India's community health workers' struggle for recognition

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India's ASHA and anganwadi workers are rallying under the slogan "Community health work is work!" to demand fair pay and treatment for the essential services they provide.

Over the last year-and-a-half, one of the most visible groups of workers throughout the COVID-19 pandemic in India have been the Accredited Social Health Activists (ASHAs), a cadre of community health workers appointed by the National Health Mission (NHM). These hitherto invisible women were seen not only going house to house across the country in villages and cities conducting surveys for tracing and treating purposes, building COVID-19 awareness and providing support for those in home quarantine, but also made themselves heard through their protests and strikes demanding better working conditions.

Over a million women across the country work as ASHAs, a program that was started in 2005 to bridge the gap between the community and the health system. They play multiple roles, as activists, volunteers and workers providing public services covering a range of public healthcare services including maternal and child health and communicable and non-communicable diseases. While they have been appointed by the government, they are not recognized as employees and are only paid "incentives" that are linked to certain tasks or targets. On average, ASHAs earn between ₹2000 to ₹9000 a month (about US$26 to 120).

Another cadre of women workers, employed under the Integrated Child Development Services (ICDS) are anganwadi workers and helpers. An anganwadi is a community mother-and-child care center that provides education, health and nutrition services for young children, pregnant and lactating women and adolescent girls. Almost 28 million women work under this program and, like ASHAs, they are not recognized as workers. Rather, they are seen to be "honorary workers" who are paid an honorarium rather than a salary. The honorarium for anganwadi workers ranges between ₹4,500 to ₹15,000 (about $60 – $200) a month, with the central government contributing ₹4,500 and some states topping it up with their own funds.

Anganwadi workers conduct pre-school education and are in charge of a range of other services such as growth monitoring, provision of supplementary nutrition, nutrition counseling and so on. This being an older program, it has more established workers' unions who have at various times managed to make significant — though still inadequate — gains towards improving their remuneration (especially in some states). However, anganwadi workers are still not regularized as employees and even the Supreme Court accepted the government's position of them being "honorary" workers. As a result of which, they remain outside the purview of all protective labor legislation. The average remuneration of ASHAs and anganwadi workers is often even less than the prevailing minimum wage in a given state.

ASHAs and anganwadi workers form the backbone of essential public health and nutrition services provision, but their work remains mostly unrecognized — just as all the care work that women do

within their households is not counted as work. Describing the situation of these workers, Adil Shariff, General Secretary of the Indian National Municipal and Local Bodies Workers Federation says, “It is very sad that these workers are even not recognized as workers by either the government or the public. They do not even come under the definition of ‘workman’ [sic] given under Trade union act and as such don’t get any benefits which are applicable for contract or outsourced workers. They are not included under any social security provisions and don’t get minimum wages.”

Shariff explains how in Telangana, a state in southern India, ASHAs are paid only ₹7000, or less than half of the minimum wage of ₹17,000 that unskilled workers like street cleaners are receiving. Moreover, their salaries are often paid “with a delay of 3-4 months.” Meanwhile, according to Shariff, workers are often forced to advance the rent for anganwadi centers out of their own pockets because the funds only come in twice a year.

During the COVID-19 pandemic, the role of these workers — especially ASHAs — became even more critical. Their working hours extended beyond usual and during the months-long national lockdown or when cases were at the peak they were on call 24/7. Their work towards ensuring that all adults get vaccinated continues, however, their working conditions are as pathetic as ever. Sometimes, their earnings are even reduced because the regular services for which they got paid incentives were disrupted during lockdowns. Almost everywhere across the country, ASHA workers have also faced delays in their honorarium payments of up to six months.

The government announced an additional payment of just ₹1,000 a month for COVID-19-related work and there was not much support given in the form of PPEs. Most workers were just given face masks, but even these were not of good quality and needed to be replaced. Many workers faced stigmas in their communities and at home because they were viewed as at-risk and as potential carriers of the virus because they were interacting with so many people.

In addition, there have been instances of ASHA workers who got no help for their own treatment when they were diagnosed as being COVID-19 positive. According to official records, up until April 2021, 109 ASHAs lost their lives to COVID-19-related activities, but media reports and testimonies of union workers reveal that there were even more deaths which have not been acknowledged due to lack of COVID-19 certification and so on.

Political Economy

The COVID-19 pandemic has brought the important role of community health workers (CHWs) as well as their precarious working conditions to the fore. But these are all issues that long predate the pandemic. Within the South Asia region, CHWs working as health volunteers for very low remuneration are common not just in India but also in Nepal, and Bangladesh. In India and Pakistan, CHWs comprise almost half the total health workforce and are overwhelmingly women from poor and modest backgrounds. CHWs are part of the large workforce across the world, paid as well as unpaid, that contributes to care work – including health care, child care, disability care, health care and the whole gamut of activities that falls under social reproduction.

According to the ILO, globally there are around 57 million unpaid “voluntary” workers providing long term care work. Care work is undermined and undervalued as it is seen as a natural obligation of women and an extension of the work they do within their households. Feminist economists have written about how such a gender division of labor arising out of patriarchal norms is in fact a manner in which women’s labor subsidizes capitalist economies by reproducing and maintaining the labor force for free. It also subsidizes the health system by providing cheap labor.

This is further exacerbated in the context of neoliberal economic policies across the world, especially

in developing countries, that result in insufficient public investments in healthcare services. In countries such as India, following neoliberal economic reforms, employment in the public sector has seen greater contractualization with fewer people being employed on regular and permanent bases. Contractualization basically involves employing people in short or long-term contracts without security of tenure, regular pay-scale, pension benefits and so on. They are employed directly or through outsourcing agencies. Therefore, even cadres such as nurses and auxiliary health workers are employed on contract basis at lower wages and no job security. CHWs are located at the front lines in this system filling the gaps in service provision while being labeled as volunteers and honorary workers whose work is therefore not even counted.

Locating CHWs in this context, Kate Lappin, Regional Secretary for the Asia and Pacific Region at Public Services International (PSI) explains, "Different types of care work, including nursing is vastly underpaid because it is historically women who do that work… we see [that] care [work] more broadly — which includes some of the work that CHWs like ASHAs and anganwadi do but also things like elderly care, disability care — is underpaid and not valued."

And this is not unique to India, obviously, Lappin points out: "In many countries [care work is] privatized and not seen as a state obligation. Instead [it is] seen as a domestic obligation of women that can be outsourced to the private sector, using women's low-paid labor to make money." In countering this, Lappin suggests that "we need to reorganize the way that we think about care – we need to value care, value the workers who deliver care, see that there's a state obligation and also recognize that people have a human right to care and that they shouldn't be dependent on (unpaid labor of) women or on their capacity to pay."

What we see all around is that public health systems are dependent on women's under-paid labor and this is becoming even more intense with public health systems themselves facing severe funding crunches. The way in which CHWs and other such workers providing public services are different from other public sector workers is that they deliver services that states are mandated to provide as a matter of right to citizens.

Educate, Organize, Agitate

Since long before the pandemic, health workers across the world have been organizing to fight for their rights. Community health workers such as ASHAs and anganwadi workers are relative newcomers to labor organizing, but over the past years they have started to unionize and federate at both regional and national levels. In the southern state of Tamil Nadu, unions achieved the implementation of the special time-scale pay for anganwadi workers and in a number of other states, unions have made small gains for anganwadi and ASHA workers in terms of increased pay and social security benefits. In Mumbai, community health workers won social security rights through the court but the Municipal Corporation is yet to implement these orders. Across the border in Pakistan, the All-Pakistan Lady Health Workers Association (APLHWA) fought in a sustained manner for the rights of Lady Health Workers (LHWs) resulting in them being regularized and recognized as public sector employees back in 2013 already.

Successes such as these give a fillip to organizing the workers, says Kannan Raman, Sub-Regional Secretary for South Asia, PSI. He discusses how PSI was initially focused on the public *sector* workers, but how this was later expanded to include public *service* providers, including also those working in the private sector providing public services, such as nurses working in private hospitals.

The fact that these workers are providing public services makes them accountable to the communities they serve as well. For the general public that supports and demands public investments for better health services and good quality public services, front-line workers are often

the face of these services and have to bear the brunt of citizen dissatisfaction. At the same time, the workers themselves are greatly disempowered and need the support of the public to get better working conditions for themselves.

Talking about union action by CHWs, Adil Shariff says that although it is regrettable that at times the public suffers as a result of labor actions initiated by the unions, “sometimes we have to do it to raise our voice and concerns.” In order to get support from the public, it is important to raise awareness about the work they are doing and the problems they are facing, he adds.

Unions of workers in these sectors have recognized that regularizing the workforce and improving work conditions is one of the best ways of improving the quality of public services and therefore demand for greater investments overall. Therefore, the joint demands of 10 PSI-affiliated CHW unions across South Asia includes the demand for a people-centered healthcare system and an increase in budgetary allocations for public health to at least 5 percent of the country’s gross domestic product (GDP).

Another challenge in organizing CHW workers is that they are predominantly women whose families may object to their participation in such activities. This means that they face barriers both within the household and in their workplaces, along with the double burden of household work and their day jobs.

Abha Chaturvedi who is with the Hind Mahila Sabha Indian Women Association (HMSIWA) an organization in Kanpur, a city in the North Indian state of Uttar Pradesh, that unionizes public service workers talks about these challenges, “People don’t easily accept women’s leadership. This has been my experience… Building leadership is also difficult — if we train 10 women, we hope that at least five will come forward to give time for union activities. They are sometimes not able to participate in union activities also because their family members don’t allow it — getting family support is also very important. This also takes effort, in many cases I have managed to talk to families and convince them.”

Despite these challenges, the organizations and collectives of front-line health and nutrition workers have only been growing in strength. During the COVID-19 pandemic, the workers have staged numerous protest demonstrations and conducted strikes. Given the insecure nature of their jobs, this has also required a lot of courage from the workers. Many observe that even though they are not treated as regular workers, the work ethic among these workers is very strong. According to Abha, “these women take their work very seriously. They work because they feel a pride and dignity that they are doing respectable and important work. They are also very motivated, if they are given some assurance and moral support that we will stand with them they are ready to fight.”

Workers participating in the protests have indeed faced repression of various sorts. For instance, the states of Delhi and Haryana initiated police investigations against workers who participated in a protest during the COVID-19 pandemic demanding better pay, protective gear and fixed tenures, and in the state of Madhya Pradesh protesting CHW workers were threatened with dismissal.

Building Solidarities

The ASHA and anganwadi workers unions are also strengthened by their participation in the larger movements against contractualization, demanding better labor protection and working conditions for workers in the informal sector and so on. There are federations of different unions at the national and state level, both those that are affiliated with independent unions such as PSI or with party-linked central trade unions. They highlight issues of precarity in employment across workers within public services as well as other informal sector workers. These federations also work together

towards their common goals and in negotiating with governments.

Along with the strength from building solidarities with other workers organizations, the unions also derive strength from sharing and collaborating with CHWs across the South Asian region. PSI's charter for community health workers across the South Asian region — in the time of COVID-19 — demands their recognition as public health workers, a collective voice in decision making processes, occupational safety and health protection, dignity at work, care for the workers and a people-centered health care system.

Using their role as global union within the ILO, the PSI has also made a joint submission from across Asia and Africa to feed into the ILO Convention related to nurses that is currently under revision. They argue that the work of CHWs can be included in the different categories of nursing personnel that the Convention covers. These issues are also raised at the WHO where PSI represents workers. Such forums not only allow for issues of CHWs to be highlighted at the global level, but also pins the responsibility equally on global governance institutions which have promoted such policies across the world. As Kate Lappin, PSI Regional Secretary says, "Global institutions that pushed this model are also culpable — not just national governments"

Pandemic as an Opportunity

The pandemic has increased the burden of labor for community health workers manifold while also putting them at great risk. It has also exposed the inequities both within the health workforce as well as within society at large. While some have profited immensely from the pandemic, millions of health workers have been putting themselves at risk on a daily basis, toiling hard to keep people safe.

A large proportion of the human resources in health services are women, who work hard to make health services accessible to all, but whose work is neither recognized nor remunerated adequately. COVID-19 has made their work more visible and as such it offers an opportunity to give greater visibility to the issues they experience as workers. "During [the] COVID-19 [pandemic], CHWs have been honored and garlanded — which is great — but what about honoring their basic rights as workers?" asks Abha Chaturvedi of the Hind Mahila Sabha, while also pointing out how as a result of training and discussions more and more women are coming forward to participate in union activities.

The current situation has also exposed the weakness of the public health system in India where the system got completely overwhelmed under the pressure of rising COVID-19 cases. During the second wave in the summer of 2021, there were thousands of patients across the country without access to oxygen cylinders or even hospital. Ventilators remained unused because the human resources required to operate them were not available. India's public spending on health is only about 1.1 percent of its GDP and it is clear that it has to be substantially increased soon. The country's own National Health Policy aims at spending 2.5 percent of the GDP on health by 2025.

The intensified struggles of health workers during the pandemic, with the alliances that have been built with other workers movements, gives hope that not only will their work be recognized but that the voices against the patriarchal and neoliberal economic logic that continues to dominate economic and health policy across the world will also get bolstered.

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