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TECHNICAL REPORT

An Assessment of Community Health Volunteer Program Functionality in Madagascar

NOVEMBER 2012

This assessment report was prepared University Research Co., LLC (URC) for review by the United States Agency for International Development (USAID) and authored by Christiane Wiskow (URC), Francis Antonio Homsi (URC), Sarah Smith (EnCompass LLC), Emily Lanford (URC), Tana Wuliji (URC), and Lauren Crigler (Initiatives Inc.) The assessment was carried out under the USAID Health Care Improvement Project, which is managed by URC and made possible by the generous support of the American people through USAID.

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Abbreviations

AIM	Intercooperation Association Madagascar
ANC	Antenatal care
ASOS	Action Socio Sanitaire et Organisation Secours
CARE	Cooperative for Assistance and Relief Everywhere
CHV	Community health volunteer
CHW	Community health worker
CHW AIM	Community Health Worker Assessment and Improvement Matrix
CIMCI	Community Integrated Management of Childhood Illness
CRS	Catholic Relief Services
FGD	Focus group discussion
FP	Family planning
GFATM	Global Fund for HIV/AIDS, TB and Malaria
GH Tech	USAID Global Health Technical Assistance Project
HCB	Health center- or health post-based (doctor and supervisor)
HCI	USAID Health Care Improvement Project
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
KMS	*Kaominina Mendrika Salama* (certified champion communes approach)
MNCH	Maternal, newborn, and child health
MOPH	Ministry of Public Health
MSIS	Multi-Service Information Systems
NGO	Nongovernmental organization
NSA	National Strategy Application (GFATM)
ODDIT	Diocesan Organization for the Development of Toamasina
PSI	Population Services International
RH	Reproductive health
SDC	Social development committee
SN2	USAID/Santénet2
STD	Sexually transmitted disease
TA	Technical assistant
TB	Tuberculosis
UNICEF	United Nations Children's Fund
URC	University Research Co., LLC
USAID	United States Agency for International Development
WASH	Water, sanitation, and hygiene
WHO	World Health Organization

EXECUTIVE SUMMARY

Worldwide, over 3.5 million community health workers (CHWs), many of them volunteers, contribute to efforts to improve health. In the context of the human resources for health crisis in 57 countries, CHWs are increasingly the backbone of primary health care services. There are over 13,000 community health volunteers (CHVs) providing health services in Madagascar, many of them trained and supervised by local, international, and faith-based NGOs with some supervisory support provided by the public health system and communities. Community health workers/volunteers are often recruited, managed, or supported through CHW *programs of support.* For the purposes of this report, a program of support is an organizational system having structures and processes that provide operational and technical support to CHWs. As these programs of support scale up, stakeholders seek to understand the functionality of these support systems. Such understanding could guide efforts to improve and/or expand existing programs of support and create new ones.

The U.S. Agency for International Development (USAID) Mission in Madagascar asked the USAID Health Care Improvement Project (HCI) to: 1) assess the functionality of programs of support for CHVs and 2) particularly explore issues surrounding the supervision of those volunteers. HCI had previously undertaken research that identified and defined, first, 15 CHW program "components" that contribute to CHW performance, such as training, incentives, and supervision, and, second, interventions typically performed by CHWs in maternal, newborn, and child health (MNCH); HIV/AIDS; and TB. That research informed the development of the "CHW Assessment and Improvement Matrix" (Crigler et al., 2011), a toolkit that guides the self-assessment of CHW program functionality. The CHW AIM methodology was used in Madagascar to assess the functionality of CHV programs of support in three regions in September 2011.

Methodology

The assessment applied the toolkit's approach to assess the functionality of programs supporting CHV work. Additional qualitative research more closely examined supervision of CHVs through focus group discussions and interviews. The research focused on CHWs who were volunteers (thus CHVs) who had been trained to provide basic health care services and health-promoting activities in their communities in the regions of Atsinanana, Analamanga, and Androy. Four programs of support were assessed, including Santénet2's (SN2) in all three regions and a Government managed program for CHVs in Androy. UNICEF provided the initial training of government-managed CHVs in Androy. Many of the program support functions were provided through SN2 by local NGOs, with some clinical supervision support provided by the public health system and general supervision provided by communities. Support for CHVs in UNICEF supported regions was provided by the public sector by the district management and health facility leaders, with an initial period of 6 months of support provided by the NGO ASOS.

The CHW AIM methodology has three main steps: 1) document review, 2) assessment workshop, and 3) validation visits.

For step 1, documentation relating to each program of support was gathered and reviewed before each region's workshop, and findings from the review were triangulated with those from the workshop and validation visits. Each workshop engaged a wide range of stakeholders who scored each of the 15 components in their program of support on a scale of 0 (non-functional) to 3 (best practice); note-takers recorded the votes. Workshop participants then reviewed lists of interventions on MNCH; family planning; and water, sanitation, and hygiene. After establishing whether the interventions were part of their program, participants determined whether the interventions were functional. The note-takers captured comments that shed light on how the CHV program of support functioned.

After each workshop, the research team visited communities not represented at the workshop to hold discussions with stakeholders there to validate and/or supplement the workshop information as well as examine supervision issues more closely through qualitative focus group discussions and interviews.

Findings from the applying the methodology in Madagascar are presented in this report, along with recommendations from both the participants and research team. Limitations are also presented and include weaknesses in communication that likely result from translating tools and discussions from English to French to Malagasy and back as well as from not audio-recording the discussions.

Findings

Using the toolkit scoring system, which has a maximum score of 45, the four NGOs in Atsinanana gave their programs of support the highest scores, ranging from 39–41 points. The SN2 program in Analamanga earned 34 points but was only partially functional in one component, rendering the entire program only partially functional according to the methodology. Androy's SN2 program of support and the Government managed program were both non-functional with 28 and 19 points, respectively.

Several patterns emerged among the 15 CHV program components. Recruitment was uniformly scored as a best practice, with comments indicating that community involvement and/or the application of selection criteria warranted the high score. Such involvement was essentially a community's participation in selecting a CHV; supervising him/her; awareness raising; and, in some communities, building a hut where the CHV could offer services. As part of the community involvement component, community-level communication was often faulted for failures to successfully inform community members that CHV services were limited.

Equipment and supplies generally scored low (non-functional in two regions and partially functional in one), with repeated expressions that the Government should help more in this area. (Exceptionally, three NGOs in Atsinanana scored this component as a best practice, citing help from health centers when stock-outs occurred in communities.) Country ownership also scored somewhat low (non-functional in two programs of support and partially functional in two others), generally for not contributing to CHV efforts other than to provide forms and requiring reports. Weak government support often emerged as a concern in discussions about training, incentives, and supervision. Favorable comments about the Government acknowledged its community health policy (MOH, 2008).

Other components scored high or low with no clear patterns among programs or components: Community involvement, opportunity for advancement, documentation and information management, and program performance evaluation tended to score well. Workshop participants indicated high functionality of UNICEF-trained CHVs in the CHV role (related to the understanding of that role), initial training, incentives, referral system, and opportunity for advancement.

Continuing training was scored as partially functional to best practice, with Atsinanana rating it a best practice due to the community-level monthly review meetings. Such meetings enable local supervisors and community representatives to provide feedback to CHVs. Androy's SN2 program of support scored a best practice for initial training due in part to community and health center involvement in such training.

Referral systems received high scores, but many comments indicated that CHVs do not receive feedback from health centers to guide follow-up care.

With regard to the *interventions* (e.g., antenatal care, childbirth care) presented in the toolkit or developed for this research, most CHVs found their activities to be functional in all the services they provided; discussions revealed what services they do not provide within their existing scope of work, which usually included birth care, therapeutic food for nutrition, and hygiene for adolescents. Androy's UNICEF-trained CHVs followed the nationally defined service packages and was thus focused on community-integrated management of childhood illness (CIMCI).

A separate assessment examined supervision from the perspectives of CHVs, supervisors, and communities. SN2 encourages supportive supervision and has a substantial supervision program buttressed by forms and incentives (for supervisors) for timely completion. Generally, these three groups saw supervision as helpful in ensuring service quality. They understood the supervision approach and reported that it was a good way to improve services through a combination of control, capacity building, and support to CHVs in problem solving. However, some participants seemed not to see the distinctions between evaluation and broader supervision tasks, such as providing guidance on an as-needed basis and advocating for materials at higher levels of the health system.

Supervision was provided by community members (for community relations), medical personnel (for clinical practice), and sponsoring agencies (for programming). A detailed performance evaluation was generally done biannually at first but quarterly at the time of the assessment. Supervisory visits at CHV sites where the CHV could be observed working with a client were rare, due to distances, lack of transportation and time, and the fact that CHVs were often farmers and would not be available during the day. Supervision practices commonly included a review of CHV materials/supplies and their organization, review of reports on activities and patient documentation, and questions on knowledge and methods of work. Simulation exercises on common CHV services and interventions were primarily done during monthly review meetings, where CHV activities were discussed.

Supervisors in all three regions showed a common understanding of supervision as a combination of quality control of CHV activities and support to CHVs with the aim of ensuring quality services and encouraging CHVs in their efforts. They saw identifying problems and helping CHVs find solutions as a core supervision task, as were explaining CHV roles and tasks and building relationships between CHVs and their communities. They equated successful supervision with motivating CHVs to perform better.

Community representatives served as the CHV's closest supervisor and as the link between him/ her and the greater community. They would urge villagers to take advantage of the CHV's presence and village chiefs to support the CHV as only they can. One community representative reported that the culture did not adopt behavior change easily but that he was making progress in building support for CHVs. They also reviewed health data and statistics to help develop community plans and monitor action plans.

Recommendations

The four programs did not differ in any remarkable way with regard to recommendations. They call for stronger coordination between the CHV program and other entities, including community representatives, the health care center, and the greater public health system. Stronger coordination, participants felt, would generate greater respect for and understanding of CHVs and their programs, more reliable supplies, and better supervision. For the government managed program for UNICEF-trained CHVs, stakeholders stressed a need for the use of information generated by CHVs and higher levels of the health care system to inform decision making and action; Atsinanana alone requested that initial training be conducted in the community.

CHVs felt positively about supervisors' attitudes and behavior and reported that supervision had positive effects. Their expectations from supervisors varied: CHVs in Analamanga wanted encouragement and new knowledge; those in Atsinanana wanted the supervisor to link the CHV with other entities (e.g., the NGO or health center), and those in Androy wanted more help solving problems. The last group recommended more frequent supervision visits with more time for individual supervision; more guidance, coaching, and advice adapted to their work situations; and feedback on the results of evaluation sessions. An Androy CHV also recommended visits by donors and other authorities for a better understanding of the CHVs' situations.

Supervisors recommended home visits where supervisors could observe and coach a CHV and where communities could be made aware of the value of CHVs; they also referred, however, to time constraints. They requested mobile phones and help with resolving stock-outs.

Community representatives felt the CHV programs of support were improving the public health and viewed supervision favorably but felt hindered by the lack of transport and, sometimes, of information on the results of clinical and program supervision. They recommended support, mostly in the forms of funds, supplies, and training. One expressed concern about the amount of time demanded of CHVs.

Conclusions

SN2 and UNICEF should be recognized for their efforts to expand and strengthen CHV programs. Overall, CHV programs of support were found to be strongest in recruitment, initial training, community involvement, opportunities for advancement, and documentation and information management. Future plans should seek to sustain these strengths and address identified weaknesses in equipment and supplies, individual performance appraisal, and country ownership. Filling these gaps would present opportunities for shared learning, greater coordination between stakeholders, and the application of improvement methods to develop and test interventions to address programmatic weaknesses and improve the effectiveness and sustainability of CHV programs.

I. INTRODUCTION

Community health workers (CHWs) are internationally recognized for helping to reduce morbidity and mortality. Since 1978, the World Health Organization (WHO) has been promoting CHWs to perform selected health care tasks at the community level (WHO, 1989). "CHW" generally refers to individuals who, with limited training and support, provide health care and health education to people who live in their communities. A CHW is a health worker who 1) performs a set of essential health services, 2) receives standardized training outside the formal nursing or medical curricula, and 3) has a defined role within the community and the larger health system. Depending on the context, CHWs not only have various titles (such as community health volunteers, health promoters, outreach workers, village health guides, and peer educators), they also perform different tasks (WHO, 1989). They typically offer basic health care and health promotion services outside health facilities and in a community setting, conducting community outreach, home visits, and public education; mobilizing attendance at clinics; and sometimes staffing small or mobile health posts. Increasingly in some countries, they are also extending the health system's reach *within* health facilities, taking on such tasks as promoting child growth monitoring, updating patient records, and providing health education and patient support, thus relieving overburdened health professionals.

The CHW role is becoming more important as governments struggle to address health workforce shortages caused by migration, HIV-related illness, and inadequate infrastructure (see Box 1). Furthermore, realization is growing that the number of professional providers is significantly lower than is needed to provide care for rural populations in resource-poor countries (WHO, 1989).

Box 1: The Health Worker Crisis

The High Level Taskforce on Innovative Financing for Health Systems estimated in 2009 that 3.5 million more health workers were needed in 49 low-income countries—roughly double the current number in these countries—to achieve the health-related Millennium Development Goals. Fifty-seven countries—36 of them in sub-Saharan Africa—have a critical workforce shortage, defined as a density of health professionals below 2.3 per 1000 population. Madagascar's situation is particularly pronounced, with 2.9 physicians and 3.2 nurses per 10,000 population (Africa Health Workforce Observatory, 2007).

As in other countries, Madagascar's problem is aggravated by an uneven distribution of the health workforce; for instance, the Analamanga region, which surrounds the capital, has almost 50% of the country's skilled health workforce serving only 15% of the region's population. Furthermore, over 40% of the population lives in geographic areas with very limited access to health facilities (Agarwal et al., 2011). The insufficient number of health professionals, their misdistribution, and the shortage of facilities result in limited and unequal access to health care.

Often indigenous to the community in which they work, CHWs can be trusted sources of both information and services. They can provide a critical link between the community and health system, enabling it to provide culturally appropriate, cost-effective care while increasing community engagement in health outcomes and creating long-term involvement with the primary care system (IntraHealth International, 2012). By carrying out basic health tasks, CHWs enable skilled health providers to concentrate on more complex care.

Perhaps most importantly, CHWs can increase the availability of and access to life-saving primary health care services to rural and remote populations. In Madagascar, the term community health volunteers (CHVs) is the most appropriate descriptor since they are not remunerated for their services. Madagascar has 22 regions, 119 districts, 1579 communes, 17,485 *fokontany* (here "villages"), and 121,679 localities (INSTAT, n.d.). Some but not all communes have health centers, and some but not all villages have at least one CHV. Madagascar has more than 13,000 CHVs and plans to scale up to 34,000.

A. Background

The main donors have frozen direct budget support and other donor development aid to Madagascar since the coup d'état in early 2009. This is particularly catastrophic given that Madagascar was highly aid dependent, with 45% of the Government budget in 2007 financed through foreign assistance; 76.8% of this was used for public investment. The first health joint review in two years, conducted in December 2010, raised concerns regarding overall decreased budget allocation to the health sector and the deteriorating situation of community-based health centers that lacked essential drugs, medicines, and equipment, including basic lifesaving items for the treatment of diarrhea, acute respiratory infections, malaria, and severe malnutrition (UN, 2011).

There are potentially high risks of increased unvaccinated or incompletely vaccinated children; of low immunization coverage; and, finally, of the resurgence of outbreaks due to ruptures of the cold chain, which in turn would be primarily due to a shortage of fuel for freezers/refrigerators at sub-national level. Most health centers have not received their complete monthly allocation of fuel and budget since January 2009. (MOH, 2012). Some were conducting, at the time of the assessment, only one or two vaccination sessions per month due to cold chain rupture. Mobile and outreach activities had slowed (and in some cases stopped) due to a lack of funds The budget for the purchase of essential drugs fell by 30% between 2009 and 2011, with payments consistently delayed in 2010 (MOH, 2012). In October 2011, Madagascar's political movements finally signed a SADC [Southern African Development Community]-negotiated roadmap for a multi-party transitional government. Since then the UN and a number of multilateral organizations (European Union, World Bank, African Development Bank) have started a progressive re-engagement at central and peripheral levels with transitional plans.

B. Madagascar's Health Indicators

Madagascar's infant and child mortality rates have improved over the past decade with the neonatal mortality rate reduced from 40 per 1000 live births (1997 DHS) to 24 per 1000 live births (2008-2009 DHS) and the under-five mortality rate from 159 per 1000 births (1997 DHS) to 58 per 1,000 (WHO, 2009). However, challenges—relating to the accessibility and quality of services, the availability of medicines and supplies, the use of data for planning and monitoring, and the capacity to manage health services—are barriers not just to improved health status but also to social and economic development. Madagascar has the sixth highest malnutrition rate worldwide, with approximately 20% of the population affected, and maternal mortality ratios remain extremely high at 440 maternal deaths per 100,000 live births. Table 1 lists selected health indicators for Madagascar.

Table 1: Selected Indicators, Madagascar 2009

	Madagascar
Total population (thousands)	19,625
Life expectancy at birth (years)	65
Adult mortality rate (per 1000 adults 15–59 years)	236
Under-5 mortality rate (per 1000 live births)	58
Maternal mortality ratio (per 100,000 live births)	440
Prevalence of HIV (per 1000 adults 15–49 years)	2
Prevalence of TB (per 100,000 population)	478
Percentage of population vulnerable to malaria (%)	90
All-cause under-5 mortality rate (per 1000 population)	72
Healthy life expectancy at birth (years)	49

Source: WHO, 2009

C. Madagascar's Policies for Community Health

In 2007, the Government launched the Madagascar Action Plan (2007–2012), articulating ambitious health objectives to be accomplished by late 2012, including cutting the infant mortality ratio in half (from 76 to 38 per 1000 live births), the maternal mortality ratio by 40% (from 550 to 330 per 100,000 live births), and the reported number of malaria cases by 75% (UN, 2006). Additional areas of emphasis are TB, sexually transmitted diseases (STDs), and malnutrition in children under five. Specific action plan activities include supporting prevention and surveillance activities, improving patient care and case management, reinforcing existing programs, and implementing a data-for-decision-making system. In response, the Ministry of Health prepared the National Health Sector Strategy and Development Plan, which outlines the necessary interventions—within a logical framework of priorities, activities, and results—to accomplish the action plan objectives (RTI, 2008).

In 2009, the Ministry published the National Community Health Policy to guide the promotion and harmonization of community-based health services by assessing lessons learned from Madagascar's multiple small-scale health initiatives (MOH, 2008; Agarwal et al., 2011). The policy's primary objectives are to increase demand for health-related services, promote their availability, and establish their local delivery. However, the subsequent political crisis, in addition to funding limitations, has prevented implementation at the regional level. Madagascar's 2009 Global Fund National Strategy Application described plans to reach scale with 34,000 CHWs to be trained and equipped to provide rapid diagnostic tests and artemisinin combination therapy (GF, 2012). Estimates suggest that more than 62 nongovernmental and other organizations are supporting CHW programs in Madagascar; they were also involved in the development of the national policy. Additionally, collaboration occurs between those organizations and donors and between those organizations and individual health centers. The Ministry of Health is launching a guide to inform the establishment of best practices for national policies related to community health.

D. Malagasy Community Health Volunteers

Madagascar's Government recognizes CHVs as an effective vehicle for reaching its predominantly rural population. CHVs were trained between 2007 – 2009, with the implementation of CIMCI from 2010. More than 13,000 CHVs are providing health services, many of them trained and supervised by local, international, and faith-based NGOs. USAID/Madagascar implements two large, integrated community-based primary health care projects where CHVs provide family planning, maternal health, and community case management, as well as water, sanitation, and hygiene communications and services.

The tasks CHVs perform are distinguished by training level and category. Level 1 CHVs have been trained to provide basic counseling and health education, while level 2s have had more advanced training, enabling them to also diagnose certain conditions and provide some treatments. For example for family planning, level 1 CHVs offer the standard days method (cycle beads), condoms, and pills and refer for long-acting and permanent methods, whereas level 2 CHVs also provide injectable contraceptives.

After six months of practice at level 1 and upon completing advanced training, level 2s must demonstrate being able to apply the knowledge/skills acquired during that training. They are assessed by supervisors to determine whether they meet expectations. If so, they receive a level 2 certificate. CHVs in either level can focus on one of two categories: An "AC-mère" (translated here as "CHV/mother") provides maternal and reproductive health services; an "AC-enfant" ("CHV/child") focuses on child health care. Each level and category varies in tasks and scope of practice (authorization to practice). Madagascar is seeking to upgrade all CHVs to level 2, so the distinction between these levels may cease. Box 2 illustrates the services provided by CHV/mother and CHV/child in Santénet2-supported programs.

Box 2: Santénet2 (SN2) CHVs

CHV/Mother

Level 1: Promotion of integrated reproductive health (RH) care and family planning (FP)

- Information on FP methods and distribution of oral contraceptives, barrier methods, and standard days method
- Messages on the prevention of sexually transmitted infection, including HIV
- Safe motherhood (antenatal care, intermittent preventive treatment, nutrition)
- Postpartum FP

Level 2: All the services provided under level 1 plus injectible contraceptive Depo-Provera

CHV/Child

Level 1: Promotion of child health services

- Essential nutrition actions
- Growth monitoring and promotion
- Promotion of the Expanded Program on Immunization
- Malaria, diarrhea, and acute respiratory infection prevention

Level 2: All the services provided under level 1 plus community case management of malaria, diarrhea, and acute respiratory infection

Table 2 shows the distribution of CHVs in all 22 regions, separating CHVs supported by USAID SN2 and trained by UNICEF. All regions have CHV programs, but only Androy has both a SN2 program and a Government managed program supporting CHVs (trained by UNICEF).

Table 2: SN2 and UNICEF Data on CHVs, by Region

Region	Population (est. 2004)	Number	
		SN2[1]	UNICEF trained[2]
Diana	485,800	0	0
Sava	805,300	793	0
Itasy	643,000	357	0
Analamanga	2,811,500	608	0
Vakinankaratra	1,589,800	1133	0
Bongolava	326,600	0	0
Sofia	940,800	0	0
Boeny	543,200	235	30
Betsiboka	236,500	0	66
Melaky	175,500	0	
Alaotra-Mangoro	877,700	555	374
Atsinanana	1,117,100	1199	36
Analanjirofo	860,800	870	310
Amoron'I Mania	693,200	704	0
Haute Matsiatra	1,128,900	1057	0
Vatovavy-Fitovinany	1,097,700	1145	0
Atsimo-Atsinanana	621,200	582	95
Ihorombe	189,200	306	0
Menabe	390,800	0	
Atsimo-Andrefana	1,018,500	1080	254
Androy	476,600	981	312
Anosy	544,200	453	0
	17,573,900	**12,058**	**1476**

Sources: [1]Personal communication from Dr. Josoa Samson, Director, Community Health System, SN2, February 2012; [2]UNICEF, 2012.

CHVs are often farmers who devote as much as a third of their day to their CHV work. The MOHFP was, at the time of the evaluation, formalizing a structure to recognize them and strengthen their relationship with public health clinics.

As in other countries with similar socio-economic conditions, Malagasy CHVs encounter numerous challenges. They are often not recognized as legitimate providers, which stems from the wide range of expectations and working in community settings and reduces their visibility to supervisors and their credibility as public health workers in the community's view. Furthermore, they commonly lack formal education or training, which limits opportunities to expand their scope of responsibilities. Stock-outs of essential medicines, together with a lack of supplies and equipment to facilitate diagnosis and treatment, hinder CHV service delivery and, ultimately, credibility. Hence, clients often either forgo care or seek services from a health center—both of which further erode the community's confidence in its CHVs (IntraHealth International, 2012).

E. Purpose of the Assessment

CHVs do not work in isolation and are supported by *programs of support*—defined in this report as an organizational system that includes structures and processes providing operational and technical support to CHVs. Such support is important in enabling CHVs to perform and serve the needs of the community. The U.S. Agency for International Development (USAID) Mission in Madagascar requested an assessment of the functionality, effectiveness, and sustainability of programs supporting Malagasy CHVs to provide primary health care services in rural communities. The main assessment objectives were to:

1. Assess the functionality of CHV programs of support to identify strengths and weaknesses in three regions, and
2. Examine CHV supervisory practices.

Applying both qualitative and quantitative approaches would ensure depth and breadth of understanding. Assessment reports will inform the expansion of CHV networks under the Global Fund National Strategic Application and the USAID-funded Mahefa project implemented by the John Snow Research & Training Institute (JSI, 2011).

This report presents the findings of the qualitative assessment, which was done by the USAID Health Care Improvement Project (HCI), managed by University Research Co., LLC (URC). This component used the Community Health Worker Assessment and Improvement Matrix (CHW AIM) toolkit (Crigler et al., 2011) to assess the *functionality* of these programs at both the organizational and system levels and explored the use of supervisory tools and practices. To date, the CHW AIM has been applied in over 25 instances by a range of stakeholders.

The USAID Global Health Technical Assistance Project (GH Tech), along with the Centers for Disease Control and Prevention and other stakeholders, undertook the *quantitative* assessment, evaluating the *quality* of CHV services by conducting a cross-sectional survey of a probability-based sample of USAID/SN2 and CHVs in UNICEF-supported regions. Although undertaken separately, the quantitative and qualitative studies are complementary. The findings from this report and that of GH Tech will be triangulated and synthesized into a single report that will include recommendations for implementing partners for future activities supporting CHVs in Madagascar. The qualitative assessment focused primarily on SN2 programs of support in three regions, although in one region it included the Government managed program of support for CHVs (trained by UNICEF), not for comparative purposes but to enable the sharing of experiences and lessons learned.

F. Assessed Programs

At the time of the assessment in September 2011, two organizations—the USAID-funded SN2 and UNICEF— supported CHV activities in Madagascar. In both, CHVs did not relate directly to the donor but rather participated in a program managed by an NGO that contracted with the donor or in a program managed by the Government. Sponsorship from the SN2 program consisted of providing training, requiring reports on activities, occasionally sending an organizational supervisor to the CHV's site to try to offer assistance and/or guidance, and having the supervisor conduct a performance evaluation that covered organizational matters (but not clinical skills). Support to CHVs was provided by UNICEF between 2007-2009, mostly comprised of training, with the mainstay of support provided by the public health system.

SN2 contracted 16 implementing partners (three international organizations and 13 local NGOs) to apply the *Kaominina Mendrika Salama* (KMS)—or certified champion communes—approach. KMS empowers communities and makes health services accountable. KMS seeks to strengthen participatory community development by 1) setting up an organizational framework that includes establishing a social development committee (SDC) in each community and 2) building the capacity of community leaders in needs assessment, action planning, and the monitoring of health interventions. SDCs comprise only community leaders who supervise the CHV from the community's standpoint, specifically with respect to awareness raising, demand promotion, and stimulation activities.

1. Santénet2

SN2 (2008–2013) is a five-year program implemented by RTI International. Activities focus on strengthening community-level health services (Box 2) in selected geographic areas to achieve the health goals set by the Malagasy Government. In collaboration with 16 implementing partners, SN2 targets 800 *Kaominina Mendrika (KM),* or champion communes, in 16 regions (of 22), covering about two-thirds of the country.

SN2 is a major component of USAID's fourth phase of assistance to the health sector in Madagascar under Strategic Objective 5, which includes:

- Improving child survival, health, and nutrition;
- Reducing unintended pregnancy and improving healthy reproductive behavior;
- Preventing and controlling infectious diseases of major importance; and
- Reducing the transmission and impact of HIV/AIDS (RTI, 2008).

Box 3: Santénet2's Key Roles

- Enhancing CHV service delivery in communities more than five kilometers from a health center (RTI, 2008};
- Supporting more than 12,000 CHVs who provide information and services in maternal, newborn, and child health (MNCH); nutrition; FP and RH; malaria; STDs/HIV/AIDS; and water, sanitation and hygiene (WASH);
- Empowering female adolescents and young women (ages 15–24) to become pro-active managers of their health to improve health outcomes over time (RTI, 2008);
- Expanding the demand for and use of community health services through health promotion and information and education campaigns;
- Improving CHV training while fostering stronger linkages among stakeholders and community supply chains for essential medicines and supplies; and
- Promoting the adoption of more frequent supervisory visits to CHV work sites (RTI, 2008).

SN2 employs a conceptual framework consisting of three components: 1) developing and strengthening key aspects of the community health system; 2) empowering community participation and accountability in setting and achieving community health goals; and 3) linking the two previous components to have a greater impact in reducing maternal, child, and infant mortality, the fertility rate, chronic malnutrition in

children under five, and malaria prevalence. SN2 also seeks to expand access to water, sanitation and hygiene and works to maintain a low HIV prevalence rate.

SN2 coordinates with district health authorities only to share information (not to collaborate, such as to jointly supervise CHVs), so it added "independent supervisors" to the supervisory system, which avails health center- or health post-based (HCB) doctors who are part of the national public health system (personal communication from a key informant) and SDC members. One challenge is the lack of coordination between SN2 and district health facilities.

Of the 12,058 (2,008 Level 1 and 10,050 Level 2) CHVs working in the SN2 program, over half of level 2 CHVs were based in the three assessed regions (Table 3).

Table 3: Number of SN2 Level 2 CHVs by Region, NGO, and Type (Mother/Infant)

Region	NGO	Level 2 CHV (Mother)	Level 2 CHV (Infant)	TOTAL
Atsinanana	CRS	138	128	266
	CARE	158	143	301
	ODDIT	53	218	271
	MSIS	46	45	91
Analamanga	AIM	424	421	845
	SN2	25	25	50
Androy	ASOS	319	358	677
	CRS	222	228	450
Total		**1385**	**1566**	**2951**

Note: CRS stands for Catholic Relief Services; CARE for Cooperative for Assistance and Relief Everywhere; ODDIT for Diocesan Organization for the Development of Toamasina; MSIS for Multi-Service Information Systems; AIM for Intercooperation Association Madagascar; and ASOS for Action Socio Sanitaire et Organisation Secours.

At the time of the evaluation, SN2 was preparing to phase out its CHV program by July 2013. Its quarterly evaluation of NGO CHV programs reviewed program implementation and community commitment in general terms. SN2 provides feedback to CHVs on their performance during monthly activity review meetings when community representatives and supervisors are present.

2. UNICEF's CIMCI Program

UNICEF Madagascar operates within the overall framework of its Maternal/Child Survival and Development program and focuses on CHV activities related to child health, hygiene, and nutrition (Box 3). It promotes CHVs as a cost-effective way to improve the health outcomes of those would otherwise lack access to treatment.

Box 4: UNICEF's Key Roles

- Scaling-up the Community Integrated Management of Childhood Illness (CIMCI) initiative in 26 out of 111 districts, covering 252,800 people (UNICEF, 2012.). This community-based approach, first launched by WHO and UNICEF in 1995, addresses common health issues that afflict children under five by focusing on health promotion, illness prevention, and community case management, with particular emphasis on the most common childhood illnesses.
- Supporting CHVs to educate people about the importance of screening mechanisms for early detection of malnutrition. UNICEF worked with partner organizations to screen 260,000 children in southern Madagascar in 2011, while also launching a campaign there to distribute supplementary food to help prevent malnutrition (UNICEF, 2012).
- Strengthening the relationship between health services and communities and improve selected family practices (Agarwal et al., 2011).
- Training CHVs on CIMCI.
- Training CHV supervisors on CIMCI in health centers.
- Encouraging CHV supervision.

UNICEF launched CIMCI training for CHVs in Androy in 2009, on a request from the local NGO Action Socio Sanitaire et Organisation Secours (ASOS), when the region experienced a nutrition emergency. The first phase of training was a pilot and targeted 12 of 19 communes. Key informants reported that selecting CHVs was a challenge that year as it was difficult to find capable people among the poorly educated population, so only one CHV per village was trained. UNICEF financed the training and initial stock of equipment and supplies, such as management tools and medicines, and contracted ASOS for six months to implement the pilot phase.

The pilot phase experienced problems due to lack of coordination between the NGO and the health system. The health center managers were not involved in this stage of CHV training, which negatively affected their supervision. Rather, the NGO ASOS provided support to the MOH on implementing the pilot phase of the c-IMCI program, and the NGO team and health center managers worked together on training the CHVS and on monitoring the program. Regular supervision visits were planned for every six weeks but did not materialize in 2009. In 2010, health center managers were trained in CIMCI and started to supervise the CHVs. UNICEF is not responsible for providing a program of support to CHVs in Androy and was mainly responsible for the initial training of trainers, equipment and supplies in the first six months.

Difficulties related to coordination between the NGO and the health system were observed during the pilot phase of the program. While the objective was for supervisory visits to be held every six weeks, this was not realized in 2009. In 2010, health center managers were trained in CIMCI and began supervising the CHVs. UNICEF was primarily responsible for providing initial training, equipment and supplies during the first six months of the program. At the time of the assessment, regular stock-outs of medicines and other materials were of concern.

CHVs received medicines directly from the health centers via Population Services International through GFATM Round 7 funding. The district-level person in charge of CHVs reported a total stock-out of medication since January 2010 but did not mention attempts by the district to request supplies.

The district health teams said that they could not follow up with the CHVs due to lack of transportation and funds. Lacking funds to specifically do so, the teams visited health center managers quarterly—while conducting other programs' field activities when possible—and asked managers how they worked with the CHVs.

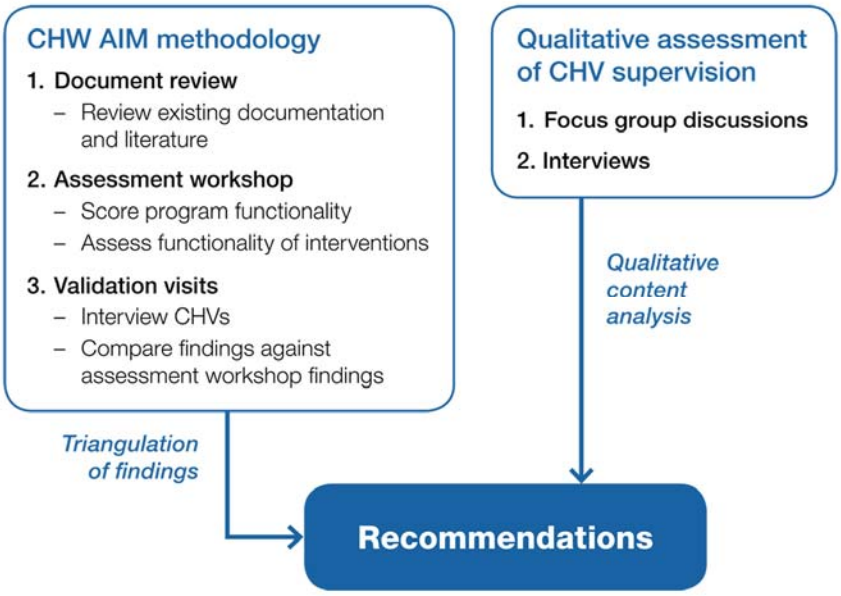
The National Strategy Application (NSA) is a program that is funded by the 9th Round of the GFATM to support the implementation of the National Strategic Plan against malaria. NSA funds were also allocated to support the scale up of CIMCI and to strengthen support to CHVs through supervision and refresher training. The CHV programs of support and interventions had not yet been supported with NSA funds at the time of this assessment.

II. METHODOLOGY

As noted, the objectives of this assessment were to examine 1) the functionality of programs supporting CHVs in Madagascar in three regions and 2) CHV supervisory practices. The assessment looked at SN2 programs of support in all three regions and support for UNICEF-trained CHVs in one. Both were assessed in September 2011 not for comparative purposes, but rather to facilitate the sharing of experiences and lessons learned. To assess Madagascar's CHV programs qualitatively, the assessment applied two approaches (Figure 1):

1. The CHW AIM methodology, which assessed program functionality, and
2. Focus group discussions (FGDs) and semi-structured interviews, which explored supervision practices.

Figure 1: Overview of Assessment Methodology



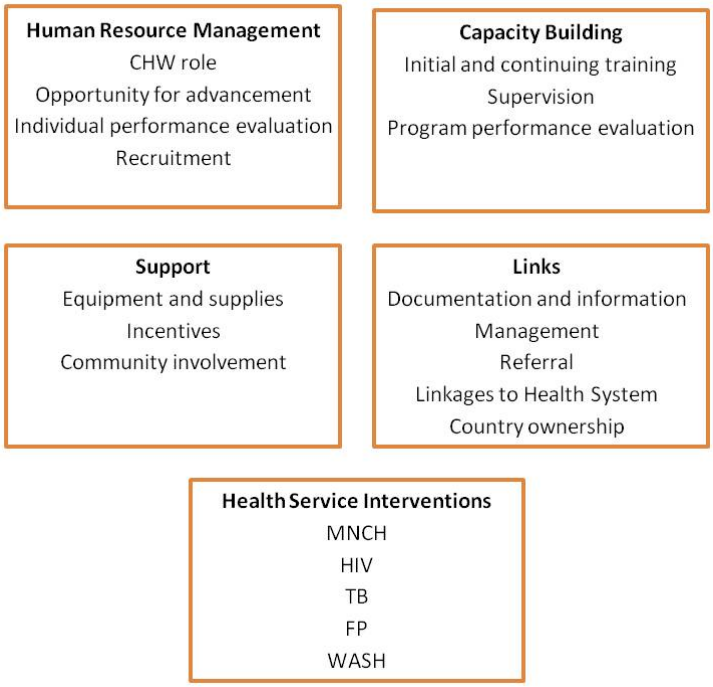
A. The CHW AIM Methodology

HCI developed the CHW AIM toolkit (Crigler et al., 2011) to help organizations 1) assess the functionality of their CHW programs and 2) improve program performance. It has been applied in 25 countries by a wide range of organizations to assess and improve CHW programs. The CHW AIM methodology has three main steps: 1) document review, 2) assessment workshop, and 3) validation visits.

The methodology guides stakeholders through a participatory self-assessment ("self" because stakeholders have an interest in the program they assess) to rate the functionality of 15 support elements, or "components"—such as recruitment, training, and incentives—that are needed for a CHW program to function effectively (Figure 2, components are defined in Appendix 1). These components were identified through a systematic review of literature and subsequent field-tests in multiple country settings. The CHW AIM toolkit also includes checklists of health *interventions* (i.e., services) in MNCH, HIV/AIDS, and TB care (Crigler et al., 2011, pp III-1–7 for MNCH interventions). These checklists help stakeholders assess the functionality of services delivered by CHWs and were adapted to the Malagasy context in an August 2011 stakeholder workshop. Appendix 2 provides the interventions used in Madagascar: those for MNCH (from the toolkit) and those for FP and WASH, which were developed for this assessment.

Preparations leading up to the assessment include the adaptation of the service intervention checklists to the country context and training local facilitators to implement the CHW AIM process. HCI conducted a training workshop in Madagascar (September 12–13, 2011) to build the capacity of 10 in-country participants to apply the CHW AIM methodology, including six regional experts and four representatives of key partner organizations.

Figure 2: CHW Program Components in the CHW AIM Toolkit



1. Document review

The assessment began with a review of documents by the assessment team to gather the necessary background information on how the program is organized and managed. This review is guided by a standardized, structured questionnaire (Crigler et al., 2011, pp VI-2–4), and its results help the assessment team lead the assessment workshop with targeted information. Where documentation is not available, key informants are sometimes asked for details. In Madagascar two programs in two regions lacked the required documentation: the Catholic Relief Services (CRS) program in Atsinanana (an SN2 implementing partner) and the program of support for UNICEF-trained CHVs in Androy.

2. Assessment workshop

This workshop engages a diverse group of stakeholders in discussing and assessing the functionality of CHV program components (recruitment, training, etc.) and interventions provided by CHVs (in MNCH, etc.). The participatory process asks that stakeholders first examine, individually (although they are in a group setting) their own experience with their program to rate functionality, and then come to consensus as a group. The group then identifies gaps in functionality and discusses possible steps for improvement.

Scoring CHV program functionality

During the workshop, stakeholders use a matrix that includes the definition of each component and four levels of functionality criteria: Non-functional (score of 0), partially functional (score of 1), functional (score of 2), or a best practice (score of 3). The criteria used at each level for each component describe situations commonly seen in CHW programs and provide enough detail for stakeholders to rate the component/intervention from their perspective (see Appendix 1).

Facilitators can use a plenary session to discuss each component in depth before asking individuals to score them. Sometime break-out sessions are used if the group is too large or more than one program is assessed. Once individuals have individually scored all components, they return to the plenary to seek

consensus on scores through group discussion and experience sharing. To be considered functional, each component must be rated at least a 2 (functional), giving a minimum cumulative score of 30.

Assessing functionality of interventions provided by CHVs

Once the program components are scored and consensus is achieved, stakeholders turn to the lists of interventions (see Appendix 2), devoting the second part of the workshop to scoring them. Working as a group, stakeholders score Interventions according to the expected CHV tasks—if they agree that the expected tasks are carried out, the intervention is considered functional.

Box 5: Managing Multi-program Assessments

The CHW AIM methodology suggests that one program of support be assessed per workshop but is sufficiently flexible to enable multi-program assessments through program-specific break-out groups. For this assessment, consensus among NGOs supported by a common source of support was facilitated but not forced where differences were identified. The following described the management of the assessments three regional workshops.

- In Analamanga (SN2), the assessment workshop focused on one program of support managed by one NGO. Consensus was facilitated.
- In Atsinanana (SN2), four NGOs manage CHV programs of support, so participants split into NGO-specific groups in scoring functionality.
- In Androy (SN2 and UNICEF), participants split into three groups: two SN2-funded NGOs and one group for UNICEF-trained and Government supported CHVs.

The interventions listed in the CHW AIM toolkit are considered high-impact, evidence-based interventions, and were developed by technical experts, USAID working groups, and other key stakeholders before testing in multiple countries. They are not intended to define what each CHW program *should* deliver as one package of services, rather they are intended as a menu of services that CHVs *could* provide. A pre-assessment stakeholder meeting (on August 4, 2011, in Antananarivo) reviewed these lists and made modifications to better align them with the tasks Malagasy CHVs were expected to perform and to ensure complementarity with the quantitative survey questions. For this assessment the MNCH, FP, and WASH intervention lists were used for the SN2 programs of support, and the MNCH interventions were used for the UNICEF-trained CHVs, in alignment with the nationally defined package.

In intervention-specific break-out groups, the workshop participants discussed whether their CHV program provided the expected services/activity/sub-activity and whether the activity included counseling, service provision, or referral (Box 6). The methodology allows stakeholders to pre-select services approved as part of the CHW role (as in the August 2011 workshop), or, if services are listed that are not part of the CHW role, they can be marked as "not applicable." This exercise does not assess the quality of the services provided, only whether each is provided.

Box 6: Example of an Antenatal Care Intervention

Within MNCH, antenatal care (ANC) includes five possible activities (according to the CHW AIM toolkit [Crigler et al., 2011, p III-1]), the first of which is anticipatory counseling (Appendix 2, first intervention listed). In anticipatory counseling, a CHV would be expected to counsel in two areas: birth and complication preparedness and newborn care. This activity would be considered complete and therefore functional if the CHW counsels in both areas. It is not expected that the CHV would necessarily provide other MNCH services unless they had been defined as part of her role.

3. Validation visits

To validate the scores from the workshop and learn more about implementation, the methodology calls for visits to communities for semi-structured interviews with up to three CHVs who did not attend the

workshop (Appendix 3). Based on these interviews, the workshop scores and recommendations might be revised. In Madagascar, validation visits in each region were conducted in two communities, and interviews were conducted with two CHVs in every community.

4. Follow-up

While the CHW AIM methodology has three *main* steps (document review, assessment workshop, and validation visits), there is also a fourth, which was applied as part of this assessment. The fourth step provides that during the assessment workshop, stakeholders engage in discussions about the strengths and weaknesses of their program and begin to develop an action plan for improvement as a follow-up to the workshop. Action plans started during assessment workshops are further informed by the validation visits, and complete action plans include suggested ways to monitor implementation and a plan for periodic progress review. For this assessment, suggestions were gathered from all workshop participants to inform further discussion and planning by key stakeholders.

B. Qualitative Assessment of CHV Supervision

The USAID Mission in Madagascar asked HCI to examine CHV supervision beyond the scope of the CHW AIM toolkit. Key stakeholders provided input to determine the aspects of supervision—pertinence, usefulness, strengths, and weaknesses—that should be explored and agreed on. Their comments informed the development of the interview and FGD guide and recommended targeting CHVs, supervisors, and communities (Appendix 4).

C. Sampling

1. Selecting regions

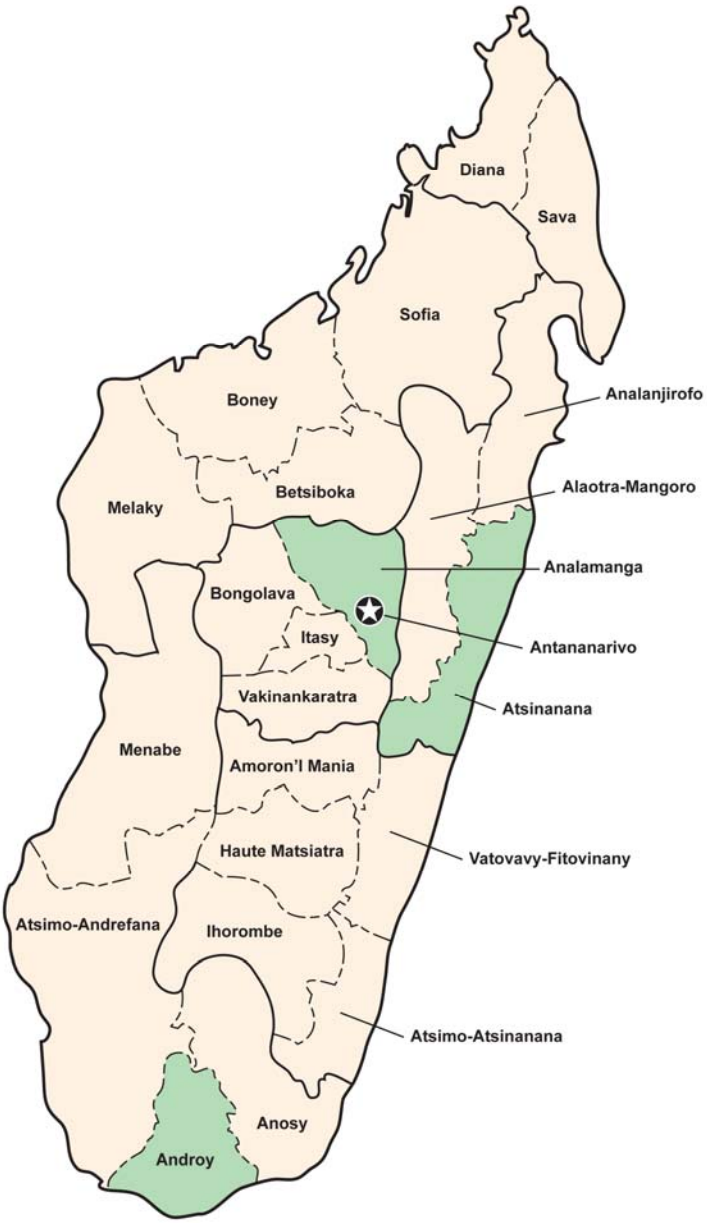
The three regions are shown in Figure 3. Selecting regions was closely coordinated with the team conducting the quantitative assessment to ensure comparability of findings. Brief descriptions of the regions follow.

Analamanga is in the center of Madagascar and surrounds the capital. Its population is 2.65 million. It is divided into eight districts and 132 communes. In this region, Association Intercooperation Madagascar (AIM) was the only NGO implementing the SN2 program.

Atsinanana is a rural region on the east-coast. Its population was estimated as 1.12 million in 2004. It is divided into seven districts. The four NGOs that implemented the SN2 program here were CRS, Cooperative for Assistance and Relief Everywhere (CARE), Multi-Service Information Systems (MSIS), and Diocesan Organization for the Development of Toamasina (ODDIT), each having a distinct organization and structure to support the same CHV services.

Androy is in the south and characterized by chronic food insecurity, poverty, a low educational level, lack of access to water, lack of food, and malnutrition. It is divided into four districts, 51 communes, and 881 *fokontany* (villages). Both a SN2 and a program of support for UNICEF-trained CHVs were included in the assessment for the purposes of sharing experiences and lessons learned among participants, and not for comparative purposes. UNICEF was one of the first organizations to pilot CHV programs in Androy, so the spread of its reach, in terms of the number of CHVs it had engaged, was extensive.

Figure 3: Qualitative Assessment Regions in Madagascar



2. Selecting communes

For each region, the assessment team selected a number of communes to ensure 1) broad coverage of communities and participants and 2) that those who participated in the workshop did not participate in the validation visits. Some of these communities were also the sites for interviews with community representatives for the supervision research. Table 4 shows the geographic distribution of assessment activities, covering 12 localities.

Table 4: Geographic Distribution of Assessment Activities

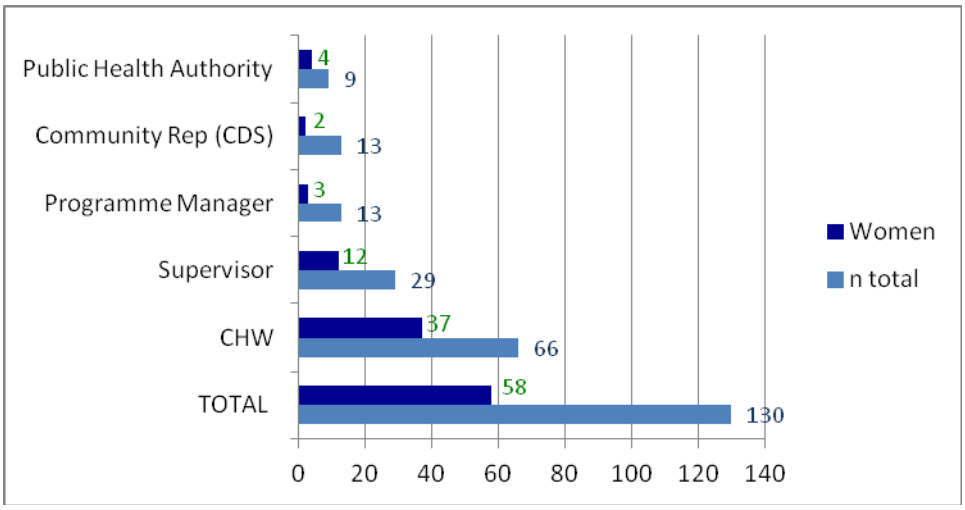
Activity	Locality: Region and commune/village		
	Analamanga	**Atsinanana**	**Androy**
CHW AIM			
Workshop	Antananarivo	Mahanoro	Ambovombe
Validation visit 1	Anjeva Gare	Sosobahy/ Ampasimadinika	Ambanisarika
Validation visit 2	Ambanitsena	Tsarasambo	Tsimananada
Supervision			
FGDs with CHVs & Supervisors	Merimandroso	Vatomandry	Ambovombe
Interview SDC 1	Anjeva Gare	Sosobahy/ Ampasimadinika	Ambanisarika & Ambovombe
Interview SDC 2	Ambanitsena	Tsarasambo	Not applicable

3. Selecting participants

Workshop participants were carefully selected so the workshop would reflect a balanced representation of all program staff groups (managers, supervisors, and CHWs) and other key stakeholders involved in CHW activities (health and other public authorities at the district and regional levels and representatives of partner and donor organizations).

Just under half (45%) the participants were female (Figure 4). While the figure shows that overall fewer than half the supervisors were female, substantially more than half were in Analamanga.

Figure 4: Participants by Category and Gender (n = Number of Participants)



For ethical reasons, involving CHVs required considering the implications for their clients, as pulling CHVs from work reduced clients' access to health services.

To select participants, the following criteria were applied:

- Participants should represent several districts in each region.
- CHV participants should include both CHV/mother and CHV/child at level 2, who were thought to be better equipped to use and critique the methodology than were CHVs as level 1.
- Other workshop participants should represent all staff levels of the program and relevant stakeholders; we invited different categories of program staff according to profession, function, and

hierarchical level as well as representatives of public health authorities and key CHV program stakeholders.

- CHVs interviewed during validation visits should not be the same as those who participated in the workshop.
- FGD and interview participants for the supervision component should not be the same as those who participated in CHW AIM assessment activities.

Furthermore, as part of KMS, the community appoints two individuals to monitor the implementation of KMS activities. Among community members, they are the best informed about KMS activities, so the assessment approached and interviewed them as community representatives during validation visits. Other community representatives were also selected, according to their role and function. For example, in the SN2 program, the community is involved in supervising CHVs through an SDC. Within this 15-member committee, members are responsible for social quality issues, including all issues concerning CHVs. Semi-structured interviews were conducted with SDC members in each SN2-supported region.

For the supervision assessment, three groups were selected: CHVs, supervisors, and community representatives involved in supervision. The supervisors (district officials) had been invited while all other participants were selected on the basis of their not having participated in the CHW AIM application. This selection criterion would ensure that the supervision discussions were not influenced by the CHW AIM discussions. Level 2 CHVs were selected from the locality's highest and lowest performing CHVs, and the medical inspector responsible for health services in the district and NGO representatives also participated. The assessment's 130 participants are described in Table 5.

Table 5: Assessment Participants by Activity, Region, and Category

Activity	**Participants**			
	Analamanga	Atsinanana	Androy	TOTAL
CHW AIM Workshop & validation visits	**19**	**28**	**28**	**75**
Assessment workshop	15	24	24	63
Workshop participants by category				
CHV	*7*	*8*	*12*	*27*
Supervisor (HCB & TA)	*5*	*6*	*3*	*14*
NGO program manager	*2*	*5*	*6*	*13*
Regional/district public health authority	*1*	*5*	*3*	*9*
CHW validation visits	4	4	4	12
Supervision: FGDs & interviews	**19**	**19**	**17**	**55**
Supervision participants by category				
CHV	*10*	*8*	*9*	*27*
Supervisor (HCB & TA)	*5*	*7*	*3*	*15*
Community representative (SDC)	*4*	*4*	*5*	*13*
TOTAL	**38**	**47**	**45**	**130**

Note: TA stands for an NGO's technical assistant, who supervises CHVs from the NGO's standpoint; SN2 programs of support have TAs but not UNICEF-supported activities.

D. Data Collection

Qualitative assessment activities were conducted from September 14 to October 2, 2011. The core assessment team comprised an international technical consultant and a local coordinator. In each region a team of two regional experts supported local preparatory activities, including liaising with CHV program managers and reviewing documents; they also assisted in facilitating the workshop, FGDs, and interviews and in documenting the assessment results. No discussions were audio-recorded due to logistical and budgetary constraints. Notes were taken at each point of data collection.

The assessment team's working languages were French and Malagasy. All activities involving participants and stakeholders were conducted in Malagasy, except in Androy, where local facilitators communicated in the local dialect (Antandroy). Some tools (functionality and intervention lists, functionality scoring and documentation sheet, and FGD and interview guides) were translated from French into Malagasy. The document review guide was translated into French.

Workshop and most FGD and interview notes were recorded in Malagasy and translated into French. FGDs and interviews were conducted in Malagasy, and notes from both were summarized in French. Table 6 shows data collection activities by component and region.

Table 6: Data Collection Activities by Component and Region

	Activity	Analamanga	Atsinanana	Androy	**TOTAL**
CHW AIM	Workshop	1	1	1	**3**
	Validation visits: semi-structured individual interviews with CHVs	4	4	4	**12**
Supervision	FGDs with CHVs	1	1	1	**3**
	FGDs with supervisors	1	1	1	**3**
	Semi-structured interview with supervisor for UNICEF-trained CHVs	Not applicable	Not applicable	1	**1**
	Semi-structured interviews with SDC members	2	2	1	**5**

1. Workshop

Each workshop included break-out sessions to score the functionality of components and interventions; each break-out group selected a rapporteur to take notes and report to the plenary. Recommendations for action were discussed in plenary and recorded separately by program.

2. Validation visits

Field visits were undertaken in two communities in each region and included:

1. Relative to CHW AIM: Two regional experts each interviewed one CHV and a CHV-mother or CHV-child (these CHVs had not participated in the workshop).
2. Relative to supervision: The national coordinator and international expert used the questionnaire guide to conduct semi-structured interviews with the two relevant SDC members.

Only one supervisor in Androy supporting UNICEF-trained CHVs was interviewed. No community representatives were interviewed during the visits to UNICEF-trained CHVs.

The information and data were collected during the assessment activities and recorded in different ways.

3. CHW AIM methodology

Information from the document review (by regional experts) was noted on a detailed questionnaire guiding the review (Crigler et al., 2011, pp VI-2–4). The regional experts asked the NGOs for documents and tried to answer questions based on the questionnaire. They could not obtain copies of the original documents in Malagasy.

Functionality scores and their justification, plus recommendations for action items were recorded by the rapporteurs, who noted the final scores and justifications on a specific sheet (Crigler et al., 2011, pp VI-9–10). Workshop participants reviewed and noted the scope of CHV MNCH service provision on copies of the intervention lists. The regional experts who conducted validation visit interviews with CHVs used an interview guide from the toolkit (Crigler et al., 2011, pp VI-5–8 and Appendix 3). They noted information directly on the guide.

The results were reviewed by the regional teams, respectively. The final review and summary were done by the international technical consultant based on the translated materials.

4. Supervision component

FGDs and semi-structured interviews were the main means of exploring the perceptions, views, and recommendations of program managers, CHVs, and supervisors. Three FGDs were held with each of these target groups. Group size ranged from five to 10 participants. FGDs were conducted with each target group separately because 1) in separate groups the questions could be better aligned with the roles of the program's CHVs and functions of those programs and 2) group discussions among colleagues facilitate open exchange of views and opinions. Five interviews were held with SDC members in the three regions.

The assessment developed discussion guides for each group to address participants' specific situations in terms of their roles and functions (Appendix 4). For each target group the same question guides were used in all regions. Some questions overlapped with workshop topics, enabling validation.

Regional experts used the discussion guides to conduct the FGDs and interviews, which typically lasted 60–100 minutes. Notes were taken by a member of the assessment team and were reviewed and consolidated in Malagasy before being summarized in French.

E. Analysis

Assessment information was compiled and triangulated in accordance with the CHW AIM methodology. All information from the FGD and interview summaries was analyzed using qualitative content analysis to extract, identify, and structure major topics and statements. The considerable information was structured along pre-determined themes.

III. RESULTS

A. CHW AIM Outcomes

This section presents the results of applying the CHW AIM methodology and conducting the supervision research in the three regions; the application involved seven NGOs implementing the KMS approach under the auspices of USAID SN2 project plus the Government managed program for UNICEF-trained CHVs in Androy. This section describes program functionality by region to provide context-specific information with a view toward follow-up action planning. The results of the Androy programs are described separately.

Workshop participants reported commonalities as well as differences among the CHV programs, some of them due to differences 1) in regional socio-economic conditions and/or 2) among the NGOs.

1. Analamanga

Program functionality

Participants in the Analamanga workshop gave the SN2 program 34 points (out of a maximum of 45). They judged it as being a best practice in five of the 15 components, functional in nine, and partially functional in one. Since one component was scored as partially functional, the entire program was only partially functional, in accordance with guidance in the CHW AIM toolkit. Findings are summarized in Table 7.

Table 7: Analamanga Program Functionality Scores

CHV program component	Rationale for component scoring and comments on documentation and from validation visits
3. Best practice	
Recruitment	CHVs were chosen from the communities with community involvement. Clear recruitment criteria were applied. Supported by documentation.
Community involvement	Communities actively supported CHVs. Supported by documentation.
Opportunities for advancement	Participants felt opportunities for advancement were provided to well-performing and interested CHVs. No documentation found.
Documentation and information management	CHVs and communities worked with the supervisor to use data to solve problems at the community level as well as to undertake action planning. Supported by documentation.
Program performance evaluation	In each community, two SDC members were responsible for evaluating and guiding CHV activities. They met regularly, usually biannually, with CHVs and NGO representatives, to evaluate the program. No documentation found.
2. Functional	
CHV role	Participants reported that while CHVs understood the CHV role, the community, health center staff, and those at the district level sometimes had expectations that exceeded that role and CHV capacity. Community supervisors confirmed this during FGDs, saying the population and CHVs sometimes experienced conflicts when people's expectations exceeded the CHV's scope of work. Some supervisors reported that they had to repeatedly inform community members that CHVs were not doctors or nurses and therefore could deliver only limited services. The Community Health Policy provides a general framework to guide the implementation of community health programs and an outline of the areas of CHV work but does not articulate CHW roles and tasks.
Initial training	Participants reported that the public health system was not involved in initial or continuing training and that some CHVs had had to wait more than six months after initial training for additional courses.
Continuing training	
Supervision	Participants saw supervision as well done, but the lack of visits by supervisors to the community limited supervision's effectiveness.
Individual performance appraisal	Supervisors biannually performed structured, individual performance appraisals, but no rewards were given for good performance. Documentation indicated that communities were not involved in these evaluations.
Incentives	Financial incentives were limited to revenues from selling health products and per diems during trainings and supervision events. Nonfinancial incentives included the training itself; certificates; and such materials as uniforms, backpacks, and raincoats.
Referral system	The referral system was seen as well organized and functioning, but CHVs said they received no feedback from the referral sites even though the documentation showed that a referral sheet required the physician to record appropriate patient information and return the sheet to the CHV.
Linkages to health system	Participants acknowledged that there was a lack of integration in the use of data. Other factors, such as informal exchange of information and/or materials from the system to the CHVs, may have influenced this score, but further information was not recorded.
Country ownership	The assessment observed that no national budget was allocated to CHV programs. A community representative said that they did not understand why the budget for health activities was not assigned such that the community alone could manage those resources. The representative's understanding may have been mistaken, since no documentation could be found indicating that any funds flowed from the national budget to CHV efforts. That is, no line item for CHV programs was in the national health budget.
1. Partially functional	
Equipment and supplies	The availability of materials and equipment was deemed satisfactory, but medicine stock-outs were common: Participants reported regular stock-outs of essential materials (particularly report forms) lasting more than a month, two or three times a year.

Intervention lists

All interventions/services provided by Analamanga CHVs were functional, with the exception of one activity on the WASH list.

MNCH intervention list

CHV services covered all services on the MNCH intervention table (Appendix 2) except birth care. With regard to malaria prevention, the assessment found that insecticide-treated nets were out of stock at the regional level, so CHVs could not perform tasks related to nets.

FP intervention list

All tasks on the FP list were determined to be done except FP counseling for men.

WASH intervention list

Promotion of household-level hygiene, sanitation, and clean water handling was a CHV focus. All activities suggested as essential by the checklist were offered, except for the installation and cleaning of water storage tanks.

Community-level WASH promotion was fully undertaken by CHVs with the exception of participation in international activities, such as World Day of Water, which workshop participants and interviewed stakeholders considered part of the CHW role. No explanation was given for this shortcoming.

Participant recommendations

Workshop participants recommended greater involvement by the public health system at local and district levels: 1) in CHV selection, training, and activities; 2) in health expenditures at the community level; and 3) in sustaining community health activities.

They also recommended that community health representatives of the Committee on Safety, a community structure that pre-dated the SDC, discuss how to motivate CHVs.

Concerning the interruptions in supplies, participants called for more efforts to ensure their continuous provision and availability.

2. Atsinanana

Functionality

This region's four NGOs worked in separate break-out groups to score their programs and settled on high scores for functionality in a narrow range: CARE scored 39 points; CRS had 41; MSIS had 39; and ODDIT had 39. Eight of the program components were scored as best practices. Three of the four programs were rated as functional by all four NGOs. ODDIT scored one component (individual performance appraisal) as partially functional, rendering its overall program partially functional. Table 8 summarizes the findings for components where consensus on scoring was reached across all four NGOs.

Table 8: Atsinanana Program Functionality Scores: Components with Consensus across Programs

CHV program component	Rationale for component scoring and comments on documentation and from validation visits
3. Best practice	
Recruitment	All four groups saw their recruitment component as a best practice because the communities participated in the selection of CHVs; defined selection criteria were respected; and the selection of CHVs was officially recognized and supported by SDC members and HCB supervisor-doctors.
CHV role	The CHV role was reportedly understood by CHVs and communities, although some weakness was noted in communication between the population and CHVs. Documentation showed that one NGO had written job descriptions for CHVs.
Continuing training	Participants considered the monthly, community-level review meetings as a best practice for continuing training as they fostered feedback from HCB doctor-supervisors and community representatives to CHVs.
Community involvement	Community involvement was rated a best practice for three reasons. SDC members facilitated community involvement; during visits in the villages and at the health centers, SDCs liaised with the population and encouraged collaboration with CHVs; and the validation visits to this region found that both communities had build huts to serve as offices where the CHVs could see patients.
Referral system	It was considered a best practice that the health centers gave feedback on patient care to CHVs, enabling patient follow-up. However, this may not be the case everywhere in the region: In some discussions, participants reported the lack of such feedback.
Opportunities for advancement	The possibility of advancing from CHV level 1 to 2 rendered opportunities for advancement a best practice; also other forms of continuing education were reported.
Documentation and information management	The workshop notes on documentation and information management offer no justification for the high score given to this component; perhaps no comments were offered simply because participants were fully satisfied with its functionality.
Program performance evaluation	Program performance evaluation was seen as a best practice for having clear indicators (e.g., monitoring the weight of children) for measuring achievements. However, such indicators existed only at the program level, not at the CHV performance level, and none existed for FP activities.
2. Functional	
Supervision	The local HCB supervisor-doctor supervised clinical aspects, the NGO TA supervised logistics, and the SDC members supervised community relations. However, the consensus score for this component was downgraded from a best practice to functional after validation due to the lack of home visits that would have allowed supervisors to observe CHVs practicing. Also, the NGO TA and HCB supervisors were reported to not have contact with the community.
Incentives	Incentives were reported to be limited to financial gain from selling medications and per diems. NGOs differed regarding rewards from the community: Some noted their absence while others reported little gifts. Documentation indicated that incentives were not performance based and that the MOHFP provided no financial support.
Linkages to health system	Linkages to the health system were considered functional (e.g., through referrals, the use of data, and supervision) but limited due to the lack of material support for CHV activities. One NGO noted that the health center helped by providing medications when stock-outs occurred at the community or NGO level.
Country ownership	Country ownership was judged functional thanks to the national CHV program policy. The main criticism in this component was the lack of Government financing.

Differences among Atsinanana programs

The third column in Table 9 highlights the differences in the functionality of CHV programs where consensus was not reached.

Table 9: Atisanana Functionality Scores: Components with Differences among Programs

Functionality level	Consensus across all programs	Differences among programs
3: Best practice	Recruitment CHV role Continuing training Community involvement Referral system Opportunities of advancement Documentation and information management Program performance evaluation	Initial training: CRS, ODDIT Equipment and supplies: CRS, MSIS, ODDIT Individual performance appraisal: CARE, CRS
2: Functional	Supervision Incentives Linkages to health systems Country ownership	Initial training: CARE, MSIS Equipment and supplies: CARE Individual performance appraisal: MSIS
1: Partially functional	Not applicable	Individual performance appraisal: ODDIT
0: Non-functional	Not applicable	Not applicable

Note: The column headed "Differences among Programs" lists the programs that received the score indicated in the first column. For example, CRS and ODDIT scored a best practice in initial training, but CARE and MSIS did not (they are indicated as having scored at the functional level).

Two NGOs considered initial training as functional rather than a best practice (earned by the other two NGOs) (column three, Table 9) because training was physically conducted outside the community and with no community involvement.

In regards to Santenet2, communities selected the CHV candidates. Training was conducted based on training curricula and tools compliant with national and international guidelines and standards. Qualified trainers were mobilized to ensure training. Communities did not have a role in training CHWs, because they do not have the authority to participate in technical program training.

With regard to equipment and supplies, three organizations gave their programs best practice scores, while one gave it a functional rating: Some of these programs received support from the health centers for stock-outs.

ODDIT rated its individual performance component as only partially functional due to the lack of rewards for good performance.

Intervention lists

All NGOs reviewed the intervention lists: The services were the same for all NGOs and all three areas were judged functional.

<u>MNCH intervention list</u>

CHVs provided all tasks under childbirth care within their scope of practice. Under postnatal care, CHVs did not provide special care for the low birth weight infant. Further, they did not provide two postpartum FP methods (education on the lactational amenorrhea method and permanent methods).

<u>FP intervention list</u>

Participants noted limits in the scope of interventions for the two-day contraceptive method. Further, specific FP services for youth and men were not assigned, and CHV provided no FP activities in health centers. While it was most common for CHVs to provide services either in their own homes or those of their clients, they would also accompany patients to the health centers as needed.

Key informants noted that CRS excluded certain contraceptives, such as condoms, from its services due to religious beliefs but did not indicate whether CRS CHVs observed this restriction.

WASH intervention list

Limitations in the scope of WASH interventions included: 1) no fixed dates or times for follow-up visits were arranged with households; 2) the improvement, maintenance, and cleaning of community water and storage tanks were not part of the CHV tasks.

Participant recommendations

Participants offered several suggestions for improvement. They recommended improving communications between CHVs and the population, for example through more and repeated explanations of the nature and scope of CHV services. They also said initial training should occur in and involve the community. Supervisors should regularly accompany CHVs on home visits, they said. They suggested rewards for those who work hard and achieve the set objectives. For motivating CHVs, they said that community awareness should be raised of the importance of CHVs work so that the villagers would acknowledge and respect these volunteers. They saw improving the referral system through good coordination with the health authorities as necessary and recommended a strategy for emergency transfers. To enhance information management, participants urged organizing discussions with villagers to provide information on the achievements and results of CHV activities. For better health system involvement, participants suggested that the health centers provide materials and supplies. CHVs were believed to work in collaboration with the public health system, so the national community health policy should be implemented, including sufficient resources for CHV programs. Lastly, they said that the Government should reach agreements with donors to fund the programs.

3. Androy: SN2

Functionality

Androy's SN2 program was scored as non-functional. While most components were rated at functional levels, the program total was 28 points, below the minimum of 30. Additionally, four components were scored as only partially functional. Both NGOs reached consensus on all interventions. Findings are summarized in Table 10.

Table 10: Androy Program Functionality Scores, SN2

CHV program component	Rationale for component scoring and comments on documentation and from validation visits
3. Best practice	
Recruitment	Recruitment criteria were well-defined and respected during the selection process and the community participated in CHV selection.
Initial training	Community representatives (the two SDC members) and the health centers were involved in the training. Training covered all topics related to the CHV's tasks.
2. Functional	
CHV role	The CHV role was seen as functional, but one participant noted that the CHV tasks and responsibilities were not well known by the Regional Health Management Team and that CHVs lacked support from local stakeholders. Interviews with community representatives supported this finding with reports that some village chiefs were reluctant to accept CHV activities.
Continuing training	This training was said to be not well coordinated with health centers. For example, if the CHV training and the monthly review meeting fell on the same day, the health center could not participate in the training.
Supervision	Supervision was judged functional however it was observed that supervisors could not visit CHVs at their village sites, mainly due to lack of transport. FGDs with supervisors confirmed this.
Incentives	Communities did not contribute financial or in-kind incentives to CHVs.

CHV program component	Rationale for component scoring and comments on documentation and from validation visits
Community involvement	Since they did not visit the villages, HCB and TA supervisors had insufficient communication with communities.
Referral system	The referral system was judged positively in both directions, referral and back-referral, but since communities lacked any means to transport patients to the health center, participants rated this component as only functional.
Opportunity for advancement	Opportunities for advancement were seen as functional since competent CHVs could upgrade their qualification through training from level 1 to level 2.
Documentation and information management	Documentation and information management was scored as functional; participants observed that the communities were not informed about CHV activity reports and that supervisor-community discussions on CHV performance were not held.
Linkages to health system	Weak linkages between the SN2 program and the public health system were thought to be attributable to restrictions in the type of interaction permitted between SN2 and the public health system.
1. Partially functional	
Equipment and supplies	The provision of equipment and supplies was reported as not functioning well. At the community level, long periods of stock-outs for certain products—such as L'Actipal, a treatment for malaria—were noted.
Individual performance appraisal	Participants noted the absence of evaluation tools, and the documentation mentioned no evaluation process. The validation visits revealed that no official evaluation was conducted in the previous year. Some inconsistent information emerged: It was confirmed that the SN2 supervision checklists were used and that they included an element on individual performance. Performance was observed individually, and the CHV was classified according to a standardized scheme. However, the appraisal was conducted as part of supervision and not as a distinct performance appraisal.
Program performance evaluation	SN2's quarterly evaluation of NGO programs reviewed program implementation and community commitment in general terms. Participants called attention to the lack of feedback on activities to the community. Documentation supported the low score as the evaluation of CHVs' performance was not based on program objectives and indicators.
Country ownership	Participants noted that country ownership was limited because CHVs were not officially recognized as an integral part of the public health system. They said the political situation had weakened collaboration between the SN2 program and the health system. Documentation revealed a ministerial note describing the terms of reference for CHVs and that the health system, through HCB supervisors, played a role in supervising CHVs, but the Government's failure to budget for community health programs limited this component's score.

Intervention lists

Services offered within the three areas were functional, except for some WASH-related activities.

MNCH intervention list

Most services were provided, but not childbirth care. Two tasks—newborn care counseling and referral for maternal hemorrhage—were noted as not done but were considered part of the work. The reasons for not doing them were not recorded.

FP intervention list

All family planning interventions were implemented except the two-day method and implants, and CRS did not authorize the delivery of certain contraceptive methods. (A CRS informant said that in practice CRS CHVs provided condoms after obtaining them from other sources.) At the logistical level, CHVs did not manage stocks though notified the health center or NGO supporting the CHV program if they needed more supplies.

WASH intervention list

CHVs did not provide interventions related to water storage and handling; food storage practices (special, protected locations for food storage and the separation of raw and cooked food.

Participant recommendations

The provision of equipment and supplies at the community level should be improved, perhaps through the health centers. Participants proposed the development of instruments for individual performance appraisal and the better coordination of all stakeholders in performing evaluations. They strongly recommended community awareness raising on CHV work to enhance community involvement.

Participants also recommended improving the communication between NGOs and MOHFP and that the Regional Director of Health receive community health activity plans. They further recommended integrating CHV activities into the public health system and improving coordination between the MOHFP and program managers, starting before a project is launched.

4. Androy: program of support for UNICEF-trained CHVs

Functionality

The program totaled 19 points—below the required minimum of 30 points for functionality—through the scoring/consensus process, deeming it non-functional. One component was rated as a best practice, five as functional, six as partially functional, and three as non-functional (Table 11).

Table 11: Androy Program Functionality Scores, UNICEF-trained CHVs

CHV program component	Rationale for component scoring and comments on documentation and from validation visits
3: Best practice	
Recruitment	CHV selection criteria were respected and applied.
2: Functional	
CHV role	Participants noted that local authorities did not support CHVs in their work.
Initial training	Participants indicated that the communities did not participate in the initial training.
Incentives	Participants reported financial and non-financial incentives during training, and the validation visit revealed some recognition and thanks during community assemblies.
Referral system	While rated functional, participants commented on the lack of feedback from the health centers to CHVs regarding referred patients.
Opportunity for advancement	The increase of knowledge through the work and the potential for continuing training were described by participants as opportunities for CHV advancement.
1: Partially functional	
Continuing training	Continuing training was considered only partially functional because it was not implemented according to the established program plan.
Community involvement	Participants noted that community members only occasionally participated in CHV activities.
Documentation and information management	The main critique on documentation and information management was the lack of data exchange and use of data in decision making.
Linkages to health system	Partial support by the public health system was acknowledged as occurring through linkages to the health system.
Program performance evaluation	Participants commented that program performance evaluation was sometimes not conducted and that no feedback was given on performance.
Country ownership	Country ownership received a low rating due to the lack of national funds. The program was mainly financed by donors, primarily UNICEF.
0: Non-functional	
Equipment and supplies	The equipment and supplies component was considered non-functional because provision was poorly organized. The validation visits and key informants confirmed stock-outs of

CHV program component	Rationale for component scoring and comments on documentation and from validation visits
	medications and other materials lasting more than a year.
Supervision Individual performance appraisal	With regard to supervision and individual performance appraisal, CHV frustration was particularly acute: They said neither supervision nor evaluation occurred. During the validation visit, one CHV said he saw his supervisor less than twice a year.

Intervention list

The program focus is limited to child health, so participants reviewed only the MNCH interventions (or CIMCI package). Functional services included ANC, advice on breast-feeding in the first six months, child immunizations, and integrated management of childhood illness.

Participant recommendations

To motivate CHVs, participants recommended that communities be encouraged to acknowledge, respect, and support CHVs in their work. To raise awareness of the CHV role among community leaders and supervisors, build support for CHVs, and raise community involvement, they called for the organization of community meetings. They recommended informing the population about the content of CHV training so people would understand the limits of CHV services. The health system should also provide more support, they said, particularly in enhancing supervision.

Participants also recommended an improved implementation that would follow the established training program plan. With regard to supplies, they noted the need for good and close collaboration between the different program actors. Concerning supervision and evaluation, they urged a plan of action and a strategy that would be respected. They also called for regular refresher or other courses. They said that feedback to the CHVs and information exchange should be improved, at the level of back-referrals as well as for documentation in general. The information in CHVs' reports should be taken into consideration for planning and decisions.

Lastly, participants suggested facilitating advancement for those CHVs who work well.

B. Supervision

This section opens with a description of the supervisory practices in the three regions. It then provides the results of the FDGs and interviews undertaken for the supervision assessment.

Different programs avail different actors—HCB doctors; NGO technical assistants (TAs, limited to SN2 programs); SDC members; the medical inspector; and, occasionally, SN2 program managers—to jointly or separately supervise CHVs. Someone in Atsinanana noted individuals regularly leaving these positions, while a CHV in Androy noted continuity among the TAs. These actors and CHVs attend monthly review meetings organized at the commune level (chief of the health center or post). The distances they must travel to attend these meeting are often considerable.

As all CHVs come to these meetings at the same time, they face long waiting times, for which they request a subsistence allowance. They receive allowances for their travel costs only for the biannual performance appraisal, not for routine supervision, such as the review meetings.

Supervisors receive compensation (travel and per diem) when they travel to make a supervisory visit.

1. SN2 supervisory practices

SN2 introduced a strategy in 2009 for CHV supervision to improve the quality of CHV performance and services. The strategy allows for supervision to be organized at the commune level or at a health center. Tools were developed that consist of detailed checklists.

SN2 supervision guidelines call for supportive supervision, defined as "the art of supporting the other person allowing him/her to make use of his/her best competencies, while observing norms and standards

of practice" (USAID Madagascar, 2009). SN2 distinguishes supportive supervision from routine supervision by adding three practices to the former: the observation of CHV practice, an evaluation of such practice, and the immediate strengthening of competencies. The supervisor's task is to guide, help, train, and encourage the CHV after a formal evaluation of his/her competencies and skills, using the supervision tools (USAID Madagascar, 2009). The supervision guide recommends: 1) good preparation, including announcing the supervision visit, reviewing CHV data, and readying the observation exercises; 2) creating a positive atmosphere of trust through encouragement and explanation of the supervision objectives; and 3) finding solutions for technical and logistical challenges.

A different checklist is provided for each of the four focus areas/levels (that is, CHV mother level 1 and 2 and CHV child level 1 and 2). Each performance evaluation has five parts, presented in five sections in each checklist:

1. General information (provided by the NGO) on the CHV.
2. CHV functionality: Does the CHV have all the materials and equipment necessary for the tasks? How well does he/she use the management tools to report activities?
3. Performance: The CHV's technical competencies are verified through observations of his/her work or through simulation exercises.
4. The CHV's knowledge of management tools, the referral system and documentation, and attitudes toward and behavior with patients.
5. A supervisor-provided summary report on the observations, measures discussed, and recommendations for follow-up.

Competencies are evaluated according to a scoring system allowing the supervisor to monitor each CHV's knowledge and skills over time. A score above 70% is considered satisfactory, 50–70% as sufficient but requiring follow-up, and below 50% as insufficient and requiring training and close follow-up.

Evaluation is usually done by a HCB doctor at least biannually. An individual's supervision report is shared with the TA and filed at the health center. SN2 gives the local supervisor a financial incentive upon timely delivery of a completed report. SDC members monitor awareness-raising, demand promotion, and stimulation activities through on-site visits with the CHVs.

SN2's concept of supportive supervision equates to an individual performance evaluation. Calling it "supervision" may be one reason why the functionality scoring for individual performance appraisal does not reflect the existence of a performance evaluation practice.

2. Supervisory practices and processes in UNICEF supported regions

UNICEF supports the use of government tools and processes in managing CHVs in Madagascar. Throughout this assessment, FGDs and interviews found broadly consistent perceptions in key aspects of supervision. For example, all participants had a common understanding of the approach of supervision: They saw it as a useful component to ensure and improve the quality of service delivery through a combination of quality control, capacity building, and providing support to CHV in problem solving.

In general, supervision was applied in groups at the commune level, mostly during monthly review meetings and involving community representatives and sometimes TAs and the HCB supervisor-doctor. The detailed (biannual) evaluation was done using the SN2-developed evaluation forms (for the SN2 programs). FGD and interview participants confirmed that supervisory visits at CHV sites were rare.

These participants reported that supervision practices commonly included a review of CHV materials/ supplies and their organization, a review of reports on activities and patient documentation, and

questions on knowledge and methods of work. Simulation exercises on common CHV services and interventions were done during the review meetings or other occasions.

The next sections set out comments on supervisory practices by each type of stakeholder group that participated in the FGDs and interviews.

3. CHVs' perspectives

The CHVs' **understanding of supervision** included the quality of CHV performance as well as the supportive and training aspects (i.e., coaching); help in accomplishing the mission; and facilitating CHV work. They highly appreciated supervisors' support, advice, and collaboration in finding solutions for problems and perceived such help as encouraging and motivating good performance. Moreover, they thought that supervision ensured that their activities contributed to improving community health and overall community development.

With regard to **frequency,** CHVs indicated that in all regions, communes conduct monthly review meetings. The Analamanga group said the frequency of NGO participation in supervision had been reduced from monthly to quarterly. Similarly, the frequency of supervision by a HCB doctor-supervisor had fallen from quarterly to biannual. These reductions are part of the phasing out of SN2 and also resulted from budget constraints.

Regarding their **organization,** supervision meetings are announced in Analamanga and are usually conducted by one to three persons, while in Atsinanana one person usually does them. Visits to villages take place occasionally in Atsinanana. Local supervisory visits in Androy are sometimes known in advance, but NGO TAs do not announce their visits. The monthly review meetings take place mostly either in schools or health centers. Androy CHVs mentioned that the community representatives sometimes came to the village for other reasons and conducted supervision activities and that supervisors' visits to villages were rare, due to security concerns, so CHVs bring their activity reports to the review meetings.

With regard to **supervision practices,** CHVs in all regions reported the same core activities: review of their activity reports, documents, and stocks of materials. Analamanga CHVs also mentioned sharing experiences and competencies, explaining problems and seeking solutions, and creating and subsequently reviewing action plans. In Androy simulation exercises were conducted when patients were present.

The supervision **tools** were clear for CHVs in Analamanga, where different supervisors used different tools. That is, community representatives used just notebooks and pens; HCB doctors used flipcharts, and the SN2 programs used supervision tools. Atsinanana CHVs referred to various supervision forms they found useful, including some for data and statistics. Androy CHVs said that they did not know the content of the supervision tools. In Androy and Atsinanana, CHVs said they did not receive any feedback on the results of the supervision: Supervisors only recorded that the CHV had been appraised.

In general, CHVs felt positively about **supervisors' attitudes and behavior.** CHVs and supervisors had good relationships and collaborated well, someone in Analamanga reported. Supervisors show their respect for CHVs, acknowledge CHV work, consider CHV expectations, and give frequent and detailed advice, an Atsinanana participant remarked. CHVs in Androy reported that their supervisors knew the area very well, were cooperative and listened to problems, answered questions, and gave generously of encouragement and advice, even if their help was limited.

The CHV **expectations** related to supervision varied among the regions. Participants in Analamanga wanted encouragement and new knowledge, while those in Atsinanana wanted more community recognition. In Androy, SN2-sponsored CHVs said that supervision should link the CHV with the NGO, donors, and the MOHFP. CHVs in Atsinanana and Androy expected more supervision, with the later hoping for an increase in frequency to solve problems more quickly. Androy participants also

wanted compensation from their NGOs and huts to serve as offices, which, they said, would motivate them and enhance the value of their work and their status in the community.

CHVs saw the **effects of supervision** in a very positive light. Analamanga CHVs appreciated the feedback they received on the effects of their work on the community, for example in changing health indicators. Those in Atsinanana and Androy reported that supervision encouraged and motivated them by acknowledging the value of their work. The also said it raised their recognition and social status. Androy CHVs valued increasing their knowledge and competencies, and hence their personal development.

Asked for their **vision** of ideal supervision and **recommendations for improvement,** CHVs called for more frequent supervision with more time allocated to the individual CHV and supervision visits in their villages. They said such visits would allow more effective supervision through direct observation of activities and practical demonstrations, for example of ways to organize their materials. Overall, they wanted more guidance, coaching, and advice adapted to their work situations. They requested that the results of the supervision sessions be released to them and the community for a better understanding of their responsibilities and performance. An Androy CHV also recommended visits by donors and other authorities so that they would have a better understanding of CHV situations.

4. Supervisors' perspectives

Discussions with supervisors included local supervisors, HCB doctor-supervisors, NGO TAs, and SN2's independent supervisors. Although SDC members also had a supervisory role, they were not included in the supervisor groups but rather in that for community representatives (below).

Supervisors all showed a common **understanding of supervision** as a combination of control of CHV activities and support to CHVs that would ensure quality services and encourage CHVs. Supervisors saw identifying problems and helping CHVs find solutions as core tasks. In Analamanga, they included in their responsibilities serving as a conflict mediator, such as when communities had expectations exceeding the CHV's authority. Supervisors in all three regions felt part of their responsibility was explaining CHV roles and tasks and building relationships between CHVs and their communities. They also saw capacity building during the review meetings and providing technical guidance as part of their work.

Atsinanana supervisors interpreted having received two motorbikes as **support** for their work, although distances still precluded frequent visits to the CHVs. Local supervisors also interpreted SN2's independent supervisors as support. Independent supervisors regularly discussed the performance and problems concerning CHVs with the local supervisors. Supervisors found the various supervision tools supportive, while Androy supervisors noted training as a major support.

Supervisors in all regions acknowledged the systematic nature of the supervision structures but saw lack of home visits as a **major challenge**. In Analamanga, the distances to the communities and motivating CHVs were also seen as major challenges: Most supervisors there had to walk to villages to perform supervision, and one mentioned the physical strain due to her age. Perhaps related to transport difficulties, supervisors in Analamanga and Androy noted difficulties in maintaining good relationships with CHVs. Atsinanana supervisors saw organization as a major challenge, referring to 1) SN2's reduction of review meetings and NGO field visits and 2) the difficulties in conducting visits due to lack of transport and CHVs' absences during the day to do farm work. Androy supervisors were primarily concerned about the lack of appropriate motivation of CHVs; for example, a CHV had requested a hut to enable his/her work and afford privacy, but the request was not filled.

The **organization** of supervisors' work varied by region. Analamanga supervisors met quarterly with the TA to exchange experiences and information. In the other regions, supervisors saw themselves as working alone, although they used district health service meetings as opportunities to exchange

information with other supervisors. It is possible that this difference is related to the fact that more women than men are engaged in CHV work in Analamanga than in the other regions.

How much **time** supervisors can devote to CHVs varied widely. In Analamanga, the number of CHVs per supervisor varied from six to 30, depending on the distances between communes. Also, supervisors indicated that CHVs needed different amounts of supervision, with CHVs with less competency requiring more supervisor-provided follow-up and training, so the time required differed from one CHV to another. In Atsinanana, supervisors distinguished between the monthly reviews and the biannual evaluation using the SN2 supervision tools: On average they spent 15 minutes with each CHV during reviews while the evaluation took 60–90 minutes per CHV. To indicate the level of burden supervision entailed, two Androy HCB supervisor-doctors noted that they, respectively, oversaw 23 villages with 46 CHVs and 62 villages with 124 CHV, with the responsibility of seeing each CHV on a fixed day every month when the CHV was expected to bring his/her report to the health center.

With regard to **locations** supervisors confirmed that visits to villages were rare. Most supervision took place at the commune level and health centers. Androy supervisors arranged visits to three nearby villages every two months, alternating with review meetings at the health center. Additionally, they leveraged CHV attendance at biannual vaccination campaigns to provide focused support and supervision. Only in Analamanga did supervisors say that reviews took place mainly in the field, but it was not clear whether they were referring to villages or the commune level.

Community involvement in supervision occurred mainly through the participation of SDC members at the review meetings where these community representatives discussed CHV work and problems with the HCB supervisor. In Androy, supervisors supported CHV efforts with the population by using meetings during vaccination campaigns (when all village chiefs would be present) to discuss sensitization on FP, hygiene, etc. Androy used structured protocols to establish objectives with villages, and supervisors reviewed progress at a meeting six months later.

Regarding **content,** discussions with supervisors confirmed the major activities discussed above: review of materials, problem solving, capacity building, and encouragement.

The main **tools** supervisors discussed were the evaluation forms (checklists) SN2 had recently introduced for biannual application. While in general the forms were considered useful, some supervisors aired criticism and suggestions for improvements. In Analamanga, supervisors saw the tools as very useful, serving as guidelines and orientation and helping maintain focus on the evaluation. In the other two regions, supervisors considered them too complicated and time-consuming. In Atsinanana, supervisors remarked that these forms contained some items they saw as useless and/or overlapping with other reporting requirements. Also, the information CHVs provide for these forms could not be verified as the evaluation did not occur at CHV work sites. Androy supervisors reported the time required for completing these checklists as 45–90 minutes with an average of 60 minutes. One participant said the biannual appraisal of 124 CHVs took two to three days, constituting considerable additional workload.

The initial **supervision training** was reported to vary broadly by region. Supervisors said the time required ranged from two hours to three days and the topics ranged from the use of supervision tools to a full introduction of the scope of supervision approaches and related tasks, including social competencies (e.g., communication and coaching skills).

They thought the key supervision **competency** was the technical knowledge of CHV work and secondarily good social and communication skills: listening well, facilitating knowledge transfer through clear feedback, explaining ways to work, manage conflict, and accept negative feedback from CHVs in a professional way.

Asked for important factors of **successful supervision**, supervisors referred mainly to motivating CHVs (Analamanga) and following up on the recommendations and advice given to CHVs during review

meetings. Information on such recommendations/advice is mainly obtained from CHV reports and through direct/indirect patient feedback (e.g., when patients report that a CHV had referred them to the health center or accompanied them when they were afraid to go). Some patients complained to supervisors if the CHV did not follow the supervisors' recommendations. Some supervisors would test a CHV on the supervisor's advice during the subsequent review meeting.

Supervisors' **recommendations** included organizing a meeting where they could thoroughly review the tools to revise and adapt them to the practice level and improve their coherence with other reporting requirements (Atsinanana). Androy supervisors suggested translating the forms into Malagasy, dividing them according to theme (MNCH, FP, etc.), and rotating their use based on the themes while increasing the frequency of evaluation visits from biannual to quarterly. This would shorten the evaluation time while allowing them to see CHVs more often.

Recommendations for improved supervision show a clear desire for regular home visits to make supervision more effective through observation and feedback in the CHV environment and to enhance collaboration with the communities and strengthen the CHVs' position vis-à-vis the community. Supervisors asked for transport to enable more frequent visits (although they also lacked sufficient time for this activity). Atsinanana supervisors suggested quarterly refresher trainings for CHVs near where they work and noted that doing so would require an additional full-time equivalent position. Other priorities to improve CHW services were improving communication means (i.e., mobile phones) and preventing stock-outs. Analamanga and Androy supervisors, noting the importance of the CHV motivation, expressed concern over the CHV's ever-growing workload, which took a third of each day and was considered unacceptable. Supervisors indicated that small, periodic financial incentives could encourage and help retain CHVs.

5. Community representatives' perspectives

Community representatives were members of the SDCs and had an important **role** in supporting CHV activities. At the technical level, they may have had the least authority among the various types of supervisors, but their mandate as SDC members provided them with critical authority within the community. Hence, they act as facilitators and mediators between the CHV and the villagers. They also advise the community of the importance of CHV services and help solve problems, problems that are often based on misunderstandings of the CHV role and scope of work. SDC members are also responsible for facilitating communication with the population (often through the village chief), particularly when problems or conflicts arise.

Community representatives help 1) select CHVs and 2) provide supervisory support during the monthly review meetings. Their task is not to monitor CHVs at a technical level (clinical or sponsor concerns) but rather at the level of performance of activities and implementation of recommendations.

Community representatives also act as a focal point for CHVs with regard to their relationship with the population, regularly advising CHVs and helping solve community-level problems. They particularly support CHV work in sensitizing people to health issues and advocating with village chiefs for support where collaboration is lacking. One representative noted that in the beginning, villagers said that they did not know what CHVs did since they were not doctors. In an Atsinanana village the representative convinced the village chief to build a hut where the CHV could see patients. An Analamanga representative reported that he sensitized the men in his village in family planning, as the female CHV was prevented by cultural norms from doing so. Androy's community representatives reported that especially in the initial phases of the CHV program, the village population lacked confidence in the CHV, so he introduced the CHV to the community and explained CHV roles and tasks. They often advised the population on health and hygiene, availing such opportunities as visits to the health center and market days. They noted, however, that the culture made people reluctant to change and mistrustful of CHVs, so bringing about new health practices was difficult. Also, personal conflicts between village

chiefs could hinder CHV interventions: Where one chief supported those activities, another withheld support just to express disrespect for of the first chief. The representative said that CHVs consequently need support from sources other than village chiefs. They reported having worked closely with three or four communities that were supportive of CHV activities. These communities served as reference points and models for good practice in the region. By demonstrating how change can be implemented, these communities would help convince others to be more accepting of new health practices.

Representatives from one community in Atsinanana reported having recently taken more responsibility: They had received training to supervise CHVs and their activities, and during the last three to four months they had started organizing the review meetings themselves, while TAs and local supervisors were still present. In Analamanga and Atsinanana, community representatives reported being involved in reviewing the data and statistics on health and in developing community action plans and monitoring their implementation. The Analamanga representatives said that the time allocated for CHVs during review meetings was not sufficient and that CHVs had asked for more support. They responded to CHVs' questions as needed.

With regard to supervision's **quality and effects**, these representatives found supervision useful and important for the success of the CHV program. Some from Atsinanana said that the supervision system was effective because it involved three different and complementary levels: NGO, health center, and community. Strengths noted were the capacity-building component of review meetings and quality control. The Androy representatives believed that capacity building and repetition were particularly important due to CHVs' low educational levels. An Atsinanana representative said that achieving the objectives established in the community action plan demonstrated the quality of supervision. Further, information from the population showed the quality of CHV work and facilitated follow-up. Many representatives, however, reiterated the time and transport challenges in following up with CHVs in their villages. In Analamanga and Atsinanana the reduction in frequency of technical assistance and local supervision was seen as potentially eroding the quality of CHV services.

Satisfaction on the **exchange of information** between supervisors and community representatives varied by region and community. Some representatives reported satisfying collaboration with the health centers and other supervisors; they exchanged information and received feedback on supervision reports and evaluations. Others, in Analamanga and Atsinanana, while appreciating good, collaborative relations with the health centers, noted that they lacked access to supervision reports, but were informed of evaluation results, recommendations, and other developments during the review meetings. In Androy, community representatives felt left behind by the NGOs: They said they were not informed of the training content CHVs received and that during review meetings they had a passive role while the other supervisors discussed the CHVs.

Recommendations included determining how to finance the CHV program to make it sustainable. One representative called for a line item in the Government budget at decentralized levels to cover CHV services. Another said that some FP services were free at health centers but that CHVs had to ask for a fee to recoup the costs of medicines and supplies, though the service was free. This particularly applied with medications that were purchased through the community. Poverty in remote areas precluded asking for contributions from the communities.

Analamanga's community representatives were concerned about stimulating and sustaining CHVs' motivation. They acknowledged the efforts CHV had to make and cited a need for financial incentives. One representative explained that the work interfered with a CHV's personal (especially marital) life, since many were approached at night, especially for MNCH emergencies. In one case, a CHV's husband opposed his wife's CHV activity due to the frequent disruptions. Financial incentives, e.g., compensation for travel expenses, could help retain CHVs. Providing resources to communities to organize incentives was suggested.

Atsinanana representatives said the frequency of supervision should be increased to once every two months rather than six. They called for financial incentives for supervisors to motivate better work on their part. Androy community representatives asked for transport and telephones.

This group prioritized improving competencies and knowledge. Someone suggested establishing a program of continuing training and refresher courses at the health centers.

Many community representatives said they had seen significant improvement in their communities' **health status,** health behavior, and utilization of health centers since the start of the CHV programs. They were committed to sustaining the CHV activities even if the SN2 programs of support shut down. The Androy representatives believed that more time was needed with external help to further establish and sustain the CHV activities, which needed a lot of energy and effort to achieve some change.

IV. DISCUSSION

A. Summary

1. Program functionality

Program functionality for the SN2 program of support varied in the three regions, perhaps due to differences in organizational implementation, socio-economic forces, and/or cultural variances. For example, various key informants noted that Androy was more disadvantaged, not only economically and environmentally but also with regard to education and reluctance to change behavior.

Overall, the assessment indicates a positive result with regard to the functionality of the SN2 program: Most components achieved scores of best practice or functional. Nevertheless, areas for improvement exist. Table 12 displays an overview of the consensus functionality scores for all SN2 programs; the colors distinguish functionality levels from 0 (not functional) to 3 (best practices).

Keeping in mind the limitations of comparing programs among regions, it can be said that the programs in Atsinanana were rated as the most functional, followed by Analamanga and Androy. The table shows that Atsinanana's four NGO programs, assessed by NGO, could not achieve consensus in all components and that only its individual performance evaluation shows a discrepancy as to whether a component was functional or only partially functional. In Analamanga, each component was deemed functional except for equipment and supplies, which was partially functional. Androy, on the other hand, had four components that were partially functional.

The program of support provided to UNICEF-trained CHVs was seen as non-functional, with an overall score of 19. This program's approach differs significantly from that of SN2 in regards to the scope of interventions, organizational structure, and follow-up. The fact that both Androy programs received lower scores than those in the other regions suggests that local influences rather than program management brought its scores down. FGDs and interviews confirmed this possibility and highlighted cultural barriers and the resistance of local authorities to CHV activities.

Table 12: SN2 Functionality Scores, Three Regions

	Component	Analamanga (1 NGO)	Atsinanana (4 NGOs)	Androy (2 NGOs)
1	Recruitment	3	3	3
2	CHV role	2	3	2
3	Initial training	2	3/3/2/2	3
4	Continuing training	2	3	2
5	Equipment and supplies	1	3/3/3/2	1
6	Supervision	2	3	2
7	Individual performance evaluation	2	3/3/2/1	1
8	Incentives	2	2	2
9	Community involvement	3	3	2
10	Referral system	2	3	2
11	Opportunity for advancement	3	3	2
12	Documentation & information management	3	3	2
13	Linkages to health systems	2	2	2
14	Program performance evaluation	3	3	1
15	Country ownership	2	2	1
	Total	**34**	**39/39/39/41**	**28**

Legend: 0 (not shown) = non-functional; 1 (orange) = partially functional; 2 (pink) = functional; 3 (green) = best practice; white = mixed results.

Despite regional differences, common patterns emerged across regions, organizations, and programs in terms of program strengths and weaknesses among programs, as seen in Table 13.

Table 13: Strengths and Weaknesses, All CHW Programs

Strengths	Weaknesses
Recruitment (best practice)	Equipment and supplies
Initial training	Individual performance appraisal
Community involvement	Country ownership
Opportunities for advancement	
Documentation and information management	

2. Supervision practices and tools

Supportive supervision was found useful for ensuring and improving the quality of services by building capacity and supporting CHVs in problem solving. In general, supervision occurred at the commune level, mostly during review meetings, and involved community representatives, the NGO, and the health center. Performance evaluations were done biannually, but supervisors rarely visited CHV sites. Large distances, the lack of transport, and time restraints hindered site visits, which would likely make supervision more effective.

Community representatives saw their roles—as facilitators and mediators between the CHVs and villagers—as important in supporting CHV activities. In exercising their mandate and authority as SDC members, they stressed to villagers the importance of CHV services and helped solve problems that often arose from misunderstandings over the CHV role.

Recommendations for improving supervision included visits by supervisors to CHV sites for observation and feedback and continued efforts to improve CHV-population relations. CHVs desired more frequent supervision and a better understanding of the collaboration between the NGOs and the public health system. SN2 reported that the logistical and financial challenges to implementing more frequent supervisory visits are overwhelming. For example, SN2 supports CHVs in over 5,925 fokontany that are located approximately one hour or five kilometers away from the nearest formal health facility, thus requiring that supervisors walk on average two hours or nine kilometers to perform a supervisory visit. SN2 calculated that field visits for each CHV they support would require 27,000 human-days, which equates to an additional $3.5 million in program costs and 160 supervisors. SN2 also reported that over the course of FY11 and early FY12, the current level of regular supervision had resulted in consistent improvement in CHV clinical and managerial skills. (Personal communication with Volkan Cakir, 5/18/2012)

Discussions by SN2 stakeholders on supervision tools focused on SN2's recently introduced supervision and evaluation tools. Supervisors had mixed opinions on the effectiveness of these tools. They saw them as helpful in providing guidance for performing a structured and systematic evaluation, but some felt they were too long, complicated, and duplicative relative to other reports. They took about an hour (range: 45–90 minutes) to complete, a significant time commitment for supervisors, who were mostly HCB doctors and thus had considerable other responsibilities.

Recommendations for improving the tools included translating them into Malagasy. Another suggestion was to 1) divide the key tool into sections by theme and apply each following a theme-based rotation and 2) revise it to meet practical needs. Doing so would require organizing a meeting with supervisors (HCB doctors and TAs) to review the tool and then more evaluation sessions.

Androy CHVs said that they did not know the content of their program's supervision tools. In Androy and Atsinanana, they said they did not receive any results of evaluations conducted during supervision and feedback following supervision. One would expect that knowing the contents and objectives of supervision instruments and the outcome of an evaluation would help a CHV achieve program objectives.

B. Limitations

The CHW AIM methodology assesses the functionality of a program of support at the organizational level; it does not evaluate the quality of actual services. It relies on secondary evidence and self-reports, so its findings cannot be used to evaluate individual CHW performance or CHW contributions to coverage, effectiveness, or impact.

This assessment was the first use of the French version of the CHW AIM toolkit. Translating it from English to French and then to Malagasy resulted in less-than-desirable language precision. In general, translations need to be carefully done and tools carefully adapted to the local context to ensure that

participants understand the approach. For instance, the translated version could be piloted or back-translated. The assessment team adapted the tools during facilitators' workshop but time limits precluded piloting.

The supervision component explored the topic only in the context of the selected CHV programs, so findings are limited to that context.

In Androy, given the multiplicity of organizations supporting CHV programs over the previous years, the research team had difficulty finding UNICEF-trained CHVs who had experience in only one program. Thus, the experience with other programs may have "tainted" the experiences and perceptions of CHVs in the review of each program in this assessment.

Sessions for which data were collected were not audio recorded, so statements may have been missed or misunderstood. Also, since several persons were involved in collecting, recording, translating, analyzing, and reporting the data from both the toolkit and supervision discussions, some details may have been lost despite care in handling information.

The 15th functionality element in the CHW AIM toolkit is country ownership, defined as "the extent to which the ministry of health has: integrated the CHW cadre in health system planning (e.g., policies in place); budgeted for local/district/national financial support; and provided logistical support (e.g., supervision, supplies) to sustain CHW programs at the district, regional and/or national levels" (Crigler et al., 2011, p II-10). Given the current political situation, achievement of functional or highly functional scores for either the SN2 program or the program of support for UNICEF-trained CHVs was impossible, affecting the overall scores for both.

V. CONCLUSION AND RECOMMENDATIONS

Along with some participant recommendations, this section reports some key issues that should be considered as areas for action with regard to CHV program strengthening:

SN2 and UNICEF should be recognized for their efforts to build CHV programs and thus support the public health system. The programs were strongest in five areas (recruitment, initial training, community involvement, opportunities for advancement, and documentation and information management) and weakest in three (equipment and supplies, individual performance appraisal, and country ownership). This finding suggests that program managers should sustain and build on features of the strong areas while looking for ways to strengthen the weak ones. Androy's low scores recommend putting more effort and resources into this region. Filling these gaps would present opportunities for shared learning, greater coordination between stakeholders, and the application of improvement methods to develop and test interventions to address programmatic weaknesses and improve the effectiveness and sustainability of CHV programs. More-specific recommendations follow.

Coordinating program and health system efforts: Public health system support of CHV programs—through training, supervision, materials, and assistance with community health activities—would strengthen these programs and enable them to be more effective in protecting the public health. The long-term objective should be to have partially parallel operating systems that are harmonized and integrated, as proposed in the Ministry of Health community health policy (MOHFP, 2009).

Materials and supplies: Supplies (particularly medicines) should be made available where the need is greatest and their use would be most effective by strengthening the supply chain.

Motivating CHVs: Supervisors and community representatives raised concerns about motivating CHVs. Better motivation would likely improve CHV program sustainability. While their voluntary status is generally supported, introducing some financial incentives (e.g., reimbursement for transportation to and from work and review meetings) was requested. Their increasing workload was seen as eroding their quality of life and probably their motivation. Ways to reduce or manage that workload should be

explored and could include recruiting more CHVs and providing transportation, huts for patient visits, and cell phones.

Supervisors could not visit CHVs due to distances, lack of transport, and time. Instead, CHVs had to go to the health center or community chief to deliver reports, attend review meetings, and be evaluated. Burdening the person in the weakest position with these activities should be resolved to free CHV time for patients and health promotion, the functions they appear self-motivated to perform.

Supervision: CHVs should know the content of evaluation forms so that they can work toward meeting the expectations expressed therein. They should be informed of comments that are recorded on their evaluation checklist.

The reduction in supervisory sessions from quarterly to biannually as part of the SN2 phase-out, was a concern of community representatives, supervisors, and CHVs. The infrequency of site visits by HCB supervisors was commonly seen as a weakness. Recommendations for improving the effectiveness of supervision included frequent visits by supervisors to CHV sites, observation, and feedback focused on improving relations with the population. Supervisors recommended a review of the individual performance evaluation tools to shorten and simplify them while reducing overlap with other reporting requirements. The evaluation system was seen as weak, in part due to a lack of understanding of the distinction between "supervision" and "performance evaluation." SN2's supervision approach and tools include a quarterly, individual appraisal component, but is not perceived as such by participants. Further, providing rewards for good performance would likely make this investment more effective.

Supervisors expressed a need for help in overcoming communities' failure to understand the limited scope of CHVs' tasks and authority.

Referral systems should be strengthened to ensure the doctor receiving a referral provides appropriate information to the CHV who made it; CHVs asked for this process, and such strengthening would improve follow-up care. Health facility constraints need to be addressed to ensure functional referral systems.

Community relations: For a CHV program to succeed, CHVs must be recognized by their communities as being an asset. CHVs asked for assistance not only in building their credibility but also in diffusing information on their scopes of practice in providing diagnosis and treatment. One community representative's efforts are commendable. He used three or four communities that were supportive of CHV activities as models for good practice. His objective was to demonstrate through reports (data) from these communities how change can be implemented. Such "model CHV" demonstrations could raise awareness amongst other communities and convince communities to recognize and support CHVs.

Further research: Reports that population-level behavior change is particularly difficult in Androy should be examined with the goal of determining its validity, and, if valid, identifying ways to overcome it. Interventions to make improvements in the thematic areas discussed could potentially be developed and tested through the application of improvement methods and analysis of real-time data by improvement teams at the community level. This could bring together key stakeholders to collaboratively innovate and apply solutions and share lessons to address threats to program functionality and improve CHV performance.

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VII. APPENDICES

Appendix 1: The 15 Components of the CHW Program Functionality Matrix

	Component Definition	Level of Functionality: 0= non-functional; 1=partially functional; 2= functional; 3 = highly functional			
		0	**1**	**2**	**3 (best practice)**
1	**Recruitment** **How and from where a community health worker (CHW) is identified, selected, and assigned to a community, including selection criteria.**	CHW not from community and the community plays no role in recruitment. No or only a few criteria exist and are not well known or commonly applied.	CHW is not recruited from the community and the community is not involved in recruitment but does approve of the final selection. Some criteria exist and are well known and applied but are general and/or do not address specific issues such as gender and marital status.	CHW is recruited from the community and the community is consulted on the final selection, or if due to special circumstances the CHW must be recruited from outside the community, the community is consulted on the final selection. Some criteria exist about literacy levels but do not address gender, marital status, or if the CHW should come from local community or not.	CHW is recruited from community with community participation, or if due to special circumstance the CHW is recruited from outside the community, the community participates in and agrees with the process and is consulted on final selection. All selection criteria—literacy, gender, marital status, local residence—are met when possible.
2	**CHW Role** **Alignment, design and clarity of role from community, CHW, and health system perspectives.** **A role is a general description of how the "job" contributes to the organization; expectations define actions and behaviors necessary for the CHW to be successful; tasks are measurable activities that the CHW performs when providing services.**	No formal CHW role is defined or documented (no policies in place) Role is not clear or agreed upon among CHW, community, and formal health system.	No formal CHW role is defined or documented (no policies in place) General expectations (e.g. working time) and tasks (e.g. nutrition counseling) are given to CHW but are not specific. CHW and community do not always agree on role/expectations, such as demanding services or commodities not offered by CHW.	CHW role is clearly defined and documented (policies exist), but community played no part in defining the role. Role is clear to CHW and community but with little discussion of specific expectations. General agreement on role among CHW, organization, health system, and community although occasional demands are made on CHW that he/she cannot meet.	CHW role is clearly defined and documented; organization, health system, community, and CHW design the role/expectations and tasks and policies that support the CHW's role. Specific expectations (e.g. workload, client load, time per patient, maximum distance and role of community) and tasks (weighing children for nutrition guidance, providing food supplements for HBC clients) are clear among CHW organization, health system, and community and services/ commodities not offered by CHW are accessible at referral sites. Process for updating and discussing role/expectations and tasks is in place for CHW and community.

	Component Definition	Level of Functionality: 0= non-functional; 1=partially functional; 2= functional; 3 = highly functional			
		0	**1**	**2**	**3 (best practice)**
3	**Initial Training** **Training provided to CHW to prepare for role in service delivery and ensure he/she has the necessary skills to provide safe and effective care.**	No or minimal initial training is provided. Minimal initial training is provided (e.g., 1 workshop) that does not meet global or national recommendations for duration and content. CHWs are not enrolled in training within six months of joining the program although some CHWs attend workshops on specific topics.	Initial training is provided to all CHWs within six months of recruitment, but training does not meet national or international guidelines for duration and content. No on-the-job training is offered. No participation from community or from health center.	Initial training is provided to all CHWs within six months of recruitment that meets agreed-upon guidelines for duration and content. Content of training includes at a minimum: CHW role, links with health center, appropriate technical content, referrals, documentation, and intrapersonal communication. No participation from community or government health service during initial training.	Initial training based on defined expectations for CHWs is provided to all CHWs within six months of recruitment Content of training includes: core CHW topics[1], appropriate technical content, documentation, and gender sensitivity. Training is consistent with national or facility guidelines for community care, and government health service is involved in training. Some on the job training is conducted in the community with community participation, e.g. as role players, feedback providers, etc.
4	**Ongoing Training** **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 provides some coaching.	Ongoing training is provided but is irregular or occurs less frequently than every 12 months. Partner organizations/NGOs provide occasional workshops on specific vertical health topics. No training plan exists and no tracking is done of which CHWs have attended training.	Ongoing or refresher training is provided at least every 12 months, for all CHWs. A training plan exists, although tracking of which CHWs have been trained is weak. Government health system or health facility is not involved in refresher training.	Ongoing training is provided at least every 6 months 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 Government health system or health facility is involved in training with health workers participating in training and/or conducting training at the health center

[1] Core training for CHWs: ability to access resources, coordination of services, crises management, leadership, organizational skills, intrapersonal communication skills, confidentiality (Source: *Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals: A Systematic Review and Recommendations for Scaling Up*, Global Health Workforce Alliance, 2010).

	Component Definition	Level of Functionality: 0= non-functional; 1=partially functional; 2= functional; 3 = highly functional			
		0	**1**	**2**	**3 (best practice)**
5	**Equipment and Supplies (including job aids)** **Requisite equipment and supplies are available when needed to deliver the expected services.**	No or incomplete, equipment, supplies, and job aids provided Inconsistent supply and restocking to support defined CHW tasks.	Equipment, supplies, and job aids are provided Stockouts of essential supplies occur regularly (two or more times per year) and last more than one month. No regular process for ordering supplies exists (CHWs order when they run out).	Equipment, supplies, and job aids are provided Stockouts are limited. Supplies are ordered and available on a regular basis although procurement can be irregular. Organization and/or health facility takes account of CHW needs when ordering their supplies Supplies are not checked or updated regularly to verify expiration dates, quality, and inventory.	All necessary supplies, including job aids, are available with no substantial stockout periods. Organization and/or health facility takes account of CHW needs when ordering their supplies. Supplies are checked and updated regularly to verify expiration dates, quality, and inventory.
6	**Supervision** **Consistent support for coaching, problem solving, skill development, and data review**	No supervision or regular evaluation occurs outside of occasional visits to CHWs by nurses or supervisors when possible (once a year or less frequently).	Supervision visits conducted between two and three times per year to collect reports/data (or reports are collected through group meetings at the health facility). Supervisors are not trained in supportive supervision Supervisors are not assigned to CHWs or communities or are unknown to CHWs and communities No individual performance support offered on work (problem-solving, coaching)	Regular supervision visits at least every three months that include reviewing reports, monitoring data collected and providing problem-solving support to CHW. Supervisors are trained in supportive supervision and have basic supervision tools (checklists) to aid them The supervisor does not consistently meet with the community and does not make home visits with the CHW or provide on-the-job skill building Data/information is used for problem solving and coaching during supervision meetings	Regular supervision visit every 1–3 months that includes reviewing reports and monitoring data collected. Supervisors are trained in supportive supervision, have the technical skills to do service delivery observations, and have basic supervision tools (checklists) to aid them. Data is used for problem solving and coaching during supervision meetings Supervisor visits community, makes home visits with CHW, and provides skill coaching to CHW.

	Component Definition	Level of Functionality: 0= non-functional; 1=partially functional; 2= functional; 3 = highly functional			
		0	**1**	**2**	**3 (best practice)**
7	**Individual Performance Evaluation** **Evaluation to fairly assess work during a set period of time**	No regular structured evaluation of performance by CHW	A structured evaluation is conducted once a year that is not based on individual performance and includes an evaluation of only coverage or monitoring data There are no rewards for good performance	A structured evaluation is conducted once a year that is based on individual performance and includes an assessment of service delivery and an evaluation of coverage or monitoring data (national/program evaluation) Community is not asked to provide feedback on CHW performance There are some rewards for good performance such as small gifts, recognition, etc.	At least once a year an evaluation that includes individual performance including an assessment of service delivery based on documented supervisory feedback and an 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 the community plays a role in providing rewards.
8	**Incentives** **Financial (salary, bonuses, transportation, money for meals, income from sale of products)** **Non-financial (training, certification, advancement opportunities, formal recognition, uniforms, medicines, bicycles) Community incentives (food, labor, recognition)**	Program is completely volunteer: no financial or non-financial incentives are provided	No financial or non-financial incentives provided by the program but recognition from community is considered a reward and the CHW is sometimes given small tokens from the community	Some limited financial incentives are provided such as transport to training, but there is no salary or bonus Some non-financial incentives are offered Community offers gifts or rewards (e.g. labor, farming, formal recognition at events)	Incentives are balanced, with both financial and non-financial incentives provided, and are in line with expectations placed on CHW, e.g., number and duration of visits to clients, workload, and services provided Incentives are partially based on performance relevant to expectations and include advancement opportunities and/or certification Community offers gifts or rewards

	Component Definition	Level of Functionality: 0= non-functional; 1=partially functional; 2= functional; 3 = highly functional			
		0	**1**	**2**	**3 (best practice)**
9	**Community Involvement** **Role that community plays in supporting (supervising, offering incentives, providing feedback) CHW**	Community plays no role in 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 (discusses role or objectives, provides regular feedback) CHW is widely recognized and appreciated for providing service to the community Community has little or no interaction with supervisor	Community plays an active role in all support areas for CHW such as developing role, providing feedback, solving problems, providing incentives and helps to establish CHW as a leader in community. CHW is widely recognized and appreciated for providing service to community Community leader(s) has ongoing dialogue with CHW regarding health issues using data gathered by the CHW Community interacts with supervisor during visits to provide feedback and solve problems
10	**Referral System** **The process for: determining when referral is needed logistics planning for transport/payment to a health care facility when required how a referral is tracked and documented**	No referral system in place CHW might know when and where to refer clients, but no logistics planning in place by the community for emergency referrals information is not tracked or documented	CHW knows when to refer clients (danger signs, additional treatment needed, etc.) CHW and community know where referral facility is but have no formal referral process/logistics, forms Referral is not tracked by organization, community, or CHW	CHW knows when to refer clients (danger signs, additional treatment needed, etc.) CHW and community know where referral facility is and usually have the means to transport clients Client is referred with a slip of paper and informally tracked by CHW (checking in with family, follow-up visit), but info does not flow back to CHW from referral site.	CHW knows when to refer clients (danger signs, additional treatment needed, etc.) CHW and community know where referral facility is, usually have means for transport and have a functional logistics plan for emergencies (transport, funds) Client is referred with a standardized form and information flows back to CHW with a returned referral form

	Component Definition	Level of Functionality: 0= non-functional; 1=partially functional; 2= functional; 3 = highly functional			
		0	**1**	**2**	**3 (best practice)**
11	**Opportunity for Advancement** **The possibility for growth and advancement for CHWs, including certification, increased responsibilities, path to formal sector or change in role**	No opportunities for advancement offered	Advancement opportunities are sometimes offered to CHWs who have been in the program for a specific length of time No other opportunities are discussed with CHWs Advancement is not related to performance or achievement	Advancement is sometimes offered to CHWs who have been in the program for a specific length of time Limited training opportunities are offered to CHWs to learn new skills to advance roles Advancement is intended to reward good performance or achievement, although evaluation is not always consistent , clear or transparent	Advancement is offered to CHWs who perform well and who express an interest in advancement if the opportunity exists Training opportunities are offered to CHWs to learn new skills to advance their roles and CHWs are aware of them Advancement is intended to reward good performance or achievement and is based on a fair evaluation
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 defined process for documentation or information management is followed Information is sometimes collected from CHWs (e.g. annually) by program	Some CHWs document their visits in notebooks which they take with them to the facility for review, but a standardized record format does not exist CHWs do not discuss quality of monitoring forms and do not have discussions with supervisors regarding data collected CHWs are not involved in problem solving in the community using data collected	CHWs document their visits and provide data on a standardized format Supervisors monitor quality of documents, discuss them with CHWs, and provide help when needed CHWs/communities do not receive data analyzed and no effort to use data in problem solving in the community is made	CHWs document their visits consistently Supervisors monitor quality of documents and provide help when needed CHWs/communities work with supervisor to use data in problem solving at the community level

	Component Definition	Level of Functionality: 0= non-functional; 1=partially functional; 2= functional; 3 = highly functional			
		0	**1**	**2**	**3 (best practice)**
13	**Linkages to Health System** **How the CHWs and communities are linked to the larger health system** **Health system is made up of government, regions, districts, municipalities, and individual health facilities that provide resources, finances, and management to deliver health services to the population**	Links to health system are weak or non-existent; CHW program works in isolation from health system	Health system recognizes contribution of CHWs to overall system but provides little or no support *Example:* Policies exist that describe CHW role and occasional monitoring visits occur from MOH to communities (yearly).	Health system provides some support to the fundamental mechanics of CHW program *Training: supports initial and continuous training* *Supervision: guidelines exist ; health system supervisors have some involvement in CHW supervision* *Referrals: health system guidelines are used for referrals* *Some equipment/ supplies: are supplied by the health system to CHWs but may be incomplete or irregular so NGO ensures complete supply.* *Incentives: health system does not provide monetary or non-monetary rewards , but community or NGO does* *Advancement: provides some opportunities through certification, use of data: CHW monitoring data are included in health facility/system reporting and national health monitoring information system*	Health system has comprehensive support mechanisms for all fundamental aspects of CHW program *Training: health system provides initial and continuing training and on-site coaching* *Supervision: guidelines are clear; assigned supervisors visit CHW for performance review, coaching, and problem solving and document results* *Referral: health system guidelines include referral, counter-referral, and information is used to improve system* *Equipment/supplies: consistently supplied, tracked and resupplied to CHWs by health system* *Incentives: monetary or non-monetary rewards from health system based on performance* *Advancement: provides consistent opportunities though certification, job path, etc.* *Use of data: CHW monitoring data are reviewed, analyzed, and included in health facility/system reporting and national health monitoring information system*

	Component Definition	Level of Functionality: 0= non-functional; 1=partially functional; 2= functional; 3 = highly functional			
		0	**1**	**2**	**3 (best practice)**
14	**Program Performance Evaluation** **General program evaluation of performance against targets, overall program objectives, and indicators carried out on a regular basis**	No regular evaluation of program performance related to CHW interventions	Yearly evaluation conducted of CHW activities (may be sample), but it does not assess CHW achievements against program indicators and outcomes No feedback is provided to CHWs on how they are performing relative to program indicators and targets CHW program is realizing less than 75% of its targets (up to the end of the most recent quarter)	Yearly evaluation conducted of CHW activities (may be sample) that assesses CHW achievements in relation to program indicators and targets Assessment does not include evaluation of the quality of service delivery provided by CHWs, and the community is not asked to provide feedback on CHW performance Feedback is provided to CHWs on how they are performing in relation to program indicators and targets but does not include assessment of performance against service delivery standards CHW program is reaching at least 75% of its targets (up to end of the most recent quarter)	Yearly evaluation conducted of CHW activities (may be sample) that assesses CHW achievements in relation to program indicators and targets The assessment includes an evaluation of the quality as well as the quantity of service delivery provided by CHWs, and the community is asked to provide feedback on CHW performance. Health facility workers are also asked to provide feedback based on data received from CHWs. Feedback is provided to CHWs on how they are performing in relation to program indicators and targets and against service delivery standards. CHW program is realizing 75% or more of its targets (up to the end of the most recent quarter)
15	**Country Ownership** **The extent to which the ministry of health has: integrated the CHW cadre in health system planning (e.g. policies in place); budgeted for local/district/nationa l financial support; and provided logistical support (e.g. supervision, supplies) to sustain CHW programs at the district, regional and/or national levels**	CHWs are not recognized as part of national health system and no plans are in process to create or support a CHW cadre. No financial support is provided to CHW program (it is externally funded and managed) No supervision or supplies are provided to existing CHWs	CHWs are recognized as helpful in communities but their role is not formalized CHWs that exist are fully supported by external funding Some supervision is provided by district health offices in conjunction with NGO supervision; supplies for CHWs are not specifically allotted (CHWs use supplies allotted to health facilities)	CHWs are recognized as part of the formal health system (policies are in place that define their roles, tasks, relationship to health system) Minimal local/district budgets exist but financing is not sufficient or budgets are not fully funded Some supervision is provided by district health offices in conjunction with NGO supervision; supplies for CHWs are not specifically allotted (CHWs use supplies allotted to health facilities)	CHWs are recognized as part of the formal health system (policies are in place that define their roles, tasks, relationship to health system) Adequate local/district budgets exist and are generally fully funded Supervision is provided by local/district/central health offices; supplies for CHWs are specifically allotted and generally available

Appendix 2: French CHW Interventions

A. Interventions SMNI des AC

(Matrice adaptée pour Madagascar)

Instructions générales: Cette liste fournit une vue d'ensemble des activités en rapport avec la santé maternelle, néonatale et infantile (SMNI). Passer en revue la liste avec les participants et cocher les activités qui font partie du rôle de l'ASC. Seules les activités cochées devraient être examinées dans le Tableau 1.

Vue d'ensemble de la matrice des interventions d'un programme SMNI		✓
Service	**I. SOINS PRENATALS**	
Activités	Conseils d'anticipation	
	Nutrition maternelle	
	Anatoxine tétanique	
	Vermifugeage	
	Paludisme	
Service	**II. SOINS DE L'ACCOUCHEMENT**	
Activités	Accouchement propre/prévention des infections	
	Gestion active de la troisième phase de l'accouchement (GAPTA) pour la prévention de l'hémorragie post-partum (HPP)	
	Soins néonatals essentiels immédiats	
	Complications néonatales maternelles	
Service	**III. SOINS POST-PARTUM/POST-NATALS**	
Activités	Visite à domicile/contact avec la mère/le nouveau-né dans les deux-trois jours suivant la naissance	
	Soins néo-natals essentiels	
	Conseils sur la nutrition maternelle	
	Soins spéciaux pour les bébés de faible poids à la naissance (soins Kangourou)	
	Planification familiale post-partum	
Service	**IV. NUTRITION INFANTILE**	
Activités	Alimentation du nourrisson et du jeune enfant (ANJE): Conseils pour l'allaitement immédiat après la naissance, allaitement maternel exclusif pendant six mois; aliments complémentaires appropriés en fonction de l'âge	
	Suppléments de vitamine A (deux fois par an pour les enfants âgés de 6-59 mois)	
	Suivi de la croissance	
	Gestion communautaire de la malnutrition aiguë (GCMA) à l'aide d'aliments thérapeutiques prêts à être utilisés	
Service	**V. VACCINATION DES ENFANTS**	
Activités	Cartographie/suivi de la couverture vaccinale	
	Participation aux campagnes de vaccination	
	Vaccin du bacille Calmette-Guérin contre la tuberculose (BCG)	

	Injection diphtérie, tétanos, coqueluche (DTC)	
	Polio	
	Vaccin contre Haemophilus influenzae de type B (HIB)	
	Hépatite B	
	Rougeole	
	Autres vaccins (par exemple, contre le pneumocoque, le rotavirus, etc.)	
Service	**VI. MALADIES DE L'ENFANT**	
	Prise en charge intégrée des maladies de l'enfant (PCIME)	
Activités	Infections respiratoires aigues	
	Diarrhée	
	Fièvre et Paludisme	

Tableau 1. Matrice des interventions de santé maternelle, néonatale et infantile (SMNI)

INTERVENTIONS DE SANTE MATERNELLE, NEONATALE ET INFANTILE Pour être considéré comme un AC fonctionnel qui fournit des services de SMNI, il faut que les tâches de l'AC comprennent au moins l'une des activités complètes de SMINI listées ci-dessous		**Conseiller**	**Effectuer**	**Transférer/ référer**	**Non applicable**	**Non effectuée**	**COMMENTAIRES**
I	**SOINS PRENATALS**						
a	**Conseils d'anticipation**						
	Préparation à la naissance/conseils sur la préparation aux complications (signes de danger; accoucheuse qualifiée)						
	Conseils pour les soins du nouveau-né						
b	**Nutrition maternelle**						
	Conseils d'ordre général						
	Suppléments de folate de fer						
c	**Anatoxine tétanique**						
d	**Vermifugeage**						
e	**Paludisme**						
	Moustiquaires imprégnées						
	TPIg						
II	**SOINS D'ACCOUCHEMENT**						
a	**Accouchement propre/prévention de l'infection (lavage des mains, nettoyer lames)**						

INTERVENTIONS DE SANTE MATERNELLE, NEONATALE ET INFANTILE Pour être considéré comme un AC fonctionnel qui fournit des services de SMNI, il faut que les tâches de l'AC comprennent au moins l'une des activités complètes de SMINI listées ci-dessous		**Conseiller**	**Effectuer**	**Transférer/ référer**	**Non applicable**	**Non effectuée**	**COMMENTAIRES**
b	**GATST pour la prévention des HPP (utéro-toniques, serrage tardif du cordon/excision, traction contrôlée du cordon, massage utérin)**						
c	**Soins néonatals essentiels immédiats**						
	Réchauffement et séchage immédiats						
	Initiation précoce de l'allaitement maternel						
d	**Complications néonatales maternelles**						
	Orientation pour dystocie						
	Réanimation du nouveau-né						
	Faible poids à la naissance/soins aux nourrissons prématurés						
	Orientation pour soins de pré-éclampsie						
III.	**SOINS POST-PARTUM/POST-NATALS**						
a	**Visites à domicile/contact avec la mère/nouveau-né dans les 2-3jours suivant la naissance**						
b	**Soins néonatals essentiels**						
	Allaitement maternel exclusif pendant six mois						
	Protection thermique						
	Vaccination du nouveau-né						
	Soins des yeux du nouveau-né						
c	**Conseils sur la nutrition maternelle**						
d	**Soins spéciaux pour les bébés de faible poids à la naissance (soins kangourou)**						
e	**Planification familiale post-partum**						
	Conseils de planification familiale						
	Contraceptifs oraux						
	Préservatifs						
	Education MAG						
	Produits injectables (Depo-Provera, etc.)						
	Méthodes de longue durée et permanentes (DIU/ligature des trompes; implants)						

INTERVENTIONS DE SANTE MATERNELLE, NEONATALE ET INFANTILE Pour être considéré comme un AC fonctionnel qui fournit des services de SMNI, il faut que les tâches de l'AC comprennent au moins l'une des activités complètes de SMINI listées ci-dessous		**Conseiller**	**Effectuer**	**Transférer/ référer**	**Non applicable**	**Non effectuée**	**COMMENTAIRES**
IV	**NUTRITION INFANTILE**						
a	**AMJE: Conseils pour l'allaitement immédiat après la naissance, l'allaitement maternel exclusif pendant six mois; l'âge pour les aliments complémentaires appropriés**						
b	**Suppléments de vitamine A(deux fois par an pour les enfants de 6-59mois)**						
c	**Suivi de la croissance**						
d	**GCMA - recours à des aliments thérapeutiques prêts à être utilisés**						
V	**VACCINATIONS DE L'ENFANT**						
a	**Suivi du statut vaccinal au niveau communautaire**						
b	**Participation aux campagnes de vaccinations**						
c	**Participation aux SSME Avril et Octobre**						
d	**BCG**						
e	**DTP**						
f	**Polio**						
g	**HIB**						
h	**Hépatite B**						
i	**Rougeole**						
j	**Autres vaccins (par exemple, pneumocoque; rotavirus, etc.)**						
VI	**MALADIES DE L'ENFANT**						
a	**Prise en Charge Intégrée des Maladies de l 'enfant (PCIME)**						
	Rechercher les signes de danger						

INTERVENTIONS DE SANTE MATERNELLE, NEONATALE ET INFANTILE Pour être considéré comme un AC fonctionnel qui fournit des services de SMNI, il faut que les tâches de l'AC comprennent au moins l'une des activités complètes de SMINI listées ci-dessous		**Conseiller**	**Effectuer**	**Transférer/ référer**	**Non applicable**	**Non effectuée**	**COMMENTAIRES**
	Evaluer les symptômes						
	Classer les symptômes						
	Identifier les traitements						
	Traiter l'enfant						
	Conseiller la mère comment donner le traitement à domicile et quand revenir						
	Suivre l'enfant malade						
b	**Infections respiratoires aigues**						
	Recherche des signes de danger et référence						
	Evaluer et classer les symptômes						
	En cas de pneumonie, traiter avec des antibiotiques (Cotrim)						
	En cas de pneumonie, faire revenir l'enfant après 2 jours						
	Faire revenir immédiatement en cas de signe de danger						
	Conseiller la mère comment donner le traitement à domicile et quand revenir						
c	**Diarrhée**						
	Recherche des signes de danger et référence						
	Evaluer, classer les symptômes						
	En case de la diarrhée simple traiter avec SRO/Zinc (Viasur)						
	Conseiller la mère comment donner le traitement à domicile et quand revenir						
	Conseils d'hygiène (Traitement de l'eau au point d'utilisation, Lavage des Mains avec du Savon)						
	Faire revenir l'enfant systématiquement après 2 jours						
	Faire revenir immédiatement en cas de signe de danger						

INTERVENTIONS DE SANTE MATERNELLE, NEONATALE ET INFANTILE Pour être considéré comme un AC fonctionnel qui fournit des services de SMNI, il faut que les tâches de l'AC comprennent au moins l'une des activités complètes de SMINI listées ci-dessous		**Conseiller**	**Effectuer**	**Transférer/ référer**	**Non applicable**	**Non effectuée**	**COMMENTAIRES**
d	**Fièvre et Paludisme**						
	Recherche des signes de danger et référence						
	Dépistage avec test de diagnostic rapide						
	Evaluer, classer les symptômes						
	En cas de paludisme, traiter avec ACT (Actipal/ ASAQ)						
	Conseiller la mère sur comment donner le traitement à domicile et quand revenir						
	Conseils sur l'utilisation continue de moustiquaires imprégnées						
	Traitement du paludisme conformément aux directives						

B. Interventions Planification Familiale des AC

Instructions générales: Cette liste fournit une vue d'ensemble des activités en rapport avec la planification familiale. Passer en revue la liste avec les participants et cocher les activités qui font partie du rôle de l'ASC. Seules les activités cochées devraient être examinées dans le Tableau 2.

Vue d'ensemble de la matrice des interventions d'un programme		✓
Service	**I. IMPLICATION DE LA COMMUNAUTE EN MATIERE DE PLANIFICATION FAMILIALE ET COMMUNICATION POUR UN CHANGEMENT DE COMPORTEMENT**	
Activités	Activités de mobilisation Communautaire	
Service	**II. PRESTATION DE SERVICES DE PLANIFICATION FAMILIALES**	
Activités	Conseil en planification familiale	
	Méthodes contraceptives	
Service	**III. AUTRE : SYSTEME, LOGISTIQUE**	
Activités	Documentation des services PF	
	Maintient de ses propres fournitures	
	Utilisation d'aides de travail et d'outils pour les conseils et la prestation de services	
	Entretient de relations avec l'établissement de santé et les agents de santé	
	Services fournis au domicile	
	Services fournis au poste de santé	

Tableau 2. Matrice des interventions de planification familiale

INTERVENTIONS DE PLANIFICATION FAMILIALE Pour être considéré comme un AC fonctionnel qui fournit des services de Planning Familiale, il faut que les tâches de l'AC comprennent au moins l'une des activités complètes de PF listées ci-dessous		**Conseiller**	**Effectuer**	**Transférer/référer**	**Non applicable**	**Non effectuée**	**COMMENTAIRES**
I	IMPLICATION DE LA COMMUNAUTE EN MATIERE DE PLANIFICATION FAMILIALE ET COMMUNICATION POUR UN CHANGEMENT DE COMPORTEMENT						
a	**Activités de mobilisation communautaire** (rassemblements de la communauté, présentations de pièces / chansons, etc.)						
	Impliquer les leaders de la communauté pour qu'ils appuient la planification familiale (chefs, leaders religieux)						
	Promouvoir la sensibilisation communautaire et les connaissances en matière de planification familiale (bon moment et bon espacement des grossesses pour la santé, avantages pour la santé d'une limitation des naissances, importance de retarder la première grossesse)						
	Gérer les rumeurs ou les fausses informations (sensibiliser les communautés concernant la PF, fournir des renseignements et des preuves concernant la sûreté, démystifier)						
	Utiliser / renforcer les messages sur la PF						
	Suivre les établissements locaux pour améliorer la qualité des soins (soutenir la communauté pour qu'elle tienne les établissements pour responsables, vérifier la disponibilité des méthodes et des prestataires)						
	Impliquer les réseaux sociaux ou les groupes communautaires pour qu'ils incorporent les messages et les informations de PF (groupes de mères, coopératives agricoles, etc.)						
	Impliquer les personnes qui décident dans les familles (belles-mères, maris / hommes, etc.)						
	Impliquer les jeunes et les sensibiliser (mariés ou célibataires, à l'école ou pas à l'école)						
II	**PRESTATION DE SERVICES DE PLANIFICATION FAMILIALE**						
a	**Conseils en PF**						
	Intentions de grossesse • Désire retarder ou limiter les grossesses • Désire une grossesse maintenant						

	INTERVENTIONS DE PLANIFICATION FAMILIALE Pour être considéré comme un AC fonctionnel qui fournit des services de Planning Familiale, il faut que les tâches de l'AC comprennent au moins l'une des activités complètes de PF listées ci-dessous	**Conseiller**	**Effectuer**	**Transférer/référer**	**Non applicable**	**Non effectuée**	**COMMENTAIRES**
	• Risque IST						
	Connaissances en matière de la fécondité • Jours de fécondité et de non fécondité • Probabilité d'une grossesse • Retour à la fécondité après une fausse couche ou un avortement						
	Bienfaits pour la santé de : • L'espacement des grossesses • La limitation du nombre des grossesses • Retarder la première grossesse						
	PF postpartum • Risque de grossesse • Méthodes appropriées						
	Planification familiale post-avortement • Risque de grossesse • Méthodes appropriées						
	Approches conviviales pour les jeunes						
	Approches conviviales pour les hommes						
	Conseils en PF pour les couples et le partenaire						
b	**Méthodes contraceptives**						
	Accès lors de la grossesse (liste de contrôle pour la grossesse ou critères)						
	Information sur la gamme des méthodes de PF						
	Préservatifs (masculin et féminin)						
	Contraceptifs oraux : première distribution à une femme						
	Contraceptifs oraux: distribution consécutive à la même femme						
	Contraceptifs injectables: première administration à une femme						
	Contraceptifs injectables: administration consécutive à la même femme						
	Contraception d'urgence						
	Méthode des jours standard						
	Méthode deux jours						
	Implants (pose et retrait)						

INTERVENTIONS DE PLANIFICATION FAMILIALE Pour être considéré comme un AC fonctionnel qui fournit des services de Planning Familiale, il faut que les tâches de l'AC comprennent au moins l'une des activités complètes de PF listées ci-dessous		**Conseiller**	**Effectuer**	**Transférer/référer**	**Non applicable**	**Non effectuée**	**COMMENTAIRES**
	DIU (pose et retrait)						
	Méthode de l'aménorrhée de la lactation (MAL) (éducation, transition, utilisation de la carte de la cliente MAL)						
	Conseils sur les effets secondaires et causes de l'abandon						
	Stérilisation féminine						
	Stérilisation masculine						
	Approches et services pour les jeunes						
	Approches et services conviviaux pour les hommes						
	Plans de suivi (à quel moment et comment obtenir la dose suivante, conseils sur les effets secondaires et l'abandon, transition entre méthodes, par exemple de la pilule à un injectable, si désiré						
III.	**AUTRES : SYSTEMES, LOGISTIQUE**						
a	**Documentation des services PF**						
	Tenue des dossiers des clients						
	Incorporation des dossiers des services dans le SGIS						
c	Maintient de ses propres fournitures (stock adéquat de contraceptifs et de matériel didactique, entreposé correctement)						
d	Utilisation d'aides de travail et d'outils pour les conseils et la prestation de services						
e	Entretient de relations avec l'établissement de santé et les agents de santé						
f	Services fournis au domicile						
g	Services fournis au poste de santé						

C. Interventions WASH des AC

(Matrice adaptée pour Madagascar)

Instructions générales: Cette liste fournit une vue d'ensemble des activités en rapport avec l'eau, assainissement et hygiène (Water, Sanitation, Hygiene – **WASH).** Passer en revue la liste avec les participants et cocher les activités qui font partie du rôle de l'ASC. Seules les activités cochées devraient être examinées dans le Tableau 3.

Vue d'ensemble de la matrice des interventions d'un programme SMNI		✓
Service	**I. PROMOTION WASH AUPRES DES MENAGES**	
Activités	Evaluer les pratiques WASH actuelles des ménages	
	Introduire les pratiques améliorées et des options	
	Aider les ménages à choisir des options réalisables	
	Effectuer un suivi des ménages concernant les plans pour une hygiène familiale améliorée	
Service	**II. PROMOTION WASH COMMUNAUTAIRE**	
Activités	Amélioration et entretien des installations	
	Promotion et information	

Tableau 3. Matrice des interventions eau, assainissement et hygiène (Water, Sanitation, Hygiene – WASH)

INTERVENTIONS EAU, ASSAINISSEMENT ET HYGIENE (WATER, SANITATION, HYGIENE – WASH) Pour être considéré comme un AC fonctionnel qui fournit des services de WASH, il faut que les tâches de l'AC comprennent au moins l'une des activités complètes de WASH listées ci-dessous		**Conseiller**	**Démontrer**	**Effectuer**	**Non applicable**	**Non effectuée**	**COMMENTAIRES**
I	**PROMOTION WASH AUPRES DES MENAGES**						
a	**Evaluer les pratiques WASH actuelles des ménages**						
	Traitement de l'eau						
	Stockage de l'eau						
	Elimination hygiénique des excréments (adultes et enfants)						
	Lavage des mains avec du savon aux moments critiques						
	Manipulation et stockage des aliments						
b	**Introduire les pratiques améliorées et des options**						
	Traitement de l'eau • Filtrage • Chloration (Sur'Eau) • Chauffer l'eau jusqu'à l'apparition de bulles						

INTERVENTIONS EAU, ASSAINISSEMENT ET HYGIENE (WATER, SANITATION, HYGIENE – WASH) Pour être considéré comme un AC fonctionnel qui fournit des services de WASH, il faut que les tâches de l'AC comprennent au moins l'une des activités complètes de WASH listées ci-dessous	**Conseiller**	**Démontrer**	**Effectuer**	**Non applicable**	**Non effectuée**	**COMMENTAIRES**
• Désinfection solaire (SODIS)						
Stockage et manipulation de l'eau • Récipient à goulot étroit • Récipient avec robinet • Couvercle rigide pour récipient à goulot large • Récipient réservé pour prendre l'eau traitée (Zinga) pendues à des clous ou des crochets						
Elimination hygiénique des excréments • Utiliser une latrine familiale • Utiliser une latrine familiale améliorée (pour qu'elle puisse être fermée, nettoyée et qu'elle soit protégée de la pluie) et utiliser de Dalle Sanplat • Enterrer les excréments • Utiliser des pots pour enfants • Jeter les excréments des enfants dans des latrines						
Lavage des mains au savon aux moments critiques • Se laver les mains après avoir déféqué, après avoir manipulé des excréments d'enfants, avant de manger, avant de faire la cuisine • Avoir ce qu'il faut pour se laver les mains (par exemple, eau, savon ou cendre et cuvette) à proximité de la latrine • Avoir ce qu'il faut pour se laver les mains à proximité de l'endroit où l'on fait la cuisine • Utiliser des techniques simples pour se laver les mains telles que les « Tippy Taps »						
Manipulation et stockage des aliments • Laver les aliments avec de l'eau traitée • Se laver les mains avant de manipuler des aliments • Couvrir les aliments pour les protéger des saletés et des mouches • Stocker les aliments dans un endroit permettant d'éviter une éventuelle contamination par des saletés ou des mains • Séparer les aliments crus et les aliments cuits						

INTERVENTIONS EAU, ASSAINISSEMENT ET HYGIENE (WATER, SANITATION, HYGIENE – WASH) Pour être considéré comme un AC fonctionnel qui fournit des services de WASH, il faut que les tâches de l'AC comprennent au moins l'une des activités complètes de WASH listées ci-dessous		**Conseiller**	**Démontrer**	**Effectuer**	**Non applicable**	**Non effectuée**	**COMMENTAIRES**
c	**Aider les ménages à choisir des options réalisables**						
	Passer un accord verbal avec le ménage pour qu'il adopte une pratique améliorée réalisable						
	S'entendre sur une date et une heure pour une vérification / visite de suivi						
d	**Effectuer un suivi des ménages concernant les plans pour une hygiène familiale améliorée**						
	Se rendre chez le ménage à la date / à l'heure convenues						
	Passer en revue l'accord et les progrès en rapport avec l'adoption jusqu'à présent de pratiques améliorées						
	Aider le ménage à choisir une autre pratique complémentaire et/ ou progressive et fixer une date pour un nouveau suivi						
II	**PROMOTION WASH COMMUNAUTAIRE**						
a	**Amélioration et entretien des installations**						
	Amélioration des installations sanitaires communautaires						
	Entretien et nettoyage des installations communautaires						
b	**Promotion et information**						
	Mobilisation communautaire pour mettre un terme à la défécation à l'air libre.						
	Participation aux journées internationales à thème: Journée mondiale de l'eau, Journée mondiale du lavage des mains, etc.						

Appendix 3: CHW AIM Validation Questionnaire (Crigler et al., 2011, pp VI-5–8)

Instructions: *Use this document either before or after the assessment workshop to verify the scoring established by workshop participants. Try to visit 2-3 field sites that did not participate in the workshop and interview up to 6 CHWs in total. Then compare responses with the scores and action plan to determine if any changes to either document are necessary. If conducted prior to the assessment, use the information as a guide during the discussion. If the interviews are after the assessment, discuss the changes with those who participated in the assessment.*

Type/title of Community Health Worker (CHW) _____ Date _____

1. How long have you worked as a CHW? _____Months

2. Were you recruited to be a CHW by:
   (Check all that apply)
   1. The community _____
   2. The government _____
   3. NGO/CBO _____
   4. Other (please explain) _____
      _____

3. Please describe how you were recruited.

4. How were you assigned to the community(s) in which you currently work?

5. Do you know what you are expected to do as a CHW?
   Yes No

6. Please describe the key tasks for which you are responsible.

7. Do you feel that what you do as a CHW meets the expectations of the community?
   Yes No

8. Please describe the initial training you received to prepare you for your role as a CHW.

   Date _____

   Duration _____ days

   Topics covered:

9. Please describe any additional training (refresher/ongoing training) you have received to help you fulfill your role as a CHW.

Date	Duration (days)	Topics Covered

10. If you haven't received any ongoing training, please explain...

11. Do you have the supplies and equipment you need to provide the services you are expected to deliver? Yes No

12. If you have experienced shortages or stockouts of supplies, please provide the following information about the commodity or commodities.

Commodity	Stockout in the last six months (Y/N)	Stockout Duration (weeks)	Remarks

13. How do you get more supplies?

    1. How often do you get them? Every _____
    2. What form(s) do you use? _____
    3. How do you get the form(s) and to whom do you submit them? _____

14. Who is your supervisor? Name: _____

    Title: _____

15. How often does your supervisor visit you?

    1. More than once a month _____
    2. Once a month _____
    3. Once in three months _____
    4. Once in six months _____
    5. Less than once in six months _____

16. What does your supervisor do when he/she visits you?

Activity	Done?	Example
Observation of service delivery		
Coaching and skills development		
Trouble shooting, problem solving		
Record Review		
Supply check		

17. Have you received a formal evaluation of your work in the last 12 months? Yes No

18. If yes:
    1. Who evaluated you? _____
    2. How were you evaluated? _____
    3. What was evaluated? _____

19. Does the community you work in provide you with any of the following?

Activity	Done (Y/N)	Example
Feedback		
Support (financial/gifts in kind)		
Formal recognition/appreciation		
Guidance on your work		

20. Do you refer clients for health services you do not or cannot provide? Yes No

21. Do you complete a referral form for the client to take to the facility? Yes No

22. Please describe any feedback or counter referral you receive from the facility for clients you have referred.

23. Please describe the transportation systems available to get clients to referral facilities.

24. Do you have opportunities for promotion or professional advancement through the CHW program? Yes No

25. If yes, please describe them.

26. Do you compile reports on your clients? Yes No
    If yes:

    1. What do you include in the reports?
       _____
    2. To whom do you submit the reports?
       _____
    3. How do you use the information you collect?
       _____
    4. How does the program use the information you collect?
       _____
    5. Are reports shared with the community?
       _____

27. Do you compile information from your record books into monthly or quarterly reports?

    Yes No

28. Are compiled results shared with you and other CHWs?

29. Are reports or information about the program and its results shared with the community? Yes No

30. What are your biggest challenges as a CHW?

31. What changes are needed to help you do your job better?

Appendix 4: Supervision Research: FGD and Semi-structured Interview Guides (Available in French Only)

The assessment's supervision component applied one guide per target group: CHVs, supervisors, and community members during visits to communities.

Guides de questions pour les discussions sur le sujet de **la supervision des agents de santé**

Note pour les facilitateurs:

Les questions représentent un scope des sujets à couvrir – éventuellement pas tous les sujets peuvent être abordé d'une manière approfondis mais il sera bien de les adresser. Les questions de suivi sont des exemples pour faciliter la discussion.

Objectifs :
La conclusion de la discussion devrait répondre aux questions suivantes :

- Quels éléments et aspects sont aperçu comme utile et relevant ?
- Qu'est-ce qu'il est important pour une supervision effective ?
- Quels éléments sont aperçu comme inutile?
- Quels défis empêchent une supervision constructive ?
- Qu'est-ce qu'il faudra changer pour une amélioration et comment ?

Groupe cible 1: AGENTS DE SANTé COMMUNAUTAIRES (AC)

Guide de questions AC

Aspect / sous-thème	Questions principaux	Questions de suivi / clarification
Compréhension/ définition	• Supervision: qu'est-ce que cela représente pour vous	• Est-ce que c'est plutôt le contrôle de travail • Est-ce que c'est plutôt un soutien professionnel pour vous
Périodicité/ régularité	• Est-ce que vous voyez un superviseur régulièrement	• En quel périodicité : chaque mois, une fois chaque 3 mois, 2-3 fois par an; une fois par an
Organisation	• Comment votre supervision est organisée	• Individuellement ou en groupes • Annoncée ou non annoncée
	• Quel est le lieu habituel de la supervision	• Vous déplacez-vous au centre de santé/clinique • Est-ce qu'un superviseur vous rend visite • Quelqu'un vous accompagne dans les communes
Contenu	• Qu'est-ce qu'il se passe pendant la supervision / Comment se déroule une supervision normalement	• Est-ce que vos rapports et les données sont révisés • Est-ce qu'il y a une contrôle de l'équipement et des matériaux • Est-ce que le superviseur est présent pendant que vous donnez des services en vous observant

Aspect / sous-thème	Questions principaux	Questions de suivi / clarification
		• Est-ce que le superviseur vous donnes des remarques / ses impressions • Est-ce que vous apprenez des nouvelles techniques / pratiques
Outils	• Quels outils sont utilisés pendant la supervision • Est-ce que vous avez l'impression que ses outils sont utiles pour la supervision	• Est-ce que votre superviseur utilise des outils pendant la supervision • De quels outils s'agit-il : des listes, des grilles, etc • Les outils, sont-ils utiles ou plutôt gênant • Est-ce que vous connaissez le résultat de la supervision, le rapport
Superviseur	• Qui est responsable pour votre supervision	• Quelqu'un de la commune, du centre de santé, de l'ONG • Est-ce que c'est une personne en continuité ou chaque fois quelqu'un different • Est-ce que le superviseur connaît votre commune
	• Comment le / les superviseur/s se comportent envers vous	• Est-ce qu'ils écoutent à vos soucis • Est-ce qu'ils répondent à vos questions • Est-ce qu'ils vous donnent des conseils pour une amélioration de vos pratiques • Est-ce qu'il arrive parfois qu'ils manquent de respect envers vous • Est-ce qu'ils sont reconnaissants ou plutôt critiquant
Attentes	• Qu'est-ce que vous attendez de la supervision	• Par exemple : de la reconnaissance de votre travail, des vos efforts ; du soutien /renforcement envers la commune, les services de la santé ; • Est-ce que vous preferez une supervision plus souvent
Effets	• Qu'est-ce que la supervision vous apporte pour votre travail	• Est-ce que la supervision vous aide à développer vos compétences techniques ou théorétiques • La supervision assiste – elle à résoudre des problèmes que vous envisagez • Est-ce que le feedback pendant la supervision est encourageant et motivant pour vous • Est-ce qu'il y a des éléments ou des personnes que vous découragent • Est-ce qu'il y a un suivi de la dernière supervision • Est-ce qu'on écoute et répond à vos suggestions de l'amélioration de service communautaire
Vision / amélioration	• La supervision idéale, comment la décririez-vous • Imaginez-vous comme superviseur future des AC : qu'est-ce que vous ferriez mieux ?	• Qu'est – ce qu'il faudra changer pour améliorer la supervision ; • Quels éléments voudraient la rendre plus utile et efficace ?

Groupe cible 2 : SUPERVISEURS

Guide de questions superviseurs

Aspect / sous-thème	**Questions principaux**	**Questions de suivi / clarification**
Compréhension/ définition	• La supervision : qu'est-ce que cela représente pour vous • Comment décrivez- vous votre rôle en tant que superviseur	• Quels types de supervision connaissez-vous ? (routine, formative, coaching) • Quel est votre mandat en tant que superviseur • Quels sont les objectifs clés de votre travail en tant que superviseur
Appui	• Quel appui est apporté à votre travail en tant que superviseur	• Disposez-vous de l'equipement nécessaire • Est-ce qu'il y a des moyens / soutien pour le transport • Est-ce qu'il y a un point de reférence pour vos questions
Défis	• Quels sont les défis majeurs que vous envisagez	• Quels aspects et éléments empêchent une supervision effective • Quelles lacunes observez-vous
Organisation	• Comment votre travail en supervision est-il organisé	• Travaillez-vous seul / en isolation • Est-ce que vous travaillez en équipe (par district, région ou autre) • Est-ce qu'il ya un réseau de superviseurs • Est-ce que les supervisions différentes sont coordinées et comment • Est-ce qu'il y a un calendrier des supervisions • Est-ce que vous êtes responsable des AC / affecté à des communes d'une manière continuant
	• En quels intervalles voyez-vous les AC • Combien de temps pouvez-vous consacrer à chaque AC	• En quel périodicité : chaque mois, une fois chaque 3 mois, 2-3 fois par an ; une fois par an • Une heure ou plus ou moins ? Est-ce que c'est suffisant ?
	• Quel est le lieu habituel de la supervision	• Le centre de santé/clinique de district ou la communauté • Est-ce que vous rendez visite aux AC dans leurs communauté
	• Comment les communautés sont impliqués	• Est-ce que c'est votre rôle d'impliquer les communautés • Est-ce que vous voyez les représentants des communautés régulièrement • Est-ce que les discussions avec les communautés font partie intégrales de la supervision
Contenu	• Comment vous effectuez une supervision / Comment se déroule une supervision normalement	• Est-ce que vous révisez les rapports et les données • Est-ce que vous contrôlez l'équipement et les matériaux • Est-ce que vous accompagnez les AC et les observez-vous leur provision des services • Est-ce que vous donnez des remarques / ses impressions

Aspect / sous-thème	Questions principaux	Questions de suivi / clarification
		• Est-ce que vous donnez des instructions des nouvelles techniques / pratiques
Outils	• Quels outils vous avez à votre disposition pour la supervision • Quelles sont vos idées concernant ces outils	• Est-ce que vous utilisez des outils pendant la supervision • De quels outils s'agit-il : des listes, des grilles, etc • Les outils, sont-ils utiles ou plutôt gênant ; quels éléments sont utiles et lesquels sont gênants • Est-ce que vous avez des suggestions pour l'amélioration des outils • Est-ce qu'ils manquent des éléments dans les outils
Profil de superviseur	• Qu'est-ce que vous pensez de la formation pour superviseurs • Comment décrivez-vous un bon superviseur	• Est-ce que vous étiez formé comme superviseur • Quelles compétences sont importantes pour un superviseur • Quelles attitudes sont importantes pour faciliter la supervision
Facteurs de succès	• Quels facteurs sont importants pour le succès de la supervision	• Comment vos recommandations sont traduit en activités • Est-ce que les activités sont discuté et mis en accord avec les AC • Comment assurer la faisabilité des activités suite aux recommandations • Comment le suivi est organisé • Quelle relation professionnelle avez-vous avec les AC que vous supervisez
Vision / amélioration	• La supervision idéale, comment la décririez-vous • Qu'est-ce que vous aimeriez faire mieux si possible	• Qu'est – ce qu'il faudra changer pour améliorer la supervision ; • Quels éléments voudraient la rendre plus utile et efficace ? • Qu'est-ce pourrait faciliter votre travail en tant que superviseur • Quels sont les priorités à adresser

Groupe cible 3 : Communautés

Guide de questions pour les représentants communautaires

Aspect / sous-thème	**Questions principaux**	**Questions de suivi / clarification**
Rôle	• Quel est le rôle de la communauté concernant la supervision des AC • Comment voyez-vous le rôle des communautés	• Quelles responsabilités vous avez au présent vis a vis la gestion des AC • Comment vous êtes impliqué dans le processus de supervision et son suivi • Quelles décisions la communauté prend / doit approuver • Comment vous êtes impliqué dans la mise en œuvre des recommandations • Le rôle de la communauté est-il suffisant pour assurer la pertinance de la supervision • Est-ce que parfois vous avez le rôle de médiateur entre AC, superviseur et communauté pour résoudre des problèmes ; comment vous faites cela
Qualité et effectivité de supervision	• Quelles idées avez-vous sur la supervision au présent	• Quelles sont les éléments importants • La supervision est-ce qu'elle est utile et effective ; • Est-ce que les interventions de la supervision contribuent à l'amélioration des services des AC • Quelles lacunes observez-vous • Est-ce que la périodicité est suffisant d'après vous
Communication	• Comment l'échange des informations se passe entre les superviseurs et la communauté	• Est-ce que vous recevrez un rapport sur les résultats de la supervision • Est-ce qu'on vous consulte concernant les recommandations
Vision / amélioration	• Vue de la perspective communautaire comment une supervision utile et effective devrait être effectuée	• Qu'est-ce qu'il faudra changer pour une amélioration • Quelles suggestions avez-vous pour une autoprise en charge • Quelles sont les interventions prioritaires à effectuer

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