ASSESSMENT OF COMMUNITY HEALTH PROGRAMS IN NORTHWEST SYRIA

Relief Experts Association

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Contents

EXECUTIVE SUMMARY

Background. Due to the severely affected situation in Syria and the collapse of health system, there was a need to bring health services closer to the community and expand its coverage through community health workers (hereinafter CHW) and to focus as much on prevention as on the treatment of illnesses that are most common in communities. This was done through the delivery of health activities by community health workers who focus not only on the prevention part but also the detection of illnesses and establishment of referral pathways to provide treatment for the patient by the standard health system.

Objectives. This assessment is part of the World Health Organization (WHO) efforts to strengthen community health projects implemented by different NGOs in Syria. Its objectives are to understand how to maintain and expand quality community health services, how to improve the capacity of the community health-related staff, and how to strengthen the structure and management of community health projects in Syria.

Methodology. This assessment used a review of CHW mapping and primary data collection including household (HH) surveys and key informant interviews (KIIs) with different stakeholders. Five tools with close- and open-ended questions were developed based on a framework shared by WHO and presented in Annex 1. All the tools are explained and presented in Annex 2. Quantitative and qualitative data were collected to validate the assessment findings and provide in-depth information from people with a detailed understanding of CH programming in northwestern Syria (NWS). The final sample included 23 NGOs (from which the following were interviewed: 23 key informants from the CH program management teams in Turkey, 36 key informants from the CH supervision teams in Syria, and 338 CHWs), 11 interviews with community leaders (like health directorates and medical offices), and 773 surveys with community members in 42 clusters located in communities targeted with the CHW activities implemented by the same 23 NGOs. Data collection was conducted in August and September 2020.

Summary of findings

CH roles and responsibilities. Although the supervision and management respondents reported having the same tasks in managing CH projects and supervising CHWs, their titles varied significantly. The titles weren't standardized even for the community health workers in Syria, although it seems that there is a common understanding of the CHW role in each organization. However, the case wasn't the same for the CH Supervisors and Team Leaders, as there was a variation in the reported numbers of each category between the CH management staff in Turkey and the staff who managed all CHWs in the same NGOs in Syria, although the total number of both CH Supervisors and Team Leaders was almost the same. This result indicates accurate reporting by the NGOs, but a different understanding of the roles. Also, the average number of CHWs per one Team Leader was slightly more (11.60 CHWs) than the number identified in the CH Working Group (CHWG) SOPs – a maximum of 10 CHWs or 5 teams originally

planned, which could be attributed to COVID-19 response, although many NGO respondents reported that the Group is less active now than before, and blamed it for that.

CHW scope of work. The CHWG SOPs identify 6 modules that each CHW should be trained on and provide services according to. These modules are: Basic Module, Family Health Module, Nutrition Module, NCD Module, CD Module, and Healthy Lifestyle Module. Based on the responses of NGO staff in Turkey and Syria, only 9 NGOs (out of 23) were found to cover all the modules identified in the CHWG SOPs and an additional module related to COVID-19. Nutrition was the most module covered by NGOs, while only half of the NGOs reported covering the NCD module. Most of the NGOs reported providing the standard CH services and using the WHO IEC materials. The most common materials distributed by the CHWs were the nutritional supplies and hygiene kits and materials. These services weren't only provided through outreach household visit, but also through facility-based CH activities. Additionally, COVID-19 had its impact on CH services in northwestern Syria, which included applying a number of preventive measures and focusing on related awareness messages.

CHW selection and recruitment. The required qualification and expertise were reported by most respondents to be clearly defined before the CHW recruitment. It seems that the community plays a limited role in the recruitment of CHWs, and defining their role, and expectations, as most NGOs reported that they manage the recruitment process independently according to their policies and procedures. Although some NGOs said they coordinate with the local communities and consider hiring CHWs from the same community, most of the interviewed community members and leaders didn't consider the CHWs from their communities. This aspect seemed unpleasant for host community, as many complained that the CHWs are not from their area.

CHW Training. Most NGO CHWs received initial training within six months of recruitment, and a less percentage reporting receiving ongoing/refresher training by their NGOs, which most commonly reported as quarterly and bi-annually. However, only half of the CHWs received the comprehensive approach of training and the 6 training modules identified in the CHWG SOPs and many respondents reported the lack of qualified trainers and the necessity to review the contents and update its information, especially with relation to COVID-19 materials. A high percentage of the CHWs who received the comprehensive training were satisfied, but suggested several points to improve the training and overcome the challenges and barriers they face during providing or getting the training.

CH Supervision. Despite the different understanding about the role of the CH supervision teams, most NGO respondents and CHWs confirmed that supervisors conduct supervision or regular evaluation to CHWs outside of occasional visits and provide individual performance support, which includes problem-solving, coaching, on-the-job training, promoting self-care, providing incentives, among other things. The most common frequency of these visits was weekly as reported by around half of the

supervisors (17, 47.22%) and the CHWs (181, 56.04%). Community leaders also said they have a role in supervising the CHWs in their area. As in other aspects, COVID-19 had some effects on CH supervision. Many supervisors mentioned that they reduced the number of supervision visits and started to rely more on online communication with the teams, in addition to photos and videos.

CHW data collection and reporting. Most CHWs seem to submit work reports, which were mostly found to be complete by the respondents of CH management teams and supervisors. Around two-thirds of the NGO respondents said they use a mixture of paper-based and electronic tools for reporting. The rest reported using only electronic or paper-based tools. Most NGOs who used electronic tools said they use KoBo Toolbox, while a few said they used HIS or an application they specifically designed for CH data collection. Many NGOs with Rapid Response Teams also mentioned filling an electronic form for the Nutrition Cluster and UNICEF. Most NGO respondents who don't use an electronic system wished to change to one when they can, but mentioned some barriers and challenges, including lack of tablets and budget to procure them, lack of technical capacity, and the difficulty to maintain these tablets.

CHW linkages with the health system. Only two-thirds of the CHWs are linked to specific health facilities, and were considered by a similar percentage of community members as part of the health system. Also, around three-quarters of the CHWs refer patients to the health facility using a referral form, and most referred members reported following the referral, visiting the health facility, and receiving the services they were referred for. The destination of referrals was reported as either a health facility supported by the same NGO or a health facility supported by other NGOs. In the latter case, some NGO respondents said that there was no coordination with such facilities, but they depended on the service maps to identify the nearest provider of the needed service and refer the patient to it. Some NGOs also had cars to transport patients, since the lack of transportation was the most common reason for not following the referral. However, only half of the respondent community members said that the CHW(s) who referred the beneficiaries see them back and follow-up on their cases at their household after they referred them.

Community coverage and feedback. In the selected clusters, which only included communities where CH services were provided by the NGOs that covered the area, a high CHW coverage was found according the respondents who said they have received a session from CHW(s). The coverage was slightly higher in Idleb than Aleppo communities. However, although the CHWG SOPs mentions that each household should be visited by CHWs at least once every 2 or 3 months, only around 10% of the survey respondents reported receiving multiple visits. The general community feedback about CHWs was found to be satisfactory and positive, but around one-sixth of the respondent community members expressed their dissatisfaction with the services they received from the CHW(s) and mentioned several reasons for that (the most significant one was that CHWs were not from the community), in addition to a

long list of recommendations to improve benefit from CHWs, especially recruiting CHWs from the same community.

CHW Assessment Matrix. Prior to the assessment, WHO shared a framework for monitoring and evaluating CHWs, which included different indicators and parameters. Based on the framework, UDER developed a matrix to collect information from different respondents for each indicator or item. The values of some indicators and parameters, especially in the supervision and CHW performance measurement sections, varied in the responses of different NGO key informants and CHWs. The detailed figures and findings are presented in Annex 1.

Recommendations. The following are key recommendations derived from the assessment:

1. ***For NGOs***. All NGOs should be encouraged to:
    - Follow the structure identified in the CHWG SOPs: CHWs to deliver health-related activities directly to the community and households, CHW Team Leaders for a maximum of 10 CHWs (5 teams) each, and dedicated CH Supervisors.
    - Provide CH services according to all the 6 modules (Basic Module, Family Health Module, Nutrition Module, NCD Module, CD Module, and Healthy Lifestyle Module) instead of focusing only on nutrition and COVID-19, in a community-based setting with well-established linkages to health facilities, instead of providing the CH services from the facilities only.
    - Focus more on the follow-up HH visits, and guide their CHW teams to revisit the household as recommended in the SOPs (at least once every 2 or 3 months).
    - Only recruit CHWs from the same community they work in, since the dissatisfied community members mentioned that CHWs are not from the same community, and the responses of other participants and CHWs confirmed this.
    - Enhance the coordination between CHWs and health facilities in the area they cover.
2. ***For Donors.*** Since most recommendations to NGOs are in line with the CHWG SOPs, donors may consider making it mandatory for implementing NGOs to follow these SOPs. Also, donors should consider revisiting their regulations to allow for easier procurement of tablets and electronic devices.
3. ***For CHWG.*** It is recommended that the CHWG is reactivated and regular meetings should be held to guide and organize all NGO CHW activities. The Group is also encouraged to consider updating the package and work on developing a standardized electronic system, which could enhance the reporting from all NGOs managing CH projects. ToT training covering COVID-19 and all the 6 modules should be reconducted to qualify more trainers who can visit Syria and provide the training for the CHWs.

1. ASSESSMENT BACKGROUND

More than nine years of conflict have severely affected thousands of people who suffered the consequences of conflict in Syria. The collapse of medical system caused a drop in medical services. Less than half of the country's facilities are in full service resulting in a lack of access to quality health services for the community.

Therefore, there was a need to bring health services closer to the community and expand its coverage through community health workers and to focus as much on prevention as on the treatment of illnesses that are most common in communities. This was done through the delivery of health activities by community health workers (CHWs) who focus not only on the prevention part but also the detection of illnesses and establishment of referral pathways to provide treatment for the patient by the standard health system.

2. OBJECTIVES OF THE ASSESSMENT

This assessment is part of the World Health Organization (WHO) efforts to strengthen community health projects implemented by different NGOs in Syria. Its objectives are to understand how to maintain and expand quality community health services, how to improve the capacity of the community health-related staff, and how to strengthen the structure and management of community health projects in Syria.

This assessment focuses on three major areas:

1. Programmatic components and organizational structure
2. Community health worker performance
3. Challenges and recommendations

Each of the first two assessment areas has several subsidiary categories and questions that help clarify the principal objective. The third one concerns the recommendations which the assessment made after data collection and analysis. These recommendations are important for improving community health services in the assessment areas.

3. METHODOLOGY

This assessment used a review of CHW mapping and primary data collection including household (HH) surveys and key informant interviews (KIIs) with different stakeholders. Quantitative and qualitative data were collected to validate the assessment findings and provide in-depth information from people with a detailed understanding of CH programming in northwestern Syria (NWS).

3.1. CHW mapping

In December 2019, a WHO report[1] mapped the NGO-managed CHW activities in northwestern Syria. It found that 21 NGOs implemented community health projects through 1,085 CHWs in 144 communities of Aleppo and Idleb governorates, covering a total population of 2,233,324. Based on that report, UDER extracted specific details about the NGO-implemented CH projects, including the number of governorates, districts, subdistricts, communities, CHWs, supervisors, team leaders, and the size of the catchment population.

However, since the area witnessed significant changes in population due to escalation in security situation and new IDP movements since December 2019, UDER, with support from WHO, conducted in March 2020 an updated mapping of CH programs, and analyzed the information, in terms of NGO names, locations, the total number of CHWs, and the population served by these programs. It was found that 997 CHWs worked with 19 NGOs in 124 communities (2 governorates, 9 districts, 32 subdistricts) covering a total population of 2,124,683, according to the information provided by the NGOs and the population figures obtained from the United Nation's Humanitarian Needs Assessment Program (HNAP) population updates of April 2020.

It's worth mentioning that some CHWs were found to work in more than one community and that some communities were covered by more than one NGO. With a closer look at the two mapping exercises, it was found that 19 NGOs updated their figures in March, with only two NGOs that didn't confirm any updates. Since this assessment aimed at targeting all NGOs that have CHWs in Syria, data from both exercises were combined to serve as a basis for the sampling methods for data collection, which was planned to be conducted from April to June 2020.

However, as the COVID-19 pandemic reached Turkey in March 2020 in the same month the CH assessment started and continued to flare up over the assessment implementation period, affecting all aspects of social life and work conditions even in Syria, the assessment was extended until September 2020, which postponed the data collection for two additional months. During this period, many NGOs made significant changes to their CH programs in a response to COVID-19. After giving enough period of CH programs to settle, in August 2020, UDER invited the NGOs through the Health Cluster to participate in the assessment and contacted them individually to update the CHW mapping. 22 NGOs expressed their interest to participate and provided the needed information.

Most noticeably, the total number of CHWs increased in August 2020 to 1,755, with a 758-CHW increase from the previous mapping in March 2020, most of them were recruited to participate in COVID-19 community awareness activities. The updated figures were used to draft the final plan of data collection, which was conducted in

[1] https://app.powerbi.com/view?r=eyJrIjoiYWNmMTVkYTQtZDE0ZC00OTJiLWFmMzgtMWQxZGIwY2Q3Y2Q1IiwidCI6IjIjNGVkN2U3LTZmM2EtNGU2OS1hNTQzLTM5MTgyMWNhYWNkMyIsImMiOjI9

August and September 2020. The table below summarizes the three CHW mapping exercises:

	December 2019	March 2020	August 2020
# of NGOs	21	19	22
Total # of CHWs	1,085	997	1,755
Average # of CHWs per NGO	51,67	52.47	79.77
Minimum # of CHWs per NGO	3	9	6
Maximum # of CHWs per NGO	296	150	713
# of covered governorates	2	2	2
# of covered districts	10	9	9

3.2. Data collection tools and sampling

In this assessment, primary data was collected from relevant respondents. Multiple approaches were required to collect the information needed.

According to the information obtained from the CHW mapping and UDER's understanding of the assessment, the stakeholders interviewed were in five main categories:

1. CHW project management teams in Turkey
2. CHW project supervision teams in Syria
3. CHWs
4. Community members
5. Community leaders

The data collection tools were developed for each category based on a framework shared by WHO and presented in Annex 1. All the tools are explained and presented in Annex 2.

3.2.1. NGO representatives and CHWs

For the first two categories of the stakeholders, UDER conducted Key Informant Interviews (KIIs) with NGO representatives in Turkey and Syria. In Turkey, the most

knowledgeable person of each NGO's CH project was considered representative and was interviewed, but in Syria, interviewing one person for each NGO wasn't thought to be enough due to the expected differences between geographic locations. Thus, UDER aimed at interviewing one key informant in each governorate where the NGO works. The updated information taken from the mapping exercises indicated that the number of NGOs is 22, 16 of them work in 2 governorates, and 6 work in 1 governorate. This required a target of 60 KIIs, 22 in Turkey, and 38 in Syria. The interviews were conducted by UDER's assigned interviewers and consultants, who have a strong background in community health.

For the CHWs, individual surveys were conducted with a representative sample of respondents, which was calculated at 279 using a 95% confidence level and a 5% margin of error. To account for possible outliers and exclusion of some records, the target sample size was inflated by 15% to get a total of 320, which was distributed proportionally according to the total number of CHWs at each NGO. When the planned number of CHWs couldn't be interviewed at an organization, due to different reasons like a change of the locations, termination of an NGO projects, or unwillingness to participate, other CHWs from different organizations were targeted to reach the representative sample.

The above-mentioned interviews were used to gather quantitative and more in-depth information from respondents who had comprehensive views of their community health services and CH projects.

Additionally, UDER asked the NGOs to share certain documents to review and confirm their existence, and provided the NGO representatives with a form to fill the requested information before the interview to allow for a sufficient time for preparation. UDER, with support from WHO, highlighted the objectives of this assessment and clarified how it could result in better CH projects, to encourage NGOs to share such documents and information.

The table below shows the planned KIIs and surveys with NGO representatives and CHWs:

	Total #	Average # per NGO	Minimum # per NGO	Maximum # per NGO
# of NGOs	22[2]			
# of CHWs	1,755	79.77	6	713
# of KIIs in Turkey	22	1	1	1

[2] A 23rd NGO was identified during the data collection phase and included in the assessment.

# of KIIs in Syria	38	1.73	1	2
# of CHW surveys	320	14.55	1	130

3.2.2. Community leaders and members

KIIs were conducted with community leaders, including people from the health authorities in the targeted areas, like Health Directorates, Medical Offices, Local Councils, and local health professionals, among others. UDER aimed at interviewing one key informant under this category in each district where NGOs have CH activities. According to the CH mapping, the maximum number of districts was 10, so the target was 10 as well.

Household surveys were used to collect information from community members. At the same conditions above, the representative sample for the targeted population of 2,124,683 at a 95% confidence level and a 5% margin of error is 385[3]. Taking into consideration a 15% increase, the target sample size was decided at 443. The total number of surveys was originally distributed to 30 clusters (15 surveys each) based on the population covered by the CHWs in each district. According to the SOPs developed by the Community Health Working Group (CHWG) in Gaziantep, each pair of CHWs covers 200 households or 1,000 individuals. Thus, the larger the number of CHWs in a district, the more population is covered by CH activities, and the more clusters are allocated.

Probability proportional to size sampling was used to ensure the equal probability of selection of clusters across locations. The urban/rural location was taken into account since the access to health services in these rural communities is likely to be much more challenging than in urban communities. In 2018, the World Bank estimated[4] that 46% of the Syrian population was rural. As such, it was planned to allocate half of the total clusters to rural locations. After calculating the number of clusters in each district, it was equally divided in half for rural and urban clusters. When the number of clusters in a district was odd and couldn't be divided in half, a shift toward urban or rural clusters was made according to what the most prevalent classification of the communities in the district was. Based on the World Bank estimates and the HNAP population updates in April 2020, a threshold of 14,000 was used to classify communities as urban or rural. While not an ideal approach, it was perceived as an acceptable method given the uncertainties of available population estimates.

[3] The calculation is based on the normal distribution formulas, using the following site: http://www.raosoft.com/samplesize.html

[4] https://data.worldbank.org/indicator/SP.RUR.TOTL.ZS?locations=SY

Each cluster was randomly assigned to a single district community selected to conduct 15 surveys. Households from four separate areas of the community were randomly selected to ensure a representative sample.

The table below shows the planned clusters for conducting surveys with community members:

District	Population	Estimated % of unique CHWs (out of total CHWs)	Clusters	Rural	Urban
Afrin	229,072	14.85%	4	2	2
Al Bab	148,494	4.55%	1	0	1
Ariha	38,146	3.47%	1	0	1
A'zaz	283,539	12.97%	4	2	2
Harim	912,266	31.58%	9	4	5
Idleb	284,713	18.91%	6	3	3
Jarablus	36,497	1.98%	1	1	0
Jebel Saman	81,133	5.64%	2	1	1
Jisr-Ash-Shugur	110,823	6.04%	2	1	1
Total	2,124,683	100%	30	14	16

3.3. Selection and training of enumerators

102 field enumerators (21 males and 81 females) were selected based on their qualifications and their previous experience in CH projects. More female enumerators were selected because most of the CHWs in NWS are females, so it would be more convenient for them to be interviewed by female researchers given the cultural norms in northwest Syria. They were divided into teams of 2 enumerators, supported by a coordinator and a team of supervisors to coordinate and supervise the field visits and communication with different NGOs and stakeholders.

The training was conducted over two stages on two separate days. On the first day, the trainer conducted an online training from Turkey targeting the coordinator and the supervisors. On the second day, the trained supervisors conducted the training

physically for the field researchers. Due to the COVID-19 outbreak, the field enumerators were distributed into small groups to limit their number per training session and they were guided to follow strict social distancing and preventive measures. The training covered: purpose of the assessment, methodology of data collection, workplan, general data collection ethics, in addition to clarifying and testing of all tools.

By the end of the training, all field researchers were provided with a manual in Arabic to use as a reference during data collection.

3.4. Data quality

UDER implemented measures throughout the assessment process to ensure data quality was prioritized. The enumerator training covered the topic of data quality.

Pilot testing of all tools was also conducted by enumerators, firstly in the training, and then with the respondents. Based on the feedback provided by enumerators, some edits were made to the tools to ensure they were appropriate and working correctly. During the training, UDER also clarified any confusion or misunderstanding the enumerators had about questions in the tools, to ensure that they were asking questions to respondents in a correct manner.

Regular reviews of the submitted data were also conducted by the UDER team in Turkey to confirm tools were being used correctly and data collection was being conducted in line with the plan. Regular feedback was provided to enumerators to ensure KII and survey data were detailed and complete. Kobo Toolbox which was used in data collection enables a review of data in real-time, and any incomplete survey submissions have been deleted.

3.5. Data protection and confidentiality

Data confidentiality is a priority for UDER and one of its main values. UDER ensured data confidentiality throughout the assessment with the following procedures:

- All enumerators already signed a Code of Conduct which includes data confidentiality.
- Informed consent was obtained by the field researchers from respondents before they start data collection. This consent included that results will remain anonymous and will be used to improve services. Field researchers also confirmed to respondents that any response they deliver will not influence their ability to access services and will only be used for broader analysis without their names or any identifiable information. As a result of this consent, all the names of the participant NGOs weren't included in any part of this report, and so the names of the communities they work in since some communities are covered by

one NGO only. Thus, only the names of governorates and districts were mentioned, because all districts were covered by CHWs from multiple NGOs.

- Data was collected by a password-protected tablet through a mobile application, Kobo Toolbox, then all data was erased from the device once it has been uploaded online.
- All data was stored in a private cloud account with access limited to the staff who were involved directly in the data analysis and reporting.

3.6. Actual data collection

Data were collected from 23 NGOs in Turkey and Syria in August and September 2020. Although the field researchers aimed at following the data collection plan, some changes occurred due to the reasons mentioned in the table below, which also clarifies the actual data collected:

Tool	Plan	Actual	Comments
Interviews with CHW project management teams in Turkey	22 (1 interview per NGO)	23	One additional NGO was identified during data collection and included in the assessment.
Interviews with CHW project supervision teams in Syria	38 (1 interview per each governorate the NGO work in)	36	An additional interview was conducted with the 23rd NGO. four planned interviews weren't conducted, because the four NGOs had only one supervisor for all their CHWs in Idleb and Aleppo, in addition to the inability to reach the 2nd supervisor for one NGO. To compensate, two additional interviews were conducted with two NGOs that had more supervisors than planned.
Interviews with community leaders	10	11	An additional interview was conducted to obtain the views of more institutions.
Surveys with CHWs	320 (proportionally distributed on NGOs according to their total number of CHWs).	338	And additional 18 surveys were conducted to obtain the views of more CHWs.

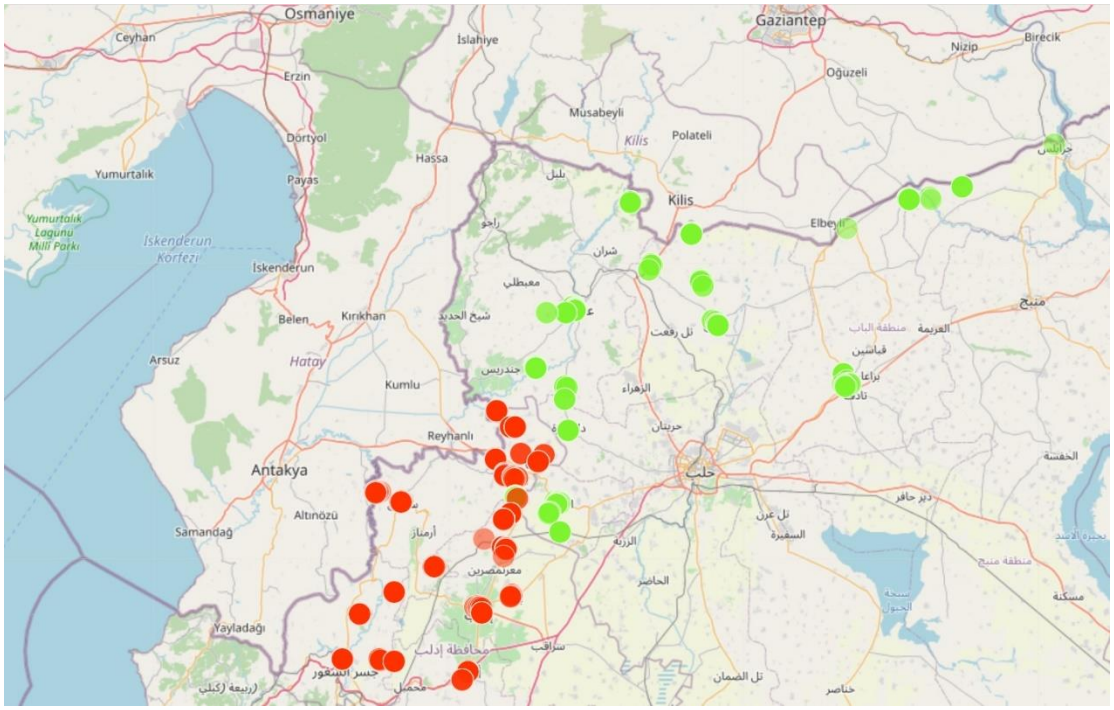
Surveys with community members	450 (30 clusters in 9 districts, 15 surveys in each cluster)	773 (42 clusters in 9 districts, 18.41 surveys on average in each cluster)	Additional clusters were targeted because the NGOs increased their CHW coverage due to COVID-19, so it wasn't possible to target all of them in both Idleb and Aleppo governorates in 30 clusters only. More surveys per cluster were also conducted as back up to account for the survey respondents who reported that they didn't receive any CH services (13.58%). These respondents weren't asked any questions related to CH services.

The table below shows the planned vs. actual surveys conducted with community members in the 9 accessible districts of Aleppo and Idleb governorates. there was a slight shift towards the rural areas in an attempt to represent the actual NGO CHW coverage, as it turned out that they target more rural areas with CHW activities than urban areas.

	Plan		Actual	
District	Clusters (Rural, Urban)	Surveys	Clusters (Rural, Urban)	Surveys
Afrin	4 (2,2)	60	4 (2,2)	85
Al Bab	1 (0,1)	15	2 (1, 1)	32
Ariha	1 (0,1)	15	2 (1, 1)	50
A'zaz	4 (2,2)	60	5 (3,2)	89
Harim	9 (4, 5)	135	11 (6, 5)	200
Idleb	6 (3, 3)	90	7 (3, 4)	126
Jarablus	1 (1, 0)	15	1 (1, 0)	17
Jebel Saman	2 (1, 1)	30	7 (4, 3)	122
Jisr-Ash-Shugur	2 (1, 1)	30	3 (2, 1)	52

Total	30 (14, 16)	450	42 (23, 19)	773

The map below shows the locations visited by the field researchers for the assessment (green for communities in Aleppo and red for communities in Idleb).



3.7. Data collection challenges and limitations

The following challenges were faced in data collection:

- The assessment looked at the availability of CHWs in northwestern Syria and the different approaches adopted by NGOs to implement their CH projects. Most NGOs changed their approach in Syria after the pandemic, focusing on delivering messages for COVID-19 prevention and adopting new methods for service delivery, and increased their CHW coverage. This resulted in changes in the data collection activities from the plan and in updating the tools during the fieldwork to add more questions about COVID-19 after the feedback received from field researchers.
- The assessment required conducting some social activities, like group training and face-to-face interviews, which wasn't possible at the originally planned period for data collection in April and May, when the pandemic was at its beginning in the area and the prevention guidelines weren't well established. Postponing the data collection allowed for conducting such activities with better quality during the extension period, because COVID-19 was then better understood and the preventive measures were more oriented. Yet, this caused

some field challenges. For example, UDER couldn't interview the planned respondents in one area, because they were isolated after one of their contacts was infected by COVID-19.

- The assessment relies to a great extent on the cooperation of the targeted NGOs, specifically in identifying the locations, facilitating the data collection, and making their staff available for the interviews. Although most NGOs responded very well and provided the needed information promptly, some NGO responses came late, resulting in delayed field activities. In a few cases, the field staff rejected to participate in the interviews despite obtaining permission from their NGO management in Turkey.
- The assessment included 23 NGOs with different CH approaches and organizational structures. This made it harder to identify the respondents, due to adopting different position titles and service delivery methods. For example, only a third of the participants in the CH supervision team interviews in Syria had positions titled as CH Supervisors, while the rest were acting as supervisors but with different administrative titles according to their NGO structures.

4. DEMOGRAPHICS AND GENERAL INFORMATION OF RESPONDENTS

4.1. Locations

The field data collection was conducted in northwestern Syria in Aleppo and Idleb governorates. With all tools, there was an increased number in Idleb than in Aleppo, which is contributed to a higher number of population and CH activities in Idleb. The table below shows the distribution of different interviews and surveys on both governorates:

Tool	Aleppo (#, %)	Idleb (#, %)
Interviews with CHW project supervision teams in Syria	12, 33.33%	24, 66.67%
Interviews with community leaders	4, 36.36%	7, 63.64%
Surveys with CHWs	92, 27.22%	246, 72.78%
Surveys with community members	345, 44.63%	428, 55.37%

4.2. Sex of respondents

Although there was a balance in male and female participants in the survey with the community members, this wasn't the case with other responders. The number of male participants was significantly higher in the interviews with community leaders and CHW management teams in both Syria and Turkey because such positions are mainly held by male individuals. For the CHWs, the respondents were mostly female, which is in line

with the CHWs figures reported by NGOs, indicating that around 70% of all CHWs are female.

The table below shows the distribution of male and female participants in different interviews and surveys:

Tool	Female (#, %)	Male (#, %)
Interviews with CHW project management teams in Turkey	6, 26.09%	17, 73.91%
Interviews with CHW project supervision teams in Syria	12, 33.33%	24, 66.67%
Interviews with community leaders	1, 9.09%	10, 90.91%
Surveys with CHWs	279, 82.54%	59, 17.46%
Surveys with community members	398, 51.49%	375, 48.51%

4.3. Age of respondents

All the respondents were 18 or above, with a higher average age in community leaders and members than CHWs and CHW management teams in Syria and Turkey. The youngest average age was for the CHW respondents, while the oldest was for the community leaders.

The table below shows the age information of the different responses:

Tool	Minimum age	Maximum age	Average age	Median age
Interviews with CHW project management teams in Turkey	27	43	33.96	34
Interviews with CHW project supervision teams in Syria	25	48	33.17	34
Interviews with community leaders	32	69	42,18	41
Surveys with CHWs	20	53	29.52	28
Surveys with community members	18	80	37.65	36

4.4. Residential status

The majority of CHW and community survey respondents were IDPs, while most of the community leaders were from the host community. A small percentage of CHWs (23, 6.80%) reported that they aren't IDPs but not from the host community either, as they live in a different community other than their home community.

The table below shows the distribution of IDP and host respondents on different tools:

Tool	Host (#, %)	IDP (#, %)
Interviews with community leaders	7, 63.64%	4, 36.36%
Surveys with CHWs	138, 40.83%	177, 52.37%
Surveys with community members	310, 40.10%	463 59.90%

4.5. Level of education

CHWs and community members were asked a question about the highest level of education they have completed. While most of the CHWs reported having a university or a college degree, almost half of the community members reported that they have completed primary or intermediate school. Some CHWs said they are still studying at the university, and a few others reported completion of higher education degrees. The CHWG SOPs include that persons have to complete secondary education at least to be selected as a CHW, and it was found that almost all respondent CHWs (333, 98.52%) met this condition, with a few exceptions (4, 1.18%) who reported only completing intermediate education.

The table below shows the different levels of education of CHWs and community members.

Level of education	CHWs (#, %)	Community members (#, %)
No formal schooling	NA	128, 16.56%
Primary or intermediate education received	4, 1.18%	447, 57.83%
Secondary school completed	71, 21.01%	111, 14.36%
College/ University completed or still studying	262, 77.51%	87, 11.25%

4.6. Additional general information about community members

Additional background questions were asked to community members who participated in the survey. Their reported household sizes ranged from 1 to 30, with an average of 6.04 and a median of 6. Two-thirds (509, 65.85%) of respondents reported having

children aged less than 5 years in their households, while less than a third (221, 28.59%) reported having adults aged 60 years or above. About half of the respondents confirmed that their households included at least a member with health problems or medical conditions.

5. FINDINGS

5.1. CH roles and responsibilities

Since one of the main objectives of the assessment was to understand the different CHW programmatic components and organizational structures, several questions in this regard were asked to NGOs' CHWs and their management and supervision teams in Turkey and Syria. The CHWG SOPs don't include specific roles or responsibilities for the CH project management teams but identify three different field levels: CHW, CH Team Leader, and CH Supervisor.

The respondents in Syria reported working in their positions for around one year and a half on average (CHWs: 1.56 years, Supervisors: 1.52 years), but the average duration was slightly less for the respondents in Turkey (1.32 years).

Although the supervision and management respondents reported having the same tasks in managing CH projects and supervising CHWs, their titles varied significantly. The respondents in Turkey were from a range of administrative levels that included Officer, Coordinator, Manager, and CEO, and took the responsibility of managing and coordinating CHWs, Nutrition, Health, or general program activities. In 43.48% of the cases (10 respondents), the title included both CHW and Nutrition at the same time. The case wasn't the same for the supervision teams in Syria, where around half of the respondents were dedicated CH staff, but in different administrative levels that included Assistant, Officer, Coordinator, Manager, and Supervisor. The rest of the respondents were in other programmatic positions. This is not in line with the roles identified in the CHWG SOPs, where dedicated CH Supervisors should be available and responsible for providing technical supervision and guidance to the CH team leaders and CHWs in their areas.

Only a third (13, 36.11%) of the CH supervision teams in Syria were responsible for managing and supervising all their NGOs' CHWs in NWS, while the rest reported their responsibility of part of the CHWs.

The titles weren't standardized even for the community health workers in Syria. 26 workers (7.69%) reported different titles than CHWs. That included Nutritionist, Protection Worker, TB Support Worker, Referral Facilitator, RRT (Rapid Response Team) Worker, despite they work as CHWs.

The NGO respondents were asked several questions about these three positions to identify their availability and numbers and to identify if the same understanding of the roles and responsibilities was present at all NGOs.

For CHWs, the NGO management teams expressed different structures and methods for service delivery, the most common were as follow:

- Community-based CHWs
- CHWs as part of Rapid Response Teams
- Health facility-based CHWs
- CHWs as part of nutrition teams
- CHWs as part of mobile clinics
- COVID-19 CHWs
- A mixed structure according to each project

The table below shows information about the number of CHWs as updated by the CHW management staff in September 2020:

Total # of CHWs		1,809
# and % of male CHWs		527, 29.13%
# and % of female CHWs		1,282, 70.87%
Minimum # of CHWs per NGO		9
Maximum # of CHWs per NGO		781
Average # of CHWs per NGO		78.65
Median # of CHWs per NGO		36
CHWs per districts		
District	Population	Total # and % of CHWs
Afrin	229,072	193, 10.67%
Al Bab	148,494	28, 1.55%
Ariha	38,146	85, 4.70%
A'zaz	283,539	133, 7.35%
Harim	912,266	621, 34.33%
Idleb	284,713	425, 23.49%
Jarablus	36,497	21, 1.16%
Jebel Saman	81,133	115, 6.36%
Jisr-Ash-Shugur	110,823	188, 10.39%

Despite the varying numbers and structures between NGOs, it seems that there is a common understanding of the CHW role in each organization. To verify that, the numbers of CHWs reported by the management staff in Turkey and the staff who supervised all the CHWs in Syria were compared. There were minor variations in the individual values, which could be attributed to the different timing of the interviews, but the total number of CHWs was almost the same (the difference was too small: 0,17%). This was also strongly confirmed by all NGO respondents and CHWs when they were asked if the formal CHW role is defined or documented. 21 key informants in Turkey (88.24%), 35 CH supervisors in Syria (97.22%), and 334 CHWs (98.82%) responded with yes. Most of the respondents said this role is defined in the contract, but a varying percentage mentioned the ToR and SOPs as well. For verification, the

NGOs were asked to share a document that defines the NGO formal CHW role. Only 6 organizations (26,09%) responded and shared different documents, half of them were ToRs and SoPs based on the CHWG SOPs, two were NGO specific ToRs, and one was a ToR based on the Rapid Response Team's.

The case wasn't the same for the CH Supervisors, as the CH management staff in 13 NGOs reported having a total of 46 CH Supervisors, but the staff who managed all CHWs in the same NGOs in Syria reported having 28 CH Supervisors, translating into an 18-CHW variation (39.13%). This finding could be attributed to a different understanding of who is a CH Supervisor, especially that the titles and positions vary a lot. The key informants confirmed this and reported one of the following possible roles for their CH Supervisors:

- Supervisors are the same as Team Leaders (this could explain considering Team Leaders as Supervisors)
- No Supervisors at all
- One Supervisor for each community/area
- One Supervisor for a certain number of CHWs
- One supervisor per each facility the CHWs work in
- A mixed structure according to each project the CHWs belong to
- Supervisor tasks are assigned to a certain position in the NGO

Based on the numbers provided by the CH management teams, the table below provides information about CH Supervisors.

Total # of CH Supervisors	94
# and % of male CH Supervisors	53, 56.38%
# and % of female CH Supervisors	41, 43.62%
Minimum # of CH Supervisors per NGO	0
Maximum # of CH Supervisors per NGO	18
Average # of CH Supervisors per NGO	4.27
Median # of CH Supervisors per NGO	2.5
Average # of CHWs per one CH Supervisor	19.24
Median # of CHWs per one CH Supervisor	15.43
Minimum # of CHWs per one CH Supervisor	2.17
Maximum # of CHWs per one CH Supervisor	71.00

The Team Leaders represented a middle case between CHWs and CH Supervisors. When the numbers of Team Leaders in 13 NGOs were compared as mentioned above, the CH management staff reported having a total of 108 Team Leaders and the staff who managed all CHWs in the same NGOs in Syria reported having 125 Team Leaders, translating into a 17-CHW variation (13.60%). The variation percentage is much less than in CH Supervisors, but the number is too close. If the total number of CH Supervisors and Team Leaders was calculated and compared in the same way, the

result would be 154 by CH management teams and 153 by CH supervision teams. This result indicates accurate reporting by the NGOs, but a different understanding of the roles. This was also confirmed by the key informants when asked about the possible roles for their Team Leaders. Their combined responses matched the roles of the CH Supervisors mentioned above.

Based on the numbers provided by the CH management teams, the table below provides information about Team Leaders.

Total # of Team Leaders	156
# and % of male Team Leaders	63, 40.38%
# and % of female Team Leaders	93, 59.62%
Minimum # of Team Leaders per NGO	0
Maximum # of Team Leaders per NGO	40
Average # of Team Leaders per NGO	6.78
Median # of Team Leaders per NGO	4
Average # of CHWs per one Team Leaders	11.60
Median # of CHWs per one Team Leaders	8.00
Minimum # of CHWs per one Team Leaders	2.05
Maximum # of CHWs per one Team Leaders	72.00
Average # of Team Leaders per one CH Supervisor	1.66
Median # of Team Leaders per one CH Supervisor	2
Minimum # of Team Leaders per one CH Supervisor	0
Maximum # of Team Leaders per one CH Supervisor	6

In a closer look at the figures in the table above, the average number of CHWs per one Team Leader is 11.60, which is close to the number identified in the CHWG SOPs (a maximum of 10 CHWs or 5 teams). This slight increase could be attributed to COVID-19, as one NGO representative said: “We increased the number of CHWs per Team Leader to become a leader for 20 CHWs, due to the lack of funding required to apply the supervision mechanism as before COVID-19.” Another NGO respondent blamed the CH Working Group, saying that his NGO didn’t follow the CHWG SOPs because they were not aware of their availability, adding that “we weren’t invited to any meeting”. However, most NGO respondents were familiar with the CHWG SOPs and even confirmed their participation in the Group since its establishment, yet they requested to reactivate it and encouraged to conduct more regular meetings.

In conclusion, while there was a common understanding of the CHW role in each organization, participant NGOs demonstrated different understanding and structures of the CH Supervisor and Team Leader roles and responsibilities. All NGOs should be encouraged to follow the structure identified in the CHWG SOPs: CHWs to deliver health-related activities directly to the community and households, CHW Team Leaders for a maximum of 10 CHWs (5 teams) each, and dedicated CH Supervisors. Also, many

NGO respondents reported that the CH Working Group is less active now than before. It is recommended that the Group is reactivated and regular meetings should be held to guide and organize all NGO CHW activities.

5.2. CHW scope of work

The CHWG SOPs identify 6 modules that each CHW should be trained on and provide services according to. These modules are: Basic Module, Family Health Module, Nutrition Module, NCD Module, CD Module, and Healthy Lifestyle Module. An additional module related to COVID-19 was added to the survey and NGO respondents were asked about the modules their NGO CHWs cover. Nutrition was the most module covered by NGOs (22 NGOs, 95.65%), while only half (12, 52.17%) of the NGOs reported covering the NCD module. Two NGOs reported having additional dedicated modules for PFA and GBV. Based on the responses of NGO staff in Turkey and Syria, only 9 NGOs (39.13%) were found to cover all the modules. The table below shows detailed information about the coverage of each module:

Module	#, %
Family Health	18, 78.26%
Nutrition	22, 95.65%
Healthy Lifestyle	14, 60.87%
NCD	12, 52.17%
CD	14, 60.87%
COVID-19	21, 91.30%
Other	2, 8.70%

To verify the delivery of the modules for beneficiaries, they were asked about the topics of the CH sessions they received. COVID-19 and other communicable diseases were the most prominent topic, which was confirmed by 429 (64.22%) survey participants. The other topics are clarified in the table below.

Topic	#, %
Disease awareness and detection	188, 28.14%
Reproductive health	100, 14.97%
Child health	171, 25.60%
Personal and environmental hygiene	234, 35.03%
Nutrition	277, 41.47%
Vaccines	85, 12.72%
COVID-19 or other CDs.	429, 64.22%
Hypertension, diabetes, or other NCDs.	96, 14.37%

NGO key informants were also asked about the services their NGO CHWs provide. The table below shows the percentage of each service.

Service	#, %
Deliver health information	22, 95.65%
Assess common health problems	16, 69.57%
Promote healthy behaviors and environment	19, 82.61%
Prevent diseases in the community	15, 65.22%
Identify symptoms and risk factors of common diseases	19, 82.61%
Conduct basic tests, like MUAC and blood pressure and glucose	19, 82.61%
Refer cases to the health facility	22, 95.65%
Follow-up the patient case upon return from the health facility to the community	15, 65.22%
Distribute some materials, like hygiene kits, nutrition supplies, etc	21, 91.30%

To know more about their services, NGOs were asked about the type of IEC materials they use and to share a copy of them for desk review. Although 23 NGOs responded to the questions confirming that 21 of them (91.30%) use the WHO materials and 13 (56.52%) also use their specific materials, only 6 NGOs (26.09%) shared a sample copy of the materials, which all were based on WHO materials, in addition to other materials from UNICEF mainly covering nutrition topics.

NGOs were also asked about the materials they distribute to beneficiaries, and again the nutritional supplies were the most common ones (14 NGOs, 66.67%). Hygiene kits and materials scored high as well (13, 61.90%). The table below shows the percentage of each material the NGO CHWs distribute.

Distributed materials	#, %
Nutritional supplies	14, 66.67%
Hygiene kits or materials	13, 61.90%
IEC materials	10, 47.62%
PPE or disinfectants	7, 33.33%
Lice shampoo	5, 23.81%
Scabies cream	3, 14.29%
Oral rehydration salt (ORS)	5, 23.81%
Chlorine	3, 14.29%

These services weren't only provided through outreach household visits. When the CHWs were asked about how they provide the CH services, more than half of the respondents (182 CHWs, 53.85%) reported providing them through community-based HH visits only, and 138 CHWs (40.83%) said they provide them in a facility- and community-based setting. Only 18 CHWs (5.33%) reported providing facility-based CH services only. This is consistent with what was reported by the community members

when asked about the location of the sessions they've received. 603 (90.27%) said they received them in their households, while the rest said in the facilities or other public places like mosques, neighbor houses, shops, etc.

As COVID-19 affected all the world, it also had its impact on CH services in northwestern Syria. During the interviews with NGO key informants, almost all of them said some changes happened in their CH programs, which can be summarized as follows:

- Replaced all the activities that include people gathering with one-to-one activity
- Focused on COVID-19 awareness-raising activities
- Applied prevention measures during CH services (like social distancing, wearing masks, using hand sanitizers, etc.)
- Stopped distributing paper-based brochures and used adhesive posters instead
- Distributing soap and PPE
- Reduced team member gatherings
- Asked parents to do some activities instead of CHWs, like measuring MUAC
- Stopped conducting basic tests for NCDs (hypertension and diabetes)
- Increased CHW coverage
- Provided COVID-19 training
- Increased the number of male CHWs to make their movement easier
- Limited the referral to health facilities
- Limited the number of HH visits and their duration.

In conclusion, participant NGOs demonstrated different type of service delivery and scope of work. All NGOs should be encouraged to follow the CHWG SOPs and provide CH services according to all the 6 modules (Basic Module, Family Health Module, Nutrition Module, NCD Module, CD Module, and Healthy Lifestyle Module) instead of focusing only on nutrition and COVID-19, in a community-based setting with linkages to health facilities, instead of providing the CH services from the facilities only. As clarified in the CHWG SOPs, the community members should receive community health services through outreach visits by CHWs to reduce accessibility obstacle due to transportation and travel distance and to maximize the coverage of the health system by active community engagement. As for the services that the CHWs provide, the collected data specifically identified a lower reporting of follow-up visits for the same households. All NGOs should focus more on these follow-up visits, and guide their CHW teams to revisit the household as recommended in the SOPs (at least once every 2 or 3 months).

5.3. CHW selection and recruitment

The CHWG SOPs include a list of criteria for selecting CHWs, the first of them is being a member of the targeted community and to be recruited from the same community. The respondents were asked different questions related to this aspect.

23 (100%) NGO respondents in Turkey, 34 (94.44%) CH supervisors in Syria, 11 (100%) community leaders, and 335 (99.11%) CHWs confirmed that the required qualification and expertise were clearly defined before the CHW recruitment. When asked if the community played any role in the recruitment of CHWs, and defining their role, and expectations, less than a third of CH supervisors (11, 31.43%) said yes, although the percentage was around half in responses of the CH management in Turkey (11, 47.83%) and the community leaders (6, 54.55%). In recruitment, the reported role included nominating CHWs, sharing the vacancy announcements, participating in the recruitment committee, and sharing the names of CHWs with local authorities for clearance in a few areas.

For other roles than the recruitment process, one NGO said it established a feedback mechanism to collect information from the community to identify the needed messages and practices to be corrected and collected data from local NGOs and health directorates to identify the locations with higher needs for CHWs.

Although most NGOs reported that they manage the recruitment process independently according to their policies and procedures, they also said they coordinate with the local communities and consider hiring CHWs from the same community. However, when the community members were asked if the CHWs who delivered the sessions were from the community, only 251 (37.57%) said yes. The percentage was even less (3, 27.27%) in the responses of the community leaders. 214 CHWs (63.31%) said they work in the same community they live in, but 99 CHWs (46.26%) of them were IDPs, so the community members could've thought they are not from the community. When beneficiaries were asked if they know the name(s) of the CHW(s) who delivered the session, only 153 (22.90%) said yes. This aspect seemed unpleasant for host community, as many complained that the CHWs are not from their area. One respondent said: "most of them are not from the area and should be escorted by someone from the local council".

As a recommendation, All NGOs should consider only recruiting CHWs from the same community in their future CHW recruitment processes, especially that they reported managing the recruitment process independently.

5.4. CHW Training

According to the CHWG SOPs, each CHW must complete a training and successfully pass the evaluation by the end of it, then undergo a refresher training every three months. Around 90% of all NGO respondents and CHWs (309, 91.42%) confirmed that their NGO CHWs received initial training within six months of recruitment. However, fewer CHWs (243, 71.89%) said they receive ongoing/refresher training by their NGOs. When the CHWs who receive ongoing training were asked about the frequency, their responses were as follows:

Frequency	#, %
Monthly	55, 16.27%
Quarterly	71, 21.01%
Bi-annually	102, 30.18%
Annually	17, 5.03%
Other	70, 20.71%
Refused to respond	23, 6.80%

It seems that the quarterly and bi-annually frequencies are the most common, which was also confirmed by the respondents of CH management teams (10, 53,63%) and the CH supervision teams (17, 62,96%). The surveyed CHWs mentioned other types of training as well, like receiving coaching and on-the-job training through ad hoc visits by their supervisors (277, 81.95%), attending ad hoc workshops on specific vertical health topics provided by NGOs (200, 59.17%), and continuous capacity development (263, 77.81%), whose objective was to reinforce initial training (180, 68.44%), teach CHWs new skills (207, 78.71%), and help ensure quality (142, 53.99%).

When asked if they received the comprehensive approach of training and the 6 training modules, half of the respondent CHWs (168, 49.70%) positively confirmed. This was consistent with what was reported by the key informants of the CH management teams (11, 47.83%) and the CH supervision teams (19, 52.78%). Of the CHWs who received the comprehensive training, a high percentage (154, 91,67%) were satisfied or very satisfied. This was also confirmed by the other NGO respondents, saying that “the package is excellent and rich with information.” However, some CHWs complained that the topics were hard to understand and that the duration was insufficient.

To improve the comprehensive package, the respondents suggested several points which can be summarized as follows:

- Increase the training duration
- Add more details to Module 1
- The manual should be reviewed for typos and grammar errors
- Add more photos
- Update the topics (especially those related to communicable diseases due to COVID-19)
- Expand some topics like nutrition, psychosocial support, and CD
- Add more content about communication skills
- Add more clarifications so CHWs can understand the topics
- Add new topics about protection, PSEA, and GBV.

Whether the CHWs received the comprehensive training package or not, the NGO respondents and CHWs mentioned facing plenty of barriers and challenges during providing or getting the training. These included:

- Lack of qualified trainers
- Compromised security situation
- A large number of CHWs that need to be trained are in distant areas with difficult transportation
- COVID-19 challenges (like lack of venues appropriate for social distancing and application of prevention measures)
- Financial challenges
- The duration of training wasn't sufficient
- Bad internet and lack of electricity for online training
- Challenges related to training on NCD and the tests for hypertension and diabetes
- Bad weather conditions in summer and winter
- Online training is not as good as physical
- Lack of demonstration means and practical scenarios in the training
- Lack of training completion certificate
- Lack of babysitting services for mother CHWs

To overcome these challenges and barriers, the respondents provided the following recommendations:

- Invest more in online technologies to provide training
- Add more practical sessions and demonstration means
- Conduct the training on stages, a specific topic in each stage
- Conduct the training at near communities to CHWs
- Share the training materials with trainees before the training
- Coordinate training activities to avoid gaps in CHW work
- Increase financial support for training
- Distribute CHWs to groups to reduce the number of trainees per training
- Use more simple materials
- Provide trainees with transportation and accommodation
- Advocate with donors to ask all NGOs to train their CHWs
- Increase the NCD training duration
- Add topics for team leaders related to leadership skills
- Make senior CHWs escort junior ones to share the experience
- Conduct field visits by supervisors to observe the activities and correct the wrong ones
- Provide better venues and qualified trainers
- Increase the duration of the training
- Provide heating and cooling to overcome bad weather conditions
- Provide certificates of completion
- Consider the security situation
- Provide babysitting services for mother CHWs

The respondents also mentioned other types of training they would like to receive, which included:

- Infection prevention and control
- COVID-19
- Communication and leadership skills
- Referral mechanism
- PFA
- IYCF
- CMAM
- PSEA
- Administrative and reporting skills
- Triage mechanism
- Psychosocial support
- Child and woman protection
- First aid
- GBV
- Photography
- English language
- Computer skills
- Risk management
- Self-care

In conclusion, around half of the CHWs working in northwestern Syria are not trained on the comprehensive package and the six-module training curriculum and many respondents reported the lack of qualified trainers and the necessity to review the contents and update its information, especially with relation to COVID-19 materials. The CH Working Group is encouraged to consider updating the package and reviewing its contents according to the suggestions mentioned above. ToT training covering COVID-19 and all the 6 modules (Basic Module, Family Health Module, Nutrition Module, NCD Module, CD Module, and Healthy Lifestyle Module) should be reconducted to qualify more trainers who can visit Syria and provide the training for the CHWs.

5.5. CH Supervision

According to the CHWG SOPs, CHWs should be supervised through field visits and on the job coaching, with weekly meetings or visits to discuss and evaluate the work plans. Despite the different understanding about the role of the CH supervision teams, most NGO respondents and CHWs confirmed that supervisors conduct supervision or regular evaluation to CHWs outside of occasional visits. The most common frequency of these visits was weekly as reported by around half of the supervisors (17, 47.22%) and the CHWs (181, 56.04%). Around three quarters (26, 72.22%) of the respondent CH

supervisors in Syria said they were trained and 32 (88.89%) said they have the basic supervision tools they need for supervision.

When asked if they provide any individual performance support, 30 (83.33%) respondent CH supervisors said they do, and 269 (79.59%) CHWs said they receive such support, which includes problem-solving, coaching, on-the-job training, promoting self-care, providing incentives, among other things, like "giving drawing classes" to improve their mood and identifying "the hero of the week" to encourage the rest of the team.

33 CH supervisors (91.67%) also said they provide a summary of CH performance and areas that need further improvement, which was confirmed to be received by a similar percentage of CHWs (315, 93.20%).

As in other aspects, COVID-19 had some effects on CH supervision. Many supervisors mentioned that they reduced the number of supervision visits and started to rely more on online communication with the teams, in addition to photos and videos.

The CH supervision wasn't limited to the NGO supervisors only, as 7 (63.64%) respondent community leaders said they have a role in supervising the CHWs in their area. This supervision included providing work permissions from local authorities, solving some problems the CHWs face, conducting supervision visits, following up on some cases, and monitoring working hours.

In conclusion, the participant NGOs reported conducting supervision or regular evaluation to CHWs, but they are encouraged to follow the CHWG SOPs in this aspect, especially regarding conducting the supervision visits on weekly-basis and coordinating with local community representatives.

5.6. CHW data collection and reporting

Data collection and reporting is an essential part of the CHWs work, with a detailed process flow clarified in the CHWG SOPs. Almost all interviewed CHWs (337, 99.70%) said they submitted work reports in the last month. These reports were found to be complete (did not have missing information) by 19 (82.61%) respondents of CH management teams and 30 (85.71%) CH supervisors.

Around two-thirds of the NGO respondents said they use a mixture of paper-based and electronic tools for reporting. The rest reported using only electronic or paper-based tools. Most NGOs who used electronic tools said they use KoBo Toolbox, while a few said they used HIS or an application they specifically designed for CH data collection. Many NGOs with Rapid Response Teams also mentioned filling an electronic form for the Nutrition Cluster and UNICEF.

"We collect data on paper during the CHW visits, then a data entry fills the data in Excel," said one of the NGO respondents, and many others repeated the same method. When asked why CHWs do this instead of directly collecting data using electronic forms, NGO respondents mentioned some barriers and challenges, including lack of tablets

and budget to procure them, lack of technical capacity, and the difficulty to maintain these tablets. There was also a concern that "poor people (especially in camps) could be sensitive to using expensive tablets by CHWs," said one NGO respondent. Another respondent said: "We developed our own application to collect data. The CHWs faced difficulty using it at the beginning, but they are used to work on in now. There were some errors, which were fixed later, yet I can say that our application now is not excellent, but good." One supervisor in Syria added: "With Kobo, we don't have access to data, so we don't know if the uploaded forms are correct or not."

Due to these challenges, one NGO respondent even said they were using an electronic system in the past, but returned to the paper-based forms. This wasn't the plan of most NGO respondents, who wished to change to the electronic system when they can, especially those that reduced or stopped using paper due to COVID-19. Other changes in the data collection and reporting were attributed to the pandemic, like reducing the number of questions in the form to reduce the time of data collection, adding questions related to COVID-19, and training the CHWs on the EWARN reporting mechanism.

In conclusion, the participant NGOs confirmed submitting the required reports, but data collection and reporting tools varied significantly between NGOs, although most of them expressed their interest to change to an electronic system. However, donors have strict rules about procuring tablets and tools required to do this upgrade. Donors are encouraged to provide solutions and make it easier to procure electronic tools. The CH Working Group should also work on developing a standardized electronic system, which could enhance the reporting from all NGOs managing CH projects.

5.7. CHW linkages with the health system

According to the CHWG SOPs, one of the main objectives of CHWs is to maximize the coverage of the health system. To assess this, the tools included a set of questions about this aspect.

When the CHWs were asked if they were linked to a specific health facility, two thirds (226, 66.86%) said they were. A higher percentage of 73.08% (247 CHWs) said they referred patients to the health facility using a referral form. However, most CHWs (291, 86.09%) and supervisors (32, 88.89%) said that CHWs were recognized in their communities as a part of the health system. Except for one, all the interviewed community leaders (10, 90.91%) confirmed this, but only two thirds (451, 67.51%) of the surveyed community members agreed.

Those who didn't consider CHWs as a part of the health system mentioned several reasons, which included different expectations from the standard CHW role, like the fact that CHWs are not doctors nor health professionals (or "they don't even dress like doctors or nurses" as one community member put it) and didn't provide medical services, prescribe drugs, nor know how to diagnose diseases. One respondent said:

“We don't even trust doctors and pharmacists due to fake certificates, so how we can trust these workers?”.

Community members were asked if they or anyone in their household received a referral to a health facility by a CHW, and 138 (20.66%) responded with a yes. Most of them (115, 83.33%) received a referral form and a slightly less percentage (112, 81.16%) said that the referred member followed the referral and went to the health facility. A high percentage (99, 88.39%) also confirmed receiving the service they were referred for. The table below shows the most common reasons identified by the 24 community members who responded the question about the reasons for not following the referral:

Reason	#, %
Transportation was not available	7, 29.17%
Did not feel it was necessary to go to the health facility	7, 29.17%
Transportation was expensive	7, 29.17%
Did not know if the health facility provided the necessary services	3, 12.50%
Security conditions were unfavorable	3, 12.50%
Road conditions were poor	2, 8.33%
Did not know if the health facility was open	2, 8.33%

The destination of referrals was reported as either a health facility supported by the same NGO or a health facility supported by other NGOs. In the latter case, some NGO respondents said that there was no coordination with such facilities, but they depended on the service maps to identify the nearest provider of the needed service and refer the patient to it. Some NGOs also had cars to transport patients, since the lack of transportation was the most common reason for not following the referral.

Only half (68, 49.28%) of the respondent community members said that the CHW(s) who referred the beneficiaries see them back and follow-up on their cases at their household after they referred them. This could be related to COVID-19, as some NGOs reported making changes in their referral mechanism due to the pandemic, which included reducing the number of referrals to health facilities and the number of the household visits, including the follow-up ones. Other NGOs reported coordinating with EWARN to refer COVID-19 suspected cases, conducting the follow-up visits online through WhatsApp, and suspending using paper-based referral forms, because they could spread the virus and “give the referred patients a feeling that they will be prioritized when visiting the health facility, but they will not,” said one of the NGO respondents. This particular reason was frequently mentioned by the community members as a reason for dissatisfaction.

In conclusion, since not all NGO CHWs are linked to health facilities, there is an area for improvement in this aspect. First, a comprehensive map of services should be developed to identify all types of services in northwestern Syria. Second, the coordination between CHWs and health facilities in the area they cover should be enhanced, with more focus on follow-up visits to referred community members.

5.8. Community coverage and feedback

Since community members are the main stakeholders involved in CH services, a significant part of the assessment focused on their feedback and perspectives. The selected clusters only included the communities where CH services were provided by the NGOs that covered the area. The households were randomly selected from four separate areas in each cluster, with a plan to interview an equal number of male and female members, which was approximately achieved.

Two of UDER's field researchers conduct a survey with a female community member

668 (86.42%) of the total 773 respondents said they have received a session from CHW(s), which indicated a high CHW coverage in the visited clusters. The coverage was slightly higher in Idleb (88.55%) than Aleppo (83.77%) communities.

Two-thirds of the respondents who received a CH session said that it was the first visit in the last month. Although the CHWG SOPs mentions that each household should be visited by CHWs at least once every 2 or 3 months, only 67 (10.03%) survey respondents reported receiving multiple visits.

Most of the relevant survey respondents (575, 86,08%) thought that the session was delivered at a convenient time. For the rest of the respondents who found the time was not convenient, the reasons were as follows:

Reason	#, %
Busy with friends or neighbor visits at the time of the session	285, 74.61%
Busy with household chores at the time of the session	135, 35.34%
Busy with childcare/household member responsibilities at the time of the session	68, 17.80%
Was not feeling well at the time of the visit	52, 13.61%
Would prefer the CHW made an appointment before visiting	51, 13.35%
Had to leave the house around the time of the visit	42, 10.99%
Relevant household members were not present	33, 8.64%

When the respondents were asked if they had any questions for the CHW, less than a half (285, 42.66%) said yes, and most of them reported that the CHW was able to answer questions (226, 79.30%) and seemed convincing in the information they provided about the topic (203, 71.23%). Similar percentages of respondents said that the information provided was useful (444, 66.47%) and they trust the health information (447, 76.15%) and the services (461, 69.01%) provided by the CHWs.

The table below clarifies the reasons for considering the CH information provided as not useful:

Reason	#, %
The topic was not relevant	33, 27.73%
The topic was not appropriate	19, 15.97%
Already knew the material covered in the session	17, 14.29%
Didn't agree with the information presented in the session	14, 11.76%
Information in the session made me worry/feel afraid	14, 11.76%
The session would have been better if presented to a different family member	14, 11.76%
Session was confusing	9, 7.56%

To explain the reasons above, some respondents mentioned examples. A female respondent said: "the topic was very sensitive to me because I'm not able to have children and felt bad when they started talking about reproductive health. I started crying during the session." Another female added: "they talked a little about nutrition although there are no children in our household. Then they talked about hypertension in a very scary way, that I felt it's a fatal disease." However, most respondents disagreed and considered "the CHWs as very helpful, because they educate us about how to keep ourselves and our children healthy," said one female respondent.

Additional reasons were mentioned by the survey respondents for not trusting the health information and services provided by the CHWs, which can be summarized as follows:

- CHWs may provide wrong information because they don't have medical background
- Beneficiaries don't trust NGOs
- They are young females and wear make-up and perfumes
- They are not qualified and hired in an unfair way
- They don't show that they care and are not from the community
- They don't meet their promises
- They may cause harm if the materials they distribute are expired
- They refer us to PHCs which don't give us medications nor prioritize our case.

Finally, the respondents were asked about their general satisfaction with the services they received from the CHW(s). the table below shows the satisfaction rates:

Satisfaction level	#, %
Very satisfied	105, 15.72%
Somewhat satisfied	322, 48.20%
Neutral	127, 19.01%
Somewhat not satisfied	71, 10.63%
Not satisfied at all	39, 5.84%
Refused to respond	4, 0.60%

The dissatisfied respondents mentioned several reasons for their dissatisfaction, which were similar to the ones mentioned above for not trusting the CHW, but also included:

- CHWs only visit HHs to take photos or collect names and information
- They don't distribute anything, but just "talk" and go
- They don't target all population groups, but only women and children
- CHWs themselves don't follow the instructions they tell people to follow
- The number of their visits is limited
- They may spread COVID-19
- The security situation is not suitable for their services

- Their instructions are against the traditions
- The way they talk to and communicate with people is not appropriate
- They don't have the needed equipment or supplies to do some basic tests
- They ask embarrassing questions
- They don't know the available services in the area

The respondents were asked if they have recommendations to improve benefit from CHWs, and they suggested a long list, which included the following:

- Distribute more materials
- Consider the special cases in the HHs, like People with disabilities
- Provide new and updated information, which is adjusted to the Syrian context
- Provide better services, like basic medical tests and first aid
- Provide transportation for referrals
- Improve the coordination and linkages with health facilities and local authorities
- Train the CHWs and develop their skills
- Conduct follow-up visits for the referred members
- Only hire CHWs from the same community
- Increase the CHW coverage
- Avoid taking photos and collecting data
- CHWs should have manners and be honest
- All CHWs should be females
- Provide HH visits instead of CH services at health facilities
- Increase the number of CHW supervision visits
- Increase their self-confidence to be more convincing
- Change their visit times for more appropriate ones

In conclusion, the general community feedback about CHWs was found to be satisfactory and positive, with an exception related to significantly low follow-up visits by CHWs. A high percentage of community members and leaders recognized CHWs as helpful, considered their information and services to be useful, and requested to continue supporting these projects and increase their coverage. As recommended in a previous section, more focus on follow-up visits is important as well.

5.9. CHW Assessment Matrix

Prior to the assessment, WHO shared a framework for monitoring and evaluating CHWs, which included indicators and parameters for the following two main components:

- Monitoring of programmatic components and organizational structure
- Community health worker performance measurement framework

Based on the framework, UDER developed a matrix to collect information from different respondents for each indicator or item. The detailed figures and findings are presented in Annex 1.

Most importantly, it was found that the values of some indicators and parameters in the CHW Assessment Matrix, especially in the supervision and CHW performance measurement sections, varied in the responses of different NGO key informants and CHWs. Better communication should be established in two ways, from the project management to the field for more insights into the aggregated data they receive, and from the field to the project management for more field updates and challenges.

6. CONCLUSIONS AND RECOMMENDATIONS

Key conclusions and recommendations for each aspect covered in the assessment include:

CH roles and responsibilities

While there was a common understanding of the CHW role in each organization, participant NGOs demonstrated different understanding and structures of the CH Supervisor and Team Leader roles and responsibilities. All NGOs should be encouraged to follow the structure identified in the CHWG SOPs: CHWs to deliver health-related activities directly to the community and households, CHW Team Leaders for a maximum of 10 CHWs (5 teams) each, and dedicated CH Supervisors. Also, many NGO respondents reported that the CH Working Group is less active now than before. It is recommended that the Group is reactivated and regular meetings should be held to guide and organize all NGO CHW activities.

CHW scope of work

Participant NGOs demonstrated different type of service delivery and scope of work. All NGOs should be encouraged to follow the CHWG SOPs and provide CH services according to all the 6 modules (Basic Module, Family Health Module, Nutrition Module, NCD Module, CD Module, and Healthy Lifestyle Module) instead of focusing only on nutrition and COVID-19, in a community-based setting with well-established linkages to health facilities, instead of providing the CH services from the facilities only. As clarified in the CHWG SOPs, the community members should receive community health services through outreach visits by CHWs to reduce accessibility obstacle due to transportation and travel distance and to maximize the coverage of the health system by active community engagement. As for the services that the CHWs provide, the collected data specifically identified a lower reporting of follow-up visits for the same households. All NGOs should focus more on these follow-up visits, and guide their CHW

teams to revisit the household as recommended in the SOPs (at least once every 2 or 3 months).

CHW selection and recruitment

The dissatisfied community members mentioned that CHWs are not from the same community, and the responses of other participants and CHWs confirmed this. The first criteria for selecting community health workers in the CHWG SOPs is being a member of the targeted community and being recruited from within his/her community. All NGOs reported that they do the recruitment process independently and they should consider this aspect in their future CHW recruitment processes.

CHW Training

According to the CHWG SOPs, each CHW must complete a training and successfully pass the evaluation by the end of it, then undergo a refresher training every three months. Around half of the CHWs working in northwestern Syria are not trained on the comprehensive package and the six-module training curriculum and many respondents reported the lack of qualified trainers and the necessity to review the contents and update its information, especially with relation to COVID-19 materials. The CH Working Group is encouraged to consider updating the package and reviewing its contents according to the suggestions mentioned in the report. ToT training covering COVID-19 and all the 6 modules (Basic Module, Family Health Module, Nutrition Module, NCD Module, CD Module, and Healthy Lifestyle Module) should be reconducted to qualify more trainers who can visit Syria and provide the training for the CHWs.

CH Supervision

According to the CHWG SOPs, CHWs should be supervised through field visits and on the job coaching, with weekly meetings or visits to discuss and evaluate the work plans. The participant NGOs reported conducting supervision or regular evaluation to CHWs, but they are encouraged to follow the CHWG SOPs in this aspect, especially regarding conducting the supervision visits on weekly-basis and coordinating with local community representatives.

CHW data collection and reporting

Data collection and reporting is an essential part of the CHWs work, with a detailed process flow clarified in the CHWG SOPs. The participant NGOs confirmed submitting the required reports, but data collection and reporting tools varied significantly between NGOs, although most of them expressed their interest to change to an electronic system. However, donors have strict rules about procuring tablets and tools required to do this upgrade. The key informants requested from the donors to provide solutions and make it easier to procure electronic tools. The CH Working Group should also work on developing a standardized electronic system, which could enhance the reporting from all NGOs managing CH projects.

CHW linkages with the health system

According to the CHWG SOPs, one of the main objectives of CHWs is to maximize the coverage of the health system. Since not all NGO CHWs are linked to health facilities, there is an area for improvement in this aspect. First, a comprehensive map of services should be developed to identify all types of services in northwestern Syria. Second, the coordination between CHWs and health facilities in the area they cover should be enhanced, with more focus on follow-up visits to referred community members.

Community coverage and feedback

The general community feedback about CHWs was found to be satisfactory and positive, with a significant exception related to low follow-up visits by CHWs. A high percentage of community members and leaders recognized CHWs as helpful, considered their information and services to be useful, and requested to continue supporting these projects and increase their coverage. As recommended in a previous section, more focus on follow-up visits is important as well.

Acknowledgments: UDER gratefully acknowledge the hard but careful work of data collectors in Syria; the willingness of the respondents to provide the information we sought, and to the NGOs and other stakeholders who provided their valuable perspectives for the implementation of the assessment.

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7. ANNEXES

7.1. Annex 1: CHW Assessment Matrix – Results collected from 5 groups

Assessment categories/questions	CHW project management in Turkey	CHW project supervision in Syria	CHWs in Syria	Community members	Community leaders
A) Monitoring of Programmatic Components and Organizational Structure					
1. ROLE AND RECRUITMENT: HOW THE ROLE AND SELECTION OF CHW ARE CLEAR					
Formal CHW role is defined or documented	88.24% (21 out of 23)	97.22% (35 out of 36)	98.82% (334 out of 338)	NA	NA
Required qualification and expertise are clearly defined prior to recruitment	100% (23 out of 23)	94.44% (34 out of 36)	99.11% (335 out of 338)	NA	100% (11 out of 11)
CHWs are from the community	All of them from the community: 52.17% (12 out of 23) None of them are from the community: 4.35% (1 out of 23) Some of them are from the community, and some are not: 43.48% (10 out of 23)	All of them from the community: 25.71% (9 out of 35) None of them are from the community: 5.71% (2 out of 35) Some of them are from the community, and some are not: 68.57% (24 out of 35)	63.31% (214 out of 338)	37.57% (251 out of 668)	All of them from the community: 27.27% (3 out of 11) None of them are from the community: 18.18% (2 out of 11) Some of them are from the community, and some are not: 54.55% (6 out of 11)
The community plays role in recruitment, role and expectations	47.83% (11 out of 23)	31.43% (11 out of 35)	NA	NA	54.55% (6 out of 11)
2. TRAINING: HOW PRE-SERVICE TRAINING IS PROVIDED TO THE CHW AND, HOW ONGOING TRAINING IS PROVIDED					
Minimal initial training is provided within six months of recruitment	95.65% (22 out of 23)	88.89% (32 out of 36)	91.42% (309 out of 338)	NA	NA
Ongoing training is provided	82.61% (19 out of 23)	75% (27 out of 36)	71.89% (243 out of 338)	NA	NA
Coaching/ on-the-job training is provided in ad hoc visits by supervisors	73.91% (17 out of 23)	83.33% (30 out of 36)	81.95% (277 out of 338)	NA	NA
Partner organizations/NGOs provide ad hoc workshops on specific vertical health topics	73.91% (17 out of 23)	77.78% (28 out of 36)	59.17% (200 out of 338)	NA	NA

Refresher training is provided at least annually	82.61% (19 out of 23)	75% (27 out of 36)	71.89% (243 out of 338)	NA	NA
Continuous capacity development is provided to reinforce initial training, teach CHWs new skills, and to help ensure quality.	56.52% (13 out of 23)	63.89% (23 out of 36)	77.81% (263 out of 338)	NA	NA
What are the barriers or challenges that you faced during getting the training?	Narrative report	Narrative report	Narrative report	NA	Narrative report
What may be done to improve the initial training?	Narrative report	Narrative report	Narrative report	NA	Narrative report
What is the type of ongoing training you would like to receive, in which topics and how frequent?	Narrative report	Narrative report	Narrative report	NA	NA
3. TRAINING MANUAL: FEEDBACK ON THE COMREHENSIVE APPROACH OF TRAINING AND THE 6 TRANINING MODULES					
Please provide your overall feedback about the training modules	Narrative report	Narrative report	91.67% satisfied (154 out of 168)	NA	NA
What are the missed or extra information in each module?	Narrative report	Narrative report	Narrative report	NA	Narrative report
What other topics should be added to the training modules based on your working experience with the community?	Narrative report	Narrative report	Narrative report	NA	Narrative report
4. SUPERVISION: HOW SUPPORTIVE SUPERVISION IS CARRIED OUT					
Supervision or regular evaluation occurs outside of occasional visits to CHWs by nurses or supervisors when possible	73.91% (17 out of 23)	91.67% (33 out of 36)	95.86% (324 out of 338)	NA	63.64% (7 out of 11)
Supervisors are assigned to CHWs or communities	To CHWs: 52.17% (12 out of 23) To communities: 34.78% (8 out of 23) Other: 13.04% (3 out of 23)	To CHWs: 33.33% (12 out of 36) To communities: 36.11% (13 out of 23) Other: 30.56% (11 out of 23)	To CHWs: 65.82% (208 out of 316) To communities: 25.95% (82 out of 316) Other: 8.23% (26 out of 316)	NA	NA
Supervisors are trained and have basic supervision tools (checklists)	Are trained: 78.26% (18 out of 23) Have the basic	Are trained: 72.22% (26 out of 36) Have the basic supervision tools: 88.89% (32 out of 36)	86.98% (294 out of 338)	NA	NA

	supervision tools: 73.91% (17 out of 23)				
Individual performance support is offered (e.g. problem-solving, coaching or on-the-job training)	69.57% (16 out of 23)	83.33% (30 out of 36)	79.59% (269 out of 338)	NA	NA
A dedicated supervisor conducts supervision visits at least every 3 months to the CHW	82.61% (19 out of 23)	100% (36 out of 36)	95.86% (324 out of 338)	NA	NA
The supervisor provides summary about CHW performance and areas that need further improvement	78.26% (18 out of 23)	91.67% (33 out of 36)	93.20% (315 out of 338)	NA	NA
5. DATA COLLECTION TOOLS: TO WHICH LEVEL DATA COLLECTION INCLUDING SUPERVISION AND REPORTING TOOLS ARE FRIENDLY-USED AND PROVIDE COMPREHENSIVE FEDBAK AND INFORMATION					
The supervision tools are comprehensive and easy to use	94.12% (16 out of 17)	80% (28 out of 35)	NA	NA	NA
The reporting tools are easy to be filled and helpful	91.30% (21 out of 23)	80.56% (29 out of 36)	86.98% (294 out of 338)	NA	NA
6. LINKAGES TO THE NATIONAL HEALTH SYSTEM: THE EXTENT TO WHICH CHW ARE LINKED TO DIFFERENT LEVELS OF CARE					
Links to health system are in place	82.61% (19 out of 23)	88.89% (32 out of 36)	66.86% (226 out of 338)	NA	All of them are linked with health facilities: 63.64% (7 out of 11) Some of them are linked and some are not: 36.36% (4 out of 11)
CHWs are recognized as helpful in communities and are recognized as part of health system	NA	As helpful: 88.89% (32 out of 36) As part of health system: 88.89% (32 out of 36)	As helpful: 87.57% (296 out of 338) As part of health system: 86.09% (291 out of 338)	As helpful: 72.75% (486 out of 668) As part of health system: 67.51% (451 out of 668)	As helpful: 81.82% (9 out of 11) As part of health system: 90.91% (10 out of 11)
Patient is referred with a form and informally tracked by CHW and information flows back to CHW from referral site	91.30% (21 out of 23)	88.89% (32 out of 36)	73.08% (247 out of 338)	83.33% (115 out of 138) referred with a form	NA
7. COMMUNITY HEALTH WORKERS GENERAL FEEDBACK: KEY CHALLENGES, MOTIVATIONS AND OPPORTUNITIES FOR FACILTIATING THEIR WORK AND IMPROVING PERFORMANCE					

What are the key challenges that you faced during your working experience?		Narrative report	Narrative report	Narrative report	Narrative report
What are the main factors that motivate you to continue working as a CHW?		Narrative report	Narrative report	Narrative report	Narrative report
What do you recommend for improving your motivation and facilitating your work?		Narrative report	Narrative report	Narrative report	Narrative report
B) COMMUNITY HEALTH WORKER PERFORMANCE MEASUREMENT FRAMEWORK					
Domain 1: Supportive systems					
Sub-domain A: Supervision and performance appraisal					
#/% of trained supervisors for CHWs	78.26% (18 out of 23)	NA	NA	NA	NA
Ratio of CHWs to supervisors	19.24 on average	NA	11.81 on average	NA	NA
Average # of visits per supervisor to monitor/support CHW activities in the last month	11 on average	10.25 on average	7.10 on average	NA	NA
Domain 2: CHW competency					
Sub-domain A: CHW knowledge					
#/% of CHWs who have passed knowledge/competency tests (following training)	94.14% (1703 out of 1809)	NA	92.6% (313 out of 338)	NA	NA
#/% of CHWs who express that they feel confidence in their abilities to provide health education	NA	NA	96.45% (326 out of 338)	NA	NA
Sub-domain B: Service delivery					
Average # of home visits made by CHWs in the last month	154.18 per pair of CHWs on average	NA	183.96 on average	NA	NA
#/% of CHWs with all the key stock commodities in the last reporting period	73.91% (17 out of 23)	77.14% (27 out of 35)	73.67% (249 out of 338)	NA	NA
Sub-domain C: Data reporting					
#/% of CHWs who submitted reports in the last month	93.03% (1683 out of 1809)	NA	94.67% (320 out of 338)	NA	NA

#/% of CHW reports submitted that were complete/did not have missing information	82.61% (19 out of 23)	85.71% (30 out of 35)	92.28% (311 out of 337)	NA	NA
Domain 3: CHW well-being					
Sub-domain A: Job satisfaction					
#/% of CHWs who expressed satisfaction with the community support they receive	NA	NA	77.51% (262 out of 338)	NA	NA
#/% of CHWs who expressed satisfaction with the support they receive from health facility staff	NA	NA	59.17% (200 out of 338)	NA	NA
Sub-Domain B: Attrition/retention and turn over					
In the last 3 months, #/% of CHWs who have reported on their activities	93.03% (1683 out of 1809)	NA	94.67% (320 out of 338)	NA	NA
#/% of CHW resigned or left their work in the last year	10.34% (187 out of 1809)	NA	NA	NA	NA
Domain 4: Community access					
Sub-domain A: Use of services					
#/% of households who received at least one visit by a CHW in the last 3 months	226.52 HHs per pair of CHWs on average	NA	496.65 on average (167867 total)	85.18% (569 out of 668)	NA
Sub-domain B: Knowledge of service availability					
#/% of community members that know the name of the community CHWs	NA	NA	NA	22.9% (153 out of 668)	Some of them: 27.27% (3 out of 11)
#/% of community members who can name at least 3 services that the CHW provides	NA	NA	NA	61.35% (346 out of 668)	100% (11 out of 11)
Sub-domain C: Referral/counter-referral					
% of individuals referred by CHW to the health facility per 100 clients seen	8.94% on average	12.22 on average	10.83% on average	NA	NA
#/% of clients that completed the referral at the health facility (referral completion)	63.04% on average	68.91% on average	41.03% on average	81.16% (112 out of 138)	NA
#/% of referred clients seen at receiving service (health facility) that is seen back at referring service (CHW)	62.28% on average	66.65% on average	40.01% on average	49.28% (68 out of 138)	NA
Average # of referrals made per CHW in the last month	12.29 on average	15.03 on average	12.84 per CHW on average	NA	NA
Domain 5: Community satisfaction					

Sub-domain A: Experience of care					
#/% of households who express satisfaction with services they received from the CHW in the last 3 months	NA	NA	NA	63.92% (427 out of 668)	63.64% (7 out of 11)
#/% of women who report dissatisfaction with CHW	NA	NA	NA	64.61% (230 out of 356)	NA
Sub-domain B: Credibility/trust of CHW					
#/% of clients who report they trust the health information provided by the CHW	NA	NA	NA	76.15% (447 out of 587)	72.73% (8 out of 11)
#/% of clients who report they trust the services provided by the CHW	NA	NA	NA	69.01% (461 out of 668)	72.73% (8 out of 11)

7.2. Annex 2: Data collection tools

7.2.1. KII– CHW project management in Turkey

Introduction and Consent

[Read as it is written]

Good [morning/afternoon], How are you?

My name is [facilitator name] and this is [note taker name]. We are from UDER. We are here as part of the effort to assess the CH services in the area.

The purpose of our interview today is to gather your opinions about the CH services provided. I would like to go over a few logistical points before we begin:

The interview will last about 45-60 minutes. You can leave at any time, but it would be very helpful if you stay until the end.

You will not receive any compensation or payment for participating in this interview. This interview will not be used to gather information about any person specifically. Please be assured that everything we discuss during this interview will be kept in strict confidence and your real name will not appear in any of our results. As such, please make every effort to be open and honest when responding to the questions.

Nothing you say will have an impact whatsoever on your inclusion or exclusion to any programs that are currently being implemented or will be implemented in the future. Participation is completely voluntarily and you have the freedom to withdraw at any time and the freedom not to answer one or more questions. In case you refuse, it will not involve any loss of benefits or penalty and your participation does not involve giving up any legal rights.

Do you have any questions?

Do you agree to participate?
_____ *Yes*
_____ *No*

May I begin?

A. **Date of Interview: _____**

B. **Interview Start Time: _____**

Collected by the interviewer before the interview

1. **Name of interviewer: _____**

2. **Location: _____**

3. **NGO name:** *(Select one from the list)*

Respondent information

4. **Sex** *(Select one; Do not ask aloud)*
1. Male
2. Female

5. **How old are you?** *(Enter Number)* **_____**

6. **What's your position?** *(Enter text)*

7. **Since when you're working in this position?** *(Enter date)* **_____**

KII questions

8. Please describe your NGO CHW program in Syria, in terms of CH team numbers, locations, modules covered, services provided, IEC materials, and items distributed. *(Answer the sub-questions based on the key informant response; ask for specific elements if not answered; record any additional information)*

8a. How many male CHWs does your NGO have in Syria? *(Enter number)*

8b. How many female CHWs does your NGO have in Syria? *(Enter number)*

8c. How many CHW supervisors does your NGO have in Syria? *(Enter number)*

8c.1 How many of them are male? *(Enter number)*

8d. How many CHW team leaders does your NGO have in Syria? *(Enter number)*

8d.1 How many of them are male? *(Enter number)*

8e. What are the locations of your NGO CHWs? *(Enter text)*

8f. What are the modules that your NGO CHWs cover? *(Select all that applies)*

1. Family health
2. Nutrition
3. Healthy lifestyle
4. NCD
5. CD
6. Specific COVID-19
7. Other (Please specify: _____)

8g. What are the services that your NGO CHWs provide? *(Select all that apply)*

1. Deliver health information
2. Assess common health problems
3. Promote healthy behaviors and environment

4. Prevent diseases in the community
5. Identify symptoms and risk factors of common diseases
6. Conduct basic tests, like MUAC and blood pressure and glucose.
7. Refer cases to the health facility
8. Follow-up the patient case upon return from the health facility to the community
9. Distribute some materials, like hygiene kits, nutrition supplies, etc.
10. Other (Please specify: _____)
11. Refused to respond

8h. What type of IEC materials your NGO's CHWs currently use? *(Select all that applies)*

1. WHO materials
2. NGO-specific materials
3. Other (Please specify: _____)
4. Refused to respond

8i. If possible, please share a copy of the IEC materials your NGO's CHWs currently use *(Submit document)*

8j. What are the materials that your NGO CHWs distribute? *(Select all that applies)* (Only if 8g = 9)

1. Hygiene kits or materials
2. IEC materials
3. PPE or disinfectants
4. Lice shampoo
5. Scabies cream
6. ORS
7. Nutritional supplies
8. Chlorine
9. Other (Please specify: _____)
10. Refused to respond

9. Please describe the CHW role, selection, and recruitment. *(Answer the sub-questions based on the key informant response; ask for specific elements if not answered; record any additional information)*

9a. Is your NGO CHW formal role defined or documented? *(Select one)*

1. Yes
2. No
3. Refused to respond

9b. What is the document that defines your NGO CHW formal role? *(Select all that apply)*

1. TOR
2. SoPs
3. Contract
4. Other (Please specify: _____)
3. Refused to respond

9c. Please share a document that defines your NGO formal CHW role *(Submit document)*

9d. Were the required qualification and expertise clearly defined prior to recruitment? *(Select one)*

1. Yes
2. No
3. Refused to respond

9e. Did the community play any role in the recruitment of the CHWs, role and expectations? *(Select one)*

1. Yes
2. No
3. Refused to respond

9f. Please clarify how. *(Enter text)* (Only if Q9e = YES)

9g. Are your NGO CHWs from the same community? *(Select one)*

1. Yes, all of them
2. No, none of them
3. Some of them
4. Refused to respond

10. Please describe the CHW training; how pre-service training is provided to the CHWs and how ongoing training is provided? *(Answer the sub-questions based on the key informant response; ask for specific elements if not answered; record any additional information)*

10a. Have your NGO CHWs received initial training within six months of recruitment? *(Select one)*
1. Yes
2. No
3. Refused to respond

10b. Do your NGO CHWs receive ongoing/refresher training by your NGO? *(Select one)*
1. Yes
2. No
3. Refused to respond

10c. How frequent the refresher training is? *(Select one)* (Only if Q10b = YES)
1. Monthly
2. Quarterly
3. Bi-annually
4. Annually
5. Other (Please specify: _____)
6. Refused to respond

10d. Do your NGO CHWs receive coaching/ on-the-job training in ad hoc visits by the supervisors? *(Select one)*
1. Yes
2. No
3. Refused to respond

10e. Do your NGO CHWs attend ad hoc workshops on specific vertical health topics provided by partner organizations/NGOs? *(Select one)*

1. Yes
2. No
3. Refused to respond

10f. Do your NGO CHWs receive continuous capacity development? *(Select one)*

1. Yes
2. No
3. Refused to respond

10g. What is the of objective of this capacity development? *(Select all that apply)* (Only if Q10f = YES)

1. Reinforce initial training
2. Teach CHWs new skills
3. Help ensure quality
4. Other (Please specify: _____)

10h. What are the barriers or challenges that you faced during providing the training? *(Enter text)* (Only if any training is provided)

10i. What may be done to improve the initial training? *(Enter text)* (Only if any training is provided)

10j. What is the type of ongoing training would you like CHWs to receive? *(Enter text)*

10k. In which topics would you like CHWs to receive ongoing training? *(Enter text)*

10l. How frequent would you like CHWs to receive ongoing training? *(Enter text)*

10m. Have your NGO CHWs received the comprehensive approach of training and the 6 training modules? *(Select one)*

1. Yes
2. No
3. Refused to respond

10n. Please provide your overall feedback about the comprehensive approach of training and the 6 training modules *(Enter text)*

10o. What are the missed or extra information in each module? *(Enter text)*

10p. What other topics should be added to the training modules based on your working experience? *(Enter text)*

11. Please describe how supportive supervision is carried out. *(Answer the sub-questions based on the key informant response; ask for specific elements if not answered; record any additional information)*

11a. Do your NGO CH supervisors conduct supervision or regular evaluation to CHWs outside of occasional visits? *(Select one)*

1. Yes
2. No
3. Refused to respond

11b. How your NGO CH supervisors are assigned? *(Select one)*

1. To certain number of CHWs
2. To communities
3. Other (Please specify: _____)

11c. Are your NGO CH supervisors trained? *(Select one)*

1. Yes
2. No
3. Refused to respond

11d. Do your NGO CH supervisors have the basic supervision tools they need? *(Select one)*

1. Yes
2. No
3. Refused to respond

11d1. Are the supervision tools comprehensive and easy to use? *(Select one)* (Only if Q11d = YES)

1. Yes
2. No
3. Refused to respond

11e. Do your NGO CH supervisors provide any individual performance support? *(Select one)*

1. Yes
2. No
3. Refused to respond

11f. What type of individual performance support your NGO CH supervisors offer? *(Select all that apply)* (Only if Q11e = YES)

1. Problem-solving
2. Coaching
3. On-the-job training
4. Other (Please specify: _____)

11g. Do your NGO CH supervisor conduct supervision visits to CHWs? *(Select one)*

1. Yes
2. No
3. Refused to respond

11h. How frequent do your NGO CH supervisors conduct supervision visits to CHWs? *(Select one)* (Only if Q11g = YES)
1. Daily
2. Weekly
3. Monthly
4. Quarterly
5. Bi-annually
4. Annually
5. Other (Please specify: _____)
6. Refused to respond

11i. Do your NGO CH supervisors provide summary about CH performance and areas that need further improvement? *(Select one)*
1. Yes
2. No
3. Refused to respond

12. Please describe the data collection and reporting tools your NGO CHWs use. *(Answer the sub-questions based on the key informant response; ask for specific elements if not answered; record any additional information)*

12a. What type of reporting tools do your NGO CHWs use? *(Select one)*
1. Paper-based
2. Electronic
3. No reporting tools
4. A mixture of paper-based and electronic tools
5. Other (Please specify: _____)
6. Refused to respond

12b. Do you think the reporting tools the CHWs use are easy to be filled and helpful? *(Select one)* (Only if Q12a = 1, 2, 3, 4, or 5)

1. Yes
2. No
3. Refused to respond

13. Please describe how the CHWs are linked to the health system? *(Answer the sub-questions based on the key informant response; ask for specific elements if not answered; record any additional information)*

13a. Are your NGO CHWs linked to the health system? *(Select one)*

1. Yes
2. No
3. Refused to respond

13b. Do your NGO CHWs refer patients to the health facility using a referral form? *(Select one)*

1. Yes
2. No
3. Refused to respond

13c. Do your NGO CHWs track the referred cases by receiving the information from the referral site? *(Select one)*

1. Yes
2. No
3. Refused to respond

14. I will ask you certain questions and request some numbers as part of CHW Performance measurement framework. *(Provide the key informant with the required information before the interview to prepare the numbers; answer the sub-questions based on the key informant response; ask for specific elements if not answered; record any additional information)*

14a. In your NGO, what's the number of trained CH supervisors? *(Enter number)*

14b. In your NGO, how many CHWs are supervised by one supervisor? *(Enter number)*

14c. In the last month, how many visits on average did each of your NGO CH supervisors conduct to monitor/support CH activities? *(Enter number)*

14d. What's the number of your NGO CHWs who have passed knowledge/competency tests following training? *(Enter number)*

14e. In the last month, how many HH visits your NGO CHWs made? *(Enter number)*

14f. If available, please share the last month's report disaggregated by type of home visit *(Submit document)*

14g. In the last month, did your NGO CHWs have all the key stock commodities? *(Select one)*

1. Yes
2. No
3. Partially
4. Refused to respond

14h. In the last month, how many CHWs did submit all the required reports? *(Enter number)*

14i. Were the submitted reports complete (did not have missing information)?

(Select one)

1. Yes, all of them were complete
2. No, all of them weren't complete
3. Partially, some of them were complete and some were not
4. Refused to respond

14j. In the last year, how many CHWs did resign or leave their work? *(Enter number)*

14k. In the last 3 months, how many households have your NGO CHWs visited at least once? *(Enter number)*

14l. What is the percentage of individuals referred by your NGO CHWs to the health facility per 100 individuals visited? *(Enter number)*

14m. What are the reasons for referrals and their individual percentages? *(Enter text)*

14n. What is the percentage of individuals who complete the referral at the health facility (out of all referred individuals)? *(Enter number)*

14o. What is the percentage of individuals who your NGO CHWs see back after they visit the health facility (out of all referred individuals)? *(Enter number)*

14p. What is the average number of referrals per CHW in the last month? *(Enter number)*

15. Is there anything else we should know about the topics we discussed today? *(Enter text)*

Do you have a telephone number which we can use to call you if we have any follow up questions? *(Participants are not required to answer this question)*
Name: _____
Telephone Number: _____

Interview Closing

"Thank you for your time and willingness to share your experiences with us. We have asked you a lot of questions and you have provided us with very valuable information. Please remember that all the information provided will be kept anonymous. We will use this information to help improve future programming. We will not share any of your personal information"

E. Interview End Time: _____

End of interview

7.2.2. KII– CHW project management in Syria

Introduction and Consent

[Read as it is written]

Good [morning/afternoon], How are you?

My name is [facilitator name] and this is [note taker name]. We are from UDER. We are here as part of the effort to assess the CH services in the area.

The purpose of our interview today is to gather your opinions about the CH services provided. I would like to go over a few logistical points before we begin:

The interview will last about 45-60 minutes. You can leave at any time, but it would be very helpful if you stay until the end.

You will not receive any compensation or payment for participating in this interview. This interview will not be used to gather information about any person specifically. Please be assured that everything we discuss during this interview will be kept in strict confidence and your real name will not appear in any of our results. As such, please make every effort to be open and honest when responding to the questions.

Nothing you say will have an impact whatsoever on your inclusion or exclusion to any programs that are currently being implemented or will be implemented in the future. Participation is completely voluntarily and you have the freedom to withdraw at any time and the freedom not to answer one or more questions. In case you refuse, it will not involve any loss of benefits or penalty and your participation does not involve giving up any legal rights.

Do you have any questions?

Do you agree to participate?
_____ *Yes*
_____ *No*

May I begin?

A. **Date of Interview: _____**

B. **Interview Start Time: _____**

Collected by the interviewer before the interview

1. **Name of interviewer: _____**

2. **Location: _____**

3. **NGO name:** *(Select one from the list)*

Respondent information

4. **Sex** *(Select one; Do not ask aloud)*
1. Male
2. Female

5. **How old are you?** *(Enter Number)* **_____**

6. **What's your position?** *(Enter text)*

7. **Since when you're working in this position?** *(Enter date)* **_____**

KII questions

8. Please describe your NGO CHW program in Syria, in terms of CH team numbers, locations, modules covered, services provided, IEC materials, and items distributed. *(Answer the sub-questions based on the key informant response; ask for specific elements if not answered; record any additional information)*

8a. How many male CHWs does your NGO have in Syria? *(Enter number)*

8b. How many female CHWs does your NGO have in Syria? *(Enter number)*

8c. How many CHW supervisors does your NGO have in Syria? *(Enter number)*

8c.1 How many of them are male? *(Enter number)*

8d. How many CHW team leaders does your NGO have in Syria? *(Enter number)*

8d.1 How many of them are male? *(Enter number)*

8e. What are the locations of your NGO CHWs? *(Enter text)*

8f. What are the modules that your NGO CHWs cover? *(Select all that applies)*

1. Family health
2. Nutrition
3. Healthy lifestyle
4. NCD
5. CD
6. COVID-19 specific
7. Other (Please specify: _____)

8g. What are the services that your NGO CHWs provide? *(Select all that apply)*

1. Deliver health information
2. Assess common health problems

3. Promote healthy behaviors and environment
4. Prevent diseases in the community
5. Identify symptoms and risk factors of common diseases
6. Conduct basic tests, like MUAC and blood pressure and glucose.
7. Refer cases to the health facility
8. Follow-up the patient case upon return from the health facility to the community
9. Distribute some materials, like hygiene kits, nutrition supplies, etc.
10. Other (Please specify: _____)
11. Refused to respond

8h. What are the materials that your NGO CHWs distribute? *(Select all that applies)* (Only if 8g = 9)

1. Hygiene kits or materials
2. IEC materials
3. PPE or disinfectants
4. Lice shampoo
5. Scabies cream
6. ORS
7. Nutritional supplies
8. Chlorine
9. Other (Please specify: _____)
10. Refused to respond

9. Please describe the CHW role, selection, and recruitment. *(Answer the sub-questions based on the key informant response; ask for specific elements if not answered; record any additional information)*

9a. Is your NGO CHW formal role defined or documented? *(Select one)*

1. Yes
2. No
3. Refused to respond

9b. What is the document that defines your NGO CHW formal role? *(Select all that apply)*

1. TOR
2. SoPs
3. Contract
4. Other (Please specify: _____)
3. Refused to respond

9c. Were the CHW required qualification and expertise clearly defined prior to their recruitment? *(Select one)*

1. Yes
2. No
3. Refused to respond

9d. Did the community play any role in the recruitment of the CHWs, role and expectations? *(Select one)*

1. Yes
2. No
3. Refused to respond

9e. Please clarify how. *(Enter text)* (Only if Q9d = YES)

9f. Are your NGO CHWs from the same community? *(Select one)*

1. Yes, all of them
2. No, none of them
3. Some of them
4. Refused to respond

10. Please describe the CHW training; how pre-service training is provided to the CHWs and how ongoing training is provided? *(Answer the sub-questions based on the key informant response; ask for specific elements if not answered; record any additional information)*

10a. Have your NGO CHWs received initial training within six months of recruitment? *(Select one)*

1. Yes
2. No
3. Refused to respond

10b. Do your NGO CHWs receive ongoing/refresher training by your NGO? *(Select one)*

1. Yes
2. No
3. Refused to respond

10c. How frequent the refresher training is? *(Select one)* (Only if Q10b = YES)

1. Monthly
2. Quarterly
3. Bi-annually
4. Annually
5. Other (Please specify: _____)
6. Refused to respond

10d. Do your NGO CHWs receive coaching/ on-the-job training in ad hoc visits by the supervisors? *(Select one)*

1. Yes
2. No
3. Refused to respond

10e. Do your NGO CHWs attend ad hoc workshops on specific vertical health topics provided by partner organizations/NGOs? *(Select one)*

1. Yes
2. No
3. Refused to respond

10f. Do your NGO CHWs receive continuous capacity development? *(Select one)*

1. Yes

2. No
3. Refused to respond

10g. What is the of objective of this capacity development? *(Select all that apply)* (Only if Qf = YES)
1. Reinforce initial training
2. Teach CHWs new skills
3. Help ensure quality
4. Other (Please specify: _____)

10h. What are the barriers or challenges that you faced during providing the training? *(Enter text)* (Only if any training is provided)

10i. What may be done to improve the initial training? *(Enter text)* (Only if any training is provided)

10j. What is the type of ongoing training would you like CHWs to receive? *(Enter text)*

10k. In which topics would you like CHWs to receive ongoing training? *(Enter text)*

10l. How frequent would you like CHWs to receive ongoing training? *(Enter text)*

10m. Have your NGO CHWs received the comprehensive approach of training and the 6 training modules? *(Select one)*
1. Yes
2. No
3. Refused to respond

10n. Please provide your overall feedback about the comprehensive approach of training and the 6 training modules *(Enter text)*

10o. What are the missed or extra information in each module? *(Enter text)*

10p. What other topics should be added to the training modules based on your working experience? *(Enter text)*

11. Please describe how supportive supervision is carried out. *(Answer the sub-questions based on the key informant response; ask for specific elements if not answered; record any additional information)*

11a. Do you/your NGO CH supervisors conduct supervision or regular evaluation to CHWs outside of occasional visits? *(Select one)*

1. Yes
2. No
3. Refused to respond

11b. How you/your NGO CH supervisors are assigned? *(Select one)*

1. To certain number of CHWs
2. To communities
3. Other (Please specify: _____)

11c. Are you/your NGO CH supervisors trained? *(Select one)*

1. Yes
2. No
3. Refused to respond

11d. Do you/your NGO CH supervisors have the basic supervision tools they need? *(Select one)*

1. Yes
2. No
3. Refused to respond

11e. Do you/your NGO CH supervisors provide any individual performance support? *(Select one)*

1. Yes
2. No
3. Refused to respond

11f. What type of individual performance support you/your NGO CH supervisors offer? *(Select all that apply)* (Only if Q11e = YES)

1. Problem-solving
2. Coaching
3. On-the-job training
4. Other (Please specify: _____)

11g. Do you/your NGO CH supervisor conduct supervision visits to CHWs? *(Select one)*

1. Yes
2. No
3. Refused to respond

11h. How frequent do you/your NGO CH supervisors conduct supervision visits to CHWs?

1. Daily
2. Weekly
3. Monthly
4. Quarterly
5. Bi-annually
4. Annually
5. Other (Please specify: _____)

6. Refused to respond

11i. Do you/your NGO CH supervisors provide summary about CH performance and areas that need further improvement? *(Select one)*
1. Yes
2. No
3. Refused to respond

11j. Are the supervision tools comprehensive and easy to use? *(Select one)*
1. Yes
2. No
3. Refused to respond

12. Please describe the data collection and reporting tools your NGO CHWs use. *(Answer the sub-questions based on the key informant response; ask for specific elements if not answered; record any additional information)*

12a. What type of reporting tools do your NGO CHWs use? *(Select one)*
1. Paper-based
2. Electronic
3. No reporting tools
4. A mixture of paper-based and electronic tools
5. Other (Please specify: _____)
6. Refused to respond

12b. Do you think the reporting tools CHWs use are easy to be filled and helpful? *(Select one)* (Only if Q12a = 1, 2, 3, 4, or 5)
1. Yes
2. No
3. Refused to respond

13. Please describe how the CHWs are linked to the health system? *(Answer the sub-questions based on the key informant response; ask for specific elements if not answered; record any additional information)*

13a. Are your NGO CHWs linked to the health system? *(Select one)*

1. Yes
2. No
3. Refused to respond

13b. Are your NGO CHWs recognized in communities as helpful? *(Select one)*

1. Yes
2. No
3. Refused to respond

13c. Are your NGO CHWs recognized in communities as part of health system? *(Select one)*

1. Yes
2. No
3. Refused to respond

13d. Do your NGO CHWs refer patients to the health facility using a referral form? *(Select one)*

1. Yes
2. No
3. Refused to respond

13e. Do your NGO CHWs track the referred cases by receiving the information from the referral site? *(Select one)*

1. Yes
2. No
3. Refused to respond

14. I will ask you certain questions and request some numbers as part of CHW Performance measurement framework. *(Provide the key informant with the required information before the interview to prepare the numbers; answer the sub-questions based on the key informant response; ask for specific elements if not answered; record any additional information)*

14a. In your NGO, what's the number of trained CH supervisors? *(Enter number)*

14b. In your NGO, how many CHWs are supervised by one supervisor? *(Enter number)*

14c. In the last month, how many visits on average did you/ each of your NGO CH supervisors conduct to monitor/support CH activities? *(Enter number)*

14d. What's the number of your NGO CHWs who have passed knowledge/competency tests following training? *(Enter number)*

14e. In the last month, how many HH visits your NGO CHWs made? *(Enter number)*

14f. In the last month, did your NGO CHWs have all the key stock commodities? *(Select one)*

1. Yes
2. No
3. Partially
4. Refused to respond

14g. In the last month, how many CHWs did submit all the required reports? *(Enter number)*

14h. Were the submitted reports complete (did not have missing information)?
(Select one)

1. Yes, all of them were complete
2. No, all of them weren't complete
3. Partially, some of them were complete and some were not
4. Refused to respond

14i. In the last year, how many CHWs did resign or leave their work? *(Enter number)*

14j. In the last 3 months, how many households have your NGO CHWs visited at least once? *(Enter number)*

14k. What is the percentage of individuals referred by your NGO CHWs to the health facility per 100 individuals visited? *(Enter number)*

14l. What are the reasons for referrals and their individual percentages? *(Enter text)*

14m. What is the percentage of individuals who complete the referral at the health facility (out of all referred individuals)? *(Enter number)*

14n. What is the percentage of individuals who your NGO CHWs see back after they visit the health facility (out of all referred individuals)? *(Enter number)*

14o. What is the average number of referrals per CHW in the last month? *(Enter number)*

15. Is there anything else we should know about the topics we discussed today? *(Enter text)*

Do you have a telephone number which we can use to call you if we have any follow up questions? *(Participants are not required to answer this question)*
Name: _____
Telephone Number: _____

Interview Closing

"Thank you for your time and willingness to share your experiences with us. We have asked you a lot of questions and you have provided us with very valuable information. Please remember that all the information provided will be kept anonymous. We will use this information to help improve future programming. We will not share any of your personal information"

E. Interview End Time: _____

End of Interview

7.2.3. KII – Community leaders

Introduction and Consent

[Read as it is written]

Good [morning/afternoon], How are you?

My name is [facilitator name] and this is [note taker name]. We are from UDER. We are here as part of the effort to assess the CH services in the area.

The purpose of our interview today is to gather your opinions about the CH services provided. I would like to go over a few logistical points before we begin:

The interview will last about 30-45 minutes. You can leave at any time, but it would be very helpful if you stay until the end.

You will not receive any compensation or payment for participating in this interview. This interview will not be used to gather information about any person specifically. Please be assured that everything we discuss during this interview will be kept in strict confidence and your real name will not appear in any of our results. As such, please make every effort to be open and honest when responding to the questions.

Nothing you say will have an impact whatsoever on your inclusion or exclusion to any programs that are currently being implemented or will be implemented in the future. Participation is completely voluntarily and you have the freedom to withdraw at any time and the freedom not to answer one or more questions. In case you refuse, it will not involve any loss of benefits or penalty and your participation does not involve giving up any legal rights.

Do you have any questions?

Do you agree to participate?
_____ *Yes*
_____ *No*

May I begin?

A. **Date of Interview: _____**

B. **Interview Start Time: _____**

Collected by the interviewer before the interview

1. **Name of surveyor: _____**

2. **Governorate:** *(Select one from the list)*

3. **District:** *(Select one from the list)*

4. **Subdistrict:** *(Select one from the list)*

5. **Community:** *(Select one from the list)*

6. **The institution or entity the respondent represents: _____**

Respondent information

7. **Sex** *(Select one; Do not ask aloud)*

1. Male
2. Female

8. **How old are you?** *(Enter Number)* **_____**

9. What's your residential status? *(Select one)*

1. Host
2. IDP
3. Other (Please specify: _____)

10. How long have you lived in this location? *(Enter response in years; use decimal point to indicate partial years)* (Only if Q9 = 2)

11. What's your position? *(Enter text)*

12. Since when you're working in this position? *(Enter date)* _____

KII questions

13. Are you aware of any CHW programs in your area? *(Select one)*

1. Yes
2. No

14. Please mention the information you know about the CHW programs in your area, in regards to their locations, number of CHWs and the NGOs that manage them. *(Enter text)* (Only if Q13 = YES)

15. Please name the services you know that the CHWs provide *(Select all that apply)*

1. Deliver health information
2. Assess common health problems
3. Promote healthy behaviors and environment
4. Prevent diseases in the community
5. Identify symptoms and risk factors of common diseases
6. Conduct basic tests, like MUAC and blood pressure and glucose.
7. Refer cases to the health facility
8. Follow-up the patient case upon return from the health facility to the community
9. Distribute some materials, like hygiene kits, nutrition supplies, etc.

10. Other (Please specify: _____)
11. Refused to respond

16. Please describe the CHW role, selection, and recruitment. *(Answer the sub-questions based on the key informant response; ask for specific elements if not answered; record any additional information)*

16a. Did you play any role in the recruitment of the CHWs? *(Select one)*
1. Yes
2. No
3. Refused to respond

16b. Please explain what your role was. *(Enter text)* (Only if Q16a = YES)

16c. Were the required qualification and expertise clearly defined prior to recruitment? *(Select one)*
1. Yes
2. No
3. Refused to respond

16d. Are the CHWs from the community? *(Select one)*
1. Yes, all of them are from the community
2. No, all of them are not from the community
3. Some of them are from the community and some are not
4. Refused to respond

16e. Do you know the names of the CHWs who work in your area? *(Select one)* (Only if Q = YES)
1. Yes, all of them
2. No, none of them
3. Some of them
3. Refused to respond

17. Please describe how supportive to the CHW are you. *(Answer the sub-questions based on the key informant response; ask for specific elements if not answered; record any additional information)*

17a. Do you have any role in supervising or training the CHWs in your area? *(Select one)*

1. Yes, both
2. Yes, only training
3. Yes, only supervision
4. No
5. Refused to respond

17b. Please explain what your role is in supervising or training the CHWs in your area. *(Enter text)* (Only if Q17a = YES)

17c. What are the barriers or challenges you face in the supervision or training? What may be done to overcome them and improve the work? *(Enter text)* (Only if Q17a = YES)

17d. What are the missed or extra information in the training modules? *(Enter text)* (Only if Q17a = 1 or 2)

17e. What other topics should be added to the training modules based on your working experience with the community? *(Enter text)* (Only if Q17a = 1 or 2)

17f. What may be done to improve the training? *(Enter text)* (Only if Q17a = 1 or 2)

18. Do you provide any support to the CHWs in their work? *(Select one)*
1. Yes
2. No
3. Refused to respond

18a. Please clarify the support you provide. *(Enter text)* (Only if Q18 = YES)

19. Do you receive any reports about the CHW activities in your area? *(Select one)*
1. Yes
2. No
3. Refused to respond

19a. Please clarify the types of the reports you receive and their tools and frequency. *(Enter text)* (Only if Q19 = YES)

20. Please describe how the CHWs are linked to the health system? *(Answer the sub-questions based on the key informant response; ask for specific elements if not answered; record any additional information)*

20a. Is there a link between the CHWs in your area and the health facilities? *(Select one)*
1. Yes, all of them are linked with health facilities
2. No, all of them are not linked with health facilities
3. Some of them are linked and some are not
4. Refused to respond

20b. In your community, do you consider the CHWs helpful? *(Select one)*
1. Yes
2. No
3. Refused to respond

20c. Why? *(Enter text)* (Only if Q20b = NO)

20d. In your community, do you recognize the CHWs as part of the health system? *(Select one)*
1. Yes
2. No
3. Refused to respond

20e. Why? *(Enter text)* (Only if Q20d = NO)

20f. Do your community trust the health information provided by the CHW? *(Select one)*
1. Yes
2. No
3. Refused to respond

20g. Why? *(Enter text)* (Only if Q20f = NO)

20h. Do your community trust the services provided by the CHW? *(Select one)*
1. Yes
2. No
3. Refused to respond

20i. Why? *(Enter text)* (Only if Q20h = NO)

20j. In general, how satisfied is your community with the services they receive from the CHWs? *(Select one)*
1. Very satisfied
2. Somewhat satisfied
3. Neutral
4. Somewhat not satisfied
5. Not satisfied at all

6. Refused to respond

20k.Why? *(Enter text)* (Only if Q20j = 4 or 5)

21. Is there anything else we should know about the topics we discussed today? *(Enter text)*
Please specify: _____

Do you have a telephone number which we can use to call you if we have any follow up questions? *(Participants are not required to answer this question)*
Name: _____
Telephone Number: _____

Interview Closing

"Thank you for your time and willingness to share your experiences with us. We have asked you a lot of questions and you have provided us with very valuable information. Please remember that all the information provided will be kept anonymous. We will use this information to help improve future programming. We will not share any of your personal information"

E. Interview End Time: _____

End of Interview

7.2.4. CHW Survey

Introduction and Consent

[Read as it is written]

Good [morning/afternoon], How are you?

My name is [facilitator name] and this is [note taker name]. We are from UDER. We are here as part of the effort to assess the CH services in the area.

The purpose of our interview today is to gather your opinions about the program and assess the services provided. I would like to go over a few logistical points before we begin:

The interview will last about 45-60 minutes. You can leave at any time, but it would be very helpful if you stay until the end.

You will not receive any compensation or payment for participating in this interview. This interview will not be used to gather information about any person specifically. Please be assured that everything we discuss during this interview will be kept in strict confidence and your real name will not appear in any of our results. As such, please make every effort to be open and honest when responding to the questions.

Nothing you say will have an impact whatsoever on your inclusion or exclusion to any programs that are currently being implemented or will be implemented in the future. Participation is completely voluntarily and you have the freedom to withdraw at any time and the freedom not to answer one or more questions. In case you refuse, it will not involve any loss of benefits or penalty and your participation does not involve giving up any legal rights.

Do you have any questions?

Do you agree to participate?
_____ *Yes*
_____ *No*

May I begin?

A. **Date of Interview: _____**

B. **Interview Start Time: _____**

Collected by the enumerator before the survey

1. **Name of surveyor: _____**
2. **Governorate:** *(Select one from the list)*
3. **District:** *(Select one from the list)*
4. **Subdistrict:** *(Select one from the list)*
5. **Community:** *(Select one from the list)*
6. **NGO the CHW work at: _____**

Respondent information

7. **Sex** *(Select one; Do not ask aloud)*
   1. Male
   2. Female

8. **How old are you?** *(Enter Number)* **_____**

9. **What's your residential status?** *(Select one)*

1. Host
2. IDP
3. Other (Please specify: _____)

10. How long have you lived in this location? *(Enter response in years; use decimal point to indicate partial years)* (Only if Q9 = 2)

11. Do you work as CHW in the same community you live in? *(Select one)*

1. Yes
2. No
3. Refused to respond

12. Since when you're working as a CHW? *(Enter date)* _____

13. What is the highest level of education you have completed? *(Select one)*

1. Some primary school
2. Primary school completed
3. Intermediate school completed
4. Secondary school completed
5. College/ University completed
6. Other (Please specify: _____)
7. Refused to respond

CHW questions

14. Is your formal CHW role defined or documented? *(Select one)*

1. Yes
2. No
3. Refused to respond

15. What is the document that defines the formal CHW role? *(Select all that apply)* (Only if Q14 = YES)

1. TOR
2. SoPs
3. Contract
4. Other (Please specify: _____)
3. Refused to respond

16. Were the required qualification and expertise clearly defined prior to your recruitment? *(Select one)*

1. Yes
2. No
3. Refused to respond

17. Have you received initial training within six months of recruitment? *(Select one)*

1. Yes
2. No
3. Refused to respond

18. Do you receive ongoing/refresher training by your NGO? *(Select one)*

1. Yes
2. No
3. Refused to respond

19. How frequent the refresher training is? *(Select one)* (Only if Q18 = YES)

1. Monthly
2. Quarterly
3. Bi-annually
4. Annually
5. Other (Please specify: _____)
6. Refused to respond

20. Do you receive coaching/ on-the-job training in ad hoc visits by your supervisors? *(Select one)*

1. Yes
2. No
3. Refused to respond

21. Do you attend ad hoc workshops on specific vertical health topics provided by partner organizations/NGOs? *(Select one)*

1. Yes
2. No
3. Refused to respond

22. Do you receive continuous capacity development? *(Select one)*

1. Yes
2. No
3. Refused to respond

23. What is the of objective of this capacity development? *(Select all that apply)* (Only if Q22 = YES)

1. Reinforce initial training
2. Teach CHWs new skills
3. Help ensure quality
4. Other (Please specify: _____)

24. What are the barriers or challenges that you faced during getting the training? *(Enter text)* (Only if any training is provided)

25. What may be done to improve the initial training? *(Enter text)* (Only if any training is provided)

26. What is the type of ongoing training you would like to receive? *(Enter text)*

27. In which topics you would like to receive ongoing training? *(Enter text)*

28. How frequent would like to receive ongoing training? *(Enter text)*

29. Have you received the comprehensive approach of training and the 6 training modules? *(Select one)*

1. Yes
2. No
3. Refused to respond

30. What's your overall satisfaction with the comprehensive approach of training and the 6 training modules? *(select one)* (Only if Q29 = YES)

1. Very satisfied
2. Somewhat satisfied
3. Neutral
4. Somewhat not satisfied
5. Not satisfied at all
6. Refused to respond

31. Please provide your overall feedback about the 6 training modules. *(Enter text)* (Only if Q29 = YES)

32. What are the missed or extra information in each module? *(Enter text)* (Only if Q29 = YES)

33. What other topics should be added to the training modules based on your working experience with the community? *(Enter text)* (Only if Q29 = YES)

34. Do your supervisor conduct supervision or regular evaluation outside of occasional visits? *(Select one)*

1. Yes
2. No
3. Refused to respond

35. How your supervisor is assigned? *(Select one)*

1. To certain number of CHWs
2. To communities
3. Other (Please specify: _____)

36. Is your supervisor trained? *(Select one)*

1. Yes
2. No
3. Refused to respond

37. Does your supervisor have the basic supervision tools they need? *(Select one)*

1. Yes
2. No
3. Refused to respond

38. Do you receive any individual performance support? *(Select one)*

1. Yes
2. No
3. Refused to respond

39. What type of individual performance support you receive? *(Select all that apply)* (Only if Q38 = YES)

1. Problem-solving
2. Coaching
3. On-the-job training
4. Other (Please specify: _____)

40. Do your supervisor conduct supervision visits to you? *(Select one)*

1. Yes
2. No
3. Refused to respond

41. How frequent do your supervisor conduct supervision visits to you? *(select one)* (Only if Q40 = YES)

1. Daily
2. Weekly
3. Monthly
4. Quarterly
5. Bi-annually
4. Annually
5. Other (Please specify: _____)
6. Refused to respond

42. Does your supervisor provide summary about your performance and areas that need further improvement? *(Select one)*

1. Yes
2. No
3. Refused to respond

43. What type of reporting tools do you use? *(Select one)*

1. Paper-based

2. Electronic
3. No reporting tools
4. A mixture of paper-based and electronic tools
5. Other (Please specify: _____)
6. Refused to respond

44. Do you think the reporting tools you use are easy to be filled and helpful? *(Select one)* (Only if Q43 = 1, 2, 3, 4, or 5)

1. Yes
2. No
3. Refused to respond

45. Are you linked a specific health facility? *(Select one)*

1. Yes
2. No
3. Refused to respond

46. Are you recognized in communities as helpful? *(Select one)*

1. Yes
2. No
3. Refused to respond

47. Are you recognized in communities as part of health system? *(Select one)*

1. Yes
2. No
3. Refused to respond

48. Do you refer patients to the health facility using a referral form? *(Select one)*

1. Yes
2. No
3. Refused to respond

49. Do you track your referred cases by receiving the information from the referral site? *(Select one)*

1. Yes
2. No
3. Refused to respond

50. What are the key challenges that you faced during your working experience? *(Enter text)*

51. What are the main factors that motivate you to continue working as a CHW? *(Enter text)*

52. What do you recommend for improving your motivation and facilitating your work? *(Enter text)*

53. In your team, how many CHWs are supervised by one supervisor? *(Enter number)*

54. In the last month, how many visits did your supervisor conduct to monitor/support your activities? *(Enter number)*

55. Have you passed knowledge/competency tests following training? *(Select one)*

1. Yes
2. No
3. Refused to respond

56. Do you feel confidence in your abilities to provide health education? *(Select one)*

1. Yes
2. No
3. Partially
4. Refused to respond

57. In the last month, how many HH visits you made? *(Enter number)*

58. In the last month, did you have all the key stock commodities? *(Select one)*

1. Yes
2. No
3. Partially
4. Refused to respond

59. In the last month, did you submit all the required reports? *(Select one)*

1. Yes
2. No
3. Partially
4. Refused to respond

60. Were your submitted reports complete (did not have missing information)?

(Select one) (Only if Q59 = 1 or 3)

1. Yes
2. No
3. Partially
4. Refused to respond

61. How satisfied are you with the support you receive from the community? *(select one)*

1. Very satisfied
2. Somewhat satisfied
3. Neutral
4. Somewhat not satisfied
5. Not satisfied at all
6. Refused to respond

62. How satisfied are you with the support you receive from health facility staff? *(select one)*

1. Very satisfied

2. Somewhat satisfied
3. Neutral
4. Somewhat not satisfied
5. Not satisfied at all
6. Refused to respond

63. In the last 3 months, have you reported on your activities? *(Select one)*
1. Yes
2. No
3. Partially
4. Refused to respond

64. In the last 3 months, have many households have you visited at least once? *(Enter number)*

65. What is the percentage of individuals referred by you to the health facility per 100 individuals visited? *(Enter number)*

66. What are the reasons for referrals and their individual percentages? *(Enter text)*

67. What is the percentage of individuals who complete the referral at the health facility (out of all referred individuals)? *(Enter number)*

68. What is the percentage of individuals who you see back after they visit the health facility (out of all referred individuals)? *(Enter number)*

69. What is the number of referrals made by you in the last month? *(Enter number)*

70. Is there anything else we should know about the topics we discussed today? *(Enter text)*

Do you have a telephone number which we can use to call you if we have any follow up questions? *(Participants are not required to answer this question)*

Name: _____
Telephone Number: _____

Interview Closing

"Thank you for your time and willingness to share your experiences with us. We have asked you a lot of questions and you have provided us with very valuable information. Please remember that all the information provided will be kept anonymous. We will use this information to help improve future programming. We will not share any of your personal information"

E. Interview End Time: _____

End of Survey

7.2.5. HH Survey – Community members

Introduction and Consent

[Read as it is written]

Good [morning/afternoon], How are you?

My name is [facilitator name] and this is [note taker name]. We are from UDER. We are here as part of the effort to assess the CH services in the area. I would like to spend about 10-20 minutes with you to ask you a few questions about these services.

Your results will remain anonymous and will be used with other responses to figure out what is working well and what is not working well so that we can improve services. Any response you deliver will not influence your ability to access services and will only be used for broader analysis without your name or any identifiable information.

You can ask me any questions now or at any point during the survey if you choose to participate.

Do you have any questions?

Do you agree to participate?

1. *Yes*
2. *No*

May I begin?

A.	**Date of Interview: _____**
B.	**Interview Start Time: _____**

Collected by the enumerator before the survey

1. **Name of surveyor:** _____
2. **Governorate:** *(Select one from the list)*
3. **District:** *(Select one from the list)*
4. **Subdistrict:** *(Select one from the list)*
5. **Community:** *(Select one from the list)*
6. **NGO(s) that cover(s) the community:** _____

Respondent/household information

7. **Sex** *(Select one; Do not ask aloud)*
   1. Male
   2. Female

8. **How old are you?** *(Enter Number)* _____

9. **Are you from this community or from elsewhere?** *(Select one)*
   1. From here (host)
   2. From elsewhere and have moved to this community during the conflict (IDP)
   3. Other (Please specify: _____)

10. **How long has your family lived in this location?** *(Enter response in years; use decimal point to indicate partial years)* (Only if Q9 = 2)

11. **What is the highest level of education you have completed?**

1. No formal schooling and can't read and write
2. No formal schooling but can read and write
3. Some primary school
4. Primary school completed
5. Intermediate school completed
6. Secondary school completed
7. College/ University completed
8. Refused to respond

12. How many people currently live in this household? *(Enter Number)* _____

13. Are there any children aged less than 5 years of age in the household? *(Select one)*

1. Yes
2. No
3. Refused to respond

14. Are there any older adults aged 60 years or above in the household? *(Select one)*

1. Yes
2. No
3. Refused to respond

15. Are there any household members with health problems or medical conditions? *(Select one)*

1. Yes
2. No
3. Refused to respond

15a. Please specify: *(Enter text)* (Only if Q15 = YES)

CH services questions

16. Have you or anyone in your household received a session from CHW(s)? *(Select one)*

1. Yes
2. No

17. If yes, when was the that? *(Select one)* (Only if Q16 = YES)
1. Once in the last Ramadan
2. Once before the last Ramadan but in the last 3 months
3. Once more than 3 months ago
4. Multiple times; the most recent session was in the last 3 months
5. Multiple times; the most recent session was more than 3 months ago
6. Refused to respond

18. If yes, what was the topic? *(Select all that apply)* (Only if Q16 = YES)
1. Disease awareness and detection
2. Reproductive health
3. Child health
4. Personal and environmental hygiene
5. Nutrition
6. Vaccines
7. Coronavirus or other CDs.
8. Hypertension, diabetes, or other NCDs.
9. Dental hygiene
10. Other (Please specify: _____)
11. Refused to respond

19. Are the CHW(s) who delivered the session from your community? *(Select one)* (Only if Q16 = YES)
1. Yes
2. No
3. Refused to respond

20. Do you know the name(s) of the CHW(s) who delivered the session? *(Select one)* (Only if Q16 = YES)

1. Yes
2. No
3. Refused to respond

21. Please name the services you know that the CHWs provide *(Select all that apply)* (Only if Q16 = YES)
1. Deliver health information
2. Assess common health problems
3. Promote healthy behaviours and environment
4. Prevent diseases in the community
5. Identify symptoms and risk factors of common diseases
6. Conduct basic tests, like MUAC and blood pressure and glucose.
7. Refer cases to the health facility
8. Follow-up the patient case upon return from the health facility to the community
9. Distribute some materials, like hygiene kits, nutrition supplies, etc.
10. Other (Please specify: _____)
11. Refused to respond

22. Do you think the CHWs are helpful in your community? *(Select one)* (Only if Q16 = YES)
1. Yes
2. No
3. Refused to respond

22a. Why? *(Enter text)* (Only if Q22 = NO)

23. Do you trust the health information provided by the CHW? *(Select one)* (Only if Q122 = YES)
1. Yes
2. No
3. Refused to respond

23a. Why? *(Enter text)* (Only if Q23 = NO)

24. Do you trust the services provided by the CHW? *(Select one)* (Only if Q16 = YES)
1. Yes
2. No
3. Refused to respond

24a. Why? *(Enter text)* (Only if Q24 = NO)

25. Do you consider the CHWs as part of the health system? *(Select one)* (Only if Q16 = YES)
1. Yes
2. No
3. Refused to respond

25a. Why? *(Enter text)* (Only if Q25 = NO)

26. To what extent was the information provided by the Community Health Worker useful to you or your household members? *(Select one)* (Only if Q16 = YES)
1. Very useful
2. Somewhat useful
3. Neutral
4. Somewhat not useful
5. Not useful at all
6. Refused to respond

26a. Why? (*HINT: Ask question as an open-ended manner and select the options that match the response, select all that apply)* (Only ask if Q26 = 4 or 5)
1. Topic was not relevant
2. Topic was not appropriate
3. Already knew the material covered in the session
4. Didn't agree with the information presented in the session

5. Session was confusing
6. Information in the session made me worry/feel afraid
7. Session would have been better if presented to a different family member
8. Other (Please specify: _____)
9. Refused to respond

27. Did you have any questions for the CHW? *(Select one)* (Only if Q16 = YES)
1. Yes
2. No
3. Refused to respond

27a. Was the CHW able to answer questions you had about the topic? *(Select one)* (Only if Q27 = YES)
1. Yes
2. No
3. Refused to respond

27b. Did the CHW seem convincing in the information they provided about the topic? *(Select one)* (Only if Q27 = YES)
1. Yes
2. No
3. Refused to respond

28. Was the CHW's session delivered at a convenient time? *(Select one)* (Only if Q16 = YES)
1. Very convenient
2. Somewhat convenient
3. Not convenient at all
4. Refused to respond

28a. Why? (*HINT: Ask question as an open-ended question and select the options that match the patient's response, select all that apply)* (Only ask if Q22 = 2 or 3)
1. Busy with household chores at the time of the session

2. Busy with childcare/household member responsibilities at the time of the session
3. Busy with friends or neighborhoods visit at the time of the session
4. Relevant household members were not present
5. Had to leave the house around the time of the visit
6. Was not feeling well at the time of the visit
7. Would prefer the CHW made an appointment before visiting
8. Other (Please specify: _____)
9. Refused to respond

29. Have you or anyone in your household received a referral to a health facility by a CHW? *(Select one)* (Only if Q16 = YES)
1. Yes
2. No
3. Refused to respond

29a. Have you or the referred member received a referral form the CHW? *(Select one)* (Only if Q29 = YES)
1. Yes
2. No
3. Refused to respond

29b. Did you follow the referral and go to the health facility? *(Select one)* (Only if Q29 = YES)
1. Yes
2. No
3. Refused to respond

29c. Did you receive the service you were referred for? *(Select one)* (Only if Q29b = YES)
1. Yes
2. No
3. Refused to respond

29d. What were the reasons for not following the referral? *(Select all that apply)* (Only if Q29b = NO)

1. Did not feel it was necessary to go to the health facility
2. Transportation was not available
3. Transportation was expensive
4. Road conditions were poor
5. Security conditions were poor
6. Did not know the location of the health facility
7. Did not have a family member or person to accompany to the health facility
8. Did not know if the health facility was open
9. Did not know if the health facility provided the necessary services
10. Health facility was closed/suspended
11. Costs of health services was too high
12. Other (Please specify: _____)
13. Refused to respond

29e. Did the CHW(s) who referred you see you back and follow-up on your case at your household after they referred you? *(Select one)* (Only if Q29 = YES)

1. Yes
2. No
3. Refused to respond

30. In general, how satisfied are you with the services you received from the CHW(s)? *(Select one)* (Only if Q16 = YES)

1. Very satisfied
2. Somewhat satisfied
3. Neutral
4. Somewhat not satisfied
5. Not satisfied at all
6. Refused to respond

30a. Why? *(Enter text)* (Only if Q30 = 4 or 5)

31. What do you think that CHWs should also do to improve your benefit from them? *(Enter text)*

32. Is there anything else we should know about the topics we discussed today? *(Enter text)*
Please specify: _____

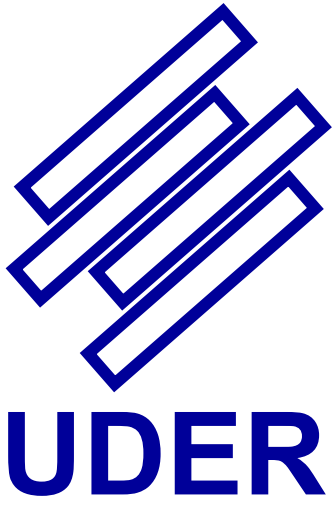
33. Do you have a telephone number which we can use to call you if we have any follow up questions? *(Participants are not required to answer this question)*
Name: _____
Telephone Number: _____

Interview Closing

"*Thank you for your time and willingness to share your experiences with us. We have asked you a lot of questions and you have provided us with very valuable information. Please remember that all the information provided will be kept anonymous. We will use this information to help improve future programming. We will not share any of your personal information"*

E. Interview End Time: _____

End of Survey



Relief Experts Association

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