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# How do we pay back? Women health workers and the COVID-19 pandemic in India

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**ABSTRACT**

This paper looks at the experiences, vulnerabilities and contributions of women health workers during Covid 19 pandemic in India. It elaborates upon their everyday struggles and issues including incidences of violence against them, poor wages, temporariness of their jobs and other labour rights. The paper further discusses the transitioning characteristics of women health workers in the context of corporate globalization in India. The paper offers a critical reading of health worker's rights from a feminist perspective and raises the challenges and opportunities the pandemic provides in rethinking the role of women health workers in India and women welfare workers in general.

**KEYWORDS**

Women health workers and welfare workers in India; ASHAs; ANMs; corporate globalization; Covid 19

## Introduction

This paper calls for the recognition of a new, essential and redefined role of women health workers as has emerged during the Covid-19 pandemic. In this paper, I share the experiences – struggles and hardships of women health workers who were in the frontline fighting the Covid-19 pandemic in India the past two years. I will provide a historical review of the specific category of women health workers called ASHAs. Through a brief analysis of the working conditions of the welfare and health care workers in contemporary India, I reveal the increasing inequalities and exploitation in the context of privatization and corporatization of healthcare work at multiple levels, contributing to gradually eroding the rights of women health care workers. The objective of the paper is to generate a deeper understanding towards revaluing the contributions of women health care workers in India, considering the current conditions as a prerogative to seek progressive steps towards regularization of their work with better wages and, most importantly, rewarding them with the dignity and respect that they deserve.

Hard work which never pays, has been the story of India's public health workers. Their hard work, care, and attentive love for the country's most vulnerable have entered a new phase of hardship under the COVID-19 pandemic.

'They hit my daughter on the head with an iron rod,' said a health worker in October 2020 to the British news service Sky News (Lazarus, 2020). The health worker added, 'One woman bit me and said I would be infected too. They beat me and my son mercilessly. All because I tracked down one of their family members who had coronavirus'. Seventeen-year-old Suman barely survived a brutal

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attack on her in May 2020, in the country's northern state of Haryana (Prasad, 2020). The attack was in retaliation against her mother, a health worker, who had put up a quarantine notice for a neighbour as part of her duties. Just a month prior to it, Subhadra, another woman health worker and her family members were attacked in her home by a man from the neighbourhood (Mohanty, 2020). These women are part of India's government-run public health scheme known as Accredited Social Health Activists (ASHA) initiated in 2005 under the National Rural Health Mission (NRHM).

Interestingly, though employed under a government scheme, ASHA workers are described as 'activists' and they are not considered part of any professional workforce. Their work is voluntary and temporary though they are employed on long-term open contracts and they are paid an incentive (not a wage or even honorarium) based on their performance. Most of the welfare workers operate on their own or in neighbouring communities. During the course of the pandemic, many stories of mental and physical abuse are shared by women who are part of the ASHA scheme and similar state-run schemes like the Anganwadis, the Auxiliary Nurse Midwives (ANMs).

Public/community health workers play a particularly significant and direct role in dealing with the pandemic. During the lockdown, ASHA workers have been collecting data on COVID-19 patients, providing counselling and creating awareness in the community. At the moment, they continue to do so in the field, doing door-to-door surveys, including in containment zones/hotspots. The work that they do creates the risk of them being boycotted and attacked by some local people in certain situations and being accused of spreading the virus. Not surprisingly, these women workers are also becoming susceptible to COVID-19, as is the case for health workers in other countries (Amnesty International, 2020).

As many scholars have already pointed out, the Covid 19 pandemic, in many ways redefined the nature of precarious forms of care and life making work (Jaffee, 2020). It redefined the role of the so-called essential worker as life making rather than profit-making (Siegmann, 2020). These scholars have also shown how the experiences of these essential workers vary in terms of the multiple locations they are placed in providing care to the community between health workers, domestic workers or sex workers. The experiences of health workers in India during the pandemic are shaped by the already existing fragile and overburdened public health system in India. There is drastic unevenness in the infrastructure between rural and urban India. Increasing privatization and corporatization of the healthcare system in the country in the contemporary times have also added disparately to the current situation (Qadeer et al., 2019). Further, in the case of India, while some effects of the pandemic are immediate, some are complex and some with a long-standing impact, often adding to the existing gender inequalities in the country (Agarwal, 2021). The heavyweight of responsibility in dealing with the outfall of the pandemic has fallen upon certain sectors of India's workers, especially the community health workers. This is recognized by health campaigns like the Jan Swasthya Abhiyan and All India Peoples Science Network (Hans et al., 2021, p. 5), which have tried to protect these workers and educate the community.

During the initial phase of the Covid 19 pandemic in 2020, India witnessed a massive and historical exodus of migrant workers from the cities back to the villages (Breman, 2020). This is a reversal to the earlier processes of multiple forms of internal migration, which have taken place in the country from the rural areas to the cities over the past several decades. In the immediate context, this exodus raised more concerns and questions around the spread of the pandemic, basic access to health care and containment of the pandemic. Most migrant workers who move from villages to the cities in search of a livelihood are dependent on welfare workers like ASHAs or Anganwadi workers for helping them with basic needs around childcare, education or basic health care,

including reproductive health needs (Hans et al., 2021, pp. 40–41). This situation also raised larger questions around the safety, security, and vulnerability of migrant workers in the context of what is considered pandemic citizenship (Chowdhory & Poyil, 2021, p. 24).

In 2006, while living in Delhi, I witnessed a massive well-organized hunger strike by thousands of women welfare workers from Anganwadis all over India, demanding better wages (these workers are still not paid a legal wage but an honorarium which can vary between states and schemes) and job security. With the inspiration I got from witnessing this strike, from then until now, I have continued to follow the struggle for the labour rights of these women welfare workers. Over the past decade, the number of state welfare workers in India have increased tremendously and the existing schemes have expanded. Between the three major welfare schemes, the Anganwadis, ASHAs and Mid-Day Meal workers, there are around 5 million women workers. Through organising efforts, women workers have successfully won wage increases. In terms of their rights towards recognition, fair wages and regularization of work, there is still a long way to go.

With the entry of the Covid 19 pandemic, the story has changed completely. By April of 2021, a second wave of the Covid-19 pandemic hit the country, with daily deaths rising to 3,600 by the end of the month. Hospitals ran out of oxygen and ICU beds, with the country's underfunded healthcare facilities swamped with patients (Shivji, 2021). There are no official reports on how many health workers died in the country due to covid, though state-wide reports suggest that the number is high (Madhav & Gurmat, 2021). While the country's health system failed to cope with the pressures of the pandemic, these women welfare workers in India were at the centre of a crisis which made it necessary and in fact, provided an opportunity to rethink and reimagine their contributions to the community.

## Women welfare and health care workers in India

Feminist scholars like Nancy Fraser (2017) discussed how the inherent contradictions within contemporary capitalism contribute to its increasing conflict with care work and social reproductive work. In the context of the covid 19 pandemic, these contradictions need to be understood in a new light, with a deeper analysis of its impact on women's livelihood, income, etc. along with an attempt to reinterpret and revalue care work and welfare work. Globally, women at the margins contribute much towards building care for the environment and for their communities. Care work, which women largely perform, is foundational for human social relations, especially for communities in the Global South (Razavi, 2012). The gendered and feminized image of women being good caregivers have further contributed to more and more women volunteering for the social welfare sector work (Palriwala & Neetha, 2009). In fact, many times, it is the very same women who have lost their land and livelihoods or are forced to migrate to the cities looking for a livelihood who are used/employed as health or welfare workers by the state and other institutions to protect and provide care to others. Story of a welfare state and its policies is not just the story of its beneficiaries. In fact, primarily, it is also the story of its welfare workers since they are the ones on the ground, making sure the implementation of schemes and policies are addressed in a meaningful way. India has a long history of welfare policies and schemes. At the level of the implementation of social welfare schemes, an important part of the story of welfare workers in India from its older days in the 1970s to now, largely neglected, has been the story of women workers in the state-run welfare schemes, providing social welfare support to the marginalized sections in the country.

Women workers in welfare schemes in India have been organizing themselves in the past few decades to address issues of their right to minimum/living wage, regularization of their work

and unionization along with the impact of broader issues like the privatization and NGOisation of social welfare schemes under the globalized neoliberal political economy. Work in these schemes of social welfare, in general, are strongly gendered and feminized in nature, reflecting on the broader patriarchal characteristics of Indian society. Further, the attempts towards privatization in multiple levels in these schemes have in fact contributed to some extent to the entry of private capital into local communities through these schemes (Sreerekha, 2017, p. 161). Further, in recent times, projects of neoliberalism and Hindu nationalism, though contradictory, have joined hand in hand to reinforce the patriarchal gender relations in regard to welfare through new laws and social policies (Chhachi, 2020).

India's public health sector is diverse and complex. In their study of rural health workers in India, Sheikh and George (2010) reveal how workers cope with poor housing conditions, unreliable transport systems and unpredictable drug supplies in the rural areas. While policymakers talk of the social welfare policies and its beneficiaries, there is not much attention given to the condition of health workers. Further, considering the nature of their work, while health workers engage actively with the community, the boundaries between their professional and personal lives are blurred. However, according to Sheikh and George, though the relationships thus formed are more informal, these informal relationships also create boundaries and hierarchies which constrain public health workers as they negotiate the interface between their roles as health workers and community expectations.

Historically, women's voluntary local organizations like Mahila Mandals contributed to the work in social welfare sectors, specifically to community/village health worker networks. Whether as Anganwadi workers, community/village health workers or as Auxiliary Nurse Midwives (ANM), many women in local voluntary organizations worked in social welfare projects both as in the status of a worker or as a helper for the worker. The relationship between the women worker and helper in these schemes are intertwined with issues of power and hierarchy, which are further shaped by caste and class-related positions in the community (Sreerekha, 2017, p. 158). Many of these women workers have been part of these schemes for decades as temporary/contract workers. Most of these women honorary or contract workers were expected to contribute to all public health matters, integrating them with multiple social welfare projects.

The Auxiliary Nurse Midwives (ANMs) in India are the predecessors of ASHAs and in their current role. ASHAs are expected to work under their guidance. In recent times, with more ASHAs joining the mission, ASHAs have become the face of community health work in India. However, ANMs continue to have a major role to play in public health especially in rural areas of India. The Auxiliary Nursing Service was started in India 1942 in response to the acute shortage of nurses during the Second World War and gradually, they became ANMs who later became a permanent staff of the public health system. In the 1970s, the role of the ANMs gradually changed from a midwife to a 'multi-purpose' public health worker, spreading their work to many sectors. Between 2014 and 2019, the current BJP government also have introduced few schemes like Beti bachao beti padhao (2015) though most of the new schemes do not directly address issues related to care or health work and the implementation of most of schemes and policies are undertaken by women welfare workers like the Anganwadi or ASHA workers.

Compared to ASHAs, ANMs were better paid, had better and longer employment contracts and were supported directly by the central government, while ASHA workers are paid an incentive purely based on the tasks they fulfil. Interestingly, ANMs included male workers, which is not the case with the ASHA workers today. ANMs were considered more skilled and professional with technical training in the nursing field. Many colleges in India (mostly privately owned)

which offer nursing or midwifery degrees, along with recruitment agencies and trainers at multiple levels, are involved in planning various training of six months to 2-year periods for midwives. In some cases, similar training is given to ASHAs with similar qualifications. In 2011, the National Advisory Council (NAC) in India recommended a convergence of work between Anganwadi Workers (AWWs), ANMs and ASHAs. While these scheme workers are officially part of the community health projects, multiple other state level welfare schemes (Kudumbashree in Kerala), and volunteers and self-help groups at the state and local level in the field of care, sanitation, etc. are also part of the community networks towards addressing public health in India.

In my study of the Anganwadi workers in India, I have seen that many women who engage in community work are from marginalized communities, and they do consider themselves to be part of a collective, working for the community and are not focused only on their individual existence. A strong belief in collective existence inspires many women to take up welfare work to go beyond the individual and the family and dedicate themselves to the community, even when they have very little resources and have no support system to rely upon. However, in some contexts, it is also desperation out of poverty and lack of livelihood which compels women to take up this work (Sreerekha, 2017). State welfare programs in the Global South have majority women workers, because women are the cheapest labour for the contemporary capitalist economy and their conventional representation as so-called natural caregivers. For governments, the availability of a cheap and desperate pool of women workers is always an advantage to employ them, forcing them to voluntarily serve their own communities (Ibid).

Historically, in the case of women's work, the boundary between voluntary and forced work has been mostly blurred. A long and complex history of a combination of voluntary work and forced work mostly by women in multiple forms and contexts are thus part of the history of public health workers in India. Similar to the definition of essential workers, which can be extended to multiple areas of work in the informal sector, the definition of health work can also be broadened and included within multiple forms of care work. Making women workers engage in voluntary, honorary or contract work in the social welfare sector under schemes initiated by the Indian government has in fact contributed to a redefining and restructuring of what is considered public sector work in India. Public sector work in the context of India otherwise comes with the benefits of formal sector work where unlike in the private sector, employment is directly linked to permanency, living wage and other benefits of the formal sector. By keeping women from local communities engaged in voluntary or honorary contract-based social welfare work, the Indian state has been successful in creating a separate space for women workers which is outside the definition of both the private and the public or the formal and the informal.

## Covid 19 and ASHA workers

India's health workers have shown tremendous courage and commitment in facing the COVID-19 crisis. A report released in September 2020 as part of the Global in Women's Health series (Down to Earth, 2020) revealed that many workers are paying from their own pocket for purchasing gloves, masks, and sanitizers. In fact, many of them are in the field without masks and hand sanitizers and lack access to many other protective measures. In the current circumstances of COVID-19, health workers in India are burdened with more and more work and struggling to survive, considering the increasing responsibilities and attacks on their labour rights.

With huge numbers of covid related deaths and severe lockdowns, talking about research and collecting information and stories has been, to some extent, unthinkable. For this reason, this

paper is mostly based on research through telephonic conversations before and after the second wave of the pandemic in India. In a diverse country like India, the experiences of health workers are hugely different between states. To know more about stories from Delhi, in the month of June 2020, I asked Mohd Akif Siddiqui, who lives and works with a non-profit in Delhi, to speak with a handful of ASHA workers from Chirag Delhi and Seemapuri region. In the absence of any external funds, I supported Siddiqui financially for his expenses towards the research with my personal savings. Since Siddiqui is part of the activist network in Delhi, we think it is important and possible to extend this research with more depth at a later stage which would prepare the community to address similar situations in the future and would further contribute to their struggle for recognition. Keeping in mind safety measures with the pandemic situation, Siddiqui spoke over the phone with six ASHA workers, all of whom live and work in various parts of Delhi. The workers were of the age between 30 and 40 and the conversations were recorded and transcribed into detailed transcripts. General information on ANMs was also collected in order to get a background and context to the work of ASHAs. Further, there are umpteen number of online materials available as short articles and reports published on the condition of health workers in India during the pandemic, which helped the research immensely.

In the past year, ASHA workers in Delhi have been in the field every day, facing the risk of getting infected themselves. They are not from privileged backgrounds where they can afford to self-isolate themselves in their homes. The pandemic has led to a cut in their incentive for attending to a smaller number of cases. Working for an incentive itself makes them vulnerable to abuse or humiliation. There is no extra pay offered even though they are working even on weekends. In most states, there is no guarantee that work will pay, or it will pay as it deserves. Only women aged between 25 and 45 years are employed as ASHAs and they are paid an incentive-based on the services or activities taken up by them. For example, getting the vaccination of an infant fetches them ₹150, a medical checkup for a pregnant woman pays ₹200, accompanying her for a hospital delivery pays ₹400 and helping with birth control pays ₹500 and so on (note: $1 USD equals ₹74 INR). The amount varies between states. Each public health centre has around ten ASHA workers, divided up as one worker for a thousand people, and there are around nine hundred thousand ASHA workers in India today.

Prior to the COVID-19 pandemic, these women had a routine of helping with pregnancies, childcare, immunization, care for the elderly, etc. They also conduct surveys and collect information on patients with cancer, leprosy, tuberculosis and HIV/AIDS and keep records of deaths in the community, including information on the cause of death. They maintain health registers and mobilize families in the community around health matters. The incentive paid to India's women workers in the state social welfare schemes like ASHA is much less than the legal minimum or living wage. In 2005, when the ASHA scheme was initiated, it offered a minimum incentive of ₹1300 ($17) per month. Fifteen years later, in most states, they are still paid an amount between ₹2000 ($26) to ₹7000 ($93) per month. Often, even while fighting covid 19, these payments are delayed for months (The Logical Indian, 2020). In order to get paid, they have to show proof of accountability for each task they take up and its completion.

With the spread of the pandemic, the regular activities of many of these health workers have been stalled. Addressing any other illnesses, including chronic ones which are unrelated to Covid must take a back seat. Further, no one else attends to those duties today. As a result, their services to those who need it most, especially the poor, remain suspended. Unlike women from both middle-income and high-income groups who can afford private hospitals and do not necessarily need help from these health workers, poor women have no options. They are fully

dependent on public health centres and health workers. The vacuum created by the pandemic is huge. Many low-income working-class women who need help with pregnancies and giving birth do not have it, leading to the deaths of hundreds of newborns and pregnant women (Press Trust of India, 2020). There is no support for women who want to take birth control and avoid unwanted pregnancies.

During the pandemic, ASHAs are expected to support those who are in self/home isolation. If the area is declared a hotspot, these workers are required to survey 50 neighbouring houses for anyone with symptoms as a preventive measure and are offered an incentive of ₹1000 for the visits. They help those with symptoms with testing and collecting reports of their results. Sometimes they help distribute masks, medicines or even food for those in need, other than providing further guidelines for home isolation. In some parts of the country, the pandemic also added addressing mental healthcare into the responsibility of ASHAs and Anganwadi workers. In the absence of a mental health care delivery system and lack of access to essential medications during the pandemic, public health workers had to ensure continuity of such care (Patley et al., 2021).

During the pandemic, regular hospital visits are risky; however, health workers cannot avoid it if they have to attend to their work. While doctors or nurses are provided with masks, health workers are not. Home visits in the community put them at a higher risk. When a worker is back home from the field, neighbours complain of putting them at risk. Like the stories of physical attacks, some workers had their neighbours stop them from completing their tasks and even threatened them so that they had to call for police protection. Following the attacks, some of these women also face an uncertain future with no support system to recover from the physical or psychological injury along with the lack of job safety. Unlike formal medical professionals who have a better support system and a safer workplace to go back to, these women health workers mostly do not have the resources or a support system whether in their families or communities to help them get back on their feet.

Production and distribution of Covid 19 vaccine in India need to be cost-effective considering its large population and economic inequality. As a country with a long history of vaccination, multiple firms in India are engaged in the production of Covid vaccine at the moment. Vaccine distribution has varied between states, impacted by decentralization and the effectiveness (or lack thereof) of local governance structures, especially public health institutions and the working conditions of public health workers. ASHAs throughout the country have had an important role to play in vaccine distribution. For the workers, if they do not get a dignified wage that will protect their future, there is no point in getting protected against the vaccine (Chitlangia, 2020). There were also reports about unexplained deaths of ASHA workers following the administration of the Covid vaccine in January 2021. However, there was no official enquiry towards finding the real cause of death while the incidences of death were reported as part of a clinical trial using health workers (Srinivasan et al., 2021).

## Impact of privatization and corporatization

In the era of computers and the internet, one would imagine it would be easier to tackle a pandemic unlike in earlier times. The introduction of new technologies in the areas of vaccines, contract tracing, etc helped tackle the pandemic and have directly supported frontline health workers. However, the pandemic exposed extreme levels of inequality and apathy towards providing basic health care to marginalized communities. While big corporations globally have been hugely investing in AI technologies, thousands died during the pandemic only due to a lack of access to oxygen cylinders in hospitals all over the world.

In the case of India, from the 1990s onwards with the opening of the Indian economy to liberalization and structural adjustment policies (SAPs), the Indian state has withdrawn in a major way from spending in the social sector and further shown way to massive levels of privatization and corporatization of the economy (Ghosh & Chandrasekhar, 2017). International institutions like the World Bank and organizations of the UN contributed to accelerating the processes of privatization of health care in neoliberal times, resulting in the increasing inequalities in access to health care in countries like India. Globally this has also inspired women's movements to challenge these processes and organize women health workers and activists against neoliberal austerity (Petchesky, 2017, p. 156).

An important challenge in the field of health workers during this era of globalization and liberalization in India has been the large-scale schematization of welfare work along with privatization of sections of it (Majumdar, 2008). In the past two decades, the social welfare sector in India has seen an expansion in terms of its attempt to universalize and reach out to more beneficiaries and employ more workers under the welfare schemes. This expansion has been influenced by the entry of private capital, influential large so-called development organizations like USAID and a beehive of local and international NGOs. These changes have helped pave the way for the neoliberal restructuring of the social welfare sector in India, mainly through private-public partnerships in the social welfare sector.

According to Chhachi (2020), it is important to understand how social welfare policies in contemporary India depart or reinforce neoliberalism. For her, this would be possible based on if they further a process of decommodification towards universalistic social citizenship-based entitlements as well as employment-based entitlements or whether they promote stratified market-based entitlements (p. 63). According to her, there has been a shift in the policies from welfare in India to financialization and market fostering individual entrepreneurism (p. 79). The current right-wing nationalist Indian government and its policies reflect a constant conflict and contradictions between its positions on support for local, national capital versus corporate capital. The difference between ANM as an older welfare scheme and the ASHA scheme and other relatively newer care work schemes both in the context of worker's rights and other impacts on its beneficiaries in many ways reflect these changes brought in through the processes of financialization and individual entrepreneurism. These changes otherwise broadly reflect the implementation of neoliberal policies in the social welfare sector in India.

Between the old and contemporary times, the changes in midwifery have been complex, revealing the tensions between what is defined as modern and traditional practices (Hollen, 2003). The modernizing process of midwifery in post-colonial societies like in India with its professionalization and institutionalization and medicalization of childbirth has already changed the face of midwifery in multiple and complex ways. This has resulted concretely in reworking the institutions and methods around which childbirth takes place. A definition of a modern midwife i.e, the standards and competencies of becoming a midwife is set today by the International Confederation of Midwives (ICM) located in the Netherlands. ICM is partnered by a long list of private corporations including Johnson & Johnson, Save the Children, Bill & Melinda Gates Foundation, MacArthur Foundation, to name a few. According to the International Confederation of Midwives, 'A midwife is a person who has successfully completed a midwifery education program that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of ICM Global Standards for Midwifery Education' (International Confederation of Midwives, 2017). The ICM documents are expected to be used as a guide globally in the education of midwives.

A transition from what was once considered midwifery in the past in many rural communities in countries like India has changed drastically and the narrative of this change is influenced and shaped by transnational corporations. By contrast the role of women public health workers has been largely limited to family planning and immunization, moving away from larger issues of reproductive health. Many ANMs in India can't complete the training needed to continue as birth attendants as per the guidelines of ICM due to multiple factors. As for ANMs, the duration of the training given to them is not long enough to quality them and at the same time, the Traditional Birth Attendant (TBA) training has been discontinued in most part of India whether for ANMs or ASHAs (Mavalankar et al., 2010, p. 52). It is important to not to romanticize the traditional face of midwifery since the old midwife and her knowledge of women's bodies, its relationship with nature and alternative medicine towards reproductive health of women must be also seen in the light of the challenges raised by the practice of casteism and poverty of the community which engaged in midwifery in the past (Malhotra, 2003).

While it's important to have a deeper understanding of the good and bad of the old, romanticized version of midwifery, it is all the more important today to have a critical take on the global standardization and corporate control of midwifery. From developing new narratives and knowledge on community health matters to producing, financing and marketing vaccines, transnational companies and the institutions that operate in tandem with powerful institutions hold enormous sway over local information, awareness and distribution of community health matters. During a deadly pandemic, transnational corporations along with the support of many state governments, have refused a waiver of patent restrictions on covid 19 vaccines leading to a 'vaccine apartheid' (Glenza, 2021).

## Conclusion

A high percentage of Covid cases in India appear to go un- or under-reported (Gamio & Glanz, 2021) and considering the number of covid affected and dead in the country, many stories are unfolding specifically from the experiences of health workers along with the community members. Increasing responsibilities have also given the health workers in India an opportunity for more visibility and recognition. In multiple states in India ASHA workers are successfully demanding increases in wages, insurance coverage and compensation for the kin of workers who died of covid.

It is undoubtedly clear that the most detrimental impact of the pandemic is on India's marginalized women who had to deal with the desperate day-to-day challenges of Covid-19. Adding to the pre-existing patriarchal structural issues like the feminization of poverty, intrahousehold dynamics and vulnerabilities along with the health situation developing around Covid-19 infections, many women at the same time have been victims of violence and abuse in recent months during the lockdown or self-isolation period. Further, in the midst of the pandemic, many sections of women have lost access to reproductive care along with other health care for other chronic illnesses as discussed earlier. It is the women welfare workers and other care workers and activists in the field who provide the much-needed care for these women.

The extension of care work to underpaid and unpaid jobs in the public sector, employing working-class women has been part of an attempt by the Indian state to incorporate women into the neoliberal welfarist development agenda. It also feeds into the cultural and social needs of local patriarchal and casteist institutions in India to use poor working-class women's labour in its favour. Beyond the fact that these women already play a superwoman role of the triple burden, they are

compelled to work on behalf of the state and the community. They feel responsible in times of crisis. They want to do more for others from their own communities. Many times, they are helping poor families or other women, leaving their own children at home with no care. The labour power of these women workers is thus fundamental to India's public health sector; it is both valuable and essential. The Covid-19 crisis is another moment, in addition to wars, sanctions, natural disasters, and other large-scale crises situations, where poor working-class women are being pushed to the limits of their survival. The risk to their lives is of course not only from the pandemic but from the lack of resources, and the lack of community and state support that could stop other women from facing the experiences of Subhadra, Suman and many others every day.

Though the pandemic made it extremely difficult to physically organize and further had an impact on the organizational capacity and bargaining power of the workers, in August 2020, more than six hundred thousand ASHA workers in India organized a massive nationwide protest demanding basic requirements and recognition (Patgiri, 2020). It is important to consider the increasing number of deaths of health workers around the world, which coincides with the lack of funding and proper protection. It is important to know and share their stories and to extend solidarity in their struggle to make the state and the community more responsible and accountable towards these workers. The story of the struggle of ASHA workers in India is not an isolated one. The burden of every crisis regularly falls on the shoulders of women workers who are asked to put their bodies in the forefront of struggles for survival. The impact of the pandemic should force the state and the communities to rethink the meaning of access to basic public healthcare as essential and health workers as essential life makers who serve as a backbone of local communities. Knowing that many of them have paid a heavy price for the community's survival, a genuine question we should ask is: how do we pay back?

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## Disclosure statement

No potential conflict of interest was reported by the author(s).

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