B7 | INFORMALIZATION OF EMPLOYMENT IN PUBLIC HEALTH SERVICES IN SOUTH ASIA

Introduction: global context of 'informal' employment in the health sector

In the past decades public provisioning of healthcare has declined dramatically (see Chapter B1). Within the public health sector, the retreat of the state from the provision of healthcare has been accompanied by reforms in the internal management and organization of public institutions and systems along the lines of the new public management (NPM) strategy. The main characteristic of the NPM strategy is "the attempt [to introduce] within the public services, which are not yet private, the motivation in accordance with the performances and the disciplines specific to the market" (Moore, Stewart and Haddock, 1994, p. 13). Such reform seek to introduce private-sector practices in the management, organization and labour dynamics of the public sector, thus creating 'internal markets' within public institutions, facilities and systems (Vabø, 2009). A common feature in countries that have adopted the NPM is the pressure they face as a result of dwindling public budgets (Mascarenhas, 1993, pp. 319–28). With a prime focus on reduction of the wage bill various practices are resorted to including: fixed-term work, temporary work, contractual work through manpower agencies, and dependent self-employment (where workers are contracted as individuals and payment is linked to productivity).

Even in times of slowing economic growth, as during the global financial crisis of 2008–2009, employment in the health and other social sectors has maintained a steady growth.[1] However, there is a growing trend towards use of non-standard forms of employment to replace permanent public health service employment (ILO, 2017, p. 21). This directly impacts the wages of health workers and, over the first decade of this century, the remuneration of health workers has decreased in relation to total health expenditure globally (ibid., p. 23).[2] (See Table B7.1)

While the trend towards informalization (see Box B7.1 regarding informal employment) of work is relatively new in high-income countries (HICs) and related to the financial crisis of 2008–2009 and the austerity measures that followed, it is a much older phenomenon in LMICs, linked to introduction of neoliberal policies and Structural Adjustment Programmes (SAPs) in the 1980s and 1990s (People's Health Movement, Medact and TWN, 2014b, 2014).

Financial constraints in the health system contribute to low motivation of health workers, difficulties in retention of the workforce and outward migration.

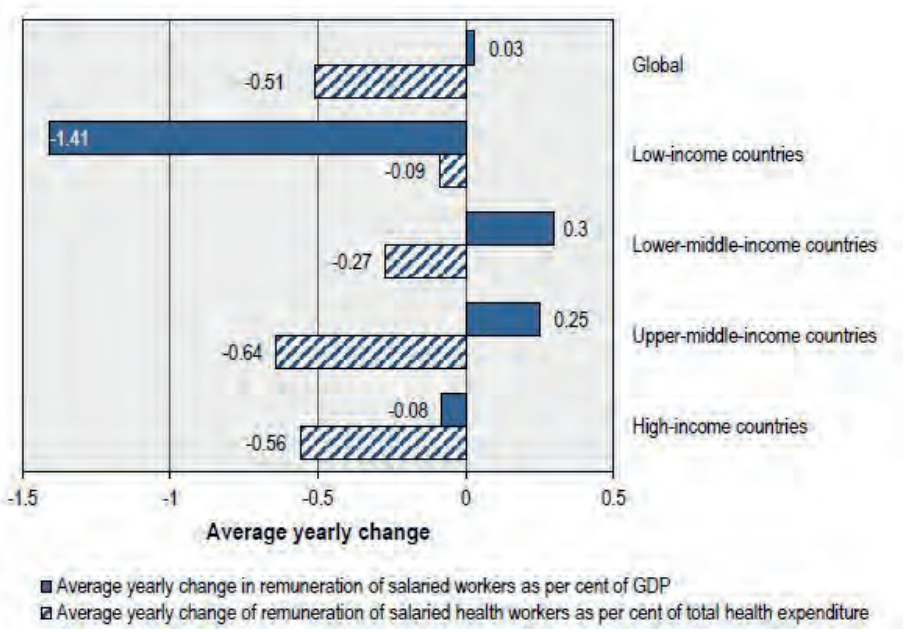

Table B7.1: Yearly change of health workers' remuneration of total health expenditure and GDP by country income level, 2000–10 (percentage)

Source: ILO: World Social Protection Report 2014–15: Building economic recovery, inclusive development and social justice (Geneva, 2014)

Box B7.1: What is informal employment?

The International Labour Organization defines this as:

"…employees are considered to have informal jobs if their employment relationship is, in law or in practice, not subject to national labour legislation, income taxation, social protection or entitlement to certain employment benefits (advance notice of dismissal, severance pay, paid annual or sick leave, etc.) for reasons such as: nondeclaration of the jobs or the employees; casual jobs or jobs of a limited short duration; jobs with hours of work or wages below a specified threshold (e.g. for social security contributions); employment by unincorporated enterprises or by persons in households; jobs where the employee's place of work is outside the premises of the employer's enterprise (e.g. outworkers without employment contract); or jobs, for which labour regulations are not applied, not enforced, or not complied with for any other reason .

Source: Hussmanns, R 2003, 'Statistical definition of informal employment: Guidelines endorsed by the Seventeenth International Conference of Labour Statisticians' (2003) Bureau of Statistics, International Labour Office, Geneva

Migration is a key driver of the current global health workforce crisis (Van de Pas, 2013). Further, in low- and middle-income countries (LMICs) as the absorption and retention of health workers (especially, but not only, professionals such as nurses and technicians) in public facilities fall, workers are pushed to the private sector, where the pay is often substantially lower. This financially unsustainable option for workers is often seen as a short-term opportunity to gain experience before finding alternatives abroad. This situation encourages the active recruitment of health professionals from LMICs by agents from HICs.

Women are among the worst impacted by downward pressure on remuneration. The global health workforce is predominantly female, but women are concentrated in lower skilled jobs, with less pay and at the bottom end of professional hierarchies (Langer et al., 2015, cited in ILO, 2017, p. 24). For example, in OECD countries, low-skill long-term care work is mostly performed by women; and in several Asian countries, community health workers (CHWs), on the lowest rung in the healthcare chain, are predominantly, if not exclusively, women. As they work within their communities and provide care that women have traditionally performed without pay, CHWs are rarely remunerated on par with the legal wage and usually work under highly informal employment conditions.

In many LMICs, especially in Africa and South Asia, the 'informal' sector dominates the economy and employment opportunities. Employment conditions are characterized by poverty wages and wage theft, employment insecurity, and abusive and undignified working conditions. Workers often accept substandard employment terms and work conditions in the expectation that in the near future this will give them access to a 'government job', that is, secure and dignified employment with a real wage.

Insecurity of tenure in the case of informal employment makes it more difficult for workers to join or form unions. Without the right to unionize and engage in collective bargaining, health workers remain vulnerable to exploitation by their employers. Ultimately this also means that public health is undermined, as informalization has a negative impact on health workers' ability to perform their duties, the organization of work within an institution and the relationship between workers and patients (Thresia, 2016). This chapter examines working conditions of two categories of health workers in South Asia: workers in public hospitals and community health workers. The case studies documented are based on primary fieldwork and research by Public Services International (PSI).

Informalization of hospital workers in South Asia: case studies

The three case studies that follow document the trends of informalization in public hospitals in Delhi, Kathmandu and Colombo.

Delhi Informal employment conditions have existed, to a limited extent, in public hospitals in Delhi prior to the introduction of neoliberal reforms in India in 1991. Since the early 1990s, reduced government expenditure on healthcare and the policy of providing a greater role for the private sector, mostly through public–private partnerships, has led to a push for contracting out non-clinical services and the use of fixed-duration contracts for unskilled workers, such as sweepers, washermen/washerwomen, kitchen staff, drivers, security personnel.[3] Professional staff were affected by these labour reforms in the early 2000s, starting with facilities run by the state government of Delhi.[4] For example, nurses were hired by hospitals on short-term contracts as a temporary measure on the pretext that it took too long to fill regular posts. However, this practice has now become the norm. After a legal struggle, nurses on fixed-duration contracts in state hospitals started receiving wages equal to those of nurses in permanent posts. However, this parity does not extend to other working conditions and benefits. The hiring of nurses on fixed-term contracts began four to five years ago in hospitals under the central Ministry of Health and Family Welfare (MoHFW) (Basu, forthcoming). MoHFW-run facilities have not followed the court order on pay parity between contractual and permanent workers.

In the early 2000s, a ban on hiring was adopted for Group C and D employees (the two 'lowest rungs' of workers in the government system). In the case of technical staff, the ban was revised to enable the filling of a third of the vacancies. This was challenged by the workers, who claimed it was impossible to decide which technical post was more important and thus qualify for permanent recruitment. In 2005, the ban on hiring was lifted for Group C workers, though hiring on fixed-term contracts continued (ibid.).

Image B7.1 Health workers demanding better service conditions at a hospital in New Delhi, India (Santosh Mahindrakar)

As hiring on fixed-duration contracts increased for professional staff (mainly nurses), even direct hiring of 'non-medical' staff was stopped and outsourced to contractors. This has led to a deskilling of workers.[5] For instance, out of a total of 150 posts for *ayahs* (helpers) in the prestigious MoHFW facility, the 1,000 bedded Ram Manohar Lohia Hospital, only 25 are permanent. In Lala Ram Swarup (LRS) Institute of Tuberculosis & Respiratory Diseases, an autonomous institute under the MoHFW, out of the 500 Group C and D workforce, 200 are employed through contractors.[6] Workers employed through contractors are subjected to a number of labour law violations, including low pay, absence of social security, and absence of paid and maternity leave and pension.[7]

Typically, the contractor enters into an agreement with the hospital management, which specifies the number of workers required. The agreement is generally for the duration of one year after which it is either renewed or a new contractor is hired. Workers are supervised by a hospital supervisor as well as by one hired by the contractor. The hospital supervisor has the final say on the work assigned and the quality of work; however, the supervisor hired by the contractor micro-manages the workers, who directly report to her/him.[8] Supervisors are not interested in, nor capable of, dealing with occupational health issues of workers who risk exposure to infections and chemicals. The contractor receives the wages from the hospital management and passes it on to the supervisor who then pays each worker. In the process, the worker is at risk of wage theft, i.e. the risk that the entire amount due is not actually passed on to the worker.

Reduction in public funding has also resulted in an increase in the number of public–private partnerships for provision of healthcare services. Consequently, a large number of employees have had to shift from being public-sector employees to becoming employees of private enterprises. Conditions of work in the private sector are worse than in the public sector. Outsourcing of services that are considered non-essential, such as laundry, has been a regular practice in public hospitals. Outsourced services have now expanded after the Delhi government passed orders to all public facilities to outsource security and cleaning services.[9] More recently, the trend has extended to clinical services such as laboratory and radiological diagnostics. In some public facilities, dialysis units have been outsourced to a private company (PHRN et al., 2017). Increased outsourcing of services by public hospitals is accompanied by a rapid rise in the number of private companies that offer these services.

Kathmandu In Nepal, most tertiary hospitals are concentrated in Kathmandu. In Kathmandu the situation regarding non-formal employment in public hospitals is similar to what has been described regarding Delhi, except that an even larger proportion of workers fall in the non-formal category.

The change in the nature of employment commenced with the adoption of the Structural Adjustment Policies (SAPs) in 1986. The reforms were justified

as necessary to reduce costs and improve efficiency (Dixit 2014). Reduced funding from the government and the promotion of 'decentralization policies', whereby hospitals have to generate parts of their budgets, resulted in hospitals seeking new avenues for income generation. This has led to the mushrooming of autonomous public facilities. This changes the ethos of the institution, and "[H]ospitals become more concerned with reducing the costs of service delivery than with delivering improved quality of care" (Basu, 2016).

In Nepal nurses have been hired on fixed-term contracts for decades. Nurses in general are paid disproportionately less than doctors and they are usually hired on fixed-term contracts of six months. Recently many nurses are being hired on three-month contracts, which are not renewed.[10] In the aftermath of the earthquake of April 2015 nurses were hired without written contracts.

For non-professional staff, 'contract work' is the norm. They face similar conditions as in Delhi: wage theft, denial of paid maternity leave and pension, multiple supervisors and insecurity of tenure. Workers report that they are often asked to change their location of work by the contractor, based on the changing demand from different hospitals. This creates difficulties in the case of occupational hazards or accidents at work as workers and their families are not sure which agency would process their claims.[11]

As well as a highly challenging situation created by insecurity of tenure, public-sector health workers' trade unions also face legal hurdles. Workers need to show a permanent contract with a government institution (which they do not have), in order to register with the Labour Department in Nepal. Under the Health Service Act, if a public-sector health worker does not register, they do not get an identity number, without which they cannot get membership in a union. This prevents the formal membership of unregistered health workers in unions and union representatives see this as a bid to weaken unions.[12]

Colombo Of the three countries studied, Sri Lanka's health system is the least privatized. While Sri Lanka too has adopted reforms to facilitate the entry of private enterprises in provisioning of health services, these reforms are primarily in the form of public subsidies to private enterprises – incentives to purchase land for private hospital construction, loans for expansion of private facilities, duty free imports of biomedical equipment and permission for professionals in the public sector to work part-time in private facilities (Kumar, 2015).

Unlike in Delhi and Kathmandu, in Colombo the norm regarding employment of the medical workforce (such as nurses and technicians) in the public sector is permanent employment with standard wages and benefits.

While there are some levels of informal employment among unskilled and non-medical workforce, the scale is limited. Contractual hiring through manpower agencies is common for security services, and for workers in cleaning and laundry departments. However, the conditions of work and benefits for fixed-duration workers are better than for their counterparts in India and

Nepal. They are generally provided with medical insurance and paid leave, and their salaries are comparable to those in permanent employment (Basu, 2016).

A common form of informal employment of medical staff is the hiring of retired nurses on fixed-duration contracts for a period of a year or two. While nurses were initially remunerated at the level of their last drawn salary, in order to reduce costs the policy was later changed to remuneration equivalent to the starting salary in the corresponding occupation. This has reduced interest in rejoining among retired nurses. In the case of posts remaining vacant, there is anecdotal evidence of existing staff taking on extra work for which they receive additional payment.[13] This trend is also seen in the case of ward attendants, where the proportion of posts kept vacant is typically high. While this is generally seen as an opportunity to augment income, in the long run the practice can negatively impact quality of care (ILO, 2017, p. 32).

Overall trends In all three countries studied, informal employment relations first cover unskilled workers, who are not directly in touch with patients, and whose work is often seen as not core to the work of the hospital, such as laundry, security and kitchen staff. As informalization spreads, ward attendants and cleaning staff are also affected. It often takes some time before technicians and laboratory staff is affected, and nurses are affected at the end of the chain.[14] Thus the level of skill plays an important role in shaping the terms of employment across the workforce.

Different categories of workers face varying degrees of deterioration of their employment conditions. Employees with fixed-duration contracts, who work directly under the management of the hospital, have relatively better terms of employment and working conditions than those who are supervised by contractors or manpower agencies.

informalization is less prominent where penetration of the private sector in the health system is low. While direct causalities are difficult to establish, it would appear that informalization of the health workforce, weakening of public healthcare institutions and the expansion of the role of the private sector are interlinked in multiple and complex ways.

Community Health Workers

The WHO characterizes Community Health Workers (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)

Though a precise classification is difficult due to the wide variation in the profiles of CHWs (Table B7.1), this definition is understood to include both a generic community-based workforce, as well as a more specialized community-

Image B7.2 A community health worker in Tripura, India (Sulakshana Nandi)

based workforce, and to exclude auxiliary or mid-level health cadres that are generally facility-based (Haines et al., 2007).

In the 1970s and 1980s, CHWs were a key component of comprehensive primary healthcare.[15] However, by the early 1990s, the enthusiasm for CHWs had diminished with many national CHW programmes having been abandoned (ibid.). The shortage of professional health workers in the mid-2000s and the move to delegate tasks (task-shifting) earlier performed by them to less trained health workers, such as CHWs, created renewed interest in CHW programmes (WHO, 2007).

There are two different perspectives on the role of CHWs. One that they are community based health advocates and agents of social change, and second, that they are an extension of the formal healthcare system. While early programmes emphasized the role of CHWs as community advocates, today's programmes emphasize their technical and community healthcare function; thus, essentially, treating them as extensions of the formal healthcare system (ibid.).

There is evidence of positive impacts of CHW programmes on health outcomes, such as a substantial reduction in child mortality (UNICEF, 2004). However, strengthening of public health systems remain necessary to maintain and build on the health gains brought about by these programmes (Haines

et al., 2007). Yet, in most LMICs public healthcare systems are fragile and under-funded, and the extensive deployment of CHWs goes hand in hand with their inadequate remuneration.

While the question as to whether CHWs should be volunteers or paid in some form remains controversial, 'satisfactory remuneration' (through material and/or financial incentives) has been identified as a factor that motivates individual CHWs, and, conversely, inconsistent and/or inequitable remuneration has been identified as a disincentive (WHO, 2007).

The following three case studies examine CHW programmes in Pakistan, India and Nepal, and discuss, respectively: the process of regularization of CHWs in Pakistan and key factors of attrition; the context in which the Nepal CHW programme has sustained on volunteerism; and the unifying demand in India for the recognition of CHWs as health workers. Table B7.1 provides details about the CHW programmes in the three countries.

TABLE B7.1: CHW Programme profile in South Asian countries

	Pakistan	India	Nepal
Workforce	Lady Health Workers (LHW)	Accredited Social Health Activist (ASHA)	Female Community Health Volunteer (FCHV)
Year of commencement of programme	1994	2005	1998
Total workforce	125,000	939,000	53,000
Population per CHW	175 Households (1,000-1,200 people)	200 households (approx. 1,000 people)	125 households (approx. 600 people)
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
Training	3 months + 3 months in field	23 days	18 days
Remuneration (annual)	US$ 1650	US$ 180 + incentives	US$ 75

Source: Compiled from descriptions of the respective programs

Lady health workers in Pakistan The Lady Health Workers (LHWs) Programme (officially the National Programme for Family Planning and Primary Health Care, FP & PHC) was created in 1994 with the aim to improve the health of communities by providing maternal, neonatal and child health, and family planning services, by integrating existing vertical health promotion programmes.

The programme has expanded over the years from an initial deployment of 30,000 LHWs to more than 125,000 LHWs. After a 15-month basic training,

a LHW is responsible for the basic health needs of between 1,000 to 1,200 people, roughly 175 households. Despite visible impacts such as immunization coverage and coverage by skilled birth attendants, there are wide disparities in the reach of the programme between and within provinces. Sindh and Punjab are significantly better served than Khyber Pakhtunkhwa (KP) and Balochistan, where security is issues for LHWs. Urban areas are better covered than rural areas, where delivery of health services in general is limited.

The programme has been substantially scaled up in the past decades. From a coverage of 50–60 per cent of the population in rural areas and urban slums in 2006 (Haines et al., 2007), it expanded to cover 85 per cent of the households in 2009 (Perry, 2017). Since then, the workforce has increased by more than a third, from about 91,000 to 125,000 today. A major portion of the funds for the programme come from government revenues, with an estimated 11 per cent covered by external donors (Perry, 2017).

The programme is a major employer of women in the non-agricultural sector in rural areas. LHWs hail from economically vulnerable households and poverty is one of the factors responsible for women seeking a job as a LHW (Khan, 2011). According to a recent survey, in the province of Sindh, the income of LHWs represents 69 per cent of their household income (Muhammad, 2017). It has also been documented that in many cases LHWs are the first women in their families, communities and villages to acquire education up to the matriculation level (10 years of schooling) and to have a paid government job (Inam, 2017).

Yet, their recognition as employees of the state with remuneration on government scales only came after a long and bitter struggle. Formed in 2010, the All Pakistan Lady Health Workers Association (APLHWA) emerged as the national platform to fight for the rights of LHWs (Diwan, 2013). The PLHWA's campaigns (including sit-ins, road blocks, rallies and national strikes) led to a gradual increase in the remuneration of LHWs and the granting of employment benefits. The struggle culminated in the recognition of LHWs as government employees through an order of the Supreme Court of Pakistan in March 2013. The Supreme Court took the view that LHWs are state employees and the court instructed the federal government to formalize their services and grant them legal wage-based remuneration and other labour rights such as holiday pay and pension.[16]

Wages are not paid regularly and LHWs have to agitate for the wages to be released – often earnings for several months remain pending. A recent survey (Muhammed, 2017) found that irregular wage payments mean that LHWs have to borrow from shopkeepers for food (including rice, wheat, pulses and vegetables) as well as to cover utility bills, medical expenses and children's education.[17]

The recognition of LHWs as paid workers in the public sphere contributes to overcoming the gendered division of public and private spaces. However,

it also makes them possible targets of regressive pushbacks, verbal abuse and violence by the communities they serve (Inam, 2017). This is in addition to the attacks on them by religious extremists, as was seen especially during the polio campaign.[18] The formal recognition of an employer–employee relationship places a greater responsibility on the state, especially in the current challenging work environment.

Accredited social health activistsin India In India the National Rural Health Mission (NRHM) aimed to improve health outcomes in rural areas. To do so, the NRHM, in 2005, created a large pool of community health workers called Accredited Social Health Activists or ASHAs.[19] Initially deployed in rural areas, according to the revised guidelines of the National Health Mission (2013), state governments can deploy ASHAs in urban areas as well. ASHAs receive 23 days of training. As of September 2016, over 939,000 ASHAs had been deployed across the country (Ministry of Health and Family Welfare, 2017).

Image B7.3 A community health worker training women to make oral rehydration solution (Sulakshana Nandi)

Specific tasks of ASHAs, as well as their remuneration, are decided by the state governments. Their remuneration is based on task-based incentives and ASHAs have to report to the health post once a week. At the end of the month the tasks completed by ASHAs are reviewed and the remuneration is calculated accordingly.

Studies have shown that the incentivized system of payment has resulted in low remuneration for a large amount of work and delayed payments (Bhatia, 2014; Som, 2016, pp. 26–42). In addition, ASHAs have irregular work hours requiring them to work at odd hours, for instance when they have to accompany pregnant women for institutional deliveries. The irregular work hours coupled with irregular remuneration puts them under great strain. Further, ASHAs are not recognized as government employees. This has implications for the employment conditions of ASHAs. There is no provision for paid leave, including maternity leave, allowances for washing of uniforms, or compensation for occupational risks encountered.

Across different states in India, ASHAs have organized themselves and are agitating for better working conditions and remuneration and for their formal recognition as health workers. In the wake of the nationally coordinated movement of ASHAs demanding a minimum fixed wage in addition to existing incentives, in December 2013 a fixed monthly honorarium of Rs 1,000 (roughly US$ 15, equivalent to less than 10 per cent of the government notified minimum wage for full-time unskilled workers) was announced for ASHAs. Some state governments have announced honorariums above this level. For instance, as 2015, while ASHAs in West Bengal receive an honorarium of Rs 1,800, those in Kerala received only Rs 1,000 (Anonymous, 2015). While the fixed monthly honorariumis an important gain, it remains grossly inadequate. Along with other social service workers in a similar situation, ASHAs across 23 states went on a strike in January 2017 to demand recognition as workers, minimum wages, pension and other social security benefits (Anonymous, 2017).

The government (federal as well as state governments) argues that the flexible system of payment for ASHAs and their non-recognition as health workers is related to the fact that they are not workers but women who have 'volunteered' their services for the betterment of their community.[20] However, it is important to note that ASHAs do not receive adequate institutional support to be able to play the role of 'agents of change'. The tasks listed linked with their remuneration are specific to healthcare extension services and ASHAs are often burdened with additional tasks (such as conducting census related activities). Most ASHAs spend almost as much (or in some cases similar) time as full-time workers in accomplishing the tasks assigned to her. Thus, their possible role as 'agents of change' mostly falls between the cracks and is dependent on individual interest in playing such a role against all odds.

The size and spread of the mobilization of ASHAs demanding their rights as workers is a sign of widespread discontent that cannot be brushed aside.

Arguably, the decision of the government with regard to the demand of ASHAs to be recognized as workers in the health sector will have consequences for the long-term sustainability of this workforce.

Female community health volunteers in Nepal Nepal's Female Community Health Volunteer (FCHV) programme was started in 1988–1989 with the aim to promote safe motherhood, child health, family planning and immunization. FCHVs also treat cases of lower respiratory tract infections and refer more complicated cases to health institutions. There are more than 54,000 FCHVs working all over Nepal, except in urban municipalities. Currently, one FCHV is in charge of around 125 households (around 600 people).

FCHVs undergo an 18-day basic training course on key elements of primary healthcare. While an estimated 70 per cent of FCHVs are illiterate (Schwarz et al., 2014), imparting of basic education is not part of the training. After completion of training FCHVs are provided with a certificate from the Ministry of Health, and a medicine kit consisting of supplies such as ORS packets, vitamin A capsules, iron tablets and so on.

FCHVs have to report to the local health post once a month. They are provided with an identity card and a register with 30 to 40 indicators to be filled in, such as maternal, infant and child deaths and details of vertical programmes implemented in their areas. Yet, FCHVs work with minimal financial support. They are provided NPR 7,000 (US$ 60) a year for their uniform, about NPR 1600 (US$ 15) 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 for the setting up of income-generating activities.

Despite the fact that FCHVs are delivering regular and vital public services, the FCHV programme was conceptualized as a short-term exercise, and it is not integrated into the regular budget of the MoH. As at 2013, the costs of the FCHV programme were fully financed by donor agencies, such as the US Agency for International Development and the United Nations Children's Fund (Perry, 2017, p. 69).

In Nepal, FCHVs have an unusual profile. Most of them come from families that have another regular source of income, a trend that is stronger in the hills and less seen in the plains.[21] A 2003 study (UNICEF, 2004) showed that poorer, lower-caste and tribal women were mostly excluded from the selection process. FCHVs themselves recognize that a woman from a poor family would not be able to become a FCHV as her family would not be able to 'afford it'. This gives an indication as to why it has been possible to run this programme which is based largely on voluntary work. However, some FCHVs have expressed concerns that, with the changes in the economy, it is becoming increasingly difficult to absorb all the costs involved in their work.[22]

The Nepal Health Sector Programme for 2010–2015 (NHSP2) has scaled up the services provided by FCHVs. However, the policy does not provide for an increase in the incentives for FCHVs. The expectation that FCHVs will provide more services without any additional support or remuneration might, in the long term, compromise the retention and recruitment of these workers (Pratap, 2012).

FCHVs have organized themselves into trade unions and associations during the last decade and are demanding better working conditions and an increase in their remuneration. While the current attrition rates are very low – 4 per cent according to some estimates – working conditions are emerging as a disincentive to FCHV recruitment and motivation (USAID, 2016).

Currently the relationship of FCHVs with the community is crafted on the understanding that the former provide voluntary services. Any change in the nature of this relationship has to be dealt with carefully to maintain the current high level of acceptance that FCHVs have in the community.

Conclusion

Community Health Workers contribute greatly to the health outcomes of rural and poor communities in South Asia. While their role has been recognized and their work valued in different ways, remuneration is inadequate. It can be argued that the underpaid (or unpaid) work of CHWs in the health system amounts to a hidden subsidy towards society at large.

Image B7.4 Unpaid work by CHWs subsidizes health systems (IndranilMukhopadhyay)

This seems to fit the pattern where, with the increase in the proportion of women in the workforce or in an occupation, wages often decline (ILO, 2017, p. 24). However, CHWs have successfully organized themselves and managed to steadily increase their remuneration. For the public health community, ensuring that adequate service provision is maintained is paramount. Only through engagement of the larger public health community with the demands of organized CHWs can both decent work and quality services be effectively realized.

Notes

1 Though there was a deceleration of employment growth in 2013, this was probably related to the impact of austerity measures in high-income countries (ILO, 2017, p. 13).

2 High-income countries and upper-middle-income countries accounted for most of the decrease of remuneration as a share of total expenditure, while salaries of health workers as a proportion of GDP decreased in low-income countries (ibid., p. 23).

3 The classification of government employees under the Central Civil Services (Classification, Control & Appeal) Rules, 1965 categorizes employees based on their salary level, where A is the highest pay scale and D the lowest. The groups are based on salary level and not occupation. See Representatives of Hospital Employees Union (HEU), interview.

4 The National Capital Territory (NCT) of Delhi has more than fifty public hospitals. This includes four hospitals under the Municipal Corporation of Delhi (municipal level); close to forty hospitals under the Government of the NCT of Delhi (state level), including autonomous bodies; four hospitals under the Ministry of Health and Family Welfare under the central government (MoHFW); as well as six hospitals under other central government ministries; and the All India Institute of Medical Sciences (under the central government).

5 Representatives of HEU and the All India Health Employees and Workers' Confederation (AIHEWC), interviews

6 Ibid.

7 Ibid.

8 Ibid.

9 Representatives of AIHEWC, interview.

10 Representative of the Nursing Union of Nepal, interview.

11 Representative of Health Professionals Organization of Nepal (HEPON), interview.

12 Ibid.

13 Representative of the Confederation of Public Service Independent Trade Union (COPSITU) (2017), interview, 26 April.

14 In the case of doctors, the process is slightly different because a mid-level or senior consultant, though on an informal contract, does not face the same level of vulnerability and can leverage the advantages of this 'flexible' employment condition.

15 The Alma-Ata Declaration defined comprehensive community healthcare as including, at least: i) education concerning prevailing health problems and the methods of preventing and controlling them; ii) promotion of food supply and proper nutrition; iii) an adequate supply of safe water and basic sanitation; iv) maternal and child healthcare, including family planning; v) immunization against the major infectious diseases; vi) prevention and control of locally endemic diseases; vii) appropriate treatment of common diseases and injuries; and viii) provision of essential drugs (WHO, 1978).

16 In an earlier order, in November 2012, the Supreme Court had increased the remuneration of LHWs to the prevalent minimum wage of PKR 7,000 at that time, or EUR 60.

17 The study finds that though 83 per cent of the children in LHWs' families go to school, the major reason for children not going to school is erratic income, and that 87 per cent of the children not going to school are girls.

18 See, for instance, *The Guardian*, 2017.

19 For more details on the programme, see People's Health Movement, Medact and TWN, 2014c.

20 The NRHM Mission Document (2005–2012) explicitly states that the ASHA "[W]ill be an honorary volunteer, receiving performance-based compensation for promoting universal immunization, referral and escort services for RCH [Reproductive Child Health], construction of household toilets, and other healthcare delivery programmes."

21 Nepal's territory is divided into three geographical regions that have specific characteristics and social dynamics, the terai (plains), the hills and the Himalayas (mountains). There is anecdotal evidence that in the terai, FCHVs are from a lower-caste community of traditional birth attendants.

22 Focus group discussion, 8 March 2017.

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