

Decent work for Community Health Workers in South Asia: A Path to Gender Equality and Sustainable Development

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Preface:

As the ‘Future of Work’ is being discussed around the world, women continue to be the most under-utilised and potentially game-changing factor for fair and prosperous economic growth. Recent research shows that a reduction in the gap in participation rates between men and women by 25 per cent has the potential to increase the GDP in Asia Pacific by as much as US\$ 3.2 trillion. A recent report by the International Labour Organization and Gallup confirmed that the majority of women and men worldwide would prefer that women work in paid jobs and find it perfectly acceptable for women to have paid work outside of the home. Why then does female labour force participation still lag behind that of males in all countries of the region?

To examine the opportunities and challenges of the future at work for women, the International Labour Organization (ILO) and the Australian Government’s Department of Jobs and Small Business have partnered in a project called “Women and the Future of Work in Asia and the Pacific”.

The following paper was part of a competitive ‘call for proposals’ under this project. It will be one contribution into the ILO’s forthcoming ‘Women and the Future of Work in Asia and the Pacific regional report’. These selected papers are meant to provide evidence-based policy recommendations to inform decision-makers on where best to invest efforts and resources to achieve the best returns for the future of work.

We warmly thank the researchers for their contributions to this project. We would also like to extend our deep gratitude to the Technical Advisory Group (TAG) members for their contributions to the project- Edgard Rodriguez, Ratna Sudarshan, Shauna Olney, Helen Lockey, Sara Elder, Rebecca Duncan, Kristin Letts, Rhea Kuruvilla. We thank them all for their guidance for the call for proposals as well as their technical inputs to the selected papers. ILO technical Coordination and inputs have been led by Joni Simpson and Aya Matsuura. Thanks to Noorie Safa for pulling the reports together and to Shristee Lamsal for her overall coordination of the Women and the Future of Work in Asia and the Pacific Regional Conference.

The responsibility for opinions expressed in articles, studies and other contributions rests solely with their authors, and publication does not constitute an endorsement by the International Labour Office of the opinions expressed in them, or of any products, processes or geographical designations mentioned.

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Acronyms

APLHWA - All Pakistan Lady Health Workers Association

ASHA - Accredited Social Health Activist

CHW - Community Health Worker

CPHC - Comprehensive Primary Healthcare

FCHV - Female Community Health Volunteer

FP&PHC - Pakistani National Programme for Family Planning and Primary Health Care

ILO - International Labour Organisation

LHW - Lady Health Worker

MDG - Millennium Development Goal

NGO - Non-Governmental Organisation

NRHM - National Rural Health Mission

PSI - Public Services International

SAP - Structural Adjustment Programme

SDG - Sustainable Development Goal

UNCSW - United Nations Commission on the Status of Women

WHO - World Health Organisation

WHR - World Health Report

Executive Summary

This paper explores the ways in which the world of work continues to entrench inequality against women, with implications for their families and the broader communities in which they live. Through a case study of the work and remuneration of one classification of workers across three South Asian countries, we demonstrate that the inequity which exists within many societies is a political choice. Our perspectives take as axiomatic that fundamental human and labour rights, as elaborated in international standards, are critical for the achievement of the sustainable development goals (SDGs).

This paper focuses on India, Nepal and Pakistan. The authors used primary research commissioned by Public Services International (PSI) in these countries over the past two years. This research is both qualitative and quantitative, based on surveys, focus group discussions and key informant interviews. The authors both reviewed the original data and incorporated relevant findings from this research. A review of relevant literature related to Community Health Worker (CHW) programs generally, and in South Asia more specifically was also used as a background.

These case studies together demonstrate that CHWs are examples of a system built on women's unpaid or low paid and devalued work.

We find that in the three countries under study, CHWs are employees of the state and work as extensions of the public health system. Yet, they are not recognised as such, except in the case of Pakistan. We find that in the case of India and Nepal, even though they perform services for the public healthcare system and are given instructions from public health officials on how the work is to be done, the government does not provide a salary or employment benefits. We therefore argue that Nepal's Female Community Health Volunteers (FCHVs) and India's Accredited Social Health Activists (ASHAs) are disguised employees of the public healthcare system, as defined by the International Labour Organisation (ILO).

Further, ASHAs in India, depend on a system of task-based incentives for complementary income to their nominal honorarium. We find that this system has negative impacts on the workers and on the patients as activities with higher incentives become prioritised over other activities resulting in healthcare that may not be a priority for the individual or community.

We find that in Pakistan, the regularisation of Lady Health Workers (LHWs) was done after a struggle by a national platform of LHW unions. In the case of India, a monthly honorarium was introduced due to the pressure of ASHA unions. We find that the right to freedom of association and the right to bargain collectively played a key role in the improvement of the employment conditions of LHWs and ASHAs.

Further, we argue that the lack of adequate remuneration for FCHVs and ASHAs means that women from rural and economically vulnerable background subsidise their countries' public health systems. The resources required to adequately remunerate them is only a fraction of the resources lost to tax evasion by corporations. We argue that tax progressive reforms can greatly contribute to the gap in financing for CHWs programs in the region.

We therefore recommend that:

- The governments of India and Nepal uphold the ASHAs and FCHVs Fundamental Principles and Rights at Work (ILO 1988). Consequently, that they promote the Decent Work Agenda in the sphere of community healthcare delivery;
- The governments of India, Nepal and Pakistan ensure the payment of wages are at a rate not less than the statutory minimum wage and are consistent with the legal principle of equal pay for equal work; i.e. considering wages afforded to workers in other sectors with a similar set of skills, qualifications and responsibilities;
- All Governments adhere to social dialogue, including genuine collective bargaining, with workers' unions, as a universally recognised mechanism for improving the wages and working conditions of women;
- The governments of India and Nepal adopt ILO Convention 87 on Freedom of Association and Protection of the Right to Organise and that the government of India adopts Convention 98 on the Right to Organise and Collective Bargaining;
- The governments of India, Pakistan and Nepal engage in progressive tax reforms that increase the contribution of large private companies, prohibit tax evasion and avoidance and utilise the additional resources for improved remuneration and conditions for CHW;
- The governments of India, Nepal and Pakistan institute systems that provide for stable and regular wages for all CHWs and ensure that payments are made in a timely manne

1. Introduction and Background

1.1 Introduction

This paper explores the ways in which the world of work continues to entrench inequality against women, with implications for their families and the broader communities in which they live. Through a case study of the work and remuneration of one classification of worker across three South Asian countries, we demonstrate that the inequity which exists within many societies is a political choice. Our perspectives take as axiomatic that fundamental human and labour rights, as elaborated in international standards, are critical for the achievement of the sustainable development goals (SDGs).

It is important to recognise that the gendered division of labour provides the scaffolding of neoliberal capitalism (Fraser 2016). Capitalism entrenches, and is dependent on, a constructed gendered differentiation of productive and reproductive work which determines both the economic and social value of work. Most social care or reproductive work is constructed to be a natural obligation of women and thus, undervalued. That work is universally either unpaid or extremely low paid compared to male dominated occupations that are of equal value considering the required skills, qualifications and responsibilities. Unequal remuneration is therefore present as a social relation at the core of the material subordination of women in the world of work.

South Asia¹ as a region has the highest rate of non-agricultural informal employment, ranging from 83.6% in India and 78.4% in Pakistan to 62.1 % in Sri Lanka (ILO/WIEGO 2013). Women's labour force participation rate in South Asia is amongst the lowest in the world at 30.5% (in 2010). In India, the participation rate of women has declined from over 40 to 27.4 percent, with the most significant decline in rural areas (Chaudary and Verick 2014). Many women are employed within the informal sector, as well as the informal component of the formal-economy (ILO 2014). The lack of alternative work opportunities is an important factor in women's decisions to work as Community Health Workers (CHWs) in South Asia.

The following case studies demonstrate that CHWs are examples of a system built on women's unpaid or low paid and devalued work, and makes recommendations accordingly.

1.2 Background

The WHO characterizes CHWs as follows:

“Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers (WHO 2007).”

This definition of CHWs includes those who perform general tasks as well as those who carry out more

1 In this paper, South Asia will be taken to include Bangladesh, India, Nepal, Pakistan and Sri Lanka. Bhutan and Maldives are included when the data is available.

specialized tasks, but excludes auxiliary and mid-level health workers that are generally facility-based (Haines et al. 2007).

In the 1960s and 1970s there was strong support for expanding access to healthcare through utilising CHWs. They were seen as a key component for meeting the comprehensive primary healthcare (CPHC) aims of the Alma Ata Declaration of 1978 (WHO 2007).

By the early 1990s the enthusiasm for CHWs programmes had diminished. Two key contributing factors were the Structural Adjustment Programmes (SAPs) of the 1980s and 90s leading to decreased government expenditure for healthcare and, secondly, the perception that CHWs can only provide 'second class' care led to decreased political backing (Roy, unpublished).

The new millennium delivered a revival in utilising CHWs programmes, evidenced by the reference to CHWs in the Millennium Development Goals and in the 2006 World Health Report (WHR). The WHR proposes CHWs as a strategy to mitigate the shortage of health workers, proposing that tasks performed by health professionals be delegated to paraprofessional health workers (WHO 2006).

We argue that this revival is dominated by a neoliberal ideology. It relies on, and entrenches, the understanding that the labour of CHWs is provided either at no or low cost, to maximise the benefits of a workforce in the absence of adequate government expenditure on healthcare.

Further, we argue that this revival brings a change in perspective regarding the role of CHWs. Originally CHWs were viewed as both an extension of the healthcare system and agents of social change through community mobilisation within a CPHC approach. Current programmes emphasize their technical and community healthcare function; essentially treating CHWs as auxiliary extensions of the formal healthcare system (WHO 2007) within a selective primary healthcare approach.

As can be seen in Table 1, most CHW projects within South Asia commenced in the 1970's, except for Pakistan and noting a period of cessation in India. The focus of CHW programmes have typically been maternal and child healthcare, family planning, health promotion and education, and immunization. This workforce provides an essential linkage between vulnerable population in rural and poor communities and the formal health system. Referrals and treatment of some health issues have been progressively added to the role of CHWs as their function evolves.

Sri Lanka is arguably the only South Asian country that does not have a large-scale CHW programme. This is possibly due to a more robust public and primary-level healthcare system, and that most healthcare occurs in public facilities. Bangladesh has a different CHWs program that is reliant mostly on the NGO sector with a remuneration model that varies from its peers. Therefore, this paper examines India, Nepal and Pakistan; all having large-scale, nation-wide and government-led CHW programmes.

Table 1: CHW programmes in South Asia

	Pakistan	India	Nepal	Sri Lanka	Bangladesh
Workforce	Lady Health Workers (LHW)	Accredited Social Health Activist (ASHA)	Female Community Health Volunteer (FCHV)	Community Health Volunteers (CHVs)	Shasthya Shebikas (SS)
Year of commencement of programme	1994	2005	1988	1976	1977
Total workforce	125,000	939,000	53,000	15,000 (approx.)	80,000
Population per CHW	175 households (1,000-1,200 people)	200 households (approx. 1,000 people)	125 households (approx. 600 people)	20 households (approx. 100 people)	250-300 households per month
Main tasks	Maternal, neonatal and child health, family planning, health promotion, immunization	Family planning, institutional delivery, child health, health education	Safe motherhood, child health, family planning, immunization	Support in prevention programmes, data collection, and health campaigns.	Health education, treatment of basic health problems, collect health information, and make referrals to health centres
Training	3 months + 12 months in the field	23 days	18 days	14 days (2 weeks)	28 days (4 weeks)
Remuneration (annual)	USD 1650	USD 500	USD 75	No remuneration at all	US 52 (monthly average of BTK 360)

(Source: Compiled by the authors based on Program documents from each country)

1.3 Methodology

The authors used primary research commissioned by Public Services International (PSI) in these countries over the past two years. This research is both qualitative and quantitative, based on surveys, focus group discussions and key informant interviews. The authors both reviewed the original data and incorporated relevant findings from this research. A review of relevant literature related to CHWs programs generally, and in South Asia more specifically was also used as a background.

2. Key Findings from Case Studies

2.1 Context of Case Studies

The political context varies within the three focus countries. India, which is the world's largest democracy, has high and increasing inequality, despite sustained economic growth. Nepal, having transitioned from a Kingdom to a Republic, continues to develop its fundamental democratic frameworks. Pakistan is a middle-income country with recent democratic, social and political instability.

Regardless, their healthcare systems have similarities characterised by underfunded public sector facilities and large private sector involvement.

Government spending in each country represents less than half of the total of all healthcare expenditure; ranging between 36% (Pakistan) and 42% (Nepal). The Nepalese expenditure incurred directly by patients is comparatively lower, possibly due to the large not-for profit sector (Table 2).

Table 2: Patterns of Health Financing in South Asia

	Bangladesh	India	Nepal	Pakistan	Sri lanka
Current health expenditure as % of GDP	2.64	3.89	6.15	2.69	2.97
Gov health expenditure as % of GDP	0.39	1.00	1.11	0.74	1.59
Gov health expenditure as a % of CHE	15	26	18	27	54
Ext health expenditure as a % of CHE	11	1	10	4	1
Out of pocket expenditure as a % of total health expenditure (2014)*	67	62	48	56	42
Current health expenditure per capita (in int \$)	41	99	43	37	87
Gov health expenditure per capita (in int \$)	6	25	8	10	47

(Source: World Health Organisation, Global Health Expenditure Database, viewed 22 December 2017)

Despite significant progress in maternal and infant mortality, health outcomes remain poor (Table 3).

Table 3: Selected health outcomes of South Asian countries

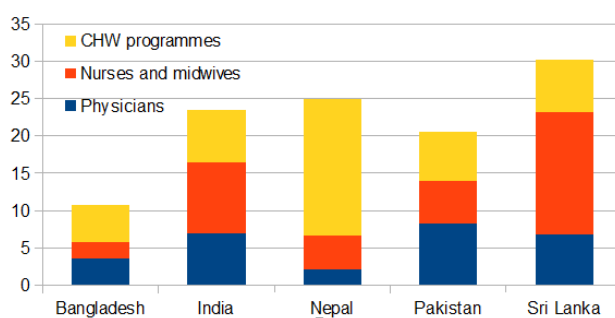
	Bangladesh	India	Nepal	Pakistan	Sri lanka
Life expectancy at birth*	72	68	70	66	75
Infant mortality rate	97	946	16	351	3
Under 5 mortality rate	119	1201	20	432	3
Maternal mortality ratio	176	174	258	178	30
Per capita income (PPP intl. \$, 2016)*	3,587	6,583	2,483	5,246	12,337

(Source: World Health Organisation, Global Health Expenditure Database, viewed 22 December 2017)

Skilled healthcare workforce shortages are considerable (Table 4) with India having one of the highest shortages in absolute terms (WHO 2006). The gender dimension within both the formal and informal healthcare systems sees women's labour at the lower end of pay scales (Standing 2000) with little or no job security (George 2008).

CHWs represent a substantial portion of the healthcare workforce (Table 4). In Nepal the workforce of this single programme is equivalent to almost three times the workforce of physicians, nurses and midwives combined. The CHWs comprise almost half of the workforce in Pakistan (43%) and India (46%), compared to that of physicians, nurses and midwives combined. A commonality across these programmes is that CHWs are overwhelmingly women with low levels of education from rural, poor to modest, backgrounds.

Table-4: Health workforce density per 10,000 population, South Asia 2016



(Source: www.indexmundi.com/2)

Funding of CHW programmes in India and Pakistan is largely through general taxation. In Nepal, the programme is funded through international aid (Perry 2017, p. 69).

2.2 CHW programmes in India, Nepal and Pakistan

India's Accredited Social Health Activists

The Indian *National Rural Health Mission* (NRHM) 2005 aimed to improve health outcomes through the creation of a large pool of CHWs, known as *Accredited Social Health Activists* (ASHAs). ASHAs receive 23 days of training. Tasks include family planning, taking pregnant mothers to healthcare institutions for delivery, mother and child health and health education. They carry a medical kit. ASHAs work in rural and urban areas and are allocated 200 households; a population of approximately 1,000 people.

Since September 2016, over 939,000 ASHAs have been deployed across the country (MHFW 2017).

Nepal's Female Community Health Volunteers

Nepal's *Female Community Health Volunteer* (FCHV) programme was started in 1988–89 aiming to promote safe motherhood, child health, family planning and immunization. FCHVs undergo an 18-day basic training course. After completion of training FCHVs are provided with a certificate from the Ministry of Health, and a medicine kit that includes oral rehydration solution packets and oral supplements such as vitamin A and iron. They are provided an identity card and a register with 30 to 40 indicators to be recorded including maternal, infant and child deaths, and details of vertical programmes in their areas.

FCHVs also treat cases of lower respiratory tract infections and refer more complicated cases to healthcare institutions. There are more than 54,000 FCHVs working throughout rural Nepal providing services to approximately 125 households (around 600 people) each.

2 In 2016, data methodology was changed for India and is less comparable with the other countries. For sake of comparability, 2015 data is given for India.

Pakistan's Lady Health Workers

The *Pakistani National Programme for Family Planning and Primary Health Care (FP&PHC)*, informally known as the *Lady Health Workers (LHWs) programme*, was created in 1994 aiming to improve maternal, neonatal and child healthcare, family planning services and integration of existing vertical health promotion programmes.

After 3-months of basic training and a 12-month period of supervision, an LHW is responsible for the basic healthcare needs of 1,000 to 1,200 people, or roughly 175 households.

There are wide disparities in the reach of the LHW programme. Sindh and Punjab provinces are significantly better served than Khyber Pakhtunkhwa and Balochistan where significant safety concerns exist. Urban areas are better covered than rural areas, where delivery of healthcare services is limited. Despite this, coverage was estimated at 85 % of households in 2009 (Perry 2017). Since then, the workforce has increased by more than a third, from about 91,000 to 125,000 LHWs.

Work-time under the programmes

In the three countries, working hours are irregular and adapt to emergency situations, such as pregnant women who need to be taken to a health facility for delivery. Yet, the routine work-time load includes regular visits to the local health facility and home to home visits in the community. In the Kathmandu valley in Nepal, a group of FCHVs identified that they spend up to 2 hours in the local health facility and up to 4 hours in the community daily. In Pakistan, Sindh-based LHWs shared that they spend around 3 hours in the community and 3 hours at the local health facility daily for 6 to 7 days a week. In India, ASHA's are reported to work at least 5 hours a day or 25 hours a week but this is probably under estimated.

While the community / community-based groups play a role in identifying potential CHWs, FCHVs, ASHAs and LHWs have a direct relationship with officers of health system for their employment and are not contracted through third parties (i.e. contractors). They are supervised by officers of the health system that would be unable to carry out these activities without them.

Role of CHWs programmes in national health systems

In these three countries, CHWs provide an essential linkage between vulnerable population in rural and poor communities and the formal health system. ASHAs, LHWs and FCHV collect information from the community through house to house visits and bring it back to the local health facility. They also carry basic health resources (vitamins, contraceptives, health education tools, etc) from the local health facilities into the community and distribute them as required.

2.3 Remuneration system of FCHVs, ASHAs and LHWs

Remuneration of FCHVs and ASHAs

Nepal's FCHVs work with minimal financial support. They are provided NPR 7,000 (USD 60) a year for their uniform, approximately NPR 1600 (USD 15) a year during the immunization campaigns, and a stipend for refreshments during the training period. In addition, the Ministry of Health and Population (2010) has established a FCHV fund in each village to set up income-generating initiatives. FCHVs must report to the local health post once a month where they receive instructions. It can be argued therefore that FCHVs are disguised employees of the public healthcare system; even though the government regulates the work, it does not provide a salary. Further, while the government covers some costs, others are incurred by the workers themselves.

This situation is not improving. The Nepal Health Sector Programme for 2010 - 2015 increased the services provided by FCHVs without increasing the incentives.

For ASHAs, although the Indian central government's guidelines define the broad framework, specific tasks and remuneration vary because they are decided by the state governments. In December 2013, following agitation from a national coordination of the ASHA workers' unions, a fixed monthly honorarium of at least INR 1,000 (roughly USD 15) was notified by the central government. Some state governments have announced honorariums above this level. As of May 2017, ASHAs in Maharashtra receive an honorarium of INR 1,000, while those in Kerala receive up to INR 7,500.

In addition to this honorarium, a system of task-based incentives provides ASHAs with a complementary income. The government estimates that, on average, ASHAs earn between INR 1,500 to 2,000 in incentives per month (USD 20 to 30 a month) (GoI 2015). Studies have shown that the incentivized system of payment has resulted in low remuneration for a large amount of work with delayed payments (Bhatia 2014; Som 2016). Further, activities with higher incentives become prioritised over other activities creating a hierarchy in the care given (Som, 2016; Sarin et al., 2016), resulting in healthcare that may not be a priority for the individual or community.

Further, ASHAs in India, like FCHVs in Nepal, are not recognized as government employees and therefore are not provided any form of paid leave, uniform allowances, or compensation for occupational risks encountered. This is even though ASHAs perform services for the public healthcare system, that they depend on attending patients for their income, and are given instructions from the public health post on how the work is to be done.

Minimum wage regulations in Nepal and India

The Nepalese Labour Act 1992 is explicit that "the minimum wage is applicable to all workers/employees irrespective of status of the employment or the length of service". In February 2016, the national minimum wage was increased to NPR 6,375 (around USD 60) for monthly salaried workers. This is a far cry from the poverty incentives currently being paid to FCHVs that amounts to NPR 8600 (around USD 75) per year.

The government of India enacted the Minimum Wages Act 1948 “with the objective of protecting the vulnerable and less privileged strata of the society from exploitation in the work place” (Labour Bureau 2009). The Act sets the template for a national minimum wage floor. Yet, in most cases, the honorarium received by ASHAs is less than the current (1 June 2017) national minimum floor wage of INR 176 a day, or around INR 4,500 a month (around US\$ 70). ASHAs remuneration ranges from INR 2,500 to 9,000 (USD 35 to 120). By the standards of the Indian state, the work of ASHAs could be described as slave labour.

Regularisation of LHWs in Pakistan

Until recently LHWs were in a similar situation as ASHAs, being paid only a nominal monthly honorarium (less than 30 USD) and being unrecognised as state employees. The change came after a campaign by LHW unions.

Formed in 2010, the All Pakistan Lady Health Workers Association (APLHWA) fought for the rights of LHWs (Diwan 2013). The APLHWA’s campaign included sit-ins, road blocks, rallies and national strikes. This led to a gradual increase in the remuneration of LHWs and the granting of employment benefits. In November 2012, the Supreme Court set the remuneration of LHWs to the minimum wage of PKR 7,000 (EUR 60).

The struggle culminated with the Supreme Court of Pakistan recognising LHWs as government employees in March 2013. The Court instructed the federal government to formalize their services and grant LHWs wage-based remuneration and labour rights such as holiday pay and pension.

Yet, despite regularisation, due wages are rarely paid on time. This contributes to LHWs feeling unappreciated and highly under-valued. This was identified as a factor that may deter others from this work and affect LHWs motivation (Muhammad 2017).

A recent study finds that recognising LHWs as paid workers in the public sphere contributes to overcoming the gendered division of public and private spaces as it provides opportunities for these women to perform roles in public spaces that are understood to be the prerogative of men (Inam 2017). However, it also makes them targets of regressive push backs, verbal abuse and violence. This is in addition to the attacks on LHW during the polio campaign. Regularisation of LHWs as employees of the state, and the consequential formal recognition of an employer - employee relationship, places a greater responsibility on the state to protect LHWs.

2.4 Importance of Remuneration for CHWs' Households

Fulfilling health and education needs of LHWs families

Pakistan's LHWs come from economically vulnerable households, a key factor for women seeking jobs as LHWs (Khan 2011). In many cases LHWs are the first women in their families, communities and villages to acquire matriculation level (10 years of schooling) education and to have a paid government job (Muhammad 2017).

According to a recent survey in the province of Sindh, LHWs income represents 69% of their households' income (Muhammad 2017). This income source has greatly contributed to the ability of LHWs families to meet their basic needs in terms of more diversified and nutritious foods, utilities such as gas and electricity, as well as medical and education costs. This Sindh-based study found that 83 % of the LHWs' children go to school, however, erratic income is the major reason for children not attending. Further, 87% of children not going to school are girls. The same study found that LHWs households have a high incidence (70%) of major disease like heart disease, hepatitis, kidney issues, asthma and ulcers. Consequently health expenditures represent roughly 15 percent of all household expenditure. It is difficult to imagine how these costs would be met without the income of the LHW.

It can be argued that the regularisation of LHWs is an important factor that enabled their families to access education and meet basic healthcare needs,

ASHAs expectations for better employment

In India, despite delays and the inadequacy of income, the financial incentives for ASHAs and their families is crucial (Som 2016). Community members are generally unaware of the source of ASHAs' income and family members feel the level of work is greater than the income. Despite this, ASHAs continue to work in the hope of obtaining a regular salary (Sarin et al. 2016). This is a common expectation of unskilled workers joining the public healthcare sector on informal employment terms (Basu 2016).

Are CHWs subsidising the public health system?

Nepal's, FCHVs have a different profile. Most come from families that have another regular source of income, a trend stronger in the hills than in the plains. A 2003 study (UNICEF 2004) showed that poorer, lower-caste and tribal women were mostly excluded. FCHVs themselves recognize that a woman from a poor family could not 'afford' to become a FCHV³. This indicates why it has been possible to run this programme wholly on voluntary work. Some FCHVs have stated that due to changes in the economy it is increasingly difficult to absorb the costs involved in their work.

Therefore, by working without a remuneration as part with the statutory minimum wage (NPR 6,375 per month, or around US\$ 60), each FCHV is providing the government an annual healthcare subsidy of NPR 76,500, which amounts to a total of NPR 4 billion. This is one fifth of the current government health budget and only 0.3% of Nepal's GDP (2016). It is also less than a quarter of the estimated loss of revenue due to corporate tax avoidance, estimated at around NPR 17.5 billion (US\$ 170 million according to Crivelli et al. 2016).

Similarly, in India, it can also be argued that ASHAs are subsidising the public health system, though the extent varies from one state to another, as both their remuneration and the statutory minimum wage are State-specific. In 2013-14, the total funds released by the central government for the ASHA programme was INR 6,86 billion (US\$ 100 million). In comparison, the estimated loss of revenue due

3 Focused group discussion, March, May, August 2017.

to corporate tax avoidance was US\$ 47 billion (Crivelli et al. 2016).

Corporate tax avoidance costs developing countries dearly. In both cases, progressive tax reforms that increase the contribution of larger corporations could contribute resources for funding a regularised FCHV and ASHA workforce.

Support from Public sector trade unions

In the three countries under discussion, CHWs have their own trade unions as well as have been part of broader public (health) sector unions. In Pakistan, in 2008 a national platform was created to coordinate between different LHWs' unions and campaign for unified demands. In India, a multiplicity of unions work either independently, as part of nation-wide coalitions, or as part of platforms with other workers in similar employment conditions, often called 'scheme workers' or 'honorary workers'. In Nepal, unionisation is more recent and only few unions of FCHVs are registered with the government of Nepal.

While public sector unions have generally opened their doors to CHWs as members, CHWs' issues have not been given priority within the agenda of these unions. As unions led by CHWs themselves assert their demands, the support from other public sector and health workers unions will be important.

3. Conclusion and Recommendations

“Everyone who works has the right to just and favourable remuneration ensuring for himself [sic] and his [sic] family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection”. (Universal Declaration of Human Rights, 1948)

We have shown that in the three countries under study, CHWs are employees of the state and work as extensions of the public health system. Yet, they are not recognised as such, except in the case of Pakistan. Across the three countries observed, CHWs are not adequately remunerated and it can be argued that FCHVs and ASHAs subsidise their countries' public health systems.

As shown in this paper, the narrative of CHWs as volunteers promotes a falsity and entrenches unequal work. Those who labour for the healthcare of communities are workers and are entitled to the rights codified in international labour and human rights treaties to which these countries are signatories; such as ILO Conventions 100 on Equal Remuneration and Convention 111 on Discrimination at Work (See table 5).

The right to “just and favourable conditions of work”⁴, must be provided to all people ‘without distinction’ which includes “work that is productive and delivers a fair income, security in the workplace and social protection for families”, in line with the Decent Work Agenda of the ILO.

4 International Covenant on Economic, Social and Cultural Rights, article 7 and elaborated through General Comment No, 23 as well as UDHR, articles 23 and 24; ICERD, article 5; CEDAW, article 11; CRC, article 32; ICRMW, article 25; CRPD, article 27

Governments have committed to ambitious health targets including to “ensuring universal access to sexual and reproductive health-care services, including for family planning, information and education” (2030 Agenda). These commitments cannot be dependent on the maintenance and expansion of women’s unpaid and informal labour. Meeting the world’s health and care targets to an optimal standard would require another 663 million healthcare workers, 339 million childcare workers and 86 million aged-care workers, most of them in Asia (Chandrasekhar and Ghosh 2016). With a large and growing gender participation gap, the automation of work and the need to transition away from an extractive, consumption-based global economy, decent work for CHWs provides an ideal strategy to advance sustainable development, gender equality and the right to health.

The supposedly volunteer nature of CHWs' work is promoted by principles of labour market flexibility and deregulation, as an integral element of neoliberalism. This is furthering precarious work, with debilitating consequences. CHWs in South Asia often work as many hours as workers that are covered by labour market institutions, including those on a minimum wage and those covered by employment protection legislation.

This situation can be turned around. There is no justifiable reason to continue paying CHWs in India and Nepal mere incentives with which they cannot make ends meet. It violates their dignity as human beings and as workers.

For change to occur the demands of CHWs to be accorded their rights based on the internationally agreed Fundamental Principles and Rights at Work must be recognised. The elimination of discrimination with respect of employment and occupation, and freedom of association with the right to collective bargaining are essential elements.

Opportunities to build momentum on policy fronts should be taken. In example, the United Nations Commission on the Status of Women (UNCSW) 61’s *Agreed Conclusions*, related to Implementing economic and social policies for women’s economic empowerment recommends that governments:

“Promote decent paid care and domestic work for women and men in the public and private sectors by providing social protection, safe working conditions and equal pay for equal work or work of equal value, thereby facilitating the transition of informal workers, including those engaged in informal paid care and domestic work, into the formal economy.”

(UN Women 2017)

In the light of the foregoing, we commend the Government of Pakistan for formalising the status of LHWs as state employees and call on other South Asian countries to afford CHWs the same right.

We further recommend that:

- The governments of India and Nepal uphold the ASHAs and FCHVs Fundamental Principles and Rights at Work (ILO 1988). Consequently, that they promote the Decent Work Agenda in the sphere of community healthcare delivery;
- The governments of India, Nepal and Pakistan ensure the payment of wages are at a rate not

less than the statutory minimum wage and are consistent with the legal principle of equal pay for equal work; i.e. considering wages afforded to workers in other sectors with a similar set of skills, qualifications and responsibilities;

- The governments of India, Nepal and Pakistan report on the progress with regard to including CHWs under the statutory minimum wage in a way that is consistent with the legal principle of equal pay for equal work to the Committee of Experts on the Application of Conventions and Recommendations on Convention 100 and 111.
- The governments of India, Nepal and Pakistan adhere to social dialogue, including genuine collective bargaining, with workers' unions, as a universally recognised mechanism for improving the wages and working conditions of women;
- The governments of India and Nepal adopt ILO Convention 87 on Freedom of Association and Protection of the Right to Organise and Convention 98 on the Right to Organise and Collective Bargaining;
- The governments of India, Pakistan and Nepal engage in progressive tax reforms that increase the contribution of large private companies, prohibit tax evasion and avoidance and utilise the additional resources for improved remuneration and conditions for CHW;
- The governments of India, Nepal and Pakistan institute systems that provide for stable and regular wages for all CHWs and ensure that payments are made in a timely manner.

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IV. Appendix / Appendices

Appendix: Comparison of Exchange Rates in South Asia

As of 1 December 2017.

	BDT	INR	LKR	NPR	PKR
1 US\$	82	64	152	102	105
1 Euro	97	77	181	121	124

(Source: Onanda currency converter, <https://www.oanda.com/currency/converter>)