World Vision
health and nutrition

Expanding World Vision's Impact Through Community Health Workers

A GLOBAL CENSUS

FEBRUARY 2016

Abbreviations

7 -11	World Vision's 7-1 Health strategy, inclusive of 7 essential life-saving interventions for the mother and 11 for the child, applied within a community systems strengthening framework
ADP	Area development programme
CHW	Community health workers
ECD	Early Child Development
ENAP	Every Newborn Action Plan
FLHWC	Frontline Health Worker Coalition
HTSP	Healthy Timing and Spacing of Pregnancy
iCCM	Integrated Community Case Management
ILO	International Labour Organization
IMCI	Integrated management of childhood illness
IYCF	Infant and young child feeding
MNCH	Maternal, newborn and child health
MoH	Ministry of Health
NGO	Non-governmental organisation
NO	National office (refers to a World Vision national implementing office)
PMTCT	Prevention of Mother-To-Child Transmission of HIV
SBA	Skilled birth attendant
SDG	Sustainable Development Goal
ttC	Timed and Targeted Counselling
WASH	Water, sanitation and hygiene
WHO	World Health Organization
WVI	World Vision International

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Expanding World Vision's Impact through Community Health Workers: A Global Census

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Cover photo: © World Vision/Jon Warren
Village Health Team member, Sara, visits families in Uganda for the Timed and Targeted Counselling programme.

Executive summary

Community health worker (CHW) programming is one of the largest portfolios in World Vision's health; nutrition; and water, sanitation and hygiene (WASH) sector, with 48 countries operating a wide diversity of CHW initiatives. We continue to work and build partnerships towards strengthening community health systems and the community health workforce, a commitment we made to the World Health Organization (WHO) Global Health Workforce Alliance in Recife in 2013.[1] World Vision has also made global commitments to support CHWs, including the Every Newborn Action Plan (ENAP) signed in 2014, in which we have committed to strengthen maternal and newborn care within our CHW programmes to reach 100,000 CHWs in 40 countries by 2020. World Vision has increasingly sought opportunities to work with governments and partners to support harmonisation and scale up CHW programming.

In 2015 the Global Health and Nutrition team undertook a global census of CHW programming activities of 66 national offices (NOs). The purpose of the census was to provide an estimate of the current scale of our work in CHW programming globally, to assist internal monitoring and our reporting on our global commitments. The census results are also used to develop CHW technical capacity statements, grant proposals, and fundraising and marketing resources.

[1] World Vision International (n.d.). 'World Vision's Global Commitment to CHWs Systems Strengthening'. www.wvi.org/world-vision%E2%80%99s-global-commitment-chws-systems-strengthening.

Key findings

- Of 65 countries that were approached, **57 NOs responded** (88 per cent response rate).
- CHW programming is a core approach for health and nutrition in **48 NOs** (84 per cent).
- World Vision is currently supporting approximately **220,370 CHWs** globally, more than twice the projected target for 2015.
- World Vision is well on the way to CHW programming at scale, with **34 of 48 NOs reporting that CHW programming is in 50 per cent or more of project sites.**
- The ministries of health in **80 per cent of these countries currently have an existing national CHW policy** in place.
- Where a national CHW policy exists, World Vision CHW programmes are **fully aligned in 65 per cent of cases.**
- World Vision directly implements CHW programming in just 25 per cent of the 48 countries; the **predominant mode of support is through the provision of technical assistance and capacity building.**
- Of our NOs conducting CHW programmes, **81 per cent (n=39) report implementing Timed and Targeted Counselling (ttC) or another form of essential newborn care.** Although we have likely surpassed our initial goal of reaching 100,000 CHWs, only two countries include chlorhexidine cord care. Further investigation is needed to determine the exact modes of care and interventions in use to extend evidence-based newborn care interventions into CHW service delivery over the next five years.
- Only **48 per cent of NOs** that responded were able to report CHW numbers using complete reporting data through World Vision's Horizon data collection system, indicating a need for further efforts to standardise reporting amongst the remaining offices and projects.

Introduction

Globally, more than 300,000 maternal deaths[2] and over 5.9 million under-5 deaths[3] due to preventable causes occurred in 2015. This is due in large part to critically low health workforce density, especially in sub-Saharan Africa and South Asia. In 2006, the WHO defined a country with less than 23 doctors, nurses and midwives per 10,000 people as having a 'health workforce crisis', and 57 countries were identified, 36 of which are in sub-Saharan Africa.[4] WHO estimated the 2013 global health workforce gap at 7.2 million workers, and at least 1 million health workers are needed within Africa to fill this gap.[5] Although some progress has been made towards increasing health workforce, the distribution of health workforce crisis countries[6] (Figure 1) is still largely reflective of the distribution of under-5 mortality (Figure 2).

▲ *Mrs Pham Thi Tuyet Mai, a Village Health Worker in Vietnam, often pays home visits to monitor child health and follow up nutrition practice of mothers and caregivers. Phan Thi Thao Nguyen Thuy/World Vision*

The health workforce density data only tells part of the story however, and the distribution of skilled health workers within a country shows massive inequities between urban and rural areas. Retention of health workers in rural communities is a major priority for building a health workforce in the Sustainable Development Goals (SDGs) agenda. Ensuring universal access to health for such underserved communities will continue to be a major challenge.[7]

[2] World Health Organization (2015). *Trends in Maternal Mortality: 1990 to 2015.* http:// apps.who.int/iris/bitstream/10665/193994/1/WHO_RHR_15.23_eng.pdf?ua=1.

[3] World Health Organization (2015). 'Under-five mortality'. http://www.who.int/gho/child_health/mortality/mortality_under_five_text/en/.

[4] World Health Organization (2006). *The world health report 2006: working together for health.* http://www.who.int/whr/2006/whr06_en.pdf.

[5] J. Campbell, G. Dussault, J. Buchan, F. Pozo-Martin, M. Guerra Arias, C. Leone, A. Siyam, G. Cometto (2013). *A universal truth: no health without a workforce.* Forum Report, Third Global Forum on Human Resources for Health, Recife, Brazil. Geneva, Global Health Workforce Alliance and World Health Organization. http://www.who.int/workforcealliance/knowledge/resources/GHWA-a_universal_truth_report.pdf.

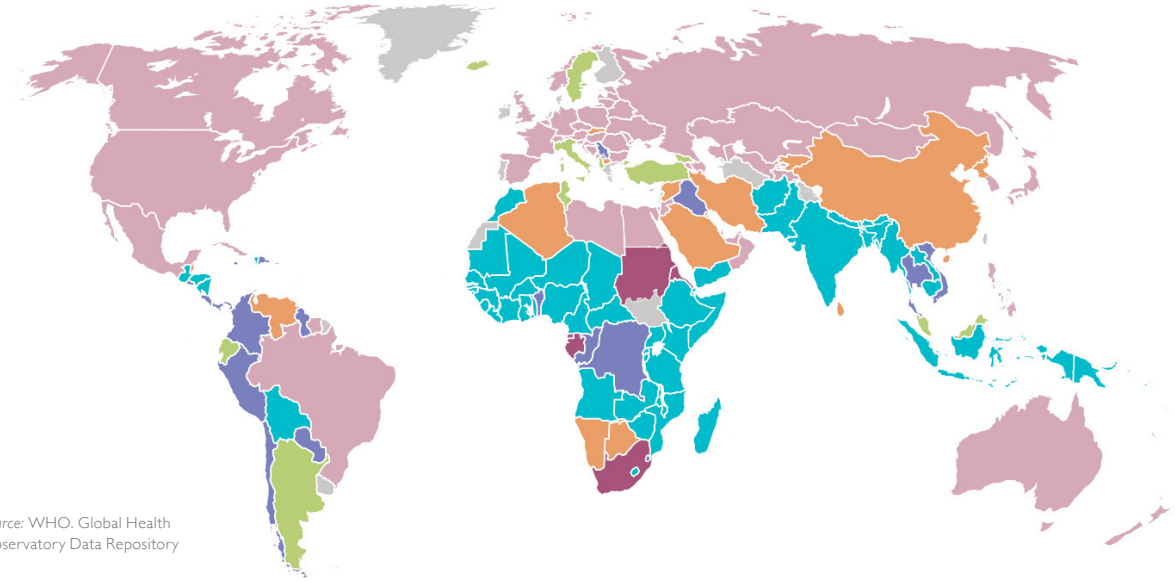
[6] Ibid.

[7] Global Health Workforce Alliance (2015). 'Global strategy on human resources for health: Workforce 2030' (Draft). http://www.who.int/hrh/resources/WHO_GSHRH_DRAFT_05Jan16.pdf?ua=1.

CHWs and other frontline health workers have been recognised, with strong evidence base, for their potential contribution in achieving universal health coverage,[8] especially in health workforce crisis countries. CHWs will be an essential resource in the era of SDGs as they are a resource for tackling rural-urban disparities in health-care access. They also offer a strategic way to ensure that health care reaches the most marginalised and vulnerable or hard-to-reach communities and families in all contexts.

Figure 1. Workforce to population ratios for 186 countries[9]

- Group 1: density of skilled workforce lower than 22.8/10,000 population and a coverage of births attended by skilled birth attendant (SBA) less than 80%
- Group 2: density of skilled workforce lower than 22.8 /10,000 population and a coverage of births attended by SBA less than 80%
- Group 3: density of skilled workforce lower than 22.8 /10,000 population but no recent data on coverage of births attended by SBA
- Group 4: density is equal or greater than 22.8/10,000 and smaller than 34.5/10,000
- Group 5: density is equal or greater than 34.5/10,000 and smaller than 59.4/10,000
- Group 6: density is equal or greater than 59.4/10,000



Source: WHO. Global Health Observatory Data Repository

World Vision's contribution to CHW programming

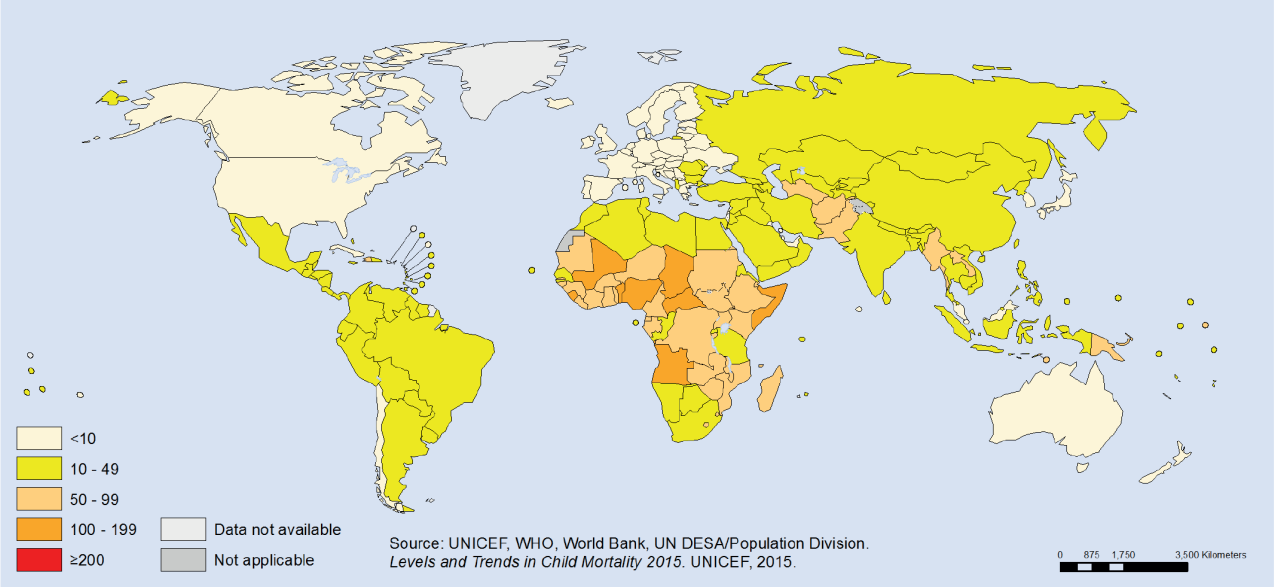
World Vision's 7-11 Health Strategy seeks to coordinate programmes and projects working in the areas of maternal, newborn and child health (MNCH), implementing seven essential evidence-based interventions for the mother and 11 interventions for the child across the continuum of care from pregnancy to the second year of

[8] Global Health Workforce Alliance (2013). *Joint Commitment to Harmonized Partner Action for Community Health Workers and Frontline Health Workers*. www.who.int/workforcealliance/knowledge/resources/chw_outcomedocument01052014.pdf.

[9] Reprinted from J. Campbell et al., *A universal truth: no health without a workforce*, p. 19. See http://www.who.int/workforcealliance/knowledge/resources/GHWA_AUniversalTruthReport.pdf.

life.[10] World Vision's integrated MNCH strategy for CHWs – Timed and Targeted Counselling[11] (ttC) – was introduced in 2011 and now reaches 23 country programmes. Integrated Community Case Management (iCCM) programming, started in 2012, now encompasses 12 NO programmes, and we continue to expand through partnership approaches. Additionally, our contributions to mobile health technologies for CHWs in 16 of these countries[12] have given traction to our work with CHWs in different countries and regions.

Figure 2. Under-5 mortality rate (probability of dying by age 5 per 1000 live births), 2015[13]



The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Source: World Health Organization
Map Production: Health Statistics and Information Systems (HSI)
World Health Organization

World Health Organization

World Vision has provided thought leadership in most contemporary CHW programming forums including with the Core Group, CHW-Central, Health Systems Global Thematic Working Group and the Global Health Workforce Alliance. World Vision is known for its advocacy work, both in building capacity for campaigns in country programmes (Child Health Now), and for our work on CHW

[10] World Vision International (n.d.). 'The 7-11 Strategy for Maternal and Child Health'. http://www.wvi.org/health/7-11-health-strategy.

[11] World Vision International (2015). *Timed and Targeted Counselling for Health and Nutrition 2nd Edition: A Comprehensive Course for Community Health Workers*. http://www.wvi.org/health/ttc-2nd-edition-english.

[12] World Vision International (2015). *Global mHealth Report 2015*. http://www.wvi.org/health/publication/global-mhealth-report-2015.

[13] Reprinted from World Health Organization (2015). 'Global Health Observatory (GHO) data: Under-five mortality'. http://www.who.int/gho/child_health/mortality/mortality_under_five_text/en/.

▲ *Jahantab, 50, has been a Community Health Worker in Afghanistan for more than 12 years. Narges Ghafary/ World Vision*

programming on a global platform and contributions towards the agenda for joint partner action for CHWs.[14] As a part of this agenda, World Vision has made a global commitment to ENAP to scale its support to CHW programmes from the estimated number of 70,000 CHWs in 2014 to 100,000 CHWs in 40 countries by 2020,[15] and continue to work and build partnerships towards strengthening community health systems.[16]

This report seeks to capture this diversity and use it to identify the key themes, priorities and opportunities in CHW programming and have a 'snapshot' of the scope and breadth of our CHW programmes to guide strategic planning for scale.

Objectives

The purpose of the census was to understand how many CHWs are supported globally by World Vision, to capture the work they do, to understand how they are supported by World Vision and to report on coverage of CHWs in World Vision operational areas. The key objectives in carrying out this census were to:

- determine the number of CHWs currently supported in World Vision programmes
- understand the type of activities conducted by CHWs which are supported by World Vision
- evaluate the predominant types of support provided by World Vision
- identify gaps in activities and need for scaling up CHW programmes.

[14] Global Health Workforce Alliance, *Joint Commitment to Harmonized Partner Action for Community Health Workers and Frontline Health Workers.*

[15] Every Newborn Action Plan (2014). 'World Vision International has committed to invest another USD $3 billion in sustainable health programming and in humanitarian emergency responses' [Press release]. http://www.everywomaneverychild.org/commitments/all-commitments/world-vision-international.

[16] World Vision International, 'World Vision's Global Commitment to CHWs Systems Strengthening'.

Methodology

World Vision is in the process of adopting a new internal monitoring system, Horizon, for capturing data consistently across all its programmes. However, the wide diversity of CHW cadres, activities and modes of operation presents major challenges to collecting reliable global data. Specifically, cadres may be excluded from the reporting data if they are not officially named as CHW within the country policy, and therefore exclude active community agents such as Care Group volunteers, Mothers Support Groups, HIV expert clients and many others.

For this reason, a survey was distributed online through SurveyMonkey® (www.SurveyMonkey.com) to regional advisors and national health coordinators in 66 NOs currently implementing health programming. Versions of the census survey were available in English, Spanish and French. The activity was designed to be completed by a national health coordinator, and it required that each health coordinator submit the numbers of CHW supported by each ADP and/or grant project from the most recent annual reports, baseline surveys or project evaluations within the past two years. Or, if reports were not available, to estimate numbers of CHWs supported for each grant project area or area development programme (ADP) – a cluster of communities around which World Vision field operations are located. These estimates would be based on the target populations in those projects and their current achieved level of scale for the CHW initiatives.

Definitions of CHWs and cadre inclusion

Central to the survey design was the definition of CHWs determining which of many variable cadres could be included in each context. Anticipating a high variance in CHW activities, titles, programme structure, and cultural contexts in which they work, participants were provided the current standard International Labour Organization (ILO) definition (Box 1), which is broad to reflect the diversity of CHWs. This definition and inclusive measure of CHWs is the approach currently advocated for by the Frontline Health Worker Coalition (FLHWC) for improved reporting of CHWs.[17]

Box 1. International Labour Organization (ILO) definition of CHW[18]

'Community health workers provide health education and referrals for a wide range of services, and provide support and assistance to communities, families and individuals with preventive health measures and gaining access to appropriate curative health and social services. They create a bridge between providers of health, social and community services and communities that may have difficulty in accessing these services.'

[17] Frontline Health Workers Coalition (2014). *A Commitment to Community Health Workers: Improving Data for Decision-Making.* http://frontlinehealthworkers.org/wp-content/uploads/2014/09/CHW-Report.pdf.

[18] International Labour Organization (2012). *International Standard Classification of Occupations 2008 (ISCO-08): Structure, group definitions and correspondence tables*, p. 192.

Data validation process

Data was validated through review of submitted reports and documents and emails. Telephone interviews were also conducted with 12 NOs as needed. The validation process was time consuming. Providing the ILO definition for CHWs together with the survey was not always adequate to get full understanding, as the definition implies greater inclusiveness than assumed. Many countries needed further clarification, particularly those with multiple cadres. In some cases, many cadres come under the ILO definition, yet under the national policy, one specific group is referred to as 'CHW'. As a result, the risk of under- or over-reporting CHW numbers was high and required validation through survey instructions, follow-up emails and phone interviews. On verification of the data, which was conducted with 12 countries, one country (Zambia) was found to have excluded a large number of community health volunteers engaged in HIV and orphaned and vulnerable children support activities by only reporting those named as CHW in policy.

Limitations of the approach

The original survey was designed to ask NOs to list currently active CHW cadres and whether each cadre was full-time, paid, with formal pre-service training; volunteer, part-time, regular engagement; or irregular/occasional volunteers. However, this question was removed after consultation with regional advisors, who suggested that the separation of data by different sub-classes would not be possible at this point in time. The survey instructions indicated that any temporary, ad-hoc volunteers were excluded from the census. Omitting these data points did reduce the effort level of survey respondents, although it did lead to further verification needed for several countries that were unsure of including all cadres. Moving forward, efforts to collect CHW data should include circulating the ILO definition but should also provide context-specific guidance with examples, especially for countries with specific national policy limiting the term 'community health worker' to just one cadre of many. Furthermore, for future reference, the separation of cadres that are formally recognised within the Ministry of Health (MoH) policies and those that operate purely in a civil society context would be more suitable.

Results

Census response

Of 57 countries that responded (88 per cent response rate), 48 had significant CHW programming and reported CHW numbers. The total number of CHWs currently reported to be supported under World Vision programmes is **220,370 CHW**s in 48 countries. This is likely to be an underestimate of the full total, as nine countries have not submitted counts, including several with CHW programmes, such as Indonesia and Mongolia, and nine countries which presented only partial data.

Table 1. Response rates for the global CHW survey

CHW survey response	Number
Number of NOs surveyed	65
Responded, with CHW programming	48
Responded, no CHW programming	9
Did not respond	8

Roughly 80 per cent of responding countries where World Vision works, including health workforce crisis countries, have a national CHW policy in place. Where such a policy exists, 65 per cent of World Vision CHW programmes are fully aligned to the government national CHW policy. World Vision conducts 'direct implementation' of CHW programmes in only 25 per cent of responding countries. By this, we mean where World Vision staff are primarily running all operations related to the CHW programme, e.g. Guatemala. In 75 per cent of settings, however, the predominant mode of support is through the provision of technical assistance and capacity building to local health structures and public health service staff to run operations in support of CHW programming. World Vision's role is either as a sole partner with the MoH or as part of a multi-stakeholder support network assisting a government programme, for example in Rwanda. It is important to remark that these data may not always be considered exclusively attributed to World Vision support in such settings.

National offices were asked to report the level of coverage of CHW programmes they had within World Vision programme areas, including ADPs and projects (Figure 3). Thirty-seven NOs reported that CHW programming is implemented in 50 per cent or greater of World Vision programme areas. In the countries with lower levels of CHW programming, other sector programming, such as nutrition, protection and education, may take greater priority. Some may suggest further opportunity

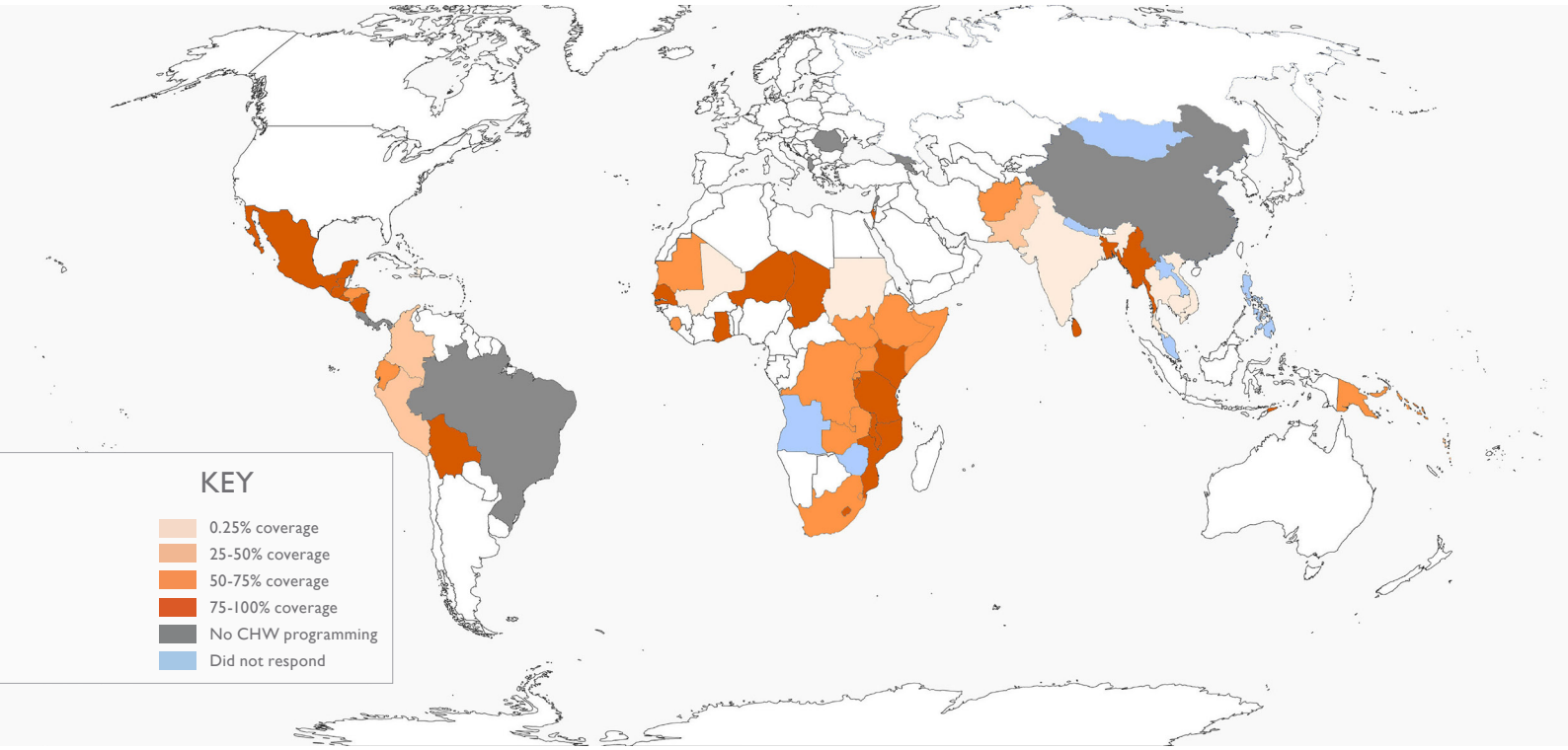
for growth, such as in India, Pakistan, Mali, Haiti and Sudan, all of which are health workforce crisis countries or have significant health worker inequity in rural areas, and are priority countries for CHW programming.

Zambia reported the largest number of CHWs (n=48,500) and Mali reported the smallest cohort (n=17), with 4,590 as the average (mean) for all responding countries. Almost half (48 per cent) of respondents used complete data reports, with 17 per cent using partially complete data reports only (i.e. some ADPs or projects within the country were missing data), and 35 per cent (n=17) estimated coverage using known population data, communities and knowledge of CHW roll out.

Box 2. Estimated coverage: Rwanda

According to accurate recent data, World Vision is supporting health programmes in 14,837 Rwandan communities as part of multi-stakeholder efforts to scale up the national CHW initiative. Latest reports suggest that 75 per cent of these communities currently have CHW programming as a major activity, with three CHWs per community.

Figure 3. Reach of CHW programming within World Vision operational areas (n=48)



As 17 countries reported that their CHW counts were based on estimates of coverage of project areas for their setting, it will be important over the next year to continue advocating for and supporting NOs to further standardise these CHW reporting indicators. It is our aim that the data will become available from the remaining countries in time for the 2016 census.

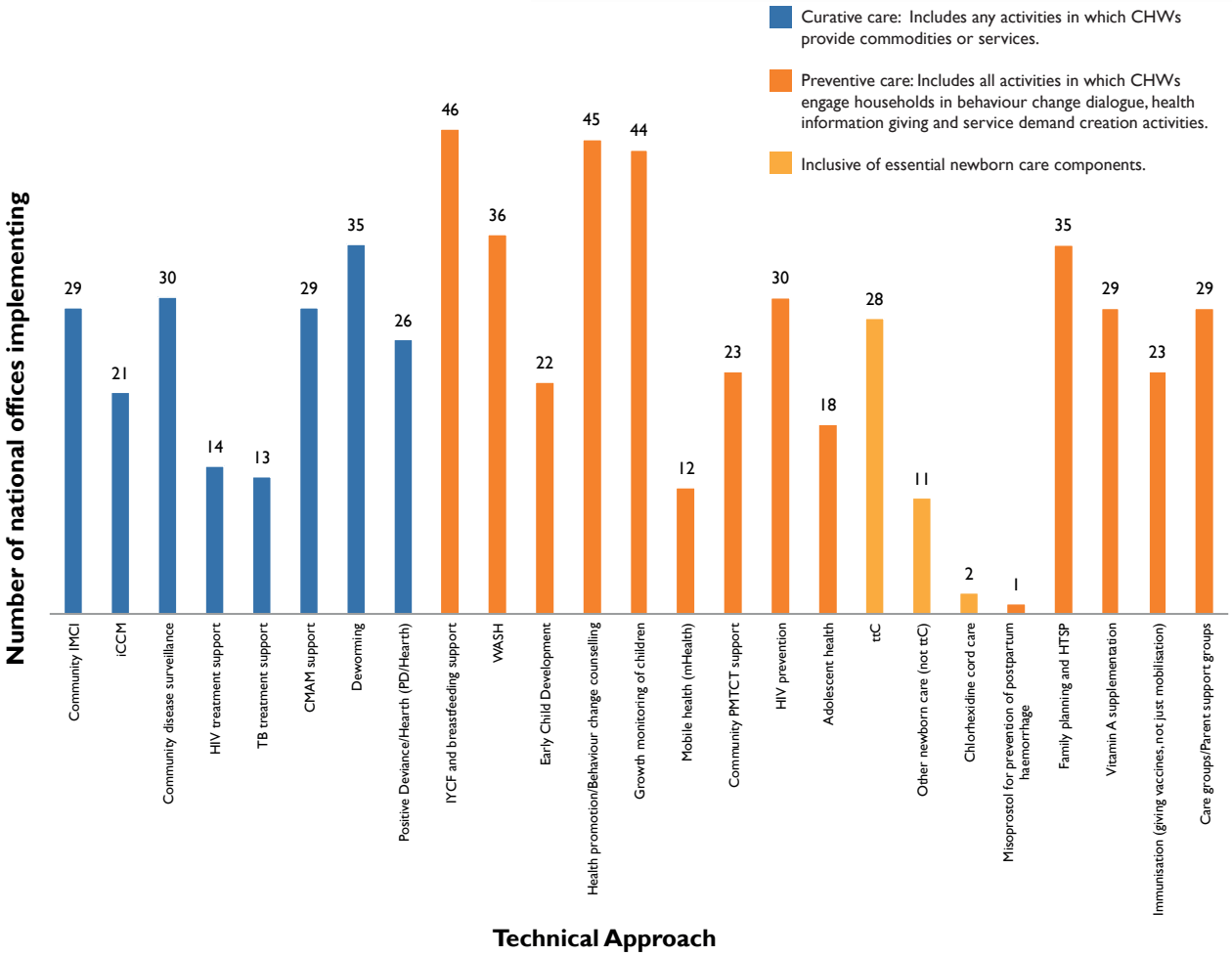
Community health worker activities

Maternal and child health and nutrition project models supported by World Vision include iCCM of Childhood Illness, Community-Based Management of Acute Malnutrition (CMAM), Community Prevention Of Mother-To-Child Transmission (c-PMTCT) of HIV and an integrated reproductive, maternal and child health behaviour-change approach based on negotiation and dialogue counselling called Timed and Targeted Counselling (ttC), which has been reviewed externally as one of the most integrated packages of care for CHWs.

National harmonisation and alignment

To understand the country context of World Vision-supported CHW programmes, respondents were asked to explain if CHW programmes for the responding country were aligned under a single CHW policy and national CHW framework under which all partners operate, and to indicate if World Vision CHW programmes were aligned to that national policy and framework. Consistent with World Vision's partnership approach, 79.8 per cent of responding NOs reported operating under a single CHW policy and national CHW framework that was fully operational (n=19) or partially operational (n=19), while 20.8 per cent were in countries that did not have a single CHW policy and national framework (n=10). Within countries that did have this policy and framework, a significant majority were fully aligned (64.6 per cent, n=31), 25 per cent (n=12) were partially aligned, and only 10.4 per cent (n=5) were not aligned.

Figure 4. Current activities of World Vision-supported CHWs



Discussion

CHWs are recognised as making a vital contribution to the reduction of mortality and the achievement of the SDGs, especially where equitable access to health is hampered by critical shortages of health workers. The findings of the census, while still to be considered cautiously until full data becomes available, give us reason to be optimistic about World Vision's current scope of CHW programming and the potential contributions we can make in improving universal access to health care for the hardest to reach communities. However, there is still much work to be done, and our end goal is to reach 100 per cent of communities in need with support for their CHWs. Significant gaps were identified in India, South East Asia and the West Africa region.

The numbers reported differ when compared alongside data from the WHO data observatory statistics on community and traditional health workers[19] and analyses completed of this cadre previously.[20] Reasons for this may include a mismatch around the definition of the cadre applied in the ILO definition, and many of these may not be included in government-collected data systems. Current thinking in the frontline health worker community is that all such cadres should be counted and reported by this broad definition as proposed by the FLHWC in 2013.[21] However, reporting by individual non-governmental organisations (NGOs) may not be the best way to achieve the end goal of comprehensive and accurate national CHW registries. Global efforts to establish a repository of data on CHW scale-up, such as the One Million CHWs Campaign 'Operations Room,'[22] require specific definitions for which cadres should be included. This report demonstrates feasibility in principle of collecting this data large-scale from NGO partners. But how such a data repository can maintain accurate counts, deal with high turnover and exclude multiple counts of CHWs by collaborating NGOs needs to be clarified. NGOs such as World Vision provide multiple levels of support for CHWs, and, increasingly, countries are moving towards more multi-stakeholder collaborations and partnership approaches. Many countries have adopted the WHO IRIS system (Institutional Repository for Information Sharing: http://apps.who.int/iris/) for the management of health workforce data, although government-reported data may exclude many community and traditional providers. Given our current findings and experience, we advocate for active CHWs (under the ILO definition) to be integrated into Health Management Information Systems within individual countries by managing data through district health authorities, which would be better positioned to prevent multiple counts.

In 2014, World Vision made a global commitment to ENAP to improve maternal and newborn health through scaling its support to CHW programmes. In 2011, World Vision was supporting an estimated 70,000 CHWs, and it was unclear if their work included newborns. However our 2014 commitment was to increase this to 100,000 CHWs in 40 countries by 2020. This census demonstrates World Vision has successfully scaled support to CHW programmes up to 220,370 CHWs, more than doubling the target of 100,000. This achievement can be attributed to huge

[19] World Health Organization Global Health Observatory data repository. http://apps.who.int/gho/data/node.main.HWF6?lang=en&showonly=HWF.

[20] G. McCord, A. Liu, P. Singh (2013). 'Deployment of community health workers across rural sub-Saharan Africa: financial considerations and operational assumptions'. *Bulletin of the World Health Organization*. 2012;91:244-253B. doi: http://www.who.int/bulletin/volumes/91/4/12-109660/en/.

[21] Frontline Health Workers Coalition, *A Commitment to Community Health Workers*.

[22] One Million Health Workers Campaign (2015). 'Data exploration tool: Sub-Sharan Africa', [Interactive map of community health workers in sub-Saharan Africa 15 February 2016]. http://1millionhealthworkers.org/operations-room-map/.

efforts made within the past three years, in particular, to roll out CHW programmes like ttC. This ensures sustainable financing structures to extend CHW programmes beyond time-limited grant settings into the long-term support activities of our ADP funding model. The initial estimate of scale made in 2013 may have underestimated the existing programming, as CHW reporting had not yet been standardised across NOs and was based on knowledge of previous project performance.

▲ *Family comes first in Rowena's priorities. Through the training she attended from World Vision in the Philippines, she become more caring to her children, especially when they get sick. Crislyn Joy A. Felisilda/ World Vision*

There are some gaps in provision of evidence-based interventions for newborn and maternal care. A total of 39 NOs (81 per cent) reported implementing ttC or another form of newborn care, but only two NOs currently support chlorhexidine for cord care and/or misoprostol for prevention of postpartum haemorrhage interventions. Advocacy efforts should be strengthened for improving the uptake and monitoring of these critical interventions, which can be delivered by trained CHWs, where country policy and high burden contexts exist.

Results showed that the most common activities that World Vision supports are infant and young child feeding (IYCF), counselling for behaviour change and growth monitoring of children, which is not unexpected given our investment over the long term. Of note, the promotion of family planning (Healthy Timing and Spacing of Pregnancy – HTSP) is supported in 36 of 48 countries (75 per cent). This is a notable result for World Vision, demonstrating the impact of internal advocacy by family planning champions, acquisition of grants including family planning activities, and capacity building of World Vision staff, as well as the inclusion of HTSP in our 7-11 Health Strategy.

Two other unexpected results are the inclusion of iCCM activities in 21 countries, of which only 15 have previously been reporting activities. Also, 18 countries support adolescent health activities by CHWs. As we are developing a stronger focus on adolescent health in 2016, with a planned adolescent health programme guidance development, this finding indicates that we are starting from a strong base

of grassroots activities in the community. Early Child Development (ECD) is not currently included in the 7-11 interventions, but 22 of 48 countries report that CHWs engage in ECD activities. Further investigation is needed to clarify what aspects are being conducted by CHWs in these countries. However, as ECD has been added to our second edition of ttC curriculum in 2015, it is hoped ECD will be integrated into all ttC programmes. We expect to see this number increase over the next two years.[23]

We are continuing our efforts to promote harmonisation of CHW programmes with MoH policies and nationalised approaches. Since we introduced the CHW principles of practice in 2013, we have made concerted efforts to align monitoring, data and supervision systems, and contribute to national programmes through technical support. The data on CHW national policy existence and World Vision's alignment is encouraging evidence that we are successfully moving this agenda forwards. Further, it shows how much scope we have to contribute to national programmes, bringing our substantial portfolio of CHW programmes as well as expertise in harmonisation and multi-stakeholder approaches. This data helps us to identify where further advocacy may be needed to establish national CHW policies and support full alignment with the government amongst NGOs and promote country ownership. Moving forwards, we will focus these efforts specifically on fragile settings and weak health systems, where health workforces are critically low, to work with the government and partners to establish strong national systems.

A prioritisation has been carried out for World Vision NOs based on health workforce status, burden and rate of child mortality, and technical capacity for implementation of CHW programming. The following table lists the 35 target countries for World Vision Health and WASH programming, and 15 are current high-priority focus countries for World Vision CHW programming (prioritised according to health workforce shortage, rural-urban health inequity and mortality, and capacity to scale up programmes).

[23] World Vision International, *Timed and Targeted Counselling for Health and Nutrition, 2nd Edition.*

Table 2. World Vision Global Health and WASH programming countries harmonisation at the national level and alignment with national policy

Country	CHW high-priority country for CHW programming	CHW programming reach in World Vision project areas	Are CHW programmes harmonised at the national level?	Are World Vision CHW programmes aligned with the national policy?
Afghanistan	High priority	50–75%	Fully operational	Fully aligned
Bangladesh	No	75–100%	Partially operational	Fully aligned
Bolivia	No	75–100%	Fully operational	Fully aligned
Burundi	No	75–100%	Fully operational	Fully aligned
Cambodia	No	0–25%	Fully operational	Fully aligned
Chad	No	75–100%	No	Partially aligned
Colombia	No	25–50%	No	No
Democratic Republic of Congo (DRC)	No	50–75%	Partially operational	Partially aligned
Dominican Republic	No	75–100%	Fully operational	Fully aligned
Ecuador	No	50–75%	No	Fully aligned
El Salvador	No	75–100%	Partially operational	Fully aligned
Ethiopia	High priority	50–75%	Partially operational	Partially aligned
Ghana	No	75–100%	Partially operational	Fully aligned
Guatemala	No	75–100%	No	No
Haiti	High priority	0–25%	Partially operational	Fully aligned
Honduras	No	50–75%	Fully operational	Fully aligned
India	High priority	0–25%	Partially operational	Partially aligned
Jerusalem, West Bank and Gaza	No	75–100%	No	Partially aligned
Kenya	High priority	75–100%	Fully operational	Fully aligned
Lesotho	No	75–100%	Fully operational	Fully aligned
Malawi	High priority	75–100%	Partially operational	Fully aligned
Mali	High priority	0–25%	Partially operational	Partially aligned
Mauritania	High priority	50–75%	Partially operational	Fully aligned
Mexico	No	75–100%	No	No
Mozambique	High priority	75–100%	Fully operational	Fully aligned
Myanmar	No	75–100%	Partially operational	Partially aligned
Nicaragua	No	75–100%	Fully operational	Fully aligned
Niger	High priority	75–100%	Fully operational	Fully aligned
Pakistan	No	25–50%	Fully operational	Fully aligned
Papua New Guinea	No	50–75%	Partially operational	Fully aligned
Peru	No	0–25%	Fully operational	Fully aligned
Rwanda	High priority	50–75%	Fully operational	Fully aligned
Senegal	No	75–100%	Partially operational	Fully aligned
Sierra Leone	High priority	50–75%	Fully operational	Partially aligned
Solomon Islands	No	50–75%	No	No
Somalia	No	50–75%	Partially operational	Partially aligned

Table 2 (continued)

Country	CHW high-priority country for CHW programming	CHW programming reach in World Vision project areas	Are CHW programmes harmonised at the national level?	Are World Vision CHW programmes aligned with the national policy?
South Africa	No	50–75%	No	Fully aligned
South Sudan	No	50–75%	Partially operational	Partially aligned
Sri Lanka	No	75–100%	Partially operational	No
Sudan	No	0–25%	No	Partially aligned
Swaziland	No	50–75%	Partially operational	Fully aligned
Tanzania	High priority	75–100%	Fully operational	Partially aligned
Thailand	No	0–25%	No	Partially aligned
Timor Leste	No	75–100%	Fully operational	Fully aligned
Uganda	High priority	50–75%	Fully operational	Fully aligned
Vanuatu	No	25–50%	Partially operational	Fully aligned
Vietnam	No	0–25%	Partially operational	Fully aligned
Zambia	High priority	50–75%	Fully operational	Fully aligned

Recommendations

A number of countries identified in this report either lack or have weaker nationalised CHW programmes, despite being places with critical workforce shortages and high needs, including Chad, Bangladesh, Democratic Republic of Congo (DRC), El Salvador, Ghana, Haiti, India, Malawi, Mali, Mauritania, Myanmar and Somalia. All of these countries are current World Vision target countries. In these places, World Vision should continue to work closely with the government and partners to provide technical support, operational approaches and tools for CHW harmonisation and partner alignment. It is recommended that those with the highest needs for CHW programmes, including fragile contexts, are prioritised for these efforts. We've identified gaps in achieving the goals of the 7-11 revised strategy, which now includes interventions such as chlorhexidine cleaning of the cord and misoprostol use for prevention of post-partum haemorrhage, where appropriate to introduce this policy. We recommend further advocacy efforts, working closely with WHO and other partners to ensure that appropriate policies are adopted and CHW care is strengthened to save newborn lives.

World Vision will continue to strengthen internal reporting systems until routine CHW data collection is available for all countries. Furthermore, we will aim to apply a two-tier CHW counting system in which formal CHW cadres recognised by the MoH are included in one tier and civil society or informal cadres in another tier. We need to work closely with evidence and learning teams to refine this data collection method.

The use of the ILO's broad definition of CHW, as recommended by the FLHWC for use in large scale,[24] led to some confusion, especially where national CHW policies are more limited than the definition. As such, future data collection efforts should aim to include cadre-specific data, and provide clarification with examples of all types of workers that would be considered CHWs for reporting purposes. This will enable World Vision to have reliable estimates of its international scope of CHW work more broadly, and also clearer national-level data.

For an annual CHW census to be completed, the survey tools used need to be more sophisticated for data capture and rapid comparison and quality control. In addition, partial saves during submission are necessary to prevent data loss or multiple submissions caused by network outages, which increase the need for data validation. The data structure should allow for multiple cadres of CHWs to be reported separately, including those formally MoH endorsed and those engaged in civil society contexts. Further, short-answer questions should be provided to gather information on sources of data and quality.

[24] Frontline Health Workers Coalition, *A Commitment to Community Health Workers.*

Annex: Counts of CHWs reported by each national office (n=48)

Coverage	Country	#CHWs
75–100%	Bangladesh	3,593
75–100%	Bolivia	500
75–100%	Burundi	3,400
75–100%	Chad	1,544
75–100%	Dominican Republic	430
75–100%	El Salvador	40
75–100%	Ghana	1,200
75–100%	Guatemala	1,650
75–100%	Jerusalem, West Bank and Gaza	144
75–100%	Kenya	4,725
75–100%	Lesotho	1,600
75–100%	Malawi	12,000
75–100%	Mexico	2,000
75–100%	Mozambique	3,000
75–100%	Myanmar	1,300
75–100%	Nicaragua	667
75–100%	Niger	1,075
75–100%	Senegal	2,250
75–100%	Sri Lanka	1,429
75–100%	Tanzania	1,709
75–100%	Timor Leste	118
50–75%	Afghanistan	2,386
50–75%	Ecuador	435
50–75%	Ethiopia	35,000
50–75%	Honduras	3,150
50–75%	Mauritania	80
50–75%	Papua New Guinea	115
50–75%	Democratic Republic of Congo (DRC)	4,471
50–75%	Rwanda	33,385
50–75%	Sierra Leone	1,753
50–75%	Solomon Islands	140
50–75%	Somalia	510
50–75%	South Africa	480
50–75%	South Sudan	700
50–75%	Swaziland	5,200
50–75%	Uganda	9,560

Coverage	Country	#CHWs
50–75%	Zambia	48,500
25–50%	Colombia	520
25–50%	Pakistan	60
25–50%	Vanuatu	212
0–25%	Cambodia	2,826
0–25%	Haiti	158
0–25%	India	22,057
0–25%	Mali	17
0–25%	Peru	1,200
0–25%	Sudan	50
0–25%	Thailand	1,500/5,000
0–25%	Vietnam	1,500
No CHW programming	Albania	0
No CHW programming	Armenia	0
No CHW programming	Brazil	0
No CHW programming	China	0
No CHW programming	Costa Rica	0
No CHW programming	Georgia	0
No CHW programming	Lebanon	0
No CHW programming	Panama	0
No CHW programming	Romania	0
Did not respond	Angola	-
Did not respond	Indonesia	-
Did not respond	Laos	-
Did not respond	Malaysia	-
Did not respond	Mongolia	-
Did not respond	Nepal	-
Did not respond	Philippines	-
Did not respond	Russia	-
Did not respond	Zimbabwe	-

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