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Charting the Rights of Community Health Workers in India: The Next Frontier of Universal Health Coverage

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Abstract

Community health workers (CHWs) have the capacity to bring essential health services to under-resourced communities. Globally, CHWs have made significant contributions to poverty alleviation, increased food security, and reductions in health inequalities. India's one million accredited social health activists (ASHAs), the largest cohort of CHWs in the world, have been credited with increasing the rate of institutional deliveries and the uptake of vaccinations. ASHAs operate at the margins of health systems and the formal health workforce, often due to misperceptions of their skills and discrimination based on gender, socioeconomic status, education, and rurality. The "voluntary" nature of their work can entrench their precarious status, which is characterized by a lack of access to employment rights, adequate remuneration, and institutional support. This article argues that the prioritization of the labor rights of CHWs in the design and implementation of the World Health Organization's 2018 *Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes* can serve to ensure safe working conditions and freedom from discrimination, coercion, and violence. It further argues that the resultant enhancement and protection of CHWs' rights and long-term security provides an essential pathway for harnessing their potential to transform universal health coverage.

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Introduction

> *By fully harnessing the potential of community health workers, including by dramatically improving their working and living conditions, we can make progress together towards universal health coverage and achieving the health targets of the Sustainable Development Goals.*[1]

In 2017, the first international symposium on the work and role of community health workers (CHWs) was held in Uganda. The symposium marked almost 100 years of an extraordinary contribution to the provision of health care across the world, particularly the delivery of "preventive, promotive and curative services" in relation to communicable diseases, maternal and child health, and noncommunicable diseases.[2] Hosted by Makerere University School of Public Health and Nottingham Trent University, the symposium brought together researchers, practitioners, policy makers, and CHWs to address issues concerning the evolution, contemporary operation, and sustainability of CHW programs. In particular, it examined the contribution of CHWs to the attainment of the Sustainable Development Goals (SDGs), noting that CHW programs had the potential to be a "huge driving force to attain at least seven SDGs," including ending poverty and ensuring food security, securing health and well-being, reducing inequalities, and enabling global health partnerships.[3]

Building on the 1978 Declaration of Alma-Ata, which acknowledged CHWs as key to the delivery of primary health care, the symposium recognized that there were significant benefits to be derived from investing in CHW programs, given their capacity to bring basic and essential health services to under-resourced, underserved, remote communities. The symposium was an important precursor to the development of the World Health Organization's (WHO's) *Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes*, and the guideline's observation that investment in "community health workers represents good value for money" was subsequently reflected in many other WHO recommendations.[4] Launched in October 2018 to coincide with the Global Conference on Primary Health Care held in Astana, Kazakhstan, the guideline speaks to measures that states might adopt to enhance the selection, training, supervision, and retention of CHWs.[5] To this end, it emphasizes the need to embed or integrate CHWs within their health systems or workforce to avoid "the risk of fragmentation, inefficiency and policy inconsistency."[6]

Underlying this aspiration is a recognition that CHWs have historically operated at the margins or independently of formal health care systems and the health workforce, a status determined largely by perceptions relating to requisite skills and the structural operation of "barriers such as racism, gender inequalities, and discrimination based on poor socioeconomic status."[7] Despite this lack of integration, the benefits of independent models of CHW delivery of health care are often fundamental to the implementation of primary health care objectives, namely brokering "linguistically and culturally appropriate" conduits to health care within diverse communities and facilitating "high levels of health promotion activity," both of which serve to reduce barriers to access to care.[8] The integrated model may, however, offer *benefits to CHWs*, including professional recognition and career advancement, consistent levels of training and supervision, and improved working conditions. For states that might derive some cost-benefit advantage from the "voluntary" and unregulated nature of the work of CHWs (particularly low- and middle-income countries), these features of an integrated health workforce might be the rationale for a reticent or delayed assumption of the model.

While the work of CHWs can undoubtedly be optimized to facilitate the equitable expansion of universal health care coverage and potentially achieve some of the SDGs, the "working and living conditions of CHWs"—seemingly essential to their engagement, optimal performance, and retention—rarely feature as a prominent focus of international CHW conferences and attendant WHO guidelines and recommendations.[9] The 2017 symposium on CHWs in Uganda did include sessions where CHWs themselves addressed the advantages, limitations, and challenges presented by their work.[10]

In addition, the Guideline Development Group responsible for reviewing and analyzing evidence and devising the 2018 WHO guideline (which included policy makers, experts, end users, CHWs, health professional associations, and delegates from labor unions) was influenced by considerations of "best practice in relation to labour rights" and the International Labour Organization's "decent work agenda" when formulating recommendations on CHW remuneration, written contracts (specifying role, responsibilities, and working conditions), and career progression.[11] In support of these recommendations, the Guideline Development Group noted that as the majority of CHWs globally were women, reliance on the voluntary nature of CHW work "could perpetuate gender disparities in access to employment and income opportunities."[12]

This article considers how the "labour rights of CHWs themselves" might be prioritized in the design and implementation of the 2018 WHO guideline.[13] Although the guideline is aimed primarily at assisting national governments and their domestic and international partners in enhancing the impact of CHW programs, a key principle informing its implementation also envisages that consideration be given to ensuring the "safe and decent working conditions [of CHWs and their] freedom from all kinds of discrimination, coercion and violence."[14] While labor rights have the potential to advance the health and well-being of CHWs, their absence remains a central barrier to the retention of this essential workforce and the achievement of universal health coverage. The lack of support, training opportunities, and adequate payment reduces the impact that health workers have on health outcomes, resulting in a weak health workforce and the undermining of universal health coverage. Drawing on a case study of CHWs in India, we trace the history of accredited social health activists (ASHAs), a cadre of workers—predominantly women and designated as "volunteers"—who form the backbone of the Indian health system. We examine the implications that their gender and voluntary status has for their working conditions and long-term security. Despite ASHAs being recognized as fundamental to the delivery of primary health care and as a solution to fast-tracking universal health coverage, they have recently become even further marginalized and undermined as a result of the COVID-19 pandemic.

Accredited social health activists: A case study from India

The ASHA program was introduced by the Ministry of Health and Family Welfare as part of the National Rural Health Mission in 2005. India's ASHAs have been touted as a solution to fast-tracking universal health coverage, achieving delivery quality, and ensuring comprehensive and accessible primary health care. Currently, South Asia requires a 50% increase in health workers to achieve universal health coverage by 2030, in line with the SDGs. It has been widely argued that the training and sustaining of CHWs, including the ASHA workforce, will be India's best chance at meeting this goal.

The ASHA program follows India's long tradition of community programs led by the Indian government since the 1960s and by the nonprofit sector since the 1970s. The program is powered by the contributions of one million female frontline health workers across India and represents the largest all-female CHW program in the world.[15] With the launch of the National Urban Health Mission in 2013–2014, ASHAs are also now available in urban areas, where they cater to vulnerable communities and people living in informal settlements. Currently, there are approximately 900,000 ASHAs in rural areas and over 64,000 ASHAs in urban areas.[16]

As an essential conduit between the public health system and the community, and as trusted community members, ASHAs extend the reach of health care centers to underserved and often rural and remote populations. In many cases, their work has been shown to be effective. For example, ASHAs have been credited with being a trusted source of health information and referral and with increasing the rate of institutional deliveries, visits to newborns within three days of their birth, and the uptake of vaccinations.[17]

India's next frontier of universal health coverage

With significant shortages in the health workforce, the ASHA program has considerable potential to increase health equity, particularly for Indians living in rural and remote areas. A central principle undergirding the program is community participation, with ASHAs available in every village in India (one ASHA per 1,000 population in rural areas).[18] The ASHA policy is based on local residency and community-based selection. Women are selected from and are accountable to the village in which they reside. ASHAs are generally married, widowed, or divorced and between the ages of 25 and 45. The selection process prioritizes women with 10th-grade qualifications or higher but allows for flexibility where necessary.[19] ASHAs are trained on an ongoing basis to gain knowledge, skills, and confidence. The vision and approach of the ASHA program reflects the values set out in the Alma-Ata Declaration, which reinforces effective primary health care as reliant "at local and referral levels, on health workers, including … community workers … suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community."[20]

The ASHA program sits alongside a number of health programs focused on achieving universal health coverage. These include Janani Suraksha Yojana, a safe motherhood intervention under the National Health Mission aimed at reducing maternal and neonatal mortality by promoting institutional delivery among poor and pregnant women.[21] Another program is Mission Indradhanush, which focuses on achieving full immunization coverage for all children and pregnant women.[22] Yet another is Ayushman Bharat Pradhan Mantri Jan Arogya Yojana, which encompasses two complementary schemes: health and wellness centers and the National Health Protection Scheme. The first seeks to provide comprehensive primary health care, free essential drugs, and diagnostic services. The second provides financial risk protection to poor and vulnerable families to cover costs arising from secondary and tertiary hospitalization. The ASHA program is not only highly complementary to these programs but crucial to their reach and effectiveness, as these projects are limited by the acute shortage of skilled health workers, and an increased coverage of essential services is not possible without qualified health workers at the community level.

The effective operation of health systems is central to the realization of the right to health. ASHAs are key institutions in health systems, playing a crucial role in ensuring availability, accessibility, acceptability, and quality, core components of the right to health as set out in General Comment 14 of the United Nations Committee on Economic, Social and Cultural Rights. The community-based ASHA model has strengthened *availability* through the delivery of health care and disease prevention activities by addressing coverage gaps for hard-to-reach populations. Further, this model has contributed to the *accessibility* of health care through nondiscrimination, physical accessibility, and information accessibility. ASHAs' recruitment from communities supports their culturally appropriate and *acceptable* modes of service delivery that are particularly sensitive to gender. In addition, the care they provide caters to the specific needs of their communities, including culturally appropriate means of obtaining consent and ensuring confidentiality. ASHAs play a crucial role in maintaining standards of health care *quality* by delivering evidence-based programs that are safe, effective, people centered, and timely (for example, by reducing waiting times and potentially harmful delays in receiving care), equitable (as care does not vary on account of ethnicity, geographic location, or socioeconomic status), and integrated (with treatment and prevention incorporated into ASHAs' activities). Critical to the progressive realization of universal health coverage and the right to health is the existence of a sufficient, equitably distributed, and well-performing health workforce. Additionally, it is imperative that national systems ensure nationwide capacity to produce a sufficient number of well-trained health workers whose terms and conditions of employment are enshrined in a domestic labor rights framework. Indeed, the effective implementation of the right to health is dependent on ensuring that "underlying determinants of health," including gender equality

and healthy working conditions, are extended and applied to CHWs themselves.[23]

Accredited social health activists' designation as volunteers

In spite of their significant contribution to India's health system, ASHAs often perform their work in precarious conditions. This is due in large part to their designation as volunteers, which has been used to justify and legitimize their exclusion from domestic rights frameworks that govern employment relations, dispute resolution, working conditions, wages, and social security. As a result, ASHAs remain perhaps the least empowered cadre of India's workforce.

This designation has been deliberate. For other categories of workers within the organized sector, India's legal system plays an important role in regulating the terms and conditions of employment. Legislative instruments such as the Factories Act, Contract Labour Act, Payment of Wages Act, Minimum Wages Act, and Equal Remuneration Act provide a broad range of entitlements and protections. For example, the Factories Act provides for the health, safety, welfare, working hours, and leave of workers in factories; the Contract Labour Act regulates the engagement of contractor and contract labor by the principal employer; the Payment of Wages Act regulates the payment of wages and provides responsibility for the payment of wages, fixation of wage period, and time and mode of payment of wages; and the Minimum Wages Act stipulates minimum rates of wages that must be paid to skilled and unskilled workers, taking into account factors such as the location and nature of work.

In addition to the voluntary status of ASHAs and their consequent exclusion from the formal regulation of employment conditions, labor-related discrimination against them is further exacerbated by their gender. Predominantly women, ASHAs face multiple, intersecting forms of discrimination due to their gender, lower socioeconomic status (as they often come from marginalized communities, including Dalits and Adivasis), rurality, lower levels of education, and low status within the health workforce.[24] In addition, women in insecure, part-time, or contract work confront many structural barriers to parity with male workers in similar work environments. Equal remuneration protections (enshrined in the Equal Remuneration Act) aim to ensure the equal remuneration of men and women and to prevent discrimination on the basis of gender in employment and professional opportunities. This relates not only to disparities in pay but also to recruitment processes, job training, and promotions. In 2002, India's second National Commission on Labour recommended legislative reform to ensure a minimum level of protection to workers in the unorganized sector given that the Labour Code on Wages Bill—which consolidates the Minimum Wages Act, Payment of Wages Act, and Equal Remuneration Act—does not include voluntary workers paid by honorarium in its definition of worker.[25]

As volunteer workers, ASHAs do not enjoy the protections offered by India's labor laws. Volunteers are generally those who enter into a service of their own free will and for little or no financial gain. Voluntarism is typically motivated by altruism rather than remuneration, and commitments are moral rather than legal. In effect, this designation allows India's central and subnational governments to utilize ASHAs as low-cost instruments of social mobilization through which the health workforce can improve health equity, access, and quality. It is unsurprising, then, that the provision of enforceable employment rights, adequate remuneration, and institutionally supported work has been noticeably absent from political discourse. The national and subnational governments, meanwhile, enjoy a great deal of freedom in designing the incentives they offer to ASHAs to encourage their participation, with minimal accountability. Despite the National Health Mission's claim that it has a well-functioning grievance redressal system, should ASHAs have a grievance in relation to their working conditions and entitlements due to their exclusion from the legal frameworks described above, there are no legal safeguards if the grievance procedure is not accessible, equitable, timely, effective, or procedurally fair.[26] Ultimately, where ASHAs' working conditions are unfavorable, their capacity and agency to

change their situation is severely compromised.

ASHAs' designation as volunteers, despite the payment of honorariums and monthly remuneration in some states, sets them apart from other workers and also shapes their lived experience in significant ways.[27] Prior to the COVID-19 pandemic, there was considerable dissatisfaction among ASHAs in belonging to the unorganized sector, despite working for government. In addition, ASHAs were burdened by a heavy workload, working long hours without receiving incentives for tasks such as medication adherence and noncommunicable disease (NCD) prevention. The inadequacy of their remuneration encouraged many ASHAs to take up second jobs to provide for their families, positions that were often compromised due to their increasingly demanding workload as ASHAs.[28]

As the COVID-19 pandemic continues, ASHAs are facing an exacerbated situation in order to carry out their lifesaving work. Further, they have often been reprimanded for using their social and political power to fight for their rights and promote their priorities—many of which do not align with national health objectives that benefit from their exclusion from labor rights. In 2020, during the COVID-19 pandemic, 22 ASHAs were threatened with dismissal by the state of Madhya Pradesh after demanding better pay, protective gear, and fixed tenures in nationwide protests, some during election rallies. The states of Haryana and Delhi filed police cases threatening termination against ASHAs for being absent from their work stations on the days of the protests.[29]

Conditions of work

During the COVID-19 pandemic ASHAs have reported exhaustion, discrimination, stigma, and inadequate personal protective equipment.[30] This has led to feelings of alienation and being undervalued.[31] Despite being more likely to come into contact with COVID-19 cases, they have experienced a lack of sanitizers and masks, forcing them to use handkerchiefs or dupattas to carry out their work. In addition, ASHAs have been required to travel long distances on foot in temperatures as high as 46 degrees Celsius.[32] While the central government has directed states to provide all ASHAs with personal protective equipment, this has often not occurred. ASHAs have reported receiving only five disposable masks (which generally last for a total of 10 days) and one sanitizer each per month of work. Due to ASHAs' low status, when additional masks become available, they are often given to higher-level health care staff. While ASHA unions have raised these issues before their state governments, there remains a significant shortage of personal protective equipment for ASHAs. In some cases, ASHAs have been asked by public health centers why they need masks at all, and ASHAs have reported that they sense that higher-level officials believe they are undeserving of such protective gear.[33]

Scope of work

ASHAs are frequently the first port of call for health-related demands, particularly where women and children face challenges in accessing health services. Since the introduction of the ASHA program, their role within their communities has expanded in response to community need. Their expanding responsibilities include the promotion of universal immunization, the provision of referral and escort services for reproductive and child health programs, and counseling for women on birth preparedness, safe delivery, breastfeeding, contraception, and the prevention of common infectious diseases. In addition, ASHAs in some states undertake NCD prevention work, including listing individuals with hypertension, diabetes, and cancers (oral, cervix, and breast); encouraging the community to screen for NCDs; and providing medication adherence support.[34] Further, ASHAs are equipped with a drug kit to provide first-contact health care, are expected to encourage community participation in public health programs operating within their villages, and are equipped with knowledge of the health facilities near their village, including the closest Anganwadi (rural child care centers), subcenters, and primary health centers where mothers can access antenatal, postnatal, and other care.

During the pandemic, ASHAs have been required to undertake additional tasks mandated by

the Ministry of Health and Family Welfare, including delivering medicines, conducting home visits to the elderly, and ensuring critical care for those on dialysis. They have been required to track, test, and monitor COVID-19 patients within their villages and cities. This has involved visiting workers in the quarantine center in the village twice a day to monitor for symptoms and report to the public health center. It has also involved door-to-door surveys between 25–50 households a day to check for symptoms—particularly among older persons, those with heart conditions and respiratory issues, tuberculosis patients, pregnant women, and other high-risk populations—and report positive cases to the public health center. A recent report suggests that ASHAs in Andhra Pradesh and Telangana have been required to monitor individuals recently returning from overseas, migrant laborers, and lorry drivers up to four times a day. Their scope of work, estimated at 2–3 hours per day pre-pandemic has now increased to 12 hours a day, and they are expected to remain on call after these formal hours of work.[35]

Underpayment and nonpayment

State health planning and budgeting makes minimal provision for the inclusion of ASHAs in human resources. They are compensated for their time only in specific situations (such as training attendance, monthly reviews, and other meetings). In addition, they are provided performance-based incentives for their services under various national health programs. These incentives are often inadequate and do not cover the full scope of services provided by ASHAs. States have been given the flexibility to design their own incentives for ASHAs, resulting in significant incentive variability across the country.[36]

For many years, ASHAs had demanded to be included within the cadre of permanent health care staff, with a fixed pay of 18,000 rupees (US $256) per month. In 2018, ASHAs, through their unions, made demands for fixed tasks and work hours. Some progress was made with the increase in honorariums and the doubling of incentives. Currently, they are entitled to 2,000 rupees (US$30) per month, conditional on the completion of their tasks. In addition, ASHAs may receive incentives for specific tasks—for example, 1 rupee (US$0.015) for every oral rehydration solution packet distributed, funded by the National Health Mission's child health program, and 300 rupees (US$4.15) for facilitating an institutional delivery, funded by the National Rural Health Mission's maternal health program. Incentives are earned for state-specific activities. Eleven states with high fertility rates offer 200 rupees (US$2.77) for the provision of family planning services.[37]

Some states (Andhra Pradesh, Kerala, Karnataka, Haryana, West Bengal, and Sikkim) have introduced fixed monthly honorariums for ASHAs or top-up incentives. In Rajasthan, ASHAs were selected from Anganwadi workers and this group continues to perform the activities of both ASHAs and Anganwadi workers. For this group, ASHAs receive fixed honorariums from the Integrated Child Development Services scheme and activity-based incentives from the National Health Mission.[38]

To support ASHAs' increased workload during the pandemic, the central government announced additional payments of 1,000 rupees (US$15) per month. Some state governments have provided additional payments. For example, in Punjab, ASHAs are provided an additional 2,500 rupees and financial aid of 10,000 rupees when they are infected with COVID-19.

Despite these developments, there remains no standard procedure for the revision of honorariums and no incentives for NCD treatment and prevention work.[39] Further, claiming and releasing payments involve lengthy processes, leading to ASHAs often going unpaid for months. There is little accountability in ensuring that their incentives and benefits are received. As volunteers and activists, ASHAs are held to account under national health programs (despite not being government employees). However, health service stakeholders have not taken ownership of other institutional mandates of the ASHA scheme, such as ensuring that village health committees engage and receive payment on time. In addition, ASHAs often pay out of pocket for work-related costs (such as travel) that should be covered by village health committees.

Social security

Social security is one area where there have been welcome improvements. For many years, ASHAs made demands for insurance and related benefits. In 2018, the Indian prime minister announced a social security benefit package for ASHAs, including life insurance, accident insurance, and pension. Prior to this, a number of subnational governments had implemented social welfare schemes using National Health Mission funds and state funds. In addition, an insurance scheme, Ayushman Bharat (discussed earlier), was launched in 2018 and provides health benefits of up to 5 lakh rupees (US$7,417) per year for families, based on Socio-Economic Caste Census data.

Framing rights: Prioritizing a model for community health worker protection

Health volunteerism in under-resourced public health systems

The notion of "health volunteerism" as foundational to CHW programs is critical to the supplementation of often overextended and under-resourced public health systems.[40] CHWs are often drawn to the role because they are keen to ensure and support the health and health literacy of their community, to build their own knowledge about health care, and to be associated with the effective operation of a health care system. Yet, the pressures they confront, both personally and professionally, frequently combine to undermine the sustainability of the CHW programs.[41] Where women make up the majority of the CHW workforce—as in the case of ASHAs—the retention of CHWs is further compounded by their vulnerability and exposure to physical harm and discrimination, the barriers posed by cultural norms, and their workplace exploitation.[42]

Addressing employment discrimination to accelerate gender equality

The year 2020 was projected to be a turning point for accelerating gender equality. It marks the 25th anniversary of the Beijing Declaration and Platform for Action, a visionary agenda for the empowerment of women. A core component of the Beijing Declaration is the elimination of all forms of employment discrimination. This includes, but is not limited to, enacting and enforcing laws that reflect principles of equal pay and workers' rights, as well as eliminating discriminatory practices by employers.[43] The declaration requires states, where necessary, to reformulate wage structures in women-dominated professions in efforts to address their low status; inadequate remuneration and exclusion from legal frameworks that would otherwise offer protections relating to employment relations; working conditions; wages; and social security.[44]

Global women's health and women's rights advocates had planned to leverage the anniversary of the declaration to trigger global collective action to transform the situation for women at work, particularly the most marginalized. In early 2020, when the COVID-19 crisis accelerated, global advocacy activities aimed at engaging global leaders in gender equality targets were stalled, with governments, international organizations, and civil society organizations turning their attention to managing the pandemic and their overburdened and inadequately resourced health systems, operationalized largely by women. Although the ASHA program has provided a significant mechanism for engaging CHWs, enhancing their skills and providing these women with a limited income, the demands of the pandemic have both exposed and exacerbated existing inequalities in social, political, and economic systems in general and in public health systems more specifically. As a consequence, the United Nations and gender equality advocates globally have expressed concern that the COVID-19 pandemic could reverse the limited progress that has been made for gender equality with the further exploitation of female health workers in insecure jobs or living close to poverty.[45]

Community health worker rights and the sustainability of India's health system

Well positioned "to build on the foundations of trust" established within their communities of service and "to communicate and implement new and rapidly evolving community-level response

measures," CHWs are clearly critical to endeavors directed at "fighting the pandemic, especially in low-income countries with vulnerable health systems."[46] It is perhaps in times of severe pressures on health care systems, as in the case of pandemics or political conflict, that the aspiration to universal health care is most acute and the need for CHWs most urgent. However, the imperatives underlying these social and political crises can create environments where the safeguards required for the effective functioning of voluntary health workers are often suspended or nonexistent. Reports of health care workers facing increased stigma, discrimination, and physical violence in the COVID-19 environment prompted a number of humanitarian and medical organizations to release a declaration in May 2020 denouncing over 200 COVID-19-related attacks on health care workers and facilities.[47] The declaration called on "all governments … to ensure that health care is protected by domestic law, that all health care professionals have a safe working environment, and that mental health support is offered not only to victims of violence, but also to those working under increased levels of stress."[48] The absence of a framework of protection for essential CHWs, such as India's ASHAs—who carry a disproportionate burden of the pandemic response—can serve to undermine the stable operation of CHW programs and the prospect of their long-term sustainability.[49]

Against WHO's forecast that the global shortage of health workers by 2030 will reach approximately 18 million, numerous studies have been undertaken to examine and enhance incentives underlying the recruitment and retention of CHWs, given their vital contribution to ensuring "access to basic health services where the formal sector falls short."[50] While most of these studies have made recommendations relating to the recruitment, training, remuneration, workplace environment, and career progression of CHWs, the extent of their implementation remains questionable. (A multicountry study conducted by researchers at the Frontline Health Project through Population Council and Johns Hopkins Bloomberg School of Public Health is yet to report on the evaluation of incentive preferences to improve performance and retention of CHWs, strengthen CHW programs, and leverage limited government resources appropriately.)[51] In addition, despite evidence of discrimination against CHWs and workplace exploitation, the recommendations seem to omit consideration of incentives that ensure the "safe and decent working conditions [of CHWs and their] freedom from all kinds of discrimination, coercion and violence."[52] The impact of discrimination on health care workers and the "close link between the fulfillment of the rights of health workers, including labour and employment rights of CHWs, and that of health care seekers" was the rationale for a dedicated plenary session at the 2017 Prince Mahidol Award Conference.[53] One of the speakers, Sarojini Nadimpally, executive director of the Indian women and health resource group Sama, described ASHAs "as central to delivering care to rural and marginalized populations" yet lacking commensurate recognition or reward: "the lowest rung of health providers … paid one rupee for every packet of sanitary napkins that they sell."[54] Speakers also highlighted the link between CHWs' accountability toward the health system and their communities and the provision of equitable working conditions and appropriate tools, reasonable remuneration, and recognition: "[H]ealth accountability is attained when governments respect, protect, and fulfill the right to health, and when health sector employees are treated respectfully."[55]

The need for a CHW charter of rights

All these initiatives—the conferences and symposiums, the guidelines and goals, the declarations and calls to governments around the world—point to a clear need to declare and protect the rights of CHWs in order to effectively address the acute deficiency of global health workers. What form this will take will necessarily be determined by local conditions and experiences and the extent to which CHWs have developed "capacity for the … collective action necessary to be heard by more powerful actors," such as staging protests and strikes, drafting and securing political support for protective legislation, and advocating for labor rights through

an organized (or unionized) cohort.[56] Given the precarious status of many CHWs across the world ("at or near the bottom of the front-line health worker hierarchy"), the variability of their working conditions, and the degree to which they are perceived as integral (as opposed to an add-on) to a public health system, the development of a normative framework, equivalent, for example, to a broad universal charter of rights for CHWs, might require impetus at a global level via the combined advocacy and intervention of international health and human rights organizations or coalitions with strong CHW representation.[57] A charter, which might combine core principles reflecting CHW accountabilities (training, performance evaluation) and rights (remuneration, equipment and clothing, protection against discrimination and violence), would offer a significant incentive toward the maintenance and expansion of CHW programs. The United States Agency for International Development (USAID) has developed a Flagship Community Health Worker Resource Package for use by ministries of health, implementing partners, USAID missions, UNICEF country offices, and investors in the health sector and other development areas to strengthen CHW programs by integrating CHWs within broader health workforces and promoting their professionalization. Enablers listed in the program include considering the rights and perspectives of CHWs.[58]

The development and adoption of a broad charter of rights for CHWs would also build on the resolution adopted in January 2019 by the 72nd World Health Assembly, entitled *Community Health Workers Delivering Primary Health Care: Opportunities and Challenges*, which urges member states to "optimize community health worker programmes … with the objective of the success of primary health care and the achievement of [universal health coverage]."[59] By reference to effective implementation of the *WHO Global Code of Practice on the International Recruitment of Health Personnel*, the resolution underscores the importance of cooperation among

> *health ministries, civil service commissions, and employers to deliver fair terms for health workers and a positive practice environment to enable their effective deployment, retention and adequate motivation to deliver high-quality care and build a positive relationship with patients.*[60]

Facing similar imperatives that underlie the recruitment of CHWs, namely the "global shortage of health personnel" and the capacity of member states to achieve "internationally agreed development goals" (such as the SDGs), the *WHO Global Code of Practice on the International Recruitment of Health Personnel* was devised to strengthen health systems by establishing voluntary principles and practices and improving legal frameworks "for the ethical international recruitment of health personnel, taking into account the rights, obligations and expectations of source countries, destination countries and migrant health personnel."[61] Although focused on the recruitment of international health personnel to serve in domestic health workforces, many of the code's guiding principles applicable to this engagement are potentially instructive in relation to safeguarding the rights of CHWs recruited to enable the operation of overburdened national health systems. These include the application of principles of transparency and fairness in relation to the recruitment of health personnel; fair labor practices in conformity with national legislation; principles of nondiscrimination to all aspects of the employment and treatment of health personnel; appropriate induction and orientation programs to enable safe and effective practices within a health system; and opportunities and incentives to enhance knowledge, expertise, and career progression.[62]

Despite the apparent benefits of a more regulated and paid CHW workforce, proponents of CHWs' health voluntarism highlight the benefits of such an approach, including a sense of altruism, social recognition, job satisfaction, peer support, and continuing education.[63] Others have argued that from a health systems perspective, what motivates CHWs is adequate remuneration regardless of whether it takes the form of performance-based incentives or a formalized, salaried position.[64] In spite of the strong ethical and moral arguments favoring the protection of CHWs' rights, the potential impact on India's health expenditure, particularly

within a pandemic environment, also remains unclear. In India, primary health care makes up only 44% of health spending, for an average of US$26 per capita.[65] Arguably, investments in the appropriate remuneration for CHWs could "crowd out" other essential services. Further, formalizing the CHW workforce may be challenging for governments influenced by the social acceptability of salaried CHWs. Health voluntarism is tied to racial, cultural, and religious notions of health care. Such health care is overwhelmingly considered "women's work," which populations may perceive to be service to community rather than employment.[66] Some scholars have also highlighted that the extension of labor rights to CHWs could transform CHWs into government extension workers, which is distinct from the initial premise of the ASHA program, which characterizes them as social health activists capable of mobilizing around health inequities faced by their communities.[67] Such a shift, it is argued, could impact their role as trusted representatives of the community.

Ultimately, in the face of CHWs' deepening poverty, increasing vulnerability, and severely limited resources, the "spirit of volunteerism" is insufficient motivation for sustaining this workforce.[68] The ASHA model can be reinforced through a strong domestic rights framework, and this need not entail the erosion of the benefits afforded by volunteerism. The successful operation of salaried health workers within hard-to-reach communities across India highlight that altruism and connection to community can and do exist alongside employment rights, adequate remuneration, and institutionally supported work. Innovative policy models informed by a CHW charter of rights could meet this aim by addressing insecure working conditions and building on ASHAs' foundation of trust within the community.

Conclusion

> *[E]ven in well-functioning programs, CHWs often have little space to negotiate for themselves at work, due to their poverty, gender, lower educational levels, poor exposure and the lack of growth opportunities. It is therefore necessary to take a rights- and gender-based perspective of CHW programs in order to strengthen both the CHWs and the programs.*[69]

A multicountry study of CHWs in low- and middle-income countries published in 2016 examined the limitations and opportunities for CHW "empowerment." Highlighting the critical role played by CHWs in empowering communities via the promotion and facilitation of access to health services, the study demonstrates the corresponding benefit of CHW empowerment in securing this objective. Urging a move away from "an instrumentalist approach to CHWs," which sees CHWs as a necessary supplement to a health workforce, the study found that "access to privileged medical knowledge, linking CHWs to the formal health system, and providing them an opportunity to do meaningful and impactful work" enhanced the health outcomes of the communities they served.[70]

At the core of CHW empowerment is the right to exercise agency, the right to safe and conducive working conditions, and the right to assert claims to accountability and redress, particularly when the design and implementation of CHW programs and work environments hamper and undermine CHW contributions. Such discrimination within the health workforce can act as a powerful barrier to health services and contribute to poor quality of care, therefore undermining India's aspirations for achieving universal health coverage. Although local CHW programs are clearly informed by distinct historical, political, cultural, and socioeconomic influences, their common objective is to enhance the health outcomes of the communities they serve which are often remote and under-resourced. On a global level, against the backdrop of poverty, climate change, displacement, gender violence, and emerging pandemics, this aspiration is directed at the achievement of some of the SDGs and the acceleration of progress toward universal health coverage. Central to both is the effective maintenance and urgent development of sustainable CHW programs and the recruitment, training, and retention of sufficient CHWs. A human rights-based approach provides clear principles for charting rights and targeting discriminatory practices and unjust pow-

er relations at the heart of the ASHA experience. The empowerment of CHWs through the delineation of their rights "is an essential prelude to them being effective in enacting their [various] roles" and to their transformation of health systems that will "'reach the unreached' with health services, develop and support community participation and health education, and help patients to manage long-term health conditions."[71]

References

1. World Health Organization (WHO), *WHO guideline on health policy and system support to optimize community health worker programmes* (Geneva: WHO, 2018), p. 8.
2. Ibid., pp. 3, 18. See also Susan B. Rifkin, "Alma Ata after 40 years: Primary health care and health for all—from consensus to complexity," *BMJ Global Health* 3/Suppl. 3 (2018).
3. Kampala Statement from the 1st International Symposium on Community Health Workers. Available at http://www.hifa.org/sites/default/files/publications_pdf/Kampala_CHW_symposium_statement-FINAL.pdf.
4. WHO (2018, see note 1), p. 8.
5. WHO, Declaration of Astana (2018).
6. WHO (2018, see note 1), p. 71.
7. S. Torres, H. Balcázar, L. E. Rosenthal, et al., "Community health workers in Canada and the US: Working from the margins to address health equity," *Critical Public Health* 27/5 (2017), p. 534.
8. S. Torres, R. Labonté, D. L. Spitzer, et al., "Improving health equity: The promising role of community health workers in Canada," *Healthcare Policy* 10/1 (2014), pp. 77, 83.
9. D. Maher, "'Leaving no-one behind': How community health workers can contribute to achieving the Sustainable Development Goals," *Public Health Action* 7/1 (2017), p. 5.
10. Makerere University College, *Symposium on community health workers and their contribution towards the Sustainable Development Goals* (2017). Available at http://www.chwsymposium.musph.ac.ug/.
11. WHO (2018, see note 1), pp. 13, 47–51.
12. Ibid., p. 48.
13. Ibid., p. 70.
14. Ibid., pp. 13, 70.
15. R. Ved, K. Scott, G. Gupta, et al., "How are gender inequalities facing India's one million ASHAs being addressed? Policy origins and adaptations for the world's largest all-female community health worker programme," *Human Resources for Health* 17/3 (2019), p. 3.
16. National Health Mission, *Update on ASHA Programme* (July 2019). Available at http://www.nhsrcindia.org/sites/default/files/ASHA%20Update%20July%202019.pdf.
17. D. Bettampadi, M. L. Boulton, L. E. Power, et al., "Are community health workers cost-effective for childhood vaccination in India?," *Vaccine* 37/22 (2019), pp. 2942–2951; S. Swain, P. Swain, K. S. Nair, et al., "A rapid appraisal of functioning of ASHA under NRHM in Orissa," *Health and Population: Perspectives and Issues* 31/2 (2008), pp. 73–79; S. S. Gopalan and V. Durairaj, "Addressing maternal healthcare through demand side financial incentives: Experience of Janani Suraksha Yojana program in India," *BMC Health Services Research* 12/1 (2012), p. 319.
18. National Health Mission, *Guidelines on accredited social health activists (ASHA).* Available at https://www.nhm.gov.in/images/pdf/communitisation/task-group-reports/guidelines-on-asha.pdf.
19. H. J. Koehn, S. Zheng, R. F. Houser, et al., "Remuneration systems of community health workers in India and promoted maternal health outcomes: A cross-sectional study," *BMC Health Services Research* 20/1 (2020), p. 48.
20. WHO, Declaration of Alma-Ata (1978).
21. Government of India Ministry of Health and Family Welfare Maternal Health Division, *Janani Suraksha Yojana: Features and frequently asked questions and answers* (2021). Available at https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=841&lid=309.
22. Government of India Ministry of Health and Family Welfare, *Mission Indradhanush* (2019). Available at https://www.nhp.gov.in/mission-indradhanush1_pg.
23. Office of the United Nations High Commissioner for Human Rights and WHO, *The right to health: Fact sheet no. 31* (June 2008).
24. Ved et al. (see note 15).
25. R. Kumar, "Code on Wages, 2019: A paradigm shift in enforcement of wage related labour laws," *Suraj Punj Journal for Multidisciplinary Research* 2394-2886/10 (2020), pp. 68–91.
26. National Health Mission, *Guidelines for establishing redressal and health helpline* (2018). Available at https://nhm.gov.in/New_Updates_2018/NHM_Components/Health_System_Stregthening/ERS/Guidelines_for_Establishing_Grievance_Redressal_and%20_Health_Helpline.pdf.
27. K. Scott, A. S. George, and R. R. Ved, "Taking stock of 10 years of published research on the ASHA programme: Examining India's national community health worker programme from a health systems perspective," *Health Research Policy and Systems* 17/1 (2019), pp. 1–7.
28. M. Abdel-All, S. Abimbola, D. Praveen, et al., "What do accredited social health activists need to provide comprehensive care that incorporates non-communicable diseases? Findings from a qualitative study in Andhra Pradesh, India," *Human Resources for Health* 17/1 (2019), pp. 1–8.
29. B. Box, *ASHA workers criminalised for fighting for their rights* (2021) Available at https://behanbox.com/3-states-wage-war-against-indias-corona-warriors/.

30. George Institute for Global Health, *Are we doing enough for the mental well-being of community health workers during COVID-19?* (2020). Available at https://www.georgeinstitute.org/profiles/are-we-doing-enough-for-the-mental-well-being-of-community-health-workers-during-covid-19.

31. B. Rao and S. Tewari, *Distress among health workers in Covid-19 fight* (June 2020). Available at https://www.article-14.com/post/anger-distress-among-india-s-frontline-workers-in-fight-against-covid-19.

32. Ibid.

33. P. Changoiwala, *The million women working on India's Covid-19 frontlines* (May 2020). Available at https://reliefweb.int/report/india/million-women-working-india-s-covid-19-frontlines.

34. Abdel-All et al. (see note 28).

35. Rao and Tewari (see note 31).

36. B. Rao, *Promised, mostly never paid: Rs 1,000 Covid wage* (2020). Available at https://www.article-14.com/post/promised-mostly-never-paid-rs-1-000-covid-wage-to-million-health-workers.

37. National Health Mission (see note 16).

38. E. Sarin, S. Smith Lunsford, A. Sooden, et al., "The mixed nature of incentives for community health workers: Lessons from a qualitative study in two districts in India," *Front Public Health* 4/38 (2016).

39. M. Abdel-All, B. Angell, S. Jan, et al., "What do community health workers want? Findings of a discrete choice experiment among Accredited Social Health Activists (ASHAs) in India," *BMJ Global Health* 4/3 (2019).

40. S. Chatio and P. Akweongo, "Retention and sustainability of community-based health volunteers' activities: A qualitative study in rural Northern Ghana," *PLoS ONE* 12/3 (2017), p. 2.

41. Ibid., p. 9.

42. Community Health Workers Central, *Gender and community health workers: Three focus areas for programme managers and policy makers*. Available at https://chwcentral.org/twg_article/gender-and-community-health-workers-three-focus-areas-for-programme-managers-and-policy-makers.

43. Beijing Declaration and Platform for Action, G.A. Res. 50/203 (1995).

44. Ibid., p. 68.

45. T. Burki, "The indirect impact of COVID-19 on women," *Lancet* 8/20 (2020), pp. 904–905.

46. M. Ballard, E. Bancroft, J. Nesbit, et al., "Prioritising the role of community health workers in the COVID-19 response," *BMJ Global Health* 5/6 (2020), p. 1.

47. Health Care in Danger, *Declaration by the health care in danger community of concern: About the current situation of violence against health care* (May 2020). Available at https://www.healthcareindanger.org/wp-content/uploads/2020/05/Declaration_HCiD_Current_Situation_against_HC_PDF1-002.pdf.

48. S. Bagcchi, "Stigma during the COVID-19 pandemic," *Lancet Infectious Diseases* 20/7 (2020), p. 782.

49. Rao and Tewari (see note 31).

50. A. Darzi and T. Evans, "The global shortage of health workers an opportunity to transform care," *Lancet* 388/10060 (2016), pp. 2576–2577; U. Lehmann and D. Sanders, *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* (University of Western Cape, January 2007). Available at https://www.who.int/hrh/documents/community_health_workers.pdf; Chatio and Akweongo (see note 40); S. Agarwal, U. Anaba, T. Abuya, et al., "Understanding incentive preferences of community health workers using discrete choice experiments: A multicountry protocol for Kenya, Uganda, Bangladesh and Haiti," *BMJ Open* 9/12 (2019), p. 1; Abdel-All et al. (see note 28).

51. Agarwal et al. (see note 50).

52. WHO (2018, see note 1), p. 70.

53. WHO, *Discrimination in health care: Determinants and consequences* (plenary session 1.2, Prince Mahidol Award Conference, 2017). Available at https://www.who.int/hrh/news/2017/PMAC2017Stigma_discrimn_meeting-report.pdf?ua=1.

54. Ibid.

55. M. Schaaf, J. Fox, S. M. Tropp, et al., "Community health workers and accountability: Reflections from an international 'think-in'," *International Journal for Equity in Health* 17/1 (2018), p. 2.

56. Ibid., p. 3.

57. Ibid., p. 2.

58. See USAID, *USAID flagship CHW resource package*. Available at https://www.hrh2030program.org/flagship-chw-resource-package/.

59. WHO, Community health workers delivering primary health care: Opportunities and challenges, EB144.R4 (2019), p. 3. Available at https://apps.who.int/gb/ebwha/pdf_files/EB144/B144_R4-en.pdf?ua=1.

60. Ibid., p. 4.

61. WHO, Global code of practice on the international recruitment of health personnel, WHA63.16 (2010), pp. 2, 3. Available at https://www.un.org/en/development/desa/population/migration/generalassembly/docs/globalcompact/WHA_RES_63.16.pdf.

62. Ibid., arts. 3.5, 4.6.

63. L. Shipton, Z. Aysha, and R. Fauziah, "Motivating and demotivating factors for community health workers engaged in maternal, newborn and child health programs in low and middle-income countries: A systematic review," *Journal of the College of Physicians and Surgeons Pakistan* 27/3 (2017), p. 157.

64. O. Hermen, M. Kok, S. Kane, et al., "Salaried and voluntary community health workers: Exploring how incentives and expectation gaps influence motivation," *Human*

Resources for Health 17/1 (2019), pp. 1–12.

65. World Health Organization, *Global spending on health: A world in transition* (Geneva: WHO, 2019).

66. A. Swartz and C. J. Colvin, "'It's in our veins': Caring natures and material motivations of community health workers in contexts of economic marginalisation," *Critical Public Health* 25/2 (2015), pp. 139–152.

67. C. J. Colvin and A. Swartz, "Extension agents or agents of change? Community health workers and the politics of care work in post-apartheid South Africa," *Annals of Anthropological Practice* 39/1 (2015), pp. 29–41.

68. Z. Trafford, A. Swartz, and C. J. Colvin, "'Contract to volunteer': South African community health worker mobilization for better labor protection," *New Solutions: A Journal of Environmental and Occupational Health Policy* 27/4 (2018), pp. 648–666.

69. K. Bhatia, "Community health worker programs in India: A rights-based review," *Perspectives in Public Health* 134/5 (2014), p. 277.

70. S. Kane, M. Kok, H. Ormel, et al., "Limits and opportunities to community health worker empowerment: A multi-country comparative study," *Social Science and Medicine* 164 (2016), p. 27.

71. Ibid., p. 32; Schaaf et al. (see note 55), p. 1.