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Invisible Leadership amongst ASHA Workers and Gendered Governance in Post-Pandemic Public Health in Karnataka

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Abstract

The COVID-19 pandemic exposed the deep structural vulnerabilities of India's public health infrastructure, particularly in rural and semi-urban contexts. Amidst systemic failures, Accredited Social Health Activists (ASHAs) emerged as de facto leaders in navigating public health crises at the grassroots. Despite their crucial roles in contact tracing, community sensitization, and managing access to essential health services, ASHA workers continue to occupy the margins of leadership recognition within institutional governance frameworks. Their leadership, embedded in gendered expectations of care work and community mediation, remains largely invisible in mainstream policy narratives and organizational leadership discourses. This paper presents a sociological critique of leadership invisibilization by examining how ASHA workers negotiated power, authority, and community trust amidst structural constraints during and after the pandemic. Drawing upon empirical data from government reports, field studies, and grassroots testimonies from Karnataka, the study interrogates the gendered division of labor that frames ASHAs as voluntary caregivers rather than formal leaders. The analysis situates ASHA leadership within frameworks of gendered governance (Goetz, 1997), emotional labor (Hochschild, 1983), and informal authority (Scott, 1990) to challenge dominant hierarchies of leadership valorization in public health management. Furthermore, the paper critiques how policy architectures systematically devalue community-based leadership practices, while romanticizing narratives of resilience and frontline heroism without corresponding structural support. By foregrounding ASHA workers' experiences, this study argues for an expanded, sociologically grounded definition of leadership that accounts for informal, relational, and gendered modalities of governance operating within India's disrupted public health landscapes. In doing so, the paper contributes to re-theorizing leadership beyond managerial or positional paradigms, emphasizing the need to institutionalize recognition, representation, and resource redistribution for grassroots women health workers. This reconceptualization is pivotal not only for equitable governance but also for building resilient, community-centered health systems capable of responding to future disruptions.

Keywords: ASHA Workers, Invisible Leadership, Gendered Governance, Public Health Systems, Crisis Management

Introduction

Leadership discourse within public health systems is often monopolized by formal, institutional hierarchies that prioritize positional authority, managerial expertise, and technocratic efficiency. However, such a narrow conceptualization of leadership tends to marginalize the everyday governance practices of community health workers, particularly women, who navigate complex social terrains amidst structural constraints. In India, Accredited Social Health Activists (ASHAs) represent the most visible yet institutionally invisible segment of grassroots public health leadership. Despite their pivotal role during the

COVID-19 pandemic, ASHAs remain excluded from leadership recognition in policy frameworks and organizational discourses, revealing a persistent gendered invisibilization of labor and authority.

Launched in 2005 under the National Rural Health Mission (NRHM), the ASHA program was envisioned as a strategy to bridge gaps between the formal health system and rural populations. By 2023, India had over 1 million ASHA workers, with Karnataka alone employing around 42,000 ASHAs across its districts (Ministry of Health and Family Welfare [MoHFW], 2023). Yet, their official designation as "volunteers" rather than formal employees perpetuates a systemic undervaluation of their labor, confining them to the peripheries of decision-making structures (Nagaraj&Purohit, 2021).

The pandemic transformed ASHAs into de facto crisis leaders. Their responsibilities expanded exponentially, encompassing contact tracing, disseminating public health information, managing quarantine logistics, and facilitating vaccination drives (Ghosh& Gupta, 2022). A Karnataka-based study revealed that during peak pandemic months, ASHAs worked an average of 12-14 hours per day, often without adequate protective equipment or financial compensation (Kumar & Ramesh, 2021). Despite these contributions, ASHAs received a mere INR 2,000 per month as honorarium, juxtaposed against the critical leadership roles they performed in pandemic response coordination (International Labour Organization [ILO], 2021).

The erasure of ASHA leadership is undergirded by what Goetz (1997) terms as “gendered governance”, the systemic marginalization of women’s informal authority within formal institutional frameworks. Goetz emphasizes that governance structures often reproduce gendered hierarchies by valorizing masculine-coded attributes of leadership (e.g., managerial rationality) while rendering feminine-coded practices like care, mediation, and emotional labor as peripheral (Goetz, 1997, p. 23). In the case of ASHAs, their embeddedness within community networks, capacity for relational leadership, and emotional labor are central to their effectiveness, yet these dimensions remain unrecognized in policy architectures.

Arlie Hochschild’s (1983) theory of emotional labor further illuminates this invisibility. Emotional labor, defined as the regulation of emotions to meet organizational expectations, is disproportionately performed by women, often without acknowledgment or remuneration. ASHA workers' roles required them to navigate community fears, manage public anxieties, and emotionally mediate between skeptical populations and impersonal state directives during the pandemic, a form of leadership heavily reliant on emotional labor but excluded from formal recognition (Hochschild, 1983).

Furthermore, the leadership exercised by ASHAs aligns with James C. Scott’s (1990) concept of “informal authority”, the unofficial, relational power individuals wield through embedded community networks and trust. ASHA workers, through years of intimate community engagement, have cultivated a leadership style grounded in trust-based negotiations, rather than positional power. However, as Scott argues, informal authority is often devalued in state bureaucracies which privilege visible, codified forms of power (Scott, 1990).

Empirical data underscores this invisibilization. A 2022 survey by the Public Health Foundation of India (PHFI) found that 78% of ASHAs in Karnataka felt they were “treated as helpers rather than health professionals” despite leading critical pandemic interventions (PHFI, 2022). Another report by Oxfam India (2022) highlighted that ASHAs faced widespread harassment from both community members and health officials, a manifestation of the systemic devaluation of grassroots women’s authority.

Policy frameworks exacerbate this marginalization. While the National Health Policy (2017) acknowledges the role of community health workers, it fails to institutionalize their leadership within health governance structures, relegating them to an “auxiliary” status without decision-making power (MoHFW, 2017). The lack of formal employment status not only denies ASHAs labor rights and social security but also symbolically erases their leadership contributions in official narratives.

This paper, therefore, seeks to reconceptualize ASHA workers’ pandemic-era roles not as acts of voluntary caregiving but as instances of grassroots leadership amidst systemic abandonment. By employing a sociological lens that foregrounds gendered governance, emotional labor, and informal authority, the study interrogates the limitations of mainstream leadership paradigms in accounting for subaltern women’s leadership practices. In doing so, the paper responds to Chakraborty’s (2021) assertion that “the frontlines of

public health crises are led by women whose labor is essential yet rendered invisible by governance structures that do not recognize leadership beyond bureaucratic titles" (p. 45). Recognizing and institutionalizing ASHA leadership is not merely a matter of symbolic inclusion but a structural imperative for equitable and resilient public health systems in the post-pandemic world.

Research Objectives

- To critically analyze the forms of informal leadership exercised by ASHA workers in Karnataka's rural and semi-urban health governance during and after the COVID-19 pandemic.
- To examine how gendered labor divisions and policy structures contribute to the invisibilization of ASHA workers' leadership roles within institutional public health narratives.
- To propose a sociologically grounded framework for recognizing and institutionalizing grassroots women health workers' leadership in India's public health governance structures.

Gendered Governance and the Structural Invisibilization of ASHA Workers' Leadership

The invisibilization of ASHA workers' leadership is deeply entrenched within the structures of gendered governance, a term that encapsulates how institutional practices systematically marginalize women's roles in decision-making while simultaneously exploiting their labor for public goods (Goetz, 1997). In India's public health ecosystem, ASHA workers embody this paradox. They are essential to the functioning of rural health governance, yet their leadership is rendered peripheral due to deeply embedded patriarchal and bureaucratic norms.

At the heart of this invisibilization is the structural devaluation of feminized labor. Nancy Fraser (2016) critiques capitalist economies for their reliance on "care economies" where women's unpaid or underpaid reproductive labor sustains the formal economic sphere. ASHA workers, despite their critical engagement in care work, are symbolically positioned as "volunteers", a designation that not only absolves the state of providing fair wages and labor rights but also structurally denies these women recognition as legitimate actors in leadership hierarchies (Fraser, 2016).

Empirical evidence illustrates the scope of this systemic marginalization. According to a 2021 survey by the Indian Institute of Public Health (IIPH), 82% of ASHA workers in Karnataka reported that they were not consulted in local health planning meetings, even when their on-ground experience could offer critical insights (IIPH, 2021). This exclusion is not incidental but reflects a broader governance logic where leadership is equated with bureaucratic position and credentialism, sidelining experiential and community-embedded forms of authority. Moreover, the conceptual framework of gendered governance (Goetz, 1997) reveals how institutional cultures perpetuate masculine-coded leadership ideals, emphasizing traits like technocratic rationality, administrative control, and hierarchical command structures, while devaluing feminine-coded leadership practices such as care mediation, emotional labor, and relational governance. ASHA workers, whose leadership is embedded in trust-based community networks and emotional engagement, are thus rendered invisible within the formal metrics of leadership efficacy.

The pandemic further exposed the exploitative dimensions of this structural dynamic. ASHA workers were thrust into frontline crisis management roles, handling community surveillance, quarantine enforcement, and vaccination outreach, without corresponding institutional empowerment or resource allocation. A 2022 Oxfam India report highlighted that 94% of ASHA workers in Karnataka did not receive adequate personal protective equipment (PPE) during the peak of COVID-19, despite being tasked with high-risk community interventions (Oxfam India, 2022). This lack of institutional support starkly contrasts with narratives that celebrated ASHAs as "frontline warriors," exposing the performative nature of state recognition that fails to translate into structural inclusion. Additionally, the informality of ASHA employment, classified as "honorarium-based volunteerism", ensures that their labor is structurally undercompensated. ASHAs receive a baseline incentive of INR 2,000 to 3,000 per month, supplemented by task-based payments (e.g., immunization drives, maternal health visits) (MoHFW, 2023). This fragmented payment structure reinforces their status as peripheral auxiliaries rather than integral governance actors, systematically obstructing their leadership visibility.

Theoretical insights from Arlie Hochschild's (1983) emotional labor framework further unpack this invisibilization. Emotional labor, defined as the regulation of one's emotions to meet organizational

expectations, forms a significant yet unacknowledged component of ASHA work. During the pandemic, ASHAs often had to mediate community resistance to public health directives, manage the psychological stress of families in quarantine, and navigate their own fears of infection, all while projecting calm and authority (Hochschild, 1983). These affective dimensions of leadership, being feminized and informal, are systematically devalued within bureaucratic governance metrics.

In this context, James C. Scott's (1990) notion of "informal authority" becomes analytically salient. ASHA workers exercise a form of leadership that is not codified in official hierarchies but is deeply entrenched in relational networks of trust and community legitimacy. Scott argues that informal authority operates through the cultivation of social capital and tacit negotiations, challenging the state's monopoly on defining legitimate leadership (Scott, 1990). However, the Indian public health bureaucracy, with its top-down administrative culture, lacks institutional mechanisms to recognize and integrate such forms of grassroots leadership.

The impact of this invisibilization is multi-layered. At the micro-level, ASHA workers experience diminished self-efficacy and chronic occupational stress due to the dissonance between their de facto leadership roles and the lack of formal recognition or support. A 2023 study by the Public Health Foundation of India (PHFI) noted that over 70% of ASHAs in Karnataka reported burnout and feelings of institutional abandonment during the pandemic (PHFI, 2023). At the macro-level, the systemic sidelining of ASHA leadership undermines the effectiveness of public health interventions, as policy designs remain detached from ground-level realities. Furthermore, the romanticization of ASHAs as "community caregivers" rather than as "public health leaders" reflects broader patriarchal narratives that equate women's work with altruism and sacrifice. This cultural framing allows governance structures to exploit ASHA labor under the guise of community service, masking the urgent need for structural reforms in labor rights, leadership recognition, and participatory governance mechanisms.

Thus, the invisibilization of ASHA leadership is not merely a bureaucratic oversight but a structurally embedded outcome of gendered governance logics that devalue feminized labor, emotional leadership, and informal authority. Recognizing ASHAs as legitimate leaders requires a paradigmatic shift in leadership discourse, one that redefines leadership beyond positional authority and integrates relational, affective, and community-centered practices as legitimate modalities of governance.

Resilience Narratives and the Politics of Recognition: State Performances vs ASHA Realities

The post-pandemic public discourse in India has been saturated with state-sponsored narratives celebrating Accredited Social Health Activists (ASHAs) as the "backbone of rural health" and "frontline warriors" (Press Information Bureau [PIB], 2022). Such rhetoric, however, operates within a carefully constructed politics of recognition, where symbolic appreciation is deployed to obscure the structural precarity and labor exploitation inherent in ASHAs' working conditions. The glorification of resilience becomes a performative mechanism that shifts the responsibility of governance failures onto individual actors, predominantly women from marginalized social strata, thereby depoliticizing systemic neglect.

The ideological function of "resilience narratives", as argued by Andrea Leverentz (2021), is to valorize coping mechanisms while deflecting attention from the social structures that necessitate such resilience. In the context of ASHAs, the discourse of resilience serves as a convenient policy tool to celebrate their adaptive capacities while absolving the state of institutional accountability. Resilience, in this framing, becomes a neoliberal virtue, a quality of individuals rather than a systemic outcome of equitable resource distribution and governance efficacy (Leverentz, 2021).

Empirical data underscores the disjunction between state performances of recognition and the lived realities of ASHAs. In June 2021, the Government of India announced a one-time COVID-19 incentive of INR 1,000 per month for ASHA workers for four months (MoHFW, 2021). However, field reports from Karnataka indicate that a significant portion of ASHAs either received delayed payments or were excluded due to administrative lapses (Nayak& Ramesh, 2022). A survey conducted by the All India Trade Union Congress (AITUC) revealed that only 58% of ASHA workers in Karnataka received this incentive in full by the end of 2022 (AITUC, 2022). Furthermore, the politics of recognition operates through spectacles of performative gratitude, clapping, awards, public felicitations, while systematically resisting the structural demands of

ASHAs for fair wages, employment security, and leadership representation. As Nancy Fraser (2000) critiques, recognition without redistribution results in "affirmative remedies" that mask the need for transformative structural change. ASHA workers are celebrated in public ceremonies but continue to lack formal employment status, labor protections, or participation in governance forums that shape public health strategies.

The Karnataka ASHA Workers Union (KAWU) has repeatedly protested this tokenism, articulating demands for formal employment recognition, inclusion in health governance committees, and a monthly salary aligned with minimum wage standards (KAWU, 2023). These protests reveal the underlying contradiction: while ASHA labor is indispensable to public health delivery, their leadership is relegated to an informal, invisible domain, external to institutional leadership architectures. From a sociological perspective, this disjunction can be understood through Pierre Bourdieu's (1986) concept of symbolic violence, wherein power operates through the internalization of hierarchies and misrecognition. The constant valorization of ASHAs as "selfless volunteers" conditions both the public and the workers themselves to accept their marginalization as normative, thus perpetuating their exclusion from leadership roles. Bourdieu's framework elucidates how symbolic acts of recognition, like calling ASHAs "the heartbeat of rural India", become instruments of structural domination when not accompanied by material redistribution and institutional empowerment (Bourdieu, 1986). Additionally, the state's emphasis on ASHAs' "natural leadership" within communities perpetuates essentialist gender norms. The notion that women, by virtue of their gender, are inherently predisposed to caregiving roles reinforces patriarchal assumptions about women's work being altruistic and non-institutional. This resonates with Joan Acker's (1990) theory of gendered organizations, which posits that organizational structures are not gender-neutral but are embedded with masculine-coded norms that systematically marginalize feminine labor practices, particularly care work. ASHAs' leadership, rooted in emotional labor, community mediation, and relational governance, remains devalued precisely because it does not conform to bureaucratic models of leadership performance.

The state's resistance to formalizing ASHA leadership is also influenced by fiscal and governance logics. Recognizing ASHAs as formal leaders would necessitate structural changes in wage frameworks, labor rights, and decision-making processes, implicating significant financial and administrative shifts. Thus, the politics of recognition becomes a strategic governance tool that allows the state to extract labor under the guise of volunteerism while avoiding the structural obligations that formal leadership recognition would entail. Moreover, media representations have played a critical role in amplifying this politics of recognition. While numerous articles and reports have highlighted ASHAs' frontline heroism, few interrogate the systemic exploitation and governance failures underlying their working conditions. This selective visibility aligns with Michel Foucault's (1977) concept of bio-politics, where states regulate populations not through overt coercion but through the strategic management of bodies and labor, constructing narratives of heroism to obfuscate neglect.

To move beyond the politics of recognition, it is imperative to reconceptualize leadership in a manner that encompasses informal, relational, and care-based practices as legitimate forms of governance. This requires integrating ASHA workers into formal decision-making structures, ensuring wage justice, and institutionalizing mechanisms for their leadership representation in public health governance frameworks. In sum, the resilience narrative operates as a double-edged sword, on one side, it celebrates ASHAs' adaptive agency; on the other, it perpetuates their structural marginalization by depoliticizing their labor struggles. Recognizing ASHA workers as leaders demands a paradigm shift in governance logics, one that dismantles performative recognition structures and reconfigures leadership as a distributed, community-embedded praxis.

Reconceptualizing Leadership and Policy Imperatives for Institutionalizing ASHA Workers' Governance Roles

The persistent marginalization of ASHA workers from formal leadership recognition underscores the urgency of reconceptualizing leadership in ways that reflect the lived realities of grassroots health governance. Existing leadership models in public administration remain anchored in Weberian bureaucratic rationality, privileging hierarchical authority, formal credentials, and positional power (Weber, 1947). However, the pandemic experience has made evident that leadership is not exclusively located within formal

titles or organizational charts; it often emerges from relational, affective, and community-embedded practices of governance, as embodied by ASHA workers across Karnataka.

To address this disconnect, it is imperative to adopt a distributed leadership framework that recognizes leadership as a dynamic, collective process rather than a static position (Spillane, 2006). Distributed leadership theorists argue that leadership functions are exercised across multiple organizational actors through networks of collaboration, negotiation, and shared responsibility. ASHA workers, through their roles in health mediation, emotional labor, and crisis navigation, exemplify this model of distributed governance. However, in the absence of institutional acknowledgment, their leadership remains informally practiced and structurally unrecognized.

From a policy standpoint:

1. **Formal employment recognition of ASHA workers**. Transitioning ASHAs from "volunteer" status to formal public health employees with labor rights, fixed salaries, and social security benefits is foundational to institutionalizing their leadership roles. This would entail reconfiguring their contractual arrangements to align with labor laws and minimum wage standards, ensuring economic security and occupational dignity.
2. I**ntegration of ASHA representatives in decentralized health governance bodies**: Panchayat-level health committees and district health planning boards must include ASHA-elected representatives, providing formal platforms for their experiential knowledge to shape health policy decisions. Such participatory governance models align with AmartyaSen's (1999) capabilities approach, which emphasizes enhancing individuals' agency through institutional structures that enable them to exercise decision-making power.
3. **Leadership training programs tailored to ASHA workers' specific governance contexts** are essential. Unlike technocratic leadership modules, these programs must focus on enhancing community mediation skills, conflict resolution, health advocacy, and policy literacy, grounded in their socio-cultural realities. This approach draws upon Freirean pedagogy (Freire, 1970), which advocates for dialogic, experiential learning that empowers marginalized actors to critically engage with power structures.
4. An equally vital policy shift involves **reforming performance metrics and recognition frameworks within public health systems**. Current evaluation models prioritize quantitative outputs (e.g., number of home visits, immunizations conducted), disregarding qualitative leadership functions like trust-building, emotional mediation, and adaptive problem-solving. Developing holistic assessment metrics that capture these relational dimensions is pivotal to valorizing ASHA leadership within institutional systems.
5. R**esource provisioning must be decoupled from tokenistic incentive structures**: The existing task-based incentive model reinforces precarious labor conditions, undermining leadership efficacy by fostering competition and resource insecurity. A shift towards guaranteed monthly salaries, supplemented by performance-based enhancements, would not only stabilize ASHA livelihoods but also facilitate leadership continuity in community health governance.
6. P**olicy narratives and public discourses must actively reconstruct ASHAs' image from caregivers to community leaders**: This involves state-led campaigns, educational materials, and media representations that foreground ASHAs as legitimate governance actors, thereby challenging entrenched patriarchal andcasteist perceptions of their roles. This symbolic reframing is integral to dismantling what Patricia Hill Collins (2000) describes as the "controlling images" that constrain marginalized women's leadership visibility.

At a broader systemic level, integrating ASHA leadership into India's Universal Health Coverage (UHC) frameworks is essential. Given their proximity to vulnerable populations, ASHAs are critical to achieving equitable health outcomes under the UHC agenda. Formalizing their leadership within UHC implementation strategies would not only enhance service delivery efficiency but also democratize governance structures by embedding grassroots perspectives at policy-making levels.

Finally, the internationalization of ASHA leadership recognition is an underexplored avenue. Global health governance platforms like the World Health Organization (WHO) and the International Labour Organization (ILO) must be lobbied to adopt frameworks that recognize and institutionalize community health workers'

leadership roles, thereby creating transnational pressure for domestic policy reforms. This global-local linkage is crucial in situating ASHA struggles within broader debates on gendered labor, informal leadership, and health governance justice.

Conclusion

The leadership of ASHA workers during the COVID-19 pandemic revealed a profound tension between the institutional valorization of public health functionaries and the structural marginalization of women's informal authority within health governance. While public discourse and state narratives framed ASHAs as "frontline warriors" and "pillars of community health," these symbolic recognitions failed to translate into material improvements in their working conditions, decision-making roles, or policy influence. The persistent invisibilization of their leadership is not merely an oversight but a manifestation of entrenched gendered governance and organizational hierarchies that devalue feminized labor and relational forms of authority. Future research should examine comparative models where community health workers have been successfully integrated into governance structures and assess the long-term impacts of leadership recognition on health outcomes. Additionally, intersectional analyses of ASHA leadership experiences across regions and social strata can offer granular insights into the differentiated pathways to empowerment and recognition. In the end, this paper contributes to a critical sociology of leadership that centers subaltern voices and challenges the epistemic hierarchies of who gets to lead, who gets to be heard, and who counts in the domain of public governance.

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