UNI global union

care

ACCELERATING DECENT WORK

Formalizing Home Care and Community Health Workers

Content

EXECUTIVE SUMMARY

Investments in labour organizing and collective bargaining underpin both recent and longstanding achievements to advance decent work for home-based and community health workers. Through recent survey data and in-depth case studies, this report demonstrates both the persistently poor working conditions that informal care workers endure and highlights promising pathways for accelerating formalization.

Home health workers and community health workers in many countries remain a largely informal and feminized workforce, excluded from standard labour protections guaranteed to other workers and often subject to low and irregular pay, long hours and unsafe working conditions, even when funded publicly. Formalization and recognition of care work as work is essential for preventing abuse and exploitation, closing gender pay gaps, improving women's participation and mobility in the workforce, and improving quality of care.

Recognition of care workers' contributions to public health—including through reducing maternal and child mortality, improving immunization rates, and serving on the frontlines during pandemics, as well as to individual care for people with disabilities, older people, and children—is growing. There is also increasing understanding of the inextricable connection between protecting the labour rights of care workers and provision of accessible, high-quality care. The ILO's Resolution concerning decent work and the care economy states,

All care workers should enjoy decent work. Decent work for care workers contributes to quality care, recruitment and retention of workers, and promotion of gender equality, counteracts the shortage of workers and builds resilient societies and economies.[1]

Survey Data

This report shares results from three different surveys focusing on care workers. These include a global online survey conducted in 2025 by UNI including 3,353 home-based and community-based health workers, a 2025 UNI survey supported by the SAGE fund with data from 1,270 community health workers in South Asia, and the 2024 PHS Monitor, an online survey that included responses from 4,142 personal and household services workers in Europe.

Across all surveys, the vast majority of workers were women, and they reported significant gaps in labour protections, benefits, and occupational safety. In Nepal, all 319 community health workers surveyed said they worked as volunteers rather than being formally employed. In the global survey, 18 per cent of community health workers said they received

"We have become home care workers, cuidadoras, because of love, because of family, because of the high level of responsibility that we have towards the people that we take care of.... We want the government, the states, and the public policy of our country to take this into account as an official job. We want to have the right to have a pension, health care, and care for us as caregivers--which we do not have."

María Elisa Alfaro
Red de Trabajadoras de Cuidados, Colombia, May 8, 2025

no benefits, and an additional 23 per cent (all from Nepal) reported only receiving a uniform allowance. Short-staffing and overwork were widespread: 53 per cent of community health workers in the global survey said staff shortages affected care quality. Additionally, 16 per cent of community health workers and 31 per cent of home-based workers said they worked more than 40 hours a week. Twenty-four percent of PHS workers in the PHS Monitor reported working more than 40 hours a week.

Access to healthcare through work was limited, with just 18 per cent of community health workers and 6 per cent of home-based health workers reporting such coverage. Access to personal protective equipment (PPE) was also low—45 per cent of community health workers in India had access, 36 per cent in Pakistan, and only 3 per cent in Nepal. In terms of training, 31 per cent of Pakistani community health workers and 23 per cent of Sri Lankan community health workers had received occupational safety training in the past six months, versus only 7 per cent in India and 6 per cent in Nepal. Thirty percent of community health workers in the global survey reported experiencing a workplace injury lasting a month or more.

Many respondents reported they did not feel safe while working. In the global survey, 32 per cent of community health workers and 25 per cent of home-based workers reporting feeling *"unsafe"* or *"very unsafe"* on the job. Despite these challenges, many care workers expressed strong pride and satisfaction in their work and in contributing to their communities.

Case Studies

Brazil

Brazil's Community Health Agent and Endemic Disease Worker programs have been central to the country's Family Health Strategy since the mid-1990s. These workers serve as core members of family health teams delivering primary healthcare. Brazil is a global model for the formalization of community health workers, who are full-time, salaried public employees receiving benefits such as paid leave, a 13th-month salary, hazard pay, and pensions. A national technical training program was established by law, with the government initially funding training for 125,000 workers. Early working conditions were precarious, but decades of organizing—including the creation of municipal associations, a state federation, and a national confederation—led to major legislative victories, including a federal constitutional amendment establishing a national salary floor. Persistent advocacy, strategic coalition-building, and direct engagement with parliament were key to securing long-term reforms.

Sri Lanka

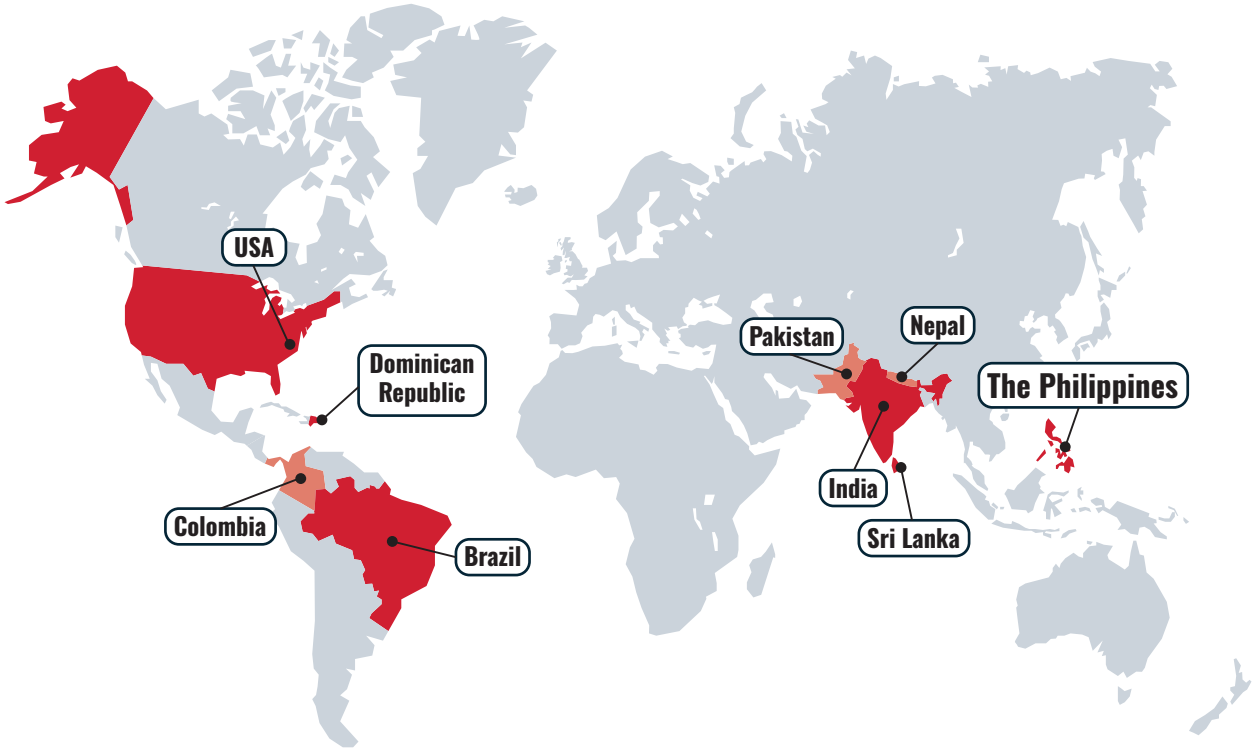
Sri Lanka's midwife program is another globally recognized model of formalized community healthcare work. Public health midwives are credited with helping reduce maternal and infant mortality. They are salaried government employees with standard benefits and undergo an 18-month government-funded training program that includes practical fieldwork and modules on sexual and gender-based violence. Despite these strengths, the program faces recruitment challenges. Midwives are respected within their communities and were able to maintain their work even during Sri Lanka's civil war. Union leadership emphasizes the importance of women-led organizing, responsive union structures, and strategic engagement across political, media, and civil society spaces to promote decent work for care workers.

The Philippines

In the Philippines, Barangay Health Workers (BHWs) are on the verge of significant reform through the pending Magna Carta which is awaiting the signature of the President for its passage into law. Currently, BHWs serve as essential frontline workers in underserved areas but are treated as volunteers, with many earning as little as $2 per month. The Magna Carta, which passed both houses of Congress and, as of this writing, is expected to become law in June 2025, would guarantee a minimum monthly honorarium of 3000 PHP (approximately 54 USD) and provide insurance, hazard allowances, and career advancement

"Our fight is for our identity as community health workers, not community health volunteers.... The government should consider us as community health workers, giving us at least the basic salary that is 17,300 per month. And other than that, we also want to be the part of social security scheme in Nepal."

Kopila Pokharel
General secretary, HEVON, Nepal, May 6, 2025



support. It also mandates training and certification to enhance the skills of BHWs. Organizing efforts, particularly by the UNI Philippine Liaison Council and the BHW Federation, were crucial in raising public awareness and pressuring lawmakers. While broad support for the bill existed, progress was delayed due to debates over financing. Ultimately, funding responsibility will be split between the national and local governments depending on the latter's income classification.

India

In India, community health workers have achieved significant gains through persistent organizing, collective action, and strategic negotiations. After investing in building membership and union structures at local and state levels, the union JSNGEF-IN submitted their demand list to the government and carried out protests, rallies, meetings, and bilateral discussions to gain attention. Their efforts have yielded concrete results, such as commitments from the Jharkhand government to amend service conditions, ensure timely honorarium payments, and provide digital tools like Android tablets. Workers continue to push for additional demands, including retirement benefits, career progression, and adequate resources for their work.

Nepal

In Nepal, Female Community Health Volunteers (FCHVs) remain classified as volunteers and, nationally, receive only a dress and transport allowance and a modest retirement benefit. Investments in union building, supported by UNI Global Union, have helped change this. As union member Kopila Pokharel noted, affiliation brought funding and staff support, enabling HEVON to expand its reach beyond Kathmandu and achieve gains such as free health insurance in Bagmati province. However, disparities persist across municipalities, and the union continues to advocate for formal recognition, fair wages, and inclusion in Nepal's social security scheme.

Pakistan

In Pakistan, Lady Health Workers (LHWs) have turned to the courts and union organizing to resist erosion of their labour rights. Despite legal victories—including a 2013 Supreme Court ruling mandating their regularization—Lady Health Workers face ongoing challenges such as delayed salaries, unfilled vacancies, and threats of privatization. As union leader Bushra Arain emphasized, budgeted funds meant for Lady Health Workers' career development have been diverted to private companies, undermining the service structure and opening the door to precarious employment models. The All Lady Health Workers Programme Union has built strong communication networks and led coordinated actions. These efforts underscore how judicial engagement and grassroots organizing together can uphold labour protections.

Washington state, USA

In Washington State, long-term care workers—primarily women, immigrants, and people over 55—were initially classified as independent contractors and faced poor conditions: low pay, no benefits, isolation, and unsafe environments. The creation of SEIU 775 in 2002, after a ballot initiative

secured collective bargaining rights, led to major gains including sick leave, healthcare, retirement, and training. Currently with about 55,000 members, the union has benefited from a centralized long-term care system under Aging and Long-Term Support Administration (ALTSA), which made organizing more efficient. Strategic alliances with care recipients, shared goals, and lobbying provisions in contracts have supported advocacy. High training standards, political engagement, and a centralized rate-setting board further strengthened the movement, which was initially supported by national SEIU funding.

Colombia

In Colombia, care work by family members assisting relatives with disabilities or chronic conditions, typically takes place without remuneration, training, or support. In 2024, UNI Americas launched the Red de Trabajadoras de Cuidados to organize these caregivers through local, peer-led outreach across Bogotá. The network now has over 250 members and focuses on building a collective voice and advocating for care work to be recognized as a profession. Their 2024 Charter of Rights calls for formalization, training access, freedom of association, and collective bargaining. Following Colombia's 2025 National Care Policy, the Red is pushing to influence its implementation and secure long-term support and funding for caregivers.

Dominican Republic

In the Dominican Republic, most home health workers lack contracts, social security, and formal training. FENAMUTRA has worked to raise their visibility, improve protections, and provide access to technical training. The "Familias de Cariño" program, launched in 2020 by CONAPE, supports caregivers with monthly stipends and has grown to include 290 workers by 2025. FENAMUTRA successfully added a 15-hour certified training course and continues to push for broader recognition. They also participate in the National Care Table with public agencies. However, new subcontracting plans in 2025 raise concerns about fragmentation and weakened standards. FENAMUTRA is campaigning for rigorous oversight, fair procurement, and enforceable labour protections to ensure workers' and care recipients' rights.

Lessons Learned

Cultivating public awareness of the contributions of home and community health workers is essential for political support and formal recognition.

Organizers in Brazil noted that one of their first challenges was to shift social perceptions and biases, and to raise awareness about the value of community health workers for the protection of health rights and outcomes. Such recognition has aided Sri Lanka's midwives to promote and enhance a decent work agenda.

National-level regulation promotes minimum standards for decent work.

A key feature of the relatively successful models of Brazil, Sri Lanka, and the upcoming reforms in the Philippines is their national scope. Minimum standards across the country ensure coherence in formalization and aid in cementing public recognition of care work. Political and economic context often mean that policy pushes and program innovations first take place at local, state, or provincial levels. Emphasizing national-level reforms helps avoid wide variations in working conditions and labour protections. Lower-income provinces and municipalities may need federal subsidies to finance salaries and benefits.

Long-term organizing and sustained political engagement is key for winning labour rights.

Union leaders underlined the priority of ongoing organizing at local, state, and national levels as a central pillar for building a care system respecting workers' rights. Organizing workers and strengthening their identities as health workers facilitates collective power and builds political voice to push for reforms and to defend against harmful setbacks.

Technical training and certification programs are a key element of formalizing care work.

A shared feature across countries with stronger models of decent work for care workers include pre-certification programs, opportunities for training and accreditation, and pathways for career progression. Building skills and qualifications supports professionalization of the care sector and improves quality of care and occupational safety and health.

Investing in worker organizing, including through initial support from national or global unions or other donors, is an impactful strategy to support formalization of care workers.

UNI support significantly increased the power and reach of local unions—resulting in concrete wins for formalization and decent work. Local unions and workers' organizations have benefited from UNI support aimed at leadership training, strengthening membership mobilization and communication, and strategic political engagement.

Organizing workers performing unpaid care work for family members is an important priority for a comprehensive decent care work agenda.

Individuals providing care for family members remain among the most isolated, dispersed, and unorganized sets of care workers. Outreach to these caregivers is critical for building individual and collective worker identities, agendas, and political voice. The challenges and priorities of home health workers, including those caring for loved ones, should be specifically recognized in national care policies and programs.

Building complementary agendas and alliances for workers and users of health care is strategic and impactful.

This has been a deeply successful practice in Washington state and provides a strategic model in other contexts. This can include building shared agendas to increase funding for the care economy, quality of care and training, and strengthening social dialogue to work through policy differences.

Consolidation and coordination aids productive social dialogue among social partners.

Fragmentation – whether among isolated and unorganized care workers, privatized third-party care agencies, unorganized users of health care, or multiple government agencies can harm the promotion of decent care work. The example of Washington state shows how the sustained dialogue and relationships between a centralized government body coordinating long-term health care, a union representing long-term care workers, and organizations representing users of home health services have been mutually beneficial for transparency, financing, quality of care, and decent working conditions.

Governments have an obligation to ensure all publicly funded care workers are fully formalized with access to all social benefits.

The examples from countries as diverse as Sri Lanka, Brazil and the state of Washington in the United States show that where there is political will, governments can fully formalize home-based and community health workers. Any government with existing care systems that fund informal workers, whether through cash payments to families needing care and support, directly through "volunteer" systems, or through contracts that fall short of full formalization, must work with care worker unions to transition these workers to fully formalized employment with access to training and professionalization. Governments currently developing new national care systems need to embed formality as a fundamental part of these new systems to ensure decent work, and quality care and support. Multilateral funding agencies should insist on full formality and access to training and professionalization as preconditions for accessing resources.

FORMALIZING HOME AND COMMUNITY HEALTH WORKERS

Home health workers and community health workers in many countries remain a largely informal and feminized workforce, excluded from standard labour protections guaranteed to other workers and often subject to low and irregular pay, long hours and unsafe working conditions, even when funded publicly.

Yet long overdue recognition of their contributions to public health —including maternal and child health, immunization campaigns, and management of infectious disease, as well as to individual care for people with disabilities, older people, and children— is growing. The needs are urgent. The World Health Organization (WHO) estimates a global shortfall of 11 million health workers by 2030.[2] According to the WHO, around 2 in 3 people who reach older age are likely to require longer-term support and care from others to perform activities of daily living, such as eating, moving around, or bathing. Yet less than 60 per cent of reporting countries include long-term care in their national competency framework for geriatric care workers.[3]

Ensuring availability and accessibility of quality care is inextricably linked with promoting a decent work agenda for care workers, including formalization and integration into public health structures, policies, and planning.

The ILO's Recommendation 204 on the Transition from the Informal to the Formal Economy and the 2024 ILO resolution on the Decent Care Work Agenda set out clear standards and approaches to improving rights and protections for care workers.[4] These include the 5R framework to recognize, reduce, and redistribute unpaid work, and to reward and represent paid care work.

As this report will show, building worker identity, visibilizing their contributions, and growing collective bargaining power has been effective for piloting innovative formalization schemes, accelerating policy reform, and defending against regressive moves to privatize the care economy. Workers' groups are also on the forefront of identifying structured training needs and advocating for certification programs and career pathways. Investing in labour organizing is a strategic approach for accelerating formalization of care work.

SURVEY DATA ON WORKING CONDITIONS

Data about the numbers, working conditions, and perspectives of care workers remains patchy. This report shares results from three different surveys focusing on care workers. These include a global online survey conducted in 2025 by UNI of institution-based, home-based, and community-based health workers, a 2025 UNI survey supported by the SAGE fund focused on community health workers in South Asia, and the 2024 PHS Monitor, an online survey focusing on personal and household services workers, employers, user-employers, and service users in Europe.[5]

The informal characteristics of care workers in many contexts, including gaps in clear worker identities and categories, the dispersion of workers across private households, and varying access to the internet make it difficult to employ random sampling with statistically significant results. However, the responses to these surveys highlight the experiences and views of thousands of care workers and provide valuable insights into areas for further research and policy action. Methods of data collection included distribution of surveys among union affiliates and allies, social media advertisements, and in the case of the South Asia survey, in-person questionnaires.

2025 Global Survey

The total survey included 15,376 respondents representing institution-based, community-based, and home-based health workers across 80 countries. Of these:

- 2,165 respondents represented community health workers across 38 countries. Of these, a large number of respondents were from Pakistan *(30 per cent)* and Nepal *(23 per cent)*. 94 per cent of these respondents were women.
- 1,188 respondents represented home-based health workers across 41 countries. 83 per cent of the respondents were women. More than half of the home-based health worker respondents were from Colombia, Turkey, and the United Kingdom.

2025 South Asia Survey

The total survey included 1,270 respondents representing community health workers from India, Nepal, Pakistan, and Sri Lanka.

- 99 per cent of the respondents were women.

2024 PHS Monitor 1

The total survey included 6,523 responses representing personal and household services (PHS) workers, PHS user-employers, other PHS users, and PHS providers organizations spanning 27 countries across Europe.

- 4,142 respondents represented personal and household services workers across 26 countries. Of these, 96 per cent were women.

"I'm very proud of being able to work as a caregiver for the elderly for over 15 years. And sometimes it's complicated by family members who don't accept what we say and pose other tasks that we can't do."

Home health worker, Brazil

Lack of labour protections and benefits

- In the South Asia survey, all of the 319 community health workers from Nepal reported working as volunteers rather than being formally employed.
- In the global survey, 18 per cent of community health workers said they received no benefits. Another 23%, representing community health workers from Nepal, said the only benefit they received was a uniform allowance.
- In the global survey, only 18 per cent of community health workers and 6 per cent of home-based workers reported receiving healthcare through their job.
- In the PHS Monitor, 57 per cent of workers said they have considered leaving the sector in the past three years. Low pay was the most commonly cited reason why PHS workers say they have considered leaving their jobs.

Occupational safety and health

- In the South Asia survey, rates of access to personal protective equipment (PPE), such as gloves, masks, and goggles, are low. While 80 per cent of community health worker respondents from Sri Lanka reported access to PPE, this number dropped to 45 per cent of respondents from India, 36 per cent of respondents from Pakistan, and only 3 per cent of respondents from Nepal.
- In the global survey, 30 per cent of community health workers said they had experienced a workplace injury lasting one month or longer.
- In the South Asia survey, 31 per cent of community health workers respondents from Pakistan and 23 per cent of community health workers from Sri Lanka said they had received occupational safety and health training, including on violence and harassment in the workplace, in the past six months. These numbers were significantly lower for community health workers in India (7 per cent) and Nepal (6 per cent).

"As home help we have a number of disadvantages. Unfortunately. Although we do a lot of mental and physical work. I don't think some laws are correct."

Home health worker, Austria

- In the PHS Monitor, around 40 per cent of workers surveyed said they had received health and safety training related to their jobs.

Short-staffing, overwork, and effects on quality of care

- In the global survey, 53 per cent of community health workers reported that they were "often" or "always" short-staffed to the extent that it affected quality of care.
- In the global survey, 16 per cent of community-based workers and 31 per cent of home-based workers reported working more than 40 hours of week.
- In the PHS Monitor, around 24 per cent of PHS workers said they work more than 40 hours a week.[6]

A community health worker who responded to the global survey from Brazil said, *"My days are long and I usually work through my lunch and breaks but never seem to catch up on work and clients. I usually work 8 hours unpaid on weekends to try to catch up. I am impatient and irritable with staff, clients, family due to lack of sleep and quiet time to relax.... More staff is needed, better wages and better management."* [7] A community health worker from Ghana said, *"I [had to] forfeit annual leave, leaving [me] depressed and exhausted during and after work. It affected my motivation to do the work, I had less concentration during working hours, and less time for family."* [8]

Many respondents to the survey noted that short-staffing limits their ability to care for all of the patients or clients seeking their services. A community health worker from Kenya said, *"There are areas which are not reached due to short staffing,"* [9] and another one said, *"In some scenarios, we had a huge number of patients we had to serve, but we were very few, so the patients became impatient, depressed, and obviously in pain."* [10]

Violence and harassment

- In the global survey, 32 per cent of community health workers and 25 per cent of home-based health workers reported feeling *"unsafe"* or *"very unsafe"* on the job.

Several of the respondents who said they had experienced violence or harassment on the job said they were not comfortable providing further details. Those who did mentioned sexual harassment, sometimes from superiors, or verbal abuse and unreasonable work demands from clients. One home health worker said her client would masturbate in front of her, and others mentioned sexually suggestive comments from their client's families. A community health worker from Pakistan said, *"It feels so bad when you are harassed that it is difficult to go to work or the workplace."* [11]

Other concerns were about working conditions. A community health worker from India said, *"We are discriminated against by [people] considering us to be low paid and temporary and also no proper place is given for spending the night."* [12] Several community health workers from Pakistan mentioned feeling unsafe during polio campaigns, which have had a history of violence.

Pride and value in care work

A strong theme throughout the survey data for many care workers was a deep sense of pride and satisfaction in the services they were providing, and their contributions to their communities.

"I wish for more support with necessary tools, [and] better terms of work and proper recognition and remuneration."

Community health worker, Kenya

"We should have more of a voice, breaks, better hourly rate of pay and travel allowance, being respected for the job we do to help people have their dignity and live in their own homes."

Community health worker, New Zealand

A Barangay Health Worker from the Philippines said, *"Even if sometimes our work is hard but I prefer to stay as community health worker because I love my job and it's heartwarming knowing that I'm able to help our community especially our tribe."* [13]

A Lady Health Worker from Pakistan said, *"I've been working as a Lady Health Worker for several years now, and it has been an incredibly rewarding experience. I've had the opportunity to work closely with women, children, and families in my community, providing them with essential healthcare services, support, and education. What I love most about my job is the trust and bond I've built with my patients. Seeing them recover from illnesses, witnessing the birth of new life, and empowering them with knowledge to take control of their health has been truly fulfilling."* [14]

A home health worker in in Colombia said, *"I love the job of caregiver, because my mission is to take care of people in need both physically and emotionally."* [15]

"We [face] a lot of harassment, but our work gives us motivation, because it is our job to help others in this way to save their money, health, and life."

Lady health worker, Pakistan

"I love helping people that need medical care. I just hope that we have sufficient medicine and equipment in order to help those in need. And also to at least make our salary as BHW increase so we can also provide for our family. Seven hundred pesos salary for a month can't even feed our family."

Barangay health worker, the Philippines

MODELS OF FORMALIZED COMMUNITY HEALTH WORKERS

Brazil

Brazil's Community Health Agent (Agentes Comunitários de Saúde) and Endemic Disease Worker programs have been an integral part of the country's public health system and its Family Health Strategy since the mid-1990s.[16] These workers are core members of family health teams that include a doctor, nurse, and a nursing assistant. Community health agents provide preventive health care, immunizations, prenatal, newborn, and child health services, and help manage infectious diseases such as HIV/AIDS, tuberculosis, and COVID.

Brazil's formalization of community health workers is a global model. Community health workers are employed as full-time, salaried public sector workers. They have benefits such as 30 days of paid leave, a 13th-month salary (an annual bonus of one month's pay), hazard pay, and pensions. After passage of a law establishing a technical training program, the national government paid for an initial cohort of 125,000 workers to undergo training.

Long-term organizing and legislative advocacy have been critical to winning these rights. In the early days of the program, working conditions were precarious with workers often earning below the minimum wage and excluded from labour protections guaranteed to other workers. According to Cândido, "We created municipal associations, formed the state federation and a national confederation, and started working on the law to professionalize CHWs. We won the legislation by mobilizing workers to participate in the process."[17]

He said that organizers built trust and awareness through workplace visits and political education, particularly in health units and worker gathering sites.[18] The workers' movement chose strategically to advocate for state and national legislation, concerned that decentralized regulations at local levels would result in deeply uneven working conditions.[19] The adoption of a federal constitutional amendment that created a national salary floor in 2010 was a turning point.

Persistent engagement with supportive members of parliament was critical to passing reforms. Advocates faced opposition to their demands from the National Association of Mayors and state health

"Making it clear to society that community health workers are important was the biggest challenge we had.... We highlighted workers' contributions to eliminating cholera, reducing infant mortality and malnutrition. We argued that workers improving health outcomes deserved healthy working conditions themselves."

Fernando Cândido
President, Sindicato dos Agentes Comunitários de Saúde de Alagoas (SINDACS), May 14, 2025

secretaries, who argued the proposed reforms were unaffordable.[20] Workers countered this with coalition-building and strategic counterproposals. Worker-led advocacy successfully pushed for community health agents to be designated as healthcare workers during the COVID-19 vaccine rollout, correcting an initial exclusion.[21]

Unions are now calling for a 30-hour work week, wage increases to triple the national minimum, restoration of special retirement benefits, and technical training across all community health agents.[22]

Sri Lanka

Sri Lanka's midwife program is another global model of formalized healthcare work. Community health workers are credited with playing an integral role in meeting Sri Lanka's targets to reduce maternal mortality, infant mortality, and eradicating malaria. Sri Lanka's midwives support maternal and child health, family planning, management of communicable diseases, as well as prevention and response to sexual and gender-based violence. Despite its many strengths, the program faces challenges with recruitment, labour shortages, and navigating shifts in health provision as the country urbanizes.

Sri Lanka's public health midwives are salaried government employees and receive standard benefits such as overtime pay, pension benefits, paid leave, and maternity benefits.

Sri Lanka's midwives, divided into those who are hospital-based, and those who are field-based, receive a stipend when they undergo government-funded training for 18 months. Upon successful completion of the program, which includes 6 months of practical fieldwork, they earn a diploma, along with certification and accreditation when they register with the Sri Lanka Medical Council. Notably, the training includes a module on prevention and response to sexual and gender-based violence.

Many midwives feel pride in their work and there is well-established recognition of the health services they provide to communities. This trust enabled midwives to continue their work, even in conflict-affected areas during the country's protracted civil war. *"Midwives could reach communities for deliveries, consultations, especially for family planning, even in war zones.... Everyone has a good understanding of what they are doing. If a midwife wears the unique uniform, they know the reason for her work. During the war, whether the Sri Lankan army or the LTTE, everyone has a good understanding of the role of midwife."*[23]

Union leaders point to the importance of worker organizing from grassroots to national levels as critical for the program's ongoing effectiveness and note the strength of women's leadership at senior levels. Devika Kodithuwakku, president of the Government Midwifery Services Association, discussed investing in relationships with actors across the country's political spectrum, media, private companies, and other workers' organizations. Building collective strength and political presence has been critical for promoting decent work for midwives, whether in responding to individual incidents such as discipline for harassment cases or for campaigning on policy and funding proposals.

Philippines

The Barangay Health Workers (BHWs) in the Philippines are on the cusp of a significant milestone toward formalization. BHWs are community health workers delivering healthcare and education, preventive services, and emergency response. They

"Once midwives complete their training and go to the field they are around age 24, 25. They may face harassment working in the field, they stand out with their white color uniform. They are giving consultations about contraception and family planning, both to women and their husbands. They are talking about sensitive topics.... There have been incidents of harassment in Sri Lanka.... We take immediate actions to support the worker and overcome the problem. .... Our team strongly does not accept this behavior, as soon as we hear those concerns, we respond as soon as possible..... midwives might face hierarchy barriers in reporting harassment. We take necessary union actions."

Devika Kodithuwakku
President, Government Midwifery Services Association, Sri Lanka, May 22, 2025

currently lack a minimum wage, social protection, and recognition as workers.

BHWs are important as a first point of contact in remote and underserved areas. Their workloads are often high, spanning entire neighborhoods, yet they are treated as volunteers. They receive a monthly honorarium, ranging from as low as US$2 to US$50, depending on the local government. The vast majority, roughly 99 per cent, are women, and as of March 2024, there were over 252,000 registered BHWs.[24] When accounting for unregistered workers, the total number reaches approximately 500,000.[25]

The Magna Carta for Barangay Health Workers is a landmark bill, passed by the House of Representatives and Senate. As of publication, the bill is expected to be signed into law by the president in June 2025. The Magna Carta would guarantee a minimum monthly honorarium of PHP 3,000 *(around US$60)*. The bill also provides transportation, subsistence and hazard allowances, insurance coverage, a health emergency allowance *(HEA)* during public health crises, cash gifts, a one-time dedicated service incentive, career advancement support, free legal services and access to government livelihood programs.[26]

Aiming to strengthen the skill profile of the sector, under the Magna Carta, BHWs will be required to complete training courses and undergo certification by the municipal or city health boards.

The push for the Magna Carta gained momentum with the election of Angelica Natasha Co, representative of the BHW Party-list, to the House of Representatives in 2019. She shepherded the bill through the House of Representatives in 2022. In the Senate, Deputy Majority Leader Joseph Victor Ejercito introduced the bill.

Worker organizing played a critical role in raising public awareness about the bill and fostering political support. Roland de la Cruz discussed the process,

"UNI and the Philippine Liaison Council actively supported the advocacy.... So every time there's a hearing, every time there's a discussion on the Magna Carta, UNI-PLC's representative...and also the president of the BHW Federation in the National Capital Region. Sister Myrna Gaite is very, very active in attending all of this Senate committee hearings, discussions, and other activities that we made in order to [keep up the] drumbeat, to make the public more aware that there is a Magna Carta that's pending in the Senate, that we need to pressure Senate to pass the Magna Carta."[27]

Despite widespread support on the importance and substance of the bill, progress was slow due to debates on budgets and financing. These discussions

"In the new law, that's the incoming Magna Carta, Barangay Health Workers are provided with certain protections. They're provided a fixed compensation, at least a minimum. Right now, it really depends on the local government how much they will give the Barangay Health Workers as volunteers.... So this is really a big step towards emancipating the Barangay Health Workers from exploitation, abuse, and prolonged poverty, especially in the rural areas."

Roland de la Cruz
UNI Philippine Liaison Council, May 7, 2025

were further delayed by changes in Senate leadership. In 2025, the Senate passed a bill that found a compromise by requiring the national government to pay for implementation in lower-income areas, while first and second-class local government units are required to adopt their own ordinances to fund implementation.

Lessons Learned

National-level regulation promotes minimum standards for decent work.

A key feature of the relatively successful models of Brazil, Sri Lanka, and the upcoming reforms in the Philippines is their national scope. Minimum standards across the country ensure coherence in formalization and aid in cementing public recognition of care work. Political and economic context often mean that policy pushes and program innovations first take place at local, state, or provincial levels. Emphasizing national-level reforms helps avoid wide variations in working conditions and labour protections. Lower-income provinces and municipalities may need federal subsidies to finance salaries and benefits.

Long-term organizing and sustained political engagement is essential for winning labour rights.

Union leaders across Brazil, Sri Lanka, and the Philippines underlined the priority of ongoing organizing at local, state, and national levels as a central pillar for building a care system respecting workers' rights. Organizing workers and strengthening their identities as community health workers facilitates collective power and builds political voice to push for reforms and to defend against harmful setbacks.

Cultivating public awareness of the contributions of community health workers to public health is essential for political support and formal recognition.

Organizers in Brazil noted that one of their first challenges was to shift social perceptions and biases, and to raise awareness about the value of community health workers for the protection of health rights and outcomes. Such recognition has aided Sri Lanka's midwives to promote and enhance a decent work agenda.

Technical training and certification programs are a key element of formalizing care work.

A shared feature across countries with stronger models of decent work for care workers include pre-certification programs, pathways for career progression, and opportunities for training and accreditation. These support professionalization of the care sector and improved standards for both quality of care and occupational safety and health.

ORGANIZING TO FORMALIZE COMMUNITY HEALTH WORKERS

India

Community health workers in India play an essential role in primary health care, and are divided among Auxiliary Nurse-Midwives (ANMs), Accredited Social Health Activists (ASHAs), and Anganwadi Workers and Helpers (AWWs). ANMs receive government salaries that vary by state. However, ASHAs and AWWs are considered volunteers, with ASHAs receiving performance-based incentives for activities such as immunization drives. Anganwadi workers and helpers receive a monthly honorarium for their work focusing on child nutrition.[28] ASHAs and Anganwadi workers lack legal recognition and access to many labour protections such as a minimum wage and occupational safety and health.

There have been some improvements in benefits over time. Anganwadi Workers and Anganwadi Helpers currently receive 180 days of paid maternity leave, 20 days of annual leave, life insurance, and access to contributory pension schemes.[29] In a consequential decision in late 2024, the Gujarat High Court ruled that Anganwadi workers and helpers should be recognized as government employees entitled to the government pay scale structure instead of honoraria.[30] This decision adds weight to national-level advocacy to recognize Anganwadi workers and helpers as government employees.

Investments in worker-led organizing and long-term campaigning have led to improvements. For example in Jharkhand province, after community health workers began organizing as described by Ashok Kumar Singh below, they have intensified dialogue with the state government and are negotiating strengthened working conditions and benefits.[31] More than 20,000 community health workers staged a demonstration in support of their 8-point list of demands to the government in September 2024.[32] As of May 2025, the government had committed to an amendment of service conditions, timely honorarium payments, and provision of Android tablets. They are engaged in negotiations over demands for simplified pay raises, increased retirement benefits,[33] seniority-based promotions to supervisor positions, and adequate funding or supply of nutritional materials. [34]

Workers have also advocated for improved occupational safety. Following the COVID-19 pandemic, they

"We formed a local committee, a block committee, a district-level committee, and a state committee.... We submitted our demand list to the government. After submitting it, we negotiated with the government.... We held one-day protests. We did all kinds of agitations, rallies, meetings, and bilaterals to get the government's notice. The government considered our demands and we achieved our demands.... it all started with a door-to-door campaign."

Ashok Kumar Singh
JSNGEF-IN, India, May 9, 2025

called for regular access to protective equipment, and not just during crises.

One factor contributing to organizing success has been worker leadership. The state general secretary for the union JSHCEF, Rekha Mandal, said, *"I am working as a community health worker and working in the union. It's positive because people know that I am like them. I am one of them. So they can trust me, because I understand their problems in the field, at work, at home, I know the actual situation of working as a community health worker in India."* [35] She noted that cross-border learning exchanges with community health worker unions in other countries would strengthen their advocacy for improved working conditions and formalization.

Nepal

In Nepal, Female Community Health Volunteers (FCHVs) are an important part of the public health system, providing maternal and child health services, immunizations, and health education to underserved and remote communities. The country's 52,000 FCHVs remain classified as volunteers and do not receive a regular salary, social protection, or other benefits.

Across the country, FCHVs are only guaranteed a dress allowance, a transportation allowance, and a one-time retirement benefit of NPR 20,000 (approximately US$150). In comparison, formal government health staff may receive NPR 3-4 million or more, with ongoing pension benefits. The retirement benefit exemplifies the fragmentation of working conditions across the country, with FCHVs in some provinces and municipalities earning the national minimum of NPR 20,000 and others earning additional amounts. For example, wealthier areas such as Chandragiri municipality and Kathmandu City provide an additional NPR 200,000 in retirement benefits to FCHVs.

Investments in worker organizing has raised the visibility of the poor working conditions of community health workers and shows the promise of building collective strength. The Union of Community Health Workers of Nepal (HEVON/FCHWU), a UNI Global Union affiliate representing more than 10,000 FCHVs across the country were able to secure free health insurance for FCHVs in Bagmati province in 2023.[36] Previously, FCHVs had to pay a 1,750 rupee premium. Through the new arrangement, the federal government will pay 50 percent and the provincial government will pay the other half.[37]

The lack of formal recognition and adequate remuneration for their labour exacerbates the social challenges that workers, predominantly women, face in participating in the workforce. Many FCHVs report that they experience conflict at home for working without pay, including those who are part of agricultural households where all are expected to contribute to household labour. The on-call nature of responding to childbirth and emergencies also means they may have to disrupt personal and community obligations.

Kopila Pokharel, a community health worker and union leader said, *"For now, our fight is for our identity as community health workers, not community health volunteers.... The government should consider us*

"Before, we didn't have a budget and we didn't have a proper team to do the work. But once we became an affiliate of UNI, then we had full-time organizers to support and guide us. They supported us with funds for activities. We were able to expand outside of Kathmandu and form committees in other provinces."

Kopila Pokharel
General secretary, HEVON, Nepal, May 6, 2025.

as community health workers, giving us at least the basic salary that is 17,300 per month. And other than that, we also want to be the part of social security scheme in Nepal." [38]

Pakistan

Like other community health worker programs in South Asia, Pakistan's Lady Health Worker Program plays a central role in provision of primary healthcare. Established in 1994, the program has been credited for increasing the country's immunization rates, strengthening family planning, and improving prenatal care.[39] Despite these contributions, Lady Health Workers have had to campaign against low and irregular payment of salaries, prohibitions on taking on additional jobs, and hazardous working conditions, including threats of violence during polio campaigns.

Unionization and mass mobilizations in the face of significant authoritarian oppression, combined with advocacy through the judicial system have played a significant role in recognizing the labour rights of Lady Health Workers, resulting in a 2013 Supreme Court order to regularize their employment and place them on a salary scale.[40] Pakistan's All Lady Health Workers Programme Union (ALPU), led by chairperson Bushra Arain, has won seven constitutional petitions in the Supreme Court. As a result, over 125,000 LHWs were regularized and received retroactive compensation.

Multiple challenges remain, including implementation of labour protections.[41] Thousands of vacancies remain unfilled, despite candidates paying application fees, suggesting mismanagement. Currently, members of the ALPU have fought against efforts to privatize the program through diversion of earmarked government funds to private companies and NGOs. These moves threaten LHW labour protections, service structure, and public accountability.

LHWs have built powerful unions. Monthly district meetings, digital tools like WhatsApp groups, and social media have enabled fast communication, documentation of grievances, and coordinated action.[42] Union advocacy also led to the end of LHWs' forced election security duties.

Lessons Learned

Entrenched attitudes that undervalue women's labour and care work slow progress towards formalization.

In South Asia, community health workers have played an essential and impactful role in delivering primary health services, however these have not been accorded commensurate public recognition or resources. Significant work is needed to shift narratives and public perceptions, as well as longstanding organizational structures that have framed community health workers as "volunteers" or "helpers." Increased opportunities for training and certification can aid in greater valuation of care work.

UNI support significantly increased the power and reach of local unions—resulting in concrete wins for formalization and decent work.

Local unions and workers' organizations have benefitted from UNI support aimed at leadership training, strengthening membership mobilization and communication, and strategic political engagement. In a relatively short period of time, for example, community health workers in Nepal have seen their membership and collective power grow. Union organizers in Jharkand province have been able to successfully place worker demands on the state government's agenda.

"Because as per the law, as per the Supreme Court order, the budget is already allocated for the Lady Health Workers service structure. But the government did not use the budget for the [LHW'S] career development, for promotion. They transferred this budget and hired a new company suddenly. All this is against the law. Basically, they want to eliminate the structure of the Lady Health Workers. You can say, slowly, slowly, in the future, they will just hire some workers on a daily basis or a third party. They won't have a voice for their rights."

Bushra Arain
Chairperson, All Lady Health Workers Programme Union (ALPU), Pakistan, May 9, 2025

FORMALIZING HOME HEALTH WORKERS

Washington state, USA

Initially, individual long-term care workers in Washington—primarily women, immigrants, and workers over 55—were classified as independent contractors and worked under poor conditions. They had low wages, no benefits, isolating and often unsafe environments, and no legal right to unionize. Labour organizing has led to transformative gains. SEIU 775, established in 2002 to represent long-term care workers after a successful ballot initiative won the right to collective bargaining with the state, has approximately 55,000 members, including 40,000 in-home care workers. Over time, they have secured paid sick leave, affordable healthcare, retirement benefits, workers' compensation, and technical training. These changes have improved both the quality of working conditions for caregivers and quality of care for consumers.

One ingredient for successful organizing in Washington is the relatively consolidated nature of its long-term care system. Policy-setting and budgeting for long-term care services is centralized in the Aging and Long-Term Support Administration *(ALTSA)*, part of the Washington State Department of Social and Health Services *(DSHS)*. Furthermore, as SEIU's deputy director for research and policy Mariana Morante, noted, *"There's one consumer-directed program where you can consolidate a lot of the home care workers. And then you have a small number of home care workers working with agencies.... And that helped us build density. There are other states... where they have a lot more fragmentation. And so then it becomes more difficult to organize and build that power going into the legislature."* [43]

"Caregivers, well, consistently put their clients first and their family members first. Everything we do to advocate for caregivers is also about creating stability and care for the people they care for. So that's always been a way that caregivers approach the advocacy.... There are some organizations for seniors and people with disabilities that understand that everyone working together improves funding."

Andrew Beane
Vice-president SEIU 775, May 5, 2025

Another strength is finding common ground among long-term care workers and consumers of long-term care. Care workers emphasize that improvements in their pay, training, and job satisfaction enhance the quality of care their clients receive. The mutual interest in maintaining a skilled and stable workforce enables strategic alliances. Although there can be differences in some policy positions, for example on particular aspects of training mandates or modalities of background checks, long-term care workers and consumer organizations often work toward a shared agenda—especially when opposing Medicaid cuts or fighting for better funding.[44] In recognition of this, some contracts between SEIU 775 and home care agencies include provisions for the care worker to take a leave day for lobbying purposes.[45]

Aiming to upgrade skills among the workforce and improve care quality, Washington has established the highest training requirements in the United States for home care workers, similar to those of a certified nursing assistant (CNA). Some clients raised concerns about the standards, including the ability to retain trusted caregivers. Creating flexibility in how the training is delivered and offering paid training opportunities has helped address these concerns.

Other key elements contributing to the formalization of long-term care workers and advances in the decent care work agenda include deep political engagement, regular dialogue with strong social partners, and transparency. A centralized rate-setting board for home care worker wages and benefits has created a productive collective bargaining process. Negotiations can focus on allocations of a set Medicaid reimbursement rate rather than debating available resources. Persistent grassroots action and political engagement have accompanied all improvements to working conditions. Beane said, "There were a significant number of marches and demonstrations at the Capitol. And there was a huge investment in politics and trying to elect people that would do the right thing for caregivers." [46]

Currently a national and global model, the strength of the long-term care workers' movement in Washington state got instrumental support in their early days. Andrew Beane pointed out, "Before we had a union, we needed resources and the National SEIU had voted to add on a fund that locals paid into to help these kinds of campaigns. And so if locals around the country didn't fund the first few years of home care workers trying to form their union, it never would have happened. And I think it was an investment that has paid off."[47]

Colombia

In Colombia, there are several categories of care workers. One group that has not been well-recognized or organized are unpaid family members, supporting relatives with disabilities, Alzheimer's, or chronic conditions. Some receive a modest government stipend, typically around US$11 per day, tied to the needs of the person they care for, often children or people with physical or cognitive disabilities. Others receive nothing. Caregivers must often pay for costs out of pocket.

In 2024, UNI launched the Red de Trabajadoras de Cuidados *(Care Workers' Network of Colombia)* as part of the Together We Care: Partnerships for Equitable Health System. [48] The network is focused on cultivating worker awareness and building worker strength. They are organizing locally, dividing Bogotá into zones to better reach care providers where they live and work. Local meetings reduce barriers of distance, time, and cost. Long-isolated care workers are beginning to connect with each other and build a collective identity and voice. María Elisa Alfaro talked about the ingredients for successful organizing: *"The leaders are getting training, and building their skills, so that the movement and the outreach are local. Care worker to care worker, and that makes a difference. Real listening. In-person. Engaging meetings."* [49]

"[If I received pay for my care work] I wouldn't have to work two other jobs and I could dedicate 100 percent to caring for my husband.... [I could get training]. Since he has physical mobility problems, I would learn how to support him in the bathroom so that I don't hurt my back, I have to dress him, I could provide support so that it does not physically affect me. Also how to provide emotional support because the pain of his kidneys is unbearable."

María Elisa Alfaro
Red de Trabajadoras de Cuidados, Colombia, May 8, 2025

The Red de Trabajadoras de Cuidados currently has more than 250 members and is reaching out to local leaders and public initiatives such as the "Manzanas del Cuidado" *(Care Blocks)*. They are taking a long-term approach to organizing and winning the protections articulated in their 2024 Charter of Rights: 1) formalization of care work as a recognized profession, 2) access to training and certification, 3) freedom of association, and 4) the right to collective bargaining.[50]

In February 2025, Colombia approved its first National Care Policy, aiming to meet the care needs of its population and to support caregivers with recognition, training, and improved working conditions. Advocates identify sustainable financing as a challenge. The Red hopes to influence the regulations and implementation of the National Care Policy.

Dominican Republic

Home health workers in the Dominican Republic typically work without contracts, social security, or basic labour protections. Most have not received formal training. The National Federation of Women Workers (FENAMUTRA) has been working to increase public recognition of home health workers, improve training opportunities, and advocate for stronger labour protections.

One innovative program, "Familias de Cariño," was launched in 2020 by the government's National Council for the Aging (CONAPE)[52]. Through this initiative, neighborhood caregivers, often single women or unemployed or retired individuals, turn their homes into spaces providing dignified care for older adults. While the program does not pay caregivers a formal salary or social security, it represents a step toward formalization and regular pay through providing a monthly stipend of DOP$15,000.00 (about USD$254). The program is growing--it began with fewer than 50 caregivers and, by 2025, included 290 individuals dedicated to elder care.

FENAMUTRA, with support from UNI Care, has successfully championed the integration of a training component into the program. The initial agreement with CONAPE involved FENAMUTRA providing 200 workers with training endorsed by the National Institute for Technical and Vocational Training (INFOTEP), and technical certification with national and international recognition. The 15-hour training includes occupational safety and health, elder care, conflict management, and workplace violence. FENAMUTRA is building on this training to push for additional training and certification opportunities .

FENAMUTRA is also a part of the National Care Table, and supporting a pilot initiative across two regions that prioritizes care for children, older people, and people with disabilities. They collaborate

"It's very important for there to be an audit, and a public tender. Because it's not just one company or one organization that's going to be contributed to the contract... It is going to be contracted to numerous companies and organizations.... It's very important for there to be oversight, and a monitoring process to make sure that what the government says about workers' rights is respected." [51]

Ruth Díaz
FENAMUTRA, Dominican Republic, May 6, 2025

with a range of organizations that comprise the National Care Table, such as the National Institute for Comprehensive Early Childhood Care (INAIPI), the National Disability Council (CONADIS), the Ministry of Women, and Supérate, the Dominican Government's primary social protection program.

FENAMUTRA is in discussions with both CONAPE and the care roundtable to fully formalize these workers. A small number of workers have now been formalized and are receiving full social benefits, but FENAMUTRA is pushing for all care workers to receive formal labour contracts that will ensure social benefits like health care and retirement, to build a long term care system that fully implements the ILO's 5R principles.

In 2025, the government is moving toward subcontracting care services through third parties, raising concerns about setbacks to formalization of home health workers, working conditions, and quality of care. The sector will face fragmentation across multiple private providers. While the Familia con Cariño program currently covers elder care costs, including worker stipends, there is no guarantee this model will be preserved as outsourcing expands. Ruth Díaz raised concerns about a subcontracting model prioritizing a business perspective rather than health rights and labour rights. She called for strong state oversight, fair procurement practices, and enforceable standards on pay, hours, and social security contributions[53].

Lessons Learned

Organizing workers performing unpaid care work for family members is an important priority for a comprehensive decent care work agenda.

Individuals providing care for family members remain among the most isolated, dispersed, and unorganized sets of care workers. Outreach to these caregivers is critical for building individual and collective worker identities, agendas, and political voice. The challenges and priorities of home health workers, including those caring for loved ones, should be specifically recognized in national care policies and programs.

Building complementary agendas and alliances for workers and users of health care is strategic and impactful.

This has been a deeply successful practice in Washington state, and provides a strategic model in other contexts. This can include building shared agendas to increase funding for the care economy, quality of care and training, and strengthening social dialogue to work through policy differences.

Training, certification, and career pathways are urgent priorities for home health workers.

Training is critical for occupational safety and health as well as quality of care. Certifications and formal recognition of home health care work can also aid labor reintegration back into the wider workforce after caregiving responsibilities are completed.

Initial investments, whether from national or global unions or other donors, in organizing unorganized care workers is a forward-looking and strategic move to support formalization of care workers.

Consolidation and coordination aids robust and productive social dialogue among social partners.

Fragmentation – whether among isolated and unorganized care workers, privatized third-party care agencies, unorganized users of health care, or multiple government agencies harms the promotion of decent care work. The example of Washington state shows how the sustained dialogue and relationships between a centralized government body coordinating long-term health care, a union representing long-term care workers, and organizations representing users of home health services have been mutually beneficial for transparency, financing, quality of care, and decent working conditions.

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