

POSITION PAPER

Health workers' rights in the time of COVID-19

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Introduction

As of 21 April, the COVID-19 pandemic has infected about [2,482,158 people worldwide and contributed to 170,470 deaths](#). In India as on 20 April, the number of people infected with COVID-19 is [17,656 with 559 deaths](#). The corona virus Sars-CoV-2 that causes COVID-19 is potent for certain biological reasons—its structure enables it to latch on to hosts easily, it has a long infection period, it is infectious even in asymptomatic carriers, and human beings have no immunity to it as yet. Hence it can spread easily and quickly. A large, sudden influx of patients can put extreme stress on both the healthcare system in India and on its health workers, as we are currently witnessing in many countries in Europe and the United States. Health workers are generally at high risk. In Italy for instance, it has been reported [a staggeringly high proportion of all those infected are healthcare workers](#). India is witnessing an increasing number of cases of infection among health workers.

The situation is made worse by the fact that COVID-19 has hit India against the backdrop of a neoliberal assault on healthcare. This assault has meant that public health facilities are in disrepair, neglected, and overburdened. At the same time, private hospitals and nursing homes have proliferated, without adequate regulation.

The main rationale for the poorly planned 27-day lockdown and its extension upto 3 May by many states, with disastrous effects on lakhs of informal and migrant workers, is that it will buy time for the government to prepare for COVID-19's likely assault. However, governments' actions till now have been both late and inadequate. The current situation is dire. Testing is inadequate, there is severe scarcity of test kits and the much-publicized antibody-based kits have barely begun trickling in, more ventilators are needed, and the availability of personal protective equipment (PPE) is poor and uneven across regions and hospitals. Moreover, the high population density in slum settlements and bastis in all towns of India makes physical distancing, even in a period of lockdown, impossible and puts the poor and a very large number of workers at risk of infection.

Additionally, health facilities can become sources of the spread of infection, with three concentric circles of risk: individual health workers in direct contact with patients; other employees including fellow-nurses, doctors, and other health workers; and three, the public coming to a hospital. Recent episodes, such as in [Delhi](#), [Mumbai](#), and [Hyderabad](#) have shown that this can occur at any health facility, not just at COVID-19-identified ones, particularly given that the current Indian testing and patient management protocol has no provision for testing symptomatic patients without a contact history and isolating those who are positive but asymptomatic. These patients might have high infectivity and will be coming into close contact with many healthcare providers without either patient or health providers knowing. There are also asymptomatic carriers in the public, many of whom will be seeking care due to co-morbidities. Health workers at the community level, such as ASHAs, who are deployed either for Covid-19 outreach and community awareness or for routine community level work such as immunisation, are also facing higher risk of exposure to the virus. Hence, *the rights and protection against risk of health workers on the one hand, and the robustness of the health system on the other, and the policies with regard to testing, all deeply intersect in the times of COVID-19.*

Because health workers are on the frontlines of our response to COVID-19, they face higher risks of infection, overwork, and stress. Hence, any strategy to fight the pandemic should consider the rights and protection of health workers, including through the following:

- (a) adequate PPE should be provided;
- (b) access to testing and treatment needs to be ensured;
- (c) health workers should be covered for COVID-19-related sick leave, quarantine and provided compensation;
- (d) workers should be allowed to opt out of performing their work in conditions that puts them at risk, without risk of losing their jobs;
- (e) proper training needs to be provided regarding procedures before workers are deployed;
- (f) representatives of health workers need to be actively involved in setting up safeguard measures in health facilities;
- (g) the organization of work in hospitals (such as patient flow in the outpatient wards) should be such that their risk of exposure to healthcare workers is minimized;
- (h) wages and overtime should be paid as per the law without any mandatory or so-called voluntary cuts;
- (i) adequate facilities should be provided across needs such as adequate accommodation, transportation, child care, and nutritious meals;
- (j) measures are urgently required to protect health workers against stigma, violence, discrimination, and sexual harassment;
- (k) existing vacancies need to be filled with a long-term perspective;

The COVID-19 crisis and the effectiveness of health systems response both in India and globally, clearly underlines the need for healthcare to be in the public sector. The related, broader issues of health workers' employment, equal pay for equal work, and rights to occupational health and safety and better working conditions is central for countries to be able to cope with COVID-19 now. We welcome the broader support and appreciation for the work that health workers are doing in the forefront in the fight against COVID-19. However, just appreciation and statements of good intent are not enough. Nor are simply clapping hands and banging plates. We need this support to be legalized through notifications and legislation by the appropriate authority at varied levels of government: centre, state, and local bodies. How robust we make the healthcare system and strengthen all health workers now is central to coping better not just with the present crisis, but how well we will be able to cope with any health crises in the future.

A precarious health workforce makes the health system more fragile

The continuous underfunding of public healthcare has meant that in public hospitals, due to budgetary tightening, vacancies of health professionals—from doctors, to nurses to paramedics—have not been filled. This imposes a heavy workload on the existing staff that was already hard for them to manage. In many facilities, especially under local bodies and poorer state governments, professional staff shortages have been dealt with by hiring on short-term contracts or deploying field staff in hospital settings, such as with ANMs. Health workers who are 'non-professionals', such as ward attendants and housekeeping staff, cleaning and security staff are most often hired through contractors, at low wages, pathetic working conditions, and too often in violation of the labour law.

While the private health sector has thrived and expanded, its workforce is highly underpaid, except for high profile and specialised doctors. Across the country, nurses in private hospitals are, at

best, [paid around the minimum wage for a skilled worker](#), and most often below this legal benchmark. This sets the scale for other staff, who also face the challenge of being hired through a third party which makes their tenure highly insecure and without social security coverage.

The workforce at the primary level of care provided in health posts and at the community level are unarguably the most neglected. Field/community health workers, such as the Accredited Social Health Activists (ASHAs) in rural settings or Community Health Volunteers (CHVs) in Mumbai, are the largest group of health workers with more than 9 lakh workers in India. [They are denied the status of a worker by the State](#). ASHAs are told they are ‘volunteer’ activists and not workers of the health system, thus denied minimum wage and any other rights of a worker under the law.

As health workers across the health system have been mobilised to respond to the pandemic, the pre-existing cracks and weaknesses in the system make it all the more fragile. Informal employment leads to unclear responsibilities towards workers, and has created blind spots in the system. ASHAs and CHVs have been deployed for case identification without adequate safeguards. Sanitation and support staff who are contractual are being preferentially deployed as compared to regular staff, so as to avoid social security obligations in case of their illness. Public hospitals will be at the centre of the response to the COVID-19 epidemic, but they will have to be reinforced by private facilities, either through collaboration, or preferably, through requisition by the government. The precariousness faced by the vast majority of the close to 40 lakh health workers has to be addressed as a matter of priority as part of health system preparedness that the lockdown is meant to enable.

Previous outbreaks of highly infectious communicable diseases have demonstrated that public health outcomes are significantly improved when labour rights are respected, and trade unions are able to effectively represent workers actually exposed and potentially exposed to the disease. The active involvement of health workers’ representatives in government decision-making is necessary to safeguard workplace safety and health and ensure the cost of the crisis is not borne by healthcare personnel.

REQUIRED MEASURES

a) Adequate provisioning of Personal Protective Equipment

Reports coming in from [Maharashtra](#), [West Bengal](#), Tamil Nadu, and Bihar point to uneven availability of PPE of adequate quality, leading to protests. Workers are worried that raincoats are provided instead of medical gowns, that eye protection and other equipment has not been provided. Workers are forced to do risky procedures without proper PPE, or asked to quit if they refuse. This is creating confusion on stress amongst the health workforce and needs to be urgently addressed.

[The guidelines of the government of India](#) - that make recommendations regarding the use of specific PPE for different categories of workers, including medical masks, gloves, gowns, eye protection, and footwear and respirators depending on the kinds of patient care - have not been adhered to. Even the WHO interim guidance of 19 March 2020 on [Rational Use of PPE for coronavirus disease \(COVID-19\)](#) have not been followed. [New guidelines](#) (dated 20 April) acknowledge the risk of infection by asymptomatic patients who visit a health facility for other health reasons, yet they do not provide guidance on PPE requirements. *We recommend that the Indian government ensures systems to monitor and enforce strict adherence to adequate guidelines for the use of PPE.*

There has been a clear and criminal lack of preparedness and stockpiling, in disregard of WHO guidelines of 27 February 2020. The Ministry of Health has [admitted a shortage of equipment and supply not meeting rising demand](#). This is compounded by an inadequate estimate of the size of the health workforce, which the government estimates at 22 lakh, while it should be closer to 40 lakh¹.

¹A 2016 estimate suggests that the number of health professionals and para professionals alone (including doctors, nurses and midwives, dentists, laboratory technicians and paramedics) was close to 25.3 lakh. The latter does not include health workers such as cleaning staff, ward attendants, ambulance drivers, ASHAs and ANMs, to name a few.

Given the uneven nature of PPE availability across regions, [we recommended that PPE be sourced in priority from domestic manufacturers](#) with a long-term view of development of domestic industrial capability, and supplied to deal with clusters of cases as they occur. This implies that *PPE procurement orders have to be increased to ensure adequate access to all health workers, and PPE be sent to regions where they are most needed.*

The shortage of necessary PPE equipment and the traditional structures of social discrimination in India could lead to certain categories of workers, such as nurses who are at highest risk, but also ASHAs, non-permanent/contract workers and cleaners, not being provided adequate PPE. *We urge that the government issue a directive that no such discrimination take place against any worker in any establishment. Health workers should not be forced to work under unsafe conditions without adequate protective equipment.*

b) Free health care for all health workers

The announcement by the Finance Minister of a special life insurance scheme for health workers is misleading and insufficient. Despite an announcement that *all* health workers would be covered, the package covers health workers in the private sector only *if* they are drafted for COVID-19 responsibilities. The recent case of [health workers getting infected at the private facility Delhi State Cancer Institute](#) shows that this is insufficient. Further, this is subject to the numbers indicated by MoHFW. The figure of 22 lakh health workers is a gross underestimation of the actual size of the workforce in the country, as mentioned earlier. *The estimate should be modified correspondingly and increased to at least 40 lakh health workers and the omission of healthcare workers in the private sectors needs to be corrected immediately to avoid the possibility of denial of compensation.*

Most importantly, this scheme is grossly insufficient as it does not provide any support to health workers and their families [unless the worker dies](#). In case health workers are infected by COVID-19 they should be given treatment, care and support free of cost. Considering that health workers in informal employment conditions are more vulnerable as employers can hide behind this informality to deny their responsibility towards them, it is important that they are given special attention in this regard. The [latest testing protocol](#) (31 March) has expanded testing only to symptomatic health care workers, whereas there is clear evidence of asymptomatic cases. As current testing protocols are restrictive, health workers might find that they are compelled to go for testing in private labs, and incur costs. Failure to detect infections early among healthcare workers may result in further spreading of the infection. *Access to comprehensive and free health care, including outpatient, hospitalisation, and regular free testing need to be ensured, with special attention to informal health workers. Special provision of regular testing needs to be ensured for health workers performing high risk tasks, even if asymptomatic.*

c) Special COVID-19 related paid leave and compensation

Health workers are at a higher risk of contracting infectious diseases, which is the case with COVID-19 as well. Reports estimate [close to 100 infections already confirmed in India](#), though there is no systematic reporting of this data. As facilities are short-staffed, managements of facilities are extending working hours. They might try to keep health workers on the job even when they are already showing COVID-19-like symptoms, [as we saw in Mumbai and in Bihar](#). Workers who have tested positive with COVID-19 should not be asked to continue with their duties if they are showing symptoms. [This is against protocols](#) and puts the workers at more risk of developing more severe symptoms if they are not able to rest adequately.

Managements of facilities might also deduct leave taken for sickness or quarantine from existing leave provisions, and when these are used up, take recourse to cutting workers' wages. Informal

ASHAs alone are estimated to around 8.5 lakh, ANMs to around 2 lakh. While there is no estimate available for ancillary health staff, it is safe to presume that at least 2 to 4 lakh, bringing the total number close to 40 lakh/4 million.

workers have a limited amount of paid leave that will run out quickly. Those on daily wages do not even have paid leave. *Special paid leave in case of COVID-19-related sickness and quarantine should be provided*, including to workers on short-term contracts and employed through a third party. *A special compensation should also be announced for health workers who contract COVID-19 in line with the WHO definition that if exposure to corona virus Sars-CoV-2 happens at the workplace, contracting COVID-19 should be considered an occupational disease.*

d) Mental health support and the right to opt out

Health workers undergo considerable stress during emergencies such as the one we are facing. Counselling and mental health support should be made available for health workers. Breaks and time-off should be maintained, as healthcare workers' burnout could contribute to both their catching the virus and its spread. *As per WHO guidelines*, health workers should not be required to return to a work situation where there is continuous or serious danger to their life or health. *Health workers' right to opt out of work when they are not provided with a safe working environment and adequate protective equipment should be respected, without undue consequences.*

Health workers who are pregnant, or have co-morbidities have higher chances to contract the infection and develop more severe symptoms. *They should not be put on duty in the COVID-19 ward and limit exposure to patients with suspected COVID-19.* Instead, they should be assigned appropriate tasks within their profession that does not expose them the virus and be accommodated if they request so.

e) Training on procedures and infection risk management

Managing the risk of infection in health facilities, both in the public and private sectors, is essential to ensure that health facilities do not themselves become hubs of infection. Part of the risk management procedure is to ensure that all health workers understand the measures that are needed to protect themselves, protect patients, and protect the facility. *The government should implement or direct facilities to implement appropriate training for the diversity of workers categories across levels of risk.*

The government needs to put in place online training programmes on infection control with a focus on COVID-19 for the entire medical workforce in the country, facility-based training for the entire workforce in each facility, including ASHA and community-based health workers attached to different health posts. All health workers should be provided with communication materials in different languages on the appropriate safeguards, including but not limited to PPEs.

The entire staff in all COVID-19 earmarked hospitals, ICU units, and isolation centres should be given training and this should include both guidelines and protocols for COVID-19 care, as well as personal safety, infection risk management and the use of personal protective equipment. The government should provide guidelines for these procedures to be followed in private facilities. A helpline should be set up for health workers who face challenges at their workplace, with a defined procedure to register complaints and interventions to resolve them. *In case private facilities fail to follow the government guidelines and resolve issues with regard to adequate safeguard measures, the state government should consider requisitioning these private facilities in order to avoid the spread of the disease due to negligence of private operators.*

f) Active involvement of representatives of health workers

The government should engage with trade unions of health workers to ensure that the guidelines effectively reach all concerned health workers. For instance, there is a need for clear information and training regarding PPE use, disposal, and care. Health worker unions are well positioned to contrib-

ute to this process, as they have the organizational ability to reach out to large sections of workers quickly. *Hence, we urge that different state governments involve health worker unions in the process of information-sharing, training, and workers' safety. Facility management should facilitate an active role for health workers' representatives in determining safety measures and safeguards of their health.*

(g) organization of work in hospitals that minimises risk of exposure to healthcare workers

The other part of risk protection is the proper organization of work processes that would limit hospital infection to patients as well as to (all) health workers. This is a part of most quality accreditation programmes, such as the [national quality assurance standards](#) for public health facilities and multiple systems for private healthcare facilities. However, only a small proportion of facilities are registered under these frameworks. One of the reasons why Kerala has reported fewer infections among workers and less spread of the virus overall is because it has much better level of accreditation and infection control. *The infection control component of the quality accreditation programmes must be implemented universally across states, including in the private sector, along with a monitoring mechanism by the government.*

h) Wages and extra-time to be remunerated as per the law

As society recognises that health workers are contributing to the common good by standing at the frontlines of the battle against the COVID-19 outbreak, longstanding violations of legal provisions with regard to their wages should be acknowledged and addressed. Notifications should be issued so that wages are provided as per existing government norms, and wage discrimination against workers in informal employment should be addressed. The current budgets of most municipal hospitals and state hospitals are too small to provide the legal wages to all workers, which has been covered up through outsourcing of services such as cleaning and housekeeping.

The central government has formalised the central role of ASHAs in containment and community outreach, highlighting once again [their role as an essential workforce of the state health system](#). Yet, the government guideline does not provide an additional budgetary allocation while, of course, all other tasks are to continue - ante-natal care, vaccination, etc. A paltry Rs 1,000 per month for April and May is to be paid by states from unspent money. Their contribution in the month of March is not even acknowledged and, without additional budgetary allocation, most State governments might not even pay this inadequate incentive. The government pretence that ASHAs are not workers of the health system amounts to discrimination against an exclusively female workforce that is paid a fraction of the prevalent minimum wage.

Central and State governments should make the required budgetary allocations to ensure that ASHAs and other health workers deployed to respond to the emergency situation are provided the remuneration they deserve, and at least as per the law. Such allocations should be incorporated in subsequent annual budgets.

As the crisis intensifies, health workers will be asked to provide extra-time on a regular basis. This extra time needs to be regulated to allow enough time-off to rest and recover. Healthcare workers' burnout aids the spread of the virus. *Breaks and time-off need to be maintained. Extra hours should also be remunerated as per the law.*

It has also been reported that public and private sector hospitals are forcing their staff to contribute to the government relief fund from their wages, in part of in entirety. *Health workers should not be asked to compulsorily or voluntarily forego their wages in full or partly.*

With the exception of specialised doctors, wages in private hospitals and other health facilities in the private sector are abysmally low. This led to the [Supreme Court recommending a wage increase across the board in the private health sector](#) (2016). The recommendation has largely been un-

implemented. In some states, such as in Delhi, the [High Court directed the state government to legislate](#) towards the implementation of the Supreme Court recommendation. Yet, no such steps have been taken. Considering that health workers in private facilities will also be involved in responding to the COVID-19 epidemic, *state governments should ensure compliance with the Supreme Court recommendations relating to wages in private healthcare facilities.*

Due to the financial crisis that preceded the COVID-19 pandemic many health workers [such as ambulance drivers](#), but also cleaning staff and ward attendants, had not received their payments for months. *The increased budgetary provision should prioritize payment of such arrears.* As the lockdown requires minimising non-essential activities and some workers have been asked to join duty on alternate days, including for those working in hospital settings, special attention should be given so that those working fewer hours because of the lockdown are paid their full salaries, even if they are hired through manpower agencies, or on short-term contracts and other informal employment conditions. For instance, safai karamcharis might find it difficult to travel to the hospital they work in because of the shutdown of public transport. *They should be considered on duty for the full period of the lock-down.* Finally, private sector hospitals are threatening to cut wages in the month of April due to fewer patients and reduced “business” in that period. *The government should actively monitor that wages of health workers are paid. A health worker helpline linked to both the Ministry of Labour and Ministry of Health should be available for health-workers to notify non-payment of wages and arrears.*

I) Adequate facilities across needs

Health workers working in high-risk areas, such as isolation wards, have to be provided the option of adequate hostel accommodation so that they can avoid going home where there are old relatives or young children whose health they are concerned about. They [should not be asked to vacate the hostel once their 14-days shift is over](#), as they risk to expose their families if they go back home. Separate restrooms for medical personal in direct contact with COVID-19 patients should be provided. Some states have taken steps to [provide accommodation to doctors in hotels near the hospitals](#) where their work. There is no justification for the same benefits not being provided to nurses and paramedics in direct contact with patients.

A large proportion of health workers are women who often face the double burden of housework and care for their families as well as work outside the house. Adequate provisions should be made to ease the burden of family care, including by providing options for crèche or childcare outside the hospital setting. This is essential since regular childcare and schools are shut.

Soap and water should be made available in all facilities for workers and the public as a basic hygiene measure. Hand sanitizers and detergent should be provided to all health workers on a regular basis to facilitate personal hygiene.

Transport to the place of work, especially for those who do not have private transport, should be provided, particularly if the lockdown is extended. There are reports of cleaning staff in cities such as Delhi not able to join work due to the lockdown and decrease in public transport facilities. This impacts the smooth functioning of hospitals, as well as creates hardship and stress for the workers who are worried that their salaries will be cut for the days they are not able to attend work. ASHA workers are facing similar issues as they have to travel from one house to an other.

Lack of nutritious food compromises immunity and puts health workers at risk of coronavirus. Adequately nutritious food needs to be made available to health workers at the hospital, through the public distribution system, or through other effective systems.

j) Stigma, social exclusion, violence and sexual harassment

We have seen during previous virus outbreaks that health workers are at risk of stigma and social

exclusion. Even during the current COVID-19 epidemic there are reports of [health workers being asked to leave their rented accommodation](#). Other reports have surfaced of health workers being [attacked or harassed during tracing of potential COVID-19 cases](#) or during their routine service delivery. Particularly distressing are reports of healthcare staff who have become [victims of COVID-19 being refused burial or cremation](#) services because of such stigma, when it is well known that there is little danger of infection from dead bodies. *The government should take appropriate steps to ensure a safe workplace and work environment, including a strong media campaign to counter stigma of all forms, and appropriate orders to outlaw stigma and discrimination. A grievance redressal mechanism should be put in place, including internal complaints committee in case of sexual harassment.*

Health workers, including nurses, bringing lapses in treatment and protocols to the attention of the public or [speaking out about their working conditions are being gagged and harassed](#). Hospital management and administrators may be stretched but unethical practices cannot be allowed to persist and *health workers' role as whistle-blowers should be protected.*

Health workers also face violence and harassment from the police while travelling to work, or crossing inter-state barriers to travel from home to their workplace. *The government should order health facilities to provide letters on the appropriate official letterhead to all health workers, with an order to the local police and administration to allow their travel, so that they are not harassed by the police and other officials when travelling to work.*

k) Filling of vacancies with a perspective of long-term hiring

Existing gaps in human resources vary between states but are generally substantial. According to information collected through an RTI in 2017, in the facilities under the Delhi government, 14% of the sanctioned posts of general duty medical officers (GDMO) were vacant (though another 4% were filled by contractual staff), and 20% of staff nurse posts were vacant (though the large majority were actually filled by contractual staff). According to reports, in Uttarakhand, 50% of sanctioned posts for medical officers and 31% for staff nurses are vacant. These vacancies need to be filled urgently, with a perspective of prioritising long-term hiring. *The waiting list of the Union Public Services Commission (UPSC) and the Staff Selection Commission (SSC) should be used as a base to fill vacancies in health facilities under the central government. The waiting list of the equivalent board or commission under each state should be used to fill vacancies in facilities under the state governments.* Kerala has undertaken this process successfully, using online interviews and video conferencing. More recently, [the Government of Tamil Nadu has appointed 530 doctors, 1,000 nurses, and 1,508 lab technicians through this method.](#)

Considering the lockdown and closure of inter-state borders, the situation might arise where candidates on UPSC) or SSC lists are not in the state where the post is available. In such cases, a temporary adjustment between sanctioned posts under the States and the Centre can be considered.

Considering the need for additional staff, those currently employed on contract should be allowed to continue with their services. However, hiring on a short-term contractual basis or through manpower agencies should not be seen as an adequate solution for increasing staffing under the impression that the time saved in hiring provides a considerable advantage. Those employed on short-term contracts and contracted through third party agencies are at risk of discrimination with regard to access to personal protective equipment, leave and other safeguards. This increases the risk of infection of this vulnerable workforce and weakens the risk management process in the facility — putting the larger public at risk.

The public expenditure on health as a percentage of GDP for 2017-18 was a mere 1.28%, while [WHO advises for at least 5% of GDP](#). *Increased budgetary allocation for health will be required to fill existing vacancies and should be incorporated into subsequent annual budgets.*

In summary, our demands are as follows:

SPECIFIC

1. The Government should provide updated guidelines regarding the rational use of PPE that also cover non-COVID-19 facilities, facilitate the production and logistics of distribution, increase PPE procurement orders to ensure adequate access to all health workers, and if required, intervene in the market to ensure that PPEs are sent to the districts/regions where they are urgently needed.
2. The government should ensure that guidelines regarding the use of PPE are strictly followed in both public and private settings, and that there is no discrimination against workers on the basis of hierarchy, employment status, or other reasons. A monitoring mechanism should be put in place in order to enforce strict adherence to PPE guidelines in public and private settings.
3. The government should ensure comprehensive health care free of cost to all health workers, including outpatient, hospitalisation, and regular testing, with special attention to informal health workers. Special provision of regular testing needs to be ensured for health workers performing high risk tasks, even if asymptomatic.
4. The government life insurance scheme should cover all health workers including in private settings and the estimate of health workers needs to be modified to reflect the real size of the health workforce in order to avoid denial of compensation in the future.
5. Special paid leave in case of COVID-19-related sickness and quarantine should be provided, including to workers on short-term contracts and employed through a third party. A special compensation should also be announced for health workers who contract COVID-19 as an occupational disease.
6. Health workers who are pregnant, lactating or have co-morbidities should not be put on duty in the COVID-19 ward. They should be assigned appropriate tasks within their profession that does not expose them to the risk of COVID-19.
7. Health workers' right to opt out of work when they are not provided with a safe working environment and adequate protective equipment should be respected.
8. The government should facilitate appropriate training programmes and materials for the diverse categories of health workers and for the different levels of risk depending on the role of workers and the role of facilities.
9. Extra hours should be regulated and remunerated as per the law. Breaks and time-off need to be maintained.
10. Adequate arrangements need to be provided to health workers in high-risk environments, such as ICUs and isolation wards, including accommodation and separate restrooms.
11. The government should take appropriate steps to ensure a safe workplace and work environment, protect health workers from harassment by the police and the community, including a strong media campaign to counter stigma of all forms, and appropriate orders to outlaw stigma and discrimination. A grievance redressal mechanism should be put in place, including internal complaints committee in case of sexual harassment.

INSTITUTIONAL

12. Central and State governments should involve health worker unions in the process of information-sharing, training, and workers' safety. This will facilitate an effective outreach to all concerned health workers. Managements should facilitate an active role for health

workers' representatives in determining safety measures and safeguards of their health.

13. The infection control component of the government's quality accreditation programmes must be implemented universally across states, including in the private sector, along with a monitoring mechanism by the government. In case private facilities fail to follow the government guidelines and resolve issues with regard to infection control and other safeguard measures, the state government should consider requisitioning the errant private facilities.
14. Management of health facilities should make adequate arrangements for health workers at the facility, including but not limited to options for crèche or child care, transport to the place of work, an official letter and an order to the local police and administration so that health workers are not harassed by the police when travelling to work, regular provision of soap and sanitizer, and adequately nutritious food at the hospital or through other effective systems.
15. Health workers who are not able to work on a regular basis due to the lockdown or due to precautionary measures should be considered on duty and paid their full wages. All governments and private facilities should refrain from asking health workers to compulsorily or voluntarily forego their wages in full or partly. A health worker helpline linked to both the Ministry of Labour and Employment and the Ministry of Health and Family Welfare should be available for health workers to notify non-payment of wages and arrears.
16. State governments should ensure compliance with the Supreme Court recommendations relating to the long overdue increase of wages in private healthcare facilities. Relevant directions should be issued in this regard.
17. There should be a health worker helpline that is able to provide online or telephonic support to health workers in both public and private sector, and protect health workers role as whistle-blowers without putting their jobs at risk. This helpline should register complaints and grievances and be linked to competent authorities who would be responsible for taking timely action on these complaints.
18. The waiting list of the UPSC and the SSC should be used as a base to fill vacancies in health facilities under the central government. The waiting list of the equivalent board or commission under each state should be used to fill vacancies in facilities under the state governments. Health workers hired on a short-term contractual basis are a vulnerable workforce at increased risk of infection. This weakens the risk management process in the facility and puts the larger public at risk.
19. Central and state governments should/must increase their budgetary allocations for health in order to cover health workforce-related costs, such as filling up vacancies, regularization of informal workers including scheme health workers, payment of wages as per the law and payment of arrears. This increase should be incorporated into subsequent annual budgets. This will be of long-term benefit for strengthening the public health system in India, and so we can cope better when the next health crisis hits us.