Community Health Committees (CHCs) and Health Facility Management Committees (HFMCs)

Program Functionality Assessment

A Toolkit for Improving CHC and HFMC Programs

coregroup

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Community Health Committees (CHCs) and Health Facility Management Committees (HFMCs):

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January 2017

Acknowledgements

This document was developed by Michele Gaudrault of World Vision International, and Karen LeBan, Lauren Crigler and Paul Freeman, independent consultants and members of the CORE Group.

The authors would like to thank participants of the CORE Group Global Health Practitioners Fall Conference 2015 for the valuable reactions and feedback provided during and after that event. Particular thanks go to Minal Rahimtoola and Camille Collins Lovell of Pathfinder International for their comments on earlier drafts of this product and suggestions for improvements. Appreciation is also extended to René Loewenson of Equinet (Regional Network for Equity in Health in East and Southern Africa) for sharing relevant research and discussion papers. Finally, thanks to the Siaya Sub-County Health Management Team, Kenya, and Lilian Chebon of World Vision Kenya for their support during field testing of this tool.

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Graphic Design

Holly Collins, CORE Group

Recommended Citation

Gaudrault M, LeBan K, Crigler L, Freeman P. Community Health Committees and Health Facility Management Committees: Program Functionality Assessment Toolkit. 2016. CORE Group and World Vision International, Washington D.C.

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Abbreviations

CHC	Community Health Committee
CHW	Community Health Worker
FGD	Focus Group Discussion
HFMC	Health Facility Management Committee
MoH	Ministry of Health
NGO	Non-Governmental Organization
WHO	World Health Organization

Section 1: Introduction

A. Background

The development of this tool originated from the CORE Group Fall 2014 Global Health Practitioners Conference, in a session focusing on community support for Community Health Workers (CHWs). In 1989, WHO recommended that CHW programs have the support of a group composed of members of the community with active links to the health sector. Such groups exist in many countries, known by various names such as village health committees, community health committees and the like. In addition to providing support to CHWs, these groups may perform other functions to include assessing and tracking local health status and issues, mobilizing communities for action to address identified issues, and advocating for improved health services. While the initial focus of the CORE Group session was to understand the support that such groups can provide to CHWs, attention turned to consider the strength of the groups themselves, and the support that they, too, require in order to perform successfully.

While many Ministry of Health (MoH) community health strategies around the world include community health committees, the reality on the ground shows that these groups are often weak and poorly supported. Literature and field experience suggest that before the strength of individual groups can be considered, there are fundamental programmatic, structural and policy elements that must be in place in order for the community health committee programs to function effectively. It was felt that ministries and partners could benefit from a tool that listed and described these recommended programming components, to use for assessment and programming improvements.

This tool has been developed to help Ministries of Health and supporting organizations to assess community and health facility committee *program* functionality against 14 elements deemed essential for program success; to review the scope of roles and responsibilities intended for the groups; to identify existing program strengths, and to address those elements assessed as weak. Note that the tool is not intended to assess *individual community or health facility groups* but rather to assess the functionality of the *program* as a whole, in line with the understanding that the prerequisites must be in place first, before the strength of the groups themselves can be considered.

Community Health Committees (CHCs) and Health Facility Management Committees (HFMCs)

There is extensive literature advocating for, and in some cases providing evidence to support, the importance of community participation as a means of improving community health outcomes. Ministries of Health and governments have acknowledged this, developing community health strategies that include varieties of community participation, to include processes of community mobilization, the work of CHWs, and the functions of community health groups.

This tool focuses specifically on two types of representative health groups; the Community Health Committee (CHC) and the Health Facility Management Committee (HFMC).

CHCs are typically embedded and located in the community and carry out their work there, are comprised of membership almost exclusively from within the community, and may or may not have a strong formal link with the health facility and the MoH at large. Their roles and responsibilities relate to identifying and addressing health issues within the community, and supporting community health workers and/or other volunteer health cadres. They may also be involved in actions of a social accountability nature; raising issues regarding health service performance, although the intention (in community health strategies) is that they

remain supported by MoH in any case; thereby distinguishing them from those groups that may occupy a fully autonomous space and whose primary function is to hold duty bearers to account.

The Bamako Initiative, sponsored by UNICEF and WHO and adopted by African ministers of health in 1987, saw the emergence of village committees involved in *health-facility* management, with particular success in West Africa. HFMCs now form part of community health strategies in many countries around the world. HFMCs are by definition attached to local health facilities and formally linked with MoH, usually include both community representatives and facility staff as members, and typically hold meetings and carry out their work at the facility, with a potentially lesser presence in the community as compared to CHCs. Roles and responsibilities relate more to facility management concerns, and the channeling of community health concerns to facility staff, than to work in the community as such.

Individual countries may have one or both types of group. This tool may be used with either CHCs or HFMCs. Two versions of the 'Roles Checklist' and 'Assessment and Improvement Matrix' are included; one for each type of group. In many ways, the programmatic and structural elements required for success are the same for CHCs and HFMCs, but there are enough differences between them to warrant the two versions.

Users

In most cases, responsibility for mandating, designing, managing and supporting a CHC and/or HFMC program lies – or should lie – with the Ministry of Health. As such, this tool is primarily aimed at supporting ministries to assist them to assess and improve these programs. Nonetheless, it is recognized that t is frequently the case that ministries work in partnership with non-governmental organizations (NGOs) or other agencies to implement and manage the CHC/HFMC programs. The tool, as such, is designed to be used by any implementing organization. Ideally, the exercise will be carried out by the supporting organization together with the Ministry of Health, and ultimately taken on entirely by MoH.

Objectives of the Functionality Assessment Process

- Assess functionality and guide improvement in programs working with CHCs and/or HFMCs
- Develop action planning and best practices to assist in strengthening CHCs and/or HFMCs
- Identify the location of functional CHC and/or HFMC programs and geographic gaps in coverage

B. Program Functionality Assessment Process

The functionality assessment exercise may be carried out at any time. In most cases, CHC and HFMC programs are in existence and ongoing; rarely will it be the case that the functionality assessment will be carried out at start-up of a new CHC/HFMC program (although it is recommended that it be carried out at the start of any implementing partner's support and involvement with a program). The functionality assessment will be used by ministries of health and partner agencies to assess the current state of CHC and HFMC programmatic and structural design and support elements at any point in time, with a view to improving the necessary elements as needed.

The tool is meant as a guide to aid progress rather than a rigid prescription and so covers key concepts relevant at this level of programmatic design and improvement, while recognizing that some adaptation to local contexts may be needed[1].

Facilitation: Although participatory in nature, the process should be led by an experienced facilitator. The facilitator's role is to guide the planning, implementation, and follow up of the assessment. He or she runs the workshop and ensures active participation, consensus, completion of tools and responsive action plans.

Participants: The assessment should be carried out during a workshop with multiple stakeholders knowledgeable about how the program is managed or supported and the geographic areas in which it functions. Between 15 and 25 participants is recommended, and should include MoH staff at appropriate levels, field managers, sub-national managers, CHC and/or HFMC members and their supervisors. The process promotes the involvement of CHC and/or HFMC members, as their experience and voice adds to a fair assessment.

Approach: The process is based on a guided self-assessment that allows a diverse group of participants to score their own programs against a checklist of roles and responsibilities, and against a matrix of 14 programmatic components. Following the review, the participants use the results to develop action plans to address areas assessed as weak.

The approach encourages rich discussions on actual, versus theoretical, impressions of CHC and/or HFMC programs. It allows host governments to quickly and efficiently map and assess programs using a rating scale based on literature support and good practice.

Limitations: The approach does not evaluate the strength of individual CHCs or HFMCs.

[1] 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).

C. Structure of the Functionality Assessment

There are two tools for assessing the functionality of the CHC and/or HFMC program:

1. Checklist of Roles and Responsibilities (CHC and HFMC versions)

The checklist contains nine categories of roles for CHCs and HFMCs. Each role category contains a list of possible responsibilities, distinguishing between those responsibilities that all groups should do at minimum in order for the program to be considered functional (labeled 'standard' in the checklist), and those that are considered context-specific or 'optional' (labeled 'per context' in the checklist).

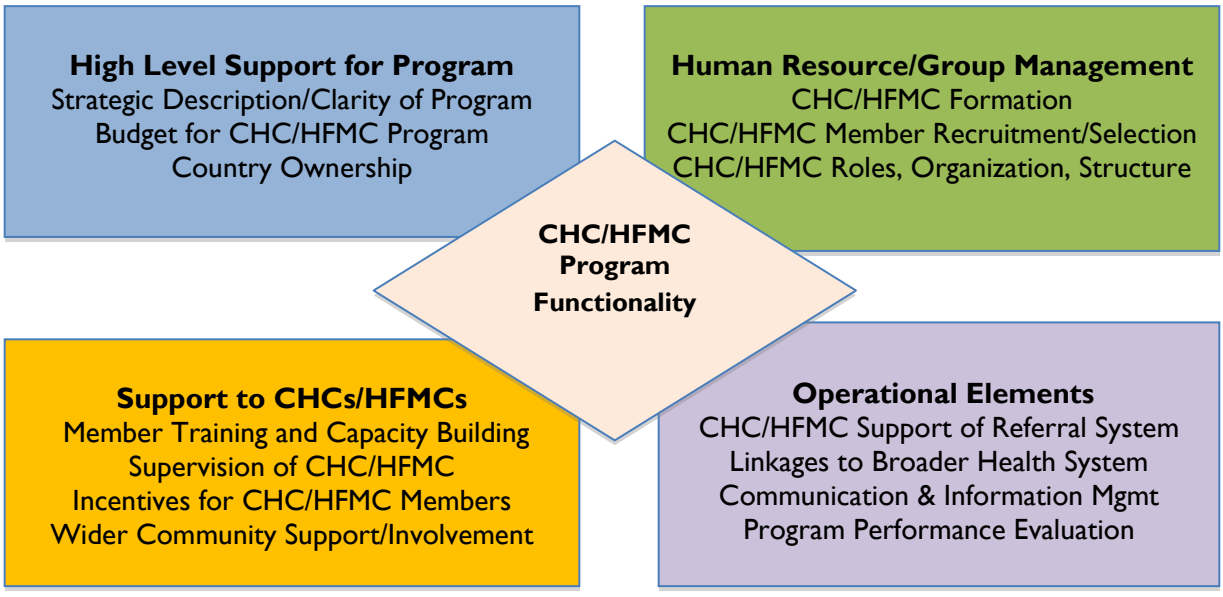
Table 1: Roles of CHCs and HFMCs

Roles
1. Link community and health service providers
2. Network with health partners and stakeholders
3. Assess and monitor community health status
4. Mobilize community outreach and action
5. Address socio-cultural norms
6. Provide leadership and governance oversight of health services
7. Mobilize resources for health activities
8. Provide support to CHW program
9. Provide oversight and support to health facility

2. Assessment and Improvement Matrix (CHC and HFMC versions)

The assessment and improvement matrix is divided into 14 components, each with descriptions of characteristics of functionality in the scoring ranges of 0-3. Figure 1 categorizes the 14 components into four main topical areas, providing an overall Program Functionality Framework

Figure 1: CHC/HFMC Program Functionality Framework



Programmatic Elements

The following 14 programmatic elements are considered essential pre-requisites for functional CHC/HFMC programs.

Table 2: CHC/HFMC 14 Essential Programmatic Elements

1. **Strategic Description and Clarity of CHC/HFMC Programming**: Whether CHCs/HFMCs are included in MoH community health strategy and their strategic intent is clearly described
2. **CHC/HFMC Formation**: How the CHCs/HFMCs are formed: what entity catalyzed and backs the program, the existence of policies and procedures, and the degree of community awareness
3. **CHC/HFMC Member Recruitment and Selection:** How members are selected and recruited to the CHCs/HFMCs
4. **CHC/HFMC Roles, Organization and Structure**: Clarity and effectiveness of CHC/HFMC organization and structure with regard to roles, expectations, decision-making and procedures
5. **CHC/HFMC Member Training and Capacity Building**: Training and capacity building provided to CHC/HFMC members to equip them with knowledge and skills to fulfill their roles
6. **Budget for CHC/HFMC Programming**: Funding available for CHC/HFMC activities, and processes for fiscal management
7. **Supervision of CHC/HFMC Members**: The extent to which CHC/HFMC members receive supportive supervision, and the incentive system for the supervisors
8. **Incentives for CHC/HFMC Members**: A balanced incentive package for CHC/HFMC members that is standardized, well known, and results in member motivation
9. **Wider Community Support and Involvement**: The extent to which the wider community is aware of, recognizes the value of and participates in the activities of the CHCs/HFMCs
10. **CHC/HFMC Support of the Referral System:** Processes for patient referrals and counter-referrals, and the extent to which the CHCs/HFMCs play a role in supporting the processes
11. **Communication and Information Management:** How data flows to and from the health system and how the CHCs/HFMCs make use of the data
12. **Linkages to the Broader Health System:** How CHCs/HFMCs are linked to the broader health system, at higher administrative levels
13. **Country Ownership**: The extent to which the MoH has policies in place that legitimize CHCs/HFMCs within the health system, and the types of MoH support to the groups
14. **CHC/HFMC Program Performance Evaluation**: General CHC/HFMC program evaluation against targets, objectives and indicators carried out on a regular basis

Section II: CHC/HFMC Program Functionality Steps and Instructions

Step 1: Pre-Workshop: Collect documents and adapt tools to program context

Collect program documents

Refer to the *Document Review Guide and Checklist for CHC/HFMC Programs* in **Appendix A.** Collect all documentation describing the CHC and/or HFMC programs and review the documents to understand how the program(s) function. If possible, speak to program managers and key MoH staff for deeper descriptive understanding. Note in the comments section of the checklist any key programming features that support or do not support good practice. Documents should be brought to the workshop as background and evidence during participant discussions.

Align CHC/HFMC Roles and Responsibilities Checklist(s)

Refer to the appropriate checklist(s) in **Appendix B**. If the assessment will be dealing with CHC programming, use the first checklist; with HFMC programming the second checklist; with both types of committees both checklists.

The checklists contain eight broad categories of roles for each type of group. Within each role category is a list of responsibilities, differentiated between core and specific-to-context. Prior to the workshop, and based on the programming documentation collected and discussions with MoH and other key implementers, determine **which categories of roles** form part of the committees' work in your country. Remove from the checklist(s) any role category that the committee(s) are not meant to perform, and print final copies of the checklist(s). The final checklist(s) should contain only those role categories that are within the purview of the committee(s) in the country, per MoH guidelines . For those role categories that remain, **do not** delete any of the responsibilities. The analysis of whether or not the committees carry out the responsibilities listed in the role categories will take place during the workshop.

Contextualize the CHC/HFMC Assessment and Improvement Matrix/Matrices

Refer to **Appendix C** for the CHC and HFMC Assessment and Improvement Matrices. Use one or both, depending on the type(s) of committee(s) you are assessing. Share the matrix/matrices with the program managers and key stakeholders. The matrices are based on good practice, but discussing them ahead of time will raise awareness about their contents and usefulness for assessing and strengthening CHC/HFMC programs. Determine if any changes are needed for the specific context. For example, you should change the titles if the committees in the country where you are carrying out the assessment go by different names; e.g. Village Health Committee, Health Center Advisory Board, etc.

Plan the Assessment Workshop

- Identify and invite participants, to include program staff, MoH representatives at various levels, CHC and/or HFMC members, CHC and/or HFMC supervisors, and representatives of CHWs or other volunteer cadres associated with the CHC and/or HFMC, if any
- Organize the field visit to take place either before or after the workshop; to carry out FGDs with between 2-3 committees of each type being assessed
- Arrange all logistics for a one or two day assessment workshop; e.g. venue, refreshments, transport, photocopies, etc.

Step 2: Assessment and Improvement Workshop[2]

Introduce the Process

You may wish to develop a brief presentation to introduce the workshop goal and objectives, and provide an overview of the *Roles and Responsibilities Checklist* and the *Assessment and Improvement Matrix*.

Explain that the CHC/HFMC program functionality assessment process is meant to ensure functionality of CHC and/or HFMC programs by rating the program(s) against 14 good practice elements, and by determining whether the CHCs and/or HFMCs are carrying out a full range of recommended responsibilities based on their roles according to program and national guidelines. The assessment and action planning process will help guide MoH and partners to improve on areas identified as weak.

The process is **not** meant to measure the performance or strength of individual CHCs and/or HFMCs.

You may also wish to lead a short session to discuss the challenges of supporting CHCs and/or HFMCs, as this would lead nicely into analyzing the programmatic components that may or may not be in place to support the committees. You could divide participants into small groups for brainstorming, followed by report back and discussion in plenary, for example.

Carry out Analysis of CHC/HFMC Roles and Responsibilities

Distribute copies of the relevant *Roles and Responsibilities Checklist(s*), per the type of group(s) you are assessing; e.g. CHC, HFMC or both. These should be the aligned, final copies of the checklist(s) that include only the role categories that the committees are meant to be carrying out per the document review and discussions regarding national guidelines that you carried out prior to the workshop. Have on hand the documents you collected prior to the workshop; e.g. national guidelines describing the CHC and/or HFMC programs and policies, etc.

Divide the participants into small groups and assign each group one or more role categories. (You may have some groups reflecting on CHCs and others on HFMCs, if you are assessing both types of committees.) Using their own knowledge and experience with CHCs and/or HFMCs, and referring to the background documents, they should determine which of the responsibilities listed in the role categories are meant to be carried out by the committees, and complete the checklist accordingly.

Return to plenary and consolidate the results on flip charts. Zero in on any responsibilities indicated as 'core' that the committees are **not** carrying out. Good practice recommends that for CHC/HFMC programs to be considered functional, the committees should ideally be carrying out a minimum range of core responsibilities – anything less than the core range is less than comprehensive and therefore less than functional. Lead a discussion to determine if the participants agree that these core responsibilities should in fact be considered 'minimum standards', and if there is a consensus for adding missing responsibilities into the committees' mandates.

If the participants (including the Ministry of Health) agree that there are gaps in the committees' range of responsibilities, the MoH may consider whether they will update guidelines to include new areas. Explain to

[2] Workshop process 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).

participants that they will fill out an action plan later in the workshop, and the MoH may choose to include actions related to the guidelines at that time.

Review the Validation Questionnaire, prepare for field visit

Ideally, the workshop will be organized such that the field visit to meet with CHCs and/or HFMCs takes place prior to scoring the *Assessment and Improvement Matrix/Matrices*. By gathering information and views directly from CHC/HFMC members the scoring will be a more accurate reflection of the status of programming, than if the scoring were carried out by relying only on the information and views of the workshop participants.

Distribute copies of **Appendix D:** the *CHC/HFMC Validation Questionnaire*. Note that the same questionnaire can be used with either type of committee. Explain that the participants will use the questionnaire as a guide for leading Focus Group Discussions (FGDs) with members of CHCs and/or HFMCs. The questions aim to provide information around the 14 elements of the *Assessment and Improvement Matrices.*

If you feel that the participants require explanation and practice carrying out FGDs you may build that into the workshop. You will need to locate materials that will prepare you to lead a session on how to carry out effective FGDs, and what to observe for when participants practice/simulate an FGD.

Carry out Field Visit: FGDs with CHC and/or HFMC members

You should aim to carry out a minimum of two FGDs with each type of committee you are assessing. (i.e. two FGDs with CHCs, and/or two with HFMCs). The number of FGDs should be increased if the types of groups or the characteristics of the settings and communities vary widely within the country, to ensure that representative information is gathered from these various contexts. The number of committee members participating in an FGD should not exceed 12, to enable good discussion by all. You will probably want to split the workshop participants into groups; with each group carrying out perhaps two FGDs in one day of field work. Ensure that all logistics are in place.

Following the field visit (either on the same day or the morning of the next day), the workshop participants will come together and debrief; sharing the information they gathered from their respective FGDs.

Score the Assessment and Improvement Matrix/Matrices

Distribute copies of the relevant *Assessment and Improvement Matrix/Matrices*, per the type of group you are assessing; e.g. CHC, HFMC or both. Distribute copies of **Appendix E**, the *Score and Score Rationale Documentation Worksheet.*

Carry out the scoring process for the first element of the *Assessment and Improvement Matrix* (Strategic Description and Clarity of CHC and/or HFMC Programming) in plenary. Read the description in the first column. Have the participants silently read the descriptions for each level of functionality 0-3 and decide how they would score their program, based on how the program matches the criteria under each level of functionality. Note that there are no 'half scores' such as 2.5. They must score a full 0, 1, 2, or 3, and the program must meet all the criteria to fit a particular score. Give the participants time to make their assessments and then ask how many scored 0, 1, 2 or 3; write the numbers on a flip chart. Ask those whose scores differ from the majority to justify their responses. Encourage discussion until consensus is reached on a final score. Ask if there are any questions, clarify them and provide feedback.

Explain that they will use the *Score and Score Rationale Documentation Worksheet* to document and justify their scores. Explain that the remaining section of the matrix/matrices will be done in small groups.

Divide the participants into groups and assign matrix elements to each group. You may have some groups assessing CHCs and some assessing HFMCs if you are working with both types of committees. Ensure that the groups are evenly balanced in terms of the types of stakeholders represented (e.g. MoH staff, implementing partner staff, CHC and/or HFMC members, etc.)

The groups should discuss and reach consensus on the score for each element assigned to them. They should refer to the program documents provided by you, the information from the FGDs and their own knowledge and experience with the committees to decide on the scores. They will record their scores and justification on the worksheet. They should also begin to think of the types of actions that could be recommended to improve the scores as necessary, and write their ideas in the corresponding column.

Once all groups have finished, return to plenary. Each small group will present their results, which should be followed by plenary discussion to reach consensus on a final score. Allow ample time for discussion at this stage – this is the heart of the functionality assessment process and deep discussion around the CHC and/or HFMC programming should take place in order to grapple with the issues that are problematic, the challenges that the programs are facing, and to think through the best ways of working through these and bringing programming up to high levels of functionality. Record the final scores on a flip chart.

***Alternative*:** As an alternative, the FGDs with the CHC and/or HFMC members may be carried out *after* the scoring process. In this scenario, the participants will score during the workshop based on their knowledge and experience with CHCs/HFMCs, and then use the FGDs as opportunities to validate and perhaps adjust the scores taking into account the perspectives of the committee members. The advantage of this alternative is that it provides an opportunity to clarify with the committees any issues that may have surfaced during the workshop discussions. The FGD questionnaire should be reviewed before the field exercise to identify the questions that refer to any such issues, so that the FGDs can focus in on those questions specifically. Nonetheless, the participants should still plan to ask *all* the questions in the FGDs. This will ensure that the scoring is not based on assumptions but, rather, on the actual views of all involved. The CHC/HFMC members may also have input into actions to be included in the action plan, below.

Create an Action Plan

Distribute copies of **Appendix F**: *Action Plan Framework*, or have the participants write on flip charts. You may break the participants into small groups again, or work in plenary. An action plan should be developed in order to: (1) incorporate new responsibilities into the committee(s)' scope of work, if required per the *Roles and Responsibilities Checklist* assessment, and (2) improve any programmatic elements scoring less than 3. Ideally the workshop participants will include those decision-makers who can authorize changes and authorize the actions needing to be taken. If decision-makers are not present then the actions can be presented as recommendations, and followed up with decision-makers at a later stage.

Next Steps and Follow Up

Ensure that steps are agreed for bringing the action plan forward prior to closing the workshop. Hold a follow-up meeting at a later date with MoH, program managers and some of the participants from the workshop, to review the action plan and to discuss how to complete it. Share the final action plan with all stakeholders for their knowledge and assistance. Discuss how the plan will be monitored. If more than one location or organization has been involved, consider a meeting of representatives from all sites to periodically share effective actions and discuss challenges and achievements.

Appendices

Appendix A: Document Review Guide and Checklist for CHC/HFMC Programs

Instructions[3]**:** This document should be completed in advance of the assessment workshop by the facilitator as part of pre-workshop preparation. If possible, conduct interviews with program managers and supervisors to review documentation and understand how the program functions and how the documentation might inform the workshop assessment and scoring process. Note in the Comments section any key elements that support or do not support good practice. Documents should be brought to the workshop as supporting evidence during participant discussions.

Review of CHC/HFMC Program Policies and Procedures

Membership and recruitment of CHCs/HFMCs		
Does the program have written guidelines for the membership of CHCs/HFMCs?	Yes_____ No_____	Comments
Does the program have written guidelines for how CHC/HFMC members should be recruited?	Yes_____ No_____	Comments
CHC/HFMC organization and structure		
Does the program have written guidelines for the leadership structure of the CHC/HFMC? (i.e. Chairperson, etc.)	Yes_____ No _____	Comments
Roles of CHC/HFMC		
Does the program have written guidelines describing the roles of CHCs/HFMCs?	Yes_____ No _____	Comments
Does the program have written guidelines specifying the roles and relationships of CHCs/HFMCs vis-à-vis CHWs?	Yes_____ No_____	Comments
CHC/HFMC member training and capacity building		
Are there program records that track how many CHCs/HFMCs/members have received training?	Yes_____ No_____	Comments
Are there written guidelines that specify what topics should be covered during training?	Yes _____ No _____	Comments
According to the program, is there a specific time period during which the CHC/HFMC should receive initial training?	Yes_____ No _____	Comments

[3] 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).

Budget for CHC/HFMC programming		
Is there an authorized budgetary line item in the health sector's budget to financially support the CHC/HFMC program?	Yes _____ No _____	Comments
Are there guidelines that specify CHC/HFMC authority on revenue generated by the health facility?	Yes _____ No _____	Comments
Supervision of CHC/HFMC members		
Are there guidelines that specify who should supervise the CHCs/HFMCs?	Yes _____ No _____	Comments
Are there program guidelines that specify how often supervision visits take place?	Yes _____ No _____	Comments
Are there written guidelines to determine what should take place during a supervision visit?	Yes _____ No _____	Comments
Do supervision checklists or any other supervision tools exist to help guide supervision?	Yes _____ No _____	Comments
Incentives		
According to program documents, are any financial or non-financial incentives provided to CHCs/HFMCs by the program or the MoH?	Yes _____ No _____	Comments
Community support		
Does program documentation specify the role that the community should play in supporting CHCs/HFMCs? (i.e. providing feedback, providing incentives)	Yes _____ No _____	Comments
Information management		
Does program documentation specify health information that CHCs/HFMCs should be accessing, analyzing and sharing?	Yes _____ No _____	Comments
Program performance evaluation		
Is there a process for conducting performance evaluations of CHCs/HFMCs?	Yes _____ No _____	Comments
Does the process include community feedback?	Yes _____ No _____	Comments
Are CHC/HFMC activities evaluated based on program targets, objectives and indicators?	Yes _____ No _____	Comments
Country ownership		
Do national policies exist regarding the role of CHCs/HFMCs?	Yes _____ No _____	Comments

Appendix B: CHC and HFMC Roles and Responsibilities Checklists

I. Community Health Committee (CHC) Roles and Responsibilities

1. Link Community and Health Service Providers

CHC Responsibilities	Recomm.	√
Work closely with Health Facility Management Committee (HFMC) where these exist to improve access of the community to health services	Standard	
Send representative(s) to health facility committee meetings or hold quarterly meetings with the HFMC	Standard	
Report community health status and represent community needs to health service providers	Standard	
Ensure that community needs are integrated in the health facility action plan	Standard	
Serve as conduit for grievances in relation to health service performance	Per context	
Facilitate feedback to community on operations and management of health facility	Per context	

II. Network with Health Partners and Stakeholders

CHC Responsibilities	Recomm.	√
Organize periodic community meetings with open participation, inviting all health stakeholders	Standard	
Meet periodically with community health partners (NGOs, CBOs, etc.)	Standard	
Facilitate working together of existing community based health actors	Standard	

III. Assess and Monitor Community Health Status

CHC Responsibilities	Recomm.	√
Conduct 'Participatory Learning & Action' (PLA) activities in the community for health situation analysis	Standard	
Identify vulnerable or high-risk groups, include in situation analysis	Standard	
Collect and analyze aggregated data from CHWs	Standard	
Monitor and report disease outbreaks	Standard	
Report community health status to health facility	Standard	
Create and maintain a 'community health information board' with relevant health information and updates	Standard	
Collect and analyze secondary data/health statistics	Per context	
Conduct periodic Focus Group Discussions with select community groups (e.g. pregnant women, adolescents, etc.) to collect primary data	Per context	
Conduct periodic Key Informant Interviews at health facilities and with other key health stakeholders	Per context	
Conduct structured barrier analysis around health practices	Per context	
Collect household/community health behavioral data on periodic basis	Per context	
Investigate adverse health events	Per context	

IV. Mobilize Community Outreach and Action

CHC Responsibilities	Recomm.	√
Develop Village Health Plans and share with community and health facility	Standard	
Improve community health literacy (e.g. organize health information campaigns, awareness raising etc.)	Standard	
Mobilize community to participate in clinic outreach events	Standard	
Support home visitation programs, community-level support groups, peer group activities etc.	Standard	
Report activities to community and health facility	Standard	
Network with other sectors and development stakeholders towards improving the health status of the community (Ministries of agriculture, education, etc.)	Per context	
Plan environmental sanitation activities (clean-ups, stagnant water removal, etc.)	Per context	
Create and manage emergency transport fund	Per context	

V. Address Socio-Cultural Norms

CHC Responsibilities	Recomm.	√
Identify harmful cultural/social norms, bring attention to them, and plan activities to challenge them	Standard	
Engage faith leaders to challenge harmful social/cultural norms	Per context	
Engage local politicians to challenge harmful social / cultural norms	Per context	
Engage media to report on actions to address harmful social / cultural norms	Per context	

VI. Provide Leadership and Governance Oversight of Health Services

CHC Responsibilities	Recomm.	√
Inform community of health rights	Standard	
Provide health facilities with community feedback on services	Standard	
Facilitate negotiations and help resolve stakeholder conflict	Standard	
Ensure health facility duty bearers are accountable to communities	Per context	
Visit health facilities to monitor health services	Per context	
Use visible community scorecards to track health service performance	Per context	

VII. Resource Mobilization

CHC Responsibilities	Recomm.	√
Facilitate resource mobilization for implementation of community work plan (Village Health Plan), ensuring accountability and transparency	Standard	
Organize and manage community contributions for community health activities	Per context	

VIII. Provide Support to CHW Program

Element of CHW program	CHC Responsibilities	Recomm.	√
CHW Recruitment	Mobilize community to review, contribute to recruitment criteria	Standard	
	Map community groups to inform recruitment process	Standard	
	Mobilize community participation in selection of new CHWs	Standard	
CHW Role	Ensure community understands CHW role	Standard	
	Define agreement (preferably in written form) on CHC's role vis-à-vis CHWs	Standard	
	Ensure community is aware of processes for grievances	Standard	
	Report to CHW supervisor when CHMS/community becomes aware of CHW infractions	Standard	
CHW Training	Orient CHC members on CHW training	Per context	
	CHMS members visit trainings (make visible connections, reinforce value)	Per context	
	Enable community feedback on training curricula (priority topics, etc.)	Per context	
	Track trainings, attendance, equity in training opportunities	Per context	
Equipment & Supplies	Monitor CHW stock control forms if relevant	Standard	
	Alert supervisor of any suspected CHW misuse of stock	Standard	
CHW Supervision	Meet periodically with CHWs to discuss concerns, address issues	Standard	
	Interact with CHW supervisor during visits to provide feedback and solve problems; invite community members to participate	Standard	
CHW Individual Performance Appraisal	Provide feedback on CHW performance	Standard	
	Solicit input from community on CHW performance	Standard	
	Ask CHW to provide feedback to CHC on its performance	Standard	
CHW Incentives	Mobilize community to ensure CHWs receive locally appropriate recognition for good performance	Standard	
Referral system	Understand and support the referral system	Standard	
	Establish community support for referrals e.g. emergency transport fund or identifying alternative transport	Per context	
Opportunity for Advancement	Recommend CHWs to health facility	Per context	
	Recommend when new CHW position should be created or additional training is needed for CHWs. (e.g. scholarship, literacy training)	Per context	
Documentation, Information Management	Understand the reporting forms that CHWs use	Standard	
	Obtain aggregated data from CHW to present in community meetings	Standard	
	Carry out spot checks in community to ensure CHWs are doing the work claimed on reporting forms	Standard	
	Identify barriers to data collection and use and helps solve issues	Standard	
Linkages to health system	Use CHW data to advocate for quality improvement in health services and timely CHW supplies	Standard	
	Ensure CHW is active, performing well, collecting accurate data	Per context	
	Recognize CHWs for performance	Per context	

IX. Provide Oversight and Support of Health Facility

HFMC Responsibilities	Recomm.	√
Support facility community outreach work	Standard	
Support facility communications with the public	Standard	
Contribute to preventive maintenance and security of the health facility infrastructure	Standard	
Mobilize community to participate in development projects at health facility	Standard	

II Health Facility Management Committee (HFMC) Roles and Responsibilities

1. Link Community and Health Service Providers

HFMC Responsibilities	Recomm.	√
Work closely with Community Health Committees (CHCs) where these exist to improve access of the community to health services	Standard	
Report community health status and represent community needs to health service providers	Standard	
Ensure that community needs are integrated in the health facility action plan	Standard	
Serve as conduit for grievances in relation to health service performance	Standard	
Facilitate feedback to community on operations and management of health facility	Standard	

II. Network with Health Partners and Stakeholders

HFMC Responsibilities	Recomm.	√
Organize periodic community meetings with open participation, inviting all health stakeholders, or participate in such meetings organized by CHCs	Standard	
Meet periodically with community health partners (NGOs, CBOs, etc.)	Per context	
Facilitate working together of existing community based health actors	Per context	

III. Assess and Monitor Community Health Status

HFMC Responsibilities	Recomm.	√
Monitor and report disease outbreaks	Standard	
Report community health status to health facility	Standard	
Create and maintain a 'facility health information board' with relevant health information and updates	Standard	
Conduct 'Participatory Learning & Action' (PLA) activities in the community for health situation analysis	Per context	
Identify vulnerable or high-risk groups, include in situation analysis	Per context	
Collect and analyze aggregated data from CHWs	Per context	
Collect and analyze secondary data/health statistics	Per context	
Conduct periodic Focus Group Discussions with select community groups (e.g. pregnant women, adolescents, etc.) to collect primary data	Per context	
Conduct periodic Key Informant Interviews at health facilities and with other key health stakeholders	Per context	
Conduct structured barrier analysis around health practices	Per context	
Collect household/community health behavioral data on periodic basis	Per context	
Investigate adverse health events	Per context	

IV. Mobilize Community Outreach and Action

HFMC Responsibilities	Recomm.	√
Develop Facility Health Plans and share with community and health facility	Standard	
Report activities to community and health facility	Standard	
Network with other sectors and development stakeholders towards improving the health status of the community (Ministries of agriculture, education, etc.)	Standard	
Create and manage emergency transport fund	Standard	
Improve community health literacy (e.g. organize health information campaigns, awareness raising etc.)	Per context	
Mobilize community to participate in clinic outreach events	Per context	
Support home visitation programs, community-level support groups, peer group activities etc.	Per context	
Plan environmental sanitation activities (clean-ups, stagnant water removal, etc.)	Per context	

V. Address Socio-Cultural Norms

HFMC Responsibilities	Recomm.	√
Identify harmful cultural/social norms, bring attention to them, and plan activities to challenge them	Per context	
Engage faith leaders to challenge harmful social/cultural norms	Per context	
Engage local politicians to challenge harmful social / cultural norms	Per context	
Engage media to report on actions to address harmful social / cultural norms	Per context	

VI. Provide Leadership and Governance Oversight of Health Services

HFMC Responsibilities	Recomm.	√
Inform community of health rights	Standard	
Provide health facilities with community feedback on services	Standard	
Facilitate negotiations and help resolve stakeholder conflict	Standard	
Ensure health facility duty bearers are accountable to communities	Standard	
Visit health facilities to monitor health services	Standard	
Use visible community scorecards to track health service performance	Per context	

VII. Resource Mobilization

HFMC Responsibilities	Recomm.	√
Facilitate resource mobilization for implementation of community work plan (Village Health Plan), ensuring accountability and transparency	Standard	
Organize and manage community contributions for community health activities	Standard	

VIII. Provide Support to CHW Program

Element of CHW program	CHC Responsibilities	Recomm.	√
Opportunity for Advancement	Recommend when new CHW position should be created or additional training is needed	Standard	
Documentation, Information Management	Identify barriers to data collection and use and help solve issues	Standard	
Linkages to Health System	Recognize CHWs for performance	Standard	
	Use CHW data to advocate for quality improvement in health services and timely CHW supplies	Standard	

IX. Provide Oversight and Support of Health Facility

HFMC Responsibilities	Recomm.	√
Oversee adherence and provision of Primary Health Care package at facility, including general norms and standards	Standard	
Monitor and report the extent the health facility is meeting and achieving the health indicators and targets set for primary health care	Standard	
Oversee and give community feedback on the operations, management and quality of services in facility	Standard	
Identify community needs and ensure they are integrated into the health facility action plan	Standard	
Monitor health facility budget and expenditure	Standard	
Monitor the extent to which facility addresses and resolves complaints submitted by the community	Standard	
Facilitate access to facility information	Standard	
Consolidate, analyze, use and disseminate data	Standard	
Interpret government health policies to the communities	Standard	
Support facility community outreach work, including patient follow up at grassroots level	Standard	
Support facility communications with the public	Standard	
Monitor procurement, storage and utilization of all facility goods and services in line with government regulations	Standard	
Develop health facility plans and budget	Standard	
Contribute to preventive maintenance and security of the health facility infrastructure	Standard	
Mobilize community contributions to community health fund	Standard	
Mobilize community to participate in development projects at health facility	Standard	

Appendix C: CHC and HFMC Assessment and Improvement Matrices

I. Community Health Committee (CHC): Assessment and Improvement Matrix

1. Strategic Description and Clarity of Community Health Committee (CHC) Programming				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
CHCs are included in MoH community health strategy and their strategic intent is clearly described	**MOH is not involved** in establishing or supporting CHCs. The CHCs may have been formed through NGO or other organizations, with no link to MoH	**MoH** is the recognized institutional body convening the CHCs, but the roles and functions of these groups are **not formalized** in policies or strategies for community health	**CHCs form part of MoH policies, strategies** and/or action plans for community health, and the strategic intent, roles and functions of these groups is **clearly described** in written documentation	**CHCs form part of MoH policies, strategies** and action plans for community health and the strategic intent, roles and functions of these groups is **clearly described** in written documentation. The policy/strategy is reviewed on a regular basis and updated as needed
If strategy calls for both HFMCs and CHCs, the strategic intent and functions of these two groups are clearly described and differentiated	Where HFMCs are operational alongside CHCs, the **MoH is not involved** in establishing or supporting the CHCs	Where HFMCs are operational alongside CHCs, **MoH** is the recognized institutional body convening these groups, but the **distinctions between the two types of groups is not described** in policies or strategies for community health	Where HFMCs are operational alongside CHCs, the existence of these two groups forms part of MoH policies or strategies for community health, but the distinction between the two groups is poorly understood in practice	Where HFMCs are operational alongside CHCs, the existence of these two groups forms part of MoH policies or strategies for community health, and the strategic intent and functions of these two groups are clearly described and differentiated

2. CHC Formation				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
How the CHCs are formed: To what extent the CHC members are organized, and clear on the purpose, mission and importance of the group's work	**CHCs exist but** meet infrequently with no clear objectives or direction	**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 CHC members have **a vague idea** of why their group should exist	**Organized CHCs exist** that meet on a regular basis and keep records of meetings CHC members **have an idea of what a healthy community is,** and agree on their overall **mission and objectives**, but are not put in writing.	**Organized CHCs exist that** meet on a regular basis and keep records of meetings CHC 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. CHCs have **written mission and objectives**
What entity catalyzed the program and backs and supports it; e.g. Ministry of Health (MoH), independent NGO efforts, etc, and whether or not there are MoH policies, procedures and to support the formation and continuance of the CHCs	**MOH is not involved** in establishing or supporting CHCs. The CHCs may have been formed through NGO or other organizations, with no link to MoH	**MoH** catalyzed the formation of the CHCs, but MoH involvement with the groups in practice is limited	**MoH** catalyzed the formation of the CHCs and MoH - often in partnership with NGOs – provides some supervision and guidance	**MoH** catalyzed the formation of the CHCs and MoH supports the groups through participation, guidance, and supervision
The degree of community awareness and participation in CHC formation	The **wider community is unaware** of the CHCs and/or the purpose of these groups	Some community members are aware of the informal organization, but the community was **not consulted** in CHC formation.	**Community members are aware** of intended structure and purpose of CHCs, and participate in some, but not all of the committee formation process	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

3. CHC Member Recruitment and Selection				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
The processes by which CHC members are identified and selected, including selection criteria, community involvement in selection, and degree of representation (of various segments of the community) of CHC members. Selection criteria should focus on: inclusiveness of all subgroups in the community and motivation of members to do work	**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 CHC 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 CHCs and some position openings, but primarily through discussion or personal relationships Community is not involved in the recruitment of CHC 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 CHC members reach most of the community through regular community communication channels (e.g. through community leaders) **Community is involved in recruitment** of CHC 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. CHC member recruitment is **intentionally communicated** through multiple communications prior to group formation and recruitment of new members. **Community is involved in recruitment** of CHC 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

4. CHC Roles, Organization and Structure				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
Clarity and effectiveness of CHC organization and structure with regard to roles, expectations, frequency, decision-making and procedures	**Roles of the CHCs** are not defined or documented The **roles of the various members** of the CHC (e.g. leaders, etc.) are not defined or documented **Expectations** of the committee are not defined or documented	CHC members may have some ideas about the **roles of the group**, but these are not documented The **CHCs** may have defined the **roles of the various members** and an **organizational structure** (e.g. leadership positions etc.) for themselves, but these are not documented **Expectations** (e.g. time commitment, frequency of meetings) and **tasks** are discussed in CHCs but are **not specific or documented, or shared with community** The **decision-making authority** of the CHCs with regard to health services is not established, is unclear or is contested	**Roles of the CHCs** are clearly defined and documented but *not* communicated to community members or MOH The **roles of the various CHC members and the groups' organizational structure** (e.g. leadership positions, etc.) are clearly defined and documented but not communicated to community members or MoH **Expectations** (e.g. time commitment, frequency of meetings) and are discussed and **specific in CHCs but have not been shared with community members** The CHCs' **decision-making authority** with regard to health services is clearly established within the CHCs but not communicated (others not aware) **No process exists for updating** and discussing roles, expectations and tasks	**Roles of the CHCs** are clearly defined and documented and are communicated to community members and MOH **The roles of the various CHC members and the groups' organizational structure** (e.g. leadership positions, etc.) are clearly defined and documented, and are communicated to community members and MoH **Expectations** (e.g. time commitment, frequency of meetings) and **tasks** are discussed and **specific and communicated to** the MOH, the community, involved organizations and the committees themselves The CHCs' **decision-making authority** with regard to health services is clearly established and communicated so that others are aware **Process for updating** and discussing roles, expectations and tasks is in place

5. CHC Member Training and Capacity Building				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
Training provided to the CHC 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, , systematic training plan to include initial and ongoing training; relevant and sufficient content vis-a-vis the CHCs' roles and responsibilities, The extent to which the training system is responsive to the fact that the CHCs are 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 CHCs can function as a whole.	**No or minimal training** is provided to the CHC members ***OR*** Minimal initial training is provided (e.g. one workshop) that does not adequately prepare the CHCs to fulfil their functions The MoH has no responsibility for training the CHCs	**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 CHC training, but rely on NGOs/other partners (training not institutionalized in MoH)	A **training plan** exists within the local health system for new committee members and **training** generally takes place . **Content** of training includes at minimum enabling CHCs to understand their roles, and basic skills needed to carry them out, to include **community health situation analysis, use of data for decision making, 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.) The MoH takes responsibility for CHC training but often requests assistance from NGOs/other partners (e.g. training partially institutionalized w/in MoH)	A **training plan** exists within the local health system and **regular training** to the plan for all CHC members takes place. **Initial training** in all necessary **content** (listed in column 2), 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 **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. The training of CHCs is fully institutionalized within the MoH and carried out by MoH/clinic staff, with NGOs/partners playing only a supportive role as needed

6. Budget for CHC Programming				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
The extent to which CHCs have the legal mandate and authority to develop an annual budget and manage revenue from the government, user fees from clinics, or donations from the community to support community health activities The extent to which processes are in place for fiscal management and the CHCs go through annual audit / verification processes	CHCs have **no budget or funding** to perform or support community activities that improve health	CHCs have **no budget** but receive **one-off funding** from MOH to tackle a specific health issue	CHCs have an **annual budget from MoH and consistent funding** to enable the CHCs and/or communities to take small, doable action to support CHWs, and other health focused activities Processes are in place for **financial management**	CHCs have the **legal mandate and authority** to develop an **annual budget** and manage revenue from the government, and donations from the community including local businesses to support community health activities CHCs are able to submit proposals for funding to other potential funding sources Processes are in place for **financial management** and CHCs go through annual **audit** / verification processes The CHCs have **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 CHC Members				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
The extent to which CHC 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 CHCs to reach their objectives and fulfill their mission. Frequency and purpose of supervisory contacts, and action and documentation resulting from the contacts	There is **no supervision** of the CHCs; neither through MoH nor **other mechanisms *OR*** Health staff are meant to supervise the CHCs 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 CHCs.	The MoH has a **formal supervisory relationship** with the CHCs, or **other supervisory mechanisms are occasionally used** **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	The **MOH** has **policies** in place that describe **regular supervision** processes to provide support, coaching and problem solving to CHCs ***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**	The **MOH** has **policies** in place that describe **regular supervision** processes to provide support, coaching and problem solving to CHCs ***AND*** An **alternative 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 CHC member development** and on the job training planned, monitored evaluated, and documented with local community leaders & wider community

Incentives for supervisors: the extent to which the supervisors of the CHCs are compensated for costs of supervisory work and provided with opportunities for continuing education for further career development.	There are **no incentives** or forms of recognition for the supervisors of the CHCs Supervisors of the CHCs are not compensated for time or expenses in order to perform their supervisory role	Supervisor(s) receive **no incentives** package, financial or non-financial but **appreciation from the CHCs** is considered a reward Supervisors of the CHCs are not compensated for time or expenses in order to perform their supervisory role	**Some unstandardized non-financial incentives** are offered to the supervisors of the CHCs Financial support is provided to the supervisors of the CHCs to **offset the direct costs** of the supervisory work	**An agreed package of non-financial incentives** is provided to supervisors of the CHCs and is in line with general expectations placed on supervisors Financial support is provided to the supervisors of the CHCs to **offset the direct costs** of the supervisory work

8. Incentives for CHC members				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
The types of incentives received by CHC 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 CHC member motivation The extent to which incentives provided are appropriate to the training, level of effort and time commitment that a CHC member needs to input to do their work satisfactorily.	CHC 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/reimbursement) CHC 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/reimbursement) There is mixed feeling among CHC 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 CHC 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/reimbursement) CHC 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 CHC members and is in line with expectations placed on members. The incentives package is **known by all**, and is uniform within a defined geographic area (e.g. district, etc.) **Community offers** appropriate forms of recognition and reward **Financial support** is provided to offset the **direct costs** of participation (e.g. transport to trainings/reimbursement) CHC 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**
The extent to which the wider community is aware of and recognizes the value of the CHCs. The extent to which the wider community recognizes its own role in supporting the CHCs, and participates in their activities and initiatives	The wider community plays **no role in ongoing support** to CHCs	Some community members **understand the role** that they can play in supporting the CHCs	The **role** that the wider community plays in **joining** the CHCs, **participating** in CHC-led activities and **supporting** CHWs is **well-understood**	**Community plays an active role in all support areas** for the CHCs, such as providing input in defining the CHC's role, providing feedback, participating in CHC-led community activities, and helps to establish the legitimacy of the CHCs in the community
	Members of the wider community **do not see a benefit** to participating in CHC activities	The wider community is **sometimes involved** with the CHCs (campaigns, education) and **some people** in the community recognize the **CHCs as a resource**	Community members **actively participate** in meetings and activities led by the CHCs	The wider community understands the value of, and is active in participating in CHC-led activities.
	There is **no involvement or attempt** to reach the **most vulnerable and marginalized** in CHC initiatives	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 CHC and community activities	There is **intentional effort to include the most vulnerable/ marginalized** in CHC and in community activities, and levels of socio-cultural/elite resistance to this are low Community members share concerns about community health with the CHCs and actively seek their involvement in addressing the concerns	The community leaders are **supportive advocates of equal participation** of the most vulnerable and marginalized The CHCs are **recognized and appreciated** for being a vehicle for the community to raise concerns, and for providing service to the community

10. CHC Support of the Referral System				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
Processes for patient referrals and counter-referrals, from CHW to clinic and back, and the extent to which the CHCs play 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 CHCs play no role in supporting it **No logistics planning** in place by the community for emergency referrals	The community, the CHCs and CHWs/ health volunteers **know where referral facility is** but have **no formal referral process/**logistics, forms The **CHCs do not have any role** in supporting the referral system	The community, the CHCs and CHWs/ health volunteers know where referral facility is and **usually have the means to transport clients** The CHCs have **processes in place to support the CHW with referral** assistance when needed	The community, the CHCs 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 CHCs manage **emergency transport funds**

11. Communication and Information Management				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
The extent to which data flows to the health system and back. The extent to which CHCs make use of data and information to identify key health issues for action and to advocate for health service improvement	The CHCs have **no access** to publicly available **health data** and do not collect any data from CHWs	Community **health data that does not identify individuals is publicly available at the community level.** CHCs may access the data on request from health facility or from CHWs	There is a **process for documentation and information flow** of health data between health facilities, CHWs and CHCs	There is a **process for documentation and regular two way information flow** of health data between health facilities, CHWs and CHCs. This data is stored in such a way that it is readily accessible to members of the public.
	The CHCs **do not use health data to guide action** to address health issues and disease epidemiology	The CHCs review community health data with CHWs and **take some action** to address the key health issues and disease epidemiology	The CHCs review community health data with CHWs, and **use the data to verify/ascertain equity in health services, to address** key issues and disease epidemiology and to improve health services.	The CHCs review community health data with CHWs, and **use the data to verify equity in health services to address** key health issues, and disease epidemiology, to improve health services, and **report back** to stakeholders
	The CHCs have **no access to or mechanism for tracking health service performance** data	The CHCs have **no access to or mechanism for tracking health service performance** data	**Mechanisms are in place** for CHCs to track health service performance and the CHCs **sometimes collect and make use of this information**	**Health service performance is openly accessible**. The flow of information –health facility to CHC to community - is such that the performance of the health facility and CHWs can be accessed.
	CHWs and health workers are **not formally accountable** to the community	CHWs and health workers are **not formally accountable** to the community	CHC and community **rights and standards** for performance of CHW duties and service provision are recorded and available to community members.	CHCs 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**
How the CHCs 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 systems are weak or non-existent; **CHCs work in isolation**	**MoH and other stakeholders recognize** contribution of CHCs to overall health system but **provide little or no support**	**MoH and other stakeholders provide some support** to the fundamental mechanics of the CHCs. CHCs **organizational goals and yearly plans are integrated** into MOH yearly plans, though **not closely monitored or supported.**	**CHCs are linked to the larger health system** and local government, with a supporting management culture that encourages **transparency and openness** between the health facility, CHCs, CHWs, community. CHCs **organizational goals and yearly plans are integrated** into MOH yearly plans, and **regularly monitored or supported.**

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

14. CHC Program Performance Evaluation				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
The extent to which program evaluation of CHC performance against targets, objectives, and indicators is carried out by the CHC 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 CHCs' mission and objectives	**Yearly evaluation** conducted of CHCs' activities but **does not assess achievements against** program **indicators** and outcomes **No feedback** provided to CHC members on how they are performing relative to program indicators and targets	**Yearly evaluation** conducted of CHCs' activities that **assesses CHC achievements** in relation to program **indicators** and targets **Feedback** is provided to CHC members but this may be informal and ad-hoc The CHC program is reaching at least **50% of its targets**	**Yearly evaluation** conducted of CHCs' activities that **assesses CHC achievements** in relation to program **indicators** and targets **Feedback** is provided to CHC members in relation to program indicators and targets The CHC 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 CHCs

II. Health Facility Management Committee (HFMC): Assessment and Improvement Matrix

I. Strategic Description and Clarity of Health Facility Management Committee (HFMC) Programming				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
HFMCs are included in MoH community health strategy and their strategic intent is clearly described	**MOH is not involved** in establishing or supporting HFMCs. The HFMCs may have been formed through NGO or other organizations, with no link to MoH	**MoH** is the recognized institutional body convening the HFMCs, but the roles and functions of these groups are **not formalized** in policies or strategies for community health	**HFMCs form part of MoH policies, strategies** and/or action plans for community health, and the strategic intent, roles and functions of these groups is **clearly described** in written documentation	**HFMCs form part of MoH policies, strategies** and action plans for community health and the strategic intent, roles and functions of these groups is **clearly described** in written documentation. The policy/strategy is reviewed on a regular basis and updated as needed
If strategy calls for both HFMCs and CHCs, the strategic intent and functions of these two groups are clearly described and differentiated	Where CHCs are operational alongside HFMCs, the **MoH is not involved** in establishing or supporting the CHCs	Where CHCs are operational alongside HFMCs, **MoH** is the recognized institutional body convening these groups, but the **distinctions between the two types of groups is not described** in policies or strategies for community health	Where CHCs are operational alongside HFMCs, the existence of these two groups forms part of MoH policies or strategies for community health, but the distinction between the two groups is poorly understood in practice	Where CHCs are operational alongside HFMCs, the existence of these two groups forms part of MoH policies or strategies for community health, and the strategic intent and functions of these two groups are clearly described and differentiated

2. HFMC Formation				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
To what extent the HFMC members are organized, and clear on the purpose, mission and importance of the group's work	**HFMCs exist but** meet infrequently with no clear objectives or direction	**Loose organization** of members meet ad-hoc to discuss key issues within the community and facility but not on a regular basis and no formal record is kept	**Organized HFMCs exist** that meet on a regular basis and keep records of meetings	**Organized HFMCs exist that** meet on a regular basis and keep records of meetings
		The HFMC members have **a vague idea** of why their group should exist	HFMCs agree on their overall **mission and objectives**, but these are not put in writing.	HFMC 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. HFMCs have **written mission and objectives**
What entity catalyzed the program and backs and supports it; e.g. Ministry of Health (MoH), independent NGO efforts, etc,	**MOH is not involved** in establishing or supporting HFMCs. The HFMCs may have been formed through NGO or other organizations, with no link to MoH	MoH catalyzed the formation of the HFMCs, but MoH involvement with the groups in practice is limited	MoH catalyzed the formation of the HFMCs and MoH - often in partnership with NGOs – provides some supervision and guidance	MoH catalyzed the formation of the HFMCs and **MoH** supports the groups through participation, guidance, and supervision
The degree of community awareness and participation in HFMC formation	The **wider community is unaware** of the HFMCs and/or the purpose of this groups	Some community members are aware of HFMCs but the community was **not consulted** in HFMC formation.	**Community members are aware** of intended structure and purpose of HFMCs, and participate in some, but not all of the committee formation processes	Community mobilization including multiple communications prior to group formation and recruitment of new members ensures **community fully aware** of intended structure and purpose of HFMCs

3. HFMC Member Recruitment and Selection				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
The processes by which HFMC members are identified and selected, including selection criteria, community involvement in selection, and degree of representation (of various segments of the community) of HFMC members. The selection and roles of health facility staff as members of the HFMC	**No or only a few criteria** exist and are **not well known** or commonly applied	**Some criteria exist** and are **communicated** but are general and/or do not address specific issues such as gender	**Selection criteria** are defined and communicated, but do not always specify representation **of gender, ethnic/tribal and disadvantaged groups**	**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.
	Health facility staff are members of the HFMC and often dominate the group to the detriment of community interests	Criteria for health facility staff as members of the HFMC specify which health staff should play which roles, but no mechanisms exist to guard against unhealthy power dynamics between health staff and community members	Criteria for health facility staff as members of the HFMC ensure that their roles are balanced against the roles of community members so that the community members have equal voice in the HFMC	Criteria for health facility staff as members of the HFMC are clear and specify that if health staff hold a leadership position in the HFMC, then other leadership positions must be held by community members, in order to ensure balance of power
	The community **plays no role** in recruitment	Community is not involved in the recruitment of HFMC members but **may approve the final selection**	**Community is involved in recruitment** of HFMC members; nominating and voting for candidates	**Community is involved in recruitment** of HFMC members**;** nominating and voting for candidates, and **marginalized** and key subgroups have a real say in recruitment
			Most selection **criteria** (literacy, gender, sub-group representation, etc.) **are met** where possible	All selection **criteria** (literacy, gender, sub-group representation, etc.) **are met** where possible
			There are no specifications on term limits or re-election of members	**Term limits** on key members or re-election on performance basis

4. HFMC Member Roles, Organization and Structure				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
Clarity and effectiveness of HFMC organization and structure with regard to roles, expectations, frequency, decision-making and procedures	**Roles of the HFMCs** are not defined or documented The **roles of the various members** of the HFMCs (e.g. leaders, etc.) are not defined or documented **Expectations** of the HFMC members are not defined or documented	HFMC members may have some ideas about the **roles of the group**, but these are not documented The **HFMCs** may have defined the **roles of the various members** and an **organizational structure** (e.g. leadership positions etc.) for themselves, but these are not documented **Expectations** (e.g. time commitment, frequency of meetings) and **tasks** are discussed but are **not specific or documented, or shared with community** The **decision-making authority** of the HFMCs with regard to health services is not established, is unclear or is contested	**Roles of the HFMCs** are clearly defined and documented but *not* communicated to community members The **roles of the various HFMC members and the groups' organizational structure** (e.g. leadership positions, etc.) are clearly defined and documented but not communicated to community members **Expectations** (e.g. time commitment, frequency of meetings) and are discussed and **specific but have not been shared with community members** The HFMCs' **decision-making authority** with regard to health services is clearly established within the HFMCs but not communicated (others not aware) **No process exists for updating** and discussing roles, expectations and tasks	**Roles of the HFMCs** are clearly defined and documented and are communicated to community members **The roles of the various HFMC members and the groups' organizational structure** (e.g. leadership positions, etc.) are clearly defined and documented, and are communicated to community members **Expectations** (e.g. time commitment, frequency of meetings) and are discussed and **specific and communicated to** the community, involved organizations and the HFMCs themselves The HFMCs' **decision-making authority** with regard to health services is clearly established and communicated so that others are aware **Process for updating** and discussing roles, expectations and tasks is in place

5. HFMC Member Training and Capacity Building				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
Training provided to the HFMC 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, systematic training plan to include initial and ongoing training; relevant and sufficient content vis-a-vis the HFMCs' roles and responsibilities, and effectiveness of training methodologies. The extent to which the training system is responsive to the fact that the HFMCs are 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 HFMCs can function as a whole	**No or minimal training** is provided to the HFMC members ***OR*** Minimal initial training is provided (e.g. one workshop) that does not adequately prepare the HFMCs to fulfil their functions The MoH has no responsibility for training the HFMCs	**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 HFMC 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 **training** generally takes place . **Content** of training includes at minimum enabling HFMCs to understand their roles, and basic skills needed to carry them out The MoH takes responsibility for HFMC training but often requests assistance from NGOs/other partners (e.g. training partially institutionalized w/in MoH)	A **training plan** exists within the local health system and **regular training** to the plan for all HFMC members takes place. **Initial training** in all necessary **content** and **ongoing training** for **skill maintenance, new skills,** new **organizational development** and health literacy strengthening Training develops committee as **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. The training of HFMCs is fully institutionalized within the MoH and carried out by MoH/clinic staff, with NGOs/partners playing only a supportive role as needed

6. Budget for HFMC Programming				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
The extent to which the HFMCs have the legal mandate and authority to develop an annual budget and manage revenue from the government, user fees from clinics, or donations from the community to support facility and community health activities The extent to which processes are in place for fiscal management and the HFMCs go through annual audit / verification processes	The HFMCs have **no budget or funding** to perform or support community or facility-level activities that improve health	The HFMCs have **no budget** but may receive **one-off funding** from MOH to tackle a specific health issue	The HFMCs have an **annual budget from MoH and consistent funding** to enable the HFMCs and/or community to take small, doable health focused activities Processes are in place for **financial management**	The HFMCs have the **legal mandate and authority** to develop an **annual budget** and manage revenue from the government, the health facility and/or donations from the community including local businesses to support community or facility-levvel health activities HFMCs are able to submit proposals for funding to other potential funding sources Processes are in place for **financial management** and the HFMCs go through an annual **audit** / verification processes The HFMCs have **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 HFMC Members				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
The mechanism by which HFMCs are supervised. This is especially important for those HFMCs managing or overseeing facility funds or budgets	There is **no supervision** of the HFMCs; neither through MoH nor **other mechanisms *OR*** An identified mechanism exists for supervision of the HFMCs; either by a local council or higher-level MoH staff (e.g. district, national) but, as an added responsibility for those involved, 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**	**A formal mechanism exists for supervision of HFMCs,** through a local government council, MoH at higher administrative levels (e.g. district, national), or other appropriate mechanism**, occasionally**	**A formal mechanism exists for supervision of HFMCs,** through a local government council, MoH at higher administrative levels (e.g. district, national), or other appropriate mechanism**, regularly**	The **MOH** has **policies** in place that describe **regular supervision** processes for HFMCs, reporting to a local government council, MoH at higher administrative levels (e.g. district, national), or other appropriate mechanism, and the supervisory mechanism operates **regularly and effectively**
Frequency and purpose of supervisory contacts, and action and documentation resulting from the contacts	There are **no supervisory contacts** with the HFMCs.	**Occasional supervisory contacts** to discuss data, goals and activities and provide input, but **not based on a review of data**, **goals and objectives.**	Regular, at **least 3 monthly supervisory contacts** using tools to discuss goals, data and current challenges. Supervision includes **review of HFMCs' use of funds**, if applicable	Regular, at least **3 monthly supervisory contacts** using tools to discuss goals, data and current challenges. Supervision includes rigorous **financial control of the HFMCs' use of funds**, if applicable
	There are **no incentives** or	**Little or no ongoing on-the-job** training as part of the supervision process	Supervision includes **assessment** of skills and **on-the-job training**	**Progressive HFMC member development** and on the job training planned, monitored evaluated, and documented

Incentives for supervisors: the extent to which the supervisors of the HFMCs are compensated for costs of supervisory work	forms of recognition for the supervisors of the HFMCs Supervisors of the HFMCs are not compensated for time or expenses in order to perform their supervisory role	Supervisor(s) receive **no incentives** package, financial or non-financial but **appreciation from the HFMCs** is considered a reward Supervisors of the HFMCs are not compensated for time or expenses in order to perform their supervisory role	**Some unstandardized non-financial incentives** are offered to the supervisors of the HFMCs Financial support is provided to the supervisors of the HFMCs to **offset the direct costs** of the supervisory work	**An agreed package of non-financial incentives** is provided to supervisors of the HFMCs and is in line with general expectations placed on supervisors Financial support is provided to the supervisors of the HFMCs to **offset the direct costs** of the supervisory work

8. Incentives for HFMC members				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
The types of incentives received by HFMC 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 HFMC member motivation The extent to which incentives provided are appropriate to the training, level of effort and time commitment that a HFMC member needs to input to do their work satisfactorily.	HFMC 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/ reimbursement) HFMC 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/ reimbursement) There is mixed feeling among HFMC 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 HFMC 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/reimbursement) HFMC 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 committees	**An agreed package of non-financial incentives** such as training, recognition, certification, etc. is provided to HFMC members and is in line with expectations placed on members. The incentives package is **known by all**, and is uniform within a defined geographic area (e.g. district, etc.) **Community offers** appropriate forms of recognition and reward **Financial support** is provided to offset the **direct costs** of participation (e.g. transport to trainings/reimbursement) HFMC 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 committees

9. Wider Community Support and Involvement				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
The extent to which the wider community is aware of and recognizes the value of the HFMCs. The extent to which the wider community recognizes its own role in supporting the HFMCs, and participates in its activities and initiatives, as required	The wider community plays **no role in ongoing support** to HFMCs	Some community members **understand the role** that they can play in supporting the HFMCs	The **role** that the wider community plays in **joining** the HFMCs, and **participating** in HFMC-led activities is **well-understood**	**Community plays an active role in all support areas** for the HFMCs, such as providing input in defining the HFMCs' role, providing feedback, participating in HFMC-led community activities, and helps to establish the legitimacy of the HFMCs in the community
	There is **no involvement or attempt** to reach the **most vulnerable and marginalized** in HFMC initiatives	Social/political hierarchies in the community and the influence and interests of the elite mean that the **most vulnerable and marginalized may be excluded** from the HFMCs' activities	There is **intentional effort to include the most vulnerable/ marginalized** in the HFMCs' activities, and levels of socio-cultural/elite resistance to this are low	The community leaders are **supportive advocates of equal participation** of the most vulnerable and marginalized in HFMCs' activities
			Community members share concerns about community health with the HFMCs and actively seek their involvement in addressing the concerns	The HFMCs are **recognized and appreciated** for being a vehicle for the community to raise concerns, and for providing service to the community

10. HFMC Support of the Referral System				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
Processes for patient referrals and counter-referrals, from CHW to clinic and back, and the extent to which the HFMCs play 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 HFMCs play no role in supporting it **No logistics planning** in place by the community for emergency referrals	The community, the HFMCs and CHWs/ health volunteers **know where referral facility is** but have **no formal referral process/**logistics, forms The **HFMCs do not have any role** in supporting the referral system	The community, the HFMCs and CHWs/ health volunteers know where referral facility is and **usually have the means to transport clients** The HFMCs have a **process in place to support the CHW with referral** assistance when needed	The community, the HFMCs 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 HFMCs manage **emergency transport funds**

11. Communication and Information Management				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
The extent to which data flows to the health system and back. The extent to which the HFMCs make use of data and information to identify key health issues for communication and to advocate for health service improvement	The HFMCs have **no access** to publicly available **health data** and do not collect any data	Community or facility **health data that does not identify individuals is publicly available at the community level.** HFMCs may access the data on request from health facility	There is a **process for documentation and information flow** of health data between health facilities and HFMCs	There is a **process for documentation and regular two way information flow** of health data between health facilities and HFMCs. This data is stored in such a way that it is readily accessible to members of the public.
Extent to which HFMCs support the government and the facility in communications with the public	The HFMCs **do not use health data to guide action** to address health issues and disease epidemiology	The HFMCs review community or facility health data and **take some action** to address the key health issues and disease epidemiology	The HFMCs review facility health data **use the data to communicate** key issues and disease epidemiology with the public and to improve health outcomes.	The HFMCs review facility health data, and **use the data to communicate** key health issues, and disease epidemiology with the public, to improve health outcomes and **report back** to key stakeholders
	The HFMCs have **no access to or mechanism for tracking health service performance** data	The HFMCs have **no access to or mechanism for tracking health service performance** data	**Mechanisms are in place** for HFMCs to track health service performance and the HFMCs **sometimes collect and make use of this information**	**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 can be accessed.
	Health workers are **not formally accountable** to the community	Health workers are **not formally accountable** to the community	**Rights and standards** for performance and service provision are recorded and available to community members.	HFMCs and community **know their rights and standards** of service provision.

12. Linkages to the Broader Health System				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
How the HFMCs 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 broader health system, local government, and other ministry and community systems are weak or non-existent; **HFMCs work in isolation**	HFMCs are **linked to the local health facility only,** with no links to the broader health system at higher administrative levels	HFMCs are **linked to district-level health management teams** and receive some support from them HFMCs' **organizational goals and yearly plans are integrated** into MOH yearly plans, though **not closely monitored or supported.**	**HFMCs are linked to the broader health system at district level** and to local government, with a supporting management culture that encourages **transparency and openness** between the health facility, CHCs, CHWs, community. HFMCs' **organizational goals and yearly plans are integrated** into MOH yearly plans, and **regularly monitored or supported.**

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

14. HFMC Program Performance Evaluation				
Component Definition	**0** **Non-functional**	**1** **Minimal**	**2** **Functional**	**3** **Standard**
HFMC Program Performance Evaluation The extent to which program evaluation of HFMC performance against targets, objectives, and indicators is carried out by the HFMC 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 HFMCs' mission and objectives	**Yearly evaluation** conducted of HFMCs' activities but **does not assess achievements against** program **indicators** and outcomes **No feedback** provided to HFMC members on how they are performing relative to program indicators and targets	**Yearly evaluation** conducted of HFMCs' activities that **assesses HFMC achievements** in relation to program **indicators** and targets **Feedback** is provided to HFMC members but this may be informal and ad-hoc The HFMC program is reaching at least **50% of its targets**	**Yearly evaluation** conducted of HFMCs' activities that **assesses HFMC achievements** in relation to program **indicators** and targets **Feedback** is provided to HFMC members in relation to program indicators and targets The HFMC 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 HFMCs

Appendix D: CHC/HFMC Validation Questionnaire

Instructions: Use this document either before or after the assessment workshop to verify the scoring established by workshop participants. Try to visit 2-3 committees that did not participate in the workshop (or 4-6 if you are assessing both CHCs and HFMCs; 2-3 of each type of group) and hold focus group discussions with committee members, using the questions in this questionnaire as a guide. The number of committee members participating in a FGD should not exceed 12 to enable good discussion by all. Following the FGDs, compare responses with the workshop scores and the action plan to determine if any changes are needed. If the FGDs are conducted prior to the assessment, use the information as a guide during the discussion. If the FGDs take place after the assessment, discuss the changes with those who participated in the assessment.

No.	Question	Responses
1	How long have you worked as Community Health Committee (or Health Facility Committee) members?	
2	How many members does this committee have? How many men/women?	
4	Please describe how you were recruited	
5	The members of the committee represent which community structures, groups and stakeholders? *(Circle all that apply and/or write the corresponding numbers in the space)* 1. Health facility staff 2. Community leaders 3. CHWs 4. Traditional healers 5. Traditional birth attendants 6. Church/faith leaders 7. Youth 8. Disabled 9. NGO/CBO 10. Women's groups 11. Other (explain)	
6	How is the committee structured? What are the leadership positions?	
7	How does the committee decide which members will hold the leadership positions?	

No.	Question	Responses
8	Please describe the key tasks for which the committee is responsible	
9	How well does the community understand the objectives and roles of the committee? Explain	
10	How well do you think what you do as a committee meets the expectations of the community? Of the health facility? Explain	
11	How often do you meet together as a committee?	
12	Do you keep written records of committee meetings?	
13	Please describe the initial training you received to prepare you for your role as a committee? When did the training take place, how long did it last, and what topics were covered?	
14	Please describe any additional training (refresher/ongoing training) you have received to help you fulfill your role as a committee	
15	Do you have the supplies and materials you need to provide the services you are expected to deliver? Explain	
16	Do you have any funds to carry out your activities?	

No.	Question	Responses
	If yes, where do the funds come from?	
	If yes, describe any training you have received on financial management	
17	Who supervises this committee?	
18	How often do you meet with your supervisor?	
19	What does your supervisor do when he/she meets or visits you?	
20	Does the community you work in provide you with any of the following? *(Circle all that apply and/or write the corresponding numbers in the space)* 1. Feedback 2. Support (financial/gifts in kind) 3. Formal recognition/appreciation 4. Guidance on your work 5. Other (explain)	
21	How active would you say the community is in participating in activities and meetings that you lead?	
22	How active would you say the more vulnerable members of the community are in participating in activities and meetings that you lead?	
23	What is the procedure for referring patients/clients to the health facility?	

No.	Question	Responses
24	Please describe the transportation systems available to get clients to referral facilities	
25	What role, if any, does the committee play in the referral process?	
26	Please describe any sources of health data and information that you receive and review	
27	How does the committee use health data and information?	
28	How often do you meet with health facility staff?	
29	What is the purpose of these meetings, and what takes place during the meetings?	
30	Have you received an evaluation of your work in the last 12 months?	
	If yes: • Who evaluated you? • How were you evaluated? • What was evaluated?	
31	What are your biggest challenges as a committee?	
32	What changes are needed to help you do your job better?	

Appendix E: Score and Score Rationale Documentation Worksheet

I: Community Health Committees

Instructions: This worksheet is for participants to note their scores and the evidence or rationale they have for choosing the score. Participants should note in the action column any interventions that can help the program move forward towards better practice. Scores can be revised (*) only if field visits or other information provides evidence that supports a different score from that agreed in the workshop.

Component	Workshop Score	Validated Score*	Rationale	Action Items	Comments
1. Strategic Description and Clarity of CHC Programming					
2. CHC Formation					
3. CHC Member Recruitment and Selection					
4. CHC Member Roles, Organization and Structure					
5. CHC Member Training and Capacity Building					
6. Budget for CHC Programming					
7. Supervision of CHC Members					
8. Incentives for CHC Members					
9. Wider community support and involvement					
10. CHC Support of the Referral System					
11. Communication and Information Management					
12. Linkages to the Broader Health System					
13. Country Ownership					
14. CHC Program Performance Evaluation					

II: Health Facility Management Committees

Instructions: This worksheet is for participants to note their scores and the evidence or rationale they have for choosing the score. Participants should note in the action column any interventions that can help the program move forward towards better practice. Scores can be revised (*) only if field visits or other information provides evidence that supports a different score from that agreed in the workshop.

Component	Workshop Score	Validated Score*	Rationale	Action Items	Comments
1. Strategic Description and Clarity of HFMC Programming					
2. HFMC Formation					
3. HFMC Member Recruitment and Selection					
4. HFMC Member Roles, Organization and Structure					
5. HFMC Member Training and Capacity Building					
6. Budget for HFMC Programming					
7. Supervision of HFMC Members					
8. Incentives for HFMC Members					
9. Wider community support and involvement					
10. HFMC Support of the Referral System					
11. Communication and Information Management					
12. Linkages to the Broader Health System					
13. Country Ownership					
14. HFMC Program Performance Evaluation					

Appendix F: Action Plan Template

Instructions: Copy as many pages of this template as needed and use to create an action plan for improving the functionality of the CHC and/or HFMC program(s)

Program Element	Issue	Improvement Activity	Person(s) Responsible	Resources Needed	Timeframe	Indicator

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