Feminization of the Health and Care Workforce in India and South Asia: Implications for Women's Labor and Decent Work

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Abstract

Globally, and particularly in low- and middle-income countries, there is a growing trend of feminization of the health workforce. A significant proportion of women in this field tend to enter the lower echelons of the health workforce hierarchy. Furthermore, their occupation and standing are often influenced by factors such as caste, class, and socioeconomic status. This chapter presents a situational analysis of the primarily female health and care workforce in India and South Asia, employed by the state in roles such as community health workers, nurses and midwives, and early childcare (*Anganwadi*) workers. These occupations are pivotal in sustaining crucial health and care functions within society. Despite their vital contributions, the working conditions of these professionals are marked by precarity, inadequate compensation, weak support systems, and other challenges.

We aim to understand the positioning of these individuals in the health workforce and the existing working conditions by examining literature and applying theories such as neoliberalism, care extractivism, social reproduction, and power and intersectionality analysis. Recently, these workers have been actively resisting state policies through unionization efforts and protests, advocating for improved working conditions and fair wages. While our primary focus is on state-recruited workers, we also extend our examination to the nursing workforce employed by the private sector. The initial analysis concentrates on India; however, subsequent sections incorporate data from other South Asian countries, where available. This inclusive approach allows for analyzing similarities and differences, aiming to provide a regional overview.

Keywords

Health workforce · Feminization · Gender · Nursing and midwifery · Community health workers · Care work

Introduction

Globally, women account for around 67% of employment in the health and care sector, making it a highly feminized sector (63.8% in low- and middle-income countries (LMICs) and 75.3% in high-income countries (HICs)) (World Health Organization (WHO) & International Labour Organization (ILO), 2022). (The health and care sector is identified by various international classification standards, to include activities such as "healthcare and social assistance," "human health activities," "residential care activities" and "social work assistance without accommodation," "ambulatory health care," "hospital work," "nursing and residential care," and "social assistance" (ref. The gender pay gap in the health and care sector: A global analysis in the time of COVID-19, 2022). In this chapter, "health and care sector" refers to the health workers working in hospitals and in primary health care and

frontline health and care workers such as community health workers and Anganwadi workers.) Among social care workers, this proportion further increases to 90% (Lotta et al., 2021).

Gender-based labor market inequalities evident across various economic sectors are also present in the healthcare sector. Occupational segregation is a major driver and consequence of gender inequality; women workers tend to be concentrated in the lower echelons of the occupational hierarchy, experiencing gender pay gaps and encountering glass ceilings (WHO, 2019). The gender pay gaps are higher in the health and care sector than in any other sector, with women in the sector earning approximately 20% less than men (WHO & ILO, 2022). Despite a gradual trend of women advancing to higher positions in occupational hierarchies, there remains an overrepresentation of women in lower-paid occupations, such as nursing, while men are overrepresented in higher-paid roles, such as medical doctors (WHO & ILO, 2022).

Focus on public employment is a significant theme in the analysis of women's work (Sinha, 2022; U.N. Women, 2015). Investments in social services generate substantial employment, particularly benefiting women in fields such as health, education, and care services and also diminish the burden of women's unpaid care and domestic work (Sinha, 2022). However, neoliberal economic policies not only impact employment opportunities by emphasizing privatization but also alter the nature of employment within the public or government sector through greater contractualization and newer forms of engagement such as incentive-based workers, part-timers, consultants and outsourcing (Sinha, 2022). With austerity reforms and increasing commercialization of health services, higher prevalence of contractual labor, poor conditions of work in the private sector coupled with nonstandard (contractual, underpaid and less secure) jobs in the public sector have become the norm (PHM et al., 2021; Thresia, 2016). Commercialization has brought about changes in the management of public sector hospitals, aligning with theories such as new public management. Hence, the feminization of the health workforce with increasing participation of women on the one hand and perpetuation of occupational segregation and concentration of women in relatively low-paying jobs on the other is observed (PHM et al., 2021; Shannon et al., 2019; WHO & ILO, 2022).

With the aim of highlighting the intersections between the feminization of the health workforce and the overall gender division of labor wherein women are seen as being responsible for all social reproduction and care-related activities, this review focuses on the nursing cadres and community health workers (CHWs). The work carried out by nurses, CHWs, caregivers, and food preparation workers, whether in the state or private sector, is particularly undervalued. The frameworks and theories of neoliberalism, "care extractivism," social reproduction, power, and intersectionality offer a valuable context for analyzing the health workforce through a gendered lens. (Care extractivism "marks the intensified commodification and exploitation of the resource labour in social reproduction for the purpose of managing crisis situations without burdening the state or the health industry with additional costs and responsibilities" (Wichterich, 2020, p. 122).) The primary focus of this chapter is on India, supplemented with information from other countries in South Asia to provide a more comprehensive regional perspective.

Based on a narrative literature review, this chapter examines data reflecting these trends, with a specific focus on India and other South Asian countries. A manual recursive search was carried out between May 2023 and June 2023, using Google Scholar and the Google search engine for scientific papers, doctoral dissertations, official websites of multilateral agencies for policy reports, official government websites for government orders, news portal websites for media reports and other grey literature (policy reports, petitions, statements, etc.) from India and South Asia. The search strategy included the keywords: "healthcare workers," "community health workers," "*Anganwadi* Workers," "nurses," "midwives," "care work," "feminization," "health worker unions," "South Asia," and "India." Additional scientific studies and technical reports on human resources in health to the authors' knowledge were obtained, and the bibliographies of those studies were also examined.

The authors of this chapter are public health researchers who are also involved in solidarity work (Mishler & Steinitz, 2001) with health movements and health worker unions. This has lent strength to the research as it has enabled the authors to identify issues that are critical for women health workers and incorporate them into the article. We are conscious of our positionality and have maintained reflexivity through the research process. The external peer-review process has further helped to maintain rigor in research.

Women at the Margins: Health Workforce in India and South Asia

The proportion of women in the health workforce has been increasing globally. This increase in women's participation in the health workforce is accompanied by their larger share in the lower rungs of the health workforce hierarchy. A study of 25 countries finds that feminization in the health workforce, particularly in lower-middle- and upper-middle-income countries, saw "an increase in the proportion of women in allied and support professions alongside a less-steep increase in the proportion of women in clinical and technical professions in all country groups" (Shannon et al., 2019).

These global trends are reflected in the data for India. Based on an analysis of NSS employment data for India for different years, Sinha (2022) finds that the share of women in the health workforce increased from 29.7% in 1993–1994 to 48.9% in 2017–2018 (Table 1). On the other hand, women workers constitute only 23.3% of the total workforce in India (Sinha, 2022).

Based on 2017–2018 National Sample Survey data, Karan et al. (2021) further estimate that women workers constitute nearly 80% of all nurses but only 29% of

Table 1 Share of female to total healthcare workforce

Share of female to total workforce	1993–1994	2004–2005	2011–2012	2017–2018
Health	29.7	37.4	42.6	48.9

Source: Sinha, D. (2022). Unpacking sectoral trends in female employment in India. In Samantroy, E., & Nandi, S. (Eds.). *Gender, Unpaid Work and Care in India*, Routledge Taylor and Francis

allopathic doctors and 13% of AYUSH doctors (Karan et al., 2021). (In 2017–2018, India changed it methodology to measure the employment situation in the country. Prior to 2017–2018, Employment-Unemployment Surveys (EUS) was used, while post 2017–2018, Periodic Labour Force Survey (PLFS) is being used (https://thewire.in/labour/illusory-or-real-unpacking-the-recent-increase-in-womens-labour-force-participation-in-india).)

Changing Nature of Employment and Feminization

One consequence of the stagnation of and cuts in health budgets in South Asian countries following structural adjustment policies in the 1980s and 1990s has been the emergence of nonstandard forms of employment in the healthcare sector (such as contractual or voluntary services) replacing "standard" employment or regular/permanent work (Akhter & Das Shimu, 2016; ILO, 2016). Informalization of employment in public healthcare and related services slowly became prevalent in countries like Bangladesh, India, Nepal, and Pakistan (Baru, 2003). Contractualization, job insecurities, and poor working conditions result in a less committed workforce, and in-service capacity building becomes difficult due to insecure tenures and discontinuities in service (Thresia, 2016).

As highlighted earlier, it is crucial to analyze these trends through a gender lens, as the increasing casualization of labor in the healthcare sector is concomitant with its feminization. The frontline cadre of CHWs in India, called ASHAs (Accredited Social Health Activists) and *Anganwadi* workers under the Integrated Child Development Scheme (ICDS) providing nutrition, health, and early childhood services, are all-women by design (Ved et al, 2019). (Anganwadi workers are honorary workers who look after the Anganwadi/early childcare centres for children from 3 to 6 years and responsible for providing services like preschool nonformal education, supplementary nutrition, etc. (https://pib.gov.in/PressReleasePage.aspx?PRID=1578557).) These occupations are low in the occupational hierarchy but sustain critical health and care functions, including providing primary healthcare and maternal and child health services. The working conditions for these workers, however, are characterized by precarity, insufficient wages, a fragile support system, deficient infrastructure (such as inadequate facilities for toilets, accommodation, and transport), and lack of occupational safety measures (including instances of sexual harassment, physical and psychological violence, as observed during the COVID-19 pandemic) (Park et al., 2023; Closser et al., 2023). Additionally, there is often inadequate training, supervision and support provided (Kapilan, 2020; Sinha et al., 2021a; Chatterjee, 2020; George et al., 2020).

The framework of social reproduction has been found useful in understanding the processes of concentration of women in the health and care sector (Fortunati, 1995). The framework takes into account the various forms of waged and nonwaged work that go into maintaining life and is related to the structures that make up the social system being reproduced (Rao et al., 2021). This framework helps in understanding how certain work that is traditionally confined to the domestic space remains

underpaid and undervalued even when it enters the market and employment sphere (Barbagallo, 2016). The tasks of social reproduction are largely assigned to women, who are seen as being "naturals" in these roles, carrying forward the gender-based division of labor into the market, state and other public spaces (Ferguson, 2019; Federici, 2010). In the context of the healthcare sector, this results in women becoming concentrated in nursing and other "caring" jobs (Hoang Minh Uyen, 2023).

The undervaluation of care work in the economy has also been analyzed through an intersectional lens using the concept of "care extractivism." This can be applied especially to the role of CHWs in making health services available to people without a high financial burden on the state (Aye et al, undated). In the subsequent sections, we delve into these issues concerning nursing cadres and frontline workers in India and other South Asian countries.

The Dire Situation of Nursing and Midwifery Personnel

Nursing-related formal and informal work is highly feminized across South Asia. For instance, as seen above, 80% of nurses and midwives in India are women (Karan et al., 2021), and in Bangladesh, 90% of nurses and 100% of midwives are women. In Nepal, Pakistan, and Sri Lanka, the midwifery cadres consist exclusively of women. In India and Pakistan, a significant number of nurses are predominantly employed in contractual positions, intensifying their vulnerability as women workers, particularly in the aftermath of the COVID-19 pandemic (PHM et al., 2021; Bibi, 2020; The Dawn, 2020). The growing commercialization and privatization of public healthcare in these countries have additionally exacerbated the precarious nature of employment conditions for nurses. In India, there is a growing trend of outsourcing public services to the private sector, a practice that entails hiring workers through agencies and engaging staff in essential and enduring activities on short-term contracts (Sinha, 2022). This approach not only deprives workers of their rights but also leads to divisions within the workforce.

Since colonial times, the field of nursing in India has been characterized by a predominance of women and has long faced systemic challenges related to education, training, regulations and leadership (Das & Singh, 2022; Mayra et al., 2021; Varghese et al., 2018). (It is important to note that India does not have a cadre of competent independent midwives, and midwifery education is provided as part of the nursing education (Mayra et al, 2021) Therefore, in this chapter, while referring to nurses, we also talk about midwives (also see the table).) Nursing is situated within gendered expectations of caregiving and is often viewed as menial work, in contrast to the work of doctors, who are perceived to be providing specialized services and making clinical decisions. Nurses-midwives receive inferior treatment by the medical fraternity as well as society, where nursing is associated with "dirty work" linked to notions of "purity and pollution" (Ray, 2016). An ethnographic study done in West Bengal state showed that within the health workforce, while historically doctors came from "upper" castes, the nursing staff came from "lower"

castes (Ray, 2019). Hierarchies also exist within the nursing profession, with formally trained nurses delegitimizing traditional nursing practice and delegating caring work to lesser-trained women (Ray, 2019). A Gujarat-based study showed that 49% of qualified nurses working in private hospitals came from marginalized caste groups (Scheduled Castes and Scheduled Tribes), earning 9% less than similarly qualified and practiced nurses from general caste categories (Seth, 2017).

Nursing occupations in India broadly include Auxiliary Nurses & Midwives (ANM), Staff Nurses, and Community Health Officers (CHOs). Additionally, in nursing colleges, nurses function as Nurse Tutors (details of their roles and educational qualifications are given in Table 2).

Nurses and Midwives in the Indian Public Sector

Nearly half (49%) of the nurses and midwives in India work in the public sector (Karan et al., 2021) as regular/permanent workers or as contractual workers. Regular workers enjoy job security and benefits such as travel allowance, rental allowance, children's education allowance, housing and medical benefits, pension, etc. (Bisht & Menon, 2021). Contractual workers are a heterogeneous group, including nurses hired under fixed-term contracts by state (regional) governments and those hired as daily wage workers, usually directly by district administrations. Fixed-term contracts may or may not be renewed on an annual basis. Such appointments are justified based on the assertion that recruiting regular staff is a time-consuming process, posing potential compromises to the efficiency of healthcare operations (Basu, 2016; Bisht & Menon, 2021). Those working on contractual terms earn substantially lower wages and experience inferior working conditions than nurses in permanent positions (World Health Organization and State Health Resource Centre, 2019). The wages of those hired on a daily wage basis are usually the lowest (Scroll.in, 2021). During the COVID-19 period, the government increased the hiring of nurses on ad-hoc contracts to deal with the escalating workload, including outsourcing of nurses through private third parties. Many of these nurses were laid off after a few months of services and were not absorbed by the government (The Hindu, 2021b). Presently, contract-based nursing positions in the public sector surpass permanent positions, amplifying job-related precarity and adversely impacting working conditions, as evidenced by various state experiences.

The situation for nurses deteriorated significantly during the COVID-19 pandemic, as they were compelled to work without sufficient personal protective equipment (PPE) for extended hours under immense psychological pressure. Tragically, many lost their lives after contracting the virus, and some even died of suicide (Kapilan, 2020). The situation exacerbated prevailing gender- and caste-based discriminatory practices. For nurses belonging to the Scheduled Castes (SC), working in a COVID-19 ward brought an additional burden of stigma, as illustrated by the following quote by a female nurse from an SC community:

Table 2 Women's health workforce in public and private sectors in India

Cadre	Sector	Level of functioning	Roles & responsibilities	Education
Frontline workers				
Community health workers	Public	Community-based work	Ante-natal and postnatal care of mother and child. Providing medicines for minor ailments. Supporting the work done by ANM.	Training of married women who are residents of the village, are between 25 and 45 years of age and are literate.
Anganwadi workers	Public	Works in anganwadi centers	Providing nutritious meals to children under 6 years of age. Monitoring the weight of children. Health and nutrition counseling to mothers with newborns. Supporting ASHA workers.	Training of married women who are residents of the village and have completed secondary school and above.
Nurses and midwives				
Auxiliary nurse & midwife (ANM)	Public	ANMs provide community-based services at Health and Wellness-Sub Centers (HWC-SCs), Primary Health Centers (PHCs)	Responsible for family planning services and maternal and child health services, including delivery, postnatal care, immunization, etc. Outpatient services for communicable and noncommunicable diseases. Maintenance of records, documentation, and reporting to Medical Officers (doctors).	Two years course after 10th grade (secondary school)
	Private	ANMs work in private nursing homes, not-for-profit hospitals, and other private hospitals.	Restricted to maternal and child health services, including conducting delivery, postnatal care, and immunization. Limited outpatient services.	

(continued)

Table 2 (continued)

Cadre	Sector	Level of functioning	Roles & responsibilities	Education
Staff nurses	Public	Staff nurses work at facilities and are known as staff nurses (SN). For example, Subdistrict Hospitals (SDH), District Hospitals (D.H.), Maternal and Child Health Hospitals, Medical Colleges and Hospitals, Nursing Colleges, Super-specialty Hospitals (SSH) Nurses with postgraduate degrees work as Nurse Tutors in academic institutions such as Nursing colleges	Responsible for family planning services and maternal and child health services, including delivery, postnatal care, and immunization. Outpatient services for communicable and noncommunicable diseases, emergency services, etc. Maintaining clinical records and inventory. Supervision and administrative tasks. Specialised work or teaching responsibilities for those working in academic roles.	BSc in Nursing (2 years course) after 12th grade ii) Postbasic Course in BSc Nursing Postgraduate courses in nursing: MSc, postbasic speciality diploma courses, MPhil, PhD
	Private	Noncorporate Multispecialty hospitals, corporate hospitals, private nursing colleges	Same as above.	
CHOs	Public	In some states, nurses with a BSc degree work also work as community health officers (mid-level health providers) at HWC-SCs. They are involved in facility-based work but also have some community components to their work.	Screening, diagnosis and management of patients for noncommunicable diseases and communicable diseases. Compiling medical and program-related reports and submitting them to medical officers. Supervising ANM and ASHA workers. To manage inventory, supplies, etc.	Nurses who are CHOs have BSc Nursing degree

Source: Compiled from multiple documents by the authors

> "And there is always the stigma—which, in the case of nurses who are also Dalits, is a double burden. The family has always known discrimination. And now a new layer to the stigma—being a nurse fighting COVID-19," says Thamizh Selvi. "The moment I step into our street, even familiar faces shut the door on me. I feel bad, but I also try to understand. They are obviously worried about their own safety," she adds (Muralidharan, 2021).

ANMs are positioned near the bottom of the health system hierarchy, often regarded as occupying a lower status than staff nurses (Das et al., 2022). Currently, ANMs provide a range of services and have taken on a central role in providing primary care to the community (John, 2017). The role of ANMs has been historically dictated by regressive gender roles within a caste-based society operating within a capitalistic patriarchal order (Iyer & Jesani, 1999). A study in one state in India details the gendered power dynamics between ANMs and male health staff (Das et al., 2022), highlighting the ANMs' lack of autonomy and decision-making power, micro-aggressions, limited agency, little access to resources and discrimination from the male staff. ANMs fear repercussions when they raise their voice against management, which is predominantly male (Das et al., 2022). They are often compelled to undertake certain clinical responsibilities for which they may not have been trained (Das et al., 2022, p. 117). The study also found that the dual practice of doctors (in the public and private sectors) affects the ANMs' work, as doctors want to prioritize their private practice (Das et al., 2022, p. 117).

The naming conventions for health cadres have recently been updated to Rural Health Officers—Male (for MPW Male) and Female (for ANMs). However, despite these changes, gender disparities persist in people's perceptions and their roles. For instance, Urmila Dugga, a female RHO and a Gond Adivasi woman from Chhattisgarh's Narayanpur district, shared that patients refer to her as "sister," while her male counterpart is addressed as "doctor *sahib*" (David, 2021). Research has also underscored the subpar working conditions and inadequate infrastructure at primary healthcare facilities where ANMs are stationed. Often, ANMs lack access to toilet facilities or dedicated resting areas within the subhealth center. Furthermore, numerous subhealth centers lack essential amenities, including the labor room and other patient spaces (Das et al., 2022).

ANMs in the public sector experience abysmally slow career progression and growth, often leading to frustration and affecting their work quality (Varghese et al., 2018). ANMs work closely with the community and often have to deal with village elites and leaders, who are men, a situation that became particularly challenging during the pandemic. ANMs from marginalized caste groups are frequently subjected to caste-related discriminatory practices, including untouchability (Iyer & Jesani, 1999; Seth, 2017; Ray, 2019). They are often under pressure to meet targets related to sterilization or institutional deliveries and get reprimanded by their superiors if they are unable to meet the targets. One study showed that even though ANMs are usually the first point of contact for community members at a health facility, no security staff was assigned to the maternity wing where only ANMs were posted (Das et al., 2022). ANMs occasionally face harassment and threats from family members of patients concerning inappropriate delivery of health services (Das et al., 2022).

Nurses in the Private Sector

As discussed above, about half the nurses in India are employed in the private sector (51%) (Karan et al., 2021), often on short-term contracts that are not extended beyond 1–3 years (WHO et al., 2022). In smaller nursing homes, nurses are recruited without formal documentation (WHO et al., 2022). Private hospitals often hire unqualified nurses for exploitative wages and no job security (WHO et al., 2022). According to an estimate from a cross-sectional study in Gujarat, 18% of nurses working in private hospitals did not have formal nursing qualifications (Seth, 2017), and 39% of the 127 nurses in the study had no contracts. Permanent public sector nurses were estimated to earn 105% more than private sector nurses with the same qualifications, years of work and caste background (Seth, 2017).

A Delhi-based WHO study showed that nurses working in the private sector are overworked and underpaid in the city (WHO et al., 2022). Many qualified and unqualified nurses in big corporate hospitals and not-for-profit hospitals alike do not even receive minimum wages. Only a handful, with many years of experience in senior supervisory positions, can secure permanent positions. Private-sector health facilities in other South Asian countries, including Nepal and Pakistan, are also known for underpaying nurses while having them work for long hours (WHO et al., 2022). Studies have documented a lack of basic amenities for female nurses, including those who are pregnant. Additionally, these studies have highlighted unsafe work environments and a deficiency in maternity entitlements for nurses (WHO et al., 2022).

Shortages and Migration of Nurses

A shortage of ANMs and nurses in the public sector in India has led to their being overburdened (John, 2017; Karan et al., 2021). Recruitment of nurses in insufficient numbers in private hospitals as cost-cutting measures results in overworked nurses (Nair & Healey, 2006). The shortage problem is common across South Asian countries. Bangladesh has one of the lowest densities of nursing personnel (public & private combined), with only five nurses per 10,000 population (Haakenstad et al., 2022). Pakistan has a low density of 8.3 nurses per 10,000 population, while Nepal and Bhutan fare better, with 28.4 and 27.8 nurses per 10,000 population, respectively (Haakenstad et al., 2022). The chronic shortage of nurses results from the health system's failure to retain existing nurses and provide them with adequate training and support.

Migration of Nurses

While countries like India face a shortage of nurses, they simultaneously experience huge out-migration of trained nurses. A recent study showed that 53% of foreign-trained nurses in the United Kingdom are from India and the Philippines, and 94% of foreign-trained nurses in Saudi Arabia are from Egypt, India, the Philippines, and Sudan (WHO, 2023). A study of nurses from Kerala, India, showed that migration to

Middle-Eastern countries, especially Kuwait and Saudi Arabia, is increasingly feminized, with around 0.7 million women migrants from Kerala in 1990 compared to 1.6 million in 2013 (Zachariah & Rajan, 2016; Walton-Roberts et al., 2022). The failure of the government to improve recruitment standards, working conditions, fair pay, job security and career progression of nurses has led to an increase in work-related temporary and permanent migration to foreign countries among nurses with BSc, MSc and other advanced degrees (PHM et al., 2021; Rajan, 2022; WHO, 2022b). The migration of Indian nurses to Middle-Eastern countries began in the 1950s and 1960s after the oil boom, when many nurses from Kerala, a state producing many well-qualified nurses, took up employment in these countries (WHO, 2022b). Recent studies show that nurses from India are now also migrating to OECD countries like the UK, Ireland and Germany (Oda et al., 2018), which face an increased demand for nurses because of their aging nursing workforces and resultant shortages (WHO, 2022b; People's Health Dispatch, 2023). Bilateral agreements between these governments and Indian states are also being forged to facilitate the migration of nurses (The Hindu, 2021c).

Studying nursing from a gendered perspective, it has been found that many women pursue nursing to migrate and financially support their families (Nair, 2016). Overall, the working conditions and earnings of nurses who have migrated improved (WHO, 2022b). However, out-migration also intensified the pre-existing shortage of nurses in the sending country (WHO, 2022b).

Acknowledging the ambivalent consequences of out-migration and contradictory effects on nursing work, Wichterich (2020) expands on the concept of "care extractivism" in the context of the out-migration of nurses. In the case of global migration, care capacities are extracted from poor to rich regions and, in this case, by wealthy countries in the Middle East and the North from the Global South through "care value chains," resulting in "care extractivism by wealthy countries and the violation of care workers' rights abroad." The vulnerability of nurses in a foreign country, particularly with hostel accommodations, enables management to implement "just-in-time" work deployment mechanisms, fostering harassment, sexual violence, rights violations and prevention of collective bargaining. In the context of the global workforce, Fraser (2016) has theorized this as a "care gap" in countries of the global North, which is filled by migrant workers, who are imported from poorer countries to take up the care work previously done by women in the global North. Migration also relates to the need of the previously colonized and debt-ridden countries of the global South to gain and maintain much-needed foreign exchange reserves through remittances.

Community Health Officers in India: A New Cadre and their Their Challenges

Community Health Officers (CHO) is a new cadre of Mid-Level Health Providers (MLHP) who have been introduced as a part of comprehensive primary healthcare (CPHC) under the component of the Ayushman Bharat–Health and Wellness Centre initiative (AB-HWCs) in 2018 (National Health Systems Resource Centre

(NHSRC), 2021b). While other cadres, such as practitioners of alternative medicine, have been recruited as CHOs, several states have selected nursing personnel (Table 1). Although there is no national-level gender-disaggregated data available, the CHO cadre seems to be predominantly consisting of women with many states such as Chhattisgarh, West Bengal and Karnataka recruiting existing nursing personnel for this position (Commissionerate of Health Medical Services Medical Education and Research, 2019; Directorate of Health Services West Bengal, 2019). Having a mid-level healthcare provider at the level of the subhealth center delivering healthcare services related to maternal and childcare and communicable and non-communicable diseases has shown positive results in rural and remote areas of India (Brar et al., 2021; Garg et al., 2022a; Nandi, 2022; WHO, 2022a).

CHOs face similar challenges as nurses and ANMs, being appointed on a contractual basis under the National Health Mission, although states have the flexibility to introduce permanent positions. CHOs get a fixed base salary, which varies across different states and an additional 40% incentive based on performance (The Hindu, 2022b; The Outlook, 2023).

Considering the precarity associated with contractual positions and the issue of low salaries in certain states, CHOs across the country have been advocating for the regularization of their positions (The Hindu, 2022b; The Outlook, 2023). CHO unions have also been demanding better salaries and travel and dearness allowances. They also lack other benefits that come with regular jobs, such as health and retirement benefits. Following multiple protests, the union government has asked states like Telangana to regularize the CHO positions (The Hindu, 2022b).

CHOs, who are predominantly women, also encounter challenges related to workplace safety. An alarming case was reported in Chhattisgarh, where an indigenous woman serving as a CHO at a subhealth center in the Manendragarh-Chirmiri district was gang-raped by three local men (ABP News, 2022). In Jharkhand, women CHOs have been advocating for postings in their home districts to enhance their work–life balance and ensure their safety (Times of India, 2023).

Wo-manning the Frontline: Accredited Social Health Activists (ASHA) and Anganwadi/Early Childcare Workers (AWW)

A majority of South Asian countries, including Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka, have national CHW programs (UNICEF, 2022), with women being predominating and being paid honorariums that are usually below the minimum wage, or sometimes no remuneration (Afghanistan, Sri Lanka). CHWs are among the lowest rungs of workers in the occupational hierarchy in the public sector. This section primarily focuses on Accredited Social Health Activists (ASHA) in India, supplemented by some discussion on *Anganwadi*/ early childcare Workers (AWW).

In India, ASHAs and AWWs are community-level workers employed at the village level, with a peculiar relation with the state, being considered “volunteers” and not employees. About one million ASHAs work under the National Health

Mission (since 2005) of the Government of India, with each ASHA serving a population of 1000 on average (NHSRC, 2021a). While WHO suggests that CHWs are selected by community consensus to improve community participation in health, in most countries, except for India, they are selected by civil services rules, with little to no community involvement, leading to practices of favoritism in some countries (UNICEF, 2022). Within India's Comprehensive Primary Healthcare Program, launched in 2018 (NHSRC, 2021b), ASHAs' tasks have expanded to include population enumeration, community-based health risk assessment, and health promotion for chronic illnesses. While a study showed an overrepresentation of SC and ST women as ASHAs in relation to their population in the district (NHSRC, 2011), this is not necessarily a sign of progress as it is probably a reflection of the concentration of women from marginalized communities in lower-paying jobs as well as the process of selection of ASHAs from within the communities they serve.

Approximately 1.3 million *Anganwadi* workers and 1.2 million *Anganwadi* helpers (AWHs) work under the Integrated Child Development Services (ICDS) scheme, which started in 1975 as a pilot project and later universalized. Under this scheme, AWWs/AWHs are envisaged as honorary (women) workers from the local community, volunteering their services part-time toward childcare and development (Ministry of WCD, 2019). Their roles and responsibilities include organizing nonformal preschool activities, health and nutrition counseling to mothers with newborns, growth monitoring, cooking and supplementary nutrition feeding, etc. (Ministry of Women and Child Development, undated).

Across South Asian countries, CHWs have a similar work profile involving house-to-house visits with a special focus on maternal and child health, infectious diseases and, most recently, noncommunicable diseases. In these countries, their work demands long working hours, tackling emergencies, and fulfilling target-driven responsibilities. CHWs are also given additional responsibilities when needed, often without adequate training, support and payment commensurate with the work (UNICEF, 2022). During COVID-19, these workers were at the frontlines, screening and vaccinating people against COVID-19, often in the absence of appropriate PPE and facing violence and discrimination (Sinha et al., 2021a; Sinha & Rajeev, 2023; Chatterjee, 2020; Chitnis, 2020).

Excessive workload in poorly supported environments is found to be a barrier to the effectiveness of CHWs' work (UNICEF, 2022). CHWs in the Kathmandu valley of Nepal and Sindh province of Pakistan reported spending 6 h in the facility and community daily for 6–7 days a week (UNICEF, 2022). In India, too, it was found that in the states of Telangana and Bihar, most of the ASHAs and AWWs reported spending 6–8 h a day on the job (Sinha et al., 2021b). Lady Health Workers in Pakistan reported experiencing sexual harassment from both senior and junior staff, including management (Mumtaz et al., 2003; Steege et al., 2018).

Terms of Employment and Remuneration of ASHA and AWW

Although the work done by the CHWs is equivalent to full-time work, across South Asian countries, they receive a meager pay. Most CHWs are women with low levels

of education from rural, poor-to-modest backgrounds (PSI, undated). They serve an average population of 100–1500 households and receive an annual remuneration of between USD 52 and 1500 USD (Public Services International, undated).

In India, the ASHAs and AWWs are considered "honorary volunteers" and not state employees (Ministry of WCD, 2021; National Health Mission, undated). ASHAs earn money through task-based incentives, although some states, like Haryana, Himachal Pradesh, and West Bengal, also pay them a fixed amount in addition to performance-based incentives (NHSRC, 2021) (see Table 3). As a result, the honorarium of AWWs can amount to Rs. 13,000 in Delhi, Rs. 12,500 in Haryana, and Rs. 10,000 in Chhattisgarh (The Hindu, 2022a; Hindustan Times, 2022; Zee Business, 2023). In 2022, in a big win, the Supreme Court of India ruled that AWWs and AWHs are entitled to payment of gratuity (Sebastian, 2022).

However, in no state are the total incentives on par with minimum wages (Dasgupta et al., 2022; Dandamudi & Sreeram, 2022), and the payments are marred by delays (Jafri, 2023; Kumar, 2023). In a 2022 study with *Mitanins* (as ASHAs are called there) in Chhattisgarh, it was found that, on average, they earned less than 60% of the legal minimum wage and that the monetary compensation accounted for only half the work done by them, with the rest remaining unpaid (Garg et al., 2022b). Recent ethnographic studies by scholars document the significant (unpaid) emotional labor carried out by ASHAs, including forging and sustaining close personal relations with women in the communities (Marwah, 2021a).

During the COVID-19 pandemic, additional incentives of Rs. 1000 per month for ASHAs and Rs. 500 per month for ASHA facilitators were introduced for new COVID-19-related tasks, but in various states, these incentives were never paid (Rao, 2020). What is worse is that some states, like Chhattisgarh, tried to take back the COVID-related incentives paid to *Mitanins*, which was widely opposed by the unions (Hussain, 2021).

The work of AWWs and ASHAs involving going around houses in the community was seen as a deviation from traditional gendered norms and looked down upon (Shrivastava et al., 2023; Closser & Shekhawat, 2022). Over time, however, perception has shifted significantly, with these roles now being seen as "honorable" (Closser & Shekhawat, 2022). Women working in these positions have now become more acceptable for families, and there is also a recognition of the political capital associated with such positions; moreover, the anticipation of a permanent government job makes these positions attractive, especially in the context of few job opportunities for women (Closser & Shekhawat, 2022). Vrinda Marwah (2021b) conceptualizes such anticipation as the Indian state holding "promissory capital" for its workers.

Training and Support for ASHA and AWW

The education and training component of the CHW program in South Asian countries is often underfunded. Preservice training is found to be inadequate in countries like Bangladesh, Nepal, and Sri Lanka, with training lasting between 3 and 18 days. In Bangladesh, training is not conducted by any accredited training

Table 3 State-specific incentives for ASHA from state funds

SN	Name of states	State-specific incentives for ASHAs from state funds
1	Andhra Pradesh	Provides balance amount to match the total incentive of Rs. 10,000/PM/ASHA
2	Arunachal Pradesh	100% top-up, frequency of disbursement quarterly
3	Assam	Rs. 1000/PM/ASHA from FY 2018–2019
4	Bihar	Rs. 1000/PM/ASHA for defined indicators related to immunization, child health, maternal health, family planning, etc. (for achieving any fours out of six defined indicators)
5	Chhattisgarh	75% of the matching amount of incentives over the above incentives earned by an ASH as a top-up on an annual
6	Delhi	Rs. 3000/PM/ASHA for functional ASHA (against the 12 crore activities performed by ASHA)
7	Gujarat	Provides 50% top-up—frequency of disbursement quarterly
8	Haryana	Rs. 4000/PM/ASHA and 50% top-up (excluding routine recurring incentive) and Rs. 450/- additional linked with the performance of 05 Major RCH activities
9	Himachal Pradesh	Rs. 2750/PM/ASHA
10	Kerala	Rs. 6000/PM/ASHA
11	Karnataka	Rs. 5000/PM/ASHA
12	Manipur	Rs. 1000/PM/ASHA recently declared by state FY 2021–22—modalities of payment still to be finalized
13	Madhya Pradesh	100% against 7 specified activities (Janani Surakshana Yojana, Home Based New Born Care, follow up of children who are Low Birth Weight and discharged from Special Newborn Care Unit, follow-ups, iron sucrose follow-ups of Anaemic PW, early registration of PW, full immunization and complete immunization)
14	Meghalaya	Rs. 2000/PM/ASHA
15	Maharashtra	Rs. 3500/PM/ASHA from FY 2021–22
16	Odisha	Rs. 1000/PM/ASHA from state fund launched on April 1, 2018
17	Punjab	Rs. 2500/PM/ASHA
18	Rajasthan	Rs. 3564/PM/ASHA
19	Sikkim	Rs. 6000/PM/ASHA
20	Tripura	Provides 100% top-up against 08 specified activities and 33.33% top-up based on other activities
21	Telangana	Provides balance amount to match the total incentive of Rs. 7500/month
22	Uttarakhand	Rs. 5000/year and Rs. 3000/PM/ASHA with 10% top-up
23	Uttar Pradesh	Rs. 1500/PM/ASHA linked with the proportion of routine incentives to be paid to the ASHAs in the particular month
24	West Bengal	Rs. 4500/PM/ASHA

Source: From ASHA update 2020–21 https://nhsrcindia.org/sites/default/files/2023-03/Annual%20ASHA%20Update%202021-22%201.pdf

institution (UNICEF, 2022). However, countries like Maldives have better pre-service training programs, in which CHWs receive training for up to 18 months by accredited government training centers. In-service training in most South Asian countries had challenges related to quality and delivery. Poor training and support are some of the reasons for the high CHW turnover reported in these countries (UNICEF, 2022).

In India, a number of gaps remain in the training of ASHA workers (NHSRC, 2021). Among the states, Chhattisgarh, Odisha, and Jharkhand are better performers than Uttar Pradesh and Bihar in terms of training and ASHA-population ratios. Even in the case of AWWs and AWHs, studies have identified insufficient training and support as a major barrier to program success (Scott et al., 2020). In terms of institutional support structure for ASHAs, presently, most states have a well-established support structure for community processes (NHSRC, 2021).

In India and across South Asia, the CHW workforce predominantly comprises women in their 20s and 30s (NHSRC, 2011; Closser & Shekhawat, 2022). Women in this age group are "situated within family structures where power is a function of both age and gender." Families play a crucial role in their work, from leveraging political connections to secure employment to adjusting household responsibilities to facilitate their professional commitments (Closser & Shekhawat, 2022).

In terms of infrastructure, only 70% of *Anganwadi* centers had drinking water facilities, and only 63% had toilet facilities (Scott et al., 2020).

In 2021, the National Health Systems Resource Centre made several recommendations to support the work of ASHAs, including those that are more specific for women, such as ensuring safety and security. These are yet to be implemented (NHSRC, 2021).

Reproducing Existing Social Hierarchies

Along with the gendered hierarchies in the health workforce, the intersectionality of caste and class has also emerged as important. Within the health staff, ASHAs report poor treatment in hospitals from the hospital staff, including nurses (Rajalakshmi, 2012; Bhonsle & Prasad, 2020). For those belonging to the oppressed castes, caste and gender-based discrimination exists in their everyday work, and these "patterns of caste hierarchy among women are replicated across South Asia" (Ved et al., 2019). There seems to be an overrepresentation of SC and ST women in the ASHA cadre, which could well be a reflection of the concentration of women from marginalized communities in lower-paying jobs. At the same time, we also know that political connections are drawn on to get women into AWW and ASHA jobs, given the poor state of employment in India, which is likely to benefit the dominant castes (Closser & Shekhawat, 2022). There are also reports of AWWs belonging to oppressed castes being transferred to other villages due to pressure from dominant caste Hindus in

their villages (Ganesh, 2019) or due to refusal by families to let their children eat food made by them (Shreyas, 2022). This social violence also emerged during COVID-19 (Chatterjee, 2020; George et al., 2020).

The Challenge of Increasing Digitalization and Surveillance in the Work of ASHAs and AWW

An ambivalent aspect of the professionalization of nursing is the growing emphasis on documenting all activities (Wichterich, 2020). ASHAs and AWWs, too, are trying to cope with increased documentation tasks, which overburden them (Bhatia, 2017, Jain et al., 2020). For example, a common grievance relates to the number of records and registers that an AWW has to maintain (Kaur et al., 2016), also seen in the case of ASHAs for the NCD screening process or AWWs in the POSHAN scheme (Gokhale, 2023). (POSHAN Abhiyaan is the Government of India's flagship program that was launched on March 8, 2018, to improve nutritional outcomes in the country in a phased manner, by adopting a synergized and result-oriented approach.) This documentation, intended to collect data for the efficient delivery of services, comes at the "expense of the professional and personal well-being of the workers and arguably the communities they serve" (Meena et al., 2022).

The integration of digital technologies for documentation has also led to the introduction of surveillance discipline, incorporating technologies such as CCTV, tracking apps, etc. The integration of surveillance raises questions about power dynamics, and interrogating power relations is a crucial aspect of feminist analysis (Foucault, 1975; Rudschies, 2022). In recent times, scholars have endeavored to interpret surveillance through a feminist lens, employing frameworks such as social justice and power relations in the context of surveillance technologies (Shephard, undated; Gill, 2019). In the context of nurses, it has been pointed out that these surveillance methods "discipline the worker to carry out self-assessments and self-optimization, thereby increasing competition among them and intensifies care extraction by imposing the free-market logic of efficiency, standardization, and competition, which skews the caring logic of nursing and medical ethos" (Wichterich, 2020).

Leadership and Unionization of Women Workers: Struggles and Achievements

Unionization of women health workers has been seen across South Asia (Biswas, 2022), with nurses and frontline workers leading in organizing, mobilizing, and advocating for their labor rights. Key mobilization focuses have been their regularization as government employees and appropriate remuneration. Their struggle extends beyond seeking improved working conditions and better pay. It encompasses resistance against neoliberal policies by actively rallying against commercialization and privatization of healthcare services and advocating for strengthening

of the overall government health system and infrastructure (The New Indian Express, 2023a; NewsClick, 2022; PSI, undated; Srivastava, 2022). The more recent cadre of CHOs is also part of these agitations (Singh, 2023; The Hindu, 2022b). As a result of these campaigns, there have been some improvements in working conditions. Still, the unions are yet to be integrated into the decision-making processes within the governance system.

In Pakistan, the Lady Health Workers formed the LHW Association in 2009 (Ali, 2019) and, soon after, started demanding a wage increase and regularization. In 2012, the Supreme Court ordered that they should be paid PKR 7000 (EUR 60), equivalent to the then-minimum wage of a full-time skilled worker (Khan, 2011), and in 2013, LHWs were recognized as government employees (PSI, undated). Since then, the LHW national and regional associations have been protesting for social security registration, pensions, free healthcare, and other social security measures (Khan, 2011). During COVID-19, they continued to demand better working conditions and regularization, forcing the government to meet some of their demands (Bacha, 2020). However, they have often been subjected to violence and harassment by community members and staff from other government departments (PSI, 2018).

Nurses' unions in India have been making efforts to improve their situation both in the private and public sectors (Times of India, 2018; Zee News, 2020), with nurses in government hospitals being more organized compared to the private sector (Nair et al., 2016; PHM et al., 2021). Their concerns, which encompass issues such as inadequate salaries, working double shifts, and unfavorable nurse–patient ratios, illustrate the comprehensive scope of the challenges brought about by the extraction of care. Within this context, the range of demands varies for regular and contractual nurses (Wichterich, 2020). A landmark judgment by the Supreme Court of India in 2016, in response to a petition filed in 2011, paved the way for the development of government guidelines on salary and working conditions for private sector nurses along with pay parity with the public sector nurses and advice to the states to legislate these recommendations (Ministry of Health and Family Welfare, 2016). While these recommendations were met with resistance from private hospital associations, the nurses' unions in many states have pressured the governments to implement the order. However, no concrete steps have been taken by states to formulate corresponding regulatory legislation (WHO et al., 2022).

In the state of Kerala, India, nursing unions in the private sector, though led by male nurses, have taken a prominent role in organizing efforts to improve working conditions, an initiative primarily instigated by concerns related to the bond system and loan indebtedness (Nair et al., 2016). Notably, the United Nursing Association (UNA) achieved a significant milestone in 2018 when the Kerala state government officially declared a minimum basic salary of Rs. 20,000 (240 USD per month). (To give an idea, national minimum daily wage is approximately INR 178 (equivalent to US$2.15), which translates to around INR 5340 (approximately US$65) per month (https://www.india-briefing.com/news/guide-minimum-wage-india-2023-19406.html/#:~:text=India%20boasts%20the%20most%20competitive,approximately%20US%2465)%20per%20month).) This move has strengthened the

bargaining power of nurses in other states, too (Wichterich, 2020; The New Indian Express, 2018). Other nursing union groups have questioned the larger neo-liberal policies of cost-cutting, demand hiring of nurses, increased state budgets, etc. (Wichterich, 2020).

ASHAs have unionized in varying degrees in different states; they intensified their agitations during the COVID-19 pandemic, and their strength was visible to people, even in urban areas (Santosh & Kane, 2023; Ravichandran, 2020; Bhowmick, 2021). An interesting dimension of ASHA unions has been the coalitions formed and solidarity forged with trade union federations such as the Centre of Indian Trade Unions (CITU) and Public Services International (PSI) and social movements such as the Jan Swasthya Abhiyan (Santosh & Kane, 2023; PSI, 2020), leading to their concerns and demands being integrated into mainstream labor and social movements.

As a result of their struggles, in some states, such as Sikkim (PTI, 2022), Andhra Pradesh (ToI, 2019), and Telangana (The Hindu, 2022d), ASHAs now receive fixed and higher amounts as well as social security measures (Table 3). The state of Telangana pays Rs. 10,000 (120 USD) per month and has also announced paid maternity leave for ASHAs (NIE, 2023b). The ASHAs have been demanding higher wages (Rs. 24,000 (289 USD)–Rs. 26,000 (313 USD)), equivalent to the minimum wages of skilled workers (The Hindu, 2023, Newsclick, 2022). (To give an idea, national minimum daily wage is approximately INR 178 (equivalent to US$2.15), which translates to around INR 5340 (approximately US$65) per month.) ASHAs and AWWs also face backlash, such as arrests, police cases and work termination, for their protests and demands (The Wire, 2022; Lalwani, 2020; The Hindu, 2022c). In Maharashtra, following street protests and sustained legal action, all 4000 women community health volunteers employed by the Municipal Corporation of Greater Mumbai (MCGM) won the right to provident funds and pension funds (Romero, 2019).

SHRC Chhattisgarh, India, provides additional social security support and career progression avenues for ASHAs (*Mitanins*) (SHRC Chhattisgarh, 2013). During 2010–2014, the government also provided scholarships and reserved 40% of the seats in government ANM training centers for *Mitanins* (National Rural Health Mission & SHRC Chhattisgarh, 2013). So far, around 2000 *Mitanins* have graduated as ANMs and 236 as Nurses. Of the regular government posts, 5% are reserved for *Mitanins* trained as ANMs and Nurses and around two-thirds of the graduates were recruited by the government (SHRC Chhattisgarh, 2021). The state government also provides cash incentives to *Mitanins* for completing high school and getting an undergraduate degree. Scholarships are provided for the education of *Mitanin's* children. Mitanins are covered under Life Insurance of Rs. 50,000 (600 USD) in the event of her husband's death. A maternity entitlement of Rs. 25,000 (300 USD) is also provided to *Mitanins*. These initiatives are funded primarily by the state government through the *Mitanin Kalyan Kosh* or the *Mitanin* Welfare Fund (SHRC Chhattisgarh, 2023). At the national level, the National Health Mission Steering Group chaired by the Union Health & Family Welfare Minister has recently approved a cash incentive of Rs. 5000 (60 USD) each for ASHAs passing the

certificate examinations for RMCHA+ and also expanded the package of services (Mission Steering Group, 2022). Such positive examples from states and centers can be replicated by other states, too.

Nursing Union Leadership: "Delivered by Women, Led by Men"

Despite these gains, studies point to weak nursing leadership, emphasizing the role of gender in shaping perceptions of the nursing profession. Policy-makers tend to view these issues as "second-class issues." The prevailing perception that nursing is considered unskilled, comparable to menial jobs, further contributes to the lack of attention and reforms to empower the nursing workforce (Varghese et al., 2018, p. 6).

Studies have shown that leadership positions in nurses' unions are mostly occupied by men (Wichterich, 2020; WHO et al., 2022; Biju, 2013; Nair et al., 2016). Men seem to obtain legitimacy to lead the movement due to higher societal expectations for financial independence, greater mobility, and so on (Nair et al., 2016; WHO et al., 2022). For example, a nurse from Chhattisgarh with whom one of the authors spoke shared that men are preferred in the position of State Chairperson in a Chhattisgarh union of public sector nurses since a lot of the work involves dealing with political leaders (mostly male) and meeting them at odd hours, which will not be preferred by women. Another study with private hospitals in Delhi found that private hospitals avoid hiring male nurses, who are seen as outspoken and vocal, compared to women nurses, who are seen as a "stable, obedient and subservient workforce" (WHO et al., 2022). (The national majority-male CHW program of the 1970s and 1980s in India was "phased out when male CHWs began striking to demand fair wages" (Bhatia, 2014).)

Lessons for the Health System and the State

This review on the feminization of the health and care workforce in India and South Asia has shown that, although the number of women workers in these sectors is increasing, the jobs are simultaneously becoming more casualized and often located within unsupportive work environments. It has been found that across South Asia, the workforce in the lower rungs of the occupational hierarchy within the health sector, i.e., nurses, community health, and care workers, are underremunerated and underrecognized. This situation results from the prevailing neoliberal economic order, characterized by austerity measures, budget cuts, privatization, and a general trend toward informalization of labor. Simultaneously, entrenched patriarchal norms in society devalue the work associated with social reproduction and care, contributing to the perpetuation of the gender-based division of labor. As Fraser (2016) has argued, "capitalist societies have separated the work of social reproduction from that of economic production from the industrial era." According to Fraser, associating the former with women and the latter with men, they have remunerated "reproductive"

activities in the coin of "love" and "virtue," while compensating "productive work" in that of money.

Therefore, it is unsurprising that these roles within the health sector are predominantly held by women, reinforcing societal stereotypes about the type of work traditionally expected of women. Aye et al. (undated) argue that the renewed interest in CHW programs is dominated by the neoliberal ideology, which promotes free or lowly-paid work by CHWs to substitute for a well-funded public health system. Federici (2010) talks about how the devaluation of reproductive work means that "women will always confront capital and the state with less power than men and in conditions of extreme social and economic vulnerability."

For women joining these sectors, there is a valorizing of the spirit of "volunteerism" (Dasgupta & Kingra, 2022). For instance, higher-level health officials and sometimes even ASHAs themselves refer to their work as needing to be approached with the spirit of *sewa* (service), justifying the poorly paid nature of their jobs (Wichterich, 2020; Closser & Shekhawat, 2022). In the Indian context, Wichterich (2020) argues that the stereotypes of natural "female *sewa*" and caste norms reinforce and reinvent the low valuation of care work.

On a positive note, it is evident that, in various South Asian countries, including India, engagement in these occupations has afforded women the chance to collectivize and advocate for their rights, improving their status within families and communities. Throughout this journey, notable achievements have been realized, such as the regularization of LHVs in Pakistan and increases in wages for ASHAs and AWWs in several Indian states.

Creating decent work opportunities for women ensures that women can participate in the labor market by reducing the burden of unpaid care work, and it also has benefits such as improving human development outcomes, especially for women and children (Sinha, 2022). "Having more women in public sector jobs can also facilitate efforts to increase women's and girls' access to public services" (U.N. Women, 2015). However, challenging circumstances persist for women health workers due to governments' unwillingness to intervene and rectify the prevailing power imbalances, ensuring fair terms of employment for this workforce. These imbalances are rooted in the framework of neoliberal capitalism, which relies on the reproductive labor functions of these occupations and perpetuates social hierarchies. Addressing this situation requires short-term interventions, policies, and structural socioeconomic changes. It is essential to give women health workers the remuneration, respect, recognition, and representation they rightfully deserve in decision-making processes.

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