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Article

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Abstract
Among the many stories that emerged out of India during the pandemic, one was somewhat buried under the media discourse around the migrant crisis, lockdown regulations, and economic fallout. This was the story of striking accredited social health activist workers asking for fair wages, improved benefits, and better working conditions. The Covid-19 crisis highlighted the poor health infrastructure and the precarious, and often, stigmatized nature of frontline work, managed at the community level by paramedical workers, a significant proportion of whom are women. There has been considerable attention paid by feminist groups as well as health-related civil society organizations on the gender-based inequities that have emerged during the pandemic, particularly in relation to care work. This study explores how care work performed by the accredited social health activists was framed in the mainstream media, through an examination of articles in three selected English daily newspapers over one year of the pandemic. Drawing on theoretical work deriving from similar health crises in other regions of the world, we explore how the public health infrastructure depends on the invisible care-giving labor of women in official and unofficial capacities to respond to the situation. The systemic reliance on women's unpaid or ill-paid labor at the grassroots level is belied by the fact that women's concerns and contributions are rarely visible in issues of policy and public administration. Our study found that this invisibility extended to media coverage as well. Our analysis offers a "political economy of caregiving" that reiterates the need for women's work to be recognized at all levels of functioning.

1. Introduction

Among the dominant images that stood out during the Covid-19 pandemic in India were those of frontline health workers—doctors, nurses, and community health volunteers—in situations that were seen as risky, demanding courage and commitment. There was, understandably, a heightened critical focus on the systems, policies, and people running the healthcare sector, with news and commentary around inequitable service provi-sion and infrastructural gaps, the disproportionate burden on certain sections of the population as well as on those at the lower levels of service provision. At the same time, there was a hope that this crisis, having revealed the deep-seated problems in the system, might generate the will and imagination to revamp it. Writing in the *Financial Times* in April 2020, author Arundhati Roy described the pandemic as "a portal, a gateway between one world and the next" (Roy, 2020), a possible turning point in our imagination of public health care.

Media reports from across the world and subsequent research from multiple disciplinary perspectives have underscored the differential impact of the Covid-19 pandemic on populations and communities. Hardest hit were the poor, the weak, the elderly, those with no social security, and those with already marginalized identities. Among the intersecting factors that exacerbated disadvantage in the face of the disease and its many sequelae—including lockdowns, job losses, economic hardships, social dynamics—were race (Cohen & van der Muelen Rodgers, 2021; J. Smith et al., 2021), ethnicity (Bambra et al., 2020), and gender (Kabeer et al., 2021; J. Smith et al., 2021). However, while research from a variety of disciplinary perspectives emphasized the systemic nature of many of these disadvantages, the tendency to treat the pandemic as exceptional in its impact was widespread both in political and media rhetoric/discourse (Khan, 2021; Khan & Singh, 2021; J. Smith et al., 2021).

However, scholars across disciplines who have examined the social impact of public health crises (Bambra et al., 2021; Harmon, 2016; Nunes, 2020) suggest that we have been here before; other health emergencies have offered us similar lessons, which were not only quickly forgotten, but also displayed a commitment to quickly returning to business as before, business as usual. The mainstream media, which, in the idealized social responsibility model of journalism, is expected to bear witness and draw attention to the dynamics of power and capital, tends to focus on the spectacular, somewhat ahistorical presentation of inequity in health. Coverage then falls into patterns dictated by the expediencies of the current news cycle and its associated culture, focusing on values like immediacy, conflict, prominence, magnitude, and dealing with surface level rather than deeper dynamics. This leads to an abundance of coverage of the devastating impacts of the crisis—in this case the Covid-19 pandemic—on marginalized groups, but by and large, at a level that renders them as momentary and exceptional rather than persistent and systemic. These include the differential impacts of this pandemic on people of color, women, disadvantaged castes (in India) and ethnicities, and geographic location. Additionally, any systemic focus tends to be momentary, disappearing from media attention once the crisis has passed, or a new crisis emerges (Shih et al., 2008). This has been seen in framing analyses of news related to previous health emergencies (Pan & Meng, 2016).

In this article, we examine the mainstream English-language media coverage of the Covid-19 pandemic in India, focusing on one subsection of the population—women health workers in direct care roles—to understand the ways in which gendered work and direct care occupations were represented, and how the impact of the health crisis on this group was framed and discussed. Specifically, we look at women community health volunteers, who work directly with families and serve as the link between community members and the primary health care system.

Contextualizing our work against the backdrop of lockdown measures and public health responses to the Covid-19 pandemic in India, we draw on recent literature in gender studies, development, public health, and media studies to position our analysis of media discourse relating to a group of workers who bore a significant brunt of the care work during the pandemic—frontline health workers known as accredited social health activists (ASHAs). This cadre of health workers, established in 2005, is almost entirely made up of women drawn from the communities they are intended to serve. In May 2022, the World Health Organization (2022) recognized the ASHA workers' contribution to care during the pandemic, conferring on them the Global Health Leaders Award. Following a feminist political economy (FPE) framework (Cohen & van der Muelen Rodgers, 2021; Lokot & Bhatia, 2020; J. Smith et al., 2021), we argue that care work, whether paid or unpaid, is positioned through media discourse as a natural and routine part of women's work, thus reinforcing a normalized construction of such work as gendered and simultaneously of high social yet low economic worth. Such a framing, we argue, precludes the kind of systemic overhaul that would be necessary to place economic value on care work. In the case of ASHA workers, despite their ostensible formal health worker status, we posit that this discourse reinforces the gendered expectations of selfless care and further invisibilizes their systematic marginalization in the health system and in society.

2. Covid-19, Care Work, and Gender

When the world shut down in early 2020 following the World Health Organization's declaration of a global health emergency (Cucinotta & Vanelli, 2020; World Health Organization, 2020), India was one of the first countries to implement a strict countrywide lockdown, starting from March 24, 2020, and remaining in force till May 1, 2020. Even as government bodies focused on containment and surveillance, the media began to report on parallel issues that arose from the lockdown, such as the knock-on effect it had on daily wage workers and the large numbers of the population that worked in the unorganized sector—domestic maids, cleaners, street vendors, drivers, etc.—who stood to lose their monthly earnings since they were not protected by labor laws (Agarwal, 2021; Assan & Chambers, 2014). This immediate concern grew into a larger crisis as thousands of migrant workers living and working far from their native villages were left to fend for themselves. This unforeseen situation resulted in a humanitarian crisis of enormous proportions, and the government was ill-equipped to manage it. It took civil society—individuals, NGOs, and hurriedly organized humanitarian groups—to step in and arrange food and supplies for the thousands making their way back to their rural homes—often on foot (Barhate et al., 2021; Samaddar, 2020). The widespread distress caused by these measures has been widely documented

and commented upon (Gothoskar, 2021; Rajan, 2020; Samaddar, 2020; Suresh et al., 2020).

Amidst this, the health system, both private and public, was propelled into emergency mode, with ASHA workers at the vanguard playing a role in public education, ensuring compliance with preventive health measures, monitoring infection and illness status, and later in the pandemic, motivating people to get vaccinated. Roughly one million women employed by the Ministry of Health and Family Welfare work as ASHAs mainly in rural primary care but are also associated with peri-urban and urban primary health centers. The Hindi word "*Asha*" translates to "hope," and these women are crucial to helping achieve maternal and child health goals (hospital deliveries, immunizations). Other key functions they perform involve: (a) keeping a stock of essential health-related items such as basic drugs for common illnesses (including fever, diarrhea, malaria, and tuberculosis), oral rehydration salts, folic acid tablets, disposable delivery kits, and condoms, and (b) being communication conduits for government health schemes and public health-related information. As in many other countries that employ community health workers (Brownstein et al., 2011; Pérez & Martinez, 2008; Schneider et al., 2016), these women act as critical frontline workers in providing health care options to underserved populations. The position is, however, considered a voluntary one, with each ASHA volunteer given a nominal stipend along with an outcome-based incentive structure, as described by the National Health Mission on their website (Ministry of Health & Family Welfare, 2023).

Starting in March 2020, these workers acted as the first defense against the community spread of the virus, often without adequate safety resources for themselves. Conditions of work for this group had always been the focus of activist attention (Ved et al., 2019), but the pandemic revealed just how dire the problem was. Soon enough, the resentment on the ground in the face of continued state neglect and social apathy led to protests and strikes by ASHA workers in many locations (Srivastava, 2021; Sarkar, 2021). The striking ASHA workers became a flashpoint during the first wave of the pandemic in India, with a few media reports drawing on health activists' inputs to highlight the vulnerabilities of the public health infrastructure and bringing into sharp focus the magnitude of reliance on the under-paid labor of women (United Nations Office for Disaster Risk Reduction, 2020). The ASHA worker represents an important intersectional figure; she is responsible for community health on multiple fronts, her value derives from her ability to "care" for members of the community in fine-grained ways, yet she is seen by the system as a "volunteer" whose services derive from normative expectations of women's unpaid labor, both productive and reproductive. Given the low financial rewards and relatively low educational requirements, these women tend to be drawn from relatively disadvantaged sections of society; in the Indian context, this may also reflect marginality on the basis of caste. To position the necessary affective labor performed by the ASHAs as "voluntary" also perpetuates the continuing subordination of women within an otherwise professionalized sector (Das & Das, 2021). The efforts of ASHA workers to confront this through collectivization and articulation of demands to formalize their status intensified during the pandemic—In fact, as our analysis will show, this was one story that rendered the group visible in media discourse.

3. A Feminist Political Economy of Health

We position our study within the large and growing literature on health disparities within healthcare (Venkatapuram, 2013), but focus on caregivers rather than on the provision of care. Public health crises, such as HIV/AIDS, swine flu, ebola, zika, and the most recent, the Covid-19 pandemic, have regularly shown how health inequalities emerge along the fault lines of race and ethnicity, gender and sexuality, class and caste. Additionally, research has long shown that not only are women more vulnerable to health issues than men due to social, economic, and political imperatives, but also that they bear the brunt of the care work that is required for global healthcare (Kabeer et al., 2021). Most health infrastructure across the world relies on women's unpaid and low-paid work as caregivers both at home and outside, yet this work is "conspicuously invisible" (Harmon, 2016, p. 525) in health policy and administrative measures, as well as in media discourse. Harmon (2016) points to the "paradox" of global health governance where, on the one hand, women are visible in high-profile health-related positions whereas the actual care work performed by millions of women goes unrecognized and unacknowledged. During the pandemic in India, for instance, the few visible women included Dr Sowmya Swaminathan, principal scientist at the World Health Organization, and Dr Gagandeep Kang, a senior virologist, who were seen as spokespersons for the global health establishment and the scientific community, respectively, or Kerala's Health Minister K. K. Sailaja, whose approach to health governance received positive attention. However, the experiences of everyday caregiving were rarely visible. Despite the increasing presence of women in key health governance and scientific/academic positions, gender is often not taken into account in global health strategy, policy, or practice. Harmon (2016) attributes this to patriarchal bias and gender blindness, a general tendency to ignore social and economic structures that favor men and disadvantage women. Feminist research shows that caregiving and social reproduction fall predominantly to women, tasks that are not accorded social or financial value, and thus the contribution of women is either assumed or ignored in developing public policy. Echoing this, global health policy ignores and simultaneously reinscribes gendered stereotypes of care (Das & Das, 2021; George, 2008).

The political economy of health recognizes that health is more than a genetic attribute, rather, it is a

construct determined by socio-political factors (Nunes, 2020; Venkatapuram, 2013), and emerges from the conditions in which people live. In order to understand how health and disease are constructed, framed, and represented within societies, we need to look at everyday practices and how they are situated within larger social, political, and economic contexts (Harding, 1991; D. E. Smith, 1987). Affective labor is folded into many of the roles that are conventionally performed by women, an expectation that is neither articulated contractually nor compensated financially. While unpaid care work within domestic settings is only now being recognized within policy spaces, the unpaid component of other feminized occupations is yet to be accounted for in any formal or economic sense (Nunes, 2020). A further complication arises in emerging economies, where non-domestic care work such as that performed by ASHAs is often seen as "duty" in service of social development.

For our analysis we draw on two specific theoretical approaches—the everyday political economy of health (EPEH) and FPE, the first articulated by Nunes (2020) and the second by Harmon (2016). These approaches allow us a way to investigate how power and economic imperatives work in everyday life to promote gender inequalities in the context of health. EPEH rejects a top-down approach that views inequalities in health as simply a function of insensitive or coercive policy, law, or administrative barriers imposed by local, state, or international authorities. Rather, it sees capitalism and neoliberal power as multifaceted and multi-layered, occurring at many levels and manifesting in different ways, that unobtrusively accrues economic benefit to those with the power. FPE casts a gender-focused lens on women's care work and unacknowledged labor set against a context of structural discrimination that includes intersectionalities of race, class, and caste, among others. Even as FPE's focus has been on how gender-based discrimination influences the social conditions and health of women (Syed, 2021), it also forces questions about the dynamics of the health system on the supply, and the ways in which service provision is gendered, in terms of labor and governance. Syed (2021) notes that jobs in health that involve care work, when performed by women, are often categorized as unskilled, and therefore paid less than similar jobs performed by men.

Cross-country analyses have shown that globally, unpaid care work is done mostly by women, and that they spend nearly three times more time than men in doing this work (International Labour Organization, 2018). Further, recent estimates show that 80% of the world's domestic workers are women, and 70% of the work in global healthcare and social care is also done by women (Lokot & Bhatia, 2020). Following Lokot and Bhatia (2020), we, too, define women's care work as encompassing: (a) the unpaid care work and social reproduction done by women at home and in their communities; (b) underpaid care work done by women in their roles as domestic workers, cooks, *ayahs*, and nursing assistants; and finally, (c) paid care work in healthcare and related spheres. In this article, we restrict our discussion to the type of care work done by ASHAs, which in essence, encompasses all three forms of care work when one looks at their formal and informal roles as women in health services performing care at the community level, going door to door to monitor health and illness.

4. Gender and Covid-19 in the Media

Given the critical scholarship in the field, it is reasonable to expect that media coverage during Covid-19 would reflect a sensitivity to gender issues within health care service provision and specifically the double burden placed on women frontline workers. Media coverage not only brings visibility to structural inequalities, but it also frames the terms on which public conversations take place. The civic response to the migrant crisis in the wake of the national lockdown in India was largely driven by coverage in both mainstream and alternative media, spurring the formation of civic networks of support for people in need (Barhate et al., 2021). Such a response echoes what has been seen in previous emergency situations arising from both natural and human-made disasters (Barnes et al., 2008; Iyengar & Simon, 1993). Deeper structural problems are more challenging to call out persistently, as this would require going beyond the episodic coverage that media tend to focus on. Yet there have been some gains made through consistent media re-framing of issues related to gender, health, and violence (Durham, 2015; Yagnik, 2014). Covid-19 provided an opportunity for journalists to write stories that could possibly begin to shift social attitudes towards care work and its value, making visible the unequal share of the care burden on women at the lower end of the health service system. Based on an analysis of representation of female essential workers (termed "keyworkers") in UK women's magazines, Orgad and Rottenberg (2022) note that the huge visibility of these workers in the media and their overwhelmingly positive portrayal offered an opportunity to discuss "care justice" through a critique of gender inequitable systems, but also to reinforce "care gratitude" through a celebration of such workers' heroism.

A content analysis of Covid-19-related stories mentioning female nurses across three countries (the US, China, and India) found that while they were visible as sources, the presentation of their experiences varied across contexts (DeWees & Miller, 2020). Indian media tended to position this caregiving as fulfilling a personal responsibility even as the voices of nurses expressed "frustration with stigmatization" and related violence (DeWees & Miller, 2020, p 228). The authors pointed to the need to relate these experiences to structural issues, as inputs to policy reform.

The NWMI carried out a nationwide collaborative study of articles related to Covid-19 in 12 national newspapers, in seven languages, between March and

September 2020, which showed that women and marginalized genders were central to the story in less than 5% of the sample (Khan & Singh, 2021). The NWMI report further found that:

> Women and trans people were rarely present as protagonists, sources and experts, sometimes even in stories that were directly about them. News stories on the whole tended to quote men. There were almost no news stories about Dalit and Adivasi women and the trans community in the newspaper articles studied. (Khan, 2021)

Another media analysis looked at the framing of "female organizing" during the pandemic to argue that the gaze employed by the media at the national and international levels tended to privilege existing hegemonies of caste and gender while local media "confronted" this gaze (Banerjee et al., 2022).

This article builds on and goes beyond these studies to look at the media discourse as seen across three large Indian mainstream newspapers while applying the two frameworks mentioned above: FPE and the EPEH. The attempt in this analysis is to understand whether and to what extent the media discourse went beyond episodic and neoliberal framings of care work in their coverage of ASHA workers during the pandemic. The assumptions we make, drawing from the perspective of critical FPE and the EPEH, are that journalistic coverage should, while covering ASHA workers, acknowledge and make visible in both explicit and implicit ways, the following:

- The structural conditions of work, including the dynamics of gender, and where appropriate, caste;
- The systemic inequalities within health care service delivery;
- The value and contribution of care work, including affective labor, performed by the ASHAs in alleviating the health burden.

As the studies mentioned here have shown, these are assumptions—rather, expectations—that have rarely been the basis of coverage. However, we embarked on the analysis to understand whether and to what extent the potential for disrupting "coverage as usual" had been utilized by the news media.

5. Methodology

The sample for this study consisted of articles drawn from three different national English-language newspapers—*The Hindu*, *The Times of India*, and *The Indian Express* over one year—from March 24, 2020 (the day the Indian government implemented a nation-wide lockdown) to March 24, 2021 (both dates inclusive). The newspapers were selected for their long-standing reputation as national newspapers of record and for their wide readership. While *The Times of India* is more popular in Northern India, *The Hindu* is more widely read in Southern India, and the *Indian Express* has a pan-Indian readership. A keyword search was used to draw relevant articles from the online archives of the three newspapers. Search terms included: women, gender, Covid-19, healthcare workers, ASHA workers, and frontline workers. Articles that included at least one term related to gender, healthcare, and the pandemic, along with either "ASHA" or "frontline worker" in the headline, were selected.

The search yielded a total of 244 articles of all types (news reports, features, editorials, and op-eds) containing these key terms across the three newspapers in this time period (*The Hindu*: 89, *The Times of India*: 56, and *The Indian Express*: 99). These were scanned (headlines, lead paragraphs, visuals) for relevance so as to eliminate articles that did not substantively relate to ASHAs and care work or to female frontline workers. This resulted in a pool of 79 articles (*The Hindu*: 25, *The Times of India*: 10, and *The Indian Express*: 44) across types that were included in the analysis. A majority of the 79 articles included in the analysis were short news reports of under 300 words, with a few longer essays and medium-length features. Among the 79 selected articles were 19 opinion pieces (*The Indian Express*: eight, *The Hindu*: 11), most of these written by health professionals, academics, and policy analysts.

Textual analysis (in Stuart Hall's tradition of studying representation, further elaborated on in Fürsich, 2009) was performed on this second set of articles to arrive at key narrative strands through a close reading of the headline and copy, with attention to the type of sources used, framing of the work performed by the ASHAs, and any systemic issues mentioned, either as an observation by the reporter or by a source. Textual analysis through the close reading method allowed us to understand representation through the use of linguistic and syntactic cues that positioned the subject of interest in relation to social-political and cultural structures. Through this close reading, initially of headlines and lead paragraphs, and subsequently of the entire text of the selected articles, we identified a set of key questions to ask ourselves while reading the articles:

- What subjective positions do women health care workers occupy in media coverage of the Covid-19 pandemic in India? To what extent is their care work acknowledged and how is it framed?
- How are women healthcare workers—across levels—represented in the selected news outlets?
- (How) does gender emerge as a concern in media reports of the pandemic and the subsequent lockdown in India?
- While academic and activist inquiries have pointed to the gendered nature of the pandemic's impact on India's population, to what extent do these concerns find a place in reportage and commentary?

While the first two questions were specific and were answered by a close reading of the articles, extracting quotes and identifying narrative threads, the third and fourth questions were addressed based on an overall analysis of the entire corpus of articles. The combined frameworks of FPE and the EPEH allowed us to discern whether and how women's care work was recognized and valued within the stories and how women care workers (ASHAs) were positioned as members of the health value chain.

6. Findings: Victims, Heroes, Carers as Usual

The first stage in our sampling process allowed us to gain a sense of the general direction and tone of coverage and established the fact that gender as a theme was not prominent in news stories of the pandemic except as part of the commentary on the gendered nature of job losses, or a few reports around the increase in the incidence of domestic violence and under-age marriages of girl children. To offer a sense of how rarely gender featured in the editorial pages of just one of the three newspapers, *The Hindu*, we did a quick sampling of editorials and found that of close to 450 opinion pieces that included the key term "Covid-19 impact" only 25 addressed gender explicitly and none of these focused on care work. Of *The Times of India* articles that showed up in the initial search, most were brief pieces reporting studies conducted by civil society organizations and offered with no further commentary or analysis. A scan of the bylines across the corpus of stories revealed that the few opinion pieces that directly addressed gender issues were mostly written by women.

Building on the findings of the NWMI study mentioned above (Khan, 2021), we also found that there was a general invisibility of care work or gender-related concerns in the sample of articles analyzed. Curiously enough, in the photographs carried alongside articles, women were hyper visible as domestic workers, street vendors, migrant workers, and health care staff. ASHA workers were particularly visible in photographs, their pink *saris* becoming almost emblematic of frontline care. Yet, in the accompanying text, gender as a construct was largely invisible as a concern or as a social determinant.

Our close reading, informed by the two theoretical approaches mentioned earlier (FPE and EPEH) led to the discerning of two main narrative threads that ran across the media content, relating to the gendered impact of the pandemic and more specifically, to women in care work. As Berger (1997) notes, media narratives emerge over time through the repetitive positioning of subjects in specific ways that then become dominant stories about those subjects. The two main narratives around gender in relation to Covid-19 are outlined in Table 1 along with a selection of illustrative quotes from the analyzed articles.

6.1. Narrative One: Women as Victims

This narrative was a strong thread through the year and across newspapers. While the majority of articles in the beginning of the time frame focused on the risks posed to health care workers, especially the women who were in the ASHA program, as the pandemic continued into the year, there were scattered articles about the dangers posed by the Covid-19 virus to pregnant and lactating women, as well as other crime-related stories where women were assaulted due to ill health or other pandemic-induced vulnerabilities. Three main categories of victimhood were seen: (a) physical/health-related vulnerabilities, which rendered women more susceptible to adverse health impacts; (b) crime-related, where women were harassed or assaulted by strangers, or subject to domestic abuse by spouses, parents, or siblings; and (c) economic distress due to job losses. A fourth, less frequently seen category, related to women as victims of a patriarchal order.

Physical and health-related victimhood involved both warnings based on emerging scientific data about how women were affected, as well as stories of health care workers and relatives falling ill and/or succumbing to Covid-19. There were also stories about ill-treatment of health care workers due to fears of being infected by them. With regard to crime and violence, there were stories of assault by patients, ambulance drivers, or family members putting women at greater risk than usual. News reports cited studies that noted a dramatic rise in distress calls to helplines for domestic violence and intimate partner violence. Lastly, economic distress was also a topic of discussion with regard to loss of livelihoods for women, a large proportion of whom work in the unorganized/informal sector in gendered jobs such as sanitation and personal care.

Interestingly, even as women were seen as being disproportionately affected by circumstances arising from the pandemic, there was little or no reflection on why this might be so, or mention of systemic factors that contributed to this impact—factors that have been raised by critical scholars across disciplines. Articles in *The Hindu* were to some extent exceptions to this pattern, with reports including opinions of experts who pointed to lacunae in the health system. While there were a fair number of articles describing the impact on women across these dimensions in the early phase of the pandemic (between the months of March and August), the coverage trailed off in later months, suggesting that even this little focus on gender was not sustained over time.

6.2. Narrative Two: Women as Selfless Heroes

A second narrative that we identified portrayed the women as "warriors" and "heroes." While many articles with this narrative theme were about the ASHA workers, the theme ran through other women-centered articles as well. Stories described the countless hours

Table 1. Main narrative threads and illustrative extracts from articles analyzed.

Narrative	Theme	Illustrative text: Headline	Illustrative text: Quote from article
Women as victims of the pandemic	Health-related vulnerability	Safeguarding the vulnerable among us (*The Hindu*, March 27, 2020)	"We need special measures to protect the millions of health and care workers…''
		Does the coronavirus affect men and women differently? Here's what a doctor says (*Indian Express*, September 10, 2020)	"The data from India also shows that there is almost 65:35 percent male:female death rate disparity ratio…''
	Economic vulnerability	Fallen through the cracks (*The Hindu*, November 17, 2020)	"Recent labour codes disregard women's work conditions.''
		We're not all in the same boat (*The Hindu*, January 27, 2021)	"Globally, women are over-represented in the sectors hardest hit by job losses.''
	Social and domestic violence	The invisible face of the fallout (*The Hindu*, April 21, 2020)	"Even in these disruptive times, women's safety should become a priority.''
		Gender-based violence was predictable, and preventable, fallout of lockdown (*Indian Express*, November 25, 2020)	"Till date, public discussion of the pandemic's impact on gender violence is confined to domestic violence, but violence cannot be categorized in airtight boxes… Violence is the short-hand language we use to communicate power play…''
	Systemic issues	Health worker safety deserves a second look (*The Hindu*, September 25, 2020	"Many health workers are overworked not by choice, but rather the lack of it''
		Ironing out wrinkles in India's pandemic response (*The Hindu*, March 25, 2020)	"Health workers also face physical and mental exhaustion, which affects their morale, in addition to infection risk.''
		The criticality of community engagement (*The Hindu*, April 6, 2020)	"We…need to remember the trust deficit in the system, between ASHA workers and the public.''
		Unheard and unprotected (*The Hindu*, June 28, 2020)	"The pandemic has…exposed the predominant social inequalities among the working classes….ASHAs lack masks and personal protective equipment…putting their lives in danger on exiguous incomes.''
		Covid-19 will push 47 million more women, girls, into extreme poverty by 2021: UN (*Indian Express*, September 3, 2020)	"The increases in women's extreme poverty are a stark indictment of deep flaws in the ways we have constructed our societies and economies." (Quoting a UN official)
		Explained: The worldwide gender skew in coronavirus thinktanks (*Indian Express*, October 5, 2020)	"Lack of representation is one symptom of a broken system where governance is not inclusive of gender, geography, sexual orientation, race…ultimately excluding those who offer unique perspectives.''
		A health plan for Bihar (*Indian Express*, November 24, 2020)	"Covid-19 has laid bare the state's weak public health system, systemic flaws, structural deficiencies and gaps in implementing welfare schemes.''

Table 1. (Cont.) Main narrative threads and illustrative extracts from articles analyzed.

Narrative	Theme	Illustrative text: Headline	Illustrative text: Quote from article
Women as heroes of Covid-19 times	Care work as socially valuable	About 600,000 virus-hunting women health activists go on strike (*The Times of India*, August 7, 2020)	"Losing the ASHAs would not only threaten India's containment effort, but also impact the other essential health services they provide."
		The many lessons from Covid-19 (*The Hindu*, October 27, 2020)	"Empowering our frontline health workers will yield rich dividends."
		ASHA workers: Pillars of health care (*The Times of India*, July 7, 2020)	"Covid warriors who are pleased to be serving the government in this time of need."
		"I wanted to step out, help people": Meet Veeralakshmi, first woman ambulance pilot in Tamil Nadu (*Indian Express*, September 3, 2020)	"I had no fear, I was interested in taking up this job….I wanted to step out and help the people in this difficult period." (Quote from Veeralakshmi)
	Care work as exemplifying women's natural sacrifice	ASHA workers on Covid-19 duty in DK continue to be under constant threat (*The Times of India*, April 15, 2020)	"We must respect their sacrifices and not obstruct them from discharging their duties."

put in by female nurses and doctors, a story about the first woman ambulance driver risking her life to carry Covid-19-positive patients to the hospital, a diligent administrative officer who worked right until her delivery and came back to work soon after. The articles all lauded these women for their "bravery," framing them as "pleased to serve the country in this hour of need." The use of such militaristic metaphors to describe the work of care positions it even more starkly as a duty that deserves gratitude but not compensation. Where health care workers were being harassed and vilified due to fear of the virus, the articles called for society/citizens to "respect their sacrifices and not obstruct them from discharging their duties." This narrative was relatively less visible across the corpus of stories analyzed, even though there was a popular sense of appreciation for frontline workers (celebrated in many countries by clapping, ringing bells, or lighting lamps each evening). The few stories in our sample that highlighted the contributions of individual women used appreciative but uncritical language, possibly in an attempt to keep a positive storyline during otherwise depressing times.

6.3. Accredited Social Health Activist Workers and Media Discourse

One important news story that emerged during the first year of the pandemic was that of ASHA workers who, by virtue of their responsibilities as first responders to health problems to rural and underserved communities, were in the forefront of the government response to Covid-19. Acting as a vital bridge between government health services and their communities, the critical role performed by these workers has long been a matter

of discussion among health activists. Despite their valuable interventions, they have always been seen as little more than volunteers (a term used in the official description of the role) and paid a very low monthly fixed stipend (of ₹ 2,000, increased to ₹ 4,000 per month, translating to less than $45), with additional amounts paid according to an incentive system that pays a commission for helping patients access various government health schemes (Raman, 2020). A few articles mentioned the stigma attached to frontline workers who were seen as potential carriers of infection due to the nature of their work. Across all the stories featuring ASHA workers, there was little or no attention given to systemic issues, their position in the service chain, or the additional affective labor they are often called on to deliver in communities, in this case, during a health crisis. The laudatory tone used to describe their "sacrifice" and "commitment" reinforced a sense that these are only expected of such a role, thus relegating "care" to the realm of the unpaid. In other words, placing it beyond economic value discourages quantification. This is in contrast to the finding by Orgad and Rottenberg (2022, p. 10) that women's magazines in the UK to some extent refused "the sentimentalized heroic narrative where women are simply portrayed as working for the good of others without any rancor or anger."

The media, during this time, paid more attention to ASHA workers after they went on strike in several states across the country, and while these strikes received a fair amount of coverage in all three newspapers, there was not a single follow-up story in those analyzed that attempted to examine the issues that underlay the strikes or the continuing demands of the workers. Such stories could have been an opportunity to showcase the

agency of the ASHA worker, the push to collectivize and demand recognition and reward for their work. In the current media scenario, where corporate interests and market forces determine what and how stories are told, this is not unusual.

7. Discussion: A Missed Opportunity to Value Care Work

The coverage of care work as performed by women workers assigned the job of ensuring the health of communities during the pandemic was minimal, marked by a "conspicuous invisibility" (Harmon, 2016) in the discourse. While ASHA workers as a group were visible in image and word, their location in the system as women responsible for both the instrumental and affective aspects of health labor went largely unnoticed, apart from a few opinion pieces contributed by health activists and academics. There was a failure to connect the conditions of work with social structures and governance mechanisms, with only *one* article in the entire corpus referring to the "patriarchy" as an organizing framework that constrains a more equitable sharing of care work, both paid and unpaid. This absence of discourse serves to position caregiving as an individual/local community responsibility, distancing it from the responsibility of the state, and confining it to the private or domestic realm. Here, it becomes a "natural responsibility" of women workers, hence while the quantity of work evokes empathy, the value of the work remains notional.

The emphasis on sacrifice and selfless service on the part of ASHAs as something to be rewarded with appreciation effectively keeps it from being a professional norm that can have "exchange value" in the market. MacLeavy (2019, p. 140), discussing the potential for technology to alleviate some of the caregiving burden assigned to women in the UK, notes that "societal expectations for women's role in unpaid care economy are often absent from discussions of the 'future of work' and by extension the future of work in the post-Covid-19 era." Further, she argues that there has been a general failure on the part of market economies to "culturally and numerically defeminize care work through regulation." One might argue that there needs to first be a recognition of care as productive work in order for it to first be valued in economic terms, and then to be regulated.

In India, such discussions are further complicated by the social hierarchies that relegate the burden of care work not only to women, but also to women of marginalized communities. The conversation about "defeminisation" has yet to begin, and so the implicit assumption that the ASHAs will perform the "soft" work of public health—the emotional and the surveillant labor—goes unquestioned. The responsibilities assigned to the ASHA—some written in the job description and many others assumed—reinforce her role as a woman caregiver. This aligns with the pervasive social norm of the woman being part of the (established) culture of servi-

tude (Komarraju et al., 2022) that permeates such jobs as care work (nursing, personal assistants, grooming, paramedical services) and normalizes this view of the work, obscuring the patriarchal structures that render this work as "naturally" falling to the woman's lot.

An "FPE of care" would enable a focus on the structural and institutional frameworks that adopt gender blindness in ways that invalidate the enormous burdens and responsibilities that are entailed in care work, feminizing, and thereby de-valuing the vital social and economic benefit that accrues from such work. With regard to global health governance, research has shown that the vital work that (women) health care workers do, acts as a "shock absorber" in times of health crises (Harmon, 2016), and is in fact the very foundation of a smooth functioning of the global health system (Lokot & Bhatia, 2020). Academic/scientific research in the wake of Covid-19 has also shown how gender and other inequities are exacerbated during the pandemic (Bambra et al., 2020), resulting in what can be considered a "double whammy" for women who are both negatively impacted by the fallout of such disasters and simultaneously required to carry the burden of care work both at home and in their communities with little to no monetary compensation, and absolutely no acknowledgement.

Returning to the expectations/assumptions related to coverage that were articulated earlier, our analysis showed that while there was some acknowledgment of structural issues that constrained the work of the ASHAs, and showcased their demands for better working conditions, there was little to no attention paid to affective labor as a significant part of their work, or as labor that had exchange value—as FPE emphasizes. The gendered expectations of care work were masked by the representation of ASHAs as performing a valuable "sacrifice" that deserved gratitude rather than labor that deserved compensation. The inherent inequities in the health delivery system, where mentioned, had more to do with accessibility to patients rather than issues with those involved in the provision of care. Care itself was framed largely in material terms, rather than something that was accompanied by significant emotional, mental, and psychological inputs that make up affective labor. We may posit that this invisibility of affective labor is a natural part of the dominant patriarchal norms that govern society. Our findings echo the observation of Das and Das (2021, p. 2) that media representation of ASHA workers reflects the "gendered devaluation of care work within a political economy of health increasingly dictated by a neoliberal logic."

If Covid-19 was indeed to be a turning point to new ways of thinking about work, care, and the well-being of societies, we need a dual movement: one that valorizes care while also defeminizing it. The first would allow us to see how patriarchal notions of care pattern labor markets and differentially value certain forms of work. The second would redistribute the work of care such that

the responsibility for affective and material labor is more equitably shared and recognized by the state and the market. Adopting the lens of a (feminist) political economy of care would center these concerns in global health conversations, be they in the realm of health governance and policy or media discourse. Covid-19 did not cause the gender inequities endemic to global health care; rather, it revealed the gendered division of labor and social and economic inequities embedded in the system (J. Smith et al., 2021). In India, those issues, intersecting with inequities of caste and class (among other things), resulted in an economic, social, and mental health crisis of epic proportions. Incorporating such ways of seeing into journalism teaching and training could encourage reporters and editors to reframe the questions that drive their stories and ultimately lead to complicating the coverage of social issues.

This study is of course limited by the fact that it is based on only three English language newspapers. While these may be dominant within the English language print environment in India, it needs to be acknowledged that there is a large and diverse media landscape comprising print, online, and broadcast outlets, many of which (particularly the online platforms) take a decidedly critical approach to reportage and commentary. However, these newspapers reach the influential middle class and are treated as newspapers of record in India.

8. Conclusion

Mass media can play a role in shifting habits of the mind, nudging us to see the world differently, and over time, perhaps even moving us to think and act in fairer, more enlightened ways. While a critical view of the media may place it in service of a capitalist market, there are elements within the journalistic enterprise that take on the task of social and political reform—particularly some online news outlets such as *The Wire* (https://thewire.in) and *Scroll.in* (https://scroll.in) that lie outside the corporatized structures and have maintained an adversarial or watchdog role. Covid-19 did indeed offer us such an opportunity to go beyond coverage as usual, and, for a brief moment, it seemed like we did acknowledge the deep structural inequities that marked our health system and the people who contributed to it. But it was an opportunity for the most part unutilized by the large media outlets in their routine coverage, the exception being the few expert-contributed opinion pieces.

As media scholars, it behooves us to take on the challenge of moving the academic insights gained across these different fields of study into mainstream media discourse. While the losses sustained during this crisis will take years to regain, it is vital for us—at least now—to learn from the mistakes of the past in order to mitigate the effects of the global crises that most definitely lie in our future. A robust media discourse that addresses structural inequities, adopts an intersectional feminist lens, and goes beyond episodic reporting of events would go a long way in opening up that portal to a new way of thinking about women in care work and about the societal—and economic—value of care.

Conflict of Interests

The authors declare no conflict of interests.

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