DRAFT

World Vision

Health Systems: Assessment and Improvement Matrix (S-AIM)

A tool for assessing and improving health systems in support of Community Health Worker programmes

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1a. Governance, Leadership and Management: Political Will/Policies

• Community health policy and strategy do not exist	• Community health policy and strategy exist but are incomplete or outdated	• An up to date community health policy, strategy and operational plans exists, either embedded in Primary Health Care (PHC) policy and strategy, or stand-alone	• An up to date community health policy and strategy exist, either embedded in PHC policy and strategy or stand-alone, and are integrated into the broader national health policy, strategy and plans • There is a Community Health Unit within the Ministry of Health with budget and decision-making authority
• CHW policy, strategy, guidelines and operational plans do not exist	• CHW policy, strategy, guidelines and operational plans exist but are incomplete or outdated • CHW policy, strategy, plans and guidelines are not gender responsive	• A national CHW policy, strategy and operational plans exist and are updated • CHW policy, strategy, plans and guidelines show some elements of gender responsiveness • The national community health policy, strategy and operational plans, and the national CHW policy are implemented at sub-national levels	• A national CHW policy and strategy exists, and is embedded in the community health policy and strategy • CHW policy, strategy, plans and guidelines are gender responsive[2] • The national community health policy, strategy and operational plans, and the national CHW policy are implemented at sub-national levels, and sub-national health authorities have participated in their formulation and reviews
• At least one CHW cadre exists but its roles and formalization are unclear or contested	• At least one CHW cadre exists but its roles and formalization are unclear or contested	• A formally recognized CHW cadre exists with clearly defined functions and roles	• A formally recognized CHW cadre exists with clearly defined functions and roles documented in JDs/service agreements
• There are no CHW program guidelines	• There are no CHW program guidelines	• CHW program guidelines exist and include/specify many but not all components listed in column 4	• CHW program guidelines exist and include/specify: o Full list of services to be provided by the CHWs vs. those to be referred o National standards for recruitment o A standardized CHW training curriculum with certification o An identified CHW supervisor cadre and standardized supervision system o A national CHW incentive system, to be applied by all partners o List of CHW supplies and commodities and CHW commodity management guidelines o Required CHW data collection, and subsequent data flow through to integration with national HMIS, and return

[2] See *Promoting Gender Responsive Policies and Programmes for Community Health Workers* to assist in assessing the gender responsiveness of country policies and strategies.

		• CHW program guidelines adapted to district/other sub-national levels as appropriate in countries with devolved decision-making	• CHW Guidelines adapted to district/other sub-national levels as appropriate in countries with devolved decision-making
• There are no CHW operational plans and budget	• There are no CHW operational plans and budgets	• Detailed CHW operational plans and budgets exist*[1]	• Detailed CHW operational plan and budget exist, for current and future scale, embedded within the larger Human Resources for Health country plans* • The CHW program is represented in existing processes for national and sub-national operational planning/budgeting*
• There is no oversight, regulation or accountability of CHWs providing curative services (e.g. iCCM) if applicable	• There is limited but oversight, regulation and accountability of CHWs providing curative services (e.g. iCCM), if applicable)	• There is appropriate oversight, regulation and accountability of CHWs providing curative services (e.g. iCCM), if applicable	• There is appropriate oversight, regulation and accountability of CHWs providing curative services (e.g. iCCM) if applicable • The CHW program is supported by the Ministries of Finance, Labor, Education, and other branches of government as appropriate.
			• One or more influential leaders spearhead the promotion of a well-resourced and supported CHW program. Champions • CHW voices are amplified in support of a well-resourced CHW program and CHWs are involved in high-level decision making
1 Not Enabling ☐	**2 Partially Enabling** ☐	**3 Enabling** ☐	**4 Highly Enabling** ☐

[1] All bullets marked with an asterisk (*) are taken from *Systems Areas Tool,* downloaded from the Community Health Academy's online course *Strengthening Community Health Worker Programs*. https://learning.edx.org/course/course-v1:HarvardX+CHA01+1T2020/home Accessed 11/30/2021.

1b. Governance, Leadership and Management: Coordination/Harmonization

• Partners do not consult MoH in their CHW programming	• Many partners do not consult MoH in their CHW programming	• Partner-led CHW programming is approved by MoH	• National policy exists for MoH coordination and harmonization of non-state actors involved in health and CHW programs (e.g. NGOs, program donors) • Partner-led CHW programming is approved by MoH
• Parallel CHW cadres mobilized by multiple stakeholders, not MoH-linked	• Some partners mobilize parallel CHW cadres, managed by the partner, not linked to MoH	• Partners do not mobilize parallel CHW cadres[3], de-linked to the MoH	• All partner-supported CHWs are linked to MoH
• No coordination mechanism or structure exists	• Coordination mechanisms or structures exist but are weak and not routinely active	• A national coordination mechanism or structure exists to coordinate state and non-state actor involvement in CHW programming • Sub-national coordination mechanisms or structures exist for the harmonization of state and non-state actor CHW programming	• A national coordination mechanism or structure exists to coordinate state and non-state actor involvement in CHW programming, and is active and adequately-resourced • Sub-national coordination mechanisms or structures exist for the harmonization of state and non-state actor CHW programming, and are active and adequately resourced
• Most partners do not align with MoH CHW program guidelines	• Some partners do not align with all aspects of MoH CHW program guidelines	• Partner activities do not undermine long term health system strengthening and integration of CHWs into MoH system • Partners activities to support CHW programs are somewhat overlapping and duplicative	• Partner activities include active support of long term health system strengthening and integration of CHWs into MoH system • Partners have clear, non-overlapping, non-duplicative strategies to support CHW programs
• Most partners apply competing CHW incentives systems	• Some partners apply competing CHW incentives systems	• Most partners adhere to national CHW program guidelines, including applying a common system of incentives agreed nationally	• Partners adhere to national CHW program guidelines, including applying a common system of incentives agreed nationally
• Most partners' CHW data collection systems are not linked to MoH data systems/HMIS	• Some partners' CHW data collection systems are not linked to MoH data systems/HMIS	• Most partners link CHW data collection to MoH data systems/HMIS	• Partners ensure that any CHW data collection is linked to MoH data systems/HMIS
1 Not Enabling ☐	**2 Partially Enabling** ☐	**3 Enabling** ☐	**4 Highly Enabling** ☐

[3] A "parallel cadre" is defined as one mobilized by a stakeholder other than the MoH and not operating under the auspices of the MoH. Where MoH transfers responsibility of a CHW cadre to a church-based or private-sector provider while retaining regulatory oversight, this is not considered a parallel cadre.

2a. Health Programme Financing: General

• Primary health care, community health, and the CHW program are inadequately funded	• CHW program is donor dependent as the percent of health expenditure directed to the CHW program does not meet budget requirements	• The percent of health expenditure directed at the community level is adequate to meet budget requirements	• The percent of health spending directed at the community level is adequate to meet budget requirements and expenditures are transparent (published and/or shared on request)
• Total required funding for the CHW program is unknown (costing not done)	• Budget projections for the CHW program either not done or are incomplete and there are consistent shortfalls in funding required for the CHW program	• Budget projections for the CHW program are data-driven and accurately costed • There is a multi-year investment case to support the CHW program budget requests that demonstrates a credible, executable, and financially sustainable pathway for the community health program.	• Budget projections for the CHW program are data-driven and accurately costed • There is a multi-year investment case to support the CHW program budget requests that demonstrates a credible, executable, and financially sustainable pathway for the community health program. • CHW program costs are integrated into overall healthcare workforce and/or health systems budgets*
• Little or no MoH and government engagement to increase sources of funding for CHW program	• The full range of funding opportunities for the CHW program has not been explored	• MoH has mapped the full range of potential funding sources (e.g. domestic contribution, traditional donors, private sector/individual investment, innovative financing)*	• MoH has mapped the full range of potential funding sources (e.g. domestic contribution, traditional donors, private sector/individual investment, innovative financing) and is proactive in identifying and pursuing CHW program funding opportunities, if needed*
• Existing CHW program funding is fully funded by donors and/or user fees	• CHW program is mostly funded by donors and/or user fees	• A cost-sharing model that meets the budget of the CHW program is established, with partners, donors and government sharing costs, with transparency, if domestic finance for CHW program is not 100% • The cost-sharing arrangements and financing projections show national health budgets/ domestic finance covering progressively more of the costs of the CHW program over time • The CHW program is not financed, partially or fully, through user fees	• A cost-sharing model that meets the budget of the CHW program is established, with partners, donors, government and private sector sharing the costs, with transparency, if domestic finance for CHW program is not 100% • National health budgets/domestic finance cover the majority of costs of the CHW program • The CHW program is not financed, partially or fully, through user fees • MoH/the government is transparent (i.e. publishes and/or shares on request) amounts of available and prospective funding within government and among donors and partners* • 15% of domestic budget is allocated to heal
1 Not Enabling ☐	**2 Partially Enabling** ☐	**3 Enabling** ☐	**4 Highly Enabling** ☐

2b. Health Programme Financing: Donors

• Donors undermine country leadership within their support efforts and CHW program grants by pursuing donor priorities exclusively, as opposed to intentionally aligning with country priorities	• Donors promote country leadership by aligning with country priorities within some but not all of their support efforts and CHW program grants	• Donors defer to country leadership within their support efforts and CHW program grants by aligning with country priorities	• Donors defer to country leadership within their support efforts and CHW program grants by aligning with country priorities • Donor-funded CHW programs are designed to support government priorities, by piloting potentially scalable initiatives, and/or (co)-funding existing successful programs or program components.
• Donors invest primarily in vertical initiatives	• Donor-funded CHW programs are awarded to implementing partners without consideration for government-led scale	• Donor-funded CHW programs are always designed with government-led scale in mind • Donors invest in an integrated approach for community health, while sometimes also funding vertical approaches	• Donors are invested in supporting integrated approaches for community health that will effectively address the burden of disease and align with government priorities, and only fund vertical approaches when indicated per an epidemiological need (e.g. pandemic response) • Donors give some direct funding to MoH for CHW programs
• Donors fund fragmented partner CHW programs	• Donors often fund pilot CHW programs without sufficient attention to MoH linkages for future possible scaling	• Donors support pilot innovation programs in concert with the MOH	• Donors support pilot innovation programs, research and/or evaluation in concert with the MOH
			• The percentage of total development assistance for health allocated to primary health care (PHC) is 30% • The percentage of total development assistance for health allocated to community health (e.g. CHW salaries, commodities, supervision costs, etc.) increases from the current (2021) <3% to at least 15% • Pooled donor funds?
1 Not Enabling ☐	**2 Partially Enabling** ☐	**3 Enabling** ☐	**4 Highly Enabling** ☐

3. Human Resources (Refers to human resources to support the CHW programme; not CHWs themselves)

• There are significant shortages of numbers of MoH staff at all levels to manage the CHW program	• MoH has sufficient staff to manage the CHW program in some programming areas but not in others	• MoH has sufficient staff at national and sub-national levels to manage the CHW program, although with some attrition	• MoH has sufficient staff at national and sub-national levels to manage the CHW program • Attrition rates among MoH staff supporting the CHW program are low
• There are significant capacity gaps in MoH staff responsible for the CHW program	• MoH staff responsible for CHW program at all levels have gaps in some of the capacity areas necessary for their roles	• MoH staff responsible for CHW program at all levels have the necessary technical, leadership, management and political capacity for their roles	• MoH staff responsible for CHW program at all levels have the necessary technical, leadership, management and political capacity[4] for their roles • Staff numbers and competence within the Ministries of Finance, Labor, Education, and other branches of government are adequate to support the CHW program, as needed
• Top talent is often taken from the public sector by NGOs and other partners	• NGOs and other partners often deplete human resources from the public sector	• NGOs and other partners active in CHW programming use a public sector wage benchmark to mitigate against depleting human resources from the public sector	• NGOs and other partners active in CHW programming use a public sector wage benchmark to mitigate against depleting human resources from the public sector, while public sector positions are increasingly available and sustainably funded
• The responsibilities of sub-national health authorities (e.g. provincial, district, local) in CHW program management are unclear	• The responsibilities of sub-national health authorities in CHW program management are generally clear but these staff often lack capacity and/or resources to carry out their roles	• The roles of sub-national health authorities (e.g. provincial, district, local) in CHW program management are clear and these staff have the capacity and resources to carry out their roles	• The roles of sub-national health authorities (e.g. provincial, district, local) in CHW program management are clear, and these staff receive routine support from national level (capacity building, resources, supervision)
• CHWs often report perceived or actual disrespect from health facility staff and little or no support for their roles	• CHWs do not report perceived or actual disrespect from health facility staff, but also do not report being supported by them	• Facility staff demonstrate positive attitudes to CHWs and CHWs report feeling supported by them	• Facility staff demonstrate positive attitudes to CHWs and there is health staff backing/support of CHWs in front of the community
			• MoH HRH policies are gender equitable
1 Not Enabling ☐	**2 Partially Enabling** ☐	**5 Enabling** ☐	**6 Highly Enabling** ☐

[4] Political capacity can be understood to mean the ability to engage with decision-makers and political leaders to advocate/lobby for strengthening of the CHW programme (through increased resources, improved policies, etc.), answering objections, using data and evidence to support arguments for the CHW programme, and the like.

4. Information Systems

• There is no national CHW M&E framework, or system of data flow and use	• A national CHW M&E framework exists, but no consensus on prioritized indicators	• There is one national CHW M&E framework, with prioritized indicators and standardized systems of data collection and use • The prioritized indicators in the national CHW M&E system have been selected to align with/provide data on the key country health issues and determinants	• There is one national CHW M&E framework, with prioritized indicators and standardized systems of data collection and use • The prioritized indicators in the national CHW M&E system have been selected to align with/provide data on the key country health issues and determinants* • The HMIS/DHMIS includes the key CHW programming indicators and are disaggregated by relevant social stratifiers
• There is no community health information system	• There is a community health information system but data is not routinely collected	• There is a community health information system and data is routinely collected and input	• Community health information system is integrated, and inter-operable, with the broader health information system
• Data collection by partners, if any, is fragmented and does not contribute to aggregated metrics	• The M&E frameworks, systems and data collection of partners do not align with or contribute to the national CHW M&E framework	• Implementing partners collect data in alignment and in contribution to the national CHW M&E framework	• Implementing partners collect data in alignment and in contribution to the national CHW M&E framework
• There is no national CHW master list and varying estimates of numbers of CHWs in the country	• There is no national CHW master list but MoH is able to estimate numbers of CHWs in the country	• There is a national CHW master list, with unique CHW IDs, housed in a registry, continuously maintained, shared and routinely used.	• There is a national CHW master list, integrated with the broader Health Human Resource Information System, continuously maintained, shared and routinely used. • The CHW master list is geo-referenced
• Data collected is not used for purposes other than upward reporting	• Mechanisms of data flow and utilization within the national CHW M&E system are weak, and the data collected is not used for purposes other than upward reporting	• Systems of data flow ensure that all stakeholders have access to timely and relevant information concerning the CHW program* • Data collected is used to build evidence/justification for the CHW program	• Systems of data flow ensure that all stakeholders have access to timely and relevant information concerning the community-based services* • Data collected is used to build evidence/justification for the CHW program
• Data is collected without ensuring data privacy and security	• The national CHW M&E system does not ensure data privacy and security	• The CHW M&E system has built in appropriate mechanisms of data privacy and security*	• The CHW M&E system has built in appropriate mechanisms of data privacy and security*
• Digital solutions, if any, are fragmented	• Harmonization of digital solutions is desired, but nascent	• Introduction of digital data applications in the CHW program are in alignment with existing national digital health systems or, if none, are introduced with plans for progressive uptake of the solution by MoH/government over time	• Introduction of digital data applications in the CHW program are in alignment with existing national digital health systems or, if none, are introduced with plans for a progressive uptake of the solution by MoH/government
1 Not Enabling ☐	**2 Partially Enabling** ☐	**3 Enabling** ☐	**4 Highly Enabling** ☐

5. Commodities/Supply Chain

• National supply chains are weak at all levels	• National supply chain mechanisms extend to primary health facilities, but not to communities	• National supply chain mechanisms extend to CHW-led community distribution of commodities (especially remote and difficult to reach communities) on paper but with some challenges in practice*	• National supply chain mechanisms extend to CHW-led community distribution of commodities (especially remote and difficult to reach communities) *
• Guidelines for the procurement of CHW supplies/commodities do not exist	• Procurement guidelines exists but CHW supplies/commodities are not always sourced according to the guidelines	• CHW commodity distribution and management is outlined in a national policy or guidelines • CHW supplies/commodities are sourced according to relevant procurement guidelines, ensuring enforcement of product quality standards*	• CHW commodity distribution and management is outlined in a national policy or guidelines • Mechanisms exist to ensure equitable access to community-distributed commodities • CHW supply procurement is integrated into existing health procurement systems, with clear procurement guidelines and operational procedures* • CHW supplies/commodities are sourced according to relevant procurement guidelines, ensuring enforcement of product quality standards*
• Community plays no role in oversight/monitoring of CHW commodities	• The community has a role in CHW commodity oversight but is not trained/prepared	• Community/community governance structures play a role in oversight/ monitoring of CHW commodities	• Community/community governance structures play a role in oversight/ monitoring of CHW commodities, and have received training for this role
1 Not Enabling ☐	**2 Partially Enabling** ☐	**3 Enabling** ☐	**4 Highly Enabling** ☐

6. Community Systems

• Communities were not consulted and do not engage in the CHW program	• Communities were not consulted to select/prioritize CHW activities and services, but sometimes engage with the CHW program	• Communities were consulted in the initial stages of CHW program set-up but did not play a role in selecting/prioritizing CHW activities and services	• Communities were engaged in the initial stages of CHW program design and in prioritizing the CHW activities/services, and the CHW program is responsive to community needs
• Community health governance structures do not exist	• Community health governance structures exist (e.g. village health committees), but are weak and/or have not been engaged to provide community oversight of the CHW program	• Community health governance structures exist (e.g. village health committees, health facility committees) and are engaged to provide community oversight of the CHW program	• Community health governance structures exist (e.g. village health committees, health facility committees)[5] and are functional and active[6], and provide active and meaningful oversight of the CHW program • Community health governance structures are vertically integrated through official attachment to District Health Management Teams and routinely communicate the health issues, needs, actions and successes of the community
• Civil society is weak, inactive and/or fractured	• Civil society action is nascent, with some active stakeholders loosely networked	• Civil society is active, with multiple health-related stakeholders well networked	• Civil society is active, with multiple health-related stakeholders well networked, and holds service providers to account through social accountability mechanisms
1 Not Enabling ☐	**2 Partially Enabling** ☐	**3 Enabling** ☐	**4 Highly Enabling** ☐

[5] See *Community Health Committees (CHC) and Health Center Management Committees (HCMC) Program Functionality: A Toolkit for Improving CHC and HFMC Program* for guidance on assessing the functionality of these **programmes**

[6] World Vision uses the following criteria as indication of a functional and active **group**: Leadership structure in place, at least one leader is a woman, leaders are elected by secret ballot and new leader elections are held periodically per an agreed rotation, the group has a set of written rules drafted with the participation of all members, and meets on a regular basis with the participation of at least 75% of members. Additional criteria are stipulated for those groups that are managing money

7. Service Delivery (Design) (This refers to how well the services that CHWs will be implementing have been selected and designed, *not* to the actual implementation quality/fidelity of those services)

• CHWs have not been tasked with (many of the) key services that would respond to priority health and nutrition issues	• The services provided by CHWs respond to some of the priority health and nutrition issues in the country	• The services provided by CHW respond to priority health and nutrition issues, and underlying determinants • The services provided by CHWs are evidence-based	• The services provided by CHWs respond to the actual burden of disease (priority health and nutrition issues), and underlying determinants • The services provided by CHWs are evidence-based • Training plans are future-focused with provisions for training CHWs to provide new/additional services per changing health trends/epidemiology
• Workload analysis was not done when assigning CHW-to-target population ratios/quota, or no targets were assigned	• CHWs have been assigned target populations based on numbers of households/ household allocation/ geographic distribution, rather than on workload analysis and time requirements/estimates	• The target population coverage of the CHWs is calculated based on available CHW work hours and time requirements/estimates of the service activities (workload analysis), are commensurate with the CHWs' available time, and do not result in exceeding the available time.	• The target population coverage of the CHWs is calculated based on available CHW work hours and time requirements/estimates of the service activities (workload analysis), are commensurate with the CHWs available time, and do not result in exceeding the available time.
• It is not possible for CHWs to complete their assigned duties with the population coverage they have been given without exceeding available working hours	• CHWs complain of excessive work hours required to complete their assigned duties, due to too high ratios/quota	• There may not be sufficient numbers of CHWs in the program to achieve full target population coverage with the services, but additional recruitment is planned over time	• There are sufficient numbers of CHWs in the program to achieve full target population coverage with the services
• At times of crises (e.g. humanitarian disaster, pandemic), additional responsibilities are assigned to CHWs with no additional compensation	• At times of crises (e.g. humanitarian disaster, pandemic), changes or additions to CHWs' roles may exacerbate CHW work overload	• At times of crises (e.g. humanitarian disaster, pandemic), changes or additions to CHWs' roles may initially result in increased CHW workload but then stabilize to not exceed agreed working hours without additional compensation	• At times of crises (e.g. humanitarian disaster, pandemic), changes or additions to CHWs' roles do not exceed agreed working hours without additional compensation
1 Not Enabling ☐	**2 Partially Enabling** ☐	**3 Enabling** ☐	**4 Highly Enabling** ☐