World Vision

# COMMUNITY HEALTH WORKER WORKLOAD AND REMUNERATION: WORLD VISION POSITION PAPER

# Part I: Background

## Introduction

The World Health Organization (WHO) estimates that there will be a shortage of 11 million healthcare workers in low- and middle-income countries by 2030.[1] Community Health Workers (CHWs) can help to fill this gap and indeed this will be crucial for achieving universal health coverage. Although not cost-free, CHWs are one of the most cost-effective ways to reach vulnerable families and communities to transform child health and nutrition, with an estimated $10 return for every one dollar invested[2]. There is clear and growing evidence that CHWs are effective in delivering a range of preventive, promotive, and curative health services, and that they contribute to reducing inequalities in access to services.[3] Further, as CHWs work on the front lines, interacting directly with households, the CHW platform holds the potential to address not only health and nutrition concerns, but an array of holistic issues as well, to include caregiver mental health, early childhood development, child protection, and water and sanitation, as examples.

## World Vision's work with CHWs

As of 2025, World Vision (WV) was working with close to 194,000 CHWs in 43 countries. This number rose to more than 250,000 during WV's response to the COVID-19 pandemic. These numbers could potentially increase significantly with WV's intent to scale the Nurturing Care Group (NCG) model, which involves the mobilisation of community saturation-level numbers of volunteers; generally on an order of magnitude greater than the numbers of CHWs currently on the ground. As WV takes stock of its work with community health cadres and looks to the future, it is crucial that the organisation engages ethically with these health workers, in line with the current global guidance concerning terms of service for CHWs, and with respect to national labour laws.

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[1] World Health Organization, https://www.who.int/health-topics/health-workforce#tab=tab_1, accessed 7 July 2025.
[2] Dahn B, Tamire Woldemarian A, Perry H, et al. Strengthening Primary Health Care through Community Health Workers: Investment Case and Financing Recommendations. 2015.
[3] World Health Organization: *WHO Guideline on health policy and system support to optimize community health worker programmes*, Geneva, 2018.

# Global guidance, recommendations, and consensus

**WHO:** In 2018, WHO published the WHO *Guideline on health policy and system support to optimize community health worker programmes*, to include the recommendation to *'remunerate practising CHWs for their work with a financial package commensurate with the job demands, complexity, number of hours, training and roles that they undertake'*.[4]

**Monrovia Declaration:** The Third International Symposium on Community Health Workers in 2023 released the *Monrovia Declaration*, calling on governments and other stakeholders to make professionalised CHWs the norm, including the statement, *'in line with the WHO Guidelines, ensure formalized CHWs are paid a fair wage, skilled, supervised, and supplied to deliver the highest quality care, leveraging digital tools, and offered opportunities for career progression. This must be a just transition, undertaken with consideration for gender equity and social inclusion, to protect quality jobs for women and other marginalized groups.'*

**International Labour Organization (ILO):** The ILO recommends that pay for health workers *'should reflect qualifications, responsibilities, duties and experience'*.[5]

**Donors:** Various donors have joined the call for fair remuneration of CHWs.

- The President's Emergency Plan for AIDS Relief (PEPFAR)'s 2022 guidance for all PEPFAR-supported countries includes language on fair pay: *'[CHWs] and peer workers should receive compensation aligned with partner-government policies. In instances where country policies do not specify payment, PEPFAR country programs should proactively engage, along with other donors, to promote country policy reforms'*.[6]
- The President's Malaria Initiative (PMI) updated its policy in 2021 to allow the use of PMI funds to pay CHWs wherever countries create policies and plans to employ them.[7]
- The Global Fund's Key Performance Indicators (KPIs) for countries receiving funding include tracking a country's system readiness for CHWs. Assessment criteria check whether CHWs in the country: *'have a contract specifying their scope of work, expected full-time equivalent (FTE) or expected hours per month/week/day, a level of financial remuneration that does not fall below the national minimum wage (pro-rated to their expected % FTE), timing of financial remuneration (e.g. monthly), rest days, annual leave, paid sick leave, holidays, and health insurance'*.[8]
- The Africa Frontline First initiative is a community health financing facility launched in 2022 aimed at professionalising (e.g. training, remunerating, supplying, and supervising) 200,000 CHWs in 10 countries in Africa by 2030 and has created a 'catalytic fund' hosted by the Global Fund to mobilise $100 million, with a 1:1 match from the Global Fund. The fund is currently partially funded, to begin to fulfill this purpose.[9]

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[4] Ibid.
[5] International Labour Organization. Decent Work. Available: https://www.ilo.org/global/topics/decent-work/lang–en/index. htm. Accessed: 9 January 2024.
[6] PEPFAR 2022 Country and Regional Operational Plan (COP/ROP) Guidance for all PEPFAR-Supported Countries, pp. 533, https://www.state.gov/wp-content/uploads/2022/02/COP22-Guidance-Final_508-Compliant-3.pdf, accessed 9 January 2024.
[7] U.S. President's Malaria Initiative, https://www.pmi.gov/dr-raj-panjabis-closing-remarks-at-launch-of-a-national-georeferenced-community-health-worker-master-list/, accessed 9 January 2023.
[8] The Global Fund, Key Performance Indicators (KPIs)Handbook for the 2023-2028 Strategy, October 2022.
[9] www.africafrontlinefirst.org

**Global experts:** The global literature increasingly calls for a careful look at work with community health volunteers, acknowledging that while volunteerism can have its place, close attention to their working hours is needed to ensure that these community members are not exploited. One group of experts recommends that partners aim to not exceed a workload of four hours per week when engaging volunteers: *'what global health "influencers" should stand up against is the abuse of volunteers when long hours (e.g. more than 4 hours per week) are required of people with limited agency and who are faced with a precarious livelihood'.*[10] A second group of experts increases this to ten hours per week: *'Here, we defined excessive work hours for volunteers in line with expert opinion of at least 10 hours per week of unsalaried work'.*[11]

**National Community Health Strategies:** The directive to remunerate CHWs is increasingly included in countries' Community Health Strategies, as in the examples of Burkina Faso, Kenya, Liberia, Malawi, and Niger, among others.

## The current situation of CHWs

In spite of the emerging consensus for fair pay and working conditions for CHWs, it is estimated that 50% of CHWs globally are unpaid, with this figure rising to 80% in Africa.[12] This is additionally a gender issue as 67% of the global health and social workforce are women,[13] with CHWs being in particular a primarily female workforce.

A recent study reviewed the labour conditions among CHWs in dual-tier programmes, wherein salaried CHWs oversee a 'second tier' of unsalaried/volunteer health workers. The dual-tier model is the structure used in WV's planned NCG scale-up. The study revealed that 13 (59%) of 22 unsalaried CHW cadres and one (10%) of ten salaried cadres experienced labour exploitation, defined as more than 10 hours per week working hours for unsalaried CHWs, and proportional definitions for the salaried cadres per remuneration levels and hours required.[14]

Given the realities of often little to no pay of CHWs around the world, combined with excessive working hours, and given WV's large and increasing footprint of engaging CHWs, it is urgent that WV align with the emerging consensus on fair working conditions for these cadres and put appropriate procedures into place in our programmes that work with CHWs, with that aim.

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[10] Sarriot E, Davis T, Morrow M, Kabore T, Perry H. Motivation and Performance of Community Health Workers: Nothing New Under the Sun, and Yet…" Global Health: Science and Practice, 2021, Volume 9, Number 4.
[11] Ballard M, Olinaran A et. al. Labour conditions in dual-cadre community health worker programmes: a systematic review. Lancet Glob Health 2023; 11: e1598–608.
[12] Perry HB, Zulliger R, Rogers MM. Community health workers in low-, middle-, and high-income countries: an overview of their history, recent evolution, and current effectiveness. Annu Rev Public Health 2014; 35: 399–421.
[13] WHO, https://www.who.int/health-topics/health-workforce#tab=tab_1 accessed 9 January 2024.
[14] Ballard M, Olinaran A et. al. Labour conditions in dual-cadre community health worker programmes: a systematic review. *Lancet Glob Health* 2023; 11: e1598–608.

# Part II: WV position: CHW workload and remuneration

## Definitions

**Community Health Workers (CHWs):** An umbrella term to encompass all community health cadres, paid or unpaid. Nurturing Care Group Volunteers are included.

**Community Health Volunteers:** A sub-set of CHWs. Community Health Volunteers are unpaid CHWs. 'Volunteer' means that the CHWs do not receive a salary for set hours of work.

**Pay/Salary:** A salary is routine pay for agreed hours of work. Small incentives (well below minimum wage) paid frequently or infrequently, are not considered a salary. Likewise, reimbursement of CHW expenses, such as a transport reimbursement or a lunch expense, are not considered salary. CHWs who only receive small incentives and reimbursement of expenses are **volunteers**.

**World Vision-mobilised:** Refers to CHWs that WV mobilises and supports. Those pre-existing CHWs formally linked to the Ministry of Health (MoH) are not considered WV-mobilised, even though WV may work with them and support them. This position paper refers primarily to *WV-mobilised* CHW cadres: those that would not be present and working without the WV initiative to mobilise and support them.

# Stipulations of the WV CHW workload and remuneration position

## *WV-mobilised cadres*

1. No WV-mobilised health cadre should be required to work more than eight hours per week without pay. This includes Nurturing Care Group Volunteers. If WV is unable to provide payment to a WV-mobilised health cadre, the cadre is therefore a volunteer cadre and the workload must be spread across a sufficient number of volunteers to ensure that no volunteer exceeds the eight hours per week limit.
2. If the workload of a WV-mobilised health cadre requires more than eight hours per week to complete, the cadre must be paid. This pay must be at least equal to the country's minimum wage, pro-rated for the percent of full-time equivalent (FTE) required by the function. (e.g. if the cadre works 20 hours per week, the position is half-FTE. The pay would be pro-rated at half of the country's minimum wage.) The pay is in the form of a routine salary, and is in addition to the covering of any expenses (e.g. travel and/or lunch expenses for non-routine events/trainings etc.) and any non-financial incentives also provided. As the cadre is receiving payment, it is therefore not a volunteer cadre.
3. A quantitative workload analysis must be conducted for all WV-mobilised health cadres to calculate the number of hours per week required by the assigned responsibilities, in order to thereby make the pay/no pay determination. Global Centre support is available for this exercise.
4. All WV-mobilised health cadres must track hours worked using a form provided by WV, and submit to appropriate WV supervisors. In the case of volunteers, the time tracking is meant to ensure that the eight hours per week limit is not exceeded. In the case of paid health workers, this is to ensure that pay is backed by validation of hours worked.
5. Any grant-funded programme working with a WV-mobilised health volunteer cadre (unpaid, working no more than eight hours per week) must disclose this fact. Guidance on this reporting requirement will follow.
6. WV should make reasonable efforts to explore with the national government possibilities for the long-term integration of the cadre into the government system for sustainability. In the absence of such possibilities, the WV-mobilised cadre's work can be considered to be time-bound, with an end date as of the end of the project, and communicated as such to the cadre.

## *Non-WV-mobilised cadres*

If the CHW cadre that WV is working with is not WV mobilised, then WV does not have the same authority to effect the above stipulations. Normally, such cadres are formally associated with the MoH and it is the MoH that must make any necessary adjustments to the programme. In these cases, the following WV-internal stipulations apply:

1. WV must know/learn the provisions of the CHW cadre: their agreed working hours as stipulated by the MoH, and remuneration if any.
2. If WV is working with the MoH CHW cadre, a desk-based quantitative workload analysis must be carried out for this non-WV-mobilised cadre to determine the number of hours per week required by the assigned responsibilities, in order to compare with the CHW programme provisions (as stipulated by MoH) and determine if fair pay and working conditions are in place or not. Global Centre support is available for this exercise.
3. If workload analysis reveals that CHWs are exceeding eight hours per week in the case of a volunteer cadre, or if the hours are excessive in relation to pay received in the case of a salaried cadre, WV should engage in advocacy efforts with the MoH and may use the workload analysis as a basis for the advocacy and discussion.
4. This advocacy should be included as an integral part of WV's CHW programming, ideally carried out together with other stakeholders, and emphasising the WHO CHW guidelines that call for cadres of CHWs that are formalised, paid a fair wage, skilled, supervised and supplied to deliver the highest quality care, so that WV plays a role in improving community and health systems during the project/programme tenure.
5. WV should avoid assigning additional tasks such as Timed and Targeted Counselling or Grow GMP activities to a MoH-linked CHW cadre if doing so will result in excessive working hours for the CHWs. Alternative solutions will be required for the rollout of such programming, in such a case.


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