Global Public Health

An International Journal for Research, Policy and Practice

ISSN: 1744-1692 (Print) 1744-1706 (Online) Journal homepage: www.tandfonline.com/journals/rgph20

Power, surveillance, and the limits of resistance: The role of community health workers in India's health system

Baldeep K. Dhaliwal

To cite this article: Baldeep K. Dhaliwal (2026) Power, surveillance, and the limits of resistance: The role of community health workers in India's health system, Global Public Health, 21:1, 2657631, DOI: 10.1080/17441692.2026.2657631

To link to this article: https://doi.org/10.1080/17441692.2026.2657631

© 2026 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group.

Published online: 08 Apr 2026.

Submit your article to this journal

Article views: 380

View related articles

View Crossmark data

Full Terms & Conditions of access and use can be found at
https://www.tandfonline.com/action/journalInformation?journalCode=rgph20

GLOBAL PUBLIC HEALTH
2026, VOL. 21, NO. 1, 2657631
https://doi.org/10.1080/17441692.2026.2657631

RESEARCH ARTICLE

OPEN ACCESS

Power, surveillance, and the limits of resistance: The role of community health workers in India's health system

Baldeep K. Dhaliwal[a,b]

[a]Berman Institute of Bioethics, Johns Hopkins University, Baltimore, MD, USA; [b]Department of International Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA

ABSTRACT

Accredited Social Health Activist (ASHA) workers, India's community health workers (CHWs), serve as the primary link between households and the health system. They perform essential maternal and child health tasks while absorbing administrative and programmatic responsibilities. However, research on ASHAs and CHWs remains fragmented, often siloed into separate discussions of labor conditions, workplace hierarchies, and surveillance. This paper integrates these perspectives to examine how health systems rely on low-cost, flexible labor to sustain themselves. Drawing on ethnographic fieldwork in India, including participant observation and in-depth interviews, this analysis shows that ASHAs' constrained autonomy is not only the result of systemic inefficiencies, but is shaped by governance arrangements that produce and reinforce disempowerment. Findings reveal that hierarchical task delegation, economic precarity, and routine surveillance work in tandem to constrain autonomy among ASHAs. These conditions limit their capacity to resist expanding responsibilities, while simultaneously enabling the health system to function without structural reform. This analysis offers conceptual tools for understanding how informal health labor is governed, disciplined, and constrained across CHW programs in low- and middle-income countries.

ARTICLE HISTORY
Received 14 November 2025
Accepted 6 April 2026

KEYWORDS
India; community health workers; ASHA worker; qualitative research; ethnographic research

Introduction

All names have been changed for privacy reasons

Invisible power: Washing dishes and the quiet reinforcement of health system hierarchy

It had been a slow afternoon at the clinic for Aliya* and Preeti*, two Auxiliary Nurse Midwife (ANMs) workers. As ANMs, their primary responsibilities include providing health services to community members and supervising Accredited Social Health Activist (ASHA) workers. Aliya and Preeti laughed as they relaxed, sipping *chai* and calling in other workers to join them. The mood shifted as they grumbled about 'their' ASHAs being overburdened by a new government assignment. ASHAs—a type of Community Health Worker (CHW)—had been scouring the community for the last two weeks to register low-income people into a government health insurance programme. The ANMs were frustrated because this process was taking ASHAs away from their primary responsibilities.

I quietly sympathised with their grumblings, while also worrying about Leela*. I had been waiting for Leela, a 45-year-old ASHA worker, for an hour. Leela is one of India's one million ASHAs, broadly responsible for promoting health and disease prevention through community outreach (National Rural Health Mission (2005–2012) Mission Document, n.d.). She receives a guaranteed base payment of 2500 rupees (*approximately $28 USD*) per month, but she also receives wide-ranging incentive payments tied to specific tasks. She may earn 1 rupee for delivering an Oral Rehydration Solution packet, to 150 rupees (*approximately $2 USD*) for accompanying a woman to deliver her baby at a hospital.

While I waited, Leela walked through her community, diligently explaining how the *Ayushman Bharat* insurance programme worked. She explained that this was a government initiative that would reimburse

CONTACT Baldeep K. Dhaliwal bdhaliw1@jhu.edu Berman Institute of Bioethics, Johns Hopkins University, Baltimore, MD, USA

© 2026 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group.
This is an Open Access article distributed under the terms of the Creative Commons Attribution-NonCommercial License (http://creativecommons.org/licenses/by-nc/4.0/), which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited. The terms on which this article has been published allow the posting of the Accepted Manuscript in a repository by the author(s) or with their consent.

people for up to 500,000 rupees (*$5650 USD*) in medical expenses, including consultations, hospitalisations, and prescription medication. As the minutes passed, I watched the number of teacups in the sink grow.

As I was getting ready to leave, Leela walked in; her salwar kameez was a patchwork of pink and fuchsia where the heat had settled. She carefully placed her notebooks on the table. "*The enrolment app wasn't working*," she explained to Aliya and Preeti. "*I wrote down enrollees' details in my notebook, and I'll enter them into the app tonight*." They sympathised before reminding her that this *Ayushman* work should not affect her other duties. Relieved, Leela pulled out a chair to rest when Aliya abruptly stopped her.

"*Leela, you don't need to sit here. See those dishes in the sink? Just wash them and then you can go home. There's no other work you need to stay here for.*" Without protest, Leela walked to the sink and washed the dishes, including my cup. I glanced around, uncertain how to respond. No one seemed bothered that the most tired among us was doing a chore any of us could have done.

A short while later, Leela and I walked to the bus stop. "*Leela-Ji, you must have been tired when you came in*," I said as we walked. She nodded. "*So why didn't you say no when Aliya ma'am asked you to do the dishes?"* She tilted her head. I realised my question may have been unclear. *"Those dishes in the sink",* I started again. "*They weren't yours. Everyone else had been drinking tea. One cup was even mine. Anyone could have washed them."* Leela shrugged, "*It's okay. I do this work at home too, so if I do a little here, it's no trouble."*

Leela's resignation reflected the subtle but profound ways that power permeates the health system. Power is not always enforced through explicit commands or coercion but is often enforced through the normalisation of expectations that align with created social hierarchies. Something as trivial as washing dishes shows how power shapes the boundaries of what is acceptable, whose labour is valued, and why these requests go unquestioned.

From force to subtlety: The shifting definition of power

The concept of 'power' is notoriously difficult to define, with a plethora of interpretations, definitions, and frameworks. Initially envisioned by 16th century philosophical thinkers as a way to maintain control—through force, manipulation, or even immoral actions (Machiavelli & Goodwin, 2003)—this definition has expanded over time, shaped by theoretical traditions. Karl Marx conceptualised power in terms of class struggle, arguing that power is an instrument of the elite, rooted in economic strength and material resources (Marx et al., 2011). Expanding on this definition, Max Weber argued power is not solely about coercion, but is about commanding obedience through institutional legitimacy (Weber & Roth, 2012). Robert Dahl later added a behavioural lens, famously describing power as '*the ability of A to get B to do something that B would not otherwise do*' (Dahl, 2007). However, these definitions avoid exploring the invisible forms of power that shape beliefs, norms, and social structures.

Michel Foucault's visualisation of power offered a fundamentally different approach, moving beyond centralised authority, force, manipulation, and visible coercion. Foucault rejected the idea that power is wielded by a specific group and argued that power is diffused throughout society (Foucault, 1977). Foucault emphasised the everyday mechanisms that power operates in, particularly surveillance, non-coercive discipline, and the normalisation of changing roles. He argued that these power mechanisms permeate every aspect of life, shaping individuals into "*docile bodies*", or compliant, self-regulated individuals who conform to expectations without overt coercion.

This analysis of power is situated within Foucault's framework, as this definition captures the nuances and subtle complexities of power in health systems. Moreover, several decades of global research have similarly applied Foucault's theories on power to health systems research (Cheek & Rudge, 1993; Moreno-Mulet et al., 2025; Warin, 2011). This perspective allows for a deeper examination of how power operates across health systems, shaping formal structures, interpersonal relationships, and societal norms.

Health systems and India's ASHA programme

Power permeates relationships and shapes how health systems function at every level (Nichter, 1986; Sheikh et al., 2014; Walt, 2006). Although biomedical research often overlooks the distribution of power in health systems (Lee, 2015; Shiffman, 2014), power dynamics influence everything from intervention design, to workload distribution, to patient outcomes (Gilson et al., 2014). In hierarchical systems like India's, power and autonomy decline at lower levels, reinforcing systemic inequities (Hofstede, 2011).

Figure 1. Hierarchy of state health system in India.

These patterns come into focus in India's ASHA programme, the largest all-female CHW initiative in the world (Ved et al., 2019). ASHAs, like many CHWs, bridge the community and health system. The ASHAs' official mandate is both expansive and vague. Guidelines describe her as a health activist, but also an educator, a health facilitator, a data collector, a programme implementer, and a first-contact healthcare provider. This scope signals flexibility and community engagement, but because her work is defined so loosely, nearly any initiative can be framed as her duty. Yet this broad mandate does not translate into authority within the health system. Although ASHAs are seen as community guides for navigating the health system and serving as a primary resource for health issues (Kalne et al., 2022), their position in the health system is precarious. While not classified as 'employees', the ASHAs' workload exceeds what could be considered part-time or voluntary labour (Singh, 2023). ASHAs are expected to perform essential, arguably full-time, responsibilities to sustain the health system. This contradiction allows the system to benefit from their labour, while avoiding systemic change. Importantly, this contradiction is not unique to India; across global health systems, CHWs occupy similarly ambiguous positions. As Figure 1 illustrates, ASHAs sit at the lowest level of the health system hierarchy, with limited formal authority or protection.

Fragmented perspectives on power, financial precarity, and surveillance in health systems

Broadly, healthcare organisations operate within top-down hierarchical structures, where individuals' responsibilities are dictated by training and expertise (Bresnen et al., 2017; Essex et al., 2023). Hierarchy is ingrained in healthcare, often based on level of training (Colenbrander et al., 2020; Lempp & Seale, 2004), and with those in 'lower' positions expected to defer to those in power (Brown, 2019; Stein et al., 1990; Stein, 1967). However, much of the literature on these hierarchies focuses on formally-trained workers in institutional settings in high-income countries (Essex et al., 2023); this overlooks how these dynamics may extend to informal health workers whose ambiguous status within health systems may deepen vulnerability to hierarchical control.

Beyond institutional hierarchies, some research has examined how actors in low-income settings rely on financially disempowered CHWs to sustain health delivery through an inexpensive, flexible workforce (Ballard et al., 2023; Cornwall & Brock, 2005). Studies have highlighted how unsalaried CHWs frequently work beyond their assigned hours, manage complex tasks, and, in many cases, receive compensation below the international poverty line (Ballard et al., 2023). While this literature convincingly documents individual conditions of CHWs, it does not explore how these conditions facilitate the long-term sustainability of a health system.

Similarly, while research explores how monitoring systems and surveillance contribute to distrust and a hostile work environment (Al-Rjoub et al., 2008; Hoffman et al., 2003; Holland et al., 2015; Lee & Kleiner, 2003), little attention has been given to how excessive surveillance, compounded with the informal status of health workers, can reinforce disempowerment. Surveillance in health systems can be a tool for quality control and accountability. But in contexts where CHWs lack formal protection, it may also function as an additional layer of coercion; this is something that the literature has not extensively explored.

Collectively, these bodies of literature on power in health systems, financial precarity, and surveillance address important, but fragmented, aspects of broader questions of labour exploitation. While workplace

hierarchy has been studied, there is limited exploration of how (or if) the unstable nature of informal workers sustain low-cost health system functionality. Further, much of the literature on CHW finances and labour exploitation rarely examines the larger questions of whether the continued reliance on an over-burdened and undercompensated CHW workforce contributes to a destabilised health system. This study was designed to examine this question more closely.

The existing literature overlooks a crucial question: *"How does the offloading of tasks, financial exploitation of CHWs, and the constant surveillance of their work, intersect to sustain a fragile health system?"* I argue that through subtle mechanisms, surveillance, and non-coercive discipline, ASHAs are constrained from meaningfully resisting directives from the health system. These dynamics are not necessarily deliberately designed, but in practice they create a workforce that is constrained and economically dependent, which enables the health system to function without major reform.

Reflexivity

At the time of data collection, I was a third-year PhD student in International Health with formal training in qualitative methods, medical anthropology, and ethnography, as well as prior professional experience as a qualitative researcher. Most data collection was conducted independently during my doctoral dissertation research. I am of Indian origin and fluent in the local language, which shaped my access during data collection and my interpretation during analysis. Conducting interviews, participant observation, transcription, and translation without interpreters facilitated immersion, and it also reduced complications in understanding the meaning of words. My insider-outsider identity (Narayan, 1992) created a unique, largely beneficial, dynamic for me. I was enough of an insider that participants felt comfortable being honest with me, but I was also enough of an outsider that participants went into substantial detail to ensure that I understood what they were describing. However, my outsider positionality as an American almost certainly shaped data generation and analysis. Practices that participants described as "just how things were" initially appeared unfamiliar to me, which led me to probe into more arrangements considered to be normal. While this facilitated deeper interrogation of everyday dynamics, it may have shaped my analytic emphasis. For a subset of five interviews with ASHA workers, a local MPH student from a nearby university served as a notetaker to document non-verbal interactions and contextual dynamics. While this support was limited due to her academic commitments, her notes as a local resident provided an additional observational lens that may have informed my interpretation of interactions and power relations during data collection.

Theoretical perspectives on gender

It is impossible to disentangle power from gender; accordingly, this work is also grounded in Feminist Political Economy, an analytical framework that examines how gender, class, and power dynamics shape economic systems, and critiques mainstream economic approaches for overlooking unpaid care work (Cantillon et al., 2023). While this analysis is primarily focused on governance strategies, gendered expectations form the foundation through which these strategies become legitimate and enforceable. CHW programmes are overwhelmingly made up of women, with women making up approximately twice the number of CHWs as men (Perry et al., 2014). Women are often expected to occupy these roles for practical reasons, such as their ability to access spaces that men cannot, as well as for ideological ones (Closser & Shekhawat, 2024). Women are also frequently idealised as "superior CHWs" (Singh & Aridi, 2010), largely because their gender is presumed to make them more caring and self-sacrificing (Chant, 2008; Friedemann-Sánchez & Griffin, 2011). Although focusing on gender is essential in any analysis of power, an over-emphasis on gender can mask and, to an extent, facilitate labour exploitation. While gender is undeniably woven throughout this analysis, the primary analytic focus will be on governance mechanisms and the systemic arrangements through which labour exploitation is produced and sustained.

Methods

This study leveraged an ethnographic approach, combining participant observation and in-depth interviews to understand the role ASHAs have in health systems in two urban settings in northern India. BKD took written informed consent from all participants in the study, while promoting ongoing participant

agency and engagement, in line with the American Anthropological Association's ethical guidelines (American Anthropological Association, 2012). Ethical approval was granted by Johns Hopkins Bloomberg School of Public Health, an in-country academic institution, and a national regulatory health authority. The names of the in-country institutions are withheld to safeguard the privacy and security of collaborators and participants. As ethnography has the potential to blur lines between research and friendship (Wong, 1998), BKD engaged in ongoing discussions to clarify whether participants intended their shared experiences to be treated as research data or as personal discussions not covered by the consent document.

BKD conducted participant observation with 28 ASHA workers in 2023. The ASHA workers ranged from 27–57 years of age, and the time that they had spent in their role ranged from 3 months to 8 years. These ASHAs were in either an urban or a peri-urban district. BKD engaged with them six days a week for several hours a day as they completed their day-to-day activities. She primarily observed door-to-door community outreach activities, vaccination sessions, hospital visits, survey work, ad-hoc tasks, meetings, and the interactions between ASHAs, the community members, and others in the health system; BKD also engaged with ASHAs and their families socially. While completing participant observation, BKD took jottings subtly and expanded these jottings into formal notes daily. In addition to being involved in all ASHA activities and conducting informal interviews daily, BKD led 13 additional formal interviews with ASHAs. The interview guide, as well as guiding documents for participant observation of ASHAs, were initially guided by the Community Health Worker–Health Systems Interface framework (Scott et al., 2019). This framework helped identify salient dimensions of ASHAs' roles from their own perspective, as well as from the health system and community perspective. The guides were refined iteratively based on learnings.

This study also incorporated methodological triangulation with other stakeholders in the health system. BKD conducted a structured review of national and state-level ASHA programme guidelines and policy documents to contextualise governance arrangements, and these documents informed the development of interview guides for stakeholders in the health system. BKD conducted 12 formal interviews with district, state, and national-level stakeholders, such as policymakers and health system implementers using these guides.

Lastly, this study included a half-day, informal, participatory financial data collection exercise to document economic dimensions of ASHAs' work. Twenty-five ASHAs attended the session and completed a hand-written spreadsheet to record the time they spent on each work-related task, the out-of-pocket costs incurred when completing tasks, and the incentive amounts earned for each task. This participatory finance workshop served to document how incentive-based payment systems functioned in practice. This exercise informed follow-up interview questions, and the learnings from this exercise supported the analysis.

BKD transcribed and translated all interview recordings independently; a practice commonly used in ethnographic research to support interpretive depth. After completing data collection, BKD inductively developed a codebook of primary codes and sub-codes and applied this codebook to all transcripts and field notes using MAXQDA (VERBI Software, 2022). During analysis, BKD also used the policy documents that supported the stakeholder interview guide development to interpret discrepancies between official programme design and practice.

Results

This section examines how power manifests in the everyday experiences of ASHAs, demonstrating how work is systematically pushed downward, surveillance reinforces compliance, and financial incentives operate as a labour control tool. These findings aim to show how power was leveraged to enforce ASHAs' primary responsibilities, and to compel them into facilitating the introduction of a government health insurance programme. By examining their routine duties and newly assigned tasks, these findings aim to illustrate how power is continuously reinforced, both in maintaining the status quo and in adapting to emerging policy demands.

Part 1: Task delegation

The hierarchical structure of the health system ensures that tasks are continuously pushed downward (Figure 1) until they become the ASHAs' responsibility; someone with the least authority to resist but is

essential for carrying out the system's demands. While ASHAs largely reported having positive relationships with their supervisors, these positive relationships did not reduce the expectation that ASHAs would absorb new tasks. Naina*, an ASHA of three years, detailed her frustrations with this system. *"I'll tell you the biggest issue. This extra work always comes in my lap. The district officer will tell the senior medical officer. They tell the medical officer mam, who tells the lady health visitor. Then she tells our ANM mam. Ultimately who does it? The ASHA. We're the ones who motivate people."*

While some 'extra work', as Naina described it, is directly related to the role of an ASHA, ASHAs can, and are, brought in to support any task that requires extensive manual work. During a stakeholder interview, I asked why ASHAs were brought in to support 'extra work' in addition to their core responsibilities. The stakeholder replied, "A*t least with most tasks we give ASHAs, they are still related to health. Other people from the government will even tell us to bring ASHAs into the elections if they need to. This is just the mindset of people. They use the ASHAs to fill any orders.*" This sentiment was further affirmed in an interview with a central-level government stakeholder. "*It's not only health department these days, you know. Other departments also go on forcing their work on the ASHAs. Everybody wants the ASHA to do everything*." Although everyone in the system, unintentionally or intentionally, played a role in facilitating this, they were largely not comfortable with taking advantage of the ASHAs' need for money or their close connections to the community.

In an interview with a higher-level health worker, she explained that all government mandates, ranging from programme implementation to environmental education, were her responsibility to implement. Overwhelmed, she would often bring the ASHAs in to implement these mandates. She leaned across the table at this point in the interview and tapped my notebook. "*But write this down. Every single government programme shouldn't come down to my ASHAs."* Her frustration was also evident to the ASHAs, who never resented their direct supervisors for delegating work to them. Most ASHAs described their direct supervisors (ANMs and Lady Health Visitors, as described in Figure 1) as supportive and protective from unreasonable demands. But even in these cases, supportive interpersonal relationships did not change the expectation that ASHAs needed to absorb additional tasks; this underscored the limits of individual goodwill within broader governance arrangements.

Across the health system, this pattern reflected a broader condition of bureaucratic overload, where accumulating directives were constantly redistributed downward through administrative hierarchies. Even senior officials who had the most power in the health system expressed frustration with the volume of mandates that they were expected to enforce, emphasising that they were also responding to orders beyond their control. This bureaucratic overload contributed to a system that relied on ASHAs to absorb institutional strain. By leveraging ASHAs to complete tasks, the health system avoided addressing structural inefficiencies such as understaffed programmes; this further embedded ASHAs in a cycle of supporting a disjointed system. As a result of this system, when the government needed assistance registering people for a government insurance programme—the *Ayushman Bharat* Insurance Programme—ASHAs were the default choice.

Task delegation in practice: Ayushman Bharat programme registration

One Saturday morning, three ASHAs and I walked the quiet streets of a neighbourhood when their phones rang simultaneously. Startled, they reached into their bags and saw a message in their ASHA group chat; they were required to attend a mandatory training on Monday, just two days later. The message did not include details of what the training would cover or why they needed to attend, but two of the ASHAs were thrilled. As they had only started their work a few months prior, they had not yet attended a formal training session.

"Right now, our ANM ma'am has just shown us where to go and told us about what to do! In this Monday training, we'll get everything else explained," Lakshmi* excitedly stated. I was unsure how she made this leap, but I smiled back. As the excitement wore down, the conversation turned to concerns over the costs associated with getting to the training, anxieties over losing a day's incentives, and the quiet hope they would be compensated for attending the training.

That Monday I arrived at the district hospital and watched the ASHAs arrive. Lakshmi arrived in a rickshaw with two other ASHAs; they weren't sure if they would be compensated for the training, so they

shared a rickshaw to minimise the 80-rupee (*approximately $1 USD*) cost. After some initial zigzagging through the hospital, we were seated in folding chairs in the middle of a ward undergoing construction, and the training began. The trainer began by saying that the government had given this district a mandate to register all eligible people into the *Ayushman Bharat* Insurance Programme. "*This is an insurance programme designed to provide up to 5 lakh (500,000 rupees) per family, per year, to assist with medical costs,*" the trainer quickly explained. As the state government only gave each district one month to complete this task, ASHAs were being asked to enrol people, as they, "*knew everyone in their assigned area.*" The trainer continued, saying that ASHAs had no set hours, so they could do this work in the evenings.

Although poor connectivity made it difficult for the ASHAs to download the *Ayushman Bharat* mobile application (app) where they would need to register people, the trainer began rushing through the instructions anyway. She held up her own small phone to a room of over thirty people, quickly explaining how to log in, how to search for a person in their area, and how to complete the registration. After this very brief walkthrough, with many ASHAs still struggling at the first step, we looked at each other in confusion.

Finally, an ASHA asked the question that was likely on everyone's mind: "*What's the financial incentive for this registration?*" The trainer assured them that they would receive 8 rupees per person they enroled. However, that wasn't all; the ASHA who registered the highest number of people across the state would win 1 lakh (*100,000 rupees, or approximately $1,100 USD*). This would be a significant increase from her monthly base payment of 2500 rupees (*$28 USD*). Seema*, another ASHA worker, stood up and asked another question, after unsuccessfully convincing other ASHAs to join her. "*How are we supposed to do this when we have our other work? What is going to happen to that work?*" While others nodded in agreement, a senior health officer stated that they could register people when they had weekly immunisation camps, or they could do this at night after completing other work. Seema sat down defeated; her attempt at resistance foiled immediately. Senior health officials left soon after, satisfied that they had checked this task off their own expansive to-do lists.

This training session demonstrated how ASHAs were constantly burdened with additional responsibilities under the assumption that their flexible schedules and low pay made them consistently available. The expectation that ASHAs would absorb new tasks was unquestioned, as people in the health system knew that the ASHAs' work was constantly surveilled and ASHAs struggled to resist.

Part 2: Surveillance and lack of resistance

Foucault argues that surveillance is a powerful tool that reinforces compliance and power hierarchies. Surveillance ensured that ASHAs remained accountable to the health system and limited their ability to resist work. This surveillance was most evident in the ASHAs' incentive-reporting process. Even though ASHAs had long lists of tasks to complete for the day, they would never forget to stop and take a picture with a tired mother and newborn after a postnatal care visit; or pose next to a pregnant woman after taking her for a vaccine. After a long day, I watched an ASHA diligently put the pictures we took that morning into a WhatsApp group. I asked her, "*Are you showing your friends how cute the babies were?*" She glanced up, laughing at my question, "*No, these are for our incentives.*" She turned her phone so I could see. "*This is the ASHA from another area. She went to check on a baby, and she put the picture in the chat. So, she gets her incentive*".

Confused, I asked, "*So someone cheques each of these before you get each incentive?*" She nodded, "*The medical officer cheques them. She has a bit of an attitude—she comes almost every week to check our work or test us.*" Later that week, I heard more about these 'tests' in an interview with Ananya*. As Ananya and I settled in a quiet corner to start the interview, she was guarded and cautious; but a few minutes later, a moment of recognition softened the space between us. She beamed when I mentioned my paternal roots, eagerly telling me that her maternal family came from the same region. We laughed as we tried to guess whether our families may have known each other, and a new ease settled. Taking the chance to restart, I asked why she was initially nervous. She sighed, lowering her voice. "*Our medical officer shows up all the time unannounced. During ANC visits, child health checkups, vaccine sessions…she just appears. She stands over us, watching everything. She questions how we write things, so I thought your questions would be like that. She barks at us if we forget to ask a mother something, and sometimes, she threatens to dock*

our incentive pay." Confused, I asked, *"Can she do that?"* Ananya shrugged, her expression unreadable. "*Who knows? Probably not. But we are ASHAs. Anyone can do anything to us*".

Ananya's words captured the power dynamics that governed ASHAs' work. From group chat photo submissions to unannounced inspections, omnipresent surveillance kept them in a state of vigilance.

Surveillance and lack of resistance in practice: "Why can't you just say no?"

The effects of their surveillance became especially visible during the *Ayushman* registration push. For three weeks, I accompanied ASHAs door-to-door as they registered people for the *Ayushman Bharat* programme. Although ASHAs had received a list of households that should be eligible for enrolment, the rapid movement of urban populations meant that lists were often already outdated. Much of our time was spent tracking down people who no longer lived at the address on the list, turning this task into hours of low-yield labour.

One afternoon, Jaya, an ASHA, was being scolded for her low enrolment numbers. Jaya meekly tried to explain to her supervisor, Rani*, that many people on her list no longer lived at the addresses on the list. Rani responded sharply; if that was true, Jaya needed to obtain written proof from the local community leader that these people had moved. As we walked to the community leaders' home, Jaya said quietly, "*Rani Ma'am needs something to justify my low numbers to her superiors. And now the work becomes mine*." The community leader also did not take her word. Instead, he assigned her another round of verification. He said he would only give Jaya this letter if she collected signatures from each current resident that confirmed the former tenants (on her list) had moved. As we left, I said, "*Jaya-Ji, he can't make you do this. He's not your supervisor.*" She looked at me, genuinely confused, "*But how will I say no?*" When I asked other ASHAs why they couldn't refuse tasks outside their scope, they expressed similar confusion and frustration at my question: *"Baldeep-Ji, they just say 'this is your duty.' They send it in the group chat, and we have to do it. That's it."*

To understand this more clearly, I asked others in the hierarchy (Figure 1). Some ANMs brushed my question off, often saying, "*This is the work of ASHAs. Ask them*." Varsha*, an ANM I knew well, admitted the situation was unfair but insisted she also had limited power. She had refused to cancel an immunization session to convert it into an *Ayushman* drive, as her supervisors had instructed her to do. "*It's my job to give people vaccines. How can I not do it?*" she asked me helplessly. Ironically, Varsha requested ASHAs to handle the *Ayushman* registrations before and after her immunization drive to appease her supervisor. Her resistance protected her own core responsibilities, but not the ASHAs'. A Lady Health Visitor reframed the task as ultimately beneficial for ASHAs, saying improved access to healthcare through the *Ayushman* programme would improve the overall health of the community, and ultimately reduce the ASHAs' workload over time. This explanation aligned with public health logic, but it shifted immediate strain onto incentive-based workers. Finally, I asked Prachi*, a district officer, whether ASHAs were allowed to refuse out-of-scope work; she said that only senior officials could collectively push back on work. Prachi explained how she and her peers had sent a formal letter resisting a separate task. When I asked if a similar letter could have been prepared for ASHAs, she replied, *"This doesn't apply to ASHAs. They can be brought into any task."* I walked away from these interviews still feeling dissatisfied. It seemed that resistance existed in the health system for others because there was always a network of ASHAs who would absorb tasks for modest incentives.

My realisation underscored how the health system benefits from ASHAs' labour. As the default workforce for unassigned or time-consuming tasks, ASHAs absorbed excess burdens that others refuse or could not take on. By maintaining this imbalance, the health system reinforced ASHA disempowerment but also ensured its own uninterrupted functioning.

Part 3: Coercion through financial incentives

Foucault explains how power operates through subtle mechanisms of control, and not overt force (Foucault, 1977). Financial incentives for tasks function as one such mechanism for ASHAs, as they depend on them to supplement their base payment. As ASHAs are at a particularly vulnerable position in the health system, and in constant need of supplementing their base payment, they often agree to most incentive-

based tasks. As salaried employees in the health system know this dynamic exists for ASHAs, work is pushed further down until it reaches the ASHA; a woman who is financially vulnerable, cares deeply about supporting her community, but also needs to supplement her income. While this largely manifests in health-related work, ASHAs are pulled into any work that requires manpower.

When discussing their involvement in non-health work, several ASHAs explained how they chased the promise of 700 rupees (*approximately $8 USD*) during a recent election. One ASHA said, "*They got us all to this election training and told us that we'll get 700 rupees. We started working with these hopes. They made us go house-to-house to see who was eligible to vote. First, we went to each house—we made nothing. Then we got to the polling location at 5:30 am. Any place where people had drunk tea and threw the cup, the ASHAs were the ones going and picking them up. They said because people need masks and sanitisers, this was health-related, so this was our duty. Then after the election they told us you need to get the incentive from the hospital. So, we used our own money and got there—then you know what they said? 'Your booth level officer (BLO) should give this to you'. Then we went back to ask the BLO, and they said, 'you need to ask the state government'. Then we tried to go to the senior medical officer, and he said go to the district commissioner officer. Ma'am, in this effort to get 700, think of how much we spent. Then finally we found out that we were only supposed to be getting 250, but that didn't even happen. We finally gave up following up on this. They made us go crazy! We got all their votes put in, and they didn't even give us 1 rupee after that.*"

While their supervisors did not intend to deceive them, ASHAs experienced these moments as manipulation. This feeling was largely consistent across ASHAs, and it dissuaded them from wanting to support the *Ayushman* registration process.

Coercion through financial incentives in practice: Ayushman registration and incentives

I went to meet Puja* one chilly morning, and before I could say anything, she bluntly said, "*These Ayushman cards have really put a lot of problems on us. This isn't some big incentive. We get money from going around and finding pregnant women, not from this kind of work!*" Puja's frustration wasn't just about the task itself; it was about how this task disrupted the work she relied on to supplement her base pay. Registering people for the *Ayushman* cards took time away from finding pregnant women, identifying those needing vaccines, and escorting women to deliver babies; these tasks were tied to higher incentives. In addition to not being able to pursue higher incentives, Puja also reported that she lost money. She had paid out-of-pocket to attend the training session, made multiple trips to get technical assistance with the registration app, and even purchased a notebook to manually track registrants when the app wasn't connecting. In this type of system, ASHAs assume financial risks in exchange for uncertain rewards.

Later that week, Sheena*, another ASHA, and I spent the day walking through each alley in her area, trying to find more people to register. She had been berated for not enroling enough people into the *Ayushman Bharat* programme, but also for not making sufficient progress on a population-level health survey. When Sheena explained to her supervisor that she had been prioritising her *Ayushman* work, the supervisor responded, "*Well you should be doing the Ayushman cards during the day, and your survey work at night.*" When we were alone, Sheena voiced her frustration. "*We have our own families. Our own home responsibilities. Are we supposed to work 'day and night'?*".

The impossibility of the demand was evident, and there was no recognition that ASHAs were already overburdened and navigating competing demands. But this is how discipline functions; through surveillance, imposed norms, and a sense of duty that makes resistance seem futile. The promise of incentives, the fear of reprimand, and the internalised duty to serve the community work in tandem to ensure that ASHAs remain governable and willing to push themselves beyond their limits with little protest.

When I went to a district officer for a second interview, I mentioned that ASHAs were afraid that they wouldn't receive their payments for the Ayushman work. This officer had been warm and engaging in the first interview, but when I mentioned these financial concerns, their tone changed. "*ASHAs just say that—of course we will pay them*." After a follow-up question to better understand the payment mechanisms, they told me this was just my '*outsider mindset*', and they stood up to leave the room. I realised my probing went too far, and I had become just another 'academic theorising about others' lives' (Narayan, 1992); no longer a daughter of India, just a nosy outsider with too many questions.

Four months later, I learned that the Ayushman registration was still going on, despite it being initially framed as a short-term push. An ASHA explained, *"The seniors say 'do it, do it' but they're not giving the incentive. So, we told them we're not doing more Ayushman registration until they pay for the old* ones. *For one month they told us 'don't worry it'll be on your next months' pay, just enrol people', so we did. But still it wasn't given. Maybe it will be given next month…"*.

Discussion

ASHAs' labour is shaped by a health system that maintains their compliance through subtle yet pervasive mechanisms of control. While prior research has examined CHW labour conditions, surveillance, and financial exploitation separately, this paper demonstrates how these synergistically suppress resistance and sustain the labour that underpins the health system. This paper aims to extend previous analyses by arguing that ASHAs' disempowerment is not just an accidental side effect of bureaucratic inefficiency, but a governance effect produced through institutional arrangements, incentive structures, and hierarchical delegation. By embedding ASHAs in rigid hierarchies, creating economic precarity through incentive-based pay, and enforcing constant surveillance, the health system conditions ASHAs into being docile, governable workers.

This analysis does not intend to claim that policymakers or health system designers explicitly intend to suppress ASHAs' agency. Rather, it shows how existing institutional arrangements and incentive-based labour models produce governance effects that constrain resistance and normalise compliance. This paper contributes to global health scholarship by bringing together fragmented literatures on labour precarity, surveillance, and hierarchical control to demonstrate that CHW disempowerment is structurally generated, and not an accidental by-product of programmatic issues.

Existing scholarship often highlights that CHWs exercise discretion and shape policy implementation; however, the findings discussed in this paper diverge from this scholarship. For example, in South Africa and Brazil, CHWs used informal decision-making and local authority to facilitate or challenge policy (Lehmann & Gilson, 2013) (Nunes & Lotta, 2019). In contrast, ASHAs in these sites lacked discretionary power, as their compliance was enforced through financial precarity, surveillance, and hierarchical control mechanisms. Attempts to push back against unreasonable workloads or out-of-scope tasks were quickly shut down; even sympathetic supervisors were constrained by their own hierarchies, and they were rarely able to intervene on behalf of ASHAs, illustrating how ASHAs are governed through a system that suppresses agency.

Downward delegation of tasks, surveillance, and financial instability work in tandem to limit ASHAs' resistance. This reinforces their position at the bottom of the health system, while allowing the system to offload tasks onto them indefinitely. While monitoring and surveillance mechanisms are framed as tools for quality assurance and performance support, many researchers and implementation scientists encourage "mutual accountability" (Lauren Crigler et al., 2013; Schaaf et al., 2018). These models encourage monitoring through the combination of supervisory oversight, community evaluations, and accountability channels for CHWs. In the sites examined here, however, monitoring operated largely as a top-down compliance mechanism with limited reciprocal accountability, shaping how surveillance was experienced by ASHAs in practice. By keeping ASHAs in this position, the health system avoided addressing structural gaps or redistributing workloads upward.

While previous work states ASHAs' disempowerment is a labour issue (Ballard et al., 2023), this paper argues it is also about governance. Their disempowerment allows the health system to avoid structural reform, maintain hierarchical authority of the health system, and consolidate power at the top, while extracting labour from the bottom. These findings further reflect governance patterns within global health systems, where reliance on community-based labour serves as a solution for investment in broader health system strengthening. However, these patterns may also be understood through the lens of bureaucratic overload, where multiple schemes, trainings, and mandates exceed the system's administrative capacity and are managed through downward delegation. In this context, reliance on ASHAs emerges less from intentional exploitation, and more from institutional strain. But because ASHAs are structurally positioned to absorb excess demands, bureaucratic overload becomes a mechanism through which governance operates, normalising task expansion and limiting resistance.

Although this strategy seems to allow the health system to function and address community needs, these mechanisms can create long-term consequences for workforce sustainability and service reliability. In the short-term, ASHAs provide an inexpensive and flexible workforce that can absorb expanding responsibilities without requiring health system adjustments. Tasks get completed, community health initiatives are implemented, and gaps in the system are filled. But over time, the reliance on overburdened and underpaid CHWs can create mistrust and compromise health delivery. Ethnographic methods make these governance mechanisms particularly visible, offering insights that are often obscured in surveys, programme evaluations, or systems analyses.

It would not be accurate to say that ASHAs do not demand change; they do, and some change occurs. But this change is often piecemeal, requires social capital, and is typically met with retaliation. With the COVID-19 pandemic as a catalyst, thousands of ASHAs mobilised nationally to demand pay increases, protective equipment, and recognition as formal workers (Ghosh, 2021; Shanthosh et al., 2021). Their protests were loud, visible, persistent, and in many cases, successful (Krishna, 2024; TNM Staff, 2025). In 2025, over 26,000 ASHAs in one South Indian state staged an almost year-long protest, demanding better pay and formal recognition as workers in the health system. In response, the government formed a high-level committee to review their demands ("ASHA protest: Kerala govt sets up panel to study demands; workers dismiss it as eyewash tactic, 2025), and increased their base payment by 1000 rupees (*approximately $11 USD*) a month. After this pay increase, ASHAs ended their strike, and reported that they planned to continue their protests through less disruptive rallies (After 265 days & Kerala ASHA workers to end strike in front of Secretariat, 2025). Small pay increases—in conjunction with police crackdowns, suspensions, and threats—suggest that improvements pacify unrest, rather than transform structural conditions (Chowdhury, 2020; Jain, 2021). Despite some takes that have argued ASHAs are delicately and strategically driving policy change (Santosh & Kane, 2025), the response to ASHAs' protests is usually one of calculated concessions. The core model of labour remains intact: incentive-based pay, undefined hours, and ever-expanding responsibilities to continue to extract labour for low pay.

ASHAs' labour is inseparable from the well-documented feminised norms of care and service (Hay et al., 2019). This analysis' focus on power is not to say that gender is not significant—gender is deeply intertwined with CHW programmes and power, and gendered expectations are the foundation on which governance strategies become legitimate and enforceable. Some reports refer to female CHWs as the 'superior CHW' (Singh & Aridi, 2010) when compared to men, due to their portrayal in global health and development programmes as the more giving, moral, and caring gender (Closser & Shekhawat, 2024). However, by centreing on governance mechanisms, this analysis seeks to interrogate institutional arrangements that systematically produce and sustain inequities. This is not because identity is irrelevant, but because over-emphasising gender alone risks obscuring deeper mechanisms. Similarly, other literature explains ASHAs' endurance through the language of care for their communities, another commonly applied gendered argument (Gopalan et al., 2012; Karuga et al., 2025; Tripathy et al., 2016).

An ASHAs' love for her community is often leveraged to normalise low or irregular pay and the expansion of her responsibilities (Chant, 2008). In practice, this framing functions as a governance tool that shifts financial risk from the state onto financially vulnerable women, making this appear acceptable or even expected. In this analysis, ASHAs described performing essential health system functions while absorbing costs of transport, supplies, and time, usually without timely or guaranteed payment. These arrangements can be conceptualised as a form of financial violence—a pattern in which their financial vulnerability is leveraged to secure labour. While female CHWs experience multiple forms of workplace violence, they are more exposed to financial exploitation because of their ambiguous employment status, lack of formal labour protections, and position at the lowest levels of the health hierarchy (Closser et al., 2023). Evidence from dual-cadre CHW programmes further supports this pattern, with over half (59%) of unsalaried CHWs and 10% of salaried CHWs working under exploitative labour conditions (Ballard et al., 2023).

The mechanisms that constrain ASHAs mirror broader patterns across global CHW programmes. Fragmented approaches to studying CHW labour, surveillance, and hierarchy obscure how these forces interact to produce disempowerment and limit policy reform. Without recognising this interdependence, policymakers risk implementing piecemeal reforms, such as insufficient pay increases and training modules, rather than addressing the structural conditions that suppress CHWs. Transforming CHW labour requires

shifting attention from surface-level inequities to the deeper governance structures that determine who is heard, who is overlooked, and whose exploitation is normalised in the name of health system efficiency.

Limitations

This work was not without limitations. The research was conducted in two urban settings in a single Indian state and draws on in-depth interviews with 28 members of the health system. ASHAs' experiences are not monolithic, and variation exists across contexts. Given the substantial interstate variation in programme design, implementation, remuneration structures, and governance, these findings are not intended to be representative of all ASHAs across India's national programme. This analysis focuses on how, within the specific urban settings examined here, these governance structures, normalise labour intensification. Additionally, the study employed an ethnographic design that prioritised depth over breadth which is why the sample size is modest relative to the scale of India's ASHA workforce. This approach allowed for analytically rich insights and thematic saturation, rather than striving for generalisability. The focus on urban ASHAs also limits the applicability of findings to rural contexts, where work structures, relationships, supervision, and expectations may differ. This analysis is interpretive and relational, and it conceptualises surveillance, financial precarity, and hierarchical task delegation as interlocking governance mechanisms that jointly shape constrained autonomy, rather than as discrete or competing causal drivers. This study also does not provide a comprehensive analysis of national ASHA guidelines or broader health policy documents. While policy documents are critical to understanding the ASHA programme, understanding the full scope of policies was outside of the scope of this ethnographic analysis. Finally, findings are shaped by the positionality of the researcher and the relational nature of ethnographic fieldwork. While reflexive practices were followed throughout data collection and analysis, participants' accounts may have been influenced by local power dynamics, perceived risks of speaking openly, or the presence of the researcher. Despite these limitations, this work provides insights into power in the health system, and it provides a foundation for comparative research across other contexts within India.

Conclusion

The consequences of ASHAs' disempowerment are not only structural, but deeply personal. This became clear when an ASHA asked, with genuine curiosity, "*Tenu ASHA di jinta ini kyu ah?*"—why was I so concerned about ASHAs? Her question captured how routine these arrangements had become within everyday work relations, and how limited the space was to question them. In that brief exchange, the dynamics analysed throughout this paper became tangible realities that shaped her role in the health system. ASHAs' struggles are part of a global pattern in which health systems depend on undervalued labour to function. These mechanisms occur across CHW programmes worldwide, revealing a broader governance pattern, rather than a country-specific anomaly. Without addressing structural dynamics, reforms will continue to be piecemeal and insufficient. Future research should move beyond documenting workload to examine how governance, surveillance, and bureaucratic decision-making shape CHW roles. Meaningful policy changes also require formal recognition of CHWs, predictable salaries rather than incentive-only pay, and mechanisms that allow CHWs to raise concerns without fear. The question she asked has stayed with me because it crystallises a broader paradox in global health: health systems rely on the labour of lower-level, typically female actors, yet this labour remains structurally undervalued and institutionally marginal. Ensuring CHWs have greater agency requires closer attention to the governance structures that shape their roles and constrain their capacity to refuse or renegotiate work, rather than continued reliance on informal endurance to sustain system functioning.

Acknowledgements

I am deeply thankful to the ASHAs who made this research possible. Their candour, perseverance, and care offered invaluable insights into the realities of India's health system. I am especially grateful for the trust they placed in me and for their willingness to speak openly about both their struggles and their strength.

I also extend my sincere appreciation to the Auxiliary Nurse Midwives, Lady Health Visitors, Medical Officers, and health officials at the district and state levels who contributed their expertise and perspectives.

This paper would not have been possible without the guidance of my doctoral advisor, Dr. Svea Closser, who provided invaluable mentorship, sharpened my theoretical thinking, and pushed me to develop the analytical framework underpinning this work. I also benefited from the thoughtful feedback of Drs. Anita Shet, Beth Resnick, Jill Owczarzak, Kerry Scott, Nalini Visvanathan, Musarrat Rahman, and Peter Winch, whose insights helped sharpen the argument and framing. I am grateful to the peer reviewers who provided thoughtful comments which further shaped my writing.

Finally, I want to recognise the many people whose work often goes unseen. The health workers, community members, family members, and fellow researchers who contributed in countless ways. This paper is a reflection of their dedication and a shared commitment to building stronger community health systems.

Author contributions

CRediT: **Baldeep K. Dhaliwal:** Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Writing – original draft.

Disclosure statement

No interests to declare.

Data availability statement

The qualitative codebook, as well as select excerpts from transcripts, which support the findings of this study are available on request from the corresponding author. The data are not publicly available due to their containing information that could compromise the privacy of research participants.

References

After 265 days, Kerala ASHA workers to end strike in front of Secretariat. (2025). The Hindu. https://www.thehindu.com/news/national/kerala/kerala-asha-workers-to-end-strike-in-front-of-secretariat/article70224273.ece

Al-Rjoub, H., Zabian, A., & Qawasmeh, S. (2008). Electronic monitoring: The employees point of view. *Journal of Social Sciences*, *4*(3), 189–195. https://doi.org/10.3844/jssp.2008.189.195

American Anthropological Association. (2012). AAA Statement on Ethics Principles of Professional Responsibility. https://americananthro.org/about/policies/statement-on-ethics/

ASHA protest: Kerala govt sets up panel to study demands; workers dismiss it as eyewash tactic. (2025). Mathrubhumi. https://english.Mathrubhumi.com/news/kerala/asha-protest-kerala-govt-sets-up-study-panel-but-receives-flak-tpoqunz0

Ballard, M., Olaniran, A., Iberico, M. M., Rogers, A., Thapa, A., Cook, J., Aranda, Z., French, M., Olsen, H. E., Haughton, J., Lassala, D., Carpenter Westgate, C., Malitoni, B., Juma, M., & Perry, H. B. (2023). Labour conditions in dual-cadre community health worker programmes: A systematic review. *The Lancet Global Health*, *11*(10), e1598–e1608. https://doi.org/10.1016/S2214-109X(23)00357-1

Bresnen, M., Hodgson, D., Bailey, S., Hyde, P., & Hassard, J. (2017). *Managing Modern Healthcare: Knowledge, Networks and Practice* (1st ed.). Routledge. https://doi.org/10.4324/9781315658506

Brown, J. S. (2019). Ending the doctor-nurse game by enhancing the role of the ward nurse. *BMJ*, 364, l698. https://doi.org/10.1136/bmj.l698

Cantillon, S., Mackett, O., & Stevano, S. (2023). *Feminist Political Economy: A Global Perspective* (1st ed.). Agenda Publishing. https://doi.org/10.1017/9781788212656

Chant, S. (2008). The 'Feminisation of poverty' and the 'Feminisation' of anti-poverty programmes: Room for revision? *The Journal of Development Studies*, *44*(2), 165–197. https://doi.org/10.1080/00220380701789810

Cheek, J., & Rudge, T. (1993). The power of normalisation: Foucauldian Perspectives On Contemporary Australian Health Care Practices. *Australian Journal of Social Issues*, *28*(4), 271–284. https://doi.org/10.1002/j.1839-4655.1993.tb00928.x

Chowdhury, S. (2020). ASHA workers criminalised for fighting for their rights. https://behanbox.com/2020/10/21/3-states-wage-war-against-indias-corona-warriors/

Closser, S., & Shekhawat, S. S. (2024). *Running on Hope: Female Community Health Labor in Rajasthan*. Vanderbilt University Press. India.

Closser, S., Sultan, M., Tikkanen, R., Singh, S., Majidulla, A., Maes, K., Gerber, S., Rosenthal, A., Palazuelos, D., Tesfaye, Y., Finley, E., Abesha, R., Keeling, A., & Justice, J. (2023). Breaking the silence on gendered harassment and assault of community health workers: An analysis of ethnographic studies. *BMJ Global Health*, *8*(5), e011749. https://doi.org/10.1136/bmjgh-2023-011749

Colenbrander, L., Causer, L., & Haire, B. (2020). If you can't make it, you're not tough enough to do Medicine': A qualitative study of Sydney-based medical students' experiences of bullying and harassment in clinical settings. *BMC Medical Education*, *20*(1), 86. https://doi.org/10.1186/s12909-020-02001-y.

Cornwall, A., & Brock, K. (2005). *Beyond buzzwords "poverty reduction","participation" and "empowerment" in development policy*. UNRISD.

Crigler, L., Gergen, J., & Perry, H. (2013). *Supervision of Community Health Workers. USAID/Maternal and Child Health Integrated Program*. https://nhchc.org/wp-content/uploads/2019/08/09_CHW_Supervision.pdf

Dahl, R. A. (2007). The concept of power. *Behavioral Science*, *2*(3), 201–215. https://doi.org/10.1002/bs.3830020303

Essex, R., Kennedy, J., Miller, D., & Jameson, J. (2023). A scoping review exploring the impact and negotiation of hierarchy in healthcare organisations. *Nursing Inquiry*, *30*(4), e12571. https://doi.org/10.1111/nin.12571

Foucault, M. (1977). *Discipline and punish: The birth of the prison* (1st American ed.). Pantheon Books.

Friedemann-Sánchez, G., & Griffin, J. M. (2011). Defining the boundaries between unpaid labor and unpaid caregiving: Review of the social and health sciences literature. *Journal of Human Development and Capabilities*, *12*(4), 511–534. https://doi.org/10.1080/19452829.2011.613370

Ghosh, A. (2021, July 7). India's all-women frontline defence against COVID-19openDemocracy. https://www.opendemocracy.net/en/5050/indias-all-women-frontline-defence-against-covid-19-fight-for-fair-pay/

Gilson, L., Schneider, H., & Orgill, M. (2014). Practice and power: A review and interpretive synthesis focused on the exercise of discretionary power in policy implementation by front-line providers and managers. *Health Policy and Planning*, *29*(suppl 3), iii51–iii69. https://doi.org/10.1093/heapol/czu098

Gopalan, S. S., Mohanty, S., & Das, A. (2012). Assessing community health workers' performance motivation: A mixed-methods approach on India's accredited social health activists (ASHA) programme. *BMJ Open*, *2*(5), e001557. https://doi.org/10.1136/bmjopen-2012-001557

Hay, K., McDougal, L., Percival, V., Henry, S., Klugman, J., Wurie, H., Raven, J., Shabalala, F., Fielding-Miller, R., Dey, A., Dehingia, N., Morgan, R., Atmavilas, Y., Saggurti, N., Yore, J., Blokhina, E., Huque, R., Barasa, E., Bhan, N., …Levine, R. (2019). Disrupting gender norms in health systems: Making the case for change. *The Lancet*, *393*(10190), 2535–2549. https://doi.org/10.1016/S0140-6736(19)30648-8

Hoffman, W. M., Hartman, L. P., & Rowe, M. (2003). You've got mail and the boss knows: A survey by the center for business ethics of companies' email and Internet monitoring. *Business and Society Review*, *108*(3), 285–307. https://doi.org/10.1111/1467-8594.00166

Hofstede, G. (2011). Dimensionalizing cultures: The hofstede model in context. *Online Readings in Psychology and Culture*, *2*(1), 8. https://doi.org/10.9707/2307-0919.1014

Holland, P. J., Cooper, B., & Hecker, R. (2015). Electronic monitoring and surveillance in the workplace: The effects on trust in management, and the moderating role of occupational type. *Personnel Review*, *44*(1), 161–175. https://doi.org/10.1108/PR-11-2013-0211

Jain. (2021). ASHA workers' rights violations in the time of COVID-19: A critical reflection COVID-19 & the Constitution. https://covid-19-constitution.in/analyses/asha-workers-rights-violations-in-the-time-of-covid-19-a-critical-reflection

Kalne, P. S., Kalne, P. S., & Mehendale, A. M. (2022). Acknowledging the role of community health workers in providing essential healthcare services in rural India-A review. *Cureus*. https://doi.org/10.7759/cureus.29372

Karuga, R. N., Karim, O., Jahan, S., Ngunjiri, A., Kabaria, C., Oduor, C., Omanga, E., Wairiuko, J., Seekles, M., Dean, L., Otiso, L., Okoth, L., Naher, N., Okoth, P., Koiri, R., Nduati, R., Rashid, S., Gachigua, S., Kabir, S., …McCollum, R. (2025). Protective factors and stressors that influence the mental wellbeing of community health workers in south Asia and sub-saharan Africa: A scoping review. *SSM - Health Systems*, *5*, 100147. https://doi.org/10.1016/j.ssmhs.2025.100147

Krishna, N. R. (2024). Empowering or exhausting? Covid-19 experiences of accredited social health activists (ASHA) in kerala. *The International Journal of Community and Social Development*, *6*(4), 399–417. https://doi.org/10.1177/25166026241290671

Lee, K. (2015). Revealing power in truth: Comment on "Knowledge, moral claims and the exercise of power in global health. *International Journal of Health Policy and Management*, *4*(4), 257–259. https://doi.org/10.15171/ijhpm.2015.42

Lee, S., & Kleiner, B. H. (2003). Electronic surveillance in the workplace. *Management Research News*, *26*(2/3/4), 72–81. https://doi.org/10.1108/01409170310784014

Lehmann, U., & Gilson, L. (2013). Actor interfaces and practices of power in a community health worker programme: A South African study of unintended policy outcomes. *Health Policy and Planning*, *28*(4), 358–366. https://doi.org/10.1093/heapol/czs066

Lempp, H., & Seale, C. (2004). The hidden curriculum in undergraduate medical education: Qualitative study of medical students' perceptions of teaching. *BMJ*, *329*(7469), 770–773. https://doi.org/10.1136/bmj.329.7469.770

Machiavelli, N., & Goodwin, R. (2003). *The prince*. Dante University Press.

Marx, K., Engels, F., & Pascal, R. (2011). *The German ideology, Parts I & III*. Martino Publishing.

Moreno-Mulet, C., Valdivielso-Navarro, J., Miró-Bonet, M., Carrero-Planells, A., & Gastaldo, D. (2025). Transgressive acts: Michel foucault's lessons on resistance for nurses. *Nursing Philosophy*, *26*(1). e70008. https://doi.org/10.1111/nup.70008

Narayan, K. (1992). *Storytellers, saints and scoundrels: Folk narrative in Hindu religious teaching*. Motilal Banarsidass.

National Rural Health Mission (2005-2012) Mission Document. (n.d.). National Health Mission. https://nhm.gov.in/images/pdf/guidelines/nrhm-guidelines/mission_document.pdf

Nichter, M. A. (1986). The primary health center as a social system: PHC, social status, and the issue of team-work in south Asia. *Social Science & Medicine*, *23*(4), 347–355. https://doi.org/10.1016/0277-9536(86)90077-8

Nunes, J., & Lotta, G. (2019). Discretion, power and the reproduction of inequality in health policy implementation: Practices, discursive styles and classifications of Brazil's community health workers. *Social Science & Medicine*, *242*, 112551. https://doi.org/10.1016/j.socscimed.2019.112551

Perry, H. B., Zulliger, R., & Rogers, M. M. (2014). Community health workers in Low-, Middle-, and high-income countries: An overview of their history, recent evolution, and current effectiveness. *Annual Review of Public Health*, *35*(1), 399–421. https://doi.org/10.1146/annurev-publhealth-032013-182354

Santosh, S., & Kane, S. (2025). Extending kingdon's multiple streams policy framework through an analysis of how community health workers in India are driving policy changes. *Community Health Equity Research & Policy*, *45*(3), 245–260. https://doi.org/10.1177/2752535X231222654

Schaaf, M., Warthin, C., Manning, A., & Topp, S. (2018). Report on the 'Think-In' on Community Health Worker Voice, Power, and Citizens' Right to Health. (Learning Exchange Report. https://accountabilityresearch.org/wp-content/uploads/2018/01/Learning_Exchange_Report3_January-18-1.19.18.pdf

Scott, K., George, A. S., & Ved, R. R. (2019). Taking stock of 10 years of published research on the ASHA programme: Examining India's national community health worker programme from a health systems perspective. *Health Research Policy and Systems*, *17*(1), 29. https://doi.org/10.1186/s12961-019-0427-0

Shanthosh, J., Durbach, A., & Joshi, R. (2021). Charting the rights of community health workers in India: The next frontier of universal health coverage. *Health and Human Rights*, *23*(2), 225–238.

Sheikh, K., George, A., & Gilson, L. (2014). People-centred science: Strengthening the practice of health policy and systems research. *Health Research Policy and Systems*, *12*(1), 19. https://doi.org/10.1186/1478-4505-12-19

Shiffman, J. (2014). Knowledge, moral claims and the exercise of power in global health. *International Journal of Health Policy and Management*, *3*(6), 297–299. https://doi.org/10.15171/ijhpm.2014.120

Singh, V. (2023). ASHA workers in India: A quest for socio legal identity. *Society and Culture Development in India*, *3*(1), 301–307.

Singh, P., & Aridi, J. O. (2010). One million community health workers technical task force report one million community health workers. *Technical Task Force Report*. https://doi.org/10.13140/RG.2.2.24892.05763

Stein, L. I. (1967). The doctor-nurse game. *Archives of General Psychiatry*, *16*(6), 699. https://doi.org/10.1001/archpsyc.1967.01730240055009

Stein, L. I., Watts, D. T., & Howell, T. (1990). The Doctor–Nurse game revisited. *New England Journal of Medicine*, *322*(8), 546–549. https://doi.org/10.1056/NEJM199002223220810

TNM Staff. (2025). ASHA workers call off strike after karnataka govt agrees to raise honorarium, The News Minute. The News Minute. https://www.thenewsminute.com/karnataka/asha-workers-call-off-strike-after-karnataka-govt-agrees-to-raise-honorarium

Tripathy, J. P., Goel, S., & Kumar, A. M. V. (2016). Measuring and understanding motivation among community health workers in rural health facilities in India-a mixed method study. *BMC Health Services Research*, *16*(1), 366. https://doi.org/10.1186/s12913-016-1614-0

Ved, R., Scott, K., Gupta, G., Ummer, O., Singh, S., Srivastava, A., & George, A. S. (2019). How are gender inequalities facing India's one million ASHAs being addressed? Policy origins and adaptations for the world's largest all-female community health worker programme. *Human Resources for Health*, *17*(1), 3. https://doi.org/10.1186/s12960-018-0338-0

VERBI Software. (2022). *MAXQDA 2022 [Computer software]*. maxqda.com.

Walt, G. (2006). *Health policy: An introduction to process and power (8th impr)*. Zed Books.

Warin, M. (2011). Foucault's progeny: Jamie oliver and the art of governing obesity. *Social Theory & Health*, *9*(1), 24–40. https://doi.org/10.1057/sth.2010.2

Weber, M., & Roth, G. (2012). *Economy and society: An outline of interpretive sociology* (Nachdr., Vol. 2), Univ. of California Press.

Wong, L. M. (1998). The ethics of rapport: Institutional safeguards, resistance, and betrayal. *Qualitative Inquiry*, *4*(2), 178–199. https://doi.org/10.1177/107780049800400203