

Operations Room Utility Survey Report

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One Million Community
Health Workers Campaign

Table of Contents

EXECUTIVE SUMMARY	3
INTRODUCTION	4
BACKGROUND	4
METHODOLOGY	6
UTILITY SURVEY	6
DATA ANALYSIS	7
RESULTS	7
GENERAL QUESTIONS: CHW COUNTS AND CAPABILITIES	7
DATA COLLECTION, VALIDATION AND PERFORMANCE INDICATORS.....	12
TOOLS, SOFTWARE AND MOBILE TECHNOLOGY	14
OPERATIONS ROOM UTILITY.....	15
DISCUSSION.....	17
CHW COUNTS, CAPABILITIES, AND DATA MANAGEMENT	17
OPERATIONS ROOM UTILITY.....	19
LIMITATIONS	20
CONCLUSION & NEXT STEPS	21
APPENDICES	22
APPENDIX A. UTILITY SURVEY (ENGLISH).....	22
APPENDIX B. UTILITY SURVEY (FRENCH).....	29
APPENDIX C – REGISTRATION FORM (ENGLISH)	37
APPENDIX D. REGISTRATION FORM (FRENCH)	42

Executive Summary

In support of national Community Health Worker (CHW) scale-up initiatives, the One Million Community Health Workers (1mCHW) Campaign has built a virtual Operations Room, an online dashboard to track CHW activities and operations across sub-Saharan Africa (SSA). The dashboard contains data on CHW counts and population coverage, thereby empowering governments and partners with information on the CHW landscape to prioritize and allocate resources appropriately.

Over the past several months, the Campaign collected information from the global CHW community concerning desired functional features of the Operations Room so that its potential can be maximized to meet all stakeholders' needs. This "Utility Survey" (English - Appendix A, French - Appendix B) was disseminated on February 24, 2014 in lieu of the original CHW Registration Form (English - Appendix C, French - Appendix D), which was released on August 1, 2013 to aggregate data on CHW counts, capabilities and geographic coverage. The Utility Survey contained 36 questions and was administered online through Qualtrics, an online survey software. The survey was sent to 79 organizations and the Campaign received 18 responses between February and April 2014, resulting in a 23% survey response rate. This response rate is considered a success, given that the general response rate to e-mail surveys has been found to vary between 25% and 30%.¹ This report analyzes responses to 22 questions of interest, nine of which overlap with the original Registration Form (which also had a response rate of 23%). Analysis on overlapping questions incorporated all data collected to date, for a total of 51 responses from both the Utility Survey and Registration Form combined. The question types included in this survey are open-ended, yes/no and multiple choice, allowing for both qualitative and quantitative assessment of the data.

Overall, results revealed that survey respondents manage anywhere from 10 to 45,000 CHWs per field office, with a small majority of respondents (15 out of 51) overseeing a cadre of less than 100 CHWs. The average CHW-to-household ratio is 149 households per CHW, although responses range from 12 to 550 households. CHWs represented in the sample provide an average of 10 different health services to their communities, over 90% of whom deliver community health promotion and counseling and referrals. Overall, respondents provide approximately seven items and eight different medical supplies to their cadre of CHWs, often including data collection forms, referral forms, MUAC tape, oral rehydration salts, zinc, and family planning supplies. Nearly all respondents (50 out of 51) use pen and paper or ledgers to collect data, 19 of which also use non-smart mobile phones. With regard to Operations Room utility, ten out of 16 respondents (63%) ranked the usefulness of a global CHW registry as "very useful." In general, organizations highlighted the functionality of the Operations Room as a hub for sharing and gathering useful information on performance indicators, global best practices, and innovation in the field.

While the results of this survey are limited in generalizability given our small sample size, the information presented in this report captures one of the first comprehensive views of CHW programs across sub-Saharan Africa. The Campaign hopes that these results will be used as an impetus for more rigorous evaluation of CHW programs and practices. We aim to utilize the information gathered here to extend the current Operations Room into an instrument that will help estimate gaps in human resources for health (HRH).

¹ Sánchez-Fernández et al., "Improving retention rate and response quality in Web-based surveys," *Journal of Computers in Human Behavior* 28, no. 2 (2012): 507-514.

Introduction

Background

There is an increasing need for systematic tracking of CHW operations that is readily available for governments and organizations to use for human resources for health (HRH) gap analysis and planning. Although there is key interest among multiple stakeholders in achieving CHW scale-up, it is a logistical challenge to identify CHW coverage and capacity, the level and quality of training, and resources available at the district level. The goal of the Operations Room is to offer a harmonized approach to CHW reporting and establish a clear view of the number of CHWs and their capabilities, ultimately providing information about where to close gaps in HRH so that substantive CHW scale-up can be achieved.

The Operations Room has completed Phase 1 of its three-phase development plan (Table 1). Phase 1 involved gathering information on basic CHW counts and capabilities from governments, non-governmental organizations (NGOs), and other civil society organizations (CSOs), as well as ascertaining governments' current engagement status with the Campaign. Data for Phase 1 was collected through a public questionnaire (titled "Registration Form") to convey that CHW data would be registered in the Operations Room platform in exchange for a tangible benefit to the respondent, rather than a questionnaire survey demanding unilateral information exchange.

Table 1.
Operations Room Development Plan

	Phase 1:	Phase 2:	Phase 3:
When	Year-End 2013	Year-End 2014	Mid-Year 2015
Phase	Basic Data Collection	Pilot	Begin Operations Room Scale-up
Activities	<ul style="list-style-type: none"> Collate information from 1mCHW Campaign's CHW Registration Form supplemented by web-based research 	<ul style="list-style-type: none"> Implementation preparation for live monitoring systems 	<ul style="list-style-type: none"> Roll-out of live systems in initial countries Determine launch timing for remaining countries

Expected Outputs	<ul style="list-style-type: none"> Country-specific demographic data Basic CHW counts Initial gap analysis on CHW capabilities Coverage of public and private CHW operations on-the-ground (including services provided and basic needs assessment) 	<ul style="list-style-type: none"> Determine data and management reporting 'needs requirements' for HRH analytics Identify infrastructure needs 	<ul style="list-style-type: none"> Finalize linkages between real-time monitoring and HRH analytics platform with official national health statistics Identify impact measures Identify process improvements/best practices Devise sustainability plan
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Phase 1 Progress

The Registration Form was used to encourage governments and CSOs to record their CHW numbers in a global registry. It went live on August 1, 2013 and was disseminated through contact networks, representing a selective sample of all known CHW program implementers in SSA. The Operations Room, which officially went live on November 4, 2013, reflects basic national demographic indicators, and – drawing from the results of the Registration Form – displays the number of CHWs and maps their approximate geographic location.

Long-term Goals

During Phase 2, the Campaign plans to continue the development of the Operations Room, expanding it to become a global level and country level CHW information platform, identifying indicators for HRH that can serve as global standards for a CHW registry. This phase will culminate in the implementation of a near real-time monitoring system in a selected pilot country (in Phase 3). As outlined in Table 1 above, the main outputs of Phase 2 are to:

1. Determine data and management reporting needs requirements for HRH analytics; and
2. Identify infrastructure needs and required resources for implementation

In Phase 3, a CHW registry with the ability to import and/or export information through iHRIS and/or DHIS2 will be developed as a prototype open source registry capable of supporting country level registration and tracking of CHWs. The specific goals and objectives of this CHW registry are to:

- **Improve service performance information:** Create reliable and readily available service-based data that will allow the governments and civil society organizations the capability to track service quality and patient care over time.
- **Improve record of standards-driven worker competencies:** Provide documentation of post-training competencies and areas in need of improvement. This will ensure that the CHW

workforce is adequately trained and equipped for the tasks performed, and deployed in areas of greatest need.

- **Improve communication between management systems:** Link the information collected on performance and competencies to an up-to-date health worker registry, thus providing health-sector leaders with data on health worker needs and quality of services to support decision-making processes.

Using lessons learned in the development of a prototype open source registry in a pilot country, this information will then be used to provide recommendations and guidelines for other countries and demonstrate the value and utility of a large scale CHW registry (Phase 3).

Methodology

Utility Survey

In collaboration with Direct Relief, a Utility Survey (Appendix A and B) was developed to query the global CHW community concerning the desired functional features for Phase 2 of the Operations Room. Expanding upon the initial Registration Form, the Utility Survey collected information on what types of data and indicators would be most useful for governments and organizations to see displayed and how they would, in turn, utilize the collective outputs of the Operations Room. The survey is meant to inform the overall development of the Operations Room so that its potential can be maximized to meet all stakeholders' needs.

Pilot

To ensure that the content of the survey would produce useful information for the global CHW community, the Campaign first circulated a draft of the survey to a selective sample of CHW program implementers. This draft was circulated between November 2013 and February 2014. The Campaign received feedback by members of the Frontline Health Workers Coalition including World Vision and University Research Co., the MDG Health Alliance, and members of the GSK 20% Re-investment Group – Amref Health Africa (formerly AMREF), Care International, and Save the Children. After initial feedback was collated, appropriate modifications were made to some questions and the survey was further refined with the GSK 20% Re-investment Group.

The final version of the Utility Survey was sent to the GSK 20% reinvestment group to disseminate to their country offices and also uploaded onto our website² in lieu of the CHW Registration Form on February 24, 2014. Targeted email outreach was made to Ministries of Health in sub-Saharan African countries and Campaign partners through the Campaign's Field Specialists. Email outreach was also made to participants of the CHW Registration Form to capture their experiences using Phase 1 of the Operations Room and to ensure that their voices were reflected in Phase 2. The survey was administered online with the option to download the paper form for submission to the Campaign's general email address: info@1millionhealthworkers.org. Results are still being collected on a rolling basis, but the analysis for this report was performed on data collected until April 7, 2014.

² <http://1millionhealthworkers.org/operations-room-map/registerchws/>

Data Analysis

Twenty-two questions were selected for analysis in this report out of a total 36 questions on the Utility Survey. Questions that did not provide substantive data (e.g., requests for uploading supportive documents) were excluded from the analysis. The design of the Utility Survey included various forms of questions to gather the most accurate data possible. The question types included in this survey are open-ended, yes/no and multiple choice. The variation in question formats allowed for both qualitative and quantitative assessment of the data. Open-ended questions were assessed qualitatively by summarizing the key themes that emerged and substantiating the summary with direct quotes or citations from the respondents. Quantitative assessment was performed via simple computational analyses using tables and percentages generated in MS Excel.

The Utility Survey recycled 11 questions that were originally used in the Registration Form. Recognizing this overlap, the Campaign presents the combined results from the Utility Survey and the Registration Form for 9 of the 11 shared questions. These combined results generated a sample size of 51 respondents for overlapping questions, compared to a smaller sample size of 18 respondents for questions that were unique to the Utility Survey. Sample sizes are explicitly stated for each question in the Results section below. The countries (20) represented in our analysis include: Benin, Comoros, Democratic Republic of Congo, Eritrea, Ghana, Kenya, Lesotho, Liberia, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Sierra Leone, Tanzania, Togo, Uganda, and Zambia.

Results

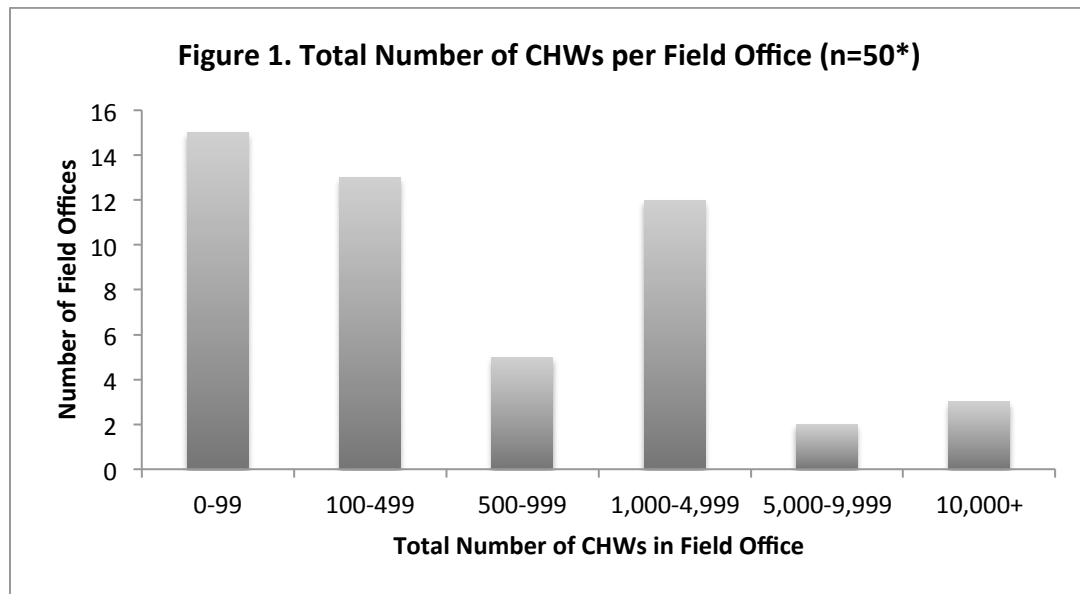
General Questions: CHW Counts and Capabilities

1. How does your organization define community health workers?

Although the definition of a community health worker (CHW) varied across respondents, the majority of organizations indicated that CHWs are individuals who live and work in the community and provide health promotion and disease prevention services. A few CHW cadres in the sample also perform curative services. Seven respondents (out of a total of 17) specified that CHWs are unpaid volunteers who are elected by the community in which they work. The actual number of unpaid CHWs is likely higher, since nine respondents did not specify whether CHWs were volunteer or paid workers. Only one respondent, the Ministry of Health (MoH) of Eritrea, indicated that CHWs are paid (either cash or in-kind) positions. Some respondents defined CHWs by the level of training completed, which ranged from six weeks (Integrated Systems Strengthening Program, Zambia) to ten days (Save the Children, Sierra Leone). A few respondents commented on the relationship between their cadre of CHWs and those of the government: “We are moving towards a definition that distinguishes between the MoH affiliated and nationally defined cadres, and complementary cadres of community health volunteers which may remain civil society affiliated” (World Vision, UK). Similarly, in Malawi, the Global AIDS Interfaith Alliance (GAIA) trains “community caregivers” to work either alongside government employed health surveillance assistances (HSAs) or in their absence in remote areas.

2. How many CHWs does this field office currently manage?

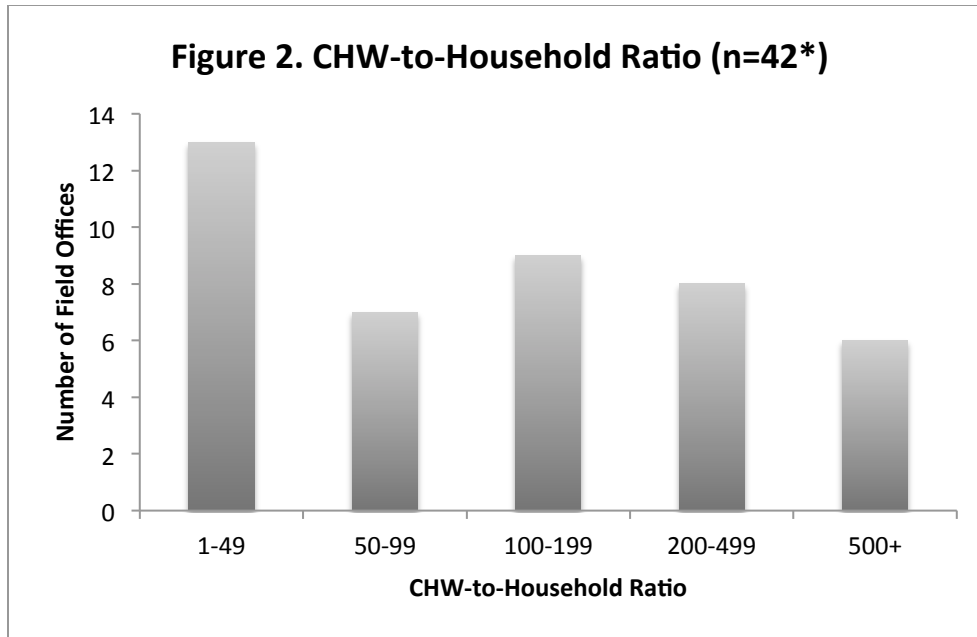
Responses were collated into six response categories representing different ranges in the total number of CHWs managed by each field office (Figure 1). Responses ranged from 10 to 45,000 CHWs per field office. Fifteen out of 51 total respondents indicated that their field office currently manages a cadre of less than 100 CHWs, and 13 respondents stated that they manage a cadre of 100 to 500 CHWs. Twelve respondents oversee a cadre of 1,000 and 5,000 CHWs. A minority of respondents manage between 500 to 1,000 or 5,000 to 10,000 CHWs. The three respondents that supervise cadres of over 10,000 CHWs include: the MoH in Rwanda (45,011), UNICEF in Uganda (20,000) and Amref Health Africa in Kenya (13,586).



Note: An outlier of 75,000 CHWs, was removed for analysis since this figure is representative of multiple field offices across sub-Saharan Africa.

3. How many households are served by each CHW?

Out of 43 total responses, the average CHW-to-household ratio was 149 households per CHW. This average excludes the outlier of 10,000 households per CHW reported by 1 respondent on the assumption that 10,000 households is likely an unfeasible caseload for a CHW. Diagram 2 graphically displays the range of responses. Any responses that were reported as ranges (e.g., 50 to 100 households) were assigned an average value (e.g., 75) to categorize CHW-to-household ratios into five distinct categories. Nearly one-third of respondents reported a CHW-to-household ratio of 1:49. The four other categories showed a fairly even distribution of household ratios, with the largest ratio being 550 households per CHW.



Note: An outlier of 10,000 households was removed for analysis.

4. Which activities are your CHWs carrying out?

Respondents indicated which services their CHWs currently deliver out of the list provided in the survey. On average, CHWs represented in the sample provide nearly 10 different services. As shown in Table 2, 92% of respondents indicated that their CHWs conduct community health promotion and counseling, while 90% provide community referrals to and from nearby health facilities. Additionally, approximately three-quarters of respondents indicated that their CHWs provide sanitation inspection/education (WASH), pre-natal and post-natal care, community case management of diarrhea, and monitoring of malnutrition. The least prevalent services were community case management of dysentery (20%) and HIV testing and counseling (27%). Over half of respondents (57%) listed “other” services not included in the response categories. These services included: first aid and injury care; home and community based care for people living with HIV; exclusive breastfeeding counseling; bed net and drug distribution; TB screening; and screening for gender-based violence.

Table 2.
CHW Activities (n=49)

Activity	Percentage of Respondents Offering Service
Monitoring of malnutrition and other danger signs	78%
Immunizations	53%
Community health promotion and counseling	92%
Disease surveillance	59%
Growth monitoring	59%
Family planning services	69%
Pre-natal/Post-natal/Maternal care	75%

Referrals to/from health facilities	90%
HIV testing and counseling	27%
CCM of diarrhea	75%
CCM of pneumonia	49%
CCM of malaria	55%
CCM of dysentery	20%
CCM of newborn sepsis	24%
Sanitation inspection/education (WASH)	73%
Other	57%

5. Which items are provided to your CHWs?

Table 3 illustrates common items and commodities provided to CHWs. On average, each organization provides approximately seven items to their cadre of CHWs. Almost all of the organizations represented in the sample (96%) provide data collection forms to their CHWs and the majority of respondents (86%) also provide referral forms. About one-third of respondents provide uniforms, boots, money for transportation, or a backpack to their CHWs. A cell phone or smart phone was the least common item indicated. Other items not listed in the chart below, but reported by respondents, include an ARI timer, weighing scale, raincoat, and microfinancing for income-generating projects.

Table 3.
Items for CHWs (n=50)

Item	Percentage of Respondents Offering Item
Uniform	32%
Medical kit	60%
Flashlight	26%
Umbrella	22%
Boots	36%
Cell phone/smart phone	20%
Bicycle	26%
Money for transportation	34%
Backpack	40%
Batteries	20%
List of households	40%
Data collection forms	96%
Maternal, child, and family health booklets	64%
Referral forms	86%
Job aids/household counseling cards	66%
Other	12%

6. Which medical supplies are provided to your CHWs?

On average, respondents indicated that they provide approximately eight different medical supplies to their CHWs. As outlined in Table 4, the most common medical supplies distributed to CHWs include: MUAC tape, oral rehydration salts, zinc, and family planning supplies such as condoms and contraceptives.

Table 4.
Medical Supplies for CHWs (n=48)

Medical Supply	Percentage of Respondents Offering Supply
MUAC Tape	65%
Oral Rehydration Salts (ORS)	79%
Artemisinin-based Combination Therapies (ACTs) for Malaria	50%
Zinc	67%
Deworming Tablets (i.e. Albendazole)	44%
Antibiotics for Pneumonia/TB	44%
Sputum Containers for TB Sputum Collection	10%
Diluted Soap	29%
Bandages	42%
Anti-inflammatory, antipyretic, or analgesic medicines	35%
Cotton balls/swabs	48%
Stethoscope	6%
Blood Pressure Meter	8%
Thermometer	33%
Timer	48%
Rapid Diagnostic Tests (RDTs) for Malaria	44%
Bag Valve Mask (Ambu Bag)	2%
Family Planning Supplies (i.e. Condoms, Contraceptives)	63%
Anti-Malarials	38%
Vaccines (e.g. Rotavirus, Pneumonia, Measles, Hib, DPT)	10%
Vitamin A	27%
Insecticide-Treated Bed Nets	35%
Plumpy'nut, other RUTF, or other nutritional supplements	17%
Chlorhexidine or Other Antiseptic	25%
Other	15%

7. What is the annual budget and sources of funding for your CHW program?

The annual budget for CHW programs varied among the organizations surveyed. The range was \$30,000 USD to \$2 million USD per year. Though there were some organizations that indicated that they received funding from their headquarters (e.g., UNICEF country offices), the majority of organizations stated that

their funding came from external sources including: AusAID, Barr Foundation, CIDA, DANIDA, GlaxoSmithKline (GSK), SIDA, UNICEF, USAID, individuals, family foundations, and Christian congregations.

8. What is your opinion of the general status of CHWs and their functionality in your district/region/state/country?

Survey respondents reported both positive and negative opinions on the general status of CHWs and their functionality. Positive opinions on the status of CHWs underscored CHWs as vital to the health of rural communities. CHWs were described as well respected individuals within the community who provide much needed frontline health services, including health education and referrals. Frequently cited negative components of CHW programs included high rates of attrition, lack of motivation, and lack of compensation, career development and/or a standardized incentives package. Other barriers to functionality included unreliable supply chains, lack of funding, uncoordinated and disjointed CHW activities, lack of transport, and inadequate supervision and support systems. NGO respondents cited sustainability as a key issue and highlighted the need for political commitment to CHW programs. Many NGOs mentioned the need for CHWs to be recognized by the Ministry of Health and formally incorporated into the health system.

Data Collection, Validation and Performance Indicators

9. Please describe the standard data collection practices for your CHWs.

The preponderance of respondents indicated that CHWs partake in routine monitoring and data collection during home visits, often using standard data collection forms. Examples of standard data collection tools used include those approved by the MoH for HIV, TB, immunizations and growth monitoring. Lesotho Red Cross Society stated that data collected by CHWs daily is submitted on a monthly basis to the nearest health facility for compilation. The MoH of Eritrea and UNICEF Liberia both noted the incorporation of community-level data into the Health Management Information System (HMIS), although Liberia is still currently working toward this goal.

10. In what capacity do your CHWs report to the local MoH?

The majority of organizations represented in the sample have CHWs formally report to the District Health Office, often on a monthly basis. For example, in Sierra Leone, CHWs affiliated with Save the Children report to Peer Supervisors, who compile and submit data to the Primary Healthcare Unit (PHU), who then submit to the District Health Management Team and, lastly, the Ministry of Health and Sanitation. Multiple respondents cited a similar chain of command, where data collected by CHWs at the community level flows to the district, regional and national levels. GAIA in Malawi indicated that CHW activities are reported on as needed basis to the District Health Officer (DHO), notifying the DHO of disease outbreaks or common health problems as they arise.

11. How often does your organization provide reports on CHW operations to the following entities?

Table 5 enumerates the number of organizations who report on CHW operations at least once a month to different entities. More than two-thirds of respondents (71%) indicated that they report to the health facility at least once a month. It is worth noting that only 59% of respondents report to their headquarters at least once per month. Forty-seven percent of respondents indicated that they report to

the local government at least once a month and 41% report to the Central Ministry of Health at least once a month. About two-fifths of respondents report to both the organization's headquarters and the health facility at least once per month.

Local Government	Health Facility	Ministry of Health (Central)	Organization Headquarters	Organization Field Office
8 (.47)	12 (.71)	7 (.41)	10 (.59)	7 (.41)

12. What software does your organization currently use to manage CHW data?

Out of 18 total respondents, 14 use Microsoft Excel to manage CHW data, 9 use paper forms, and 5 use both Microsoft Excel and paper forms. Two respondents use Microsoft Access in addition to paper forms and Excel. No other software packages were mentioned.

13. Please describe your validation procedures for CHW data (e.g., my organization random samples villages for follow-up).

The survey respondents have unique data validation procedures and many are at different stages in the data validation process. A few organizations indicated that data verification has not yet started as they are in the early phases of implementation (UNICEF, Liberia) or are seeking to improve the current system (Save the Children, Sierra Leone and UNICEF, Mauritania). Other organizations reported selecting a random cluster of community case management reports for review and/or conducting supervisory visits to assess CHW performance (CHS, Benin and Amref Health Africa, Tanzania).

Some of the more comprehensive data validation procedures include those employed by CARE in Benin, which has a two-tiered process: (1) mobile data collected by CHWs is integrated into the CommCare application and uploaded directly to the service, where the project management team interprets and validates the data; and (2) for CHWs who do not use mobile phones, data are reported to the health facility for quality control. In Malawi, GAIA's Field Coordinators use Excel to compile data from pen and paper ledgers and send reports to the US-based monitoring and evaluation manager for review and analysis. Similarly, in Mozambique, Save the Children employs a monitoring and evaluation officer to handle data verification procedures at the district level each month.

14. What are the key performance indicators you use to monitor the impact of your CHW program?

Some organizations reported general key performance indicators to monitor impact, while others mentioned more specific indicators. General key performance indicators included outputs, such as the number of: health education talks given by CHWs to households, referrals made by CHWs, cases treated by CHWs, CHWs trained, and commodity stock outs. More specific key performance indicators included: the number of children under five treated for diarrhea, malnutrition, pneumonia, and malaria, the number of maternal and child deaths, and the number of referrals for TB screening of suspected cases, deliveries, and HIV tests.

Tools, software and mobile technology

15. What tools do your CHWs use to collect data during their fieldwork?

Organizations used multiple methods of data collection, including pen and paper or ledgers, smart and non-smart mobile phones, and tablets. Nearly all respondents (50 out of 51) indicated that they use pen and paper or ledgers to collect data (Table 6). Of those 50 respondents, 19 also use non-smart mobile phones, one organization uses tablets (UNICEF, Eritrea) and one organization uses smart phones to collect data in the form of a pilot project (Save the Children, Mozambique). Only one respondent (Lwala Community Alliance, Kenya) uses only non-smart mobile phones for data collection.

Table 6.
CHW Data Collection Tools (n=51)

Data Collection Tool	Number of Respondents
Pen and paper/ledger	50
Non-smart mobile phone	20
Smart phone	1
Tablet	1

16. What do your CHWs use mobile phones/smart phones/tablets for?

Nineteen respondents reported varying and overlapping uses of these technologies (Table 7). Approximately half of these respondents (47%) indicated that their CHWs use mobile phones, smart phones, or tablets for patient tracking. More than half of respondents use mobile devices for pregnancy tracking (53%) and 37% use these technologies for job aids. Although it was not included as a response category, three respondents reported using these technologies to assist with referrals. Other responses included reporting stock outs of drugs, family planning counseling, TB case finding, and RapidSMS.

Table 7.
Use of Mobile Phones and Tablets (n=19)

Use of Technology	Number of Users (%)
Patient tracking	9 (47%)
Monitoring and evaluation for case management	5 (26%)
Malnutrition screening	1 (5%)
Pregnancy tracking	10 (53%)
Quality improvement	3 (16%)
Disease surveillance and reporting	6 (32%)
Job aids (i.e. decision support tools)	7 (37%)
Active case finding for cough/fever	2 (11%)
Training	2 (11%)
Increasing community awareness and knowledge	6 (32%)
mBanking	1 (5%)
Other	6 (32%)

The data also revealed the versatility of mobile phones, smart phones, and tablets in the field. Organizations reported many overlapping uses of these technologies, some indicating as many as seven (CARE, Benin; Rianya Youth Group, Kenya; and MoH, Rwanda). For example, the MoH in Rwanda reported using mobile technology for patient tracking, monitoring and evaluation for CCM of select illnesses, malnutrition screening, pregnancy tracking, disease surveillance, job aids, and active case finding for cough/fever. Survey results reflect what was found in a recent study by Braun et al (2013), which presents a systematic review of literature on CHWs and their use of mobile technology including: collecting field-based health data, receiving alerts and reminders, facilitating health education sessions, and conducting person-to-person communication.³

17. How often do CHWs in your organization have access to the Internet to submit data (always, most of the time, sometimes, rarely, never)?

Out of 17 total responses, 14 respondents (82%) indicated that their CHWs never have access to the Internet to submit data, while 2 reported that their CHWs rarely have Internet access. Only 1 respondent said their CHWs sometimes have Internet access.

Operations Room Utility

18. How useful would a global community health workers registry be to your organization?

Ten out of 16 respondents (63%) ranked the usefulness of a global community health workers registry as “very useful.” Only 3 respondents ranked such a registry as being “not very useful”.

19. If information on the Operations Room were downloadable, what type of indicators and other types of data would be most useful and how would your organization use this data?

Respondents cited a range of data points that would be most useful to display in the Operations Room. Many organizations highlighted the usefulness of displaying CHW counts that are disaggregated by geographic area. Respondents also requested including CHW to population ratios as well as health status indicators. This information would help organizations and Ministries of Health identify gaps in health services and geographic coverage to inform program expansion. Respondents suggested providing data on CHW training, recent activity, capabilities, and services provided, as well as child and maternal mortality measures and disease surveillance of diarrhea, pneumonia and malaria among children under five. Organizations also want to view programmatic indicators, including commodities received and used by each CHW program, referrals and home visits made by CHWs, supervisory visits, and CHW qualifications and characteristics, including gender and education level. Other organizations highlighted the functionality of the Operations Room as a hub for useful information on performance indicators, global best practices, and innovation in the field.

³ Rebecca Braun, Caricia Catalani, Julian Wimbush, and Dennis Isrealiski, “Community Health Workers and Mobile Technology: A Systematic Review of the Literature” (June 12, 2013), <<http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0065772>>.

20. Please describe how your organization would like to become involved in the Operations Room.

Themes that emerged from open-ended responses to this question included sharing data to obtain updated information on CHW numbers and capabilities (CARE, Benin and World Vision, UK). Respondents also hoped to contribute to the use of country-level dashboards to identify areas not currently covered by government employed CHWs (GAIA, Malawi) and to guide the harmonization of approaches in calculating CHW incentive rates (CARE, Benin). World Vision UK stated that the Operations Room would be a useful platform for giving feedback on CHW program design and how it relates to the CHW Principles of Practice.⁴ Respondents also hope to contribute toward building the Operations Room into a learning platform by sharing best practices and successes and challenges in the field.

21. How do you imagine potentially using the Operations Room dashboard within your organization?

Respondents were presented with various uses of the Operations Room and asked to rate the importance of these uses as “very important” “somewhat important” or “not important.” Overall, the majority of respondents ranked a number of different Operations Room functionalities as “very important.” Specifically, 88% (15/17) of respondents deemed the following three capabilities to be “very important”: (1) understanding the activities of other organizations, (2) sharing CHW materials and best practices with external partners, and (3) researching CHW activities and operations.

Additionally, 82% (14/17) of respondents indicated that it would be very important for their organization to utilize the Operations Room to develop partnerships with other organizations to improve and/or scale-up CHW operations within their current region. Additionally, half of respondents indicated the importance of utilizing this same functionality to scale up CHW operations in new regions. Similarly, although 76% (13/17) of respondents indicated that it would be “very important” to use the Operations Room to identify gaps in CHW coverage and opportunities for scale-up within their current region of operations, only 47% (8/17) noted the importance of this same functionality in expanding operations to new regions. These data suggest that the Operations Room would be most useful to organizations for their current region of operations.

Moreover, 70% (12/17) of respondents expressed that it would be “very important” for their organization to utilize the Operations Room for the following purposes: motivating local government on the importance of CHWs, understanding their organization's work in the context of others' CHW operations, and using data to refine the organization's CHW resources (training curriculum, job aids, etc.). Half of respondents indicated that they consider it very important to use the platform as a way to find material from other implementing partners for their organization's CHW operations.

Thirteen out of 17 respondents (76%) stated that they consider it either very important or somewhat important to use the platform as a primary reporting system for their organization's CHW operations. Over 90% (16/17) deemed it very important or somewhat important to “incentivize donors or potential donors” using the Operations Room. In this regard, having a country or region-level dashboard that

⁴ Polly Walker, Shannon Downey, Lauren Crigler and Karen LeBan, “CHW ‘Principles of Practice’ Guiding Principles for Non-Governmental Organizations and Their Partners for Coordinated National Scale-up of Community Health Worker Programmes (Washington, D.C. April 2013), CORE Group and World Vision International, <http://www.coregroup.org/storage/Program_Learning/Community_Health_Workers/CHW_Principles_of_Practice_Final.pdf>.

displays gaps in human resources for health may be valuable to organizations not only for the improvement, management and scale-up of operations but also for galvanizing and/or justifying funding for their programs.

Lastly, organizations suggested additional uses of the Operations Room outside of those provided. One organization suggested using the dashboard to monitor data on the number of CHWs disaggregated by sex. Another organization commented that they would use the Operations Room as a platform to support the MoH to take ownership of CHWs, particularly with respect to supervision and ensuring that CHWs were included in the government's budget for 2015.

22. Please describe how the Operations Room could be improved to meet your organization's needs.

Respondents mentioned improvements to the Operations Room such as enabling connections to other organizations and government officials to promote collaboration in the field and ensure complete coverage of CHWs in rural areas. Organizations also indicated that promoting connections with different organizations in other countries or regions would be beneficial. This way, organizations could share successes, challenges and lessons learned across geographic boundaries. Therefore, building the capacity of the Operations Room to serve as a platform for information sharing should be an important next step in the dashboard's development.

Discussion

CHW Counts, Capabilities, and Data Management

The Campaign did not explicitly define CHWs in the Utility Survey. A non-random sampling method was used to target specific individuals within the Campaign's network of partner organizations who work with CHWs in SSA. Thus, in lieu of providing a definition, respondents were encouraged to define "community health workers" as an open-ended question on the survey. This question aimed to capture an accurate and inclusive depiction of CHWs based on respondents' valued knowledge and experiences in the field. Many organizations specified that CHWs are elected by their communities to provide health promotion and disease prevention within the community. Some organizations also mentioned the provision of curative services. Many respondents indicated that CHWs are unpaid volunteers, although paid CHWs were also represented in the sample. A few organizations defined CHWs by length of training completed and others commented on the distinction between CSO-based CHW cadres and MoH cadres.

Results showed that CHWs are defined based on a multitude of indicators, which include but are not limited to: incentive schemes (if any), MoH or NGO-affiliation, training received, length of training, and primary location of work (e.g., community or health facility). The diversity of responses emphasizes the need for an easily accessible CHW definition and CHW registry, where such indicators can be compiled and standardized for CHW program planning, scale-up and policymaking at the global level.

Obtaining accurate CHW-to-household ratios is a key step in assessing population coverage. Unfortunately, this data is difficult to ascertain, particularly in remote areas where population sizes may be unknown, terrains are unique, and some catchment areas may be considerably more dispersed or clustered than others. Results for question three, which solicited CHW-to-household ratios, were reported as ranges (e.g., 50-100). These ranges may reflect a high degree of variability and thus there are limitations to quantifying such responses given the small sample size. Within the survey sample, a

fairly even distribution of CHW-to-household ratios was reported, although it is important to note that almost one-third of respondents reported low ratios of less than 50 households per CHW. More data is required to confidently assess whether current CHW-to-household ratios are optimal in the context of achieving systematic rural coverage of CHWs in Campaign countries and beyond. Continuing to capture this data in Phase 2 of the Operations Room will be essential to ascertaining gaps in CHW coverage.

Overall, services provided by CHWs also showed large variability. The most common activities reported were: health promotion and counseling, referrals to and from nearby health facilities, sanitation inspection/education (WASH), pre- and post-natal care, community case management of diarrhea, and monitoring of malnutrition (Table 2). Additionally, 57% of respondents listed “other” services not included in the response categories. The breadth of services provided by CHWs depends on many factors, including but not limited to: the specific health needs of the population being served, the capacity of the field office to train CHWs and monitor and supervise their activities, availability of funding, and supply chain management. Recognizing these factors, the range of CHW activities reported is highly encouraging. Results indicate that regardless of whether CHWs are volunteer workers (as the majority reported are), they are active in their role and provide a wide array of essential health services to their communities. This notion was also reflected in question eight, where respondents described their opinion on the general status of CHWs as “well-respected,” “vital to the health of rural communities,” and “individuals who provide much needed frontline health services.”

The most common medical supplies distributed to CHWs are MUAC tape, oral rehydration salts, zinc, and family planning supplies, such as condoms and other contraceptives (Table 4). It is encouraging that the most frequently reported medical supplies and activities did in fact overlap, suggesting that the majority of CHWs providing the services mentioned above are partially, if not fully, equipped to do so. A simple amalgamation of Tables 2 and 4 displays this overlap (Table 8).

CHW Activity	Percent of Respondents	Medical Supply	Percent of Respondents
Family planning services	69%	Family planning supplies	63%
Monitoring of malnutrition	78%	MUAC tape	65%
Monitoring of malnutrition	78%	Nutritional supplements	17%
CCM diarrhea	75%	ORS	79%
CCM diarrhea	75%	Zinc	67%

The only comparison in which medical supplies were lacking was in the provision of nutritional supplements (e.g., PlumpyNut) to CHWs performing monitoring of malnutrition. However, treatment and/or community case management of malnutrition was not provided as a response category in question 4, which may explain this discrepancy. It is likely that CHWs who monitor nutritional status refer malnourished children to the nearest facility, especially considering that nearly all of the CHWs represented in the survey sample (90%) provide referrals to/from health facilities and 86% are provided with referral forms.

In addition to referral forms, almost all respondents (96%) provide their CHWs with data collection forms (Table 3). This is consistent with question 9, which asked for a description of standard data collection practices for CHWs. The majority of respondents stated that CHWs partake in routine

monitoring and data collection during home visits, often using standard data collection forms. In addition, more than two-thirds of respondents (71%) indicated that CHWs report to the local health facility at least once a month (Table 5). These results are promising; they reveal that CHWs represented in the sample routinely document their activities, often reporting directly to the health facility. Such results have positive implications on the value-add of CHWs in strengthening health systems to support a continuum of care.

Nearly all respondents (50 out of 51) reported that they use pen and paper or ledgers to collect data (Table 6). Of those 50 respondents, 19 also use non-smart mobile phones, and only one organization uses smart phones. This is consistent with question 4, in which the provision of mobile phones to CHWs was the least common item provided overall (Table 3). In general, there is room for improvement in this area. Paper-based data management systems can be updated to capitalize on the use of mobile technology in the CHW sphere. Those organizations that do use mobile devices reported many overlapping uses of these technologies, which reveals the versatility and usefulness of mobile technology in the field. The Campaign aims to continue reporting on CHWs and mHealth in Phase 2 of the Operations Room to measure progress in this regard.

The Campaign also included survey questions to assess whether data is organized, validated and analyzed in a timely and efficient manner following collection. Consistent with the results above, it was found that half of respondents (9 out of 18) use paper forms to manage CHW data and the majority of respondents use Microsoft Excel or a combination of paper forms and Excel (question 12). The data validation procedures described were generally well established (question 13). Although some respondents do not currently have a standard validation process in place, they indicated a desire to improve this. These results are encouraging in the context of measuring and improving CHW performance, ensuring quality of care, and expanding organizations' data management capacity. While upgrading paper-based systems remains an area for improvement, barriers such as limited access to the Internet (question 17) and general poor infrastructure in some locations present considerable challenges that need to be addressed.

Operations Room Utility

Overall, survey respondents echoed the Campaign's vision of the Operations Room as a hub for information on performance indicators, global best practices, and innovation in the field. Respondents provided very detailed and useful information on the desired utilities and functionalities of the Operations Room. Question 19 revealed specific indicators and types of data that would be of use to stakeholders, such as: CHW counts disaggregated by geographic area, CHW qualifications and characteristics, including gender and education level, CHW to population ratios, training, recent activities (e.g., number of household visits and/or referrals) and services provided. Respondents also want to see health status indicators, such as child and maternal mortality measures and disease surveillance of diarrhea, pneumonia and malaria among children.

While the Campaign aims to build in most, if not all, of these "CHW indicators" into the Operations Room platform, it is important to recognize the multitude of challenges that exist in collecting and validating such comprehensive data. Indeed, many of these challenges were discussed in the first part of this section. However, aggregation of these data points onto a visual map can ultimately contribute to the use of country-level dashboards, where viewers can more easily identify high-need areas for expansion to inform planning at the district or regional level. By continuing to collect data on CHW

cadres, the Operations Room aims to illustrate areas not currently covered by government-run CHW programs to make the CSO community aware of relevant MoH activities, and vice versa.

Overall, respondents highlighted the importance of the Operations Room as a hub to research CHW activities and operations within and across countries in SSA. Notably, understanding the activities of other organizations within respondents' current region of operations was a functionality of particular importance. This functionality helps organizations put their work into the broader context of CHW operations within their region, thereby identifying gaps in coverage and taking advantage of strategic partnerships and opportunities for scale-up. Additionally, organizations also noted the value of making connections across countries or regions in order to share information, successes, challenges and lessons learned across geographic boundaries.

Limitations

There are several limitations to the Utility Survey that should be noted. First and foremost, the survey relied entirely on self-reporting. This has both positive and negative implications for the data collected. Although the survey was piloted prior to dissemination, some questions may have remained unclear or open to interpretation. This may have impacted both the validity and reliability of the results and also likely contributed to unreported data. In some cases, many questions were skipped entirely, and thus the sample size of some questions varied significantly compared to others. The Campaign used listwise deletion to account for all missing data. This resulted in the performance of a granular analysis of each question based on its individual sample size, as opposed to utilizing the entire sample size. However, the self-administered format also allowed for respondents to complete the survey on their own time, give proper thought to open-ended questions, and compile any documents that may have been helpful in completing the survey. This may have been a particular advantage in the responses to the open-ended questions, which detailed qualitative data that was essential to helping the Campaign team develop Phase 2 of the Operations Room and ensure that stakeholders' needs were considered.

It is also important to note that the sample size (18) for the Utility Survey was small, representing only 23% of total survey disbursements. The reasoning for this could be linked to the fact that the Campaign employed both a purposive and snowball sampling approach. The Campaign deliberately targeted organizations within its partner network and those, partners were encouraged to widely distribute the survey to organizations that may not be in the Campaign's network but would be interested in participating. Thus, these results may be biased toward the pool of participants that were purposefully sampled, thereby limiting their generalizability. The Campaign recognizes that the survey results are not representative of all CHW programs in SSA.

Despite the limitations listed above, it is important to note that the data gathered from the Utility Survey has helped capture one of the first views of CHW programs across a specific region of the world. Very little is known about CHW programs across sub-Saharan Africa. Therefore, these results should be used as an impetus for more rigorous evaluation of CHW programs and practices. Additionally, by using a wide variety of question types, the Campaign has discovered very important and relevant information that has yet to be captured by other evaluations of CHW programs. These findings are crucial in moving forward research and data collection on CHW systems.

Conclusion & Next Steps

For the upcoming phase of the Operations Room development plan (Phase 2), the 1mCHW Campaign aims to work with various technology partners (e.g., Direct Relief, ESRI, IntraHealth, and UNICEF) to extend the current Operations Room into an instrument that will help estimate gaps in HRH. The primary goal for this phase is to develop both a global and country-specific CHW information platform, which includes policies and protocols (i.e., identify indicators of the World Health Organization's Minimum Data Set (MDS) for HRH that can be adapted to serve as global standards for a CHW registry).

In moving ahead with the next phase, the Campaign seeks to comply with and promote the “CHW Principles of Practice,” which are a set of guiding principles for NGOs and their partners working towards coordinated national scale-up of CHW programs.⁵ Specifically, the Campaign will work to motivate partners to comply with Principle Six.⁶ The Campaign is in active conversations with governments to underscore the value of data transparency. The Campaign has also had conversations with key CSOs operating in Africa as well as African regional bodies about collective monitoring and reporting needs and is soliciting information of current reports and assessing the formats that are currently in use. In doing so, the Operations Room will contribute to the following:

1. Improving the capacity of health system managers to oversee CHW workforces;
2. Providing a management and reporting system to generate the evidence required to make smart investments and appropriate allocation of resources decisions; and
3. Allowing for the systematic integration of CHWs into the formal health sector and national HRH frameworks.

⁵ Walker, “CHW Principales of Practice”, 2013.

⁶Principle 6: “Support unified mechanisms for reporting and management of CHW data that promote consistent quality monitoring, supervision and accountability to existing health structures and communities, reinforcing local use of data for decision-making.”

Appendices

Appendix A. Utility Survey (English)



One Million Community Health Workers Operations Room Utility Survey

In support of national Community Health Worker (CHW) scale-up initiatives, the One Million Community Health Workers (1mCHW) Campaign is building a virtual Operations Room, an online dashboard to track CHW activities and operations across rural low-income sub-Saharan Africa. The dashboard contains data on CHW counts, population coverage and workforce analytics, thereby empowering governments and partners to prioritize and allocate resources appropriately and creating a platform for field level feedback. The Operations Room also reports on the operational planning and implementation status of each country's CHW scale-up process. In addition, it will house a CHW Deployment e-Toolkit to directly support field managers who are responsible for scale-up. Visit the Operations Room at <http://1millionhealthworkers.org/operations-room-map/>

We understand that there exists various nomenclature and scope of work regarding CHWs. For ease of reference, the Campaign defines CHWs as lay community members who are trained and equipped to provide basic curative and preventative health services to populations in rural and low-resource communities.

We appreciate your participation in this survey to help us improve and develop the Operations Room. The information submitted in this survey will be used to populate the Operations Room map and will be used exclusively for the purposes of the 1mCHW Operations Room.

** Please note that if your organization manages multiple cadres of CHWs with distinct job descriptions, we ask that you please fill out a separate survey for each.*

Contact Information

Field Office

- Organization:
- City:
- Country:
- Telephone:

Primary Contact

- First Name:
- Last Name:
- Job Title:
- Country of Residence:

- Telephone:
- Email:

Community Health Worker Activities

1. By what name are Community Health Workers known in your country?
2. How does your organization define Community Health Workers?
3. How many Community Health Workers does this field office currently manage?
4. Are there other organizations that work with this same cadre? *Please list them.*
5. Which geographical areas (latitude, longitude coordinates or nearest town) are covered by this cadre of CHWs?
6. How many households are served by each CHW?
7. What is the total annual budget and sources of funding for your CHW program?
8. Please attach the Terms of Reference for your CHWs.
9. Is there a supervisor for your CHWs within your organization?
 Yes
 No
10. Who is the supervisor for your CHWs? *Please include a job description.*
11. Please attach the Terms of Reference for your CHW supervisors.
12. Which activities are your CHWs carrying out? *Please select all that apply.*
 - Monitoring of malnutrition and other danger signs
 - Immunizations
 - Community health promotion and counseling
 - Disease surveillance
 - Growth monitoring
 - Family planning services
 - Pre-natal/Post-natal/Maternal care
 - Referrals to/from health facilities

- HIV testing and counseling
- Community Case Management (CCM) of diarrhea
- CCM of pneumonia
- CCM of malaria
- CCM of dysentery
- CCM of newborn sepsis
- Sanitation inspection/education (WASH)
- Other (please specify):

13. Which items are provided to your CHWs? *Please select all that apply.*

- Uniform
- Medical kit
- Flashlight
- Umbrella
- Boots
- Cell phone/smart phone
- Bicycle
- Money for transportation
- Backpack
- Batteries
- List of households
- Data collection forms
- Maternal, child, and family health booklets
- Referral forms
- Job aids/household counseling cards
- Other (please specify):

14. Which medical supplies are provided to your CHWs? *Please select all that apply.*

- MUAC Tape
- Oral Rehydration Salts (ORS)
- Zinc
- Artemisinin-based Combination Therapies (ACTs) for Malaria
- Deworming Tablets (i.e. Albendazole)
- Antibiotics for Pneumonia/TB
- Sputum Containers for TB Sputum Collection
- Diluted Soap
- Bandages
- Anti-inflammatory, antipyretic, or analgesic medicines
- Cotton balls/swabs
- Stethoscope
- Blood Pressure Meter
- Thermometer
- Timer
- Rapid Diagnostic Tests (RDTs) for Malaria
- Bag Valve Mask (Ambu Bag)
- Family Planning Supplies (i.e. Condoms, Contraceptives)
- Anti-malarials
- Vaccines (e.g. Rotavirus, Pneumonia, Measles, Hib, DPT)
- Vitamin A

- Insecticide-Treated Bed Nets
- Plumpy'nut, other RUTF, or other nutritional supplements
- Chlorhexidine or Other Antiseptic
- Other (please specify):

Community Health Worker Reporting

15. Please describe the standard data collection practices for your CHWs.

16. Please attach a sample report submitted by your CHWs.

17. What tools do your CHWs use to collect data during their field work?

- Pen and paper/ledger
- Non-smart mobile phone
- Smart phone
- Tablet
- Other (please specify):

18. Which organization supplies the technology and resources for m/eHealth?

19. What do your CHWs use mobile phones/smart phones/tablets for?

- Patient tracking
- Monitoring and evaluation for case management of select illnesses
- Malnutrition screening
- Pregnancy tracking
- Quality improvement (tracking and evaluation of CHWs own performance)
- Disease surveillance and reporting
- Job aids (i.e. decision support tools, informational diagrams, general tips, etc.)
- Active case finding for cough/fever
- Training (including refresher training)
- Increasing community awareness and knowledge regarding specific health issues
- mBanking (payment of CHW salary)
- Other (please specify):
- Our CHWs do not use mobile phones/smart phones/tablets

20. How often do CHWs in your organization have access to the Internet to submit data?

- Always
- Most of the time
- Sometimes
- Rarely
- Never

21. What is the normal network speed available to CHWs in the field? *Please select all that apply.*

- 2G
- 3G

- 4G
- LTE
- Wireless
- None
- Other (please specify):

22. Is your organization currently producing routine reports (for local government, health facilities, MoH, etc.) on CHW operations?

- Yes
- No

23. In what capacity do your CHWs report to the local MoH?

24. How often does your organization provide reports on CHW operations to the following entities?

	Never	Less than once per month	Once per month	2-3 times per month	Once a week	More than once a week
Local government						
Health Facility						
Ministry of Health (Central)						
Organization Headquarters						
Organization Field Office						
Other						

25. Please attach your reporting template or a sample report provided to the above entities.

26. What software does your organization currently use to manage CHW data? *Please select all that apply.*

- Microsoft Access
- Microsoft Excel
- SQL
- Google Docs
- Paper forms
- Other (please specify):
- None

27. Please describe your validation procedures for CHW data. *(e.g. my organization random samples villages for follow-up)*

28. What are the key performance indicators you use to monitor the impact of your CHW program?

29. Please attach a sample report of your key performance indicators.
30. What is your opinion of the general status of CHWs and their functionality in your district/region/state/country? *(Positives and negatives of the system/program, areas in need of improvement, etc.)*

Operations Room Participation

The 1mCHW Operations Room was built on the realization that there is an increasing need for systematic tracking of CHW operations that is readily available for organizations and nations to use. Although there is key interest by all partners in achieving CHW scale-up, it is a logistical challenge to identify CHW coverage and capacity, the level and quality of training, and the available resources at the district level. The Operations Room will offer a harmonized approach to CHW reporting and establish a clear view of the number of CHWs and their capabilities. In turn, this provides information on where to close the gap on human resources for health (HRH) support so that CHW scale-up can be achieved.

The 1mCHW Campaign is currently working to collect data on the numbers, locations, and competencies of Community Health Workers (CHWs) in Africa, in addition to identifying indicators that can serve as global standards for CHW reporting.

31. How do you imagine potentially using the Operations Room Dashboard within your organization? *Please select the relative level of importance of each function to your organization.*

	Very important	Somewhat important	Not important
Research CHW activities and operations			
Sharing of CHW materials and best practices with external partners			
Understand the activities of other organizations			
Encourage involvement from other non-profits and/or health providers in CHW operations			
Incentivize donors or potential donors			
Internal strategy development to improve CHW operations			
Motivate local government on the importance of CHWs			
Identify gaps in CHW coverage and opportunities for scale-up within your current region			
Identify gaps in CHW coverage and opportunities for scale-up in new regions			

Develop partnerships with other organizations to improve and/or scale-up CHW operations <i>within your current region</i>			
Develop partnerships with other organizations to improve and/or scale-up CHW operations <i>in new regions</i>			
Understand the effectiveness of CHWs			
Use platform as primary reporting system for your organization's CHW operations			
Use data to refine your organization's CHW resources (training curriculum, job aids, etc.)			
Use material from other implementing partners for your organization's CHW operations			
Other			

32. If information on the Operations Room were downloadable, what type of indicators and other types of data would be most useful and how would your organization use this data?

33. How useful would a global community health workers registry be to your organization?

- Very useful
- Somewhat useful
- Not very useful
- Not at all useful

34. Is your organization interested in participating in the One Million Community Health Workers Operations Room Project?

- Yes
- No

35. Please describe how your organization would like to become involved in the Operations Room. *How do you make your community health workers count?*

36. Please describe how the Operations Room could be improved to meet your organization's needs.

Appendix B. Utility Survey (French)



Sondage sur l'utilité du Centre Virtuel d'Opérations de la Campagne Pour Un Million d'Agents de Santé Communautaires

Pour soutenir les initiatives d'intensifications nationale des Agents de Santé Communautaires (ASC), la Campagne Pour Un Million d'Agents de Santé Communautaires (1mASC) est en train de mettre en place un Centre Virtuel d'Opérations, et notamment un tableau de bord en ligne pour suivre les activités et les opérations des ASC à travers l'Afrique subsaharienne.

Le tableau de bord virtuel contient des données sur la localisation des agents de santé, la population qu'ils couvrent et l'analyse de la main d'oeuvre, donnant ainsi les gouvernements et les partenaires un pouvoir à établir des priorités et d'allouer des ressources de manière appropriée et de créer une plate-forme pour les informations et comptes rendus au niveau du terrain.

Le Centre Virtuel d' Opérations produit également des rapports sur les plans opérationnels et la mise en oeuvre des activités d'intensification, à l'échelle de chaque pays. En outre, il abritera un e-Toolkit de déploiement pour appuyer directement les responsables sur le terrain qui sont responsables de la mise à l'échelle du projet. Visiter le Centre Virtuel d'Opérations à <http://1millionhealthworkers.org/operations-room-map/>

Nous comprenons qu'il existe divers nomenclature et l'étendue du travail des ASCs. Pour une raison de commodité, la Campagne définit un Agent de Santé Communautaire comme étant un citoyen membre de la communauté, formé et équipé pour fournir des services curatifs et préventifs de santé de base aux populations dans leurs communautés rurales et à faibles ressources.

Nous vous remercions de votre participation à ce sondage qui nous permettra d'améliorer et de développer le Centre Virtuel d' Opérations. Les informations soumises dans ce sondage seront utilisées pour enrichir la carte géographique du Centre Virtuel d' Opérations et seront utilisées exclusivement aux fins du Centre Virtuel d' Opérations de la Campagne Pour Un Million d'ASCs.

** Veuillez noter que si votre organisation gère de multiples cadres d'ASCs avec des responsabilités très distinctes, nous vous demandons de remplir un sondage pour chaque cadre.*

Coordonnées

Bureau sur le terrain

- Organisation:
- Ville:

- Pays:
- Téléphone:

Contact Principal

- Prénom:
- Nom de Famille:
- Titre au travail:
- Pays de Résidence:
- Téléphone:
- Email:

Les Activités de l'Agent de Santé Communautaire

1. Sous quel nom un Agent de Santé Communautaire est connu dans votre pays?
2. Votre organisation donne quelle définition à l'Agent de Santé Communautaire?
3. Votre bureau présentement gère combien d'Agents de Santé Communautaires?
4. Y-a-t-il d'autres organisations (OBCs, NGOs, etc.) qui emploient le même cadre des ASCs? *Prière les lister.*
5. Quels sont les zones géographiques qui sont couvertes par ce cadre d'ASC? *Veillez nous fournir une carte avec des coordonnées (e.g. Nairobi, Kenya -- Latitude: -1.2833300, Longitude: 36.8166700) qui indique la localisation géographique exacte afin que nous puissions mettre les activités des ASC sur le site web du **Centre Virtuel d'Opérations**.*
6. Combien de ménages sont desservis par chaque ASC?
7. Quel est le budget annuel total et les sources de financement de votre programme d'ASC?
8. Veillez joindre les termes de références de vos ASC.
9. Y-a-t-il un superviseur pour les ASC au sein de votre organisation?
 Oui
 Non
10. Qui est le superviseur de votre ASC? (e.g. l'infirmière de la communauté) *Veillez indiquer ses responsabilités.*

11. Veuillez joindre les termes de référence des superviseurs de vos ASCs.

12. Quelles sont les activités que mène votre ASC? *Veuillez sélectionner tout ce qui est applicable.*

- Surveillance et/ou suivi de la malnutrition et d'autres signes de danger
- Vaccinations
- Promotion de la santé communautaire et conseil
- Surveillance de maladies
- Suivi de la croissante
- Services de planification familiale
- Soins Prénatal/Post-natal/maternel
- Renvoi a destination de / en provenance des établissements de santé
- Conseil et dépistage du VIH
- Gestion des cas (CCM) de diarrhée
- CCM de pneumonie
- CCM du paludisme
- CCM de la dysenterie
- CCM de la septicémie néonatale
- Inspection de l'assainissement / l'éducation (WASH)
- Autre (prière spécifier):

13. Quels articles sont fournies à vos agents de santé communautaires? *Veuillez sélectionner tout ce qui applique.*

- Uniforme
- Trousseau Médical
- Lampe torche
- Parapluie
- Bottes
- Te phone/smart phone
- Vélos
- Argent pour le transport
- Sac-à-Dos
- Piles
- Liste des ménages
- Formulaire de collecte de données
- Les carnets sanitaires pour la mère, l'enfant et la famille
- Fiches de référence
- Matériel audio-visuel de l'emploi/cartes de conseils de famille
- Autre (veuillez spécifier):

14. Quels sont les approvisionnements médicaux que reçoivent vos ASCs? *Veuillez sélectionner tout ce qui applique.*

- rubans métrique (millimétrés) pour mesurer la circonférence du bras
- sels de réhydratation orale (SRO)
- Zinc
- Polythérapies à base d'artémisinine (ACT) pour le paludisme
- Comprimés vermifuges (ex. l'Albendazole)

- Antibiotiques contre la pneumonie / TB
- Conteneurs pour le prélèvement d'expectoration pour diagnostiquer la tuberculose
- Savon liquide
- Bandages/pansements
- Anti-inflammatoire, antipyrétique, ou médicaments analgésiques
- Boules de coton
- Stéthoscope
- Tensiomètre
- Thermomètre
- Chronomètre
- Tests de diagnostic rapide (TDR) pour le paludisme
- Dispositif à masque et ballon d'anesthésie (BVM)
- Approvisionnements relatifs à la contraception (ex. préservatifs, contraceptifs)
- Antipaludiques
- Vaccins (par exemple, le rotavirus, la pneumonie, la rougeole, Hib, DTC)
- Vitamine A
- Moustiquaire Imprégnée d'Insecticide à Longue Durée
- Plumpy'nut, autre ATPE, ou d'autres suppléments nutritionnels
- Chlorhexidine ou autre antiseptique
- Autre (veuillez spécifier):

Le reportage de l'Agent de Santé Communautaire

15. Veuillez décrire les pratiques de collecte de données standard pour vos ASC.
16. Veuillez fournir un exemplaire de rapport soumis par vos ASCs qui illustre les pratiques de collecte de données standard pour vos ASC.
17. Quels sont les outils que vos agents de santé communautaires utilisent pour recueillir des données au cours de leur travail sur le terrain?
- Stylo et papier/cahier
 - Téléphone mobile simple
 - Smart phone
 - Tablette électronique
 - Autre (prière spécifier):
18. Quelle organisation fournit la technologie et les ressources pour ce composant du projet (eHealth)?
19. Pour quelle raison vos ASCs utilisent-ils les téléphones portables, les téléphones intelligents et les tablettes électroniques?
- Suivi du patient
 - Suivi et évaluation de la gestion de certaines maladies
 - Dépistage de la malnutrition
 - Suivi de grossesse

- Amélioration de qualité (suivi et évaluation de la bonne performance de l'ASC)
- Surveillance de maladie et des rapports
- Aides d'emploi (ex. outils d'aide à la décision, des diagrammes d'information, conseils généraux, etc)
- Dépistage rapide de la toux et de la fièvre
- Formation (Y compris formation de recyclage)
- Sensibilisation croissante de la communauté et des connaissances sur des problèmes spécifiques de santé
- Système bancaire électronique (paiement du salaire de l'ASC)
- Autre (veuillez spécifier):
- Nos ASCs n'utilisent pas de téléphones mobiles, de téléphones mobiles androids ni de tablettes électroniques

20. A quelle fréquence les ASC de votre organisation ont ils accès a l'internet pour soumettre des données?

- Toujours
- La plupart du temps
- De temps en temps
- Rarement
- Jamais

21. Quelle est la vitesse normale du réseau disponible aux ASCs sur le terrain? *Veuillez sélectionner tout ce qui est applicable.*

- 2G
- 3G
- 4G
- LTE
- Sans fil
- Aucun
- Autre (veuillez spécifier):

22. Est ce que votre organisation soumet des rapports périodiques (pour les collectivités locales, les établissements de santé, Ministère de la Santé, etc) sur les opérations ASC?

- Oui
- Non

23. A quel titre est ce que vos ASCs soumettent leurs rapport aux autorités locales du Ministère de la Sante?

24. A quelle fréquence votre organisation fournit elle des rapports sur les opérations des ASCs aux structures suivantes?

	Jamais	Moins d'une fois par mois	Une fois par mois	2-3 fois par mois	Une fois par semaine	Plus d'une fois par semaine
Gouvernement local						
Centre de Santé						

Ministère de Santé (Niveau Central)						
Siège de l'Organisation						
Bureau local de l'Organisation						
Autre						

25. Veuillez joindre votre modèle de rapport ou un exemplaire d'un rapport fourni aux entités ci-dessus.

26. Quels sont les logiciels que votre organisation utilise présentement pour la gestion des données de l'ASC? *Veuillez sélectionner tout ce qui est applicable.*

- Microsoft Access
 Microsoft Excel
 SQL
 Google Docs
 Formulaires papier
 Autre (veuillez spécifier):
 Aucun

27. Veuillez décrire vos procédures de validation des données de l'ASC. *(par exemple : pour le suivi, mon organisation choisit des villages au hasard)*

28. Quels sont les indicateurs de performance clés que vous utilisez pour suivre l'impact de votre programme d'ASC?

29. Veuillez joindre un exemplaire d'un rapport d'indicateurs de performance clés que vous utilisez pour faire le suivi de l'impact du programme de vos ASCs.

30. Quelle est votre opinion sur la situation générale des ASC et leur fonctionnalité dans votre quartier / région / état / pays? (Positifs et négatifs du système / programme, les zones qui ont besoin d'amélioration, etc)

La Participation au Centre Virtuel d'Opérations

Le Centre Virtuel d'Opérations de la Campagne Pour Un Million d'ASCs a été établi sur la réalisation du besoin croissant d'un suivi systématique des opérations ASC qui soit facilement disponible pour les pays et les organisations à utiliser. Bien qu'il y ait un intérêt primordial de tous les partenaires dans la mise à l'échelle du projet d'ASC. On note un défi logistique quant à l'identification de la couverture des ASCs, de leur capacité, de la qualité des formations, et des ressources disponibles au niveau des districts.

Le Centre Virtuel d'Opérations établira donc une vision claire des rôles des ASCs, de leurs capacités, et offrira une harmonisation des rapports. En retour, cela fournira de l'information sur les problèmes à combler dont les ressources humaines pour la santé (RHS) de sorte que la mise à l'échelle des ASCs puisse être réalisée

La Campagne Pour Un Million d'ASCs travaille actuellement a recueillir des données sur le nombre, les emplacements, et les compétences des Agents de Santé Communautaires en Afrique, en plus d'identifier des indicateurs qui pourront servir de normes globales pour les rapports des ASCs.

31. Comment envisagez vous potentiellement utiliser le tableau de bord du Centre Virtuel d'Opérations au sein de votre organisation? *Veillez sélectionner le niveau d'importance relative à chaque fonction de votre organisation.*

	Très important	Assez Important	Pas important
Faire de la recherche sur les activités et opérations des ASCs			
Partager les matériaux et les meilleures pratiques des ASCs avec les partenaires externes			
Comprendre les activités d'autres organisations			
Encourager la participation d'autres organisations à but non-lucratif et/ou prestataires de santé dans les opérations des ASCs			
Comprendre le travail de votre organisation dans le cadre des activités d'autres organisations dans le domaine des ASC			
Inciter les donateurs ou donateurs potentiels			
Elaborer une stratégie interne pour améliorer les opérations des ASCs			
Motiver le gouvernement local et/ou collectivités locales sur l'importance des ASCs			
Identifier les écarts en couverture des ASCs et les opportunités de la mise à l'échelle <i>dans votre présente région</i>			
Identifier les lacunes dans la couverture des ASC et des possibilités de mise à l'échelle <i>dans des nouvelles régions où votre organisation ne fonctionne pas encore</i>			
Développer des partenariats avec d'autres organisations pour améliorer ou mettre à l'échelle les opérations des ASCs <i>dans votre région actuelle</i>			
Développer des partenariats avec d'autres organisations pour améliorer ou mettre à l'échelle les opérations des ASCs <i>dans de nouvelles régions où vous n'êtes pas encore actif</i>			
Comprendre l'efficacité des ASCs			
Utiliser les données pour affiner les ressources ASC de votre organisation (curriculum de formation, des outils de travail, etc)			
Utiliser les données pour raffiner les ressources des ASCs de votre organisation (programme de formation, les aides à l'emploi, etc.)			

Utiliser le matériel provenant d'autres partenaires pour la mise en oeuvre des opérations des ASCs de votre organisation			
Autre			

32. Si les informations du Centre Virtuel d'Opérations étaient téléchargées, quel genre d'indicateurs ou autre type de données vous serait le plus utile et comment votre organisation pourrait elle les utiliser?

33. Quelle serait l'utilité d'un registre globale des agents de santé dans votre organisation?

- Très utile
 Assez utile
 Pas très utile
 Pas du tout utile

34. Est ce que votre organisation serait intéressée à participer au projet du Centre Virtuel d'Opérations de la Campagne pour Un Million des Agents de Santé Communautaires?

- Oui
 Non

35. Veuillez décrire comment votre organisation pourrait s'impliquer dans le Centre Virtuel d'Opérations. Comment donner vous de la valeur a vos ASCs?

36. Veuillez décrire comment le Centre Virtuel d'Opérations pourrait s'améliorer pour satisfaire vos besoins.

Appendix C – Registration Form (English)

CHW Program Information Form

Thank you in advance for your contributions to building a dashboard of CHW activities in Africa.

*** Required**

*** Name:**

*** Organization and Affiliations:**

*** Position:**

*** Email:**

Phone:

*** 1. In which country is the CHW program located?**

(Please fill out separate surveys for different programs. Note: we are only collecting data on sub-Saharan Africa.)

*** 2. By what name are Community Health Workers known in your country?**

3. How does your organization define Community Health Workers?

4. Which geographical areas are covered by this cadre of CHWs? Please provide map coordinates indicating the geographic location so that we can map your CHW activity on the Operations Room website. e.g. Nairobi, Kenya -- Latitude: -1.2833300, Longitude: 36.8166700 If you are unsure of your map coordinates, please write the name of the nearest town.

*** 5. How many CHWs are currently managed by this field office?**

6. How many households are served by each CHW?

*** 7. What is the CHW's primary location of work?**

Primary location is area where 50% or more of CHW's time is spent.

- Household
- Community health facility (e.g. health post)
- Other community facility (not health)
- Health facility outside the community
- Other (please specify):

*** 8. Do the CHWs work full time?**

Full-time work is approximately 35 hours per week, or 20 days per month.

- Yes
 No

*** 9. Are the CHWs paid or unpaid?**

- Paid, they are salaried employees
 Paid, but only performance-based rewards
 Unpaid, but they receive other financial incentives
 Unpaid, but they receive non-financial incentives
 Unpaid, completely voluntary service
 Other (please specify):

10. If paid, list the monthly amount.

(Please specify the currency in parentheses)

11. What is the minimum required level of education for a person to be selected for training as a CHW?

- None
 Primary School
 High School
 High School + 1 year of vocational training (e.g. nursing, medical)
 High School + 2 years of vocational training (e.g. nursing, medical)
 Other (please specify):

12. What is the average age of the CHWs?

- under 20 years of age
 20 - 29 years of age
 30 - 39 years of age
 40 - 49 years of age
 50 - 59 years of age
 60 years of age and older

13. How long is the initial CHW training program?

- No initial training requirement
 Less than 3 months
 3-6 months
 More than 6 months
 Other (please specify):

14. How often do the CHWs receive regular in-service training or scheduled refresher courses?

- Once per year
 Twice per year
 Three or more times per year
 They do not receive regular in-service training or scheduled refresher courses
 Other (please specify):

15. How often does your organization provide reports on CHW operations to the following entities?

	Never	Less than once per month	Once per month	2-3 times per month	Once a week	More than once a week
Local government						
Health Facility						
Ministry of Health (Central)						
Organization Headquarters						
Organization Field Office						
Other						

16. Which services do your CHWs provide? Check all that apply.

- Monitoring of malnutrition & other Danger Signs
- Immunizations
- Community health promotion & Counseling
- Disease surveillance
- Growth monitoring
- Family planning services
- Pre-natal/Post-natal/Maternal care
- Referrals to/from health facilities
- HIV testing and counseling
- Community Case Management (CCM) of diarrhea
- CCM of pneumonia
- CCM of malaria
- CCM of dysentery
- CCM of newborn sepsis
- Sanitation inspection/education
- Other (please specify):

17. What person directly supervises the CHWs?

(e.g. a district health officer, community nurse, etc.)

18. What is the availability of cellular telephony and Internet connectivity (2G/3G/4G) in the catchment area? Check all that apply.

- 2G
- 3G
- 4G
- Wi-Fi
- Other (please specify):

19. What tools do your CHWs use to collect data during their field work?

- Pen and paper/ledger
- Non-smart mobile phone
- Smart phone
- Tablet
- Other (please specify):

20. What do your CHWs use cellphones and/or smartphones for? Check all that apply.

- Patient tracking
- Monitoring & Evaluation for case management of select illnesses
- Malnutrition screening
- Pregnancy tracking
- Quality improvement (tracking & evaluation of CHW's own performance)
- Disease surveillance and reporting
- Job Aids (i.e. decision support tools, informational diagrams, general tips, etc.)
- Active case finding for cough/fevers
- Training (including refresher training)
- Increasing community awareness and knowledge regarding specific health issues
- mBanking (payment of CHW salary)
- CHWs do not use cellphones or smartphones to conduct their work
- Other (please specify):

21. Which items are provided to your CHWs? Check all that apply.

- Uniform
- Medical Kit
- Flashlight
- Umbrella
- Boots
- Cellphone/Smartphone
- Car/Motorcycle
- Money for Transportation
- Backpack
- Batteries
- List of Households
- Data Collection Forms
- Maternal Health Booklet, Child Health Booklet, Family Health Booklet
- Referral Forms
- Job Aids/Household Counseling Cards
- Other (please specify):

22. Which medical supplies are provided to your CHWs? Check all that apply.

- MUAC Tapes
- Oral Rehydration Salts (ORS)
- Zinc
- Artemisinin-based Combination Therapies (ACTs) for Malaria
- Deworming Tablets (i.e. Albendazole)
- Antibiotics for Pneumonia/TB
- Sputum Containers for TB Sputum Collection

- Diluted Soap
- Bandages
- Anti-inflammatory, antipyretic, or analgesic medicines
- Cotton Balls/Swabs
- Stethoscope
- Blood Pressure Meter
- Thermometer
- Timer
- Rapid Diagnostic Tests (RDTs) for Malaria
- Bag Valve Mask (Ambu Bag)
- Family Planning Supplies (i.e. Condoms, Contraceptives)
- Anti-Malarials
- Vaccines (e.g. Rotavirus, Pneumonia, Measles, Hib, DPT)
- Vitamin A
- Insecticide-Treated Bed Nets
- Plumpy'nut, other RUTF, or other nutritional supplements
- Chlorhexidine or Other Antiseptic
- Other (please specify):

23. What key innovations have you seen that should be part of the national policy discussion? (these include private sector/social enterprise mechanisms)

Where do you see the most effective work being done (greatest return on investment)?

24. Based on your previous knowledge and the questions you have answered above, please describe your opinion of the general status of CHWs and their functionality in your district/region/state/country.

Positives and negatives of the system/program, areas in need of improvement, etc.

Appendix D. Registration Form (French)

Enregistrement des données sur un Programme des ASC

Nous remercions par avance pour vos contributions à la construction d'un tableau de bord des activités des Agents De Santé Communautaires (ASC) en Afrique.

* **Votre Nom:**

* **Organisation et Affiliations:**

* **Titre:**

* **Email:**

Téléphone (+ l'indicatif international):

* **1. Dans quel pays est situé le programme?**

(S'il vous plaît remplissez des formulaires distinctes pour chaque programme. Remarque: nous ne collectons l'information que pour l'Afrique sub-saharienne)

* **2. Les Agents de Santé Communautaires sont reconnus dans votre pays par quelle appellation?**

* **3. Comment votre organisation définit un agent de santé communautaires?**

* **4. Nous envisageons de cartographier l'activité de vos ASC dans notre " Centre virtuel stratégique d'opérations". Veuillez fournir des coordonnées de la carte (latitude, longitude) indiquant votre situation géographique**

(Par exemple, . Nairobi, Kenya -- Latitude: -1.2833300, Longitude: 36.8166700)

Si vous n'êtes pas sûr de vos coordonnées de carte, donnez le nom de la ville la plus proche.

* **5. Combien d'agents de santé communautaires sont actifs?**

* **6. Combien de ménages sont desservis par chaque ASC?**

* **7. Quel est l'emplacement principal de travail des ASC?**

L'emplacement primaire où 50% ou plus de leur temps est passé.

- Ménage
- Établissement de santé communautaire (par exemple la poste de santé)
- Autre établissement communautaire (pas dans le secteur de la santé)
- Établissement de santé en dehors de la communauté
- Autre;

* **8. Les agents de santé communautaires sont engagés au travail à temps plein?**

Leur travail est considéré à temps plein si équivaut aux environs 35 heures par semaine et 20 jours par mois.

- Oui
 Non

*** 9. Sont-ils rémunérés?**

- Payés, les ASC sont salariés
 Payés, mais seulement des récompenses basés sur la performance
 Non rémunérés, mais ils reçoivent d'autres incitations financières
 Non rémunérés, mais ils reçoivent des incitations financières
 Impayés, leur service est entièrement volontaire
 Autre:

10. Si ils sont payés, indiquez-nous le montant mensuel.

(Veuillez spécifier la monnaie entre parentheses.)

11. Quel est le niveau minimal requis de l'éducation pour une personne d'être admissible à devenir un ASC?

- Aucun
 École primaire
 Lycée
 Lycée+ 1an de formation professionnelle (par exemple, soins medical)
 Lycée + 2ans de formation professionnelle (par exemple, soins medical, infirmier(ère))
 Autre:

12. Quel est l'âge moyen des agents de santé communautaires?

- Moins de 20 ans
 20 - 29 ans
 30 - 39 ans
 40 - 49 ans
 50 - 59 ans
 60ans et plus

13. Quelle est la durée du programme de formation initiale des ASC?

- Aucune exigence de formation initiale
 Moins de 3mois
 3mois à 6 mois
 Plus de 6 mois
 Autre:

14. Avec quelle fréquence les agents de santé communautaires reçoivent une formation continue régulière ou programmées des cours de perfectionnement en cours d'emploies?

- Une fois par an
 Deux fois par an
 Trois fois ou plus par an
 Ils ne reçoivent pas de formation en service régulier ou des cours de recyclage réguliers
Autre:

15. Votre organization, redige t-elle souvent des rapports sur les activités menées par les ASC selon les critères ci-dessous?

	Aucun	Moins qu'une fois par mois	Une fois par mois	2 à 3 fois par mois	Une fois par semaine	Plus qu'une fois par semaine
Gouvernement local						
Service de Santé						
Ministère de la Santé(Central)						
Siège de l'organisation						
L'office de l'organization en place						
Autre						

16. Quels sont les services qui sont fournis par les ASC? Cochez toutes les cases.

- Surveillance de la malnutrition et d'autres signes de danger
 Vaccinations
 Promotion de santé communautaire et conseils
 Surveillance des maladies infectieuses
 Suivi de la croissance
 Services de planification familiale
 les soins prénatals/post- natal/ maternelle
 Orientation des patients vers les établissements de santé
 Conseil et test HIV
 Prise en charge des cas dans la communauté (PE-C) de la diarrhée
 PEC de la pneumonie
 PEC du paludisme
 PEC de la dysenterie
 PEC de la septicemia néonatale
 Premiers secours et soins aux blessés
 Inspection/éducation assainissement (WASH):
 Autre:

17. Quelle personne supervise directement les ASC?

(par exemple un agent de santé de district, infirmière de la communauté,ect.)

18. Quelle est la disponibilité de la téléphonie et de la connectivité (2G/3G/4G) dans la zone de la chalandise?.

- 2G
 3G
 4G
 Wi-Fi
 Autre:

19. Quels sont les outils utilisés par les ASCs pour la collecte de données sur le terrain?

- Pics and cahier
- Non- smartphones
- Smartphones
- Tablet
- Autre:

20. Pour quelles fonctions, les ASCs utilisent- ils les téléphones? Cochez toutes les cases.

- Suivi des patients
- Suivi et évaluation de la gestion des cas de certaines maladies
- Dépistage de la malnutrition
- Suivi de grossesse
- Amélioration de la qualité des soins
- Suivi de maladie
- Aides de l'emploi (par exemple: outils décisionnels de soutien, des diagrammes d'information, conseils généraux, etc.)
- Recherche active des cas de toux/ fièvre
- Formation (y compris cours de recyclage)
- Accroître la sensibilisation de la communauté et les connaissances sur les problèmes de santé spécifiques
- Services bancaires mobiles (paiement pour les ASC)
- Les ASCs n'utilisent pas de téléphones portables ou smartphones
- Autre:

21. Quels matériels sont fournis aux agents de santé communautaires? Cochez toutes les cases

- Uniforme
- Trousse médicale
- Lampe de poche
- Parapluie
- Bottes
- Téléphone portable/ Smartphone
- Auto/ Moto/ Vélo
- Argent pour le transport
- Sac à dos
- les piles
- Liste des ménages
- Formulaires de collecte de données
- Livret de santé maternelle, carnet de santé de l'enfant, livret de santé familiale
- Formulaires de référence
- Outils de travail/ Cartes de conseils pour le ménage
- Autre:

22. Quelles sont les fournitures médicales fournis aux ASC? Cochez toutes les cases.

- Bandes de circonférence branchial (MUAC)
- Sels de réhydratation orale
- Zinc
- Médicamentieuses à base d'artémisinine
- Comprimés vermifuges (par exemple albendazole)
- Antibiotiques contre la pneumonie/tuberculose

- Récipient pour les expectorations de la tuberculose
- Savon dilué
- Bandages
- Des médicaments anti- inflammatoires, antipyrétiques, ou analgésiques
- Boules/coton-tiges
- Stéthoscope
- Mètre de tension artérielle
- Thermomètre
- Minuteur
- Tests de Diagnostic Rapide (TDR) pour le paludisme
- Sac Valve Mask (Ambu Bag)
- Fournitures de planification familiale (c. préservatifs)
- Antipaludéens (chloroquine à savoir, Coartem)
- Vaccins (par exemple rotavirus, la pneumonia, la rougeole, Hib, DPT)
- La Vitamin A
- Moustiquaires imprégnées d'insecticide
- Plumpy'nut, autre ATPE, ou d'autres suppléments nutritionnels
- Chlorhexidine ou autre antiseptique
- Autre:

23. Quelles sont les innovations clés dans le programme des ASC que vous avez vu qui devrait faire partie du débat politique national? (il s'agit notamment du secteur privé et mécanismes d'entreprises sociales)

Quels sont les aspects de travail les plus efficaces, qui rendent meilleur sur l'investissement?)

24. Sur la base de vos connaissances préalables et les questions que vous avez répondu ci-dessus, s'il vous plait décrivez votre opinion sur le statut général des agents de santé communautaires et leur fonctionnalité dans votre quartier/région/état/pays.

Positifs et négatifs du système/programme, les domaines nécessitant des améliorations, etc.