

EXECUTIVE SUMMARY

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

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The News Minute | Sreekesh Raveendran Nair

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



WGH | WOMEN IN
GLOBAL HEALTH

EXECUTIVE SUMMARY

COVID-19 exposed the gender¹ inequity in the global health workforce

In 2015, the Lancet Commission on Women and Health¹ estimated that women contribute \$3 trillion to global health annually, half in the form of unpaid work. It seems improbable that some of the world's poorest women would take on unpaid work in health when they already have a heavy burden of unpaid care, domestic and subsistence work. Our estimate, however, is that **six million women work unpaid and underpaid in core health systems** roles, effectively subsidizing global health with their unpaid and underpaid labor. Men also occupy health roles that are unpaid, but the vast majority of unpaid health workers are women. Typically, these women are from low-income families, with limited education, working as community health workers (CHWs) in their local communities.

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

The COVID-19 pandemic has put health center stage globally and exposed the deep inequalities between and within countries, highlighting gender inequality between women and men. Women have made an exceptional contribution to health systems, economies and societies from community to global levels since the outbreak of the COVID-19 virus. As 70% of the global health workforce and 90% of health workers in patient-facing roles³, women have shouldered the burden of health systems' delivery for more than two years of unprecedented pressure in a global pandemic.

Even before the pandemic, however, gender inequity was hard wired into the global health workforce, with women clustered into lower status sectors and jobs, marginalized in leadership, with obstacles to their career progression and frequently subject to violence and harassment⁴. In addition, the occupational

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

- Rita, Community Health Volunteer, Nepal, PSI²

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



Source: American Indian Foundation

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

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

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

- Kavita Bhatia Community health worker programs in India: a rights based review⁶

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

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

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



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

KEY FINDINGS

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

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

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

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

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

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

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

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

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

- Source: WHO What do we know about community health workers? A systematic review of existing reviews. 2020⁸

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



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

- Maes, K et al A Women's Development Army: Narratives of community health worker investment and empowerment in rural Ethiopia, Studies in Comparative International Development, 2015⁹

3. Unpaid work tasks differ, as does time commitment

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

for women health workers.

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

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

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



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

- Mary, Community based health volunteer, Kenya

- work or to training to access paid work. The role may be unpaid but periodically there may be additional tasks e.g., vaccination campaigns, that are paid.
- The role of families is complex. In some contexts, women in conservative social settings may gain autonomy through unpaid work, able to leave their houses, mix with other women and do meaningful work with an opportunity to learn. Families, particularly husbands, may coerce women to take these roles in the hope they will earn income.



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

- Maes, K et al A Women’s Development Army: Narratives of community health worker investment and empowerment in rural Ethiopia, Studies in Comparative International Development, 2015¹⁰

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

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

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

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

6. Health systems are weakened by depending on women’s unpaid work

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



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

- Sunita, community health volunteer India

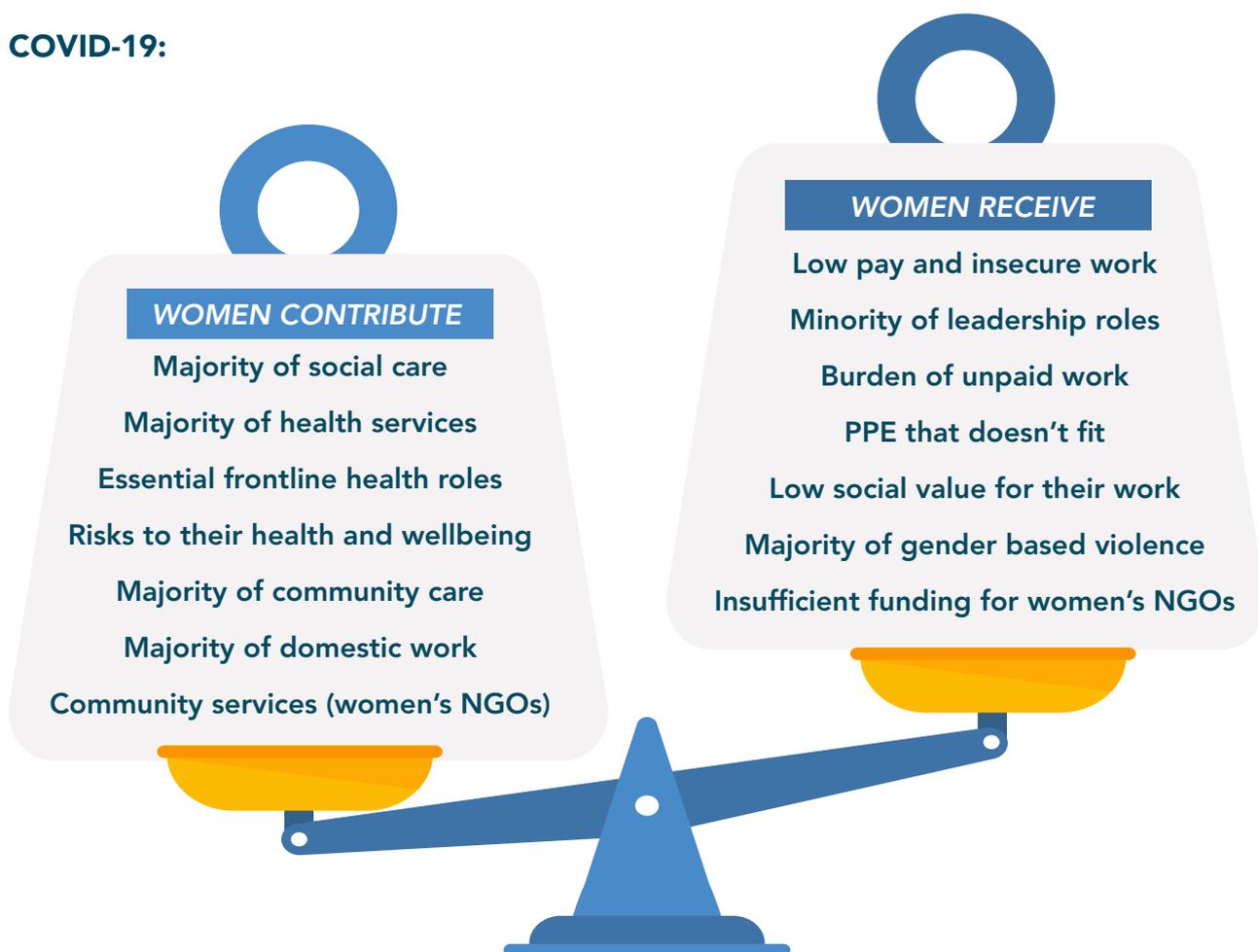
- Talent and expertise are lost to the health system if unpaid women workers are unable to progress into formal sector careers in the health sector.

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

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

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

COVID-19:



Source: Women in Global Health, Global Health Security Depends on Women, 2020¹²

RECOMMENDATIONS

1. Governments must fulfill their commitments

Governments have made commitments in various global fora including the 1995 Beijing Platform for Action and the SDGs¹³ (SDG 8) to deliver safe and decent work and end unpaid work, especially for women.

2. Follow WHO 2018 Guideline for Community Health Workers¹⁴

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

3. Follow the ILO 5R Framework for Decent Care Work¹⁵

The principles (see graphic below) are Recognise, Reduce, Redistribute, Reward unpaid work and the fifth is Representation through social dialogue and collective bargaining.¹⁶ There are examples from India and Pakistan of unpaid and underpaid women health workers improving their position through organizing and collective bargaining. It can be a challenge for women to organize where unpaid workers have low levels of education and work remotely in their communities.

4. Enable women and girls to enter formal sector jobs

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

5. Count women and value their time

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

health systems roles due to incomplete data. It is essential that unpaid workers are seen as workers and not as volunteers. Statistical measures of unpaid care work over time, such as time-use surveys¹⁷ disaggregated by sex, age etc can guide policy makers on measures to ease the burden of women's unpaid work.

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

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

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

Countries, including Ethiopia, have incorporated unpaid community health workers into the formal labor market with positive outcomes¹⁸, providing a precedent for other countries to learn from.

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

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

9. Support gender equal leadership in the health sector

Although women are 70% of the health workforce, they hold only 25% of senior leadership roles.¹⁹ Gender equal leadership can help confront the gendered myths and stereotypes that drive women's unpaid work in the health sector e.g., that the poorest women have 'free' time to work unpaid and that women are altruistic and happy to work unpaid. Women in unpaid health roles at community level express frustration at not being listened to. Health systems would be stronger based on their knowledge.

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

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

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

10. Join the Gender Equal Health and Care Workforce Initiative (GEHCWI)²⁰ led by France and Women in Global Health

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

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

Contact: GenderEqualHCW@womeningh.org



IN CONCLUSION

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

Before the pandemic, it was forecast that an additional 18 million health workers²¹ would be needed to deliver Universal Health Coverage by 2030. The pandemic has stretched health workers and health systems to the limit in most countries. Health workers have died from COVID-19 and millions have contracted 'long COVID' and have longer term health impacts from the virus. In addition, high-income countries, in particular, are experiencing a 'great resignation' of health workers, especially women nurses and midwives, who are leaving the profession due to burnout and mental exhaustion. The resignation of significant numbers of trained health workers in high-income countries is likely to drive unmanaged health worker migration from low-income countries, further weakening vulnerable health systems.

Against this backdrop, at least six million women are working unpaid and grossly underpaid in core health systems roles. These women, often referred to as volunteers, work outside the formal sector and so do not benefit from the fair pay or wider benefits merited by the contribution they make. Health systems, more broadly, fail to harness the full potential of their knowledge and expertise since, as undervalued workers, these women rarely have a career path to progress to formal sector roles.



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

Maes et al Volunteers are not paid because they are priceless, 2015²³

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



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

Closser et Shekhawat The family context of ASHA and Anganwadi work in rural Rajasthan: Gender and labor in CHW programmes 2021²²



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

Ved et al, How are gender inequalities facing India's one million ASHAs being addressed? 2019²⁴



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

Ballard et al, Are dual cadre CHW programmes exploitation by another name?, 2021²⁶



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

Jackson et al, Ethiopia's Health Extension Program, 2019²⁷



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

Omondi unpaid community health volunteer, Kenya, 2020²⁵



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

Woman ASHA community health worker, India, in Closser and Shekhawat, 2021²⁸



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

Perry et al, Health for the People, 2020²⁹

ABOUT WOMEN IN GLOBAL HEALTH

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



For more information: www.womeningh.org

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