

POLICY BRIEF

# SUBSIDIZING GLOBAL HEALTH: WOMEN'S UNPAID WORK IN HEALTH SYSTEMS

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The News Minute | Sreekesh Raveendran Nair

Women in Global Health Series: Gender Equity and the Health and Care Workforce



**WGH** | WOMEN IN  
GLOBAL HEALTH

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# DEDICATION

This report is dedicated by the Women in Global Health movement to the millions of women who have worked unpaid to keep their communities safe in the COVID-19 pandemic. We acknowledge their expertise, dedication and the value of their work. We will continue to advocate for their work to be recognized and fairly paid.

As a movement, Women in Global Health advocates for a new social contract for all women health workers based on safe, decent and equal work, including equality in leadership and decision-making.

## ABBREVIATIONS

**CHV:** Community health volunteer

**CHW:** Community health worker

**COVID-19:** Coronavirus disease identified in 2019

**GDP:** Gross Domestic Product

**GEH:** Gender Equity Hub

**GPG:** Gender Pay Gap

**ILO:** International Labor Organization

**LMIC:** Low- and middle-income country

**PPE:** Personal protective equipment

**SDG:** Sustainable Development Goal

**UHC:** Universal health coverage

**WGH:** Women in Global Health

**WHO:** World Health Organization

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# EXECUTIVE SUMMARY

## COVID-19 exposed the gender<sup>1</sup> inequity in the global health workforce

In 2015, the Lancet Commission on Women and Health<sup>1</sup> estimated that women contribute \$3 trillion to global health annually, half in the form of unpaid work. It seems improbable that some of the world's poorest women would take on unpaid work in health when they already have a heavy burden of unpaid care, domestic and subsistence work. Our estimate, however, is that **six million women work unpaid and underpaid in core health systems roles**, effectively subsidizing global health with their unpaid and underpaid labor. Men also occupy health roles that are unpaid, but the vast majority of unpaid health workers are women. Typically, these women are from low-income families, with limited education, working as community health workers (CHWs) in their local communities.

This report examines the unpaid and underpaid work done by women in health systems, asks why women take up this work and considers the impact of this work for women health workers, health systems and societies. The report draws on existing research and interviews with women health workers in Ethiopia, India, Malawi, Mexico and Zambia and aims to give voice to their diverse perspectives.

The COVID-19 pandemic has put health center stage globally and exposed the deep inequalities between and within countries, highlighting gender inequality between women and men. Women have made an exceptional contribution to health systems, economies and societies from community to global levels since the outbreak of the COVID-19 virus. As 70% of the global health workforce and 90% of health workers in patient-facing roles<sup>3</sup>, women have shouldered the burden of health systems' delivery for more than two years of unprecedented pressure in a global pandemic.

Even before the pandemic, however, gender inequity was hard wired into the global health workforce, with women clustered into lower status sectors and jobs, marginalized in leadership, with obstacles to their career progression and frequently subject to violence and harassment<sup>4</sup>. In addition, the occupational

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*“When we demanded pay according to our duties, and the work we have been doing, representatives from the local government shouted at us, saying Community Health Volunteers are always asking for money. “How much money do you need? You people are volunteers and work voluntarily!”*

- Rita, Community Health Volunteer, Nepal, PSI<sup>2</sup>

segregation of women and men into different parts of the health workforce contributes to a gender pay gap of 28%<sup>5</sup>, higher than in many other economic sectors. That gap in pay between women and men in the health workforce would be far wider if the full volume of work by unpaid women workers were included in labor market statistics. Often titled 'volunteers' or 'community activists', however, their work is generally unrecorded, as they are not counted as part of the formal labor market.



Source: American Indian Foundation

<sup>1</sup>We recognize that gender identity is not binary but in this report, we focus on women and men since data on non-binary people is not available.

Women's unpaid care work is on a continuum, extending from work in households, support to extended family and community members and for some women, work in core health systems roles such as health promotion, health counseling, delivery of basic services and vaccines. The pandemic has shone a light on the disproportionate burden of unpaid care work done by women and demonstrated the extent to which societies and economies depend on women's unpaid and underpaid labor.

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*“The roots of this widespread practice lie in the expectation that the lowest rung of the health services should work in the spirit of community service. This deprives CHWs of their rights as workers. Where these CHWs are women, caring for the health of their own community is often seen as an extension of their nurturing role within their families.”*

*- Kavita Bhatia Community health worker programs in India: a rights based review<sup>6</sup>*

The pandemic increased the load of unpaid work for women in these health systems roles and at the same time, increased the burden of unpaid work within families and communities for women everywhere. Women are expected to be the 'social shock absorbers' in every crisis, increasing their unpaid work to cover gaps in state services. The shock of the pandemic imposed a sudden spike in unpaid work on women working paid and unpaid in health systems. Women in unpaid roles, however,

tend to have the lowest status in the hierarchy, which meant additional risk and anxiety for many working on the frontlines without basic personal protective equipment (PPE).

There is strong evidence that the unpaid work done by women in health systems has positive health outcomes for other groups, including women and children in their communities. In many low-income countries, duties carried out such as, contact tracing, dissemination of public health messaging and vaccine delivery has been a critical part of the pandemic response. The interviews for this report and research studies reviewed attest to the considerable pride women health workers feel in being able to serve their communities, despite all the very real challenges of working unpaid.



Source: DFID

When searching for an explanation for the apparent paradox of why very busy women take on unpaid health work, some have argued that it is 'empowering' for women, while others have viewed it as an extension of the unpaid care role in the household that social gender norms classify as 'women's work'. Societal livelihood choices for women that are constrained by poverty, inequality of power and gender dynamics must be viewed in the context of the prevailing gender and cultural environments in which they operate. Although women may gain monetary and non-monetary benefits from doing unpaid work, it is clear that if given the choice, they would favor economic justice and fair pay over supplementary incentives, such as personal reward or goodwill in the community.

# KEY FINDINGS

## Women's unpaid and underpaid work in health: exploitation, opportunity or even, empowerment?

### 1. Calculating the number of women working unpaid and underpaid in health is complex

- Calculating the number of women working unpaid and underpaid in health systems is complicated by lack of data and different definitions but we calculate that a minimum of **six million women are working unpaid and underpaid in community health roles**.
- It is critical to take an intersectional approach since many women working unpaid in one context may belong to a marginalized ethnic, caste or religious group. They may be disadvantaged in seeking paid work by both their gender and other social characteristics.
- The majority work in low-and middle-income countries. Around one quarter of the six million women working unpaid in health are working in India.
- Women are mainly working unpaid in community health roles but in some countries, we found examples of women working unpaid in roles such as nurses.
- Men also work unpaid in health systems roles at community level but in small numbers compared to women.
- In some low-resourced health systems especially in humanitarian emergencies, government health workers in formal sector jobs may not be paid or only paid sporadically.

### 2. There are diverse forms of remuneration and incentives but none give economic security

- Women working unpaid or underpaid may receive a low fee or performance-based stipend for their work in health but are unlikely to receive any of the benefits associated with formal sector work, including social protection, pension, sick and holiday pay.
- Depending on the scheme, they may

earn a small amount of money by, for example, selling medicines or by receiving gifts and donations.

- Unpaid health workers may receive non-monetary rewards such as uniforms, bicycles or mobile phones.
- In some 'dual cadre'<sup>7</sup> systems, paid community health workers work alongside a cadre of unpaid workers.
- Non-monetary incentives can be important motivators and include status within the community, community trust and respect.
- Training and an opportunity to gain knowledge are strong incentives for some depending on the context. In

**Community health workers perform a variety of tasks, which can be clustered into six overlapping roles:**

1. delivering diagnostic, treatment or clinical care;
2. encouraging uptake of health services;
3. providing health education and behavior change motivation;
4. data collection and record-keeping;
5. improving relationships between health services and community members;
6. providing psychosocial support.

- Source: WHO What do we know about community health workers? A systematic review of existing reviews. 2020<sup>8</sup>

some contexts, unpaid women health workers have low levels of literacy and education and formal training opportunities are limited.

- In some contexts, there has been a concern that paying volunteers would reduce trust amongst the community. Portraying women particularly as 'altruistic' is a gendered assumption and denies the very real economic needs of the low-income women who are working unpaid.



*"...women's relationship with their work is complicated—that it empowers them in certain ways and deeply limits them in others. In some contexts, the ability to travel outside the home is important, and women find the health work that they do interesting and meaningful. Yet their position at the bottom of the health system hierarchy is one in which they have very little power, and is a position that many find oppressive."*

- Maes, K et al A Women's Development Army: Narratives of community health worker investment and empowerment in rural Ethiopia, Studies in Comparative International Development, 2015<sup>9</sup>

### **3. Unpaid work tasks differ, as does time commitment**

- A WHO systematic review of community health workers identified six roles typically performed by CHWs.
- Unpaid women health workers are most often engaged to work on maternal, child and reproductive health but in the pandemic, they have had wider public health and vaccination duties.
- In some health systems unpaid workers will work in male-female or same sex pairs, enabling male CHWs to access men in the community and increasing safety

for women health workers.

- Unpaid roles can be part-time and flexible to accommodate subsistence work and other responsibilities women workers have or they can be full-time which can displace household work onto other family members, especially older women and girls.
- Workloads during the pandemic increased suddenly for many unpaid women workers causing exhaustion and stress as women juggled multiple responsibilities.

### **4. Women take unpaid health roles for a mix of reasons**

- Many women in these roles report a strong ethic of wanting to serve and benefit their communities, particularly other women and children.
- Gender inequities in a particular society may give women few choices. They are less likely in low-income countries to have qualifications to enter the formal job market. Even where women are educated, there may be constraints on their mobility and moving to seek formal sector jobs outside their communities.
- Women from very poor households and marginalized social groups may have even fewer choices than other women in the community and, out of desperation, 'volunteer' to work exceptionally long hours in search of possible income.
- Women may see unpaid work as a potential opportunity. It may lead to paid



*"All the community health workers in Kenya are volunteers. We are calling on the government so we can have stipends. This would make a difference to my life. I will start eating good food, my children will be comfortable and this will motivate me."*

- Mary, Community based health volunteer, Kenya

work or to training to access paid work. The role may be unpaid but periodically there may be additional tasks e.g., vaccination campaigns, that are paid.

- The role of families is complex. In some contexts, women in conservative social settings may gain autonomy through unpaid work, able to leave their houses, mix with other women and do meaningful work with an opportunity to learn. Families, particularly husbands, may coerce women to take these roles in the hope they will earn income.



*“...officials say they are empowering rural Ethiopian women to be more equal to men, officials at the district level value their female workers specifically for the ways in which, unlike men, they are associated with housework and less likely to demand payment”*

- Maes, K et al A Women's Development Army: Narratives of community health worker investment and empowerment in rural Ethiopia, Studies in Comparative International Development, 2015<sup>10</sup>

### **5. Unpaid work may have some benefits for women but generally it undermines their economic rights and potential**

- A significant number of unpaid women health workers live impoverished lives into older age. Working outside the formal sector will deprive them of social protection and other benefits.
- Some may have opportunities to progress to paid, formal sector roles e.g. in some health systems community health workers can train to enter nursing.
- Women may be exposed to violence in the community if they are perceived as having low status or work late hours e.g., to attend a delivery. Unpaid work can also increase the risk of intimate partner violence.
- They may gain status and respectability within the community and feel genuine

satisfaction in their work. Their status will, however, depend on their ability to deliver. Medicine shortages, for example, could lose them the trust of the community.

- Women may be exhausted from the additional burden of work unless other tasks can be redistributed within the family.
- Unpaid work in health systems results from and reinforces existing socially and culturally driven gender roles which can further limit women's options.

### **6. Health systems are weakened by depending on women's unpaid work**

- Government expenditure on health systems is reduced in the short term since workers are unpaid. Investment in a strong primary health care system, however, based on safe and decent work would pay off longer term in better health outcomes.
- Unpaid health workers are likely to have higher attrition and will be less accountable. Health security is compromised.
- Unpaid work can increase inefficiencies and corruption e.g., an impoverished task-based worker may falsify, the number of vaccinations delivered to gain income.
- Discontented unpaid workers may strike or perform badly due to low morale.
- Governments have no secure social contract with health workers who may feel exploited.



*“CHVs are the main reason for the reduction in the number of COVID-19 cases in BMC territory and Mumbai. They have worked hard at grassroots level but didn't get recognition from our leaders and politicians... CHVs are very upset.”*

- Sunita, community health volunteer India



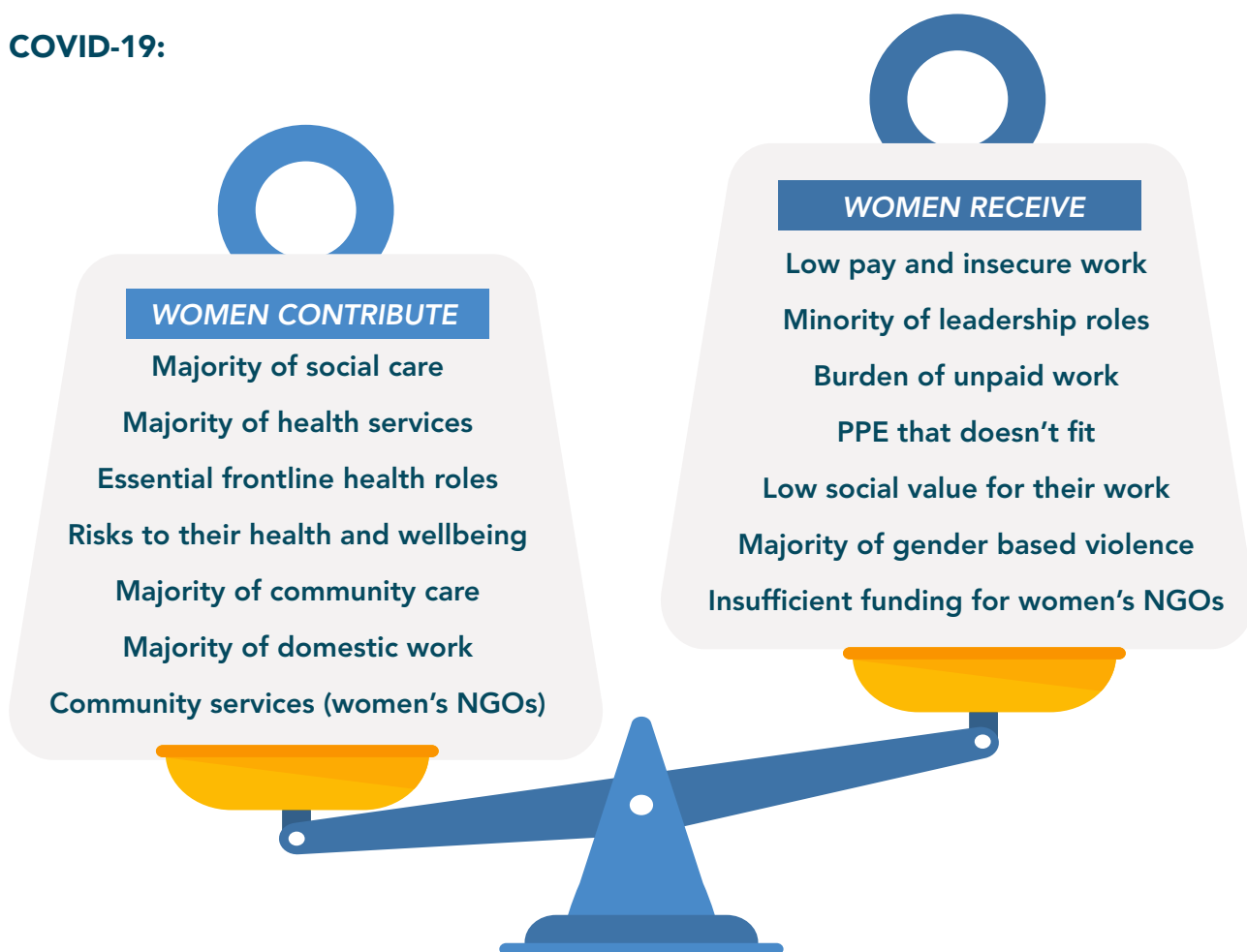
- Talent and expertise are lost to the health system if unpaid women workers are unable to progress into formal sector careers in the health sector.

**7. The pandemic increased the burden on unpaid women workers in health but raised awareness of their work**

- In the pandemic, unpaid women workers, faced with a sudden increase in work, were unable to balance unpaid work with family responsibilities and other productive work e.g., family farming.
- Health systems were critically reliant on these unpaid women e.g., to trace COVID infections in the community and deliver vaccines but they had no formal contract with them so could not guarantee they would continue to work.

- Health workers faced stigma and violence and were shunned in some communities as being vectors of the virus. Some women health workers chose to live apart from families to avoid spreading the virus.
- The low status of unpaid women in the health systems hierarchy meant many were required to find infected cases in communities and be exposed to risk but were low priority for personal protective equipment.
- Health workers went on strike during the pandemic in nearly 100 countries over pay, protection and recognition of their work. In India, the ASHA community workers organized, went on strike and leveraged improved pay and conditions.<sup>11</sup> The pandemic raised global awareness of their work and unpaid status.

**COVID-19:**



Source: Women in Global Health, Global Health Security Depends on Women, 2020<sup>12</sup>

# PART 1: BACKGROUND TO THIS REPORT

## 1.1 DEFINITIONS

In the absence of other definitions, for the purposes of this report the following two key concepts have been used:

### i) **Women’s unpaid and grossly underpaid work - characterized by being:**

- unpaid with no financial remuneration or other monetary benefits
- unpaid but with non-monetary benefits such as a mobile phone, bicycle or uniform
- paid a low, task-based stipend, incentive or per diem but not paid a regular salary or related social protection and not part of the formal labor market sector

### ii) **Women’s unpaid and grossly underpaid work in core health systems’ roles:**

- contributes to formal health systems performance goals
- is part of the formal health systems supervisory structure
- the health worker is given an official title by the health authority and may be given a uniform or other identifier to indicate their affiliation with the health system
- features health workers providing health services delivered outside the home to people who are generally not family

## 1.2 GLOBAL HEALTH: DELIVERED BY WOMEN, LED BY MEN

The unpaid and grossly underpaid work done by women in core health systems’ roles described in this report must be viewed against a much larger burden of unpaid domestic and care work done disproportionately by women due to gendered norms and expectations, and against wider gender inequities in the health workforce. Inequality between women and men in the health workforce, including in pay, is systemic, widespread and not new. In March 2019 WHO launched ***Delivered by women, led by men: a gender and equity analysis of the global health and social workforce***<sup>13</sup> based on the first comprehensive literature review on this topic. The report, a product of the WHO Gender Equity Hub (GEH) of the Global Health Workforce Network and authored by Women in Global Health, identifies gender inequities in the health and care workforce in leadership, pay, occupational segregation and decent work, and calls for gender transformative policy action to both address inequality and thereby strengthen health systems.



On average, men earn

**28%**

more than women in health  
(Gender Pay Gap)

NB: This gap would be much wider if statistics included women’s unpaid work

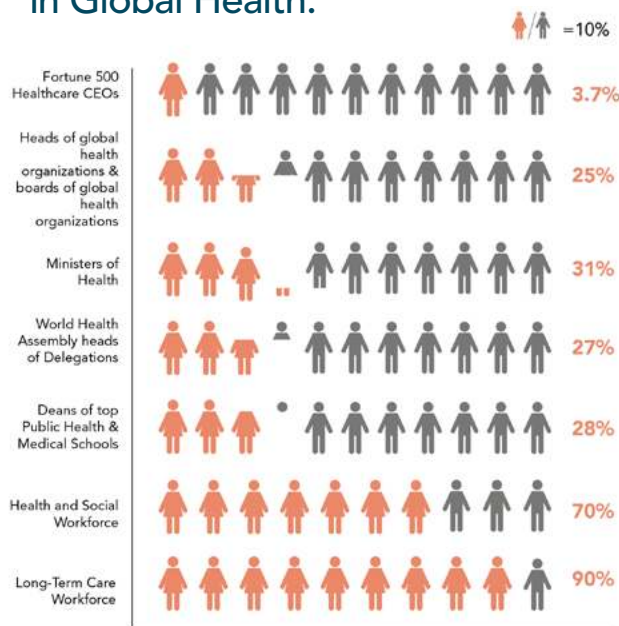
Source: Boniol et al<sup>14</sup>

The report analyzed the occupational segregation of the health workforce, with women clustered into roles given lower social status, lower pay and accorded less value because they were judged to be an extension of a woman’s socially ascribed unpaid care role. Figure 1 illustrates how women are least

represented in the most powerful and well-paid positions in the health sector. Currently, at the bottom of the hierarchy are women who do not figure in the system because their work is outside the formal system, unpaid and uncounted.

Since *Delivered by women, led by men* was published, the world has been hit by the COVID-19 pandemic, which has stress tested the resilience of health, social and economic systems, deepened inequality and further exposed gender inequities in the health and care workforce. It has also drawn attention to the women who have been on the frontlines of the pandemic response in communities, working unpaid or on performance related stipends outside the formal sector and so not included in gender pay gap or any other labor market statistics.

Figure 1: Women's Representation in Global Health:



Source: Women in Global Health

## Findings from *'Delivered by women, led by men'* on gender equity and pay in the health workforce

- The unadjusted pay gaps in health and social care, estimated at 26% in high-income countries and 29% in upper middle-income countries, are **higher than other economic sectors**.
- **Most of the gender pay gap remains unexplained** by factors such as age, experience, education, number of hours worked, or specialty choice. This **suggests discrimination and bias against women** and in favour of men.
- **Occupational segregation by gender**, with women tending to be clustered into lower-status and low-paid sectors and specialisms in health, is **associated with a gender pay gap in favor of men**.
- Equal pay for equal work **legislation and strong collective bargaining**, absent in many countries, are essential for addressing the gender pay gap in the health sector.
- The gender pay gap results in **lower lifetime income for women, reduced access to pay-related social and health benefits** (where they exist), and **increased poverty for women** in older age.
- **Women's economic inclusion**, and therefore closing the gender pay gap, is **critical to achieving the SDG overarching objective of leaving no one behind**.

## 1.3 TAKING AN INTERSECTIONAL LENS

An important finding of this report is the general and serious absence of data on the women working unpaid in health systems. The invisibility of women doing this critical work means policy makers lack the evidence on which to base health, social policy and economic decisions. It also enables gender inequality by devaluing the work women do and enables wider inequality since women working unpaid are typically drawn from disadvantaged social groups. To comprehend which women take up these roles and why, we need to take an intersectional approach to understand the complexity and cumulative nature of how different forms of discrimination combine, intersect and are amplified in relation to each other. Women belonging to a socially marginalized race, class, caste, age, ability,

ethnicity, sexual orientation or identity, will face far greater barriers accessing paid work and in particular, high-status roles. In India, caste can intersect with gender, making it harder for ASHA community health workers from lower caste families to enter the houses of higher caste families due to social taboos<sup>15</sup>. On the other hand, women recruited from lower caste communities have been able to reach the most marginalized lower caste women and consequently, have been instrumental in improving maternal and child health in those communities and collecting vital data.<sup>16</sup> Research for this report has provided insights on intersectional factors, but to a very limited extent, since it is rare to find sex disaggregated data, or data classified by other social factors.



## 1.4 WOMEN'S UNPAID WORK

Official statistics and measures of economic value such as Gross Domestic Product (GDP) grossly understate the work that women do and their contribution to families, societies and economies. If unpaid work was recorded in official statistics and included in GDP it would be the largest economic sector in the world<sup>18</sup> and the vast majority of unpaid work is done by women. Women's unpaid and grossly underpaid work in health systems must be

understood in the context of women's unpaid work, often classified under the catchall title of 'care'. Women's unpaid work may range from childcare and family maintenance work done in the household, to water and fuel collection in low income and rural communities; and cottage industries related to subsistence agriculture. None of this very real and time-consuming burden of work is visible in official statistics in most countries.

## 1.5 COMMITMENTS HAVE BEEN MADE

A number of commitments have been made by governments on fair and equal pay, decent work and gender equality that are not compatible with women's unpaid work in health systems. These commitments are embodied in a series of International Labour Organisation and UN conventions and agreements dating back over 60 years. Governments have also committed to achieving Gender Equality under Sustainable Development Goal (SDG) 3 and to promoting Decent Work under SDG 8, both with target dates of 2030. In addition, WHO's 2018 Guideline on Health Policy and System Support to Optimize CHW Programmes<sup>19</sup> strongly recommends ***“remunerating practising CHWs for their work with a financial package commensurate with the job demands, complexity, number of hours, training and roles that they undertake”*** and ***“providing paid CHWs with a written agreement specifying role and responsibilities, working conditions,***

“

**20%**

**When assigned a market value unpaid childcare becomes Australia's largest economic sector at 20% of the economy<sup>17</sup>**

remuneration and workers' rights.” Since the majority of women working unpaid in the health sector are likely to be working at community level and the majority of CHWs are women, the implementation of this Guideline would have a significant and positive impact for women and gender equality in the health sector.



Source: Patrick Adams/RTI International

# PART 2: FINDINGS

## 2.1 CALCULATING THE NUMBER OF WOMEN WORKING UNPAID AND UNDERPAID IN HEALTH

### Key Messages

- Calculating the number of women working unpaid and underpaid in health systems is complicated by a lack of data and inconsistency in definition, but we calculate that **a minimum of six million women are working unpaid and underpaid in community health roles.**
- It is critical to take an intersectional approach since many women working unpaid in one context may belong to a marginalized ethnic, caste or religious group. They may be disadvantaged in seeking paid work by both their gender and other social characteristics.
- The majority work in low-and middle-income countries. Around one quarter of the six million women working unpaid in health are working in India.
- Women are mainly working unpaid in community health roles but in some countries, we found examples of women working unpaid in roles such as nurses.
- Men also work unpaid in health systems roles at community level, but in small numbers compared to women.
- In some low-resourced health systems, especially in humanitarian emergencies<sup>20</sup>, government health workers in formal sector jobs may not be paid or only paid sporadically.

### Estimating six million women

There is no reliable data on health workers working unpaid in core health systems roles and no sex disaggregated data. There is no reliable global data on the number of community health workers, where women working unpaid are most likely to be found. **The figure in this report that six million women work unpaid and underpaid in core health systems' roles is an estimate based on scarce data and almost certainly an underestimate.** It is derived from examination of data sources, interviews, and primarily from a comprehensive report published in 2020 *Health for the People: National Community Health Worker Programs from Afghanistan to Zimbabwe*<sup>21</sup> (see table below) with detailed case studies of community health worker programs in 29 low-and middle-income countries.

That report documents 8.4 million community health workers (CHWs) for the 29 country programs, concluding that the majority are women, with not all of these unpaid. The report focuses on 29 countries and does not include CHWs working with NGOs globally or those working with vertical programs such as those for HIV, malaria, TB, Polio, immunizations and family

planning. All this suggests that the six million figure for unpaid women is an underestimate. It is also likely to be an underestimate because the report only captures women working unpaid at the community health level, and cases in other levels of health systems, such as nurses, were also identified.



*“As a new graduate in nursing, we work as ‘cover staff’ while we are in the queue for a paid job at the hospital. As cover staff, also called 08, we don’t get a regular salary and sometimes, we work very long shifts with no breaks. We only get paid for the shifts we are called to cover. The system isn’t fair as people with connections get jobs and the rest of us have to wait but we don’t know how long. Its very stressful after so long training not to have a secure nursing job and secure pay.”*

*- Maria, Qualified Nurse, Mexico*

## Unpaid and Grossly Underpaid Women Health Workers

Source: Perry ed 2020<sup>22</sup>

Country	N° of CHWs/ gender	CHW Program name/Remuneration and Rewards
Afghanistan	13,000 women current status unknown	<b>Community Health Workers Unpaid</b> Communities may provide food, clothing, commodities, and other non-monetary incentives for CHWs from time to time.
Ethiopia	3,000,000 women	<b>Women's Development Army Volunteers</b> Classed as volunteers, no monetary compensation, but receive non-financial incentives such as formal recognition from the health system, ongoing mentorship, certificates.
India	971,000 women	<b>Accredited Social Health Activists (ASHAs)</b> Classed as volunteers, receive performance-based payments, average US\$ 42-56 per month and some other benefits.
	1,300,000 women	<b>Anganwadi Workers</b> Classed as volunteers, paid "honorarium" of US\$ 50 – 130 per month.
Indonesia	500,000 almost all are women	<b>Kaders Community Health Workers</b> Classed as volunteers, unpaid except for small reimbursements for transport expenses. May receive informal compensation, e.g. free medical treatment
Kenya	86,000 majority women	<b>Community Health Volunteers</b> Some counties pay monthly incentives of US\$ 20 – 60 per month.
Myanmar	24,000 women	<b>Auxiliary Midwives</b> Unpaid
Nepal	52,000 women	<b>Female Community Health Volunteers Unpaid</b> Classed as volunteers but provided training allowances, refresher training, annual clothing allowance, access to microcredit funds, and other incentives.

Total estimated **six million women** work unpaid and grossly underpaid in core health systems roles



Source: Times

## Counting women working unpaid in health systems

In compiling this report we encountered several significant barriers in attempting to estimate the number of women working unpaid and grossly underpaid in core health systems roles:

- **Lack of data on diverse programs and roles:** the majority of unpaid women are almost certainly working at primary health care level in community roles. Community health schemes vary considerably in type, structure, titles, level of integration into health systems and the formal labor market. Many countries engage women, and some men, unpaid, often titled volunteers, who may be offered incentives, per diems or other low monetary benefits and/or non-monetary benefits with a monetary value (uniforms, bicycles etc) and/or forms of social recognition. Some countries, however, engage CHWs in formal health systems roles with salaries and other benefits. Data is scarce and sex-disaggregated data very rare, and the diversity of programs make them hard to compare. Although, as the pandemic has demonstrated, the work of community health workers is the foundation for many health systems, their contribution is often invisible in formal statistics.



*“The world has counted on CHWs to extend primary health care and fight pandemics from Ebola to COVID. We all agree we can do better by actually counting them.”*

*Dr Raj Panjabi, Special Assistant to the President and Senior Director for Global Health Security and Biodefense, White House National Security Council and Co-founder Last Mile Health, 2022<sup>25</sup>*

- **Lack of data on health workers not paid:** in addition, an unknown number of health workers, women and men, are contracted in formal, paid roles in health systems but do not receive the pay they are due. In some poorly resourced health systems, health workers may be paid late or sporadically. Embezzlement of pandemic response funds, for example, left some health workers unpaid for months in the Democratic Republic of Congo, which prompted them to strike.<sup>24</sup> Health workers may also continue working unpaid when health and economic systems are disrupted by emergencies and conflict. Since women are the majority of health workers, we must assume the majority of those not paid are women.



*“We’ve seen over the past months just how dedicated and courageous female health staff have been in showing up and doing their best to save lives every day, regardless of not receiving a salary, of having to travel long distances, working in health facilities that are struggling to function.”*

*Eloi Fillion, head of the ICRC’s Afghanistan delegation, 2022<sup>23</sup>*

## #CountCHWs

As the pandemic has highlighted, CHWs have long been on the frontlines of primary health care delivery in many countries and the majority are women. Most countries, however, do not know how many community health workers they have, where those workers are located or the roles they play in health systems. WHO estimates that there are 3 million CHWs globally but 40% of the data this calculation is based on is over a decade old.<sup>26</sup> During the pandemic, some countries were unable to estimate their need for personal protective equipment (PPE) for health workers since they did not know how many CHWs were working in their health programs. In 2022, in response to the absence of data, six global organizations launched the #CountCHWs campaign<sup>27</sup> to work for **CHW Master Lists**, a single source of data on all CHWs in a country recording their pay, jobs, spatial distribution, gender, etc. These Lists will provide essential information, including on unpaid women health workers, as the foundation for health decision-making and planning human resources in health.



## 2.2 THERE ARE DIVERSE FORMS OF REMUNERATION AND INCENTIVES BUT NONE GIVE UNPAID WOMEN HEALTH WORKERS ECONOMIC SECURITY

- Women working unpaid or underpaid may receive a low fee or performance-based stipend for their work in health but are unlikely to receive any of the benefits associated with formal sector work, including social protection, pension, sick and holiday pay.
- Depending on the scheme, they may earn a small amount of money by, for example, selling medicines or by receiving gifts and donations.
- Unpaid health workers may receive non-monetary rewards such as uniforms, bicycles or mobile phones.
- In some 'dual cadre' systems, paid community health workers work alongside a cadre of unpaid workers.
- Non-monetary incentives can be important motivators and include status within the community, community trust and respect.
- Training and an opportunity to gain knowledge are strong incentives for some depending on the context. In some contexts, unpaid women health workers have low levels of literacy and education and formal training opportunities are limited.
- In some contexts, there has been a concern that paying volunteers would reduce trust amongst the community. Portraying women particularly as 'altruistic' is a gendered assumption and denies the very real economic needs of the low-income women who are working unpaid.



*"...women stayed in these extremely low paying jobs because they and their families hoped that one day they would become permanent jobs with salaries and benefits. By providing honorable work, and keeping the idea of permanent employment in view but always just out of reach, the ASHA and Anganwadi programmes both exploited and strengthened gendered inequalities in the rural Rajasthan labor market."*

*Closser et Shekhawat The family context of ASHA and Anganwadi work in rural Rajasthan: Gender and labor in CHW programmes 2021<sup>28</sup>*

### Diverse Monetary and Non-Monetary Rewards

Health systems exist in diverse socio-economic and cultural contexts, and the remuneration and incentives for women health workers who are unpaid and grossly underpaid are equally diverse. They include:

- **Financial incentives** in the form of a low regular stipend, such as the regular stipend of US\$20 per month<sup>30</sup> paid to Thailand's one million Community Health Volunteers. Other schemes pay per diems, honoraria and performance-based incentives and stipends<sup>31</sup> which are not regular salaries and do not come with the social security and other benefits that might come with a salary. The WHO 2018 Guideline on Community Health Workers recommends against paying community health workers "exclusively or predominantly according to performance-based incentives"<sup>32</sup> These are not predictable or reliable income sources for the largely low-income women who receive them.
- **Non-monetary incentives** including work-related items such as mobile phones, bicycles and uniforms, that have value and status for women from low-income households. This can also include training to gain new skills and, in some schemes, can enable unpaid women health workers to progress to formal sector paid roles in the health system.<sup>33</sup>

- **Reimbursement of expenses** such as transport costs. It is common for health workers to report that these reimbursements are delayed, leaving them out of pocket until they are repaid.
- Access to **income generating activities**. In Bangladesh, lower-level cadres of women community health workers are able to make small commissions on the sale of health-related goods and enrol in women's savings and loans groups with microenterprise activities, including in agriculture<sup>34</sup>.
- **Social recognition**. This can be formal with prizes and certificates given by local officials or can come in the form of informal recognition by the community.



**Per diem payment for women Polio workers:** "Most of the work is carried out by female community health volunteers; she is there from morning to evening, and she must have some food to eat, for transportation she must go to the field, money only for that. No additional money. [I was] talking to an FCHV [female community health volunteer], she rightly said the money she received is very small, that it is smaller than what a laborer earns in a day. "

Government official in Nepal from Closser et al, 2017<sup>29</sup>

### Ensuring equity when health worker roles are professionalized

Despite recommendations from WHO against paying CHWs performance-based incentives<sup>37</sup>, some have argued that paying regular salaries to 'volunteer' women health workers would reduce trust from the community or reduce their efficiency. Such claims must be evidence based. In some countries, including India, government decision makers have noted that upgrading performance paid incentives to formal salaried positions could disadvantage women.<sup>38</sup> In these countries the uneducated women currently working at community level outside the formal sector would not meet the minimum education and literacy criteria set by



"...institutional actors also defended a policy of not financially remunerating CHWs, partly by constructing their capacities as so valuable that they become "priceless" and therefore only remunerable with immaterial satisfaction."

Maes et al Volunteers are not paid because they are priceless, 2015<sup>35</sup>



"Despite the life-saving work they perform, community health workers (CHWs) have long been subject to global debate about their remuneration. There is now, however, an emerging consensus that CHWs should be paid. As the discussion evolves from whether to financially remunerate CHWs to how to do so, there is an urgent need to better understand the types of CHW payment models and their implications."

Ballard et al, Compensation models for community health workers: Comparison of legal frameworks across five countries, 2022<sup>36</sup>

governments for formal sector government jobs. With voluntary and informal roles, on the other hand, education requirements can be relaxed, to include women from marginalized locations and social groups who might otherwise be excluded.<sup>39</sup> It is critical that governments analyze the potential impact from both a gender equity and intersectional point of view when moving informal sector health worker roles into the formal sector. They must consider how to mitigate the risks, once jobs are paid, of women losing jobs to men and health workers from marginalized social groups losing jobs to those with higher social status. The bottom line is that unpaid and grossly underpaid work in health undermines the economic security of women who generally come from low-income households.

## 2.3 UNPAID WORK TASKS DIFFER, AS DOES TIME COMMITMENT

- A WHO systematic review of community health workers<sup>41</sup> identified six roles (see box below) typically performed by CHWs.
- Unpaid women health workers are most often engaged to work on maternal, child and reproductive health, but during the pandemic they have had wider public health and vaccination duties.
- In some health systems, unpaid workers work in male-female or same sex pairs, enabling male CHWs to access men in the community and increasing safety for women health workers.
- Unpaid roles can be part-time and flexible to accommodate subsistence work and other responsibilities women workers have or they can be full-time which can displace household work onto other family members, especially older women and girls.
- Workloads during the pandemic increased suddenly for many unpaid women workers causing exhaustion and stress as women juggled multiple responsibilities.

### Community health workers perform a variety of tasks, which can be clustered into six overlapping roles:

1. delivering diagnostic, treatment or clinical care;
2. encouraging uptake of health services;
3. providing health education and behavior change motivation;
4. data collection and record-keeping;
5. improving relationships between health services and community members;
6. providing psychosocial support.

Source: WHO 2020<sup>40</sup>

### Women health workers reaching women

Studies of and interviews with women working unpaid and grossly underpaid in health systems have shown that their responsibilities and tasks are typically focused on maternal, reproductive and child health through reaching women in communities. This is confirmed by the compilation of CHW programs in 29 countries<sup>43</sup> (see box below). It is positive that cadres of health workers have been established to enable health services to reach women in communities with unmet reproductive health needs and high maternal, child and infant mortality. It also makes sense that these cadres should be women, typically coming from the same communities, who will be more familiar with the cultural and socio-economic context, and most able to reach women. In the majority of contexts it is more culturally acceptable and safer for female rather than male health workers to enter women's homes, especially to

### Most Common Community Health Worker (CHW) Roles - 29 country case studies:

- Maternal and child health activities
- Nutrition-related education and promotion
- Hygiene and other healthy household practices
- Family planning
- Promoting/supporting utilization of basic health care services (antenatal and postnatal care, facility delivery, immunizations, and family planning)
- Counselling/health education on warning signs for which pregnant women and sick children should seek a trained health care provider

Source: Perry et al 2020<sup>42</sup>

discuss sensitive issues such as contraception, pregnancy and childbirth. Studies from a number of countries<sup>444546</sup> demonstrate that the introduction of women community health workers has had an extremely positive impact on maternal and child health indicators, including reducing maternal death and increasing uptake of childhood vaccinations. This supports the strategy of engaging women health workers to access other women, especially women in communities hard to reach due to their location or social marginalization. Universal health coverage (UHC) requires such an approach to leave no-one behind.



Source: Devex

### Gender exploitative or gender transformative for women health workers?

Although the health systems strategy of engaging women to access women is sound in terms of access, engaging women health workers unpaid or grossly underpaid outside the formal sector, decent work, is problematic on a number of levels. First, it may be seen as an extension of the culturally gendered caregiving role that assumes women are primarily responsible for unpaid care work and child care. That makes it easier to justify treating women health workers as ‘volunteers’ who are not doing ‘real work’ and to justify the gender exploitative practice of not paying women fair



*“.....a gender transformative approach would seek to engage both men and women in changing conservative gender norms, rather than reaffirm conformity to them.”*

*Ved et al, How are gender inequalities facing India’s one million ASHAs being addressed? 2019<sup>48</sup>*



*“This is part of unpaid labor of women and is seen as an extension of the work women do at home.”*

*Ranjan Nirula, Convenor All India Coordination Committee of ASHA Workers, 2020<sup>47</sup>*

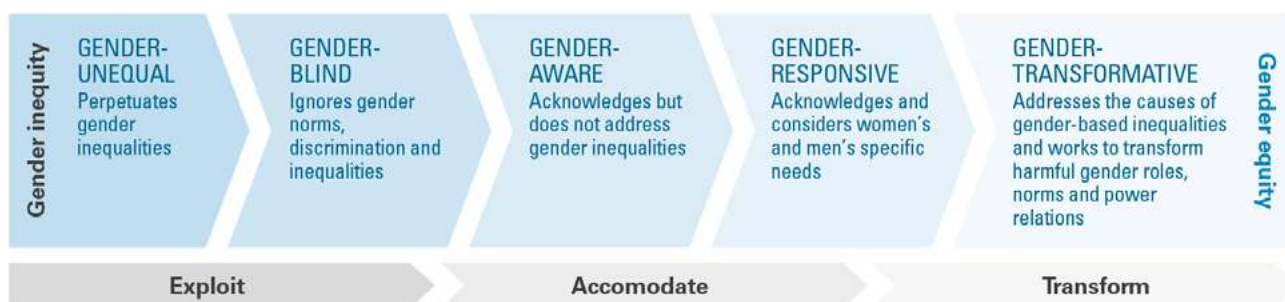
remuneration. As a result, too little protection may also be given to women in these roles, especially against the violence and harassment many face working in community outreach, and more recently, in the provision of personal protective equipment (PPE) in the pandemic.<sup>49</sup> Engaging women to work unpaid is not gender transformative (see below) in that it reinforces the gendered subordinate social and economic position of those women health workers and does not address the root causes of their status. Women health workers live within the social hierarchies and power relations in their cultures and societies and women with low status in the health system hierarchy will have limited power to challenge patriarchal power relations.

## Gender responsive or gender transformative for women service users?

Engaging women health workers to take health services to women's doorsteps is gender responsive in aiming to meet their health needs within their social and cultural context but not gender transformative. It can reinforce and not challenge the patriarchal root causes of, for example, women's disproportionate poverty and lack of autonomy within the family and restrictions on their mobility, all of which limit

their access to health facilities and services<sup>50</sup>. It can also reinforce the culturally gendered norm that caring for children and unpaid care work is women's and not men's business. Ultimately, if doorstep health services enable women to have fewer children by choice and better health, then the result will be gender transformative over time for women in those communities.

## The Gender Equity Continuum<sup>51</sup>



## 2.4 WOMEN TAKE UNPAID HEALTH ROLES FOR A MIX OF REASONS

- Many women in these roles report a strong ethic of wanting to serve and benefit their communities, particularly other women and children.
- Gender inequities in a particular society may give women few choices. They are less likely in low-income countries to have qualifications to enter the formal job market. Even where women are educated, there may be constraints on their mobility and on moving to seek formal sector jobs outside their communities.
- Women from very poor households and marginalized social groups may have even fewer choices than other women in the community and, out of desperation, 'volunteer' to work exceptionally long hours in search of possible income.
- Women may see unpaid work as a potential opportunity. It may lead to paid work or to training to access paid work. The role may be unpaid but periodically there may be additional tasks e.g. vaccination campaigns, that are paid.
- The role of families is complex. In some contexts, women in conservative social settings may gain autonomy through unpaid work, be able to leave their houses, mix with other women and do meaningful work with an opportunity to learn. Families, particularly husbands, may coerce women to take these roles in the hope they will earn income.



*"Having a salary or some stipend would be really useful... But you know, most of us are doing this work because we have something in (our) heart that tells us that we cannot let our neighbour suffer."*

*Omondi unpaid community health volunteer, Kenya, 2020<sup>52</sup>*

## Why do women take on unpaid work in health systems?

The majority of women who work unpaid and grossly underpaid in health systems come from impoverished households. The big question is why such women, who already have a heavy burden of unpaid work, agree to take on more work, either as volunteers or very low pay earners. The answer is not straightforward but can fall under the following six main motivations, and may be a mix of some or all of them:

- **Altruism:** women working unpaid and grossly underpaid in health, consistently express pride in their work and satisfaction in being able to help others in their communities.<sup>54</sup> The willingness of women to help others in their communities should be valued and not perceived as confirming the gendered myth that, unlike men, women are born with a self-sacrificing gene. This myth can be used to argue against paying women fairly for the work they do, often based on a second gender myth that women not in full-time employment are 'not working', and therefore have free time to do voluntary work.
- **Economic:** most of the women who take on unpaid roles in health systems come from low-income households and start with a heavy burden of unpaid domestic and care work, as well as other forms of work in subsistence agriculture or small business. Work in health systems is part of their livelihood strategy, and they may accept it hoping that it will lead to sporadic income; a paid, formal sector role; opportunities for training, networking and career progression.<sup>55</sup>

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*I'm a mother of two. I feel the pain of mothers whose children get affected by polio. There should be a healthy environment for children to grow in... Our work is scary and I don't feel safe at times. Polio workers have been killed, and the police who were guarding them. As a female worker, this job is more risky. We have to go to other people's homes, and a lot of times there are no women present so we have to be vigilant and alert... I think it is a great service to the country, but with inflation in Pakistan, we should be paid more.”*

*Saima, frontline health worker, Pakistan, 2022<sup>53</sup>*

- **Autonomy:** women in conservative social and cultural contexts may gain autonomy from work in health that takes them out of the home and family, and brings them into contact with other women around a respectable social purpose. They may earn very little money, but it may be the first opportunity they have had to earn income.



Source: CHWcentral

- **Advantage:** women health workers may gain various forms of advantage from unpaid work in health, including positive advantages to learn and gain social recognition as well as negative opportunities to make money illegally by, for example, selling medicines that they are engaged to distribute for free.
- **Coercion:** women may accept unpaid and grossly underpaid work coerced by husbands or families who are motivated by income and not the woman's welfare or interests. In such cases, women may have no access to or control over money they earn.
- **Gendered constraints:** women's unpaid and grossly underpaid work in health must be seen against the gendered constraints faced by women in their social and cultural context. Girls in low-income countries have a lower secondary schooling<sup>58</sup> completion rate than boys and so are less likely to have the educational qualifications to enter formal sector work. Gender norms may limit their mobility and therefore their access to paid work outside their communities. Gendered cultural norms may deem it unacceptable for married women to take paid work or work far from home but consider work in health socially acceptable

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*'Unpaid volunteer work cannot be considered a free choice in contexts where health systems are poorly resourced, poverty is rampant and access to decent work opportunities is limited, particularly for women. For women, long hours spent on unpaid volunteer labor come on top of heavy unpaid domestic work responsibilities which together are likely to exacerbate women's time and income poverty.'*

*Ballard et al, Are dual cadre CHW programmes exploitation by another name?, 2021<sup>56</sup>*

work for a woman.<sup>59</sup> Women may face these and many other gendered constraints on their access to paid work that men do not face. They may enjoy the work they do in health, but would opt to be fairly paid for that work if the option was available.



Source: AMP HEALTH

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*"Women may be 'empowered' to be more autonomous from their husbands, to take more responsibility for their own health, and socialize more with other women; but they are still not 'empowered' to negotiate over their remuneration and job conditions or to hold the government accountable for the injustices that they and their fellow villagers see and live every day."*

*Jackson et al, Ethiopia's Health Extension Program, 2019<sup>57</sup>*

## 2.5 UNPAID WORK MAY HAVE SOME BENEFITS FOR WOMEN BUT GENERALLY IT UNDERMINES THEIR ECONOMIC RIGHTS AND POTENTIAL

- A significant number of unpaid women health workers live impoverished lives into older age. Working outside the formal sector will deprive them of social protection and other benefits.
- Some may have opportunities to progress to paid formal sector roles, for example in some health systems community health workers can train to enter nursing.



*“Excessive workload, inability to transfer, few opportunities for training and advancement and so on, do not address the gendered inequalities for female HEWs (Health Extension Workers) compared to other health workers or other government employees”*

*Omondi unpaid community health volunteer, Kenya, 2020<sup>60</sup>*

- Women may be exposed to violence in the community if they are perceived as having low status or work late hours e.g., to attend a delivery. Unpaid work can also increase the risk of intimate partner violence.



*“Some women, they are just living, and they don’t know anything about the outside world. If I didn’t do this job, I’d also be like them. They haven’t had a chance to consider what they want out of life. And what could be more important than that? There’s so much more out there than doing housework and making dinner.”*

*Woman ASHA community health worker, India, in Closser and Shekhawat, 2021<sup>61</sup>*

- They may gain status and respectability within the community and feel genuine satisfaction in their work. Their status will, however, depend on their ability to deliver. Medicine shortages, for example, could cause them a loss of trust in the community<sup>62</sup>.
- Women may be exhausted from the additional burden of work unless other tasks can be redistributed within the family.
- Unpaid work in health systems results from and reinforces existing socially and culturally driven gender roles which can further limit women’s options.

### The impact of unpaid health work for the women who do it

The diversity of the programs under which women work unpaid or grossly underpaid in health make it difficult to generalize about the impact on the women health workers themselves. One point common to all is that the hours they spend on unpaid work add to the burden of work they already have and displace the opportunities for rest or other income generating activities. This entrenches gender inequality, as women do more unpaid work, earn less than men on average and

own fewer assets, and this adds to women’s disproportionate poverty throughout their lives. The additional work may leave women exhausted since it can involve walking long distances in the community going house-to-house. Closser<sup>64</sup> describes a rare example of a woman community health worker (ASHA) in India, whose burden of domestic and agricultural work was redistributed amongst other women in the family to enable the health worker to do her job. Generally, the



hours women work in health are additional to their domestic and other duties, and ‘women’s work’ is not redistributed to men in the household. Women community health workers also face violence and harassment in moving around communities, which can impact their physical and mental health.

### The power of agency

Though far from being a common experience for unpaid women health workers, some do progress into paid roles, into leadership and decision-making positions, are recognized for their expertise within the community, and gain autonomy within the family and control over income for the first time. Much depends on the integration of the cadre into the health system. For example, the ASHA community health worker scheme in India (nearly one million women) offers paid tuition for ASHAs to complete secondary school and gives them preferred admission to nursing and midwifery schools.<sup>66</sup> Although women’s unpaid and underpaid work in health generally undermines their economic security and entrenches gender inequality rather than challenging it, there are indications that the situation could be very different. If fairly paid and enabled to progress within the formal health sector, then health systems, communities and societies could fully benefit from the commitment, knowledge and expertise of an additional six million women.



*“Like Pakistan, Iran has also seen the emergence of women as local leaders and political activists. Volunteers have become skilful in gaining support from the Ministry of Health and became involved in advocacy via petitions and local media campaigns to lobby for broader health and well-being services for the community.”*

*Steege et al, How do gender relations affect the working lives of close to community health service providers? 2018<sup>67</sup>*



*“Mukabayire runs a boutique in front of her home. Splitting her time between the shop, the only source of income she has, and unpaid full-time volunteer work is quite overwhelming. While she has a passion and love for serving her community, she also has a family to feed. ‘Often I have to abandon my boutique to attend patients in the community’”*

*Community health volunteer working on COVID-19 response, Rwanda in Uwimana, A<sup>63</sup>*



*“There are now perhaps thousands of examples in which CHWs, particularly female CHWs, have discovered the power of agency they did not realize they had, enabling them to move to positions of leadership in their community and beyond, even to national legislatures. The socioeconomic benefits of poor mothers having their own income for the first time that they can use for their own benefit and the benefit of their children is now widely recognized and is one of the rationales for investing in CHW programs.”*

*Perry et al, Health for the People, 2020<sup>65</sup>*

## 2.6 HEALTH SYSTEMS ARE WEAKENED BY DEPENDING ON WOMEN'S UNPAID WORK

- Government expenditure on health systems is reduced in the short term since workers are unpaid. Investment in a strong primary health care system, however, based on safe and decent work would pay off longer term in better health outcomes.
- Unpaid health workers are likely to have higher attrition and will be less accountable. Health security is compromised.
- Unpaid work can increase inefficiencies and corruption, an impoverished task-based worker may falsify the number of vaccinations delivered to gain income for example.



*"...the state is the employer that has appointed these women workers; but by labeling them 'volunteers' and retaining them in informal working arrangements, the state has erased its own obligations around fair wages and social security."*

*Dasgupta, J and Kanika, J Women Workers at the Forefront of COVID-19<sup>68</sup>*



*"Unpaid care work fills in the gaps where there is a lack of "official"—or financed—health care. The resilience of the underfunded health-care system relies on unpaid work provided by women, while the GDP paradigm extracts unpaid labor by women in order to cut costs and achieve a much wider coverage of health care."*

*Waring, M, The Gender Pay Gap Is Wider Than You Thought, making women's unpaid care work count toward an economy for health, 2022<sup>69</sup>*

- Discontented unpaid workers may strike or perform badly due to low morale.
- Governments have no secure social contract with health workers who may feel exploited.
- Talent and expertise are lost to the health system if unpaid women workers are unable to progress into formal sector careers in the health sector.

### Investing in women health workers is investing in health security

Against the backdrop of a serious global health worker shortage made worse by the pandemic, there is an urgent need for all countries to invest in retaining their health workers and attracting new recruits to the profession. Low-income countries, especially, face very real challenges balancing health worker supply with growing demand for health services and achieving the commitment to realize universal health coverage by 2030. Engaging women health workers at the community level to act as the bridge between women in hard-to-reach communities and the health system has proven to be an effective strategy to address maternal, child and reproductive health in many countries. More recently, unpaid women health workers

have been critical to the pandemic response, contact tracing, informing communities and dispensing vaccines. However, not paying or grossly underpaying the very women who form the critical foundation for primary health care abuses their economic rights and undermines health systems. They are expected to accept job terms and conditions that men would rarely accept because the gender inequality that shapes their lives offers them very limited choices, unpaid work being one of these. They are trapped in a vicious gender cycle, generally unable to escape unpaid or grossly underpaid work because they are offered no bridge into formal sector jobs in health. Several studies<sup>71</sup> and interviews reported flaws in this system,

such as women's heavy unpaid domestic and care responsibilities plus the additional workload of their role in health leading to high attrition. Moreover, a reliance on performance incentives can distort work priorities, with health workers focused on the task that earns the incentive rather than the wider health of the patient. The conclusion of the review of CHW programs in 29 countries<sup>72</sup> was that CHWs, majority women, feel they are underpaid and that their remuneration inadequately reflects the time and effort they contribute, and due to this they are increasingly going on strike. Strong health systems, societies and economies cannot rest on women's unpaid and underpaid work.

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*“As ASHA workers have become more crucial to rural health-care delivery in these states, they have been able to join workers’ unions, make their voices heard for better work conditions and pay, and leverage local elections to urge officials to prioritize their voices.”*

*Dhaliwal, B and Shet, A On the Front Lines with India's COVID-19 Warriors, 2022<sup>70</sup>*



## 2.7 THE PANDEMIC INCREASED THE BURDEN ON UNPAID WOMEN WORKERS IN HEALTH BUT RAISED AWARENESS OF THEIR WORK

- During the pandemic, unpaid women workers faced with a sudden increase in work were unable to balance unpaid work with family responsibilities and other productive work, family farming for example.



*“Now we work all hours, with no days off”, said 33-year-old Mhaske, who used to do farm work shifts to supplement her ASHA income before the coronavirus pandemic struck India in March”*

*Reuters, India, 2020<sup>73</sup>*

- Health systems were critically reliant on these unpaid women for key activities such as tracing COVID infections in the community and delivering vaccines, but they had no formal contract with them so could not guarantee they would continue to work.
- Health workers faced stigma and violence and were shunned in some communities as being vectors of the virus. Some women



*“I’m extremely afraid of being infected when I go door-to-door. But it’s my job. It’s my duty.”*

*Yirgalem, Community Health Worker Ethiopia in Bhalla, N and Wuilbercq, E Africa’s unsung army of women wage war on COVID-19, 2020<sup>74</sup>*

health workers chose to live apart from their families to avoid spreading the virus.

- The low status of unpaid women in the health systems hierarchy meant many were required to find infected cases in communities and be exposed to risk but were low priority for personal protective equipment.
- Health workers went on strike during the pandemic in nearly 100 countries over pay, protection and recognition of their work. In India, the ASHA community workers organized, went on strike and leveraged improved pay and conditions.<sup>75</sup> The pandemic raised global awareness of their work and unpaid status.

### The impact of the pandemic on unpaid women health workers

The pandemic has had a major impact on women working unpaid and underpaid in frontline health roles, and demonstrated how much societies, economies and health systems rely on women’s unpaid work in health systems and beyond. In particular, women in community roles were drafted in to trace contacts and educate community members on COVID-19 based on the relationships of trust already established through their work. The summary below of the work done by unpaid Community Health Volunteers in Kenya was very typical of the work carried out and the difficulties faced.

## Survey Women Community Health Volunteers Kenya<sup>76</sup>

### Percentage of CHVs engaged in COVID-19 activity

- 97% Educating community members about COVID-19 prevention or treatment
- 73% Educating communities/households how to care for someone with COVID-19
- 53% Referring suspected COVID-19 cases for testing
- 49% Reporting suspected or confirmed cases of COVID-19
- 48% Contact tracing for those who may have COVID-19 in the community
- 46% Referring suspected COVID-19 cases for advanced care at facilities

### Difficulties faced

- 73% did not have adequate PPE to feel safe
- 61% said people fear CHV might spread COVID-19
- 50% CHVs feared catching COVID-19

In particular, women community health workers were sent out into communities in the early stages of the pandemic, without the personal protective equipment (PPE) they needed to reduce their risk of infection. A global survey<sup>78</sup> by Women in Global Health in 2021 established that women health workers faced PPE shortages all over the world and that PPE is typically a poor fit for women since it is modeled on men's bodies. Getting PPE to women on the community frontlines of the pandemic was complicated by global PPE shortages and also by poor government data in some countries on numbers, composition and location of the health workforce at the community level. Women working unpaid were often low priority for PPE since they were not part of the formal health workforce, despite the fact that they were going door-to-door to trace cases. In India, ASHA women community health workers were sent to trace cases without face masks or hand sanitizer.<sup>79</sup> There is no data on CHW infections, mortality from COVID-19 or long COVID. In many countries, women health workers faced stigma, abuse and violence, mistakenly



*“Because CHWs have received unprecedented attention and appreciation, this is an opportune moment to push for substantive and sustained changes to respond to their needs and enable them to occupy a more empowered position within the health system.”*

*Nanda et al, From the frontlines to centre stage: resilience of frontline health workers in the context of COVID-19, 2020<sup>77</sup>*

believed to be vectors of the disease.<sup>80</sup> Many in low-income countries worked unvaccinated even when vaccines were freely available in high-income countries and many experienced further abuse when sent out to deliver vaccines in the face of misinformation.<sup>81</sup>

## Unpaid women health workers gaining recognition

COVID-19 exposed the inequalities between and within countries, including gender inequality in the health workforce and the role of women working unpaid and underpaid. Women health workers were tasked with pandemic response public health measures and also with maintaining routine health services as before, including in critical areas such as safe delivery and health checks for pregnant women. Ironically, the pandemic interrupted performance-based incentives and increased economic insecurity<sup>82</sup> for many of these essential workers. It is generally harder for women working dispersed in communities to organize for better pay and conditions, especially since

many women in unpaid roles have low levels of education. However, during the pandemic, health workers in around 100 countries went on strike over pay, working conditions, safety and recognition, and unpaid women health workers made notable progress in countries such as India in organizing and being heard. Since the pandemic shone a light on the exceptional contribution made by women working unpaid and grossly underpaid in core health systems roles, this is the right time to put in place the safe, decent, equal and fairly paid work they need to ensure resilient health systems are in place for the next health emergency.

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*“We have been facing problems in the pandemic. We have extra work and the hours are long. People are afraid to let us in their houses and say ‘why are you bringing the virus here?’ They look at me with contempt, people harass us and sometimes I am discouraged. But we have to tell them so they are safe. I hope this will be over soon.”*

*Samina, Lady Health Worker, Pakistan, 2020*



Source: CHWcentral

“

*“Since coronavirus I am working 24/7. I have to get up early to make my meal for the family then walk a long distance as the houses are far apart, to tell people about precautions against the virus and also do my normal work on family planning and children’s health. I pass through thorns and barking dogs and come home late and I am tired but all health workers are working round the clock and we must do our work.”*

*Jennifer, Community Health Worker, Zambia, 2021*

“

*“Since the pandemic I have been called to work in the vaccination center from 10am to 5.30pm daily. This is not my normal work, but we know vaccinations are important. I prepare food for the family before I leave, walk to come here and have all my duties for my children and house when I get home. If I had pay I could focus just on this work and hire a day laborer to do my work in the fields which I can barely do now. We are struggling to get by.”*

*Alina, Community Health Volunteer, Nepal, 2021*

# RECOMMENDATIONS

## **1. Governments must fulfill their commitments**

Governments have made commitments in various global fora including the 1995 Beijing Platform for Action and the SDGs<sup>83</sup> (SDG 8) to deliver safe and decent work and end unpaid work, especially for women.

## **2. Follow WHO 2018 Guideline for Community Health Workers<sup>84</sup>**

WHO guidance advises that community health workers, the majority of whom are women, should be compensated financially commensurate with their tasks and responsibilities.

## **3. Follow the ILO 5R Framework for Decent Care Work<sup>85</sup>**

The principles (see graphic below) are Recognize, Reduce, Redistribute, Reward unpaid work and the fifth is Representation through social dialogue and collective bargaining.<sup>86</sup> There are examples from India and Pakistan of unpaid and underpaid women health workers improving their position through organizing and collective bargaining. It can be a challenge for women to organize where unpaid workers have low levels of education and work remotely in their communities.

## **4. Enable women and girls to enter formal sector jobs**

The health and care sector is expanding globally, offering job prospects for young populations in low-income countries. Girls, however, must be enabled to finish secondary school so they are eligible to access training. Governments should also enable unpaid workers in the health system to train for formal sector roles in health, giving women particularly, a career path into the formal sector.

## **5. Count women and value their time**

Ensure women's unpaid work in health systems is recorded in health workforce data. This report could only estimate roughly the number of women and men working unpaid in core

health systems roles due to incomplete data. It is essential that unpaid workers are seen as workers and not as volunteers. Statistical measures of unpaid care work over time, such as time-use surveys<sup>87</sup> disaggregated by sex, age etc can guide policy makers on measures to ease the burden of women's unpaid work.

## **6. Donor agencies and NGOs funding health programs to ensure programs do not include unpaid work**

International agencies should check to ensure they are not perpetuating economic exploitation of women in health by funding programs reliant on women's unpaid work in health.

## **7. Follow good practice in incorporating unpaid health cadres into the formal economy**

Countries, including Ethiopia, have incorporated unpaid community health workers into the formal labor market with positive outcomes<sup>88</sup>, providing a precedent for other countries to learn from.

## **8. Make the investment case for ending unpaid work in health systems**

The pandemic has stress tested health systems everywhere and demonstrated the vulnerability of those dependent on unpaid work. Health must be seen as an investment with wider social and economic benefits, not simply a cost.

## **9. Support gender equal leadership in the health sector**

Although women are 70% of the health workforce, they hold only 25% of senior leadership roles.<sup>89</sup> Gender equal leadership can help confront the gendered myths and stereotypes that drive women's unpaid work in the health sector e.g., that the poorest women have 'free' time to work unpaid and that women are altruistic and happy to work unpaid. Women in unpaid health roles at community level express frustration at not being listened to. Health systems would be stronger based on their knowledge.

## The 5R Framework for Decent Care Work: Achieving a high road to care work with gender equality

Main policy areas	Policy recommendations	Policy measures
Care policies	<b>Recognize, reduce and redistribute unpaid care work</b>	<ul style="list-style-type: none"> <li>Measure all forms of care work and take unpaid care work into account in decision-making</li> <li>Invest in quality care services, care policies and care-relevant infrastructure</li> <li>Promote active labour market policies that support the attachment, reintegration and progress of unpaid carers into the labour force</li> <li>Enact and implement family-friendly working arrangements for all workers</li> <li>Promote information and education for more gender-equal households, workplaces and societies</li> <li>Guarantee the right to universal access to quality care services</li> <li>Ensure care-friendly and gender-responsive social protection systems, including floors</li> <li>Implement gender-responsive and publicly funded leave policies for all women and men</li> </ul>
Macroeconomic policies		
Social protection policies	<b>Reward: More and decent work for care workers</b>	<ul style="list-style-type: none"> <li>Regulate and implement decent terms and conditions of employment and achieve equal pay for work of equal value for all care workers</li> <li>Ensure a safe, attractive and stimulating work environment for both women and men care workers</li> <li>Enact laws and implement measures to protect migrant care workers</li> </ul>
Labour policies		
Migration policies	<b>Representation, social dialogue and collective bargaining for care workers</b>	<ul style="list-style-type: none"> <li>Ensure women's full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic and public life</li> <li>Promote freedom of association for care workers and employers</li> <li>Promote social dialogue and strengthen the right to collective bargaining in care sectors</li> <li>Promote the building of alliances between trade unions representing care workers and civil society organizations representing care recipients and unpaid carers</li> </ul>

Source: ILO A quantum leap for gender equality: for a better future of work for all, 2019

### 10. Join the Gender Equal Health and Care Workforce Initiative (GEHCWI)<sup>90</sup> led by France and Women in Global Health

The Gender Equal Health and Care Workforce Initiative, launched in 2021, aims to increase visibility, dialogue, and commitment to action on gender equity in the health and care workforce, focusing on safe and decent work, unpaid work and the gender pay gap, equal opportunities in health and care occupations, an end to violence and harassment and equal participation of men and women in the sector

in leadership and decision making. The Gender Equal Health and Care Workforce Initiative is convening the international community to implement existing global commitments and agree on practical steps to achieve gender equity in the health and care workforce. Governments, international agencies and NGOs are invited to support the Initiative which will focus on women's unpaid work in health systems, along with other gender equity issues.

**Contact:** [GenderEqualHCW@womeningh.org](mailto:GenderEqualHCW@womeningh.org)





# IN CONCLUSION

COVID-19 has put unprecedented stress upon health systems built on weak and unequal foundations. Women health workers in many countries have been applauded for their sacrifice and commitment, but they have not been rewarded with decent work and equality in pay and leadership. Many health systems have been further challenged by COVID-19 because they are desperately short of trained health workers.

Before the pandemic, it was forecast that an additional 18 million health workers<sup>91</sup> would be needed to deliver Universal Health Coverage by 2030. The pandemic has stretched health workers and health systems to the limit in most countries. Health workers have died from COVID-19 and millions have contracted 'long COVID' and have longer term health impacts from the virus. In addition, high-income countries, in particular, are experiencing a 'great resignation' of health workers, especially women nurses and midwives, who are leaving the profession due to burnout and mental exhaustion. The resignation of significant numbers of trained health workers in high-income countries is likely to drive unmanaged health worker migration from low-income countries, further weakening vulnerable health systems.

Against this backdrop, at least six million women are working unpaid and grossly underpaid in core health systems roles. These women, often referred to as volunteers, work outside

the formal sector and so do not benefit from the fair pay or wider benefits merited by the contribution they make. Health systems, more broadly, fail to harness the full potential of their knowledge and expertise since, as undervalued workers, these women rarely have a career path to progress to formal sector roles.

This is therefore the time to value every health worker and recognize the skills and experience of the millions of women who currently work unpaid. Rather than see them as volunteers, they should be seen as change agents who are the experts in their own communities. Creating decent jobs for all women in health would significantly contribute to achievement of the Sustainable Development Goals (SDGs) by 2030 and reduce the 18 million global health worker gap. Investing in women working unpaid to enter formal sector jobs in health would have the wider benefits of increasing gender equality and women's economic empowerment. New jobs created in health could accommodate young populations in low-income countries, fuel economic growth and strengthen health systems. But these new jobs cannot be created under the current system of inequality that exists between women and men in the workforce, and global health security cannot be built on the foundations of women's unpaid work. COVID-19 has exposed the cracks in an unequal system that we must put right to build strong and resilient health systems ready to face the next emergency.

## Economic justice for unpaid women health workers: realizing the "triple gender dividend"

Increasing economic opportunities for women in health will have wide benefits, enabling the expansion of the global health workforce needed to achieve global health goals including Universal Health Coverage, and realizing a triple gender dividend seen in:

1. **Better health:** fair pay, equal opportunities and decent work will attract women into the health profession and retain women health workers, helping to fill the 18 million global health worker gap.
2. **Gender equality:** investing in women to enter formal sector paid jobs in health will increase gender equality as women gain more income, lifetime economic security and decision-making power.
3. **Economic growth:** new jobs created in health will fuel economic growth and strengthen health systems and outcomes, all contributing to UHC and the SDG targets by the 2030 end date.

# ABOUT WOMEN IN GLOBAL HEALTH

Women in Global Health (WGH) is the fast-growing women-led movement demanding gender equity in global health. While women represent 70% of the workforce and about 90% of front-line health workers, they hold just a quarter of leadership positions. Now with supporters in more than 90 countries and 41 official chapters predominantly in low-income countries, Women in Global Health campaigns for equal representation for women in health leadership; equitable pay and ending unpaid work for women health workers; protection and safe and decent work; and the prevention of sexual exploitation, abuse and harassment. These are the essential foundations for strong health systems, Universal Health Coverage and global health security.



For more information: [www.womeningh.org](http://www.womeningh.org)

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