Women’s unpaid work in health systems: the myth of the self-sacrificing gene

Women’s unpaid work is propping up healthcare worldwide, reducing women’s economic security and weakening health systems, writes Ann Keeling

Ann Keeling senior fellow

Five years ago, I attended an international meeting about the global health workforce and listened as an all male panel praised women for the unpaid work they did, particularly in caring for older people. Incensed that no women had been given the opportunity to have a say as part of the panel, I asked the panel why it was, in their view, that women and not men routinely carried out unpaid health and care work? A male panellist responded confidently that women were more self-sacrificing and just better human beings than men.

The exchange prompted a piece of research on a subject that has interested me for some time. The report Subsidizing global health: women’s unpaid work in health systems set out to answer two questions. What factors contribute to so many women taking up unpaid work, and, in the absence of any official figures, how many women are currently working unpaid or grossly underpaid in health worldwide?

We found that women do considerably more unpaid work than men, such as work caring for sick relatives and community members to plug the gap in state funded health systems. In addition to the unpaid work women do in the “private” sphere of the home and family, women also work unpaid in core roles in health systems in the public sphere. The report focuses on this work.

The promise of opportunities

The report identified multiple factors driving the unpaid work women do in the public sphere and the women interviewed in Ethiopia, Malawi, Zambia, India, and Mexico set out several reasons for their decision. Far from an innate genetic compulsion for self-sacrifice, their reasons stemmed from a combination of hope and pragmatism in envisioning how this work could be a way for them to break free of the limited choices they experience as women.

Those with few opportunities to earn income often viewed unpaid work as a potential route into paid work. Others agreed, noting that certain roles sometimes came with the promise of periodic payment for related duties, such as vaccination campaigns. In some cases, non-monetary benefits such as mobile phones or bicycles were the deciding factor.

Status in the community motivated others, particularly those who were more educated and came from wealthier families. Work in health was seen as decent and honourable. By granting female relatives the freedom to forgo other domestic or agricultural duties to deliver health programmes in the community, the family itself benefited from an improved social status in the community.

In conservative settings, several women reported the value of the personal freedoms they enjoyed as a result of the unpaid work, which offered them free passage out of the home. Far from being tied to domestic chores, they were able to move freely about the community and meet and work with other women on meaningful projects.

Several women said they were constrained by lack of education and gender norms that meant they could not travel to take paid work as a man might. In many cases, women simply valued the opportunity to learn.

Although the motivations were diverse, two points were clear: firstly, women working in health were proud of the work they were doing and felt motivated to improve the lives of the women and children in their communities, even if the work was hard. Secondly, although women valued the work, they would have chosen to be paid if that option had been available.

Uncounted, unrecorded, and unrewarded

We estimate that a minimum of six million women work unpaid or are grossly underpaid in core health system roles, despite serving as the critical interface between health systems and communities in many countries. Our estimate is conservative. The fact is no official figures exist about the number of women propping up health systems worldwide.

Though such unpaid work is nothing new, the pandemic has shone a light on the sacrifices women have made to work on the frontlines. They went door-to-door educating households on the virus, tracking contacts, and, later on, delivering vaccines.

At the recent World Health Assembly in May 2022, India’s one million women community health workers known as accredited social health activists (ASHAs) were honoured with the Global Health Leaders Award for successfully protecting the health of millions of people during the pandemic. At the start of the pandemic, however, reports were coming out of India about the unacceptable risks faced by ASHA workers who were being sent into communities without personal protective equipment and facing stigma and abuse as perceived vectors of the virus.

In 2020, they launched widespread street protests and strikes to demand better pay, protection, and working conditions. ASHA workers may have been acknowledged as global health leaders, but they
continue to be underpaid with small performance based honorariums. They are still fighting for a fair and regular salary and the benefits that come with formal sector roles.

As a first step, countries need to urgently record the number of health workers they have at the community level, whether paid or unpaid. Governments must then allocate funds to ensure the adequate payment of that work. Formalising the roles of unpaid women health workers will allow health systems to better harness their knowledge and talent.

Most of the women who work unpaid in health systems come from impoverished backgrounds, have low levels of education, and carry a heavy burden of other work within the household. Since their work is unpaid and unrecorded, policy makers seem to have assumed that because they are “not working” they have free time to “volunteer” for health work in their communities.

Unpaid care work in the community is being rationalised as an extension of the unpaid care work women do in the home. Some argue that there is no need to pay women and, indeed, there is even a debate about whether paying a regular salary would demotivate those who had previously been “volunteers.” We saw no evidence of this during our extensive interviews with women.

Women working without pay are creating social and economic value that is uncounted, unrecorded, and unrewarded. Unpaid work reduces women’s economic security and increases their lifetime poverty. It also weakens health systems. The pandemic has demonstrated the need for strong and resilient health systems, but there can be no global health security while health systems are subsidised by the unpaid work of some of the world’s poorest women.

Competing interests: I have read and understood The BMJ policy on declaration of interests and declare the following: none.

Provenance and peer review: not commissioned, not peer reviewed.

2 World Health Organization. India’s ASHA workers win Global Health Leaders Award. https://www.who.int/india/india-asha-workers#
3 Asthana S, Mayra K. India’s one million Accredited Social Health Activists (ASHA) win the Global Health Leaders award at the 75th World Health Assembly: Time to move beyond rhetoric to action?Lancet Reg Health - Southeast Asia2022;0:100029. doi: 10.1016/j.lansea.2022.100029.