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Submission to
ILO General Survey on the Nursing Personnel Convention, 1977 (No. 149) and the Nursing Personnel Recommendation, 1977 (No. 157)
From Community Health Workers in India, Nepal, Pakistan, Philippines, Malawi, South Africa and Zambia

1. INTRODUCTION

This submission to the ILO General Survey (decent work for care economy workers in a changing economy) has been prepared with unions who represent Community Health Workers (CHWs) working in India, Pakistan, Nepal, South Africa, Malawi, Zambia and the Philippines, who are currently, or have previously been, excluded from formal recognition and regulation as public health workers. The unions are affiliates of Public Services International (PSI).

Over the last four decades, rural and urban communities in some low and middle income countries in Asia and Africa have been reliant on the work of CHWs for the delivery of primary public health care. With public healthcare facilities rarely reaching remote places and the growing trend of healthcare privatisation, these workers are the primary link providing primary care and basic healthcare facilities and vital information in communities who often have limited access to public services.

The 1979 Alma Ata Declaration on Primary Health Care (PHC) calling for more health workers and greater community participation, paved the way for a large expansion in the CHW workforce. CHWs assumed a greater range of functions, from health promotion to case management, delivering significant portions of countries' maternal and child health care delivery and achieving remarkable reductions in infant and maternal mortality.

With the exception of Pakistan, the CHWs covered by this submission, have been engaged as volunteers, receiving small allowances for their work, forming a large pool of informal public health workers and lacking rights provided for in the instruments under review.

1.1 Defining nursing personnel

'Nursing personnel' are defined within C149 and R157 to include 'all categories of persons providing nursing care and nursing services'. The recommended three-tier classification structure set out in R157 consists of professional nurses, auxiliary nurses, nursing aides.

The first two classifications align with the WHO's definition of professional nurses, reflecting the two ISCO-08 classifications of nursing and midwifery professionals (222) and nursing and midwifery associate professionals (322). The third category designated as 'nursing aides' encompasses much of the health workforce outside the definition of professional nurses. It should apply to some workers who fall into various World Health Organisation ISCO-08 categories including community health workers

(ILO 3253). These workers are often not recognised as workers and are instead engaged as 'volunteers', even though they are critical to the healthcare system and doing the work of nursing personnel.

The ILO classification 3253 includes many of the core tasks of CHWs working in the seven countries covered by this submission. The work is not covered by other public health workers and it is a required component of the public health strategies. Infant vaccination and maternal health monitoring, for example, are core public health strategies that must be delivered by paid health workers.
Unions representing Community Health Workers (CHW) contend that CHWs engaged in delivering core preventative and primary health services to the public, should be entitled to the rights elaborated in the Convention. The work of CHWs is routinely defined by the government (or local and municipal governments). The tasks they complete are directed by the public health department and the data they collect are provided to the public health system. Supervision may be by other, senior CHWs, but ultimately by public sector employees.

1.2 The status of nursing volunteers

The governments in South Asia South East Asia and in Southern Africa are engaging CHWs as informal public service workers under the name of *volunteer* or *honorarium workers*. As informal or honorarium-based CHWs, women's contribution to health care remains invisible, marginal and underpaid. Often it is not even recognised as 'work'. With the underlying gendered assumption, this informalised occupation or volunteerism is not counted as employment for women, but rather an extension of what women generally do in their homes and their communities.

In some of the countries (India, Malawi), CHWs receive micro payments for some of the tasks they perform (i.e. for each baby immunised or for each set of vitamins delivered). Performance-based payments violate workers rights to decent work and also undermine public health because activities with higher incentives become prioritised, resulting in healthcare that might not be responding to the communities needs (Roy, 2020).

Where volunteer work exists, it should never be used in place of a public workforce. ILO conventions should clearly limit the use of volunteers, ensuring they can never be used to undermine wages or working conditions.

1.3 Promotion of adequate quality health services

Across South Asia, south-east Asia and Africa, CHWs work in local communities, delivering basic treatment for a range of national health programmes, mobilising and creating awareness in communities. In a scenario of poverty, widening inequality and increasing informality, CHWs fill in for an understaffed healthcare workforce and inadequate financing for health services by subsidising the cost of health services and therefore supporting developing countries' economies (Roy, 2020).

The ILO estimates that at least 41.1 health workers are required per 10,000 population in South Asia, to provide essential services to all, but currently there is a deficit of 7.1 million skilled health workers (ILO, 2014). According to the ILO, 57 million "unpaid voluntary" workers are providing long term care work. There's a shortage of 13.6 million care workers globally (ILO, 2017).

Even before the current pandemic, in Africa CHWs have experience in bringing education, contact tracing and screening in epidemics such as malaria, cholera, TB, HIV/AIDS, Ebola. During the COVID-19 pandemic, society has acknowledged that CHWs contribute to the common good by working at the

frontlines of the battle against the outbreak and they have proven especially crucial in containing the spread of the virus in vulnerable communities (Alperstein, 2020).

The Indian frontline health workers have been demanding that the central government declare ***Covid-19 as an occupational disease and guarantee compensation for workers who contract the disease*** in line with the World Health Organisation and following ILO Conventions 155, 161 and Recommendations 164, 171 and 194. In addition to this, the other demands are to have adequate funding into the health sector with a minimum target 5% of the GDP for the rebuilding of public services and halting the trend of privatization and commercialization of health and other public services. In Zambia, while risk allowances were given to Health Surveillance Assistants, they were not given to CHWs. CHWs in South Africa and Malawi have demanded the supply of PPE. As they are not recognised as employees of the Department of Health, they are not prioritised despite being at the forefront of contact tracing and testing.

2) **NURSING EDUCATION AND TRAINING**

Given the wide-ranging roles and ever-increasing tasks of the CHWs, regular training with adequate logistical support is required. CHWs should also be entitled to ongoing professional skills development and training. To keep workers updated with evolving technologies and health approaches, frequent pre-service and in-service training and capacity building programmes are required, and the compulsory move towards digitalisation of health records also requires training that is not provided by authorities (Shanmugavelayutham, 2019).

CHWs are often not provided adequate training for their work. During the time of their induction in India CHW are provided training for 23 days, while in Nepal only for 18 days. The highest training is provided in Pakistan for a period of 3 months. Furthermore, post induction CHWs may not receive ongoing training or updates. In Malawi, CHWs employed by the government are required to have the secondary certificate and undergo a 12-week training programme. There is no such regulation for CHW's who work as volunteers and training is often on an ad-hoc basis, despite having similar obligations. In South Africa, there is also no standardised training for CHWs, who may be trained for 10 days, but in reality learn on the job. In Zambia, the government has standardised a 12-month training programme for Community Health Assistants under their employment. In the Philippines, Barangay Health Workers are provided opportunities to undergo training, education and career enrichment programs under the Department of Health and the Department of Education, Culture and Sports (DECS). A second-grade eligibility shall be granted to Barangay Health Workers who have rendered five (5) years continuous service.

The lack of training was most evident during the COVID-19 pandemic when CHWs were drawn into pandemic related work without training. Unions reported that CHWs were not trained on the basics of the virus and how it is contracted, nor were they trained regarding the safety measures to be undertaken as they were doing door-to-door surveys, contact tracing and testing. Much of the training was left to NGOs to provide such as in the case of Malawi (Alperstein, 2020).

One of the primary demands has been the development of guidelines and protocols for COVID-19 care, personal safety, infection risk management, and the mandating of PPE explicitly for CHWs to the same level as other healthcare workers. This training must be accessible in all local languages and means and inclusive to all members of the workforce and community.

3) **WORKING CONDITIONS**

3.1 Wages

Income for CHWs vary across countries and may include allowances, performance-based incentives and honorarium, to fixed salaries. The nature of incentives given to CHWs reflect the unequal labour standards and keep them distinctly separate from the rest of the public health workforce.

The situation in each country is detailed in the Box (table 1), below.

Country	**India**	**Nepal**	**Pakistan**	**Philippines**	**Malawi**	**South Africa**	**Zambia**
Designation	Accredited Social Health Activist (ASHA) and Anganwadi Women Workers (AWWs)	Female Community Health Volunteers (FCHVs)	Lady Health Workers (LHWs)	Barangay Health Workers (BHWs)	Health Surveillance Assistants (HSA), Community Midwife Assistance (CMAs), Interpersonal Communication Agents (IPCAs), and Community based Distribution Agents (CBDAs)	Community Health Workers (CHWs)	Community Health Assistants (CHAs) and Community Based Volunteers (CBVs)
Wages (yearly)	500 USD	250 USD	2250 USD	60 USD- 984 USD	1936 USD	2987 USD	793 USD
Population covered by one CHW (CHW: population)	1:1000	1:600	1:1000-1200	1:120	1:1000	1:1000	1:3500
Recognition	Volunteers	Volunteers	Public Health Workers	Volunteers	Both public health workers and volunteers	Majority volunteers	Both public health workers and volunteers
No of CHWs	1007054 ASHAs 1302617 AWWs	53000	125,000	196562	HSAs: 12000	60000 (approx)	1367 CHAs 10,000-100,000CBVs

	3700 Community Health Volunteers						

Table 1: Community Health Workers Worldwide

In Pakistan, Lady Health Workers (LHWs), have had the most success in unionising and shifting the status of workers who are now recognised as public health workers. They are paid the equivalent of USD 2250 per annum. In India and Nepal, the rate may vary according to state and municipal government allowances but is approximately USD 500 per annum in India and USD 250 per annum in Nepal.

India

In India, community health workers are commonly referred to as Accredited Social Health Activists (ASHA) and declared as honorary volunteers. They are either paid an honorarium, performance-based incentives or a fixed amount. States are given flexibility to fix the incentives. There have been frequent cases of irregular and inadequate payments. Local government officials sign off on the allowances payable and, unlike public employees who receive monthly set wages, the vouchers are routinely delayed. Evidence shows that the current budgets of most municipal hospitals and state hospitals are too small to provide legal wages to all workers. In India, the state government and central government has formalized the significant role of ASHAs in containment and community outreach, highlighting once again their role as an essential workforce of the state health system. However, the government guideline does not provide additional budgetary allocations[1].

For example: The **Community Health Volunteers of Mumbai** have reported several instances where the officials would often mark their work as **unsatisfactory** without citing any reason. The workers lose out on the entire month's wage if they are unable to attend work for 7-8 days in a month.
In April, 2020 after hailing the work done by the CHWs in India, the government of India, announced a Covid incentive of Rs 1,000 a month to be paid from January to June, 2020 to ASHAs for their essential Covid-related work under the India Covid-19 Emergency Response and Health Systems Preparedness Package. The order also directed state governments to ensure that their regular honorarium of Rs 2,000 be paid along with the task-based incentives such as immunisation and ante-natal care. But the workers still await those payments[2].

Nepal

The Female Community Health Volunteers (FCHVs) are unpaid, they do not receive honorarium and instead receive limited allowances. They are provided non-wage incentives annually like dress allowance, travel, communication allowance and certain task-based allowances or festival allowance depending on the districts and municipalities.

[1] https://www.thehindu.com/news/national/tamil-nadu/it-is-all-work-and-little-or-no-pay-for-asha-workers/article32768228.ece

[2] https://www.article-14.com/post/promised-mostly-never-paid-rs-1-000-covid-wage-to-million-health-workers
https://indianexpress.com/article/cities/chandigarh/covid-management-in-punjab-villages-asha-workers-wait-for-pending-incentives-7310068/

Earlier, under the federal structure of governance allowances for certain campaigns like vitamin capsule distribution, they received allowances on the same day. But with the FCHVs coming under the local level of governance, payments are delayed by months. A 15% tax is also being deducted as taxes from their annual allowances, even though this is not paid as an income.

During the Covid-19 pandemic, the Government of Nepal had declared that 52000 FCHVs would be mobilised and provided NPR 1500. But the local level governments unwilling to pay the paltry amount to FCHVs, mobilised local cadres from the communities for collection of data on migrant workers and contact tracing, they were paid NPR 196 as COVID allowances.

Pakistan

After a long, resilient struggle by the Lady Health Workers unions, LHWs won recognition and regularisation as public health workers in 2018. They are paid above the minimum wages for unskilled workers (89.26 USD), along with other allowances and safety benefits. But the salary payments are irregular. However, the wage is much lower than a living wage or considering the amount of work that they are required to perform.

Philippines:

The government definition of a Barangay Health Worker (BHW) is "a person who has undergone training programs under any accredited government and non-government organization and who voluntarily renders primary health care services in the community upon accreditation by the local health board and in accordance with guidelines of the Department of Health".[3]

The Barangay (local government) health workers receive a monthly honorarium that ranges from 250 PHP (5 USD) to 4,000 PHP (82 USD). They are classified amongst the lowest rung of workers, volunteers who are paid an honorarium. The BHWs provide essential public health support and also provide critical public education and information.

Southern Africa

Southern Africa is a region with high poverty, unemployment and rural populations which have little access to infrastructure and public services. In such instances, CHWs are the backbone to community health where clinics and hospitals are not easily accessible. For very poorly developed countries like Zambia and Malawi, CHW's who have been incorporated into the health system are paid a salary, while volunteers are not. In South Africa, the struggle for permanent work is ongoing.

South Africa

In South Africa, there are nine provinces responsible for recruitment and hiring of CHWs. In one province, Gauteng, CHW's won their case through legal action for permanent employment with a salary. It is hoped that other provinces will follow this example.

In South Africa, in six provinces the majority of the CHWs are employed on annual contracts with the Department of Health and earn a salary of ZAR 3500 which is 5 times less than the next ranking category of health workers (assistant nurses). In two provinces are contracted through NPOs by the Department, but the salary remains ZAR 3500. In one province, Gauteng, all 8500 are permanent workers earning a salary of ZAR 8544,50 along with medical aid, housing allowance and pension.

[3] http://web.csc.gov.ph/

Malawi

There are four categories of CHWs in Malawi. Health Surveillance Assistants number at approximately 12000. They are employed by the government and earn a salary of MWK 130000. About 700 young women were recruited and trained for 18 months as Community Midwife Assistance (CMAs), but only 200 provided employment on a salary grade lower than Health Surveillance Assistants (HSA's). Interpersonal Communication Agents (IPCAs) are contract CHWs employed by NGOs. They are remunerated on a performance basis, and can do a maximum of 50 referrals a month, earning MWK 26000 (MWK 150 per session). They also obtain allowances for transport and communication at MWK 25000 and MWK 6000 respectively. Finally, volunteer CHWs known as Community based Distribution Agents (CBDAs) provide health education work in the communities, on issues like HIV and family planning. Training is ad-hoc and there is no proper record of how many CBDAs there are in the country.

Zambia

In Zambia, Community Health Assistants undergo a 12-month training programme. The scope of work includes primary health care, disease prevention and control, environmental health as health promotion and behavioural change. They earn a salary of ZMW 2600. Community Based Volunteers on the other hand are paid a stipend and may earn between ZMW 700 and ZMW 3000.

Working conditions

Often CHW are overworked and responsible for providing care for more people than they can manage or are paid for. In India, "1 ASHA per 1000 population", is assigned to approximately 200 households. In Nepal, 1 FCHV per ward is responsible for a population of 600-800; 115-231 households in rural areas. In Pakistan, 1 LHW serves an average of a 1000 population, 115-231 households.

When governments treat CHWs as volunteers, and not critical public health workers, they are exposed to higher levels of risk, harassment and marginalisation. CHWs have reported several instances of verbal abuse, physical, mental and sexual harassment. Especially with the COVID-19 pandemic, CHWs have faced heightened instances of stigmatisation and discrimination by individuals within the communities they live in and work with[4].

There have been several reported instances, especially during this Covid-19 pandemic, where CHWs working experience showed that they have made personal adjustments at times to the detriment of their own health and livelihoods.

ASHA workers have been acknowledged as "*corona yodha* (warrior)" but have not received recognition as workers, "Instead, we are being threatened of a pay cut if we don't achieve the difficult targets set up every day" [5].

In Nepal, during the Vitamin Campaign, one of the FCHVs, slipped from the mountains, leading to the loss of her life. Her family hasn't received any compensation yet from the government.

[4] https://thelogicalindian.com/trending/asha-assault-up-28786

[5] https://thewire.in/rights/unsafe-working-conditions-lost-livelihood-how-marginalised-communities-struggled-in-the-pandemic).

LHWs being public sector employees in Pakistan are entitled to leave, while they were earlier given only 20 days of leave, now they are entitled to 90 days leave, along with maternity leave. The CHWs in Nepal and India do not enjoy any such leave. They are not even entitled to the basic right of maternity leave. If a CHW wishes to take a maternity leave, they will lose their job permanently, thus forcing CHWs to work throughout their pregnancies putting their own health at risk. Being a health worker means they do not have the right to their own health.

In Malawi, Health Surveillance Assistants (HSAs) work with an expected ratio of 1 HSA to every 1000 people but often they serve an even bigger population. To meet that ratio, Malawi needs an additional 7000 HSAs (Malawi Government, 2017). This ratio is even higher in Zambia where CHWs are assigned to a health post serving a population of about 3500 people. The health post should be staffed by a trained health professional such as a nurse or midwife. The health posts are linked to a parent health centre.

Inadequate supplies have been an issue in Malawi especially during the Covid-19 pandemic, with PPE and Covid-19 protocols not always being available for frontline workers such as CHW dealing with Covid-19 patients (Delgado et al., 2020).

In South Africa, the situation is similar. The current policy proposal is for CHWs to work in Ward Based Outreach Teams (WBOT) which would be staffed by an Outreach Team Leader (usually a qualified nurse) 6-10 CHWs and a data capturer. Each WBOT is responsible for serving a population of 6000 people. CHWs also did not have adequate access to PPE in 2020 while doing Covid-19 contact tracing and testing, and this struggle for PPEs continues[6].

3.2 Gender pay gap

In South Asia and Southern Africa, CHWs are predominantly women and are paid much less than legal minimum wage, except in the case of Pakistan where the workers after a long battle have won recognition as public health workers in 2018.

70% of the world health workforce comprise of women, yet the health sector is burdened with gender discrimination and inequity. Only 25% hold senior roles, with women seldom being in positions of power. Women's work is made invisible through the formal unpaid or underpaid work and the government's claim of them being volunteers. There's a steady feminisation of the workforce, that spares the countries from investing in the workforce, premised on the belief that women anyway do care work. The public health sector is heavily subsidised by the CHW programmes in the region that is itself designed to be dependent on the underpaid and unpaid labour of women, thus further compromising women's work pushing them downwards to comprise the lowermost section of workers.

The lack of recognition as workers prevents them from receiving minimum wages and being covered by the country's labour laws. This enables the government to make cuts into the healthcare expenditure at the expense of the rights of these workers, contributing to the inequalities and deepening the gender wage gap.

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6 https://health-e.org.za/2020/08/18/community-health-workers-bolstering-covid-19-screening-left-vulnerable-without-ppe/

Of the approximate 50 – 60,000 CHWs in South Africa, over 90% of CHWs are women, mostly black women working, living and working in economically constrained communities. In South Africa CHWs are paid more than 5 times less than the next ranking category of health workers (assistant nurses). The flat rate 'stipend' of R3500 (~250 USD) per month is well below a decent living wage.

3.3 Working hours and workloads

56% of the global rural population lacks health coverage as compared to 22% of the urban population. These serious inequities are compounded by health workforce shortages. There is a deficit of 7 million skilled health workers in the rural areas and 3 million in urban areas to deliver quality health care (ILO, 2015)[7].

The pattern of CHWs work in the countries across South Asia shows that apart from working on maternal and child health related services, they are now being gradually moved to immunisation and a wide range of activities related to TB, malaria, HIV/AIDS, childhood diseases and non-communicable diseases.

In India the tasks of CHWs have increased along with other responsibilities like record keeping of home visits, accompanying patients to primary health care and hospitals. They mostly work overtime without compensation to fill in the paperwork and are on-call 24 hours in case of emergencies in their communities.

Similarly, in Southern Africa due to the shortage of health staff, CHWs have also faced increased workloads. Under normal working hours, CHWs in Malawi work 40-hour work weeks but due to task-shifting they are often forced to fill in for staff shortages and take on additional tasks (Kok and Muula, 2013, Smith et al. 2014). This may include cleaning work, caring for patients in wards, assisting patients suffering from malaria, TB and cholera and administrative work. In Zambia too, CHAs often have to fill in for health workers or to manage health posts on their own due to staff shortages. Thus they are unable to meet their expectations as the work loads are too high.

A serious concern of CHWs in all three Southern African countries is the lack of supervision and oversight. This means they work long hours, with no supervision, no clear job description, and no one to report their concerns. Without supervision and oversight mechanisms, they are isolated, and have no one to address their concerns. For example, transportation is a big impediment to work, where CHWs need to reach very rural areas, or areas without proper public transport in Zambia, Malawi or South Africa.

Digital surveillance

In one of the states in India, Haryana, the ASHA workers have been asked to download a surveillance app MDM-360 shield app on their phones. The MDM-360 shield has been developed by the government for tracking and updating daily targets of ASHA workers. The operational part is that the app will allow senior officials to track the ASHA workers and also add/delete information on the handsets provided by the department.

[7] https://www.ilo.org/global/about-the-ilo/newsroom/news/WCMS_362525/lang--en/index.htm

The workers unanimously declared the surveillance app as a breach of their privacy that will make them further vulnerable to greater scrutiny and harassment from officials and have been actively fighting against its imposition. The workers have staged protests and returned their smartphones to the health department claiming their right to privacy[8].

Increased workload during Covid-19 pandemic

With the onset of the pandemic, the CHWs were deployed for COVID-19 related activities along with their regular task-based work. In India, they were involved in contact tracing as well as building community awareness of the virus. They conducted door-to-door surveys of 30-50 households every day without proper PPE asking people if they had travelled or were feeling unwell. If anyone had any symptoms, they had to take them to the hospital for testing. With the vaccine rollout, CHWs have also been involved in vaccine awareness campaigns, without any compensation for the extra work.

In Nepal, FCHVs used loudspeakers to tell people to wash their hands and social distance and did their own research to keep their communities safe. In Pakistan while the country was under lockdown and people were not going to their offices, LHWs were out on the streets providing information and support to make everyone safe. Yet they were not given any PPE, sanitizer, or compensation. It was only after a long strike that the government agreed to pay a monthly allowance.

3.4 Job security

Considered to be working as volunteers, the workers are not covered under labour laws and they are the most precarious workers of the public health system. During the Covid-19 pandemic, there was immense pressure from the administration on CHWs to work. If unwilling to work, they were told that they would have to resign, and the administration would take someone else[9].

The CHWs across the states in India have been complaining of harassment at their workplaces by senior and health officials. While demanding better pay, protective gear during the Covid-19 pandemic, and fixed tenures, Haryana and Delhi filed police cases and Madhya Pradesh threatened dismissal of the CHWs[10].

CHWs are also mostly women workers who work in communities and have to enter people's homes without a colleague. There have been safety concerns where CHWs have been physically, sexually or verbally assaulted by community members. Such cases have been reported in South Africa, The Covid-19 pandemic also highlighted the vulnerability of CHWs, as stigmatisation and fear of the pandemic saw CHWs harassed and or abused as communities were scared to be tested,or feared getting Covid-19 by coming into contact with health workers[11].

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[8] https://timesofindia.indiatimes.com/city/gurgaon/privacy-concerns-asha-workers-to-shun-track-app/articleshow/83470224.cms

[9] https://thewire.in/society/covid-19-india-frontline-health-workers
https://thewire.in/rights/unsafe-working-conditions-lost-livelihood-how-marginalised-communities-struggled-in-the-pandemic

[10] https://www.article-14.com/post/3-states-wage-war-against-india-s-female-corona-warriors

[11] https://www.spotlightnsp.co.za/2020/05/21/covid-19-concerns-mount-over-covid-19-stigma-in-kzn/

3.5 Occupational health and safety

CHWs have shown incredible resilience and courage in the fight against Covid-19, despite facing disregard for their occupational health and safety, including the failure of governments to provide adequate PPE or training resulting in CHWs risking their lives to help others**.**

CHWs have been facing a number of issues relating to their workplace safety. Without an assigned workplace, they are often left to fend for their own. There has been several reported instances sexual harassment and workplace violence and harassment meted out on the CHWs across countries.

With a right to safety and health, CHWs' unions have been demanding that CHWs should not be discriminated and forced to work under unsafe working conditions, under the pretext of not being recognised as workers or not being important in the health chain. Governments should recognise they have an obligation to ensure a work environment free of harassment and violence. A blame-free environment where CHWs can report instances of harassment and violence or issues relating to work safety conditions and measures should be ensured without the fear of reprisals.

In Malawi, it was only after protest action by CHWs with the support of other frontline workers, that the government agreed to provide PPE to CHWs, but it was restricted to only government employed HSAs.

In South Africa, CHW have not been protected during the Covid-19 pandemic and have often not been provided with PPE or been registered by their employers with the Compensation for Occupational Injuries and Diseases Act, (COIDA) No 130 of 1993. One of the ongoing demands of CHWs in South Africa has been to be included in the Occupational Health and Safety Act which would entitle them to compensation if injured on duty.

In India, the government introduced life insurance coverage for frontline workers who had died due to COVID-19 or while on COVID-19 duty, as part of the Pradhan Mantri Gareeb Kalyan Yojana (Prime Minister's poor welfare scheme). However, in March 2021 the government issued a circular to end the insurance, leaving the workers to fend for themselves. After unions protested, the government extended it for another year. However, the majority of claims made by the families of frontline workers have been rejected or are still pending[12].

3.6 Social security

One of the major concerns facing CHWs who have worked, in some cases, for two decades, is the lack of pension and health insurance. While they have looked after the community, they fear that they will be left without access to any form of livelihood or access to quality health care.

[12] https://theprint.in/opinion/asha-workers-are-hailed-as-covid-warriors-but-only-62-have-gloves-25-have-no-masks/506623/
https://indianexpress.com/article/cities/mumbai/cotton-masks-poor-safety-equipment-incentives-319-ashas-infected-with-covid-6598990/lite/#referrer=https%3A%2F%2Fwww.google.com&_tf=From%20%251%24s)

Beyond the incentives, the ASHAs are not provided access to social security schemes such as medical, life insurance, maternity leave, educational support for the children, except the states of Jharkhand, Assam, Kerala, Chhattisgarh in India. Similar is the case with the FCHVs of Nepal.

In Malawi, HSAs are expected to reside in their catchment areas. The government has provided better housing for clinicians, nurses and medical assistants in hard to reach rural areas without proper electricity, running water and basic services. This support is not provided to HSAs.

In the Philippines, BHWs have no social security unless they voluntarily pay for their pension fund through the private fund SSS or voluntarily pay their PhilHealth contributions for their hospitalization and health benefits. They can also contribute to the Home Development Mutual Fund or commonly known as Pag-Ibig Fund, a national savings program and affordable shelter financing that is a government-owned and controlled corporation. However, all these schemes require a lot of personal financial capacity which is a burden for all BHWs.

5) **SOCIAL DIALOGUE**

Social dialogue is an integral component of the ILO decent work agenda, however decisions and policies relating to the role of CHWs have largely been made without involving CHWs. Public health policies are always improved when workers have a voice, and CHWs can provide invaluable information about the reality of delivering community health. A **democratic voice through tripartite discussions involving unions in all relevant decision-making processes, is required.**

Article 1.3 of the convention specifies that decisions to allow volunteer labour should be made in consultation with workers' organisations. The unions representing Community Health Workers in the countries involved in this survey, have not given consent to the use of volunteer labour.

Despite countries' reliance on CHWs in the pandemic, their unions and organisations have been left out of government consultations and decision-making platforms. For example, Civil Society Organisations were excluded from the Cabinet Taskforce on COVID-19.

In the Philippines, BHWs do not have the right to organise and form a union. They are not allowed to organize their own union, therefore, they cannot negotiate and thus have no bargaining power. Only recognised regular employees can join or form their own union in the country.

In South Africa, CHWs and their trade unions have been left out of collective bargaining processes. One union did not meet the required membership threshold to be included in the Public Health and Social Development Sectoral Bargaining Council because CHWs are contract workers and therefore 'abnormal appointments'. So while the main Public Sector Coordinating Bargaining Council recognised the union with it's full membership, at sectoral level, they are unable to represent CHWs[13].

[13] https://nupsaw.org.za/index.php/2020/08/24/nupsaw-welcomes-partial-victory-for-gauteng-community-health-workers-chws/

6) ENSURING COMPLIANCE

The exclusion of CHWs from the formal workforce means that there is no monitoring of compliance with international labour standards. Labour inspectors do not monitor the work of CHWs, including in relation to Occupational Health and Safety.

There have been legal decisions in favour of CHWs that have not been implemented. The 45th Indian Labour Conference in 2013, recommended that all scheme workers be provided with minimum wages, social security and pension. But this has not happened.

There are 3700 Arogya Sevikas/Community Health Volunteers (another form of CHWs) employed by the Municipal Corporation of Greater Mumbai. They are the primary link between the communities and the public health system, delivering all the essential health services in the area. After an enduringly long fight by the union, in the month of September, 2020, an order for payment of minimum wages, as per the Minimum Wages Act, 1948 along with payment of Rs. 32. 87 crores as arrears from 2015-16 by Bombay Municipal Corporation (BMC) was passed by the state labour commissioner's office. The claim was filed by the union in 2016. However, the BMC is yet to implement the order. Meanwhile, BMC as a tactic to delay the implementation that would lead to the path of being recognised as public sector workers, in a circular in 2020 declared the CHVs as vendors who would be taxed under the Income Tax Act as independent vendors[14].

8) What are the challenges and inadequacies in the current ILO standards and how should they be addressed?

The two major inadequacies, from the perspective of CHWs, are, first, that the instrument has inadequately defined Nursing Aides and it must make it clear that CHWs who undertake elements of nursing aide work, are included. Second, the instrument includes provisions for volunteers which governments may use to justify the continuation of arrangements that deny CHWs the right to decent work.

The instruments do have value but need to be amended and / or supplemented by a specific instrument covering CHWs.

Public Services International has launched a campaign for Community Health Workers in South Asia: Community Health Work is Work!

- Joint Demands of Community Health Workers in South Asia
- Fighting Covid on the frontlines: Stories of South Asia's Community Health Workers
- A day in the lives of South Asia's Community Health Workers

[14] https://publicservices.international/resources/news/community-health-workers-in-mumbai-win-their-right-to-social-security?id=10171&lang=en

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