

COMMUNITY HEALTH WORKERS:

GENDER, WORK AND REMUNERATION -

A STUDY OF SOUTH ASIA

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Abbreviations:

ASHAs	Accredited Social Health Activists
BRAC	Bangladesh Rural Advancement Committee
CHWs	Community Health Workers
FCHV	Female Community Health Volunteer
GAVI	Global Alliance for Vaccines and Immunization
Gol	Government of India
HEVON	Health Volunteers Organisation of Nepal
HV	Health Volunteer
ILO	International Labour Organisation
LHW	Lady Health Worker Programme
MDG	Millennium Development Goals
NEVA	Nepal Health Volunteers Association
NORAD	Norwegian Agency for Development Cooperation
PBI	Performance Based Incentive
PHC	Primary Health Care
PSI	Public Services International
RBF	Result Based Financing
SS	Shasthya Sebikas
USAID	United States Agency for International Development
WHO	World Health Organisation

Abstract

Most countries in South Asia rely on large scale public sector-led Community Health Workers (CHW) programs to provide promotive and primary level care to their rural and economically weaker communities. Thus acting as an essential link between the public health system and the community. CHWs are most often not considered by the state as formal employees of the public health system.

This study explores how women are engaged as CHWs for health-related work at the community level in the five South Asian countries (India, Nepal, Bangladesh, Pakistan and Sri Lanka). It is through the mapping of the different CHW models existing in South Asia their nature of work and terms and condition is explored in each of the settings. The paper explicates these specificities and commonalities of these CHW models through the three central themes i.e. gender and community health workforce; voluntarism and payment mechanism, and task shifting within CHWs programmes in South Asia. It aims to contribute to the debates on ways to optimise CHW programmes with an aim of quality healthcare for all with decent work for CHWs.

Keywords: Community Health Workers, South Asia, Volunteer Health Workers, Payment Norms, Working Condition

I. BACKGROUND

Community Health Workers (CHWs) programmes draw inspiration from the Barefoot doctors that reached more than 800 million people in China in the early 1970s. In the later decades, the inability of biomedicine to reach the rural, poor and marginalised population demanded means to reach out to these sections. This was also the time when *Health by the People* with CHWs as agents of community health programmes gained credence. Africa, India and Indonesia in the 1960s, 1970s and 1980s respectively saw the expansion of CHW programmes.

In early period, CHW programmes were shaped by a service-oriented agenda as well as by an agenda of transformation of the community (Perry, 2013). However, these programmes were on the decline by 1980s and 1990s due to multiple factors. During this time both financial and political support declined, partly due to Structural Adjustment Programmes and privatisation of health care. Subsequently comprehensive PHC and large-scale CHW programmes came under pressure. At the same time selective PHC¹ and the push for techno-centric hospital-based health care (Perry, 2013; Qadeer, 2011) gained renewed credibility. It is in this context and the then limited knowledge about CHW programmes impact (Frankel as in Perry, 2013) a section argued CHW programme as ‘second class care’ (ibid). Another factor that undermined CHW programme was its need for greater supervisory inputs.

In this millennium, compared to the seventies and eighties, there is a marked shift in the perception of the relation between CHWs and the community. In that period, CHWs were seen as more responsive to the community. In 1986, in an interregional conference at Yaounde,

¹ Selective PHC took away the focus from the communities. It reintroduced vertical healthcare programme i.e. single- disease based medical interventions. (For detailed reading refer Qadeer, 2011; Magnussen, et.al., 2004; Hall and Taylor, 2003)

Cameroon organised by WHO came with the most widespread definitions of CHWs² as

“(they) should be members of the communities where they work, should be selected by the communities should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its the organization, and have shorter training than professional workers (WHO, 1989)”.

In the nineties, the international community became less supportive of the CHW programmes, even though in 1995, a WHO meeting in Myanmar acknowledged the presence of strong CHW programmes in Africa, Asia and Latin America (Kahssay et al., 1998).

Now-a-days CHWs are increasingly being considered as a conduit between the community and the formal health service system. Gradually they began taking up roles that the formal health system and the community cannot take up alone (ibid). CHW programmes have gradually adopted this pragmatic approach in their framework. This is adapted in the context of over all large scale privatization of healthcare in South Asia that undermines the economic security of health workers particularly women health workers and relates workers performance issues to their income.

In 2000 the political support to CHWs and the recognition of their contribution was revitalised with 189 countries signing the UN Millennium Declaration to achieve the eight MDGs. It was expected that CHWs could especially contribute to health related MDGs, namely to reduce child mortality (MDG4) and to improve maternal health (MDG5). The possible way to do this was through alternative

² For information on WHO's role in promoting Community Health workers at the international level refer to Lehmann, U and Sander, D (2007) Community health workers: What do we know about them? The state of the evidence on Programmes, activities, costs and impact on health outcomes of using community health workers, WHO, Geneva.

workforce cadres and task shifting. The World Health Report (2006) acknowledged the potential of CHWs to address health workforce shortages and their ability to do different tasks at the community level. During this time there was a shift in CHWs role from 'advocates for social change' to that of doing 'technical and community management function' (Lehman and Sanders, 2007). This is furthered through an emphasis on the provisioning of curative care and supporting healthcare professionals (ibid).

'CHWs are trained to carry out one or more functions related to health care. CHWs may receive training that is recognized by the health services and national certification authority, but this training does not form part of a tertiary education certificate (Lehman and Sanders, 2007).'

The Kampala Declaration and Agenda for Global Action (March 2008) recommended to scale up CHW programmes in resource limited countries 'alongside highly skilled staff' (WHO, 2008). With multiple 'stand-alone CHW programmes' for HIV care, childhood development and maternal, neonatal and child health care (Tulenko et al., 2013), the persisting stagnation of health expenditure, and shortage of professional health care workers, is very relevant for South Asia. The ILO estimates that at least 41.1 health workers per 10,000 population are necessary to provide essential services to all in need. There is a deficit of 7.1 million skilled health workers in Asia (ILO, 2014). The other reason why CHW programmes have seen a resurgence in low-income resource countries in this past one and a half decades is the drive for universal healthcare coverage, and revival of large scale of CHW programmes to access the remotest and poorest population (Tulenko et al., 2013).

The dominant literature on work in health and social services sector has looked at paid employment in the public sector and home-based care work (unpaid or paid). The existing literature on work within the health sector has little looked at formal voluntary work, self-

employment and informalisation within CHW programmes, the debate on remuneration and the gendered aspect of this work. These marginalised forms of labour within the hierarchy of healthcare work actually make significant contributions to the health sector, economy and gives them a sense of career but with limited upward mobility. CHWs programmes have been studied but very less through the lens of workers and of different work relations: paid, unpaid, formal and informal and models of remuneration.

This report explores the specificities of CHWs work in the South Asian context. This paper examines CHWs work in South Asia (Bangladesh, India, Nepal, Pakistan and Sri Lanka) using the three interconnected themes i.e. i) Gender and CHW ii) Volunteers, Informal Workers and Payment iii) Task Shifting. The sections III to VI develops comparative understanding of CHW programme models in South Asia through the analysis of CHWs' work, its nature and working conditions. The last section discusses and concludes that there is now a need to move beyond the discourse of community recognition of CHWs and to recognise CHWs in South Asia as workers with decent and dignified employment.

II. THE THREE THEMES

Health sector context

In South Asia, the government spending on health as a percentage of GDP ranges from 0.8 in Bangladesh to 2.3% in Nepal (Table 1). This figure has marginally increased in India, Pakistan and Sri Lanka, but remains low compared to the WHO standard of 5% of GDP. Nepal has increased a bit more significantly but remains below the WHO benchmark. Bangladesh is the only country where this indicator has worsened compared to 1995. Sri Lanka is the only country in the region where government expenditure is more than private expenditure and has the lowest out of pocket expenditure (as a percentage of total health expenditure) in the region (Basu, 2016).

Similarly, it is the only country in the region where the health system remains public-led, especially when considering hospitalisation.

This lack of funding has contributed to the shortage of healthcare workforce in core and peripheral health facilities. The share of employment in the health sector in Asia and the Pacific is lower i.e. around 2.5% with the presence of informal workers in the health sector and an over-reliance on CHWs in India (ILO, 2018; 2019). Except for Pakistan, in the other four South Asian countries CHWs are working as volunteers who contribute to forming a large pool of *informal public services workers* with the government or as dependent self-employed³ with the private sector as in Bangladesh.

Table 1: Health Expenditure in South Asia

South Asia Region	Health Expenditure, public (% of GDP)		Health Expenditure, public (% of total health expenditure)	
	1995	2014	1995	2014
India	1.1	1.4	26.2	30.0
Pakistan	0.7	0.9	26.2	35.2
Nepal	1.4	2.3	26.5	40.3
Bangladesh	1.2	0.8	37.2	27.9
Sri Lanka	1.6	2.0	47.0	56.1

<http://data.worldbank.org/indicator/SH.XPD.PUBL.ZS>

<http://data.worldbank.org/indicator/SH.XPD.PUBL?end=2014&start=2014&view=map>

i) Gender and Community Health Workforce

There is a ‘clear gender dimension to both formal and informal care systems with women being appointed at the lower end of the hierarchy with poor salaries’ (Standing, 2000) with lower educational

³ Dependent self-employment – Worker performs services with an employee under contract. They depend on a small number of clients for their income. They may receive direction regarding how the work is to be done. It is also defined as disguised employment (ILO, 2018).

background, and little or no job security, as is the case of CHWs (George, 2008). In South Asia CHWs are predominantly women, are paid much less than the legal minimum wage, except in the case of Pakistan where they are now government employees. CHWs working experience shows that they made personal adjustments 'at times to the detriment of their own health and livelihoods' (ibid).

Worldwide, the composition of CHW programmes is 70% women, with 18% comprising of both women and men, and 12% of male CHWs (Lehman and Sanders, 2007). In 1997, in India, there was a policy to gradually shift from male CHWs (Village Health Guides) to women CHWs (Prasad and Muraleedharan, 2007 and UNICEF, 2004). With the launch of the Reproductive and Child Health Programme in 1997 in India women became the new target of recruitment⁴ for this role and male CHW programmes were discontinued. In Nepal from the seventies onwards, women were recruited as CHWs. Women CHWs are appointed with the underlying gendered assumption that they can do maternal health programmes, the community will easily identify with them and behavioural change can be brought through them. Yet, in Tanzania for instance, the mixed composition of CHWs did not affect the programme. This can be explained by the fact that the gender composition of CHWs is shaped by social beliefs, practices and gender relations in the community (ibid). In addition, CHWs do a wide range of work varying from semi-skilled to skilled work like documentation of different kinds of data that does not correspond to the gendered role assigned to women.

Increasingly governments in South Asia and in Africa are engaging CHWs as informal public services workers under the name of (formal) volunteers or honorary workers. As informal or honorarium-based CHWs, women's contribution to healthcare remains hidden, marginal

⁴ Gradually Male Village Health Guides (CHWs) were made to fade out and Women were recruited in their positions. Male VHGs did organize themselves in different states to claim their rights, which led to difficulties to run the program in the face of the government's reticence to respond to their demands. Until the end of VHG programme 80% of them were men (UNICEF, 2004).

and sometimes not recognised as skilled. Over the past three decades there have been studies on domestic labour by feminist researchers but very little on the aspect of informal work in the social sector (healthcare) within the public sector, thus a formal set up. Such informalised activity or voluntarism is not counted as a source of employment where women are engaged and increase the availability of cheap labour as Morel (2007) argues. Morel highlights that low-skilled and low paid work is being created in India mostly for women by the public health care system. Since the normative definition of work takes into consideration only the full-time aspect that is paid and has a career path; it does not acknowledge informalised work by women within the arena of community health care created by the public sector.

At the policy level, it is important to address the gendered experiences of CHWs as in many places CHW programmes are being scaled up to improve access to healthcare services, responsibilities are increased through the inclusion of services related to non-communicable diseases (NCDs) and, in the process, CHWs are pushed to increase their workload and responsibilities within formal health systems.

ii) Volunteers, Informal workers and Payment

Volunteering is defined by the International Labour Organisation (ILO) as “unpaid non-compulsory work; that is, time individuals give without pay to activities performed either through an organization or directly for others outside their own household” (ILO 2011). As Anherier (2005) says, when this happens within the structures of a ‘formal organisation’ it is then formal unpaid work, separating this from free volunteerism. We see a continuity regarding unpaid labour from the family into the community (and thus in society). The way women’s household work goes unrecognised and is taken as a duty; similarly, CHWs work is also not accounted for in either the GDP or as employment. Gendered nature of voluntarism can be also associated with the belief that it is a woman’s natural capacity to carry out care

work for the children and elderly. This is thrust onto the women, limiting her agency to choose work or volunteerism. Within the large canvas of volunteerism, it is important to understand who, where and why one volunteer. Through formal unpaid or underpaid work or government's terminology of volunteers, not only are women's work in the public sector invisibilised, rather feminised work and gender based power relation are embedded. Formal underpaid work stops women from entering into the formal labour market and act as means to maintain a free labour force. Thus, the state spares itself from investing in the workforce and is subsidised through the underpaid work of women or underpaid labour premised on the belief that women would obviously do care work (Denton et al. 2002, Baines 2004).

Increasingly in the public sector, we find a growing role of work termed as 'voluntary' which stands between ambiguous spaces of paid and unpaid work. Gradually CHW programmes want a certain amount of task to be done by CHWs. In the long term, it is unethical, unjust and unsustainable. At the Yaounde Conference (WHO, 1986) it was concluded that "it may be unreasonable, if not unfair, to expect individual CHWs themselves to contribute to the labour costs of the scheme" (Makan and Bachmann, 1997). This applied to situations where there are no other sources of income available to CHWs and a significant portion of the day is needed to meet the job requirements (Perry et al., 2013). Studies corroborate that CHWs need to be rightly incentivised so that their interest to remain involved in the programmes can be sustained (Kironde and Klaasen, 2002). The Kampala Declaration (WHO, 2008) recommended that all trained health workers, including CHWs, should receive 'adequate incentives', although without a clear definition of what such financial incentives would be. Overall there is an assumption that at the community level less skilled or unskilled workforce is required which can be done by local women and that the social sector is not sensitive to the scale of compensation (Heyman and Ariely, 2004 as in Singh et al, 2015).

In developing countries, unpaid labour or disguised voluntarism⁵ performed by informalised public sector workers has been perpetuated through mechanisms such as performance-based incentives. This state of work can be also described as disguised employment by the ILO wherein the workers are not protected by labour laws. There is a large body of literature that recommends PBI supported by international donors like the World Bank, GAVI, NORAD, WHO, and USAID. The World Bank has shifted to term it as RBF for health. The justification for such a fee-for-service kind of system is the increase in the utilisation of services in low-income countries, making the health system more accountable by focusing on results/output and improve efficiency in the health system (World Bank, 2013). International donors played an important role in the promotion of PBF without adequate evidence on its effectiveness (Paul et al., 2018). Another perspective has been to highlight that by displacing wage-based systems PBI and RBF work against the promotion of decent work for CHWs (ibid).

In low and middle income countries and particularly in Africa, PBI has expanded since the first decade of the 21st century. It has grown from 3 countries in 2006 to 32 in 2013 (Fritsche G B, et. Al., 2014). This method of financing promoted by the World Bank ‘as a promising approach to work towards Universal Health Coverage’ (World Bank, 2013). This system of performance does not measure the individual performance rather it takes account of an individual’s contribution ‘through working days, responsibilities and qualification’ (Meessen B, Soucat A & Sekabaraga C, 2011). This framework believes that CHWs will be motivated by the financial gain and will work in ways to maximise income i.e. to ensure revenue. From a managerial perspective, this framework acts as a tool to control the behaviour of healthcare providers (Eldridge and Palmer, 2009). In low-resource

⁵ Even though voluntarism means working on one’s own choice but the moment its impact is measured by the formal organisation it lends an appearance of disguised voluntarism.

settings, PBIs have become delivery focused such as is the case with institutional births, antenatal and postnatal care, reporting of births and deaths, child immunisation. Each completion of a health related activity by the CHW has been lined-up with a reward or an incentive (financial and or non-financial).

The introduction of PBI contradicts notions of CHWs as free volunteers. Adding financial incentives to a voluntary activity is based on exactly the opposite assumption. This unveils the disguise of volunteering and sheds light on the underpaid informalised nature of CHWs work, albeit by providing an alternative that is equally informal and inadequate from the perspective of ensuring decent work for all workers.

iii) Task Shifting

Low and lower-middle income countries like in South Asia and Africa face an acute shortage of skilled health workforce. Adequate remuneration is acknowledged to be one of the key factors that act as the motivation for healthcare workers, despite that there is no estimation of how much it impacts retention of the trained health workforce in the rural and remote areas. Despite the declining interest in CHWs programmes in the nineties, studies from countries such as Egypt, Nepal, Ecuador and Colombia did show that under certain conditions, CHWs could help in reducing morbidity and mortality through case management (Dawson et al. 2008; Bhattacharya, 2001). It was realized that mass media and social marketing approaches couldn't by themselves change behaviours at family and individual level (Bhattacharya et. al., 2001). Given this shortage, and the micro understanding that CHWs can play a pivotal role at the community level, task shifting within different cadres of the health workforce has been high on the health policy agenda as a way to improving health outcomes without increasing the expenditure towards health workforce remuneration.

The World Health Report 2006 emphasised on delegating duties to less-specialised cadres "placing strong emphasis on patient self-management and community based patient-centred pre-hospital care" (WHR, 2006, p. 25). This process, earlier known as *substitution*, is now termed as task shifting. It is defined as 'a process of delegation whereby tasks are moved, where appropriate, to less specialized health workers' (Baker, et. al., 2007; *ibid*). Largely this process has been discussed in the context of relieving doctors and nurses from direct care and support work which they are unable to provide 'because of personnel shortages and distance from communities they service' (Baker B K, et. al., 2007). The main purpose of task shifting is to increase the number of health care services provided at a given quality and cost and 'to reduce the time needed to scale up the health workforce' (Fulton et al., 2011). There are variations in the model of task shifting across countries (Seidman and Atun, 2017). The concept of task shifting is also embedded within the framework of PBIs. It is proposed that PBIs can support task shifting by motivating CHWs to take on newer roles. The assumed purpose of this output-oriented incentive system is to change the behaviour of CHWs and encourage entrepreneurial behaviour (Witter et al., 2013).

The pattern of CHWs work across South Asia shows that they have worked more on maternal and child health-related services. They have now gradually moved to immunization and a wide range of activities related to TB, malaria, HIV/AIDS, childhood diseases, NCDs and of late they are deployed for COVID 19 related activities as well.

III. OVERVIEW OF CHW PROGRAMMES IN SOUTH ASIA

In South Asia, most countries have different models of large scale public sector CHWs programs (Table 2). In Bangladesh and Sri Lanka, the present model of CHWs programmes can be traced back to the seventies. In Nepal and Pakistan, it was started in the late eighties and early nineties respectively. In India, the CHWs programme was

revived again in the first decade of this century to reach out to the poorest and marginalised population who were being left out.

Table 2: Characteristic of CHW Programme in South Asia

COUNTRIES	India	Pakistan	Nepal	Bangladesh		Sri Lanka
LOCAL NAMES of Community Health Worker	Accredited Social Health Activists (ASHAs)	Lady Health Workers (LHW)	Female Community Health Volunteer (FCHV)	BRAC Initiated: Family Welfare Assistants Shasthya Sebikas (SS)	Government operated CHW Programme 3 categories of CHWs: Family Welfare Assistants, Health Assistants ⁱ and Community Health-Care Providers	Health Volunteers
YEAR STARTED	2005	1994	1988-89	Mid 1970s Mid 1980s	1976	1976 (Mid 1970s)
COMPENSATION	'Honorary Volunteer' performance linked compensation	Monthly Salary	Volunteer	Volunteer	Monthly salary as per the government pay scale	Volunteer
AGE GROUP	25-45 years	18-45 years; Preferably married	25-45 years, preferably married	25-36 years old, youngest child is older than 2 years,	As per Government rule their entry level age is 30 years	Not available
EDUCATION / QUALIFICATION	Should be qualified preferably up to 10 th Standard or higher	Minimum 8 years of education	Preference given to those who are literate	Have some schooling preferably	12 th class for FWAs and HAs; Graduation for CHCPs	Educated young men and women
SELECTION PROCESS	Involves various community groups, self-help groups, Anganwadi Institutions, the Block Nodal officer, District Nodal	Must be recommended by the community	Selected by Mother's group with the help of local health personnel	Recruited from among VO members and are Microfinance borrowers.	Government recruitment procedure is followed	Supposed to be recruited by the community

	officer, the village Health Committee and the Gram Sabha.					
COVERAGE	One ASHA for every village at a norm of one per 1000 population or 200 households	They serve an area of 150-200 houses; an average of 1000 individual s. Visit 5 to 7 houses daily.	One FCHV per ward irrespective of the 5,000–10,000 people (or 115 to 231 households in rural areas)	Expected to visit 250-300 HHs / month or approx. population of 1,125 to 1,350.	FWA and HA: Employed in every “upazila /thana” level (3 rd tire of local Govt. administration) CHCP: Employed against each centre at the ward level	100 to 200 people (25 to 50 households)

India

Under the National Rural Health Mission (NRHM), India initiated the Accredited Social Health Activists (ASHAs) programme in 2005. It helped to revive CHWs for the second time in India after 1977⁶. The ASHA model is based on the Mitanin programme that was developed by the Government of Chattisgarh in partnership with civil society in the year 2002. In government documents, ASHAs are considered as female honorary volunteers compensated based on an 'honorarium', variable task-based incentives under different national health programmes and earning from social marketing^[iii] of various healthcare products. In the second phase of NRHM (2012) under the revised guidelines for community processes, it was emphasised to maintain the 'voluntary nature' of ASHAs, assuming it does not interfere with their other sources of livelihood (Gol, 2013). Earning from this activity was seen as a 'monetary compensation' for the time invested. As per the NRHM programme, ASHAs are to work as 'link worker', 'service provider' and 'health activists'. Most of the major

⁶ In 1977, the first national CHW scheme known as Swasthya Rakshak was initiated in villages (Bhatia, 2014).

states (high focus states⁷) have more than 90 to 95% ASHAs in place (Gol, 2016).

Nepal

Nepal has a CHWs programme called Female Community Health Volunteers (FCHVs) that began in 1988 as a partnership between Nepal's Ministry of Health and Population, and United States Agency for International Development (USAID). This program is implemented through the existing PHC system. Initially, one FCHV was appointed per ward. From 1993 onward a population-based appointment of FCHVs was adopted in 28 out of 75 districts. FCHVs are a vital link between the public health system and the community, yet they are considered as unpaid 'volunteers'. Each health facility has, in addition to one professional health worker, one Village Health Worker VHW, one Maternal and Child Health Worker (MCHW), and usually nine (but sometimes more) FCHVs to serve a catchment population of 5,000–10,000 people (or 115 to 231 households in rural areas). In 2017, there were 51,470 FCHVs of whom 47,328 and 4142 were working in rural areas and urban/municipality areas respectively (Rijal et al, 2017). According to the programme documents, preference is given to Dalit, Janajati and marginalised communities in the selection of new FCHVs. Mothers Group for Health in each ward are responsible for the selection and removal of FCHVs. FCHVs should be between the age group of 25 and 45 years and willing to work for minimum 10 years (ibid).

Bangladesh

In Bangladesh, there are two prominent CHW programmes one by the government and another CHW programme is operated by BRAC (Building Resources across Communities); largest within the NGO sector. The government-run CHW programmeⁱⁱⁱⁱ started in 1976, is tiered in three categories of CHWs: Family Welfare Assistants (FWAs),

⁷ Bihar, Chhattisgarh, Jharkhand, Madhya

Pradesh, Orissa, Rajasthan, Uttarakhand, Uttar Pradesh and Assam, consisting of 284 districts.

Health Assistants (HAs, 1995) and Community Health-Care Providers (CHCPs, 2010). There are around 56,000 government CHWs. This ongoing programme has not been evaluated but they have contributed towards reducing the under-5 and maternal mortality (Perry et. al., 2017).

BRAC's *Shasthya Shebikas* (SS), (CHW) programme was started in 1976. They are a cadre of female workforce who are recruited and trained by BRAC to provide a range of essential healthcare services to their communities. They are informal workers who do not receive a monthly salary or stipend. They are provided with financial incentives on the sale of basic medicines and selected health commodities to their community. The original Community Health Volunteer programme recruited and trained male paramedics to treat minor illness for which they received a small fee for referrals. Early CHV experience included issues related to remuneration, supervision and accountability. BRAC addressed these issues by recruiting and training cadres of female health workers. This shift reflects the underlying perception of women CHWs as ones who can be made to work as unpaid/underpaid workers and would be amenable to disciplining. BRAC has effectively scaled up the programme from 1,080 SSs in 1990 to 80,000 SSs operating in 64 districts in Bangladesh today (Reichenbach and Shimul, 2011). In 2007, BRAC introduced CHWs in urban areas under the Manoshi project to address maternal, new-born and child health. Under this project, there are two kinds of trained CHWs with formal education called *Swasthya Sebikas* and *Swasthya Karmis* who supervise SS.

Pakistan

In Pakistan, the Lady Health Workers (LHW) programme was started in 1994 under the National Programme for Family Planning and Primary Health Care. After a decade long struggle in 2013, LHWs ceased to be formally considered as volunteers and became full-time employees of the government whose salaries and allowances like other civil servants (Gill, 2017). Regularization happened over a

period of time in different provinces. The LHW programme recruits and provides basic 15-month training to young married women who provide door-to-door health services in their communities; each serving 200 households in their community. They provide maternal and child health services, general health promotion and education, and referral to local health facilities. LHWs collect routine health statistics in their catchment area and must register all women and children in their area. In 2014 Pakistan roughly had 110,000 LHWs. There is variation in regional LHW coverage. In many low-income areas many women do not meet the minimum education criteria and as a result recruitment becomes a problem (Zhu et al., 2014).

Sri Lanka

In Sri Lanka, compared to the rest of South Asia there is an absence of large CHW programme. Nonetheless, it's from the mid-1970s, Sri Lanka has seen a growth in voluntary workers in the health sector. It was started by the Family Planning Association and later it was supported by funders such as Save the Children, Oxfam, SIDA, and JOICFP (UNICEF, 2004). Public Health Division of the Ministry of Health developed its Community Health Programme 1976 onwards (ibid). Voluntarism in the lower cadre began to be seen as a pathway for employment with the government. Public Health Midwife (PHM) aided in selecting health volunteers who were then trained and supervised. Between 1976 and 1987 around 100,000 volunteers were trained. Volunteers were mostly male members of the community. Community health volunteers come to support the work of the government's front line health workers in periods of need. Later in the mid-eighties, it was decided that these volunteers could also be considered for PHM training and for unskilled jobs in hospitals (UNICEF, 2004; Walt et al., 1989).

Sri Lanka's territory is divided into Health Unit areas that are a clearly defined area with one or two Supervising Public Health Midwives (SPHM) and 20-25 PHMs. They are the "front line" health workers for providing domiciliary MCH/FP (family planning) services in the

community. Each PHM has a well-defined area consisting of a population ranging from 2,000-4,000 people (500 to 1000 households). Each PHM could train 20 volunteers to assist them in their community work (Walt et al, 1989). This volunteer programme emerged in a context of a severe budgetary constraint and as a result even though they were 'publicly recognized' but were 'seen as informal and non-institutional' (Walt et al, 1989).

In all the five countries CHWs in the public sector are linked to primary health centres except in case of the NGO model in Bangladesh. CHW programmes show variations in working relationships (paid, incentivised, unpaid) and yet similar activity being undertaken by women while being linked with the state and not-for-profit sector. In three countries (India, Nepal and Sri Lanka) CHWs are unpaid or low paid and informalised workers of the formal health sector. In Pakistan, after years of struggle, they have recently been recognised as regular employees of the health system. In Bangladesh, CHWs are a mix of regular employees in the public sector and dependent self-employed, of an NGO. In Sri Lanka, the nature of the work is significantly different due to the higher density of skilled health professionals in rural and semi-urban areas, and nature of the time commitment.

IV. ROLES, TASKS AND COVERAGE

The majority of CHWs in SA are engaged in three major roles: health promotion (preventive activity, counseling, primary health services), community mobilization (organise events, awareness creation) and treatment (diagnosis, provision, referrals, assistance and management). Over the years their tasks have increased but they may not necessarily be very clear about their tasks and roles. Presently roles and tasks of CHWs are being shaped by the purpose of improving coverage in the rural and remote areas that face lack of clinical and para-medical workforce and also to address non-communicable diseases, intimate partner violence etc. For such

contexts, WHO has recommended task shifting which is changing the nature of CHWs' work and putting greater burden on low paid and or unpaid CHWs.

India

There is wide variation in the roles and tasks ASHAs perform across states (Sundaraman et al., 2012; Saprii et al., 2015) with an overall emphasis on MCH. Their roles and tasks also depend on how each state interprets the ASHA 2006 guidelines. Different states have reported the following roles: supporting women during ANC and PNC; supporting disease control programmes, Village Health and Nutrition Days. In certain states, ASHAs have been reported of doing specific kind of works like playing a key role in palliative care (such as in Kerala) and NCDs; reporting of births and deaths, high risk pregnancy cases, low birth-weight babies (Gol, 2015). They also carry a drug kit to provide first contact curative care for symptomatic treatment. Overall the nature of their work has led to 'unprecedented mobility and public exposure' (Dasgupta, et al., 2017).

In the remote villages women found ASHAs very useful as they are from the village and provided a range of link services (Saprii et al., 2015). Doctors and nurses see them as link workers who help in primary level curative care (Saprii et al, 2015; Fathima et al., 2015). ASHAs perceived themselves more as link workers or facilitators of the health system and had a low understanding of their role as 'activist' (Fathima et al, 2015). Training did not attend to this aspect at all (ibid).

Even though ASHAs are reaching out, they show a lack of clarity in doing their health related tasks and roles (Bajpai and Dholakia, 2011) due to a lack of training and capacity building. For example ASHAs in Kerala were found to be weak in Reproductive and Child Health (RCH) issues. ASHAs from Chattisgarh, Assam, UP Mizoram could not identify pregnant women with complications (Gol, 2015). Beside a lack of understanding, poor supply of drug kits, sanitary napkins also

hindered their activities (ibid). However, the literature shows that performance-based incentives makes CHWs in India focus more on measurable aspects of healthcare (Som, 2016; Saprii et al., 2015). Activities with higher incentives are prioritized over other non-incentivized activities and this creates a hierarchy between the different tasks and responsibilities (Som, 2016; Sarin et al., 2016; 2017). In India sterilization is over prioritised and there has been a surge. ASHAs favour sterilization over other methods of family planning as they are highly paid particularly in high target states (Bader, 2017) and there is no incentive for family counseling on different family planning methods.

Beside greater emphasis on ASHAs as service providers, their roles as community mobilisers gets limited due to the nature of incentivised work; cultural and gender norms (Som, 2016; Saprii et al., 2015) and also for not residing in the same village that they work (Bajpai and Dholakia, 2011).

The central government has approved over 30 tasks for which the ASHAs can claim incentives (Gol, 2016). Revised set of guidelines for NRHM Community Processes 2013 stated that they should have a flexible work schedule working only about three to four hours per day on about four or five days per week, 'except during some mobilization events and training programmes.' However, studies estimate that they are currently working for approximately 25 hours a week, which is much more than the recommended hours (Bajpai and Dholakia, 2011). Working for more than prescribed hours is due to increase in their responsibilities, and is seen as a scope for increasing the incentives and benefits as well (Bajpai and Dholakia, 2011). Similar thoughts resonated in the Eleventh meeting (2013) of the National ASHA Mentoring Group (AMG) that

'We should not be bound by the structure of four to five hours of work for ASHA, and activities of the ASHAs should be increased with a corresponding increase in the incentives, so

that she can get up to Rs. 4000-5000 per month for up to 8-9 hours of daily work.’ (Gol, 2013, p 3).

This is clearly a full time occupation, but the incentive is not in line with the workload, hours of work and minimum wages. At the policy level this shows an undervaluation of the CHWs role with a continued emphasis on incentive-based payment not recognising the hours they put in for the tasks undertaken.

Nepal

FCHVs cover a wide range of activities like in other South Asian countries. Their activities range from preventive healthcare activities, providing counselling and advice for maternal and child health, educating families on nutrition, hygiene, and healthy behaviour. They also address other health conditions such as HIV/AIDS, providing first aid, training minor illness and symptoms, and are also responsible for collecting data and reporting them monthly.

There are varied estimates of the time load of FCHV, ranging from as low as 5 hours a week (Rasmussen, 2014) to 6 hours a day (Aye et al., 2018). The Terai-based FCHV have higher workload compared to hills and mountain FCHVs for the same number of households (USAID, undated). It is recognised that during campaigns like polio or Vitamin A supplementation they work longer (New ERA and USAID 2008) and over time their work load has increased. Now-a-days, they have to fill up registers that consists of 30-40 questions. As a result for good quality data documentation low level of literacy among FCHVs creates a concern (Govt. of Nepal, 2014).

Bangladesh

CHWs programmes within the public sector emphasis on MCH and FP related issues in the community. FWAs visit households every 2 months, focus on FP and refer women for antenatal care (ANC) and postnatal care (PNC). For two decades FWAs have been the backbone of the government's family planning programme. HAs were introduced

in 1995 and their work focus on vitamin supplementation and identification of pneumonia, malaria, TB and other cases. In addition to this FWAs and HAs work three days a week in the community clinic. CHCPs were introduced into the system very recently, in 2010. They provide ANC, PNC and treat cases whom FWAs refer and give injectable contraceptives.

Shasthya Shebikas (SSs) are provided basic training to enable them to provide door-to-door health education, treatment of basic health problems, collect health information, sell medicines and health commodities, and make referrals to health centres as necessary (Reichenbach and Shimul, 2011). On an average they visit 250-300 households per month i.e. around 10-30 households per day (Reichenbach and Shimul, 2011). In the community they work in collaboration with the trained traditional birth attendants. They also do promotive health activities, do referrals to government health centres or BRAC clinics, administer DOTS, mobilise community in participating in the national health programme campaigns (Perry et al., 2017). They play a much more diverse role compared to FWAs and CHCPs.

Their remuneration is fully dependent on selling of commodities in the community and 30% of SSs said that they wished they could sell additional health commodities, medicines and/or non-health commodities (Reichenbach and Shimul, 2011). SSs have started with selling oral contraceptives. BRAC included other items based on community needs and experiences such as WHO essential drugs, vegetable seeds, iodized salt, and soap or ash for hand washing. There are currently 21 basic items that every SS offers for sale (ibid).

Pakistan

LHWs work and responsibilities include over 20 tasks, ranging from health education about antenatal care, referral, immunization services and support to community mobilization, provision of family planning and basic curative care. In addition, the house of each LHW

has been declared as a Health House where people can come in case of emergency to receive basic treatment or guidance. LHWs are also accountable for maintaining comprehensive records for all patients under their charge by updating family registers at the health house to reflect medical histories and health conditions of each member. Each LHW is given basic items for the health house including essential drugs, contraceptives, and other supplies. These are provided free of cost. By 2007, LHWs provided more than 50% of the population access to primary care including 60–70% of the rural population. A study in the Punjab Province in 2009 showed that LHWs played an important role in altering women's health seeking behaviour (Yasin and Shahzad, 2015).

Haq and his colleagues (2008) point out that most often work load and job profile of LHWs increases and changes without any consultation with them. This has added to their work pressure. According to one study, on an average they have to visit 150 homes per month or visit 5-7 households per day (Lavasani, 2012). According to another study, each week on average, LHWs visit 27 households and meet and provide advice and consultations on an average to 22 individuals (Perry, et al., 2013).

Sri Lanka

Health volunteers help PHMs in establishing links with the communities, home visits, and provision of first aids and expand PHC activities to the peripheral areas (Walt et al., 1989). Karunathilake and De Silva (2010) explain that the role of Public Health Midwives has evolved to that of one who can cover a number of tasks ranging from home visits, awareness programmes on reproductive health in schools and community centres to other preventive activities; 'covering many aspects other than midwifery'. They also provide necessary education and advice to adolescents on RH and educates women on the importance of screening for reproductive organ malignancies, routinely assists in MCH/FP clinics which are conducted fortnightly, and link the community with the institutional

health system. It is in these activities that volunteers help PHMs by bringing people to the clinics, announcing dates of the clinics and are valued as 'extra pairs of hands' (Walt et al., 1989). PHMs' activities are supported by a system of record keeping which enables them to plan and monitor their routine activities. Thus, volunteers and PHMs were seen as an integral part of community health programmes in which 'extension of the coverage' was the prime motivation (ibid).

Task Shifting and Training

It is recognised that CHWs with good training can make wide range of health programmes effective (Aitken, 2014). In the South Asian context, CHWs have started to provide services other than MCH related services (immunisation, new-born child care, and linking to-be-mothers to healthcare institutions) like referring sexually transmitted infection cases, treating minor illness, doing advocacy for intimate partner violence cases, as well as household and primary health care level surveys and data management. The tasks of ASHAs have increased over time along with other responsibilities like record maintenance, home visits, accompanying patients etc. The experience of ASHAs from different states showed that they require greater clarity of their roles and tasks (Gol, 2015; Bajpai and Dholakia, 2011). In Nepal FCHVs are being trained to use an antiseptic on the umbilical cord and resuscitate new-borns in case they suffer from birth asphyxia (Perry et. al., 2017) and are also mobilized for mass drug administration for Lymphatic Filariasis program (Rijal et al., 2017). In 2009 in Sri Lanka Ministry of Health trained PHMs to identify Intimate Partner Violence sufferers and help them with solutions (Jayatilleke et. al., 2015). In Pakistan, while working in different public health activities LHWs shared their feeling of being overworked (Zhu et al., 2014).

CHWs have been skilful in taking on additional tasks as shown in smaller intervention studies (Perry et.al., 2017). In India ASHAs have expressed the need for better and refresher courses with regular

training to upgrade their skills and prevent themselves from skill attrition. Their tasks have increased over time along with other responsibilities (Gol, 2015; Bajpai and Dholakia, 2011) with inadequate wage compensation.

With their increasing acceptability in the remote and rural parts as seen in hilly states of India, and in Pakistan (Hafeez et al., 2011), governments see them as conduits to expand the coverage of different kinds of health care services in the most hard to reach communities. Across South Asia for the wide ranging roles CHWs need regular training, supervision and adequate logistic support. Pre-service along with continuous training and adapting to new roles with increasing CHW role portfolio is becoming the trend of the CHW programme across the globe.

Table 4: Training Duration and Components of CHWs

Training Programmes	Duration and Components
India: ASHA	A 23-day training schedule to provide the necessary knowledge & skills
Nepal: FCHV	FCHVs undergo an initial 18 days of training with 5 days of refresher training every 5 years.
Bangladesh: SS	4 weeks of basic training from local BRAC office; monthly refresher trainings (daylong); Special programme training provided later as required
Pakistan: LHW	Receive 3 months of classroom training in PHC and then have 1 year of on-the-job training. Refresher training is there. There is substantial variation in training patterns across provinces
Sri Lanka: HV	Trained by PHMs to assist them in community work

Training and upgradation of skills of CHWs is not only required for making health programmes work better but also because they have to adapt to different health programmes requiring different tasks.

With newer tasks being given to them they are being subjected to do more skilled jobs and meet indirectly the preliminary demand for qualified skilled health workers. This has contributed to task-shifting

for MCH, HIV, family planning services and NCD services as well. One of the questions *task shifting* raises is how does it contribute to cost saving. A systematic review of task shifting to CHWs in low and middle income countries showed that ‘it can be an effective way to improve the population health’ with evidence of cost savings from the programmes like that of childhood illnesses, non-communicable diseases (Seidman and Atun, 2017). This study showed that task shifting should incorporate more of non-clinical activities rather than clinical activities like ‘monitoring the supply chain or tracking patient data’. Secondly, the review also showed that it can improve efficiency across multiple diseases at the PHC and community level (ibid). Interestingly much of the cost saving and efficiency gained by shifting task is achieved by employing underpaid and informalised women at the community level.

Across South Asia CHW work as informalised public health workers providing a link between the formal health system and the community, by delivering basic treatment for a range of national health programmes, mobilising and creating awareness. In a scenario of poverty, widening inequality and increasing informality, underpaid CHWs fill in for the lack of health workforce and inadequate financing for health services by subsidising the cost of health services, and therefore supporting developing countries’ economies.

V. REMUNERATION: PAID AND UNPAID

The recent publication of WHO has showed renewed attention for strengthening the CHWs performance (WHO, 2018). Studies have shown that CHWs across the world have expressed the urge to be associated formally with the formal health care system and be recognised and remunerated as workers. The WHO Guideline on CHW Programmes (2018) 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” (Recommendation 7A). Further WHO “suggests not paying

CHWs exclusively or predominantly according to performance-based incentives” (Recommendation 7B).

In the SA region, CHWs are being given both cash and non-cash incentives. In the five SA countries under the study, the remuneration models vary ranging from allowances, performance-based incentives and honorarium, to fixed salaries. The nature of incentives given to CHWs reflect the unequal labour standards and keeps them distinctly separate from the rest of the healthcare workforce. The following section explores how CHWs are paid and what are the components of their remuneration.

India

ASHAs are envisaged as honorary volunteers and are given an honorarium and performance-based incentives; one of the largest in operation in the world. States were given the flexibility to design their own incentives to ASHAs, including based on state-specific requirement and activities. Some states have introduced fixed monthly honorarium for ASHAs out of the State budget (Gol, 2016). From 2018 onwards for routine activities, ASHAs will get a minimum of Rs.2000/- per month as honorarium from current Rs. 1000/- per month, in addition to other task-based incentives, approved at Central/State level. On an average ASHAs earn Rs 1500 to 2000/- of task-based incentive per month (Gol, 2015).

Financial remuneration is among the top three motivating factors and it was suggested that pay scales need to be re-evaluated to improve ASHAs’ performance (Saprii et al., 2015). ASHAs expressed that task-based incentives they earn through Janani Suraksha Yojana⁸ is one of their main sources of earning and explained it shapes their work and performance level (Saprii et al., 2015). ASHAs do not receive any

⁸ Janani Suraksha Yojana (JSY) is a safe motherhood intervention scheme, launched on 12 April 2005 under the National Health Mission. It is being implemented with the objective of reducing maternal and neonatal mortality by promoting institutional delivery among poor pregnant women.

money for community mobilisation, home visits and sanitation work (ibid). This acted as a disincentive even though they are an important aspect of their work. Each of these three activities had some other activities embedded within them that went uncompensated (Sarin et al., 2016). It is observed that the incentive per job is not enough and that all kinds of job are not covered.

In the majority of the states, incentives are tied to the number of beneficiaries served. In West Bengal, it is based on a fixed payment for the provision of different services. Incentives for the same work vary across states. ASHAs receive incentives within a range of Rs.50 (US\$0.83) for early registration of pregnancy to Rs 1000 (US\$16.67) for facilitating sterilisation (Sarin et. al., 2016). The current amount of payment was not proportional to the work done by the ASHAs. It is observed that ASHAs felt that the incentives were not commensurate with the effort they put in (Sarin et. al., 2016; Bhattacharya et al., 2011).

There have been frequent cases of irregular (Saprii et al., 2015), and inadequate payment (Bajpai and Dholkai, 2011). ASHAs from different states have expressed the demand for regular salary (Bajpai and Dholkai, 2011; Som, 2016; Sarin et al., 2016). Financial remuneration led to increased self-confidence and contributed to financial independence, but remain inadequate compared to the workload (Sarin et al., 2016). In Chattisgarh due to lack of alternative source of income and despite delays in payments of this small financial support, cash incentives became crucial for ASHAs' families (Som, 2016). Husbands of some ASHAs allowed them to continue working with the hope of getting a regular salary in the future. Sometimes families did not agree with the work they carry home against the level of compensation ASHAs are paid. Community people disbelieved when they got to know ASHAs are not paid salaries and they are paid selectively based on their tasks (Sarin et al., 2016). In Delhi, ASHAs are given six-point targets and in case of incomplete

work, they get Rs. 500/- per month (HRLN, 2014). In Punjab, ASHAs were penalised for not addressing incentive-based activities.

In Punjab, 80 ASHAs were dropped from the programme based on a single criterion of earning zero incentives (Gol, 2013).

Beside cash incentives, in nine states ASHAs are provided access to social security schemes such as medical and life insurance, educational support to children, pension and maternity leave. Chhattisgarh, Jharkhand, Kerala and Assam have introduced new schemes designed specifically to cover ASHAs and ASHA facilitators. In the remaining five states (Delhi, Gujarat, Madhya Pradesh, Odisha and Sikkim), ASHAs are enrolled under the National Pension Scheme – Swamlamban Yojana, Atal Pension Yojana, Pradhan Mantri Jeevan Jyoti Bima Yojana or any state-specific Chief Minister Rajya Bima Yojana (Gol, 2016). This goes to show that the state is trying to indirectly compensate ASHAs' work and yet avoids giving them formal employment.

Nepal

FCHVs are fully unpaid, except for limited allowances. During training, vaccination and deworming campaign, FCHVs are given 200 Nepali Rupees (USD 1.77) (Rasmussen, 2014). They are provided with non-wage incentives like bicycles, uniform allowance, radios, and free services from Nepal's Ex-Servicemen Contributory Health Scheme, depending on the districts. All of them are given an identification card and an annual day of honour in recognition of their service to the community. In many districts, FCHVs are enrolled under an endowment fund that gets them a loan at a lower rate of interest (New ERA and USAID 2008). Bhandari (2011) has however noted FCHVs discontent regarding the lack of monetary compensation for the work they do, and sees this as a threat to the programme as more interventions will be implemented in the future through FCHVs (Rasmussen, 2014). In 2012, FCHVs requested for certain specific social security benefits, such as access to income-generation

schemes, free schooling for their children, and health insurance (USAID, 2013).

Per day their workload and time invested are more than the 4 hours of work per day (Rijal et al., 2017). Despite the gradual increase in workload, FCHVs are interested in spending more time doing community work. However, FCHVs were not happy with being unwaged, During harvesting time women FCHVs on account of their work cannot give time to the field (Swecchya and Kamaraj, 2014) as hiring extra labour for fieldwork is costly. They have to also attend cases at odd hours interrupting their household duties and responsibilities (Swecchya and Kamaraj, 2014). They expressed even after this kind of tiring work they are not entitled to good health care services from the government (ibid). Central and district officials, health workers also expressed the need for remuneration or regular incentives (UNICEF, 2004). Even though their work is recognised through awards and certificates but it fails to address their economic insecurity. In the light of increasing cost of living unpaid work emerges as a major barrier and continue as disguised employees of Nepalese public health system (Rijal et al., 2017). The need for monthly salary heightens as their work-related expenses, such as costs of mobile calls, transportation and slippers (as they walk a lot) goes uncovered.

Bangladesh

In the early days, BRAC envisaged that SSs will work voluntarily but high attrition level led BRAC to create a system for financial incentives. To make the programme 'financially sustainable' for themselves, BRAC decided that incentives will come from the community (Reichenbach and Shimul, 2011). SSs earn their income by selling health care commodities, charge a service fee for referring antenatal cases and get incentives for achieving monthly targets from BRAC. Reichenbach and Shimul (2011) survey among SS showed that the mean monthly income of SS was Tk. 360. Their income also differs with variations in the selling of commodities (ibid). Rahman and Tasneem (2008) found an association between SSs' monthly

income and additional training from outside BRAC. Among those who earned above Tk. 300 around 26% of them were trained outside BRAC and worked for longer hours in a day. They were trained in midwifery, measuring blood pressure, pushing injection, leprosy, tuberculosis, etc. (ibid). CHWs used the 'good name' they gained from their association with BRAC to generate earning from alternative sources (Alam et al, 2014). The economic dependence of CHWs, especially those from the poorest economic background, to the income created by the programme is visible in that this income becomes necessary to meet their daily needs.

SSs perceive themselves as salespersons and not as healthcare workers or workers for the community (Ahmed, 2008). Despite the highly informalised conditions, the financial incentives made CHWs consider the Manosh project of BRAC to be a 'paid job' (Alam, et al., 2012). Financial incentives are the primary motivating factor to join as CHWs. Majority of the CHWs reported that it contributes to their household income (Reichenbach and Shimul, 2011; Rahman and Tasneem, 2008). In around 84% of households, SSs were one of the main sources of income and around 2% of SSs felt that by taking up this activity it became easier to access BRAC loans (Rahman and Tasneem, 2008). However, dissatisfaction with the pay levels in proportion to the amount of time invested results in high drop-out rates (UNICEF, 2004). Erratic income due to competition from other healthcare providers also frustrates them. In the case of TB DOTS programme, SSs are paid a certain amount per patient to follow-up the entire course of TB treatment. Earlier, when the incentive was generated through the patient, Reichenbach and Shimul (2011) found that 20% of patients were unable to pay which led to discontinuation of treatment and consequent a drop in their income.

Pakistan

Though it is probably underestimated, a study found that on an average LHW work for 5 hours a day, 6-7 days a week (USAID, 2017). After a long struggle by LHWs unions, LHWs are now considered

government employees. LHWs receive a salary at par with the minimum wage, of about USD 135 (PKR 14,000) per month in June 2017. They are not supposed to engage in any other paid activity and this is often the only source of family income. Thus it acts as critical family support (Perry, et al., 2013). In 2002, LHWs organized demonstrations and protested against delayed and insufficient stipends. In 2013, the government finally approved the regularisation of LHWs' service, and they began receiving salaries in the place of stipends. Their salary is now equal to the prescribed minimum wage of unskilled workers in Pakistan.

In addition to the demand for recognition as employees of the public health sector, LHWs in Pakistan have demanded that the organisation they formed be registered as a trade union. The union of LHW from the Province of Sindh was formally registered in 2018. Through their unions, LHWs have demanded regular payment of wages, higher financial compensation for higher qualifications and responsibilities and career development.

LHWs experienced job dissatisfaction due to poor stipend and no clear career pathways (Afsar and Younus, 2005). This was later corroborated by another study which showed that 60% and 19% of LHWs were little and moderately satisfied respectively with the stipend they received (Haq et al., 2008). Though things have improved they do face 'disrespect from male colleagues and conflict between domestic and work-related responsibility' (Haq et al., 2008). Involvement in other public health activities is overburdening them. Another reason for dissatisfaction is irregular salaries and inadequate safety while on the job (Zhu et al., 2014). With greater access to training and newer skills, their self-image and their ability to communicate with other LHWs has improved. This has also enabled them to collectivise (Zhu et al., 2014). In case of pregnancy, LHWs were earlier given 20 days but now they are entitled to 90 days leave as public sector employees.

Sri Lanka

In the mid-1980s the policy to consider volunteer health workers for Public Health Midwife training and unskilled employment of hospitals or other departmental health positions was declared. A study by Walt and his colleagues (1989) showed that 60% of the volunteers took up this responsibility/task in anticipation of future employment and 50% of them had already applied for jobs. Another factor which led them to take up health volunteering was to utilise their free time. Apart from this, PHMs annual salary ranges from SLR 31,190/- (USD168) to 58,590/- (USD 316) (which is thrice the minimum wage), they are covered by social security, including pension. They are recruited by the Ministry of Health and are government employees. Their duties include household visits, particularly for maternity and child care work. Public Health Midwives are provided with three kinds of allowance (official, field transport and community clinic allowance) so that they are retained in rural communities. They are also provided with pension schemes, cost of living allowance and subsidised mobile communication (Karunathilake and De Silva, 2010).

**Table 3: Kind of Incentives (Cash & Non-Cash)
to the CHWs in South Asia**

South Asia	Cash Incentives	Non-Cash Incentives	Remuneration* (Annual)
India ASHAs	Performance based payment based on tasks; Travel allowance	Access to Social Security Schemes in some states	USD 500
Nepal FCHV	Specific allowance for Training programmes and campaigns	Timely retirement at the age of 60, receive free services from Nepal's Ex-Servicemen Contributory Health Scheme; given an identification card and an annual day of honour in recognition of their service to the community; enrolled under an endowment fund that gets them loan at a lower rate of interest	USD 75
Bangladesh	SS: Receive incentives from BRAC for achieving monthly targets, Charge a small service fee for antenatal care, Sell health commodities earn profit	Alternative income generating scope, burden of household loan, competition with number of other providers, VO membership, and additional health training received outside BRAC	USD 52 (monthly average of BTK 360)

	Government appointed CHWs (FWAs, HAs and CHCPs)	-	FWAs, HAs: 14 th grade of National Pay scale; CHCPs: 12 th grade of National Pay scale; They receive only allowances provided in their pay structure. Receive pension after their retirement as per the Govt. rule.
Pakistan	Receive monthly salary	-	USD 1650
Sri Lanka	PHMs Official, field transport and community clinic allowance; pension schemes, cost of living allowance and subsidised mobile communication	-	USD 2,400 to 4,500
	Health Volunteers	Not Available	Not Available

*http://www.ilo.org/wcmsp5/groups/public/---dgreports/-dcomm/documents/publication/wcms_616210.pdf

The lines between CHWs as “volunteers” and informal workers within public sector health system are blurred. As an underpaid labour they are denied the recognition of workers. Country experiences echo that an adequate remuneration is a critical aspect and increasingly so in developing countries where CHWs earning helps to meet families’ financial needs. As the profile of their work changes, CHWs are increasingly becoming central cadres of the rural and urban health system, and not only providing supportive services. Based on the rationale of the objective to improve service utilisation in the SA region, cash incentive to CHWs is tied to the number of patients seen or brought to health centre for treatment. This is a form of fee-for-service financing. It was already observed that incentivised payment can interfere with public health priorities.

Considering the social and economic background CHWs come from, remuneration for their work is essential. Over the years, the amount of work has also increased for CHWs in South Asian countries. The mix of tasks includes ‘medically oriented tasks’ (Campbell and Scott,

2009) and CHWs need to be semi-skilled. Overall the changing nature of CHWs work, the work load, expectations from them and economic changes makes it difficult to work for meagre compensation. The review of PBP to ASHAs in India shows that they cannot be made to work as underpaid informalised workers. They need to be adequately paid (Wang et. al., 2012). The lack of recognition as workers is what prevents them from receiving minimum wages or salaries and being covered by other labour laws. This is seen as a solution to the cuts in healthcare expenditure, shortage of health workforce and emerge as a category of workforce who are *quasi-free*. In addition to interfering with public health priorities, this is enforced at the cost of their labour rights and contributes to inequalities and deepening the gender wage gap.

Financing of CHWs

During the 1980s CHW programmes were seen as 'low cost healthcare'. The lack of funding as a result of the SAPs contributed to their lack of sustainability. The overall budget for CHW programmes did not consider the nature of their work and lacked supportive resources like supervisory activity, transport budget and adequate salaries. With the Bamako initiative^{iv} it was found that raising community based contributions without any budgetary support from the government was not financially sustainable. Especially, it is difficult for poor communities to raise funds.

There has been an ongoing debate with regard to the usefulness of CHWs in the health sector and whether they should be unpaid or be given a salary. As large number of CHWs are involved, it was considered that recognising them as workers will enable them to unionise, demand adequate salaries and social security (Perry, et al, 2014). The instance of the LHW from Sindh, Pakistan, mentioned above illustrates this point. In this debate, the nature of their work and the level of skills that are required were not at all considered. CHW review in all the five case-studies in SA show that they are not

just lay workers, and training is becoming an increasingly important part of their work. The hours initially specified seem underestimated, and the work-load base of CHW programmes need to be re-estimated and expanded. CHWs work is complex, 'horizontal' in nature and 'not cheap' (Lehmann and Sanders, 2007). In a large number of low income countries CHW programmes are donor driven, and donors do not consider salaries as sustainable (Bhattacharya et al, 2001). This bears an impact on the long term sustainability of such large scale programmes recurring cost, except when governments of few countries such as Pakistan fund the CHW programme and are incorporated as formal health workers. Within South Asia, CHWs are termed as 'volunteers' in Bangladesh (NGO driven) and in India, Nepal and Sri Lanka where it is funded by the government. In India, when the ASHA programme was started, healthcare funding faced cutback and ASHAs are only paid cash incentives but no regular salary. At present in Nepal, government is funding the FCHV programme and earlier donors such as USAID, UNICEF and UNFPA no more financially support it. Lack of information about the budget allocation under this programme is being used as a strategy to downsize FCHV (Rijal et al., 2017). Then again, Perry and his colleagues (2017) caution that 'volunteerism' leads to high turnover rate.

Turnover rate or the Attrition level

The scope to work as CHWs gives women the scope to acquire new knowledge, opportunities, freedom and high self-esteem (Bhatia, 2014). Job seeking motivation by being part of the formal health care system and gaining a certain social status and mobility are some of the factors that enthruse young women to become CHWs in the South Asian context. However, experience shows that they are yet to be recognised as workers and are far from job security, safety, and rights. Income generation is also one of the motivating factors for the women to become CHWs as is shown by the high level of dependence that CHWs families have on their meagre income. Globally the attrition rate among CHWs ranges from 3.2% to 77% and is mostly

found among unpaid so called 'volunteer' CHWs (Bhattacharya et al., 2001). Overall high dropout/turnover/attrition rate decreases the stability of the programme', with high demand on human and financial resources for recruitment and training (Perry et al., 2017; Haines et al, 2007; Bhattacharya et al., 2001; Yiu et al, 2001).

In India, there is a low acknowledgement of absenteeism/attrition among ASHAs. In the Report of the Working Group on NRHM (2012-17) attrition rate of ASHAs range between 5% and 15% (Government of India, 2011). However, the possibility of a higher incidence of absenteeism/ attrition was indicated (Bhatia, 2014). Getting selected in other national health programmes acted as a major reason for attrition (ibid). Annually the average dropout rate of ASHAs is in the range of 2-5% across states (Gol, 2015). High turnover rate is detrimental to the sustainability of the programme and to build CHW's skills and capacity. In the state of Delhi the level of cumulative attrition-among ASHAs is 24% and the annual rate of attrition is 14% (Gol, 2014-2015).

During the nineties in Bangladesh, the dropout rate of SSs ranged from 31% to 44% with an annual dropout rate of 10-15% (Khan et al., 1998). It was found that some SS dropped out soon after joining the programme and some left after a few years of experience. One of the main reasons for these high turnover rates was inadequate and erratic performance-based income. Factors that led to the high attrition level were: household activities consumed a lot of time; very high targets set by office; reluctance to work without salary; people bought medicine on credit basis etc. SSs expressed the desire for fixed income rather than income based on meeting targets (Alam et al., 2014). In rural and urban areas the dropout rate of SSs varied between 20% and 32% depending on the location (Alam, et al., 2012). The factors for drop out between urban and rural CHWs are different and vary over the years. In the initial years of the Manoshi project, the transitory nature of urban dwelling forced SSs to quit

rather than income, social recognition, or wealth quintile (Alam and Oliveras, 2014).

In Pakistan, low stipend, limited career path and disrespect from male colleagues were reasons for LHWs dissatisfaction (Haq et al., 2008) before the regularisation of their employment status took place. In the province of Sindh, even after regularisation, remunerations are paid irregularly and the union regularly takes out agitations to ensure timely payment. However, there is gap in information regarding attrition levels of LHWs in Pakistan.

Glenton and her colleagues (2010) find that unpaid 'voluntarism' in poor communities of Nepal has been sustained by the 'sense of obligation to the community' and 'to earn religious merit'. Policymakers argue that salaries would 'kill' the spirit of the programme. They also felt that other incentives to FCHVs need to be ensured at the same time as the educational level, and tasks of FCHVs are increasing (ibid). In Nepal attrition level has been low, with less than 5% turnover per year has been sustained (Zulliger, 2017) and 53% of them have been working for the past 10 years (New ERA and USAID 2008). This is partly linked to limited opportunities (Aye et al. 2018).

Nonetheless, the CHW experience of Africa shows that there is a need for an 'adequate and sustained remuneration' in order to prevent high turnover rate or attrition (Lehmann, et al., 2004). Economic pressures in low income and low-middle income countries and lack of other opportunities push women to accept this kind of work conditions even if they do not ensure a fixed salary, social security benefits and other labour rights.

VI. VOICE OF THE CHWs AND UNIONISATION

Gradually CHWs are shouldering more and more responsibilities. The mix of tasks they take up, their location within the healthcare system

and the catchment area they work in, all play an important role in imparting services, performance and efficiency levels. CHWs everywhere have made demands for consistent supply of drugs, medical supplies, transportation, support and link with the formal healthcare system. Lack of all these things erodes the trust community puts on them and CHWs morale as well.

The nature of their work creates a challenging work environment for CHWs while in the field as well as in their relations to the formal health system. The experience of women CHWs across SA shows that they are facing increasing stress and workplace harassment. Labour rights, job insecurity, social discrimination and violence are some of the issues that have gained certain visibility through collectivisation, protest and lobbying. The work environment is very less responsive to the needs of the CHWs in this region. In the name of efficiency and to contain costs, adequate compensation for their labour and labour rights has been compromised.

Overall there are little systematic studies as to how CHWs in different countries have challenged the state. The ways CHWs have raised their resistance is explored here.

India

Over the years, ASHAs have strengthened their voice, protesting against their engagement with the formal healthcare system and their wage-form. ASHAs have formed their own trade unions under the umbrella of different national trade union centres such as All India Central Council of Trade Unions (AICCTU), All India Trade Union Congress (AITUC) and Centre of Indian Trade Unions (CITU) as well as under independent trade union formations. They want the government to recognise them as workers, fix a reasonable salary, and provide cell phones with SIM cards and currency, uniforms, medical kits, incentives and other social security benefits considering the dedicated services in the healthcare, particularly in rural areas. They have demanded a minimum pay of Rs 18,000 per month (at par

with the Seventh Pay Commission recommendation for a minimum wage of central government employees). The 45th Session (2013) of the Indian Labour Conference (ILC) recommended to recognise all scheme workers^{9v} to provide for minimum wages, social security and pension.

Moreover ASHAs work within communities embedded with deep patriarchal values. The gang-rape case of an ASHA and later murdered from Uttar Pradesh in 2016 informed how ASHAs have little protection against harassment at the workplace. They did not know how to address sexual harassment at workplace and ways of informing the health department. The credibility of the NHM as an ethical employer was questioned (Dasgupta et al., 2017). The ASHA trade unions also require to raise the issue of workplace safety beside their demand for recognition as formal workers and monthly salary.

Pakistan

In Pakistan, LHW had collectivised not only against their poor and nominal stipend but also against the backlashes they have met from the community in the face of being women workers. LHWs also reported suffering due to sexual harassment. In 2008 LHWs came together and formed All Pakistan Lady Health Workers Union. In 2010 in all the four provinces, the union demanded regularisation, delayed and inadequate wages and reimbursement of travel expenses (Khan, 2011)¹⁰. This was the first collectivised struggle by women workers in the country. They fought at three fronts i.e. firstly they unionised built

⁹ In May 2017, the Kerala ASHA Workers Federation achieved an increase in monthly fixed payment from Rs. 1500/- to Rs. 7500/- per month, which was then the highest remuneration given to ASHA workers by any state in the country. Most recently, in July 2018, ASHA workers in Haryana achieved higher wage and better working conditions. ASHA workers in Kerala have been struggling for higher remuneration and other demands since the past several years and have achieved several gains <https://www.facebook.com/CITUHQ/posts/1336399243111942>

¹⁰ Their salary could not be raised until Supreme Court of Pakistan ordered Government in 2010 to make it equivalent to the prescribed minimum wage for the unskilled workers i.e. PKR: 7000/ per month.

networks with civil society, trade unions and political parties; secondly they fought their case in the High Court and Supreme Court and thirdly, they protested, did sit-in Dharnas and boycotted the polio campaign. This struggle was a very militant and street-based struggle. In 2012 they demanded regularisation of 130,400 members of the LHW program and that their salaries be paid (Farooq, 2012).

After the 18th Constitutional Amendment health responsibilities were devolved to the provinces and irrespective of Constitutional protection, the issues of regularization, payment of salaries and provision of better service structure and terms of employment to LHWs were delayed further. Much of this was due to the local governments' poor governance. It was through sit-in strikes that the government of all provinces issued notification for the regularization of LHWs.

Table 5: Regularisation Process of LHWs in Pakistan¹¹

2009	LHWs formed an association in 2009, the All Pakistan Lady Health Workers Association (APLHWA)
2012	Supreme Court of Pakistan ordered the regularization of LHWs, Lady Health Supervisors (LHSs)
April 2014	The Balochistan government regularized 7,265 LHWs.
September 2014	The government of Sindh regularized more than 26,000 LHWs in 30 districts of the province, including the lady health supervisors, account supervisors, and the drivers with effect from 1st July, 2012.
2015	The KP government regularized 13,500 LHWs.
2016	With the support of PSI and the Workers' Education and Research Organisation (WERO), a labour support group, ASLHWA launched a <i>Campaign against Stolen Wages</i>
2018	Labour department confirmed the registration of All Sindh Lady Health Workers and Employees Union

Nepal

In Nepal, unionisation is more recent and only a few unions of FCHVs are registered with the government of Nepal (Basu, 2016). At present

¹¹ This table maps certain events in the struggle and not the entire picture.

FCHVs are registered with three trade unions viz. Health Volunteers Organization of Nepal, Mahila Swasthya Sebika Sramik Sangh (Female Health Worker Association: FeHWA) and Nepal Health Volunteer Association. The demands of these unions converge around issues of monthly allowance, retirement allowance, for free health services and life insurance (Rijal et al., 2017). In 2018 two unions (**HEVON and NEVA**) come together to ensure recognition of FCHVs as employees of the government's health system and obtain decent working conditions for their members (PSI, 2018).

Bangladesh

In Bangladesh, BRAC CHWs ability to collectivise has been limited. There has been no study on CHWs employed by the public sector. CHWs in BRAC work more as self-employed individuals where their income is based on incentives for services. This divided nature of labour itself has probably prevented them from collectivisation and voicing their problems. The government selected CHWs are not allowed to form or join Trade Union even when their working environment is not similar in each station.

It is in this challenging contexts that CHWs in some countries have come together and voiced the challenges and difficulties they face in their workspace, and their demands. These struggles also show how they are exploited by the system and are amongst the most vulnerable in the healthcare system. Overall the associations and trade unions of CHWs in India, Nepal and Pakistan foregrounded the issue of their recognition as a worker thus, fighting through the division of formal and informal labour within the formal health sector.

VII. DISCUSSION

In the South Asian region, CHWs have played a very important role and the support they have rendered to the health system and communities is of great value. They are the largest women workforce working within the formal healthcare system, and they work as unpaid

or underpaid labour, except in Pakistan. Over the last one and a half-decade, community health care programmes have reinforced the gendered division of work in the SA region. All five countries have developed a mixed model of incentive base (monetary and non-monetary incentive) informalised community health workers. In these countries, the state has responded to the much-needed peoples oriented health care requirements at the community level through low paid to unpaid labour. Even though CHWs are termed as 'volunteers', there are professional expectations from them. There needs to be greater information with regard to the scale of their workload and amount of time spent at their tasks. They are increasingly seen as a part of the healthcare team with the expectation that continuous training, refresher course and supportive services will enable CHWs to meet the desired objectives. Increasingly task-shifting/ job substitution is being asked from a workforce who receives only incentives, while that work was earlier done by formal employees.

As part of CHW programmes, large numbers of women have moved out of the private space into the public domain. The nature of working as CHWs has changed over time, with a growing range of tasks and responsibilities, such as working on preventive and curative aspects of healthcare simultaneously. For CHWs, even though this is an economic activity, yet it is not recognised as paid work. They are being denied the status of a worker. As informalised labour, there is uncertainty whether they will be recognised as holders of labour rights. As Kavita Bhatia points out, across the globe, even though there is a huge investment in training and supervision of this workforce, yet they are not considered as workers. In this process, even though women CHW's productive abilities are utilised, the division between paid and unpaid work is blurred further. Women's productive abilities outside the house, in the service of the community, become an extension of the unpaid labour done for the family, within the house. This extreme informalisation at the community level in a certain way genders certain types of healthcare work in the health system. This has not given CHWs access to paid

work, labour rights forbidding discrimination at work and social security. Even if CHW programmes have given women more agency and a certain level of empowerment, by terming them as 'volunteers', the state perpetrates and expands gender inequalities.

In South Asia, PBF is most developed in India. In India, over the years PBF /RBF has been promoted and implemented. The tendency is also for the fixed honorarium component of ASHAs remuneration to increase, in the face of union demands for regular remuneration. In Nepal the idea of non-monetary the incentive is still dominant, and in Bangladesh, SSs are dependent self-employed whose income is based on marketing performance with certain incentives paid by BRAC. Inability to meet the targets results in penalties to CHWs. This creates a competitive environment which then defines the principles of work. Secondly, it has to be remembered that in donor-funded contexts sustainability of PBFs raises concerns and it cannot replace the inherent structural barrier of under-investment in the country (Schuster et al., 2016). Thirdly, in low-income countries they are asked to share their time, knowledge and skill either freely or as underpaid workers (South et al., 2014). The experience of financial incentives to CHWs in India shows that it does not help to cease the continuous demand for future fixed monthly salary and employment. CHWs from Nepal and Bangladesh has expressed their economic insecurity and the pressure to earn more as the incentive-based income is not enough. Even though the altruistic motive of CHWs has been foregrounded, different studies and evaluations brought out the weakness of this argument, as CHWs saw this as a pathway for seeking a government job in the future.

In the long term, incentive-based payment to CHWs distorts public health priorities as already seen in the case of services where health outcomes cannot be measured in the immediate future, and services which are non-incentivised. In the context of the weak public sector with a workforce shortage and high disease burden such as in India, Pakistan, Nepal and Bangladesh, PBF/RBF dependent on state

financing or on the sale of health care product creates danger of re-verticalization of service delivery. The PBF or RBF the approach is driven through 'a package of priority services' which itself is problematic as policymakers till now have not found ways of integrating vertical programmes since the links between medical services, health services and health systems are not well developed (Qadeer, 2013). This drives healthcare systems to prioritise and take up activities with immediate tangible the outcome as well as activities where the incentives are more regularly paid, while neglecting the roles with irregular payment or discontinued payment because of unsustainable financing. Not only this, the Bangladesh experience further shows that in the case of low-income communities, partial performance-based income raised through user-charges is regressive for patients as it limits access to care.

As observed in India, PBF also undermines imparting of reproductive knowledge against the promotion of other services, thus violating women's rights to free and informed choice. Another drawback with such a model of financing is that where CHWs are dependent on user charges from patients in low-income communities, then patients are vulnerable to get targeted and coerced as seen in Bangladesh. Lohmann and her colleagues (2015) studied the perception of PBIs by CHWs in Malawi and highlighted the need to improve health care related resources otherwise 'PBI might be more stick than carrot'. Health workers reported that PBI increases the workload, and leads to conflict among co-workers with the possibility of fraudulent records. The mode of operation of PBI/RBF is crucial for CHWs accountability. In fragile, fragmented countries like Congo with low government expenditure, it is observed that for PBF to be effective it has to be embedded within wider financing and health sector reforms. In such a context, salaries for CHWs are more adequate than just PBF/PBI/RBF (Fox et al., 2014). Of late, WHO (2018) further recommends that remuneration for practising CHWs has to be 'commensurate with the job demands, complexity, number of hours, training and roles that

they undertake’ and ‘suggests not paying CHWs exclusively or predominantly according to performance-based incentives’.

CONCLUSION

The South Asian experience of CHWs does say that an adequate income, in addition to being a right, has a definite value since it valorises CHWs work and gives them recognition in their respective country’s health system. It also shows how in South Asia over the first two decades of this millennium the nature of CHWs participation in the health sector has got transformed from radical activist health work to technocratic volunteerism. In other words, the lines between ‘altruism, material award and the labour’ as demanded by the state have got blurred (Brown and Prince, 2015). CHWs continue to remain informalised worker as last extension workers of the public health system. Under different circumstances, CHWs have shown their potential in improving the functioning of the health system. Performance-oriented incentivization (financial or non-financial) is exploitative and extractive in nature, undermines their capacities, right to work, right to health and gender equality.

Pakistan shows that organising and collective action of LHWs, including by taking a legal course, helped them regularise their job and be recognised as a civil servant, with salary and allowances like other civil servants. They built up a broad-based network and created alliances with other trade unions and with civil society organisations. They, for instance, received the support of the Clerks Association, unions in the public sector and paramedical staff association. The time spent by CHWs on the work assigned to them shows the formality of their occupation, yet it does not get recognised.

This remains a continuous challenge: to recognise CHWs as workers and secure them employment with minimum wage and legal entitlements. This also means that there is now a need to move beyond the discourse of community recognition and their altruistic

spirit as the sole and sufficient motivation for CHWs. The fact that their work is essential to the public health system and is no ordinary work has to be established. There has to be a collective and broad-based struggle, as seen in the case of Pakistan. The category of CHWs as 'less specialised health care workers', is used by policymakers to judge their payments from a different perspective, that of motivation.

Regularisation is necessary, but does not address how CHWs will be accountable to their community (through local representative structures). It is essential to find an environment to reclaim this important role. It is also important for the women's movement of the respective countries to understand the interfaces of CHWs work, gender norms and structures, and public health workforce and locate them within the broader neo-liberal regimes of these countries. This will be a building block for them to support CHW unions and to see the political dynamics within which they are working, fighting for their denied labour and social protection rights, salaries, recognition as workers and, in the process, negotiating their space.

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