Community Health Management Committee Assessment and Improvement Matrix (CHMC AIM)

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DRAFT – Seeking Feedback and Field Testing

The idea for this tool was generated at a concurrent session at the CORE Group Fall 2014 Global Health Practitioners Conference.

To send feedback or participate in field testing of the tool, kindly contact Michele Gaudrault: michele_gaudrault@wvi.org

Community Health Management Committee: Assessment and Improvement Matrix (CHMC AIM)

Introduction

In 1989, WHO recommended that an effective Community Health Worker (CHW) program have the support of a group composed of members of the community who have active links with the health sector and improve governance at the local level. We refer to these groups as community health management committees (CHMCs) known by different names, such as village health committees, community health committees, ward health committees, community advisory boards, and health management committees. In most countries, these management structures provide support to the CHW at the community level and a bridge to the health system, may also be linked with the local political system and may also perform functions such as assessing and tracking local health status and issues, mobilizing for action and advocating for improved health services. Well-functioning committees can describe their roles and responsibilities and how they relate to other groups, including the CHWs, the health facility, and the district health authorities.[1]

While many countries have active community health management committees, they are generally weak. This draft tool has been developed to help organizations assess CHMC program functionality and improve program performance. An assessment of existing issues may help a ministry plan and budget for ongoing support. Built around a core of 14 components deemed essential for effective programs, CHMC AIM is meant to be used as a guided self-assessment and performance improvement process to help organizations identify program strengths and address gaps. The approach enables a diverse group of participants to score their own programs against the 14 programmatic components and 4 levels of functionality. Following the review, participants use the results to develop action plans to address weaknesses in performance.

Audience: This tool is designed to be used by any implementing partner such as a ministry of health, a non-governmental organization (NGO) or other organizations that implement and manage CHMC programs.

Objectives: CHMC AIM can be used to:
- Assess functionality and guide improvement in programs working with CHMCs
- Provide action planning and best practices to assist in strengthening CHMC programs
- Identify the location of functional CHMC programs and gaps in coverage

The tool is meant as a guide to aid progress rather than a rigid prescription and so covers key concepts relevant at this level while recognizing that some adaptation to local contexts may be needed[2].

[1] LeBan K, Perry H, Crigler L, Colvin C. 2013. *Community Participation in Large-Scale Community Health Worker Programs*. Published in Developing and Strengthening Community Health Worker Programs at Scale: A Reference Guide for Program Managers and Policy Makers, USAID, MCHIP.

[2] Description modeled after: Crigler L, Hill K, Furth R, Bjerregaard D. 2011. Community Health Worker Assessment and Improvement Matrix (CHW AIM): A Toolkit for Improving Community Health Worker Programs and Services. Published by the USAID Health Care Improvement Project. Bethesda, MD: University Research Co., LLC (URC).

Structure of the CHMC AIM Tool

The assessment and improvement matrix is divided into 14 components, each with descriptions of characteristics of functionality in the scoring ranges of 0-3.

1. Community Health Management Committee(CHMC) Formation
2. CHMC Organization and Structure
3. CHMC Operational and Strategic Planning
4. CHMC Member Recruitment and Selection
5. CHMC Member Training and Capacity Building
6. Budget for CHMC Programming
7. Supervision of CHMC Members
8. Incentives for CHMC Members
9. Wider Community Support and Involvement
10. CHMC Support of the Referral System
11. Communication and Information Management
12. Linkages to the Health System
13. Country Ownership
14. CHMC Program Performance Evaluation

Supplementary materials

The assessment and improvement matrix tool found in this document assesses the functionality of CHMC *programs*.

1. A second tool is under development that will look at the functionality of the CHMC itself.

2. A companion document is under development that will guide users in carrying out the assessment and action planning processes using the tools.

The supplementary products will be available in 2016.

Community Health Management Committee: Assessment and Improvement Matrix

1. Community Health Management Committee (CHMC) Formation				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
CHMC Formation How the CHMCs are formed: What entity catalyzed the program and backs and supports it; e.g. Ministry of Health (MoH), independent NGO efforts, etc. To what extent the CHMC members are clear on the purpose, mission and importance of the group's work Whether or not there are MoH policies, procedures and budget to support the formation and continuance of the CHMCs The degree of community awareness and participation in CHMC formation	**No CHMC exists** and community is not engaged in the process of actively managing local health services ***OR*** **CHMC exists but** meets infrequently with no clear objectives or direction **MOH is not involved** in establishing or supporting CHMCs. The CHMC may have been formed through NGO or other organizations, with no link to MoH The **wider community is unaware** of the CHMC and/or the purpose of this group	**Loose organization** of members meet ad-hoc to discuss key issues within the community but not on a regular basis and no formal record is kept The CHMC members have **a vague idea** of why their group should exist CHMCs form part of **MoH** policies, strategies and/or action plans for community health and MoH catalyzed their formation, but MoH involvement with the CHMCs in practice is limited Some community members are aware of the informal organization, but the community was **not consulted** in CHMC formation.	**Organized CHMC exists** that meets on a regular basis and keeps records of meetings CHMC members **have an idea of what a healthy community is,** and agree on their overall **mission and objectives**, but are not put in writing. CHMCs form part of **MoH** policies, strategies and/or action plans for community health, and MoH - often in partnership with NGOs – provides some supervision, guidance and resources to the CHMCs **Community members are aware** of intended structure and purpose of CHMC, and participate in some, but not all of the committee formation process	**Organized CHMC exists that** meets on a regular basis and keeps records of meetings CHMC members have a **shared vision of what their healthy community** can look like in 3 or more years, why their work is important and can only be done by them not the MOH or NGOs, and have **written mission and objectives** The **MoH** supports the formation and/ or continuance of the CHMC through participation, guidance, supervision and budgetary commitment Community mobilization including multiple communications prior to group formation and recruitment of new members ensures **community fully aware** of intended structure and purpose of group

2. CHMC Organization and Structure				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
CHMC Organization and Structure Clarity and effectiveness of CHMC organization and structure with regard to roles, expectations, frequency, decision-making and procedures	**Roles** of the CHMC members are not defined or documented **Expectations** of the committee are not defined or documented	CHMC members may have some ideas about their **roles**, but these are not documented **Expectations** (e.g. time commitment, frequency of meetings) and **tasks** (e.g. responsibilities vis-à-vis CHWs and/or other health volunteers, community-level activities) are discussed but are **not specific or documented, or shared with community** The **decision-making authority** of the committee with regard to health services is not established, is unclear or is contested	**Roles** of the CHMC members are clearly defined and documented but not communicated to community members or MOH **Expectations** (e.g. time commitment, frequency of meetings) and **tasks** (e.g. responsibilities vis-à-vis CHWs and/or other health volunteers, community-level activities) are discussed and **specific but have not been shared with community members** The committee's **decision-making authority** with regard to health services is clearly established within the committee but not communicated **No process exists for updating** and discussing roles, expectations and tasks	**Roles** of the CHMC members are clearly defined and documented and are communicated to community members and MOH **Expectations** (e.g. time commitment, frequency of meetings) and **tasks** (e.g. responsibilities vis-à-vis CHWs and/or other health volunteers, community-level activities) are discussed and **specific and communicated to** the MOH, the community, involved organizations and the committee itself The committee's **decision-making authority** with regard to health services is clearly established and communicated **Process for updating** and discussing roles, expectations and tasks is in place

3. CHMC Operational and Strategic Planning				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
CHMC Operational and Strategic Panning The CHMC has basic planning skills to develop and implement its own plan with objectives, indicators, activities, persons responsible, timelines, resources needed and monitoring of progress. **CHMC Strategic planning** After basic operational planning is mastered, the CHMC needs to develop strategic plans for those objectives which will take three or more years to achieve in line with their vision of a healthy community and achieved on the basis of annual achievements.	**No regular planning**	CHMC **plans weekly or monthly** health activities with **incomplete planning details** and minimal monitoring or feedback **Activities added as prompted** by MoH and/or NGOs	CHMC **plans weekly** health activities with at least **monthly feedback** from all health worker groups. Community members bring health problems within community to CHMC. Vague planning on monthly and yearly basis with minimal records. **Some longer term planning** on the basis of input from MoH and NGOs	CHMC **develops its plan annually** on the review of past year & MOH input and develops written plan with all elements listed in first column. Also **synchronizes its plan with MOH** and other health actors in their area. Plan is **revised** on basis of monitoring at **twice per year.** On a monthly basis, all community health worker **(CHW) groups report back** to CHMC on their activities in written form according to the monitoring plan with problem solving and revision as needed. Weekly, CHMC leaders, not necessarily through a formal committee meeting, **solve local health problems as they arise** and advise health workers on activities. **CHMC written strategic plan** is reviewed and revised **every three years** on basis of review of achievements and future operational plans developed

4. CHMC Member Recruitment and Selection				
Component Definition	0 **Non-functional**	1 **Minimal**	2 **Functional**	3 **Standard**
CHMC Member Recruitment and Selection The processes by which CHMC members are identified and selected, including selection criteria, community involvement in selection, and degree of representation (of various segments of the community) of CHMC members. The strongest most sustainable motivation for CHMC members to actively participate is internal motivation and so this should be a highlight of selection of members. Selection criteria should focus on: inclusiveness of all subgroups in the community and motivation of members to do work, and will differ depending on the health functions that different types of health workers are to perform.	**No or only a few criteria** exist and are **not well known** or commonly applied No efforts have been made to engage/mobilize the community to participate in CHMC member recruitment. The community is **unaware** when recruitment is taking place. The community **plays no role** in recruitment	**Some criteria exist** and are **communicated** but are general and/or do not address specific issues such as gender Some community members are **aware** of the CMHC and some position openings, but primarily through discussion or personal relationships Community is not involved in the recruitment of CHMC members but **may approve the final selection**	**Selection criteria** are defined and communicated, but do not always specify representation **of gender, ethnic/tribal and disadvantaged groups** Communications regarding recruitment for CHMC members reach most of the community through regular community communication channels (e.g. through community leaders) **Community is involved in recruitment** of CHMC members; nominating and voting for candidates Most selection **criteria** (literacy, gender, sub-group representation, etc.) **are met** where possible There are no specifications on term limits or re-election of members	**Selection criteria** are defined and communicated and call for representation **of gender, ethnic/tribal and disadvantaged groups** Selection criteria are **developed with** broad segment of the community. CMHC member recruitment is **intentionally communicated** through multiple communications prior to group formation and recruitment of new members. **Community is involved in recruitment** of CHMC members**;** nominating and voting for candidates, and **marginalized** and key subgroups have a real say in recruitment All selection **criteria** (literacy, gender, sub-group representation, etc.) **are met** where possible **Term limits** on key members or re-election on performance basis

5. CHMC Member Training and Capacity Building				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
CHMC Member Training and Capacity Building Training provided to the CHMC members to equip them with the knowledge and skills required to fulfill their roles The entity responsible for providing the training (MoH, clinic staff, NGO partners). Whether or not the training program is institutionalized within the MoH Details of the training: the existence of a practical, competency-based, systematic training plan to include initial and ongoing training; relevant and sufficient content vis-a-vis the CHMCs' roles and responsibilities, and effectiveness of training methodologies. The extent to which the training system is responsive to the fact that the CHMC is made up of members with different levels of intelligence and formal education. With members skills matched to the tasks they are motivated to and can perform, all members are important to fulfil the range of health activities that need to be performed and should be encouraged so the CHMC can function as a whole.	**No or minimal training** is provided to the CHMC members ***OR*** Minimal initial training is provided (e.g. one workshop) that does not adequately prepare the CHMC to fulfil its functions The MoH has no responsibility for training the CHMC	**Minimal training** is provided but is **not systematic** or according to a curriculum or a training plan; Or, a training plan exists within the local health system but is not implemented regularly. Occasional training is offered to some members through ad hoc workshops The MoH is the entity nominally responsible for CHMC training, but rely on NGOs/other partners (e.g. training not institutionalized in MoH)	A **training plan** exists within the local health system for new committee members and **regular training** takes place with ad-hoc training for all CHMC members. The MoH takes responsibility for CHMC training but often requests assistance from NGOs/other partners (e.g. training partially institutionalized w/in MoH) **Content** of training includes at minimum enabling CHMCs to understand their roles, and basic skills needed to carry them out, to include **community health situation analysis, community mobilization** and **CHW/volunteer support** Where committees are linked with CHWs, **training includes** basic information in the specific **CHW areas** (e.g. MNCH, HIV, etc.) **Adult learning methods** are used to build participatory, decision making and problem solving skills	A **training plan** exists within the local health system and **regular training** to the plan for all CHMC members takes place. The training of CHMCs is fully institutionalized within the MoH and carried out by MoH/clinic staff, with NGOs/partners playing only a supportive role as needed **Initial training** in all necessary content, and **ongoing training** for **skill maintenance, new skills,** new **organizational development** and health literacy strengthening Some training is **conducted in the community** itself, with community participating, as providers of feedback and peer co-trainers especially per senior workers. Training develops committee as a Learning Organization and **part of wider system** that can address many health needs locally and knows how and where to go to for help for new or uncommon problems.

6. Budget for CHMC Programming				
Component Definition	0 **Non-functional**	1 **Minimal**	2 **Functional**	3 **Standard**
Budget for CHMC Programming The extent to which the CHMC has the legal mandate and authority to develop an annual budget and manage revenue from the government, user fees from clinics, or taxes and donations from the community to support community health activities The extent to which processes are in place for fiscal management and the committee goes through an annual audit / verification process	The CHMC has **no budget or funding** to perform or support community activities that improve health	The CHMC has **no budget** but receives **one-off funding** from MOH to tackle a specific health issue	The CHMC has an **annual budget from MoH and consistent funding** to enable the CHMC and/or community to take small, doable action to support CHWs, and other health focused activities Processes are in place for **fiscal management**	The CHMC has the **legal mandate and authority** to develop an **annual budget** and manage revenue from the government, user fees from clinics, or taxes and donations from the community including local businesses to support community health activities Processes are in place for **fiscal management** and the CHMC goes through an annual **audit** / verification process The CHMC has **developed the attitude** that many activities can be done well with local resources and without having to seek further finances. Therefore local solutions are examined first before outside funding is sought.

7. Supervision of CHMC Members				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
Supervision of CHMC Members The extent to which CHMC members receive support and supervision from the MOH and/or through **other mechanisms** (such as committee peer supervision/support, or supervision by partner NGOs or other appropriate stakeholders) that enable the CHMC to reach its objectives and fulfill its mission. Frequency and purpose of supervisory contacts, and action and documentation resulting from the contacts Incentives for supervisors: the extent to which the supervisors of the CHMC are compensated for costs of supervisory work and provided with opportunities for continuing education for further career development.	There is **no supervision** of the CHMC; neither through MoH nor **other mechanisms** ***OR*** Health staff are meant to supervise the CHMC but, as an added responsibility, the direct and indirect costs of doing so are too high and/or they do not have the logistical means and so the **supervision responsibility goes unfulfilled** There are **no supervisory contacts** with the committee. There are **no incentives** or forms of recognition for the supervisors of the CHMCs Supervisors of the CHMCs are not compensated for time or expenses in order to perform their supervisory role	The CHMC has a **delineated supervisory relationships** with the MOH, or **other mechanisms occasionally**; **Occasional supervisory contacts** to discuss data, goals and activities and provide input, but **not based on a review of data, goals and objectives.** **Little or no ongoing on-the-job** training as part of the supervision process Supervisor(s) receive **no incentives** package, financial or non-financial but **appreciation from the CHMCs** is considered a reward Supervisors of the CHMCs are not compensated for time or expenses in order to perform their supervisory role	The **MOH** has **policies** in place that describe **regular supervision** processes for CHMCs to provide support, coaching and problem solving ***OR*** An **alternative supervision mechanism** is in place Regular, at **least 3 monthly supervisory contacts** using tools to discuss goals, data and current challenges. Supervision takes place at health facility or other central location rather than in the community Supervision includes **assessment** of skills and **on-the-job training** **Some unstandardized non-financial incentives** are offered to the supervisors of the CHMCs Financial support is provided to the supervisors of the CHMCs to **offset the direct costs** of the supervisory work	The **MOH** has **policies** in place that describe **regular supervision** processes for CHMCs to provide support, coaching and problem solving ***AND*** An A**lternative supervision mechanisms is in place** Regular, at least **3 monthly supervisory contacts** using tools to discuss goals, data and current challenges. Supervision takes place in the community **Progressive CHMC member development** and on the job training planned, monitored evaluated, and documented with local community leaders & wider community **An agreed package of non-financial incentives** is provided to supervisors of the CHMCs and is in line with general expectations placed on supervisors Financial support is provided to the supervisors of the CHMCs to **offset the direct costs** of the supervisory work

8. Incentives for CHMC members				
Component Definition	0 Non-functional	1 Minimal	2 Functional	3 Standard
Incentives for CHMC Members The types of incentives received by CHMC members Financial: support to offset direct costs of participation Non-financial: include such considerations as training, certification, recognition, community tokens of appreciation, ceremonies, etc. The extent to which the incentive system is standardized, well-known, and results in CHMC member motivation The extent to which incentives provided are appropriate to the training, level of effort and time commitment that a CHMC member needs to input to do their work satisfactorily.	CHMC program is completely volunteer; **no financial or non-financial incentives** are provided **No financial support** is provided to offset the **direct costs** of participation (e.g. transport to trainings) CHMC members may feel that the direct and indirect **costs** of participation **exceed the benefits**, and **attrition** rates may be high	**No incentives package**, financial or non-financial, is provided by the program but **recognition from the community** is considered a reward **Financial support** is provided to offset the **direct costs** of participation (e.g. transport to trainings) There is mixed feeling among CHMC members in terms of the costs/benefits of participation, and **inconsistency in member participation, with some drop-outs**	**Some non-financial incentives** are offered to CHMC members such as training, recognition, certification, but these are not standardized and uniform within defined geographic areas, and may not be commensurate to expectations placed on members **Community offers** appropriate forms of recognition and reward **Financial support** is provided to offset the **direct costs** of participation (e.g. transport to trainings) CHMC members may feel that **intangible benefits** such as pride, esteem in the community, visible community improvements, social opportunities etc. **outweigh the** direct and indirect **costs** of participation and thus are **willing to remain** on the committee	**An agreed package of non-financial incentives** such as training, recognition, certification, etc. is provided to CHMC members and is in line with expectations placed on members. **Community offers** appropriate forms of recognition and reward The incentives package is **known by all**, and is uniform within a defined geographic area (e.g. by region, district, etc.) **Financial support** is provided to offset the **direct costs** of participation (e.g. transport to trainings) CHMC members generally feel that the **tangible incentives and intangible benefits** (pride, esteem, value of the work) **outweigh the costs** of participation and are **motivated** to serve on the committee

9. Wider Community Support and Involvement				
Component Definition	0 **Non-functional**	1 **Minimal**	2 **Functional**	3 **Standard**
Wider Community Support and Involvement The extent to which the wider community is aware of and recognizes the value of the CHMCs. The extent to which the wider community recognizes its own role in supporting the CHMC, and participates in its activities and initiatives The extent of perceived community cohesion and collective efficacy	The wider community plays **no role in ongoing support** to CHMCs Members of the wider community **do not see a benefit** to participating in CHMC initiatives There is **no involvement or attempt** to reach the **most vulnerable and marginalized** in committee initiatives	Some community members **understand the role** that they can play in supporting the CHMC The wider community is **sometimes involved** with the CHMC (campaigns, education) and **some people** in the community recognize the **CHMC as a resource** Social/political hierarchies in the community and the influence and interests of the elite mean that the **most vulnerable and marginalized may be poorly represented or excluded** from the committee and community activities	The **role** that the wider community plays in **supporting and joining** the CHMC and supporting CHWs is **well-understood** Community members **actively participate** in meetings and initiatives led by the CHMC committee There is **intentional effort to include the most vulnerable/ marginalized** in the committee and in community activities, and levels of socio-cultural/elite resistance to this are low	**Community plays an active role in all support areas** for the CHMC, such as providing input in defining the CHMC's role, providing feedback, participating in CHMC-led community activities, and helps to establish the legitimacy of the CHMC in the community The wider community understands the value of, and is active in participating in CHMC-led activities. The CHMC is **widely recognized and appreciated** for providing service to the community The community leaders are **supportive advocates of equal participation** of the most vulnerable and marginalized The community considers its **social cohesion and effectiveness** to be high

10. CHMC Support of the Referral System				
Component Definition	0 **Non-functional**	1 **Minimal**	2 **Functional**	3 **Standard**
CHMC Support of the Referral System Processes for patient referrals and counter-referrals, from CHW to clinic and back, and the extent to which the CHMC plays a role in supporting the process; through information, tracking, logistics, emergency transport provisions or other	**No referral system** is in place ***OR*** A referral system exists but is **rarely used,** and the CHMC plays no role in supporting it **No logistics planning** in place by the community for emergency referrals	The community, the CHMC and CHWs/ health volunteers **know where referral facility is** but have **no formal referral process/**logistics, forms The **CHMC does not have any role** in supporting the referral system	The community, the CHMC and CHWs/ health volunteers know where referral facility is and **usually have the means to transport clients** The CHMC has a **process in place to support the CHW with referral** assistance when needed	The community, the CHMC and CHWs/ health volunteers know where referral facility is and usually have the **means for transport and have a functional logistics plan for emergencies** (transport, funds) The CHMC manages an **emergency transport fund** The CHMC **tracks referrals and counter-referrals** and ensures that CHWs follow up their counter-referral patients

11. Communication and Information Management				
Component Definition	0 **Non-functional**	1 **Minimal**	2 **Functional**	3 **Standard**
Communication and Information Management The extent to which data flows to the health system and back. The extent to which the CHMC makes use of data and information to identify key health issues for action and to advocate for health service improvement	The CHMC has **no access** to publicly available **health data** and does not collect any data from CHWs The CHMC **does not use health data to guide action** to address health issues and disease epidemiology The CHMC has **no access to or mechanism for tracking health service performance** data CHWs and health workers are **not formally accountable** to the community	Community **health data that does not identify individuals is publicly available at the community level.** CHMC may access the data on request from health facility or from CHWs The CHMC reviews community health data with CHWs and **takes some action** to address the key health issues and disease epidemiology The CHMC has **no access to or mechanism for tracking health service performance** data CHWs and health workers are **not formally accountable** to the community	There is a **process for documentation and information flow** of health data between health facilities, CHWs and CHMCs The CHMC reviews community health data with CHWs, and **uses the data to address** key issues and disease epidemiology and to improve health services. **Mechanisms are in place** for CHMCs to track health service performance and the CHMC **sometimes collects and makes use of this information** CHMC and community **rights and standards** for performance of CHW duties and service provision are recorded and available to community members.	There is a **process for documentation and regular two way information flow** of health data between health facilities, CHWs and CHMCs. This data is stored in such a way that it is readily accessible to members of the public. The CHMC reviews community health data with CHWs, and **uses the data to address** key health issues, and disease epidemiology, to improve health services and **reports back** to key stakeholders **Health service performance is openly accessible**. The flow of information –health facility to HCMC to community is such that the performance of the health facility and CHWs can be accessed. CHMC and community **know their rights and standards** of CHW duties and service provision.

12. Linkages to the Health System				
Component Definition	0 **Non-functional**	1 **Minimal**	2 **Functional**	3 **Standard**
Linkages to the Health System How the CHMCs and communities are linked to the larger health system. Health system is made up of government, regions, districts, municipalities and individual health facilities that provide resources, finances and management to deliver health services to the population	Links to health, local government, and other ministerial and CHMC systems are weak or non-existent; **CHMC works in isolation**	**MoH recognizes** contribution of CHMC to overall health system but **provides little or no support** **Policies exist** that describe CHMC role and **occasional monitoring visits** occur from MOH to CHMCs (yearly).	**MoH provides some support** to the fundamental mechanics of the committee. **MOH** or other entity **recognizes and occasionally attends** CHMC meetings. CHMCs **organizational goals and yearly plans are integrated** into MOH yearly plans, though **not closely monitored or supported.** Health system **supervisors have some involvement** in training CHMC. Health system guidelines are used for referrals and MOH recognizes role of CHMC in supporting logistics of referral CHMC facilitates and follows up requests for supplies and equipment but may not succeed. **NGOs often complete orders** for supplies and equipment that the MOH does not fulfill.	**CHMCs are linked to the larger health system** and local government, with a supporting management culture that encourages **transparency and openness** between the health facility, CHMCs, CHWs, community. **MoH has comprehensive support mechanisms** for the CHMCs, for supervising CHWs, & their communities. CHMCs **organizational goals and yearly plans are integrated** into MOH yearly plans, and **regularly monitored or supported.** Health system **supervisors are involved** in the training and supporting of CHMC Health system guidelines are used for referrals and MOH recognizes role of CHMC in supporting logistics of referral CHMC facilitates and follows up requests for supplies and equipment. **NGOs often complete orders** for supplies and equipment that the MOH does not fulfill.

13. Country Ownership				
Component Definition	0 **Non-functional**	1 **Minimal**	2 **Functional**	3 **Standard**
Country Ownership The extent to which the Ministry of Health (MoH) has: Integrated the CHMCs in health systems planning (e.g. policies are in place) Budgeted for financial support Provided logistical support (e.g. supervision, training) to sustain CHMC programs at the district, regional and/or national level	The CHMC **has no relationship with the MOH or other ministries** and receives no support.	The CHMC has **relationships with the MOH, health facility or local government**, and provides input, but is **not part of a legal or regulatory** system.	The **MOH or other ministries** have **policies** in place that integrate and include CHMCs in health system **planning and budgeting** processes.	The **MOH or other ministries** have **policies** that integrate and include CHMCs in health system **planning and budgeting** processes, and provide them with **logistical and financial support** to sustain them CHMCs have **legal frameworks** and are **registered** as a community based organization. CHMCs are **organized as an association** with a representation system for providing input to the government at district level and above.

14. CHMC Program Performance Evaluation				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
CHMC Program Performance Evaluation The extent to which program evaluation of CHMC performance against targets, objectives, and indicators is carried out by the CHMC supervisors Whether or not evaluations take place annually to input into the operational plans for the next year and the development and revision of strategic plans	**No regular evaluation** of program performance related to CHMC mission and objectives	**Yearly evaluation** conducted of CHMC activities but **does not assess achievements against** program **indicators** and outcomes **No feedback** provided to CHMC members on how they are performing relative to program indicators and targets	**Yearly evaluation** conducted of CHMC activities that **assesses CHMC achievements** in relation to program **indicators** and targets **Feedback** is provided to CHMC members but this may be informal and ad-hoc CHMC program is reaching at least **50% of its targets**	**Yearly evaluation** conducted of CHMC activities that **assesses CHMC achievements** in relation to program **indicators** and targets **Feedback** is provided to CHMC members in relation to program indicators and targets CHMC program is reaching at least **75% of its targets** The yearly evaluations are included as a **responsibility in the job descriptions** of relevant supervising health workers and managers The assessment includes **input from community members** regarding their level of satisfaction with the achievements of the CHMC

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