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.

Acknowledgements

The tool was developed by Michele Gaudrault of World Vision International with support from Redeat Zena, a World Vision International intern. Many thanks to all those who reviewed and provided feedback: Dan Irvine, World Vision International; Dan Palazuelos, Partners in Health; Carey Westgate, Community Health Impact Coalition; Madeleine Ballard, Community Health Impact Coalition; Maryse Kok, KIT Royal Tropical Institute; Rebecca Furth, CHW Central; Sally Theobold, London School of Tropical Medicine and Hygiene.

Copyediting by Katie Fike (consultant) and design by World Vision International Creative Services.

The tool was piloted in Uganda and Kenya. Thanks to all involved. **Uganda Ministry of Health:** Dr George Upenthyo, Commissioner, Community Health Services; Brenda Nakanwagi, Senior Program Officer, Community Health Services; Dr Jimmy Ochorin, Senior Medical Officer, Community Health Services; Allen Nabanoba, Supply Chain Officer; Dr Meddy Rutayisire, Health Information Systems; Emmery Mbaha, Principal Environmental Health Officer; Rosen Nampurira, Administrator, Community Health Services. **World Vision Uganda:** Benon Musasizi, Technical Programme Lead, Health and Nutrition. **Machakos County Health Team, Kenya**: Dr Judith Kimuyu, Director, Primary Health Care; Fredrick Mwendwa, Director, Community Health; Peter Muteti, Community Health Focal Person, Mwala Sub-County. **World Vision Kenya:** Dr Anne Mwangi, Technical Programme Lead, Health and Nutrition.

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Recommended Citation

Gaudrault, M., & Zena, R. (2023). Health Systems Assessment and Improvement Matrix (S-AIM): *A tool for assessing and improving health systems in support of community health worker programmes*. World Vision International.

Introduction: S-AIM and CHW-AIM

Evidence through the years has shown that in order for community health worker (CHW) services to be successful and sustainable, attention must be given to designing functional programmes where CHWs are adequately supported and integrated into the national health system. The components of CHW programme functionality are outlined in the separate Community Health Worker Assessment and Improvement Matrix (CHW-AIM), developed by USAID and partners, and include considerations such as adequate training, supportive supervision, and balanced incentives packages. These recommendations from the CHW-AIM tool were given further legitimacy with the 2018 publication of the World Health Organization's (WHO) Guideline on health policy and system support to optimize community health worker programmes which emphasises all of the CHW-AIM points and more.

This *Health Systems Assessment and Improvement Matrix (S-AIM)* was developed in acknowledgement of the fact that there are necessary pre-requisite health systems factors that are needed in order to put the CHW programme functionality components into place. The recommendation to remunerate CHWs, for example, is dependent on adequate financing allocated to community health. CHW supervision is dependent on numbers and capacity of human resources for health (i.e., the supervisors). Coherent and harmonised multi-stakeholder CHW engagement is dependent on the governance and management of community health. These and other dependencies have been categorised into the seven community health systems building blocks. S-AIM organises these blocks into a descriptive scoring matrix, providing detail on the necessary health systems features *as they relate to CHW programmes* (as opposed to the health system writ large).

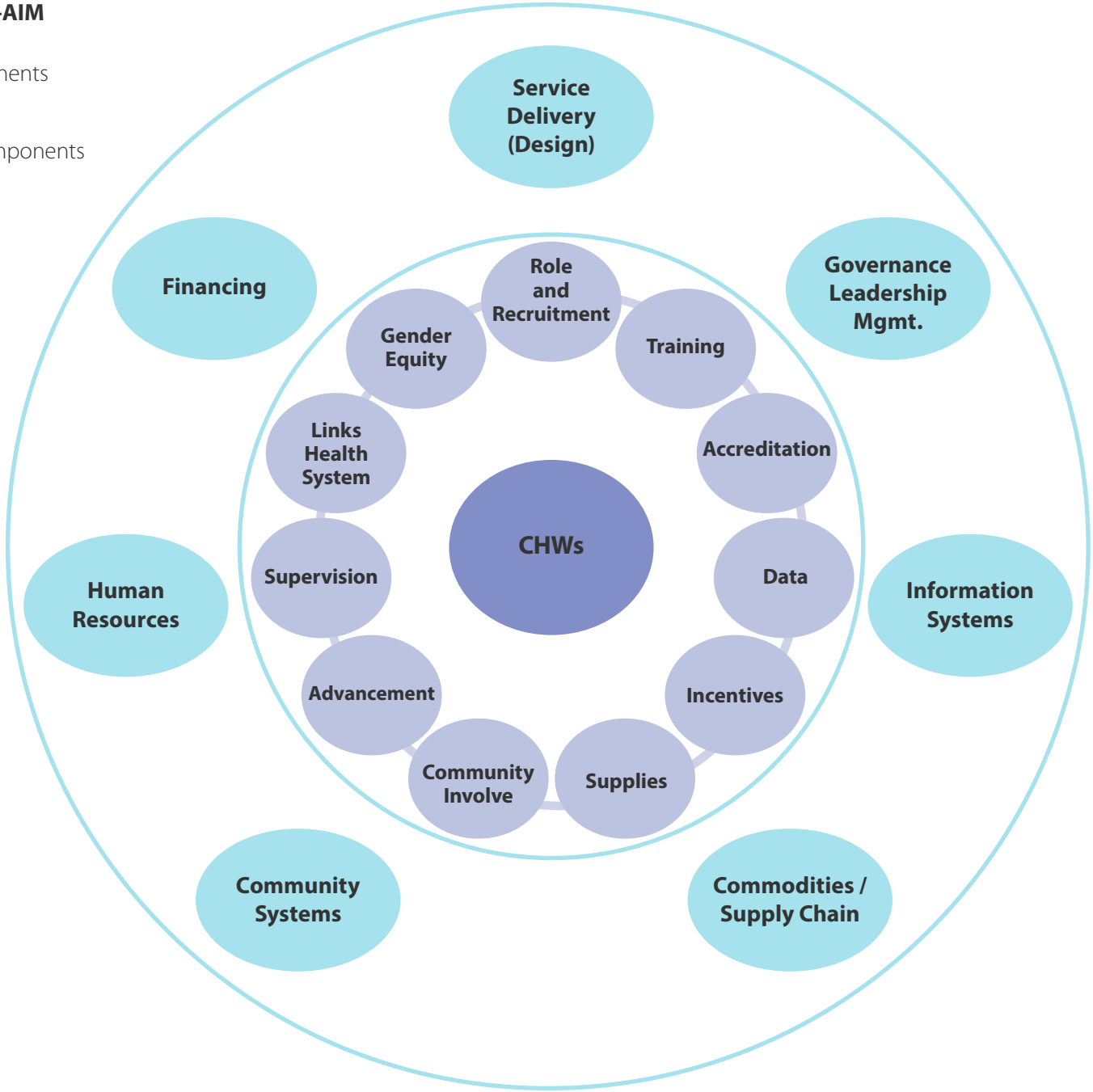
Figure 1 on the next page provides a visual representation of the relationship between the CHW-AIM and the S-AIM tools. CHW programme functionality components as detailed in CHW-AIM have a direct bearing on the motivation, effectiveness and efficiency of the CHWs themselves, and are shown in a proximate position to the CHWs. The health systems features described in S-AIM are the necessary pre-requisites that make possible the programme functionality and are thereby placed next to the CHW-AIM components and one step removed from the CHWs.

The S-AIM tool is intended as a complement to CHW-AIM. Taken together, the two tools represent a comprehensive framework for analysing, designing and improving CHW programmes, and the health systems that necessarily support them.

Figure 1: S-AIM and CHW-AIM

= S-AIM components

= CHW-AIM components



S-AIM Development

The S-AIM components are scored from 1 to 4. Criteria for determining whether a component is 1 (not enabling), 2 (partially enabling), 3 (enabling) or 4 (highly enabling for a functional CHW programme) are identified and listed in corresponding columns of the matrix. A two-step literature review was conducted to derive and validate these criteria.

First, a zero draft of the S-AIM tool was developed through a close read of 30 documents of relevance, listed in the appendix. The draft was circulated for vetting to the stakeholders listed in the acknowledgements—including programme implementers, policymakers and academics—and revisions were made per recommendations and discussion, resulting in a pilot-ready version of the tool.

A systematic meta-review was then carried out, drawing from three sources of CHW programming evidence, research reviews and resources:

1. Community Health Impact Coalition. (April 2018-October 2021). Community Health Research Roundup, Volumes 001-070. (n=533)
2. WHO. (2020). What do we know about community health workers? A systematic review of existing reviews. (n=142)
3. CHW Central. (2022). The State of the Evidence, 2021. (n=441)

A total of 1,116 titles were scanned, of which 125 abstracts were extracted and reviewed, from which 37 documents were identified for full text reading, as listed in the appendix. Of these, 19 provided statements, evidence or justifications for the S-AIM criteria and/or additional criteria for inclusion.

S-AIM was then piloted in workshops with the national Ministry of Health (MoH) in Uganda and the Machakos Sub-County Health Team in Kenya. The workshops generated a range of learnings (available upon request), including recommendations for revisions to the tool, leading to the current version, which is ready for general distribution and use.

S-AIM Users and Uses

As with CHW-AIM, S-AIM is intended to capacitate the processes of programmatic design, planning, assessment and improvement for stakeholders ranging from local non-governmental organisations (NGOs), to national policymakers and planners, to global stakeholders (Figure 2).

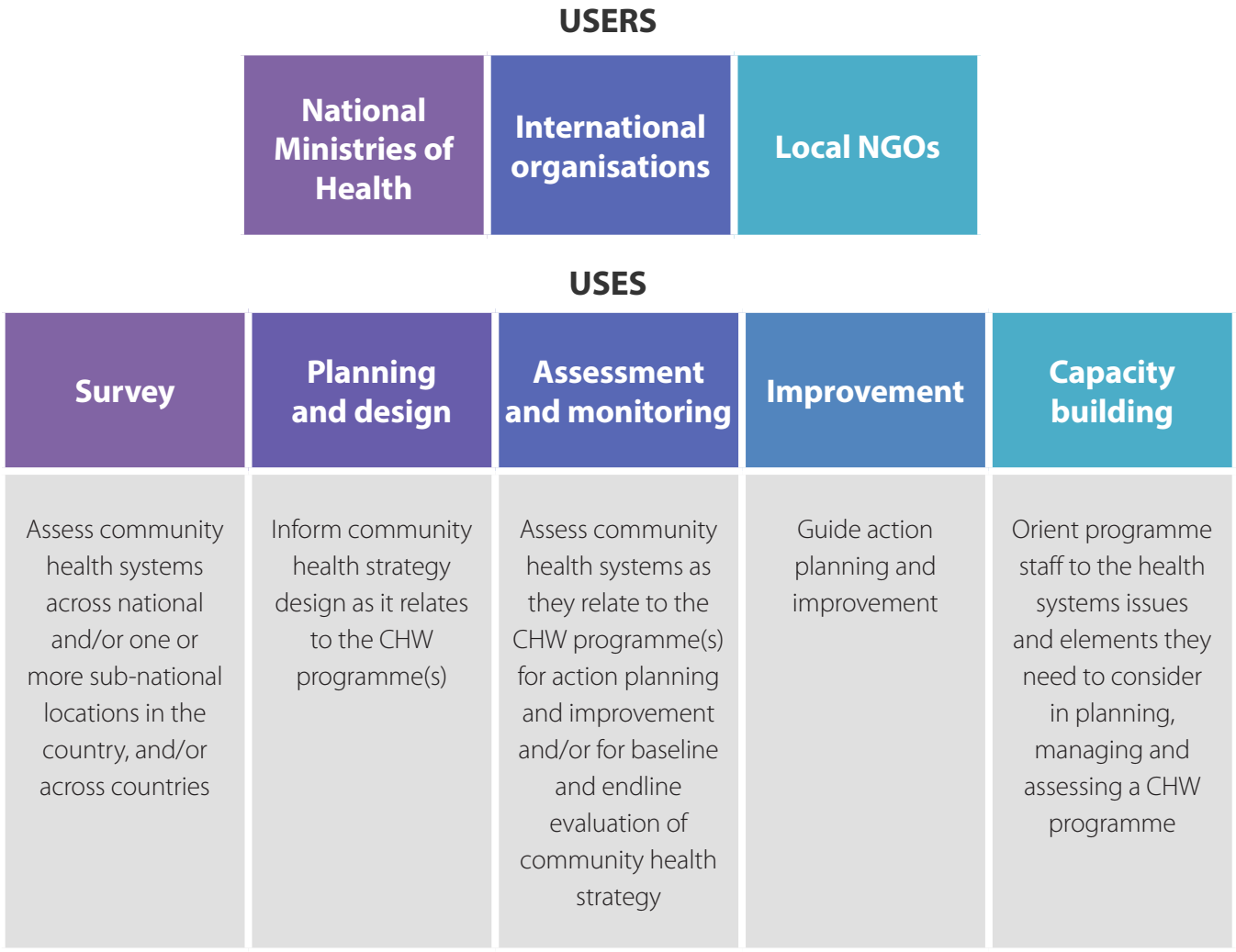


Figure 2: S-AIM users and uses (Adapted from CHW-AIM, 2013 edition and 2018 edition)

S-AIM Process

To utilise the S-AIM tool to assess health systems as they relate to CHW programmes, a general process as described in the 2013 version of CHW-AIM may be consulted if necessary. Summary recommendations for the S-AIM process are provided as follows.

Purpose: The purpose of the S-AIM process should be identified (see Figure 2 on the previous page). If health systems have recently been assessed as part of a community health strategy development process, for example, there should be clarity on the reasons for carrying out S-AIM.

Facilitation: Although participatory in nature, the process should be led by a facilitator sufficiently familiar with S-AIM to lead in-depth analysis and discussion.

Participants: The assessment is typically carried out during a workshop with multiple stakeholders, led by high-level MoH officials responsible for community health and with authority to act on the recommendations generated. To accurately score S-AIM, individuals with expertise in health finance, supply chain and health information systems should be present. Other participants include sub-national MoH managers, implementing partners, donor representatives and CHWs.

Approach: S-AIM may be carried out together with CHW-AIM or separately. Carrying out the two processes together enables a comprehensive analysis of both systemic (S-AIM) and programmatic (CHW-AIM) considerations. Carrying out S-AIM alone will identify root health systems issues from which many CHW programmatic issues emerge, and a focus on this systems level will generate important results. In either case, it is recommended to proceed through group work scoring of components with experts assigned to corresponding groups, followed by plenary discussion and recommendations.

Scoring of programmatic components

Each of the health systems components in the S-AIM matrix is subdivided into four levels to indicate the extent to which they are enabling of a functional CHW programme, ranging from not-enabling (1) to highly enabling (4) as defined by suggested best practices. Participants will agree on the score for each component.

1 Not enabling	2 Partially enabling	3 Enabling	4 Highly enabling
☐	☐	✓	☐

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

• At least one **CHW cadre** exists but its roles and formalisation are unclear or contested	• A formally recognised **CHW cadre** exists, but its roles are not clearly defined	• A formally recognised **CHW cadre** exists with clearly defined functions and roles	• A formally recognised **CHW cadre** exists with clearly defined functions and roles documented in JDs/service agreements
• **Community health policy** does not exist • **Community health strategy** does not exist	• **Community health policy** exists but is incomplete or outdated • **Community health strategy** exists but is incomplete or outdated	• An up-to-date **community health policy** exists, either embedded in Primary Health Care (PHC) policy or stand-alone • An up-to-date **community health strategy** exists, either embedded in PHC strategy or stand-alone	• An up-to-date **community health policy** exists, either embedded in PHC policy or stand-alone, and is integrated into the broader national health policy • An up-to-date **community health strategy** exists, either embedded in PHC strategy or stand-alone, and is integrated into the broader national health strategy • There is a Community Health Unit within the MoH with budget and decision-making authority
• A national **CHW policy** does not exist • A national **CHW strategy** does not exist	• A national **CHW policy** exists but is incomplete or outdated • A national **CHW strategy** exists but is incomplete or outdated • CHW policy and/or strategy are not gender responsive • The national community health policy and/or strategy and/or CHW policy and/or strategy are not fully implemented at sub-national levels	• A national **CHW policy** exists and is not outdated • A national **CHW strategy** exists and is not outdated • CHW policy and/or strategy show some elements of gender responsiveness • The community health policy and/or strategy and/or CHW policy and/or strategy are implemented at sub-national levels	• A national **CHW policy** exists and is embedded in the community health policy • A national **CHW strategy** exists and is embedded in the community health strategy • CHW policy and/or strategy are gender responsive[2] • The community health policy and/or strategy and/or CHW policy and/or strategy are implemented at sub-national levels, and sub-national health authorities have participated in their formulation and reviews
• There are no **CHW programme guidelines**	• **CHW programme guidelines** exist but are incomplete or outdated	• **CHW programme guidelines** exist and include/specify many but not all components listed in column 4	• **CHW programme guidelines** exist and include: o full list of services to be provided by the CHWs vs. those to be referred o national standards for recruitment o a standardised CHW training curriculum with certification/accreditation o an identified CHW supervisor cadre and standardised supervision system o a national CHW incentive system, to be applied by all partners o a 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 Health Management Information Systems (HMIS) and flow back to the community level

[2] See Promoting Gender Responsive Policies and Programmes for Community Health Workers (2021, available at chwcentral.org/resources)

	• CHW programme guidelines are not adapted to district/other sub-national levels in countries with devolved decision-making	• CHW programme guidelines are adapted to district/other sub-national levels as appropriate in countries with devolved decision-making	• CHW programme guidelines are adapted to district/ other sub-national levels as appropriate in countries with devolved decision-making, and sub-national health authorities participated in their formulation
• There are no **national CHW operational plans and budget** • There are no **sub-national CHW operational plans and budgets**	• **National CHW operational plans and budget** exist but are incomplete or outdated • **Sub-national CHW operational plans and budget** exist but are incomplete or outdated	• Detailed and up-to-date **national CHW operational plans and budgets** exist*[1] • Detailed and up-to-date **sub-national CHW operational plans and budgets** exist	• Detailed national **CHW operational plans and budget** exist for current and future scale, embedded within the larger health sector country plans* • The CHW programme 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., integrated community case management [iCCM]) if applicable	• There is limited oversight, regulation and accountability of CHWs providing curative services (e.g., iCCM), if applicable	• There are efforts underway to provide 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
• There is no involvement of Ministries of Finance, Labour, Education or other branches of government in the CHW programme.	• The MoH sometimes communicates with Ministries of Finance, Labour, Education and other branches of government about the CHW programme, but their interest and involvement is low	• There is some limited involvement of Ministries of Finance, Labour, Education and other branches of government in the CHW programme	• The CHW programme is supported by the Ministries of Finance, Labour, Education, and other branches of government as appropriate
• There are no influential leaders or champions promoting the CHW programme	• While individuals within the MoH promote the CHW programme, their influence with high-level political leaders is limited	• One or more influential leaders or champions spearhead the promotion of a well-resourced and supported CHW programme	• There is good momentum in the country with numerous leaders and champions and/or advocacy groups spearheading the promotion of a well-resourced and supported CHW programme
		• CHW voices are amplified in support of a well-resourced CHW programme, and CHWs are involved in high-level decision-making	• CHWs are organised in an association or other type of group to lobby for their rights as health workers
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/Harmonisation

1 Not enabling	2 Partially enabling	3 Enabling	4 Highly enabling
• Partners do not consult MoH in their CHW programming	• Some partners do not consult MoH in their CHW programming	• Partner-led CHW programming is approved by MoH	• National policy exists for MoH coordination and harmonisation of non-state actors involved in health and CHW programmes (e.g., NGOs, programme donors) • Partner-led CHW programming is approved by MoH
• Many parallel CHW cadres mobilised by multiple stakeholders, not MoH-linked	• Some partners mobilise parallel CHW cadres,[3] managed by the partner, not linked to MoH	• Most partner-supported CHWs are linked to MoH	• All partner-supported CHWs are linked to MoH
• No national community health coordination mechanism or structure exists • No sub-national community health coordination mechanism or structure exists	• National community health coordination mechanisms or structures exist but are weak and not routinely active • Sub-national community health 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 harmonisation 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 harmonisation of state and non-state actor CHW programming, and are active and adequately resourced
• Partner activities to support CHW programmes are not always known	• Partner activities to support CHW programmes are fragmented, and often overlapping and duplicative	• Partners activities to support CHW programmes are somewhat overlapping and duplicative	• Partners have clear, non-overlapping, non-duplicative strategies to support CHW programmes
• Most partners do not align with MoH CHW programme guidelines	• Some partners do not align with all aspects of MoH CHW programme guidelines	• Partner activities do not undermine long-term health system strengthening and integration of CHWs into MoH system	• Partner activities include active support of long-term health system strengthening and integration of CHWs into MoH system
• Most partners apply competing CHW incentive systems	• Some partners apply competing CHW incentive systems	• Most partners adhere to national CHW programme guidelines, including applying a common system of incentives that are nationally agreed upon	• Partners adhere to national CHW programme guidelines, including applying a common system of incentives that are nationally agreed upon
• 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

[3] A 'parallel cadre' is defined as one mobilised 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

1 Not enabling	2 Partially enabling	3 Enabling	4 Highly enabling
• Primary health care, community health, and the CHW programme are inadequately funded at national and sub-national levels	• The CHW programme is adequately funded but is donor dependent as the per cent of domestic spending does not meet budget requirements at national and sub-national levels	• The per cent of health expenditure directed at the community level is adequate to meet budget requirements at national and sub-national levels, with some donor support	• The per cent of health spending directed at the community level is adequate to meet budget requirements at national and sub-national levels, and expenditures are transparent (published and/or shared on request)
• Total required funding for the CHW programme is unknown (costing not done) • The amount of expenditure directed to the CHW programme is not tracked	• Budget projections for the CHW programme are sometimes done, but not on a consistent or regular basis • There is no investment case to support the CHW programme budget • The amount of expenditure directed to the CHW programme is difficult to compile and may not always be possible to estimate	• Budget projections for the CHW programme are data-driven and accurately costed • There is a multi-year investment case to support the CHW programme budget requests that shows total costs and projected return on investment • Expenditure allocated to the CHW programme is estimated annually	• Budget projections for the CHW programme are data-driven and costed, and integrated into overall Human Resources for Health (HRH) or health systems budgets • There is a multi-year investment case to support the CHW programme budget requests that demonstrates a credible, executable, and financially sustainable pathway for the community health programme. • There are one or more cost centres associated with community health and the CHW programme, and expenditure allocated to these cost centres is tracked annually
• There is no effort to raise funds for the CHW programme	• The full range of funding opportunities for the CHW programme has not been explored	• The MoH has mapped the full range of potential funding sources (e.g., domestic contribution, traditional donors, private sector/individual investment, innovative financing)*[4]	• The 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 programme funding opportunities*
• Little or no MoH and government engagement to increase domestic funding for the CHW programme • Existing CHW programme funding is fully funded by donors and/or user fees	• The CHW programme is mostly funded by donors and/or user fees	• A cost-sharing model that meets the budget of the CHW programme is established, with partners, donors and government sharing costs, and with transparency, if domestic finance for CHW programme 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 programme over time • The CHW programme is not financed, partially or fully, through user fees	• A cost-sharing model that meets the budget of the CHW programme is established, with partners, donors, government and the private sector sharing the costs, and with transparency, if domestic finance for CHW programme is not 100% • National health budgets/domestic finance cover most of the costs of the CHW programme • The CHW programme 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 health

2b. Health Programme Financing: Donors

1 Not enabling	2 Partially enabling	3 Enabling	4 Highly enabling
• Donors undermine country leadership within their support efforts and CHW programme 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 programme grants	• Donors defer to country leadership within their support efforts and CHW programme grants by aligning with country priorities	• Donors defer to country leadership within their support efforts and CHW programme grants by aligning with country priorities • Donor-funded CHW programmes are designed to support government priorities by piloting potentially scalable initiatives and/or (co)-funding existing successful programmes or programme components
• Donors invest primarily in vertical initiatives	• Donor-funded CHW programmes are awarded to implementing partners without consideration for government-led scale	• Donor-funded CHW programmes are almost 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 programmes
• Donors fund fragmented partner CHW programmes	• Donors often fund pilot CHW programmes without sufficient attention to MoH linkages for future possible scaling	• Donors support pilot innovation programmes in concert with the MoH	• Donors support pilot innovation programmes, 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%

3. Human Resources (Refers to human resources to support the CHW programme, not CHWs themselves. Includes extent to which CHWs are integrated into PHC teams.)

1 Not enabling	2 Partially enabling	3 Enabling	4 Highly enabling
• There are significant shortages of numbers of MoH staff at all levels to manage the CHW programme	• MoH has sufficient staff numbers to manage the CHW programme in some programming areas but not in others	• MoH has sufficient staff numbers at national and sub-national levels to manage the CHW programme, although with some attrition	• MoH has sufficient staff numbers at national and sub-national levels to manage the CHW programme, and attrition rates are low
• There are significant capacity gaps in MoH staff responsible for the CHW programme	• MoH staff responsible for CHW programme at all levels have gaps in some of the capacity areas necessary for their roles	• MoH staff responsible for CHW programme at all levels have the necessary technical, leadership, management and political capacity for their roles	• MoH staff responsible for CHW programme at all levels have the necessary technical, leadership, management and political capacity for their roles • Staff numbers and competence within the Ministries of Finance, Labour, Education, and other branches of government are adequate to support the CHW programme, 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 programme management are unclear	• The responsibilities of sub-national health authorities in CHW programme 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 programme 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 programme management are clear, and these staff receive routine support from the national level (capacity building, resources, supervision)
• There are no facility protocols for facility staff engagement with CHWs and CHW responsibilities • There is little or no communication between CHWs and facility PHC staff • CHWs often speak of (perceived or actual) disrespect from health facility staff and little or no support for their roles	• Informal agreements exist between the facility and the associated CHWs as to CHW involvement in facility PHC teams • CHWs and the facility PHC team communicate on an as-needed basis • CHWs do not speak of perceived or actual disrespect from health facility staff, but also do not speak of being supported by them	• Protocols or procedures outline CHWs involvement in facility PHC teams • Mechanisms are in place for CHWs and the facility PHC team to communicate regularly • CHWs speak of facility staff demonstrating positive attitudes to them and speak of feeling supported by them	• Protocols and procedures outline CHWs involvement in facility PHC teams and are gender equitable • Mechanisms are in place for CHWs and the facility PHC team to communicate, and CHWs participate in regular facility care team meetings • CHWs speak of facility staff demonstrating positive attitudes to them and that facility staff support them in front of the community

[5] 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

1 Not enabling	2 Partially enabling	3 Enabling	4 Highly enabling
• There is no national CHW monitoring and evaluation (M&E) framework or system of data flow and use	• A national CHW M&E framework exists, but there is no consensus on prioritised indicators	• There is one national CHW M&E framework with prioritised indicators and standardised systems of data collection • The prioritised 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 prioritised indicators and standardised systems of data collection and data use • The prioritised indicators in the national CHW M&E system have been selected to align with/provide data on the key country health issues and determinants, and are disaggregated by relevant social stratifiers • The HMIS/DHMIS includes the key CHW programming indicators
• There is no community health information system (CHIS), or there are multiple, fragmented CHIS throughout the country	• There is a national CHIS, although others may exist in the country, and data is not routinely collected	• There is a national CHIS, and data is routinely collected and input	• There is a national CHIS, and it is integrated and inter-operable with the broader health management information system
• There is no national CHW master list, and there are varying estimates of numbers of CHWs in the country	• There is no national CHW master list, but the MoH is able to estimate numbers of CHWs in the country	• There is a national CHW master list with unique CHW IDs • The CHW master list is housed in a registry • The CHW master list is continuously maintained, shared and routinely used.	• There is a national CHW master list with unique CHW IDs • The CHW master list is integrated with the broader Health Human Resource Information System • The CHW master list is continuously maintained, shared and routinely used. • The CHW master list is geo-referenced
• There is very little data collection for community health/CHWs	• Systems of data flow and utilisation 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 and utilisation ensure that stakeholders have access to timely and relevant information concerning the CHW programme and community-based services*	• Systems of data flow and utilisation ensure that stakeholders have access to timely and relevant information concerning the CHW programme and community-based services* • Data collected is used to build evidence/ justification for the CHW programme
• 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 some aspects 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	• Harmonisation of digital solutions is desired, but nascent	• Introduction of digital data applications in the CHW programme are in alignment with existing national digital health systems or, if none, are introduced with plans for progressive uptake of the solution by the MoH/government over time	• Digital data application(s) are led by the government, and partners are progressively discontinuing non-aligned digital solutions and aligning with the government application

5. Commodities/Supply Chain

1 Not enabling	2 Partially enabling	3 Enabling	4 Highly enabling
• 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)*
• There is no agreed national list of supplies and commodities to be received and managed by CHWs	• A list of supplies and commodities to be received and managed by CHWs exists but is not documented in standard policy or guidelines and is not well-known among stakeholders	• A list of supplies and commodities to be received and managed by CHWs is included in national CHW policy, strategy or guidelines document(s)	• A list of supplies and commodities to be received and managed by CHWs is formalised in national CHW policy, strategy or guidelines and included in national essential medicines/ commodities lists
• Guidelines for the procurement of CHW supplies/commodities do not exist	• Guidelines for the procurement of CHW supplies/commodities exist • CHW supplies/commodities are not always sourced according to the guidelines	• Guidelines for the procurement of CHW supplies/commodities exist and are embedded in national commodities policy or guidelines • CHW supplies/commodities are sourced according to relevant procurement guidelines	• CHW commodity distribution and management is outlined in a national policy or guidelines • 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*
• There is no forecasting of quantities of supplies and commodities needed by CHWs • Districts (or other sub-national unit) do not budget for CHW supplies and commodities	• In lieu of forecasting quantities of supplies and commodities needed by CHWs, front-line health facilities receive set amounts • Quantities received by facilities do not always include the needs of CHWs and/or are not received consistently • Districts (or other sub-national units) include budgets for CHW supplies and commodities, although not always in the amounts required	• CHW supervisors and/or health facility staff attempt to forecast supplies and commodities needed by CHWs and to place orders accordingly • Quantities of CHW supplies/commodities received usually correspond to the amounts requested • Districts (or other sub-national units) budget for CHW supplies and commodities in the quantities required	• CHW supervisors and/or health facility staff forecast supplies and commodities needed by CHWs based on CHW consumption records and place orders accordingly • Supplies and commodities received for CHWs correspond to the amounts requested • Districts (or other sub-national units) budget for CHW supplies and commodities in the quantities required and allocate the funds accordingly
• 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 • Mechanisms exist to ensure equitable access to community-distributed commodities

6. Community Systems

1 Not enabling	2 Partially enabling	3 Enabling	4 Highly enabling
• Communities were not consulted and do not engage in the CHW programme	• Communities were not consulted to select/prioritise CHW activities and services, but sometimes engage with the CHW programme	• Communities were consulted in the initial stages of CHW programme set-up but did not play a role in selecting/ prioritising CHW activities and services	• Communities were engaged in the initial stages of CHW programme design and in prioritising the CHW activities/services, and the CHW programme 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 programme	• Community health governance structures exist (e.g., village health committees, health facility committees) and are engaged to provide community oversight of the CHW programme	• Community health governance structures exist (e.g., village health committees, health facility committees), are functional and active, and provide active and meaningful oversight of the CHW programme • 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
• Local government officials are not involved in supporting the CHW programme • Elected local government officials may require CHW political support as a condition of ongoing CHW employment	• Local government officials sometimes support the CHW programme in an ad hoc manner • Elected local government officials sometimes ask CHWs to engage in political activities and there are no programme safeguards to prevent this	• Local government officials actively support community health and the CHW programme through communication with or participation in community health governance structures • There are stipulations in place that elected local government officials cannot use CHWs for political activities nor make employment dependent on political support	• Local government officials participate in community health governance structures and may have budget to support community health and CHWs • There are stipulations in place that elected local government officials cannot use CHWs for political activities nor make employment dependent on political support, and • CHW official accreditation system ensures that the CHWs' ongoing employment status is safe from political interference
• 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

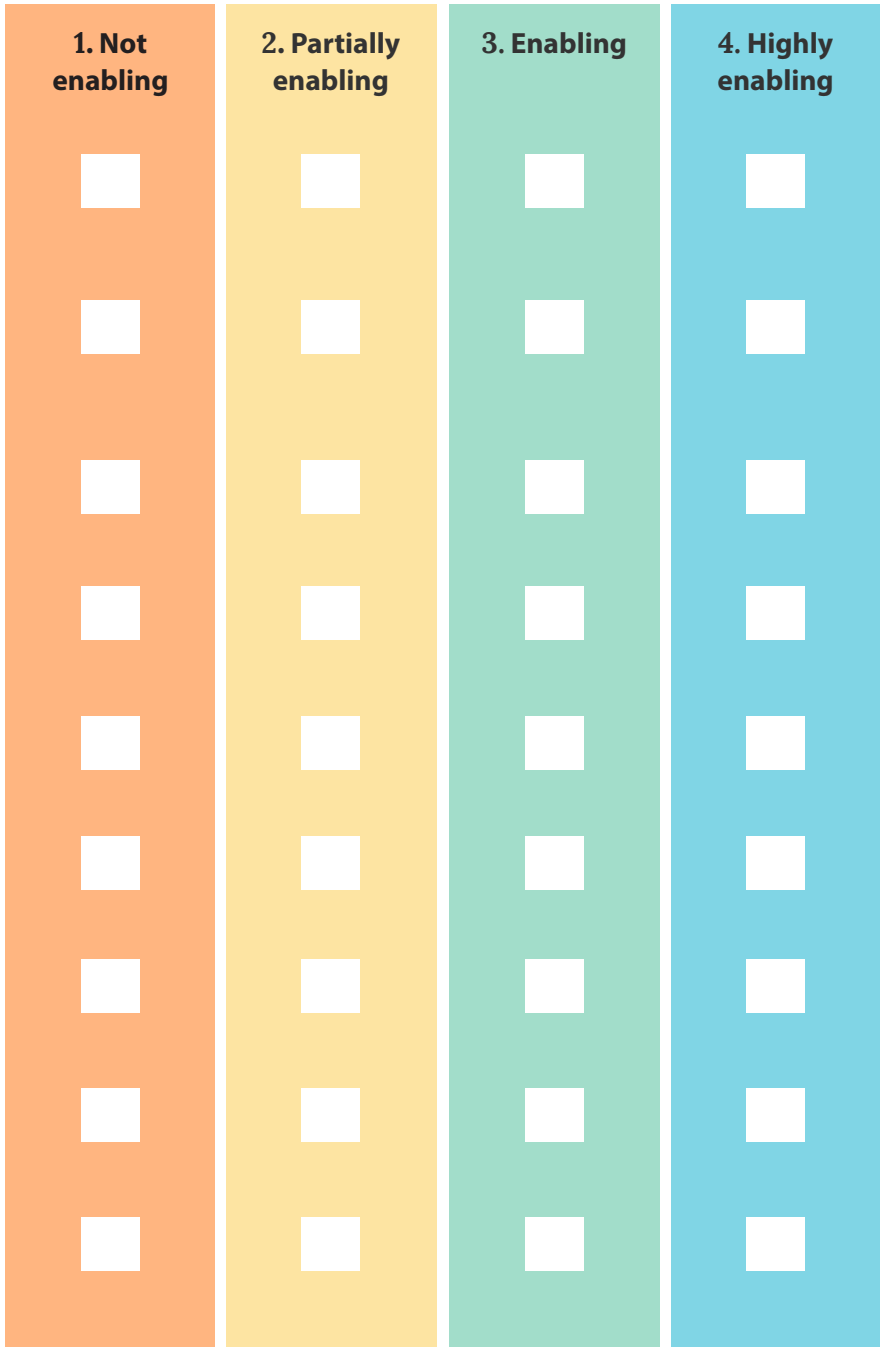
[6] See World Vision International and CORE Group's Community Health Committees and Health Center Management Committees: Program Functionality Assessment Toolkit (2016, available at wvi.org) for guidance on assessing the functionality of these **programmes**.

[7] 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.)

1 Not enabling	2 Partially enabling	3 Enabling	4 Highly enabling
• 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 CHWs 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)	• 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 programme to achieve full target population coverage with the services, but additional recruitment is planned over time	• There are sufficient numbers of CHWs in the programme 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 stabilise 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

Score overview



Appendix

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