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Rapid Assessment of Community Health Worker Programs in USAID Priority MCH Countries

Draft Tool for Field Testing

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Rapid Assessment of Community Health Worker Programs in USAID Priority MCH Countries

I. Background

As a key element of its strategic approach to maternal, child, and newborn health USAID will address the MCH human resources crisis by increasing by at least 100,000 the number of functional community health workers (CHW) serving in USAID priority countries by 2013. This document proposes a working definition of a CHW and a matrix tool for assessing and counting functional community health programs and their CHW participants. The intended audience for this tool is any USAID-supported implementing partner, such as the Ministry of Health, NGO or other organization that implements and manages CHW programs in target MCH priority countries.

The objective of the CHW Program Functionality Assessment Tool is to help USAID HPN Officers and other relevant stakeholders assess the functionality of USAID supported CHW programs and to count the number of community health workers within programs assessed as functional. In addition to counting the numbers of functional community health workers, this tool also provides an action planning and resources guide to assist program managers in strengthening their CHW programs.

II. Defining Functional Community Health Workers for MCH Services

A. Defining Community Health Workers

The term "community health worker" is a broadly used term that includes a wide range of health aides who are selected, trained, and who work in communities delivering basic health, promotion, education and mobilization services. They have many different titles and functions and range from extensions of the formal health sector, as in Auxiliary Nurses or Technicians, to village health workers and health promoters.

Expert groups have interpreted the literature to define a CHW in various ways including:

- "Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers." Source: Community health workers: What do we know about them? (WHO, 2007)
- "Any health worker carrying out functions related to health care delivery; trained in some way in the context of the intervention; and having no formal professional or paraprofessional certificated or degreed tertiary education" Source: Lehmann U, Sanders D.2005.
- "A health worker who has received training that is outside the nursing and midwifery curricula but is, nevertheless, standardized and nationally endorsed. This category can include health workers with a range of different roles and competencies and those that are providing essential services in a health facility, or in the community as part of, or linked to a health team at the facility." Source: Task Shifting: Global Recommendations and Guidelines (WHO, 2008).

B. Identifying Community Health Workers Who Provide MCH Services

For the purposes of the USAID MCH Community Health Worker Initiative, a definition of a community health worker that blends the above definitions is proposed:

> *A community health worker is a health worker that performs a set of essential MCH health services who receives standardized training outside the formal nursing or medical curricula and*

has a defined role within the community and the larger health system.

To be considered a functional CHW who provides MCH services, the CHW's job tasks must include *at least one complete* key MCH interventions listed in table 2. This list of interventions is adapted for the CHW role from the key MCH interventions listed in USAID's Report to Congress: Working Toward the Goal of Reducing Maternal and Child Mortality (USAID 2008). Interventions are grouped into the following seven categories:

1. Antenatal
2. Childbirth and Immediate Newborn Care
3. Postpartum and Newborn Care
4. Early childhood (0-5 yrs)
5. Family planning/healthy timing and spacing of pregnancy
6. Malaria (Optional- Dependent Upon Country)
7. PMTCT (Optional-Dependent Upon Country)

Each category includes several interventions, some of which have specified sub-components. When sub-components are listed, they are considered requirements for the completion of that intervention.

III. The Community Health Worker Program Functionality Assessment Tool

A. Objectives of CHW-PFA

The CHW Program Functionality Assessment Tool (CHW-PFA) is intended to provide USAID HPN Officers and other stakeholders with a rapid way to assess the functionality of community health worker programs, and of the health workers within those programs, in priority MCH countries. A set of widely accepted programmatic and clinical elements are proposed that together, provide the foundation for a strongly functioning CHW program in MCH. Although exceptions to every rule can be found, what is presented in this instrument can be considered as a set of best practices and guidelines for sustainable programs. When a CHW program meets the minimum program component criteria, individual CHW's can be counted within the program with reasonable confidence that health workers are receiving the minimum support necessary to enable their performance, and that they are also delivering at least one key MCH intervention.

The benefits to this approach are:

1. It allows USAID Missions to respond to the demand by the US Congress that USAID count and add 100,000 functional community health workers to programs in priority countries;
2. It provides an opportunity for USAID Missions and country programs to assess current and future programs based on a core set of organizational best practices;
3. It offers a framework for improvement with an action plan, resources, and technical assistance to enable programs to improve their programs' ratings.

Counting and evaluating individual CHWs, either through direct observation or survey, is a timely and very costly process. By analyzing and evaluating the support systems considered essential to the performance of a CHW, programs do more than count individuals – they provide a strong foundation for quality health worker performance, improve programmatic sustainability, and increase the level of engagement of community health workers.

The constraints of this approach are:

1. The CHW-PFA does not evaluate the quality of MCH services delivered by individual health workers; there are several other tools currently in use that evaluate the quality of services.
2. This tool does not assess the actual impact of CHW programs on communities, mothers or children.
3. The CHW-PFA tool does not offer a quality improvement (QI) process, although it should be used in conjunction with a QI process to achieve the objectives for program quality and sustainability.

B. Programmatic Components

The CHW PFA proposes twelve programmatic components supported by the literature for a community health worker program to be effective. These components are:

1. **Recruitment:** How and from where a community health worker is identified, selected, and assigned to a community.
2. **The CHW Role:** The alignment, design and clarity of role from community, CHW, and health system perspectives.
3. **Initial Training:** Training is provided to the CHW to prepare for the role in MCH services delivery and ensure he/she has the necessary skills to provide safe and quality care.
4. **On-going Training:** On-going training is provided to update CHW on new skills, reinforce initial training, and ensure he/she is practicing skills learned.
5. **Equipment and Supplies:** The requisite equipment and supplies are available when needed to deliver the expected services.
6. **Supervision:** Supervision is conducted on a regular basis to carry out administrative tasks and to provide individual performance support (feedback, coaching, data-driven problem-solving).
7. **Performance Evaluation**: Evaluation to fairly assess work during a set period of time.
8. **Incentives:** A balanced incentive package that includes financial incentives, such as salary and bonuses and non-financial incentives, such as training, recognition, certification, uniforms, medicines, etc**.** that is appropriate to the work expectations.
9. **Community Involvement:** The role that community plays in supporting a CHW.
10. **Referral System:** A process for determining when referral is needed, a logistics plan in place for transport and funds when required, a process to track and document referrals.
11. **Professional Advancement:** The possibility for growth, advancement, promotion and retirement for a CHW.
12. **Documentation, Information Management:** How CHWs document visits, how data flows to the health system and back to the community, and how it is used for service improvement.

Functionality Rating of Programmatic Components

For each of the 12 components listed above, four levels of functionality are described that range from non-functional (Level 0) to highly functional as defined by suggested best practices (Level 3). These

levels describe situations commonly seen in community health worker programs and provide enough detail to allow stakeholders to identify where their programs fall within that range. Level 3, the highest level, provides an accepted best practice for each component, and resources and tools to aid implementers in achieving that higher level of functionality are provided as part of this instrument (Appendix 1). Because each of these components is equally necessary for a program to succeed, a CHW program must be rated at least level 2 in each of the 12 components in order to be considered minimally functional.

C. Clinical Requirements

Delivery of Maternal Child Health (MCH) Intervention

A'functional' community health worker *providing MCH services* must deliver at least one of the key MCH interventions listed in Table 2 of this document**.** Table 2 provides a list of key MCH interventions classified by antenatal, childbirth and immediate newborn care, post-partum and newborn care, early childhood, family planning/healthy timing and spacing of pregnancy in the MCH care-continuum.

Scoring of MCH Intervention

As the delivery of one MCH intervention is considered qualifying criterion for this program, a separate score is not added for the first MCH service provided. However, a program that is assessed as functional in its programatic components that also offers more than one MCH intervention will increase its functionality rating by a score of 1 for each additional intervention. This approach is proposed due to the tremendous range of CHW MCH roles across countries ranging from CHW's who perform a wide range of MCH tasks to CHW's who perform very specific interventions (WHO, 2008). Programs with CHWs that provide 2 or more individual tasks score higher on the functionality scale, with one point assigned for each additional task.

IV. Applying the CHW-PFA

A. Preparation Phase

1. Understanding the CHW program/s to Assess

As the assessment should be conducted for each program (whether national, regional, or by district) that can be described as functioning consistently, it is important to consider how the CHW program is organized and managed. Is it supported by a central ministry of health or by independent NGOs? Is it a national program or more local and regional? Is it linked to public health services or does it function independently? Is there organizational consistency across communities/districts/regions? Although the size of the program or the number of community health workers within the problem is not a limiting factor, the organization of the program is important. As we are assessing the supportive structures of the program rather than the individuals within the program, consistency across the 12 programmatic components listed on page 12 will be needed. As many CHW programs differ by district or by region, it is important to plan this meeting in advance to include knowledgeable people for each district (or region) that functions distinctly. It is not possible or reasonable to expect organizations to evaluate each individual community, so program managers should identify in advance how many distinctly managed programs there are by reviewing the CHW program components.

2. Identifying Stakeholders for Meeting

The instrument is best used during a workshop with multiple stakeholders knowledgeable about a specific program. Stakeholders should include individuals that are familiar with how the program is managed or supported and the regions within which it functions. It is best applied by a diverse group of no more than 15 people (can be as few as 5) from an organization or CHW program.

Selected staff should represent field level managers, district level managers, and other individuals who are very familiar with the implementation details of the program. It is ideal to also include CHW supervisors if possible.

3. Documents Requested

When invitations to attend the CHW review session are extended to stakeholders, a list of suggested documents or pieces of information should accompany the invitation to ensure that stakeholders are prepared to assess individual components of the matrix. Suggested documents include:

- Program descriptions, job descriptions, or official descriptions of the role of the CHW and the process followed to identify and recruit the CHW
- Any information that documents the supply of equipment or supplies (frequency, minimum stock) to CHWs
- Records identifying numbers of trained CHWs, dates of recent trainings, and documents describing training content and process
- Documents that describe the supervision or monitoring process
- Records of current numbers of CHWs
- Any other documents available and pertinent to program components

Note: If documents are not available, stakeholders should be able to speak knowledgeably about each component.

4. Facilitating the Meeting

- **Introduction and Statement of Objectives**
    - Introduction to the U.S. Government MCH strategy to increase by at least 100,000 the number of functional community health workers serving in USAID priority countries by 2013
    - Improvement in quality and sustainability of CHW programs supported by USAID
    - Assess functionality of specific CHW programs and identify actions to improve results
- **Review Tool and Components in Plenary Session**
    - Discuss each section of the tool as a group. Present and define the Programmatic Components.
    - Each component will be defined and discussed as a group. Resources and links are provided within the tool to explain and more fully describe each component.

5. Completing the Assessment

- **Individual Assessment – Rating the Components**
    - Each person in the group individually assesses the CHW components in the matrix by reviewing the characteristics of every component at each stage of development.
    - For each component, each person should write the number for the stage that he/she believes best represents the current status of the CHW organization, program, or sub-program. Please note that if only part of the statement applies, record the number for the level below.

- In the blank box on the right of the matrix, please note one or two specific observations that support the level that is marked.
- This step in the assessment process should take no more than 45 minutes.

- **Group Assessment – Reaching Agreement**
  - Once individual assessments are completed, the facilitator guides the group through a discussion of each component by recording on a flip chart the individual scores and identifying any outliers (most scores will converge on a specific number). Those people whose scores are higher or lower will be asked to explain why they rated the component they way they did. Evidence will then be produced and discussed to bring the outliers back into the norm or convince the group that they are correct.
  - If multiple groups are participating (representatives from several programs) group members can discuss each component and how they individually rated each component for the program they are assessing. The facilitator can roam the room and help groups agree on each rating and share documents that might substantiate one rating or another.
  - It is important that each individual's perspective be respected as perceptions can differ depending on a person's role within the organization.
  - Where agreement cannot be reached, the lower of the two scores will be selected.
  - Once agreement is reached, an overall form is completed and evidence for each component is listed.
  - This step in the assessment process should take 2 hours allowing about 15 minutes per component.

6. Completing the Scoring Table and Counting CHWs

Once scores are agreed upon, the scoring table on page 25 should be completed by any program (or district/region) that has scored at least a '2' in each programmatic component and whose CHWs carry out at least one MCH intervention. Overall scores are recorded by tabulating all individual program assessments to get a total numeric value for a country at a certain point in time.

V. Re-applying this Instrument to Determine Newly Functional and Additional CHWs

This instrument can be applied as frequently as every 6 months in order to determine if programs have improved their functionality and now meet the minimum requirements, or to count new CHWs that have joined an already functional program. In order to qualify as newly functional, scores should be reviewed by multiple stakeholders and evidence produced or discussed that substantiates a revision of an earlier score. For new or additional CHWs to be added to a program, they must have completed the initial training component and successfully integrated into a current program.

VI. Action Planning

Programs that have not scored the minimum in each component can take this opportunity to analyze each component and understand why their programs have not achieved the minimum scores. To identify the reasons underlying the results, program should ask the question of "Why does this situation exist?" Understanding the causes can help programs create action plans to improve and score better during the next assessment.

Regardless of the functionality score, it is helpful for all program managers to review the best practices and resources provided that might facilitate action planning and program development.

For additional help in prioritizing and improving certain elements of the program, the USAID Health Care Improvement Project (HCI) can provide technical assistance through its Department of Workforce Development. Please contact Lauren Crigler at lcrigler@URC-CHS.com or lcrigler@initiativesinc.com.

VII. Resources and Best Practices

Recruitment

There is extensive evidence that supports the best practice that CHWs recruited from the community, or that the community has played a substantial role in the recruitment and selection process of, have more credibility within the community and are able to achieve more within that environment. Although identifying the candidates with the appropriate skills and abilities within the community is not always possible, actively involving community leaders in defining a role for the CHW, identifying necessary skills and characteristics, and allowing the community some say in who is assigned to them will enable CHWs to do their job more effectively.

For more on best practices for recruitment, see references

http://www.mostproject.org/CHVs/CommunityHealthWorkers.pdf (pgs. 42-43)

http://model.pih.org/community_health_workers/chw_recruitment

CHW Role

Unclear expectations and poorly defined roles for CHWs are cited as frequent causes for the failure of many CHW programs. Communities often have different expectations of the CHWs than they have themselves causing confusion and dissapointment. Frequently communities expect CHWs to perform more of a curative role, whereas in reality, many CHWs are unprepared and unable to perform such a role.

http://www.who.int/hiv/pub/imai/om_4_community.pdf (pgs. 10-12)

http://www.who.int/healthsystems/TTR-TaskShifting.pdf (pgs. 32-33)

Initial and Continuous Training

Training is an integral component to ensuring that CHWs have the capacity and skills necessary to carry out their work in the community and to provide safe, quality care. Initial training aids in defining the role of the CHW and preparing them for the work they will undertake. However, continuous training is also vital for the CHW to maintain and reinforce their present skills as well as updating them on new skills, practices and procedures.

http://www.who.int/hrh/documents/community_health_workers.pdf (pgs. 27-28)

http://pdf.usaid.gov/pdf_docs/PNADJ527.pdf (pgs. 11-12)

Equipment and Supplies

To effectively carry out their work in the community, CHWs need access to the proper equipment and supplies needed to deliver expected services. This requires procurement of supplies on a regular basis to avoid any substantial stockout periods.

http://www.communityhealthglobal.net/Topic/Topic.aspx?Action=2&li=26&parentid=20&Gid=20

Supervision and Evaluation

There is strong documentation and wide acknowledgement that for CHW programs to be successful, regular and supportive supervision must be available for CHWs. Regular supervision allows the CHW's performance to be monitored and evaluated, provides an opportunity for mentoring and problem-solving, and leads to an overall improvement in the quality of care delivered. With ongoing supervision, the supervisor can set performance goals for the CHW to attain, which can in turn be a source of motivation for the CHW. Monitoring and evaluation of the CHW will also allow the supervisor to identify areas where the CHW may need additional training.

http://data.unaids.org/pub/Manual/2007/ttr_taskshifting_en.pdf (pgs. 35-36)

http://gametlibrary.worldbank.org/FILES/595_Guidelines%20for%20Routine%20MOH%20Supervision%20-%20Malawi.pdf (you may not want to include this reference since it's from 2003 but I thought it was very useful since it provides steps and directions regarding supervision and even a checklist)

Incentives

Financial and non-financial incentives have been shown to influence the behavior and attitude of CHWs in a positive way. They are an important mechanism that can be employed to reward, retain, motivate, engage and even improve performance of CHWs.

http://www.mostproject.org/CHVs/CommunityHealthWorkers.pdf (pgs. 31-40)

http://www.ichrn.com/publications/factsheets/Incentive_systems_for_health_care_pro-EN.pdf

Community Involvement

One key component to the success of CHW programs is community involvement. The community needs to play an active role and feel invested in the CHW program. Active involvement and participation of the community helps define the role and expectations of the CHW and also enables the community to provide feedback on the CHW's performance.

http://www.phishare.org/files/4457_WorkingWithTheCommunity.pdf (pgs. 6-10)

http://www.mostproject.org/CHVs/CommunityHealthWorkers.pdf (pgs. 41-45)

Referral System

Every successful CHW program that provides quality care needs to have a referral system in place to determine when a referral is necessary as well as an available means of transportation to get the patient to a health care facility. It is essential that the CHW is able to recognize the point at which a patient needs to be referred.

http://www.coregroup.org/ccm/CCM-ch8-beta2.doc

http://data.unaids.org/pub/Manual/2007/ttr_taskshifting_en.pdf (pgs. 44-45)

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Description of Program

1) CHW Programs:

_____

_____

_____

2) Description of CHW Programs Selected for Assessment

Management /Organization Structure:

- National
- Regional
- District/Community

Supported by (financial and non-financial resources for CHW program):

- MOH
- Multilateral
- Bilateral
- NGO
- CBO
- Private

3) Is this CHW Program Linked to the Public Health Structure?

4) Number of Active CHWs

Total:_____

Region/District _____

CHW Program Functionality Assessment Score Sheet

Country:

Date of Assessment:

Name of Program:

Number of CHWs in Program:

Overall Score:

Assessment Team Participants:

Name	Organization	Position

CHW Program Functionality Assessment Tool (CHW-PFA)

Table 1 - CHW Functionality Matrix - Programmatic Functionality

	Component *Definition*	Level of Functionality: 0= non-functional; 1=partly functional; 2= functional; 3 = highly functional				Current Level/ Evidence
		0	1	2	3 (best practice)	
1	**Recruitment** ***How and from where a community health worker is identified, selected, and assigned to a community.***	CHW not from community and plays no role in the recruitment.	CHW is not recruited from community but the community (reluctantly) accepts the identified CHW after selection.	CHW is not recruited from community but the community is consulted on the final selection.	Recruited from community when possible. If not possible, the community is consulted during the process and agrees on recruitment selection.	
2	**CHW Role** ***Alignment, design and clarity of role from community, CHW, and health system perspectives.***	Role is not clear or agreed upon between CHW, community and formal health system.	No formal role of CHW exists (no policies in place) General expectations are given to CHW (initial training) but are not specific. CHW and community do not always agree on role/expectations.	Health system defines (policies exist) the CHW role but without community input. Role is clear to CHW and community but little discussion of specific expectations. General agreement on role between CHW, health system, and community.	Health system, community, and CHW design the role/expectations and policies in place that support CHW role. Role and expectations are clear to CHW and community. Process for update and discussion of role/expectations in place for CHW and community	

3	**Initial Training** ***Training provided to CHW to prepare for role in MCH services delivery and ensure he/she has the necessary skills to provide safe and quality care.***	No initial training is provided.	Minimal initial training is provided (1 workshop, etc). Some CHWs attend workshops on specific topics.	Initial training is provided to all CHWs within the first year of recruitment. Training does not include participation from community or from referral health center.	Initial training is provided to all CHWs within the six months that is based on defined expectations for CHW. Some training is conducted in the community or with community participation. Training is consistent with health facility guidelines for community care and health facility is involved in training.	
4	**On-going Training** ***On-going training to update CHW on new skills, reinforce initial training, and ensure he/she is practicing skills learned.***	No ongoing training is provided	Occasional, ad hoc visits by supervisors provide some coaching.	On-going training is provided on a regular basis. Some supervisors follow up with coaching. Note: Functional CHWs have been trained (or updated) within the last 18 months.	On-going training is provided to update CHW on new skills, reinforce initial training, and ensure he/she is practicing skills learned. Training is tracked and opportunities are offered in a consistent and fair manner to all CHWs (not only some)	

5	**Equipment and Supplies** ***Required equipment and supplies to deliver expected services.***	No equipment and supplies are provided.	Inconsistent supply and restocking to support defined CHW tasks. No formal process for re-ordering.	Supplies are ordered on a regular basis although delivery can be irregular. Stockout of supplies essential for defined CHW tasks occur at a rate of x per year/mo	All necessary supplies; no substantial stock-out periods.	
6	**Supervision** ***Supervision conducted on a regular basis to carry out administrative tasks and to provide individual performance support (feedback, coaching, data-driven problem-solving).***	No supervision or regular evaluation occurs outside of occasional visits to CHWs by nurses or supervisors when possible (1x/year or less).	Supervision visits conducted between two and three times per year to collect reports/data (or group meetings at facility to turn in monitoring forms). No individual performance support offered on work (problem-solving, coaching)	Regular supervision visit at least every three months that includes reviewing reports, monitoring of data collected and occasionally provide problem-solving support to CHW. Supervisors are not trained in supportive supervision but are facility based health workers.	Regular supervision visit every 1-3 months that includes reviewing reports, monitoring of data collected. Data is used for problem solving and coaching. Supervisor visits community, makes home visits, provides skills coaching to CHW. Supervisor is trained in supervision and has supervision tools.	

7	**Performance Evaluation** ***Evaluation to fairly assess work during a set period of time.***	No regular evaluation of performance by CHW.	Once/year evaluation that is not based individual performance and includes only evaluation of coverage or monitoring data. There are no rewards for good performance.	Once/year evaluation that is not based individual performance and includes only evaluation of coverage or monitoring data (national /program evaluation). Community is not asked to provide feedback on CHW's performance. There are some rewards for good performance, such as small incentive gifts, recognition, etc.	At least once/year evaluation that includes individual performance (local evaluation) and evaluation of coverage or monitoring data (national /program evaluation) Community is asked to provide feedback on CHW performance. There are clear rewards for good performance, and community plays a role in providing rewards.	
8	**Incentives** ***Financial= salary and bonuses*** ***Non-financial= training, recognition, certification, uniforms, medicines, etc.***	No financial or non-financial incentives provided	No formal incentives provided but community recognition is considered a reward	Some financial or non-financial incentives are provided. Examples of non-financial incentives include occasional formal recognition, additional training, and other small incentives.	Financial and/or non-financial incentives are partly based on good performance. Incentives are balanced and in line with expectations placed on CHW. Examples of non-	

					financial incentives that engage workers might include (advancement, recognition, certification process)	
9	**Community Involvement** ***Role that community plays in supporting CHW.***	Community is not involved with ongoing support to CHW	Community is sometimes involved (campaigns, education) with the CHW and some people in the community recognize the CHW as a resource.	Community plays significant role in supporting the CHW through mother's groups, networks, etc. CHW is widely recognized and appreciated for providing service to community.	Community plays an active role in all support areas for CHW, such as development of role, providing feedback, solving problems, providing incentives, helps to establish CHW as leader in community.	
10	**Referral System** ***Is there a process for*** ***- determining when referral is needed*** ***- logistics plan for transport/payment to a health care facility when required*** ***- how referral is tracked and documented***	No referral system in place: CHW might know when and where to refer client, but - no logistics plan in place by the community for emergency referral - information is not tracked or documented	CHW knows when to refer client (danger signs, additional treatment, etc) CHW and community know where referral facility is but have no formal referral process/logistics Referral is not tracked by community or CHW	CHW knows when to refer client (danger signs, additional treatment, etc) CHW and community know where referral facility is and usually have the means to transport client Client is referred with a slip of paper and informally	CHW knows when to refer client (danger signs, additional treatment, etc) CHW and community know where referral facility is and have a logistics plan for emergencies (transport, funds) Client is referred with a slip of paper and information	

				tracked by CHW (checking in with family, follow up visit) but information does not flow back to CHW.	flows back to CHW with a returned referral form and/or monthly monitoring.	
11	**Professional Advancement** ***The possibility for growth, advancement, promotion and retirement for CHW***	No professional advancement is offered.	Advancement (promotion) is sometimes offered to CHWs who've been in program for specific length of time. No other opportunities are discussed with CHW. Advancement is not related to performance or achievement.	Advancement (promotion) is sometimes offered to CHWs who've been in program for specific length of time. Limited training opportunities are offered to CHW to learn new skills to advance role. Advancement is intended to reward good performance or achievement, although evaluation is not consistent (advancement might mean path to formal sector or change in role). No path to retirement is made	Advancement (promotion) is offered to CHWs who perform well and who express an interest in advancement if the opportunity exists (advancement might mean path to formal sector or change in role) Training opportunities are offered to CHW to learn new skills to advance their role and CHW is made aware of them. Advancement is intended to reward good performance or achievement, and is based on fair evaluation.	

				clear to CHWs	Retirement is encouraged and incentives are provided to encourage retirement at a set age.	
12	**Documentation, Information Management** ***How CHWs document visits, how data flows to the health system and back to the community, and how it is used for service improvement***	No process for documentation or info management is followed	Some CHWs document their visits and group monitoring visits to facility are attended by CHWs who bring monitoring forms. CHWs/communities do not see data analyzed and no effort to use data in problem-solving at the community is made.	CHWs document their visits consistently and group monitoring visits to facility are attended by CHWs who bring monitoring forms. Supervisors monitor quality of documents and provide help when needed. CHWs/communities do not see data analyzed and no effort to use data in problem-solving at the community is made.	CHWs document their visits consistently and group monitoring visits to facility are attended by CHWs who bring monitoring forms. Supervisors monitor quality of documents and provide help when needed. CHWs/communities work with supervisor or referral facility to use data in problem-solving at the community.	

Table 2 - Community Health Worker Functionality Matrix – MCH Interventions

Interventions are grouped by category. One complete intervention requires a check mark in the column titled YES. If the intervention has key subcomponents, all subcomponents of the intervention must be completed for a YES rating. A comment box is provided to describe the intervention delivered more fully or to make notes for action planning.

	MCH INTERVENTIONS To be considered a functional CHW who provides MCH services, the CHW's tasks must include *at least one complete* key MCH intervention listed below.	**YES**	**COMMENTS**
1	**ANTENATAL CARE**		
A	Iron folate supplements Counsel Provide commodity or intervention/Assess and treat Refer for commodity, intervention, or treatment	☐ ☐ ☐	
B	Maternal nutrition Counsel Provide commodity or intervention/Assess and treat Refer for commodity, intervention or treatment	☐ ☐ ☐	
C	Counsel on birth preparedness/complication readiness (*includes counseling to use skilled birth attendant*)	☐	
D	Tetanus Toxoid Counsel Provide commodity or intervention/Assess and treat Refer for commodity, intervention, or treatment	☐ ☐ ☐	
E	De-worm Counsel Provide commodity or intervention/Assess and treat Refer for commodity, intervention, or treatment	☐ ☐ ☐	

2	**CHILDBIRTH and IMMEDIATE NEWBORN CARE**		
A	Prevent Infection/Clean Delivery (Handwashing, clean blade +/or clean delivery kit)	☐	
B	Provide Essential Newborn Care a. Immediate warming and drying b. Clean cord care c. Early initiation of breastfeeding	☐ ☐ ☐	
C	Recognize, initially stabilize (when possible) and refer for maternal and newborn complications a. newborn asphyxia b. sepsis c. hypertensive disorder d. hemorrhage e. prolonged labor and post-abortion complications	☐ ☐ ☐ ☐ ☐	
D	Prevent PPH: AMTSL or use of uterotonic alone in absence of full AMTSL competency (e.g., oral Misoprostol)	☐	
E	Provide special care for low birth weight newborns (Kangaroo Care)	☐	
3	**POST-PARTUM and NEWBORN CARE**		
A	Provide counseling on evidence-based maternal newborn health and nutrition behaviors a. clean cord care b. exclusive BF through 6 months c. thermal protection; hygiene d. danger sign recognition e. maternal nutrition, etc.	☐ ☐ ☐ ☐ ☐	
B	Assess for maternal newborn danger signs and provide appropriate referral	☐	

C	Provide treatment for severe newborn infection (when community-based treatment is supported by national guidelines)	☐	
4	**EARLY CHILDHOOD**		
A	**Infant and young child feeding, IYCF**: Provide counseling for immediate BF after birth; exclusive BF < 6 months; age-appropriate complementary foods	☐	
B	Promote growth monitoring, weighing infants and recording progress	☐	
C	Provide community based management of acute malnutrition (CMAM) using Ready to Use Therapeutic Foods (community-based recuperation of children with acute moderate to severe malnutrition without complications)	☐	
D	Community-based treatment of pneumonia a. Counsel re recognition of danger signs, seeking care/antibiotics b. Assess and treat with antibiotics c. Refer for antibiotics d. Refer after treating with initial antibiotics	☐ ☐ ☐ ☐	
E	Community-based prevention and treatment of diarrhea a. Counsel on hygiene b. Counsel on point-of-use water treatment c. Provide point-of-use water treatment d. Refer point-of-use water treatment e. Counsel on ORS f. Provide on ORS g. Refer for ORS h. Counsel on Zinc i. Provide Zinc j. Refer for Zinc	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	

F	Vitamin A supplements (twice annually children 6-59 months) Counsel Provide commodity or intervention/ Assess and treat Refer for commodity, intervention, or treatment	☐ ☐ ☐	
G	Effectively assess and recognize severe illness in children (danger signs) with appropriate referral	☐	
H	Counsel on Immunizations Mapping/tracking for immunization coverage Provide immunizations: - DTP - Polio and or measles - +/- HIB - Hep B -Pneumovax Refer for immunizations	☐ ☐ ☐ ☐ ☐ ☐ ☐	
5	**FAMILYPLANNING/HEALTHY TIMING AND SPACING OF PREGNANCY**		
A	Counsel on HTSP/contraceptives Provide contraceptives: - Condoms - Lactation Amenorrheic Method (LAM) - Oral contraceptives - Depo Refer for contraceptives: - Condoms - Lactation Amenorrheic Method (LAM) - Oral contraceptives - Long-acting and permanent methods	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
B	Provide FP counseling +/- administer contraceptives (e.g., oral contraceptives)	☐	

6	**MALARIA (optional – Dependent Upon Country)**		
A	Insecticide-treated mosquito nets to pregnant women and children Counsel Provide commodity or intervention/Assess and treat Refer for commodity, intervention, or treatment	 ☐ ☐ ☐	
B	Intermittent preventive malaria treatment (IPTp) Counsel Provide commodity or intervention/Assess and treat Refer for commodity, intervention or treatment	☐ ☐ ☐	
C	Community-based treatment of malaria (testing with Rapid Diagnostic Test or presumptive treatment per antimalarial per national guidelines.) Counsel Provide commodity or intervention/Assess and treat Refer for commodity, intervention, or treatment	 ☐ ☐ ☐	
7	**PMTCT (Optional – Dependent Upon Country)**		
A	Healthy timing and spacing of pregnancy Counsel Provide commodity or intervention/Assess and treat Refer for commodity, intervention, or treatment	☐ ☐ ☐	
B	Antibody testing to pregnant women and mothers Counsel Provide commodity or intervention/Assess and treat Refer for commodity, intervention or treatment	☐ ☐ ☐	
C	Prophylactic ARVs/HAART to pregnant women/mothers Counsel Provide commodity or intervention/Assess and treat Refer for commodity, intervention or treatment	☐ ☐ ☐	
D	Prophylactic ARVs/HAART to infants Counsel	☐	

	Provide commodity or intervention/Assess and treat Refer for commodity, intervention or treatment	☐ ☐	
E	Early infant diagnosis Counsel Provide commodity or intervention/Assess and treat Refer for commodity, intervention or treatment	☐ ☐ ☐	
F	Pregnant HIV-infected women tracking Counsel Provide commodity or intervention/Assess and treat Refer for commodity, intervention or treatment	☐ ☐ ☐	
G	HIV-exposed infant tracking Counsel Provide commodity or intervention/Assess and treat Refer for commodity, intervention or treatment	☐ ☐ ☐	

Scoring Table for Functional CHWs

CHW Program	Region/Department	Total Program Functionality Score (Min: 24/Max: 36)	Number of MCH Interventions (Min: 1 – when 2 or more, add)	Number of CHW's in Program	
				Baseline Date:	New/newly functional CHWs Date:
	1. Region A 2. Region B 3. Region C	1. 2. 3.	1. 2. 3.	1. 2. 3. Total:	1. 2. 3. Total:

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