves as key players in health governance, and felt they should be compensated more fairly. Our respondents all situated these COVID-19 experiences within the broader context and history of ASHA labor, but also through the physical, uncomfortable encounters they had while doing COVID work. More so, while they felt COVID-labor was mentally and physically grueling, requiring discernment and on-the-fly decision making, they also all discussed their more traditional job tasks in this way. These accounts included everything from taking women to the hospital for childbirth, to paying transit fare and sleeping in the hospital hallway because they were not given beds, to spending hours drinking tea with the in-laws of young women who were skeptical of her receiving institutional care. Thus, ASHAs felt that while COVID-19 was a rapid and novel escalation in responsibility, the issues they had with the COVID-19 response responsibilities were also reflective of their broader roles historically.

However, within interviews we became intrigued about why, faced with such risk and additional responsibility of COVID, ASHAs felt compelled to continue working without proper equipment and for very little pay. What emerged with a complex set of overlapping rationales, described in the following section, that included deep responsibility for continuing 'social work' and also a strategic gamble to show 'loyalty' to the government in hopes that longstanding demands for better pay might finally be heeded.

4.4. Motivations of ASHA and the rhetoric of war on the ground

Despite all of the respondents reporting fear and concern, we found the hailing of ASHAs as 'COVID warriors' was remarkably productive in shaping women's ideas of themselves as critical public servants – or soldiers. In every interview, it was evident the rhetoric of warfare and the unprecedented praise propelled ASHAs into particular forms of action. As witnessed in Kamla's opening statement of "no ASHA said no" there was also, as Rohela et al. (2020) hypothesized, a social pressure to 'soldier on' for fear of looking like a deserter if one refused to comply with orders. Kamla further explained her colleagues' reluctance to refuse service saying. *"everyone's hope was on ASHA Workers and ASHAs said, if there is hope from us then we also have to meet those hopes."*

Here we can see that the notion that one does not want to 'disappoint', reflecting familiar gendered tropes around women's care and responsibility that have long motivated community health worker programs (c.f. Closser et al., 2019). These preexisting gendered expectations of maternalistic responsibility coupled with the atmospheres of urgency in COVID-19 metaphors of war meant that women were placed in a complex position where they were asked to decide between protecting their families or the communities. Indeed, most women reported that their families protested their field engagements and they had to negotiate permission to proceed with work. Here the ASHA respondents expressed a strong conviction that since they were being called to service, it was their duty to oblige for the greater good of the village rather than their immediate kin. One ASHA recalled:

> I motivated my family by telling them, 'if the Government has chosen me for this work then I am very happy if I am able to help others. If I will stay at home then what will happen to others? The disease will surely come in the village!'
>
> She continued that
>
> I was very scared to catch the disease … but I developed a feeling in my heart that I have to win from this disease. If we have to fight then we should fight hard. I felt good that the Government felt the ASHA workers were capable enough to do this! [fight the virus]. Our health educator is so good, he says, 'ASHA is an ASHA, a hope of people and health department, you are our backbone and our roots!' (Kiran, October 20)

The notion of ASHAs[3] being the 'backbone' and the 'hope' of the nation was one that was repeated by numerous respondents and media reports. Kiran made clear that this morale boosting motivated her to work and that it *"makes you want to work more when someone values you."* Yet, many ASHAs also expressed that such recognition was exciting, because it was long overdue as their prior work with women's health was never properly recognized. One woman commented,

> Earlier, people used to think, what are these ASHA Workers? Who are they? Why should we speak to them? But today the image is such that no one is coming in front, only Ashas are coming in front, only Ashas are giving them knowledge, only Ashas are motivating where to go and what to do. People have hope from Asha Workers (Manju, August 28)

Thus, interestingly, because ASHAs had labored unnoticed for so long, they were particularly excited to finally receive proper recognition, particularly from the highest levels of government. Several women spoke specifically about PM Modi's rhetoric when discussing their newfound respect. One woman commented,

> ASHAs' importance has increased because if any outsider came into the village, everybody would say, 'call her, call her ….' And when Narendra Modi praised us then the importance increased more. Importance was already there but not so much [because] our work was only limited to pregnant women and children. We were meant for them only, and didn't go everywhere. (Kamla, November 9)

Although ASHAs appreciated the increased prestige their work was afforded, most contextualized this newfound recognition within their long-held commitment to social work, and particularly to improve conditions for the '*bahus*' (daughters-in-law) that moved to their village following marriage. This seemed to exceed gendered tropes around responsibility and altruism, as many spoke intimately about the personal

[3] The word *Asha* is a Hindi word that translates to hope.

satisfaction they felt in making close connections with women as they forged in fighting for better treatment of *bahus* in their field areas. We observed this sense of duty to the community was intensified in the time of Corona, particularly because it was much more 'visible' and far-reaching. One ASHA recalled how her family pleaded with her to leave the work once COVID came and how she resisted, saying

> I thought: how I can I leave on such an occasion? Now social service is tied to my heart … We can adjust somehow! We took gloves from somewhere and masks from somewhere. We have to go in the field. We have to speak to people at a distance. The moment is that the whole world is scared of this disease and what is to happen if I leave at such a moment? All the praise that is happening now would not have happened if ASHAs would have backed out. (Kamla, October 10)

As Kamla's statement reveals, although COVID-19 service was often propelled by ASHAs' commitment to social work, it also represented an implicit gamble in the hope for more respect. Yet while most felt that their prestige had increased, their hopes were pinned that the government would also 'see' their hard work and reward them appropriately.

4.5. The COVID-19 gamble: going to battle for better working conditions

Every ASHA interviewed unapologetically stated they felt their COVID-19 labor was something that the government should recognize through meeting long-standing demands for better wages and regular worker status beyond the minimal compensation they were offered for these direct tasks ($28). Thus, while the COVID-19 war rhetoric produced sentiments of patriotic duty and commitments to social service, many respondents also used such rhetoric as the basis of claims for greater worker rights. Many felt emboldened by the heavy praise they received and felt it would materialize into financial benefits. For example, one ASHA stated,

> [The government] says, 'a lot of hope is brought/shouldered by Ashas.' We are the Corona-Warriors. All the Asha workers have to go directly to people's houses; it is such a big deal to go into the house of someone who is Corona-positive! Ashas also have kids at home but still she puts her life on the line … For the amount of work we are doing, the payment is very little …. People continue to work hoping that the Government will think of us … Like people's hopes are on us, our hope is on the Government to do something for us like make us regular. (Sarita, November 7)

Critically, while respondents expressed sincere commitments to social work, they also felt that they should be remunerated for this labor. While Sarita is keen to be granted formal government worker status rather than being labeled 'volunteers', others had more modest hopes of having their COVID-incentive extended throughout the pandemic. Kamla lamented,

> We worked really hard but our disappointment comes from that our demands, what we were receiving during corona - Rs.1000 ($14 USD) - if they could fix that amount then that would have been nice. (Kamla, October 10)

Our research participants had differing levels of optimism about whether the rhetoric of praise would translate into better working arrangements. Many felt that such changes were inevitable given the central role they played during lockdown. Moreover, some felt hopeful due to comments made by their superiors and the intense morale-boosting they had received. One ASHA made the case:

> Government has already recognised that in such a critical time, ASHAs have not left the Government alone. Government teachers are easily sitting at home and getting fat salary almost Rs.40,000 ($540), and we get Rs.1500 ($21) per month and we are giving our entire month. Yesterday our supervisor was also saying, 'my Block is functioning only because of Asha Workers … ' The Block manager was also saying the same thing: 'only ASHA workers are the ones going into the field and working in such less income … if the Government does something for you then that is good'. (Manju, August 28)

Manju's comment leaves much to be unpacked about how the Indian health governance infrastructure move towards a decidedly neoliberal modality where ASHAs are essentially contract workers for certain tasks such as encouraging institutional childbirth. This piecemeal approach to delivering 'health' that relied heavily on hours of unpaid labor needed to persuade families to utilize various health services became untenable in the pandemic, and district health officials more clearly realized their dependence on ASHA labor. Thus, while the metaphors of war that hailed them as 'defenders of the nation' invoked a nationalistic call to duty, it also made ASHAs more strongly see their own value to the nation and emboldened their conviction to fight for better working conditions beyond the immediate lockdown. One ASHA exemplified this sentiment, stating,

> We had said that unless Government will not give us some relief with our status, we will not work further in Corona crises. Earlier the Government said they will make us regular and increase our incentive. First, they gave us hope then at the end they gave letter to the Panchayat Secretary that we are not regular and not even increasing our incentive. (Diya, December 23)

Diya is referring to a past set of rumors that ASHAs were about to be conferred regular employee status, which the panchayat secretary revealed was untrue. This experience made Diya skeptical that COVID related rhetoric on ASHA importance would materialize into better worker conditions, but also emboldened her to signal this was the 'last straw' in exploiting ASHA labor. Others also expressed that they would abandon their position if governmental praise did not transfer into tangible improvements. Saraswati stated,

> During Corona, the only thing that has increased is only respect and respect, no money had increased, (she laughs aloud at her own joke then becomes somber). But respect will not run my household. I will quit if the Government doesn't think about ASHA in the next 2–4 years (Saraswati, October 27)

Notably, in this pocket of Himachal the most coveted job for young men is a military posting. Their desire for such work, however, stems less from a calling to protect the nation and more from the job security and pension that accompanies the position. Thus, if the war metaphor is taken to its logical end it would result in official government employee status and all associated benefits. As Bates (2020) contends – war metaphors have substantial risk if their rhetorical entailments (e.g. ASHAs as warriors) are not matched with appropriate actions, such as proper awards or pensions. While some have more modest demands to see monthly increases in salaries, most women felt that regular government status would be the ultimate reward for their service.

5. Discussion and conclusion

Our work provides a novel contribution by tracing how governmental rhetoric that sought to mobilize ASHAs through the use of war metaphors resonated in the ways ASHAs both performed work and imagined their relationship to the state and communities they serve. In particular, our data show that through heavy praise and wartime calls for service, ASHAs were both proud 'warriors' and also compelled to work due to the risk of letting down their community. While many felt deep fear and that they were ill-prepared, there was at atmosphere of moral urgency that constrained their ability to "not say no". At the same time, they remained highly cognizant of the inequalities that permeated these demands on their labor. Many spoke of sacrifices made both to their own personal health as well as their families, while expressing

anger that superiors and other villagers were not being asked to expose themselves to such great risks. Existing literature notes the war metaphors imply collateral damage (Rohela et al., 2020) and in many respects the ASHAs were highly aware this could be them. We saw that preexisting gendered tropes around women's labor as less valuable (c.f. Maes, 2015; Ved et al., 2019) intersected with calls to service and worked to 'naturalize' being asked to expose oneself to risk. Given the high numbers of women working in close-to-community health positions in the global north and south, more work could examine how gendered narratives shape discourses around frontline and essential worker disposability. In particular, work might build on this study to further probe how other axes of social difference such as caste or ethnicity may have exacerbated burdens on certain already marginalized frontline workers or shaped the ways frontline workers distributed care themselves.

Yet, while ASHAs expressed a strong conviction they would "not say no" to calls to service given the urgency of the situation, their engagement was sustained through the lures of greater reward both in terms of increased prestige and recognition and the potential for improved employment conditions. It is here we argue that the hypothesized socio-spatial implications of war metaphors intersect with certain institutional histories and local politics. In particular, ASHAs themselves became emboldened to invoke notions of warriors being rewarded for their national service as an extension of the war metaphor. While Bates (2020) contends that deploying war metaphors in ways inconsistent with common understandings of war can result in political fallout and public distrust, our work highlights how these understandings are not unidimensional and are negotiated within one's particular social location and proximity to the rhetoric. Moreover, ASHAs' orientation to the war metaphor was also shaped through the everyday contingencies that highlighted both their centrality to maintaining order in the lockdown, and the unjust ways such responsibility had been lofted onto them (e.g. to regulate outside movement into the village). This has significant implication for the ASHA system in India as CHW research shows that when supervisors hint at future benefits and these are not realized, there is a strong demotivating impact and increased likelihood of attrition (Bhaumik et al., 2020; Ormel et al., 2019). Our data suggest that, given the high risks and strong rhetoric, this may be particularly true in the context of the pandemic, and thus hailing ASHAs as COVID warriors and then not properly rewarding them may prove consequential to India's public health system over the long term.

This work, thus, has broader implication for understanding health governance in India. ASHAs have been positioned as key actors within India's health governance, and the events of COVID-19 further highlight how ASHAs do far more than menial village tasks but negotiate complex situations that require calculated decision-making (see also Kane et al. 2020). They, thus, should be seen as important governance actors, rather than merely bureaucratic orderlies (see also Nunes & Lotta, 2019). This is especially true as many respondents pointed to long working hours preceding the pandemic, which were essential to gaining the local legitimacy needed to wage a successful COVID-19 response. Thus, in many ways the efficacy of India's first lockdown in controlling the virus was largely subsidized by the years of unpaid labor and rapport building done by ASHAs. This arrangement is highly precarious in its dependence on the underpaid labor of women who are mostly resource poor and express considerable critique of the demands on their labor. This highlights the fragility of India's public health system, and the contradictions that are inherent in moves to decentralized, community-based forms of governance that remain underfinanced. As such, this analysis also contributes to long-standing debates on the working conditions of CHWs within and beyond the pandemic (Ballard et al., 2020; Nanda et al., 2020), as well as geographic analyses on how social reproductive labor was the un(der)paid failsafe that shouldered the burden of COVID-19 in India and beyond given widespread hollowing out of state health services (Rose-Redwood et al., 2020). While ASHAs have long agitated for regular salaries and government benefits, the Indian government has been slow to respond. Our work highlights the necessity of meeting these demands given the tenuous social contract that appears to be holding ASHA allegiance in place. At present, several state-level ASHA protests have resulted in increases in base salary while also commanding increased attention from mainstream media (Ghosh, 2021). While state-wise gains are important, the uneven governance and social protection between states already results in deepened spatial inequities among the poor and addressing ASHA concerns at the level of the state will only exacerbate this tendency (c.f. Dreze and Sen, 2002).

Our analysis of the ways ASHAs were implicated in India's COVID-19 response both affirms broader political geographical analyses of how decades of neoliberal state 'rollback' created particular forms of vulnerability for the already exploited under COVID-19 (Eaves and Falconer Al-Hindi, 2020; Morgan et al., 2021; Sparke & Anguelov, 2020) but also calls for more work from geographers to uncover the ways such zones of exclusion produced new forms of politics demanding accountability or exhibiting more transformative politics of care and reciprocity (c.f. Springer, 2020). In so doing, we see much need for geographers to make further contributions to the literature examining the politics, practices, and socio-spatial nature of community health worker systems. While Connell and Walton-Roberts (2016) aptly note the absence of geographic engagement with health workers, we argue for the need to look further than "skilled" professionals to focus on the less visible but equally critical networks of CHWs, who are the backbone of health infrastructure in many global South countries. The logics undergirding CHW workforces are highly spatialized, focusing on women as 'bridges' linking marginalized communities to the state and deploying classic tactics of governing at a distance to ensure accountability. While geographers have made substantive contributions in theorizing the neoliberal logics that construct such spatialized interventions into health and bodies (e.g., Brown et al., 2012; Sparke, 2020, Mitchell and Sparke 2015), greater ethnographic research is needed to unpack the tensions, resistances, and affective encounters within these understudied infrastructures of care and governance. This study demonstrates that the concept of geographic contingency allow for more productive ways of understanding the tensions and variability within health systems, as well as possible mechanisms for their change, rather than relying on simple dichotomous analyses that highlight either oppression or resistance.

In conclusion, this study contributes to our understanding of the way government rhetoric operates on the ground in shaping health worker action. It demonstrates how ASHAs' roles as health governance actors expanded quickly and dramatically with multiple implications for their health, safety and status. Perhaps more importantly, it complicates notions of dutiful warriors or calculating women and shows how ASHAs' motivations to perform COVID work stemmed from complex intermingling of patriotism, service, and hope for more livable working arrangements.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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