Ministry of Health, Republic of Liberia

National Standard Operating Procedures for

Community Based Information System (CBIS)

Version 1.0 - Adapted February 1, 2017

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Acknowledgements

The Ministry of Health, on behalf of the Government of Liberia, wishes to wholeheartedly extend grateful thanks and appreciation to all institutions and individuals who participated in the development of the National Community Health Assistant Program Community Based Information System.

Our special recognition, thanks and appreciation go to the following monitoring and evaluation partners who provided technical support and other resources to the development of the Community Based Information System: CHAI, International Rescue Committee/PACS, Last Mile Health, Medical Teams International, Partners in Health, Plan International, Samaritans Purse, UNICEF, USAID and WHO.

We wish to express our gratitude to the programs of the Ministry of Health, CHSD, HMER and M&E Unit and the Training Unit.

The success of any health monitoring and evaluation system depends on the adequate training and dedication of those working at the delivery points. This guide has been prepared to help you better serve the people of Liberia and ensure that they can rely on a consistent and accurate data and information on the NCHA Program.

Sincerely,

Yah. M. Zolia (Mrs.)

Deputy Minister for Planning, Research & Development.

Abbreviations

MoH – Ministry of Health
HMIS- Health Management Information System
USAID- United States Agency for International Development
GFATM- The Global Fund to Fight AIDS, Tuberculosis and Malaria
UNDP- United Nations Development Program
NEIDS-National Essential Indicators Dataset
DHIS-District Health Information Software
UNICEF- United Nations Children's Fund
WHO- World Health Organization
IRC- International Rescue Committee
PIH- Partners in Health
LMH-Last Mile Health
NCHAP- National Community Health Assistant Program
CBIS -- Community Based Information System
CHAs—Community Health Assistant
CHS --- Community Health Services
CHT- County Health Team
SOP-- Standard Operating Procedures
DQA -- Data Quality Assurance
MOH—Ministry of Health
CHSS – Community Health Services Supervisor
HFDC -- Health Facility Development Committee
CHS- Community Health Services
CEBS-Community Event Based Surveillance
OIC- Officer in Charge
DHO- District Health Officer
CHC- Community Health Committee
CHO- County Health Officer

1. Background

Following the development of the first post-war Health Policy and Plan for Liberia 2007-2011, the Ministry of Health and partners embarked on the development of a National Health Management Information System (HMIS) followed by a National Monitoring and Evaluation (M&E) system. A series of assessments preceded these systems development processes, which showed a fragmented and dysfunctional HMIS System and no M&E system in place at the Central MOH except for delinked, non-coordination, and donor-driven M&E system that were put in place in national program to meet Global Fund reporting needs.

With support from the United States Agency for International Development (USAID) -Basics Project, the Health Management Information System (HMIS) Strategy was developed and The Global Fund to fight AIDS, Tuberculosis, and Malaria (GFATM) through UNDP supported the development of the M&E Policy and Strategy.

The development of a national HMIS strategy resulted in the creation of credible, uniform data collection and reporting systems, including the establishment of the National Essential Indicators Dataset (NEIDS) and the development of an integrated data collection instrument. The District Health Information Software (DHIS) was adopted as platform for services health data processing and management.

In 2016 as the National Community Health Assistant Program was created, the need for a community based information system within HMIS became apparent. With the support of the International Rescue Committee (IRC), Partners in Health, UNICEF United Nations Children's Fund, PLAN, and Last Mile Health, the Ministry of Health developed a comprehensive community-based information system (CBIS) as a sub-system within the HMIS. These partners formed a M&E sub-group, which informed the system and development of tools to be used to support the community health assistant program (NCHAP) through the combined experience and expertise of the MOH and Partners.

CBIS encompasses the tools, processes, and data systems that will capture information from the Community Health Assistant Program. This document assumes that the reader is familiar with the Community Health Services (CHS) policy and strategic plan for the Community Health Assistants Program.

2. Purpose

The purpose of this document is to outline the standard operating procedures (SOPs) for the Community Based Information System (CBIS). The SOP describes common procedures for data monitoring, lists the timing and responsibilities for each step, and details the deadlines in the program cycle. It is intended to clarify roles and responsibilities for all stakeholders involved in the NCHAP. It is aimed at ensuring consistency in all routine community health data collection, processing, and management processes and procedures. This document shall be used for the following:

1. Inform central and county level parties, Ministry of Health, County Health Teams (CHT), and implementing partners of CBIS procedures at each level
2. Guide the development of training materials for data collection all levels

3. Ensure compliance of actors to standardized data collection, reporting, management and quality assurance mechanisms

3. Roles and Responsibilities

3.1 Community Health Assistant (CHA)

CHAs are selected community members that are trained to act as the first point of care for clients in the community. In the CHA Program, CHAs are responsible for data collection and reporting on program indicators. All CHAs are equipped with a modular set of forms that are used to monitor daily outputs and service delivery. Implementing partners and the County Health Teams have the option of conducting additional data collection as they see fit as long as all CHA data flows remain intact and the Ministry of Health is consulted. For example, individual CHA Monthly Service Reports can be collected and analyzed to allow for performance management of individual CHAs.

3.1a Data Collection & Management

CHAs will be responsible for recording information on individuals in each household as routine visits are conducted and services are provided. The frequency of data collection will differ depending on the type of service that is being provided.

At the bottom of most CBIS forms there is a series of bolded boxes. These boxes represent data elements that will allow for the calculation of indicators within the M&E Framework (see appendix 2). These indicators will be collected through the *5.1 CHA Monthly Service Report*. To do this, the CHA will sum the column for each bolded indicator for the month. They will then transfer that sum to the CHA monthly Service Report. Each bolded box has a code that links the form and the Monthly Service Report. For example, for the *1.2 CHA Routine Visit Tracker* the first bolded box is 1.3A. This is the total number of household visits completed by the CHA for that month. The CHA will count the number of Household visits on the form and put the total in the bolded box. Then the CHA will put the same number on the *5.1 CHA Monthly Service Report* for the bolded box that has the same code, 1.3A. The visual below demonstrates how the numbered and bolded boxes on the Routine Visit form correspond to the numbered and bolded boxes on *the 5.1 CHA Monthly Service Repor*t.

3.1b Data Quality Assurance

CHAs will conduct quality assurance on his or her work daily when on routine visits and recording data. The CHA is the first point of data entry, it is important to conduct quality assurance daily at this level to verify the client information recorded is accurate. This prevents missing, blank data from being entered as data later on. The CHA will conduct daily data quality assurance accordingly. Please see Appendix V for more information and steps to the Data Quality Framework.

3.1c Routine Reporting

The CHA will be responsible for immediate reporting of priority disease triggers and monthly for routine reporting. Routine reporting for all other data elements shall occur between the 1st and the 5th of the following month to enable the facility to compile the facility reports before the 7th to county level.

The CHA will be responsible for completing the *5.1 CHA Monthly Service Report* monthly (Appendix 1) which will be captured from the modular forms used during routine visits in the community. This *5.1 CHA Monthly Service Report* should be completed on the first day of the month for the previous month. For example, on February 1st, the CHA will complete the *5.1 CHA Monthly Service Report* for all services delivered in January. If the CHA requires help completing the *5.1 CHA Monthly Service Report,* then the CHSS will help the CHA on supervisions visits and on the data collection visit to aggregate the bolded boxes on the modular forms and transfer these indicators to the *5.1 CHA Monthly Service Report*.

For example, if the timeline is for May data, then the CHA uses the CHA forms to complete the May *5.1 CHA Monthly Service Report* on June 1st. Please see Appendix 1, Figure 3 for a graphic visualization of the monthly data collection methodology.

3.1d Rapid Reporting for Community Event Based Surveillance (CEBS)

The CHA will use the *1.3 Community Trigger and Referral Form* to report any community priority event triggers as defined in the National Technical Guidelines for Integrated Disease Surveillance & Response. The CHA will identify triggers in the community and assess the signs and symptoms to see if it is a true trigger. They will then fill out the *1.3 Community Trigger and Referral Form*. There are two potential methods of reporting based on the event.

1. If the patient experiencing the trigger **is able to travel to the facility** for clinical verification, the CHA will complete the *1.3 Community Trigger and Referral Form* and either send the patient to the facility or accompany the patient to the facility.
2. If the **patient is not able to travel to the facility**, the CHA will take one of the following actions:
    a. Complete the *1.3 Community Trigger and Referral Form* and travel to the facility to deliver to the CHSS
    b. Complete *the 1.3 Community Trigger and Referral* Form and contact the CHSS by other means (i.e. phone). If this method is used, the *1.3 Community Trigger and Referral Form* should stay with the CHA until the CHSS can retrieve the form.

3.1e Data Use for Decision Making

In addition to acting as a data collection mechanism, the CHA Forms have been optimized for workflow management. These ledgers, from left to right, map out key activities to be completed by the CHA. They help the CHA with the workflow by guiding him or her through the activities. These ledgers will be kept in the community once completed. This is done to keep an accurate record in the community of the work of the CHA. This information can be utilized by the CHA, CHSS, and Community Health Committee (CHC) for decision making around health education and interventions needed. For example, the CHA can present the number of incidents of diarrhea in the community to the Community Health Committee and work to plan an intervention on sanitation and clean drinking water.

3.2 Community Health Services Supervisor (CHSS)

The Community Health Services Supervisors are key frontline leaders in the implementation of the NCHA program. In keeping with the NCHA policy, CHSSs will supervise CHAs, monitoring their performance and motivation as well as ensuring linkage between community and facility-based service delivery. The CHSS is based at the health facilities but spends the majority of his or her time supervising and providing support to the CHA's in the communities. The CHSS has the following programmatic roles:

- NCHAP facility-based management
- Training coordination and planning
- Expert facilitation
- Supportive supervision
- Quality assurance
- Supply chain coordination

Some examples of these actions filled by these roles are to manage the CBIS system and serve as first point of contact for CHAs at facility level, provide leadership and clinical supervisions to CHAs on challenges that may otherwise affect implementation, ensure sufficient logistics (stock of reporting ledgers and forms, commodities, etc.) for reporting and to aggregate data from the CHAs and submit to the relevant facility.

3.2a Data Collection

The CHSS is responsible for collecting data from the CHA's and aggregating the data into a report. The CHSS will aggregate all *5.1 CHA Monthly Service Reports* for the CHAs in his or her catchment area into the *5.2 CHSS Monthly Service Report*. This will take place at the health facility on the 5th of the month for the previous month's *5.1 CHSS Monthly Service Reports*. For example, the *5.1 CHA Monthly Service Reports* containing February data will be aggregated by the CHSS onto *the 5.2 CHSS Monthly Service Report* on March 5th.

First, each of the CHA IDs that reported through the *5.1 CHA Monthly Service Report* will be entered into the *5.2 CHSS Monthly Service Report* and then the CHSS will sum each indicator from all of the *5.1 CHA Monthly Service Reports* and record this number for each indicator on the *5.2 CHSS Monthly Service Report*. For example, for the Indicator 1.3A. on the *5.2 CHSS Monthly Service Report*, the CHSS will sum all of *the 5.1 CHA Monthly Service Reports* for the indicator numbered 1.3A. Additionally, the *5.2 CHSS Monthly Service Report* will be used to aggregate basic supervision, attendance, and audit check information from the *5.2 CHSS Supervision Report*. Missing data should be addressed by the CHSS during supervision visits before aggregating information into the *5.1 CHA Monthly Service Report.*

3.2b Data Quality Assurance

During supervision visits and/or when reports are sent to the CHSS, the CHSS is to conduct data quality assurance. Please see Appendix V for more information on the Data Quality Framework.

3.2c Data Use for Decision Making

Each CHSS is also responsible for analyzing individual CHA Forms to make informed decisions and targeted remedial supervision based on his or her findings. The CHSS can also compare data points across forms to identify patterns of poor quality. This helps the CHSS identify areas where quality improvements are needed and help them. Below is a list of a few examples the data can be used for decision making.

- While looking over the *3.1 Sick Child Form* the CHSS will notice patterns such as a large number of diarrhea cases in the CHA's catchment area and can advise the CHA to give more education on hygiene and the importance of clean water

- Demographic data can be used to know how many people there are in each age group. This data will help the CHSS advise on the CHA work plan and know approximately how many people the CHA would want to reach for providing a service such as family planning. The CHSS will also convey this information via regular updates during the Health Facility Development Committee (HFDC) meetings and to CHAs for Community Health Committee (CHCs) meetings
- The number of routine visits completed can be compared to the CHA's number of households in CHA's catchment area if each household was not visited, the CHSS can coach the CHA to visit each household each month
- If the number of patients treated for malaria within 24 hours is much lower than the number of patients treated for malaria after 24 hours, the CHSS can coach the CHA on the value of routine visits and community education on malaria
- If the number of home births is high compared to number of facility births the CHSS can coach the CHA to encourage facility delivery

3.2d Routine Reporting

Once an entire month's data has been collected by the CHSS via the *5.2 CHSS Monthly Service Report*, he/she will deliver the report to the facility for a joint review by the CHSS, OIC, and facility staff, on a monthly basis on or before the 5th of the subsequent month. Please reference the Data Collection Timeline for a review of the monthly reporting deadlines. The DHO should collect surveillance and monthly report from all facilities in his or her district and submit them to the CHT on or before the 7th.

3.2e Feedback Mechanisms

There are 3 feedback mechanism for the CHSS:

1. Feedback shall be submitted through the Health Facility Development Committee Report (HFDC) formerly the Community Health Development Committee (CHDC) to the Monthly Health Facility Development Committee meetings. This allows the facility catchment to be informed on health issues in their communities
2. In areas where cellular networks are available, the use of mobile phone should be encouraged for giving urgent feedback to CHAs
3. In addition, the CHSS should routinely provide feedback on the data to the CHA to help guide his or her work. This includes feedback on the data quality and the data used for decision making.

3.3 Officer in Charge (OIC)

The Officer-in-Charge (OIC) supervises all activities and facility staff including the Community Health Services Supervisor (CHSS). The OIC shall conduct facility-based supervision of the CHSS to ensure that CHA supervision visits are scheduled by the CHSS, and for ensuring that CHA programs and activities are successfully implemented.

The OIC's supervision also involves cross-verifying and validating all reported data. The OIC is also responsible for ensuring that all reports are submitted to the DHO and/or the county from the 5th to the 7th of the month after the reporting period.

3.3a Data Quality Assurance

The OIC along with the CHSS and other staff in the facility shall conduct a joint quality check before transmitting monthly data and reports. Please see Appendix V for the Data Quality Framework.

3.3b Feedback Mechanisms

There are 2 feedback mechanisms identified for the CHSS/OIC

1. The Monthly HFDC Report which will be submitted to HFDC meetings will allow the communities in the catchment area to be informed on the health issues in their communities.
2. In areas where cellular networks are available, the use of mobile phones should be encouraged for giving urgent feedbacks to CHSSs and CHAs.

3.3c Data Use for Decision Making

Service delivery data generated by facility from the community should not only be reported but used. In order for data to be used appropriately, the CHSS and OIC should analyze their data and determine what actions to take. This guides the CHSS in quality assurance and targeted visits to the CHA. Additionally, feedback from the district or county to the facility should trigger action to be taken in the CHSS's catchment community. For example, a high number of reported diarrhea cases should trigger more efforts in diarrhea education in the facility and the community, an increased supply of ORS and Zinc, or a creation of plans to improve the water quality source.

3.4 District Health Team

The DHO is directly responsible for the supervision of all facilitates in the district. Their primary responsibility is to collect reports from the district's facilities on a monthly basis and transmit that data to the county M&E team. The DHO is responsible to collect reports between the 5th and 7th of the month at all facilities. If the DHO cannot collect all reports, he or she is responsible to communicate this to the facility and work with the facility and county health team to collect and deliver the reports.

3.4a Data Entry

Data entry is not the responsibility of the district except in counties where the DHIS2 is used at the district level.

3.4b Data Quality Assurance

The DHO is responsible for checking the quality of the facility reports he or she receives. Please see Appendix V for more information on the Data Quality Framework.

3.4c Feedback Mechanisms

1. If there is missing data the DHO can report this to the OIC and CHSS to retrieve community ledgers and verify data.

2. If missing data is found by the County Monitoring and Evaluation team, the DHO will at times carry this information back to the OIC and CHSS at the facility.

3.4d Data Use for Decision Making

As the DHO is responsible for supervision of all facilities in the district, he is responsible for ensuring the OIC and CHSS use data available for decision making.

3.5 County Health Team

At the CHT-level, the M&E Officer under the supervision of the County Health Officer (CHO) is responsible for timely processing and transmission of data and generating reports in predefined format. The M&E Officer is ultimately responsible for optimizing data quality and meeting deadlines for data transmission. Country M&E staff also provide feedback to the facilities and conduct monthly data verification.

The county is not responsible for printing any ledgers or data collection forms for the CHA program unless there is an emergency need for forms. Forms are supplied to the counties through packaged ledgers by the central M&E Department at the MOH.

3.5a Data Entry

Data entry using the DHIS-2 should be done at the county level by the County M&E Team. The County Data Officer and Data Clerk, under the supervision of the M&E Officer, are responsible for data entry. Timeline for data entry is the 7th to 17th of the preceding month of the reporting month. For example, the data entry clerks will enter June *5.2 CHSS Monthly Service Reports* by July 7th to 17th.

The County Data Officer and Data Clerks are responsible for entering the *5.2 CHSS Monthly Service Report*, checking their work to maintain quality in entry, flagging possible data inconsistencies as they arise, and filing the data after entering.

1. As data is entered, the header information containing ID numbers and names should be verified. The Data Clerks should have either a paper or electronic copy of the correct ID numbers and names, which is used as a reference to ensure that ID numbers and names are correct. Any discrepancies in header information should be reported to the M&E Officer for investigation.
2. Any discrepancies in header information that are confirmed to be errors by the M&E Officer must be reported back to the CHSS who made the error. The correct header information should be given again.
3. As data is entered, the Data Clerks must be careful to differentiate “zeros” from “blanks” (missing data). The data entry clerk will not type in a zero if the section in question is blank.
4. Any data that is missing must be documented.
5. After data is entered and quality assurance is completed, the data entry clerk must maintain the files in ordered and marked records. The files should indicate the name of the Data Clerk, the forms the files contain, the date range of the files and the location that the files are for.

3.5b Data Quality Assurance

The Data Clerk, Data Officer and M&E Officer are responsible for data quality assurance on the paper forms as the do data entry. Please see Appendix V for more information on the Data Quality Framework.

3.5c Data Use for Decision Making

The M&E Officer is responsible for providing information from the data to various line managers, program supervisors and other stakeholders in the county. CBIS data should be analyzed and used in coordination and other management meetings. For example, the M&E Officer can be available to provide data or help the stakeholders understand the data for the CHA program such as high numbers of diarrhea in certain facilities catchment areas.

3.5d Feedback Mechanisms

There are three primary mechanisms to provide feedback:

1. Telephone calls in areas where cellular connectivity is available
2. A designated staff from the CHT M&E may travel to the facility using available transportation to seek clarification and report missing data and incorrect header information
3. During the monthly data counter verification details on data transcription/recording and reporting should be discussed and appropriate feedbacks given to facilities and corrections made.

3.6 Central Level CBIS Focal Point

The Central Level CBIS Focal Point is responsible for the overall management of the system, troubleshooting the system, and providing reports to the stakeholders as needed.

3.6a Data Analysis and Reporting

It is the responsibility of the Central Level CBIS Focal Point to build the capacity of the County Teams to run reports on the program. He or she will train county level M&E staff on how to create and run the reports. The Central Level CBIS Focal Point will analyze the data to see what troubleshooting and strategizing is needed for the program.

3.6b Data Use for Decision Making

The data and reports should be accessible to the Ministry of Health and partners to use for decision making at this point as well as for the Central level CBIS Focal Point to use in coordination and management. He or she will also work with other Health Information Systems, HIS, sub-systems to ensure interoperability.

Appendix I. Figures

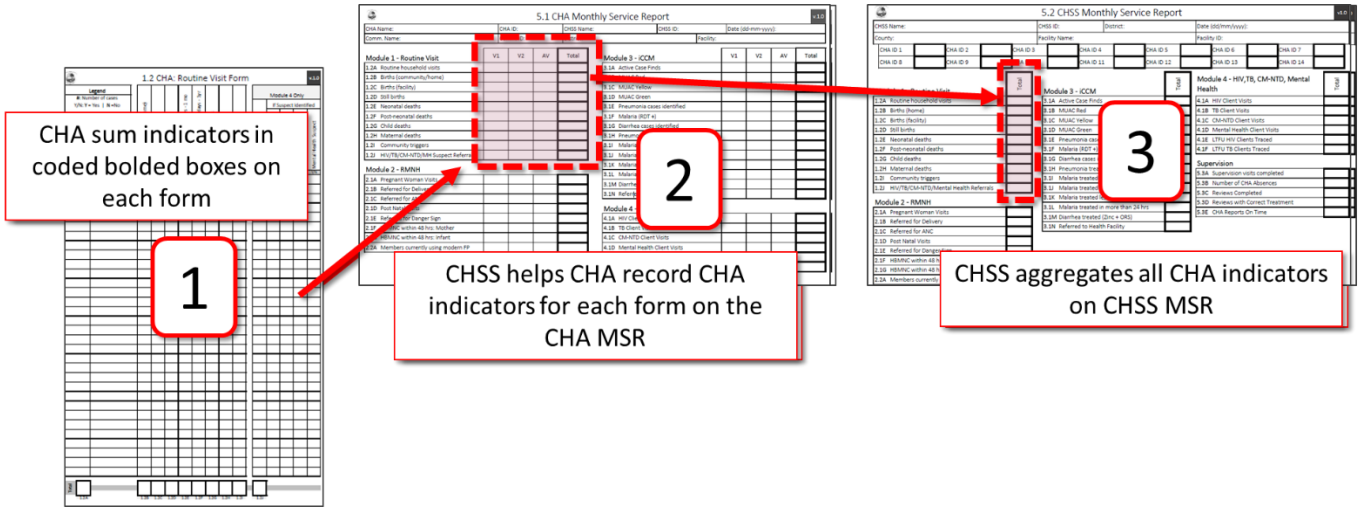


Figure 1 – Graphic showing how information is moved from CHA forms to the CHA Monthly Service Report, and to the CHSS Monthly Service Report

Data Collection Tool	Task Description	Frequency
1.1 Household Registration	Record demographic information of each household in the catchment area	Annual
1.2 Routine Visit Tracker	Record vital statistics (births/deaths) in each household	Routine Visit/Active Case Find
1.3 Community Trigger & Referral Form	Record patient symptom information, community triggers, and reasons for referral	Routing Visit/Active Case Find
2.1 Pregnant Woman, Mother and Newborn Ledger	CHA will hold one form for each pregnant woman to be completed over the course of a pregnancy and the first month of newborn life. The CHA will record pregnancy and newborn assessment, treatment, and referral information	Routine Visit/Active Case Find
2.2 Family Planning Tracking Ledger	Record family planning assessment, FP usage, and referral information	Routine Visit/Active Case Find
3.1 Sick Child Management Ledger	Record sick child assessment, treatment and referral information	Routine Visit/Active Case Find
4.1 Case Management Ledger	Records case management for HIV TB and NTD cases	Routine Visit/ Active Case Find
5.1 CHA Monthly Service Report	Records vital statistics from each module for each visit per month	Monthly

5.2 CHSS Monthly Service Report	Aggregates the CHA vital statistics from each module for each CHA in a CHSS catchment area	Monthly
5.3 CHSS Supervision Report	Records CHA visits and audit information as well as reviews on correct treatment	Routine Supervision Visits

Figure 2 – Chart of each CBIS data collection form, it's description, and the frequency it is used to collect data

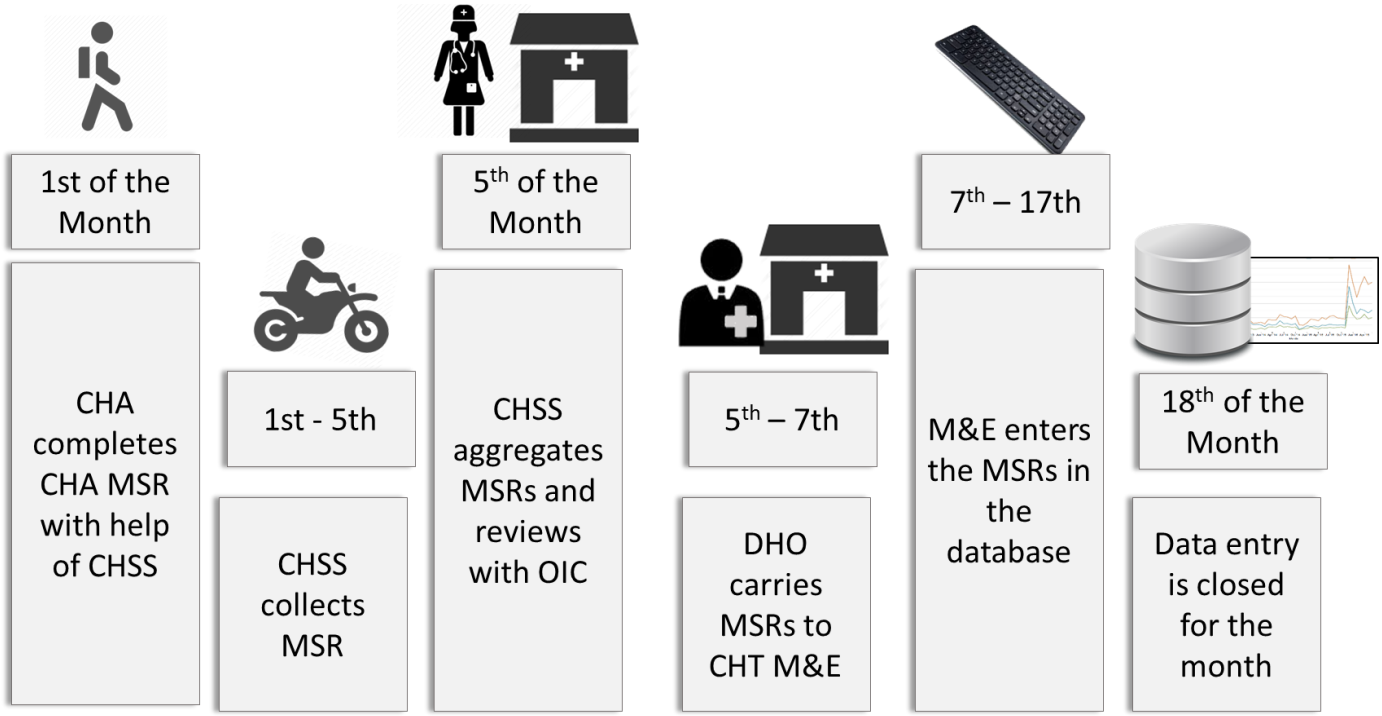


Figure 3 – CBIS Data Timeline

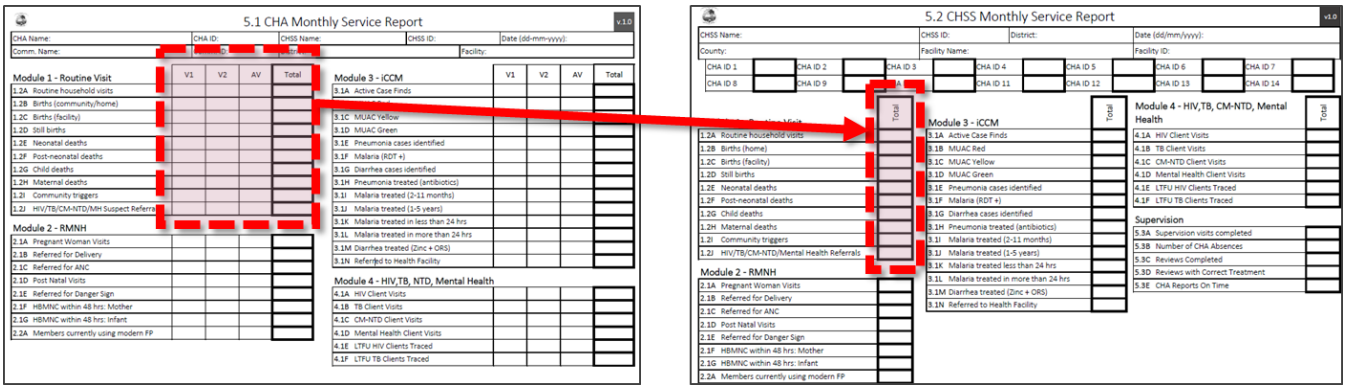


Figure 4 – CHA Monthly Service Report to CHSS Monthly Service Report Example

Appendix II– Data Collection and Reporting Tools

Module 1 – Routine Visit

Household Registration

The 1*. 1 CHA: Household Registration Form* is to record demographic information of each household in the catchment area. The CHA will *use 1.1 CHA: Household Registration* Form one time every year. The CHSS will inform the CHA when it is time to use the 1.1 Household Registration Form. After visiting and recording the demographic information for every household, the CHA will sum the columns that have bolded boxes and write the sum inside the bolded box. This is the total for each indicator. As the picture below shows, the CHSS will help the CHA aggregate these numbers and record the indicators on the *5.1 CHA Monthly Service Report*.

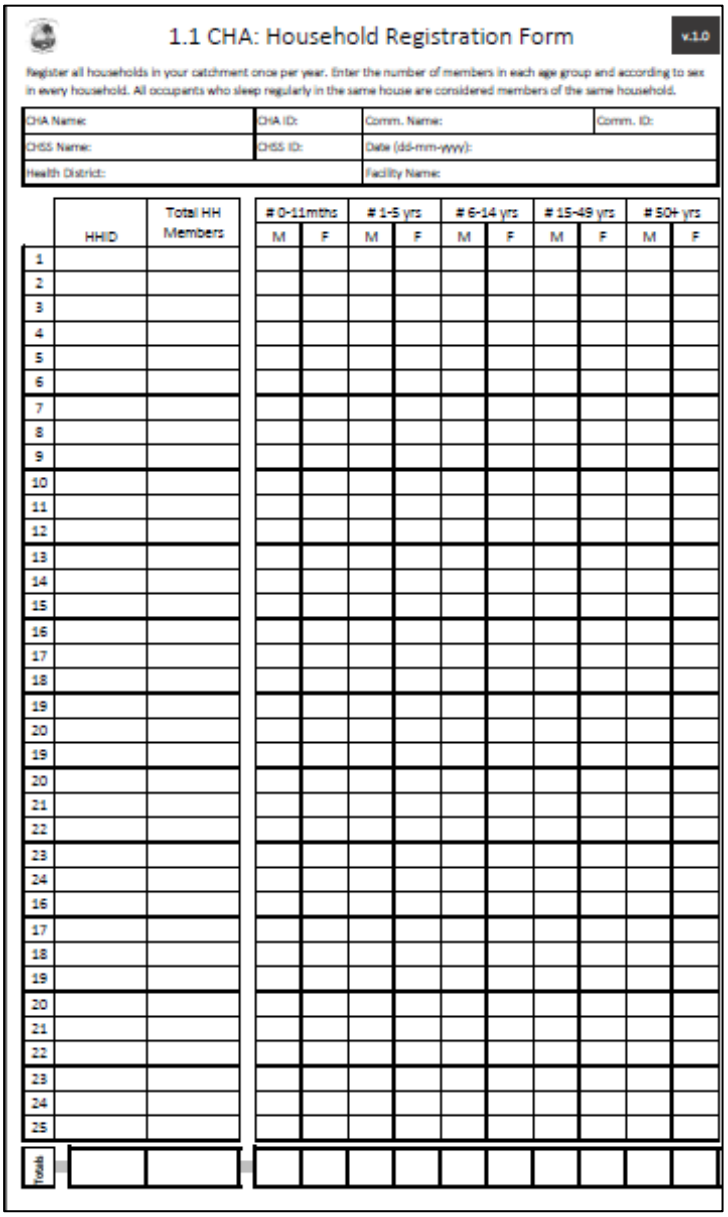
Frequency of Forms

This form is completed upon community entry and then filled annually. The CHSS will inform the CHA when it is time to use the form.

Data Collection

The form collects information at the household level, however, only aggregate community data is collected. The following aggregates are collected

- 1.1.A Total number of households in communities
- 1.1 B Total population in community
- 1.1 C Total number of males (0-11 months)
- 1.1 D Total number of females (0-11 months)
- 1.1 E Total number of males (1-5 years)
- 1.1 F Total number of females (1-5 years)
- 1.1 G Total number of males (6-14 years)
- 1.1 H Total number of females (6-14 years)
- 1.1 I Total number of males (15-49 years)
- 1.1 J Total number of females (15-49 years)
- 1.1 K Total number of males (50 or more years)
- 1.1 L Total number of females (50 or more years)



1.1 CHA: Household Registration Form

v.1.0

Register all households in your catchment once per year. Enter the number of members in each age group and according to sex in every household. All occupants who sleep regularly in the same house are considered members of the same household.

CHA Name:	CHA ID:	Comm. Name:	Comm. ID:
CHSS Name:	CHSS ID:	Date (dd-mm-yyyy):	
Health District:		Facility Name:	

	HHID	Total HH Members	# 0-11mths		# 1-5 yrs		# 6-14 yrs		# 15-49 yrs		# 50+ yrs	
			M	F	M	F	M	F	M	F	M	F
1												
2												
3												
4												
5												
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Totals												

Routine Visit Form

CHAs will use this during their regular visits to community member's houses, collecting basic birth/death indicators and acts as a launching point for other CHA modules.

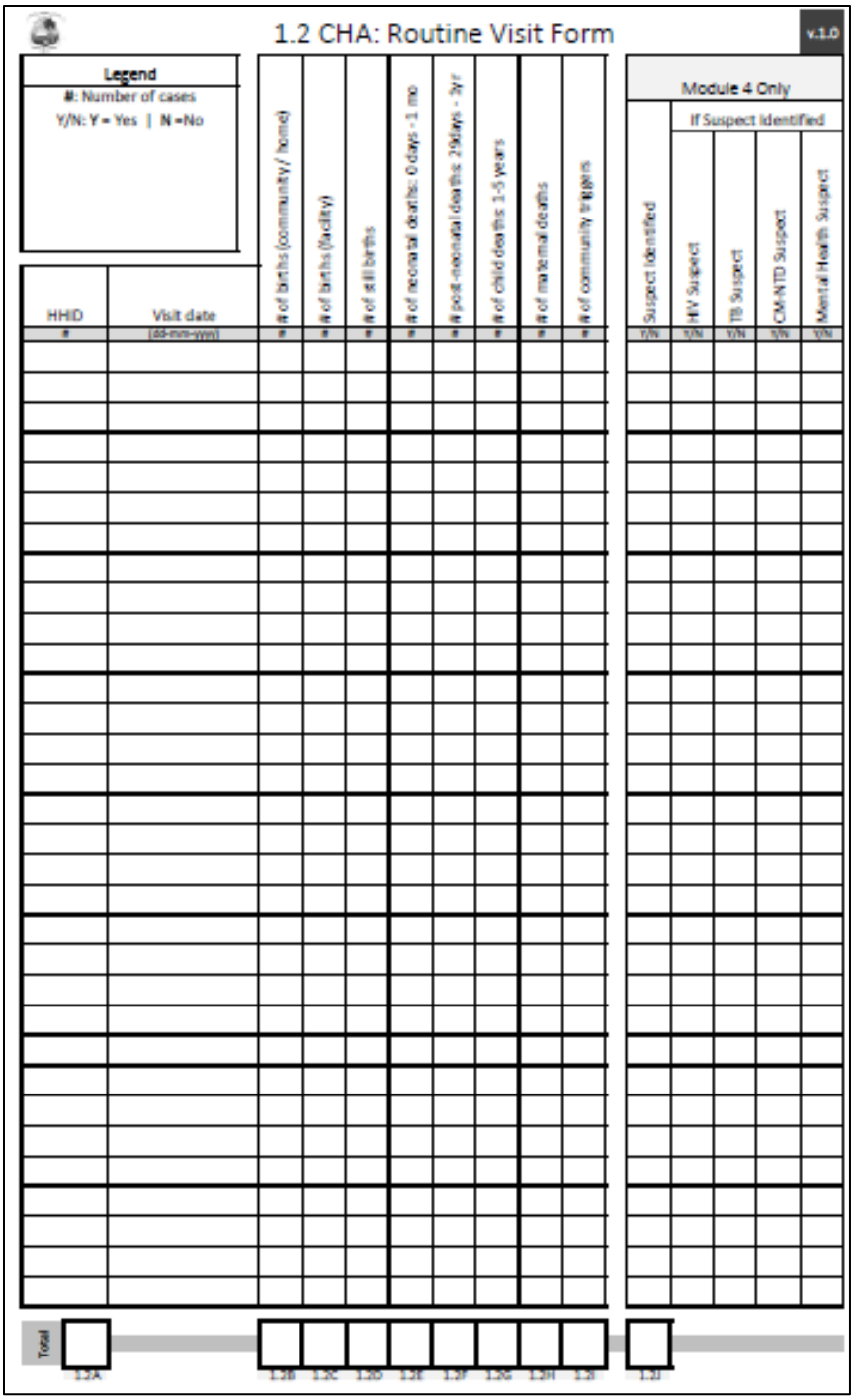
Frequency of Form

This form is completed monthly. Each month a new form is to be used.

Data Collection

CHAs will complete this form during each routine visit and complete one row per household. All data is aggregated at the monthly level in the *5.1 CHA Monthly Service Report*. The numbered and bolded boxes correspond to the indicators on the MSR than are collected. These are the following:

- 1.2A Number of household visits
- 1.2B Number of births
- 1.2C Number of births at the facility
- 1.2D Number of still births
- 1.2E Number of neonatal deaths
- 1.2F Number of post-neonatal deaths
- 1.2G Number of child deaths
- 1.2H Number of maternal deaths
- 1.2I Number of community triggers
- 1.2J Number of pregnant women identified



Community Trigger & Referral Form

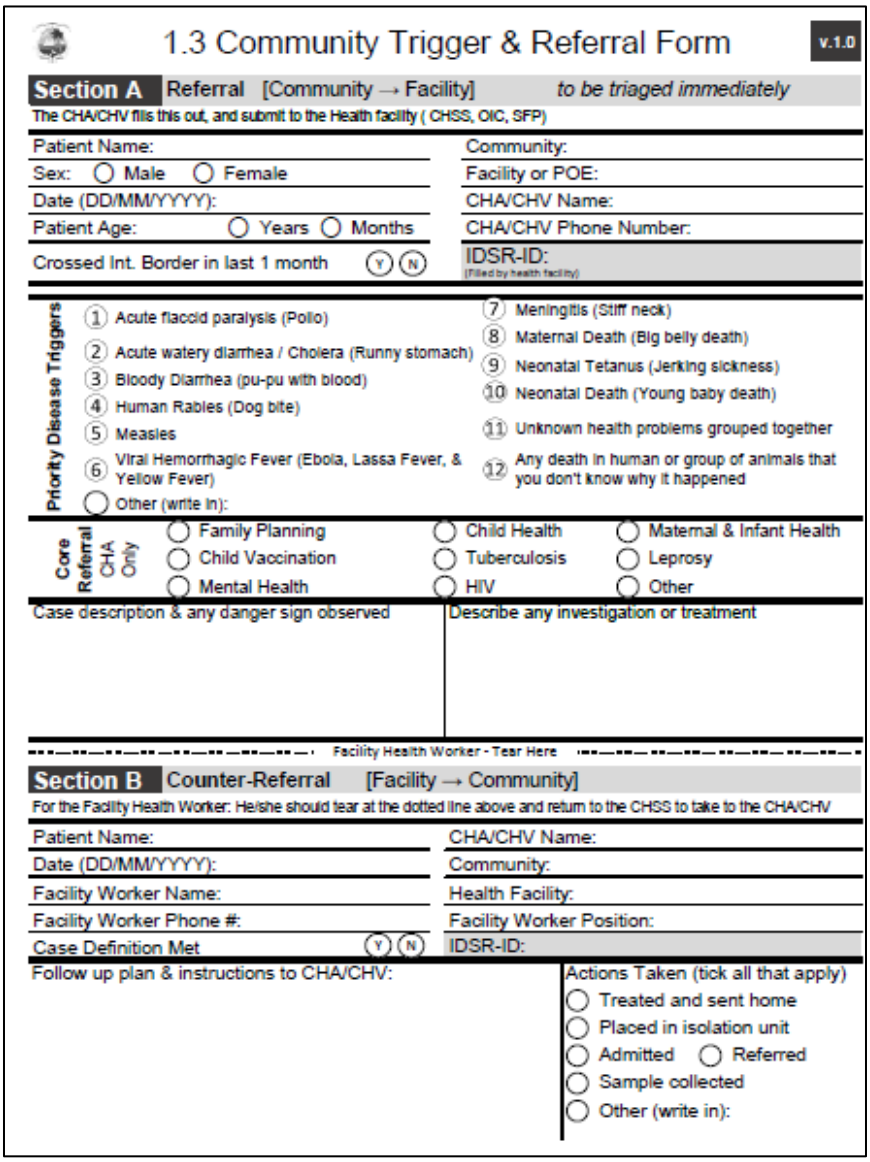
Used to refer patients to the facility, as well as counter-refer back to the CHA in the community.

Frequency of Form

This form is completed in the event of a referral or if the CHA identifies a priority disease trigger.

Data Collection

This form is first filled by the CHA and then given to the patient to deliver to the Facility Health Worker. Once treatment is completed, the Facility Health Worker will send the form back with the patient to the CHA with instructions. No discrete data points are collected via this form.



1.3 Community Trigger & Referral Form v.1.0

Section A Referral [Community → Facility] *to be triaged immediately*

The CHA/CHV fills this out, and submit to the Health facility (CHSS, OIC, SFP)

Patient Name: | Community:
Sex: ◯ Male ◯ Female | Facility or POE:
Date (DD/MM/YYYY): | CHA/CHV Name:
Patient Age: ◯ Years ◯ Months | CHA/CHV Phone Number:
Crossed Int. Border in last 1 month (Y) (N) | IDSR-ID: (Filled by health facility)

Priority Disease Triggers

1. Acute flaccid paralysis (Polio)
2. Acute watery diarrhea / Cholera (Runny stomach)
3. Bloody Diarrhea (pu-pu with blood)
4. Human Rabies (Dog bite)
5. Measles
6. Viral Hemorrhagic Fever (Ebola, Lassa Fever, & Yellow Fever)
7. Meningitis (Stiff neck)
8. Maternal Death (Big belly death)
9. Neonatal Tetanus (Jerking sickness)
10. Neonatal Death (Young baby death)
11. Unknown health problems grouped together
12. Any death in human or group of animals that you don't know why it happened

◯ Other (write in):

Core Referral CHA Only

◯ Family Planning ◯ Child Health ◯ Maternal & Infant Health
◯ Child Vaccination ◯ Tuberculosis ◯ Leprosy
◯ Mental Health ◯ HIV ◯ Other

Case description & any danger sign observed | Describe any investigation or treatment

Facility Health Worker - Tear Here

Section B Counter-Referral [Facility → Community]

For the Facility Health Worker: He/she should tear at the dotted line above and return to the CHSS to take to the CHA/CHV

Patient Name: | CHA/CHV Name:
Date (DD/MM/YYYY): | Community:
Facility Worker Name: | Health Facility:
Facility Worker Phone #: | Facility Worker Position:
Case Definition Met (Y) (N) | IDSR-ID:

Follow up plan & instructions to CHA/CHV:

Actions Taken (tick all that apply)
◯ Treated and sent home
◯ Placed in isolation unit
◯ Admitted ◯ Referred
◯ Sample collected
◯ Other (write in):

Module 2 – RMNH

Pregnant Woman, Mother, and Newborn Ledger

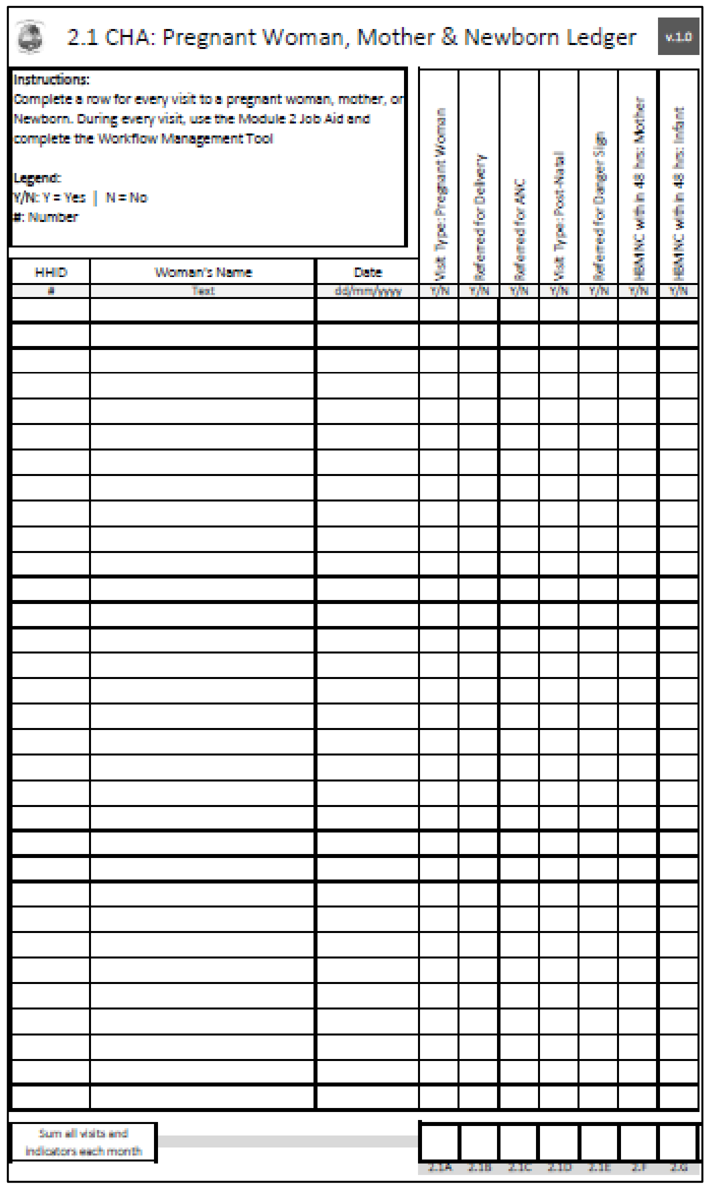
This Ledger is used to track pregnant women, mothers, and newborns across the entire cycle. When a pregnancy is first identified by the CHA, core information and a birth plan are documented. Afterwards, the CHA tracks the woman on a monthly basis, monitors the birth, and tracks follow-up visits in the first two weeks after a woman returns to the community. Referrals are specifically tracked as well.

Frequency of Form

One ledger is used per woman/newborn throughout the entire duration of pregnancy, birth, and the first two weeks after a woman returns to the community.

Data Collection

- 2.1 A Total number of pregnant woman visits
- 2.1B Total number of women referred for delivery
- 2.1C Total number of women referred for ANC
- 2.1D Total number of Post-natal visits
- 2.1E Total number infants referred for danger signs
- 2.1F Total number HBMNC within 48 hours-mother
- 2.1G Total number HBMNC within 48 hours-infant



2.1 CHA: Pregnant Woman, Mother & Newborn Ledger v.1.0

Instructions:
Complete a row for every visit to a pregnant woman, mother, or Newborn. During every visit, use the Module 2 Job Aid and complete the Workflow Management Tool

Legend:
Y/N: Y = Yes | N = No
#: Number

HHID	Woman's Name	Date	Visit Type: Pregnant Woman	Referred for Delivery	Referred for ANC	Visit Type: Post-Natal	Referred for Danger Sign	HBMNC within 48 hrs: Mother	HBMNC within 48 hrs: Infant
#	Text	dd/mm/yyyy	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Sum all visits and indicators each month			2.1A	2.1B	2.1C	2.1D	2.1E	2.F	2.G

Family Planning Tracker

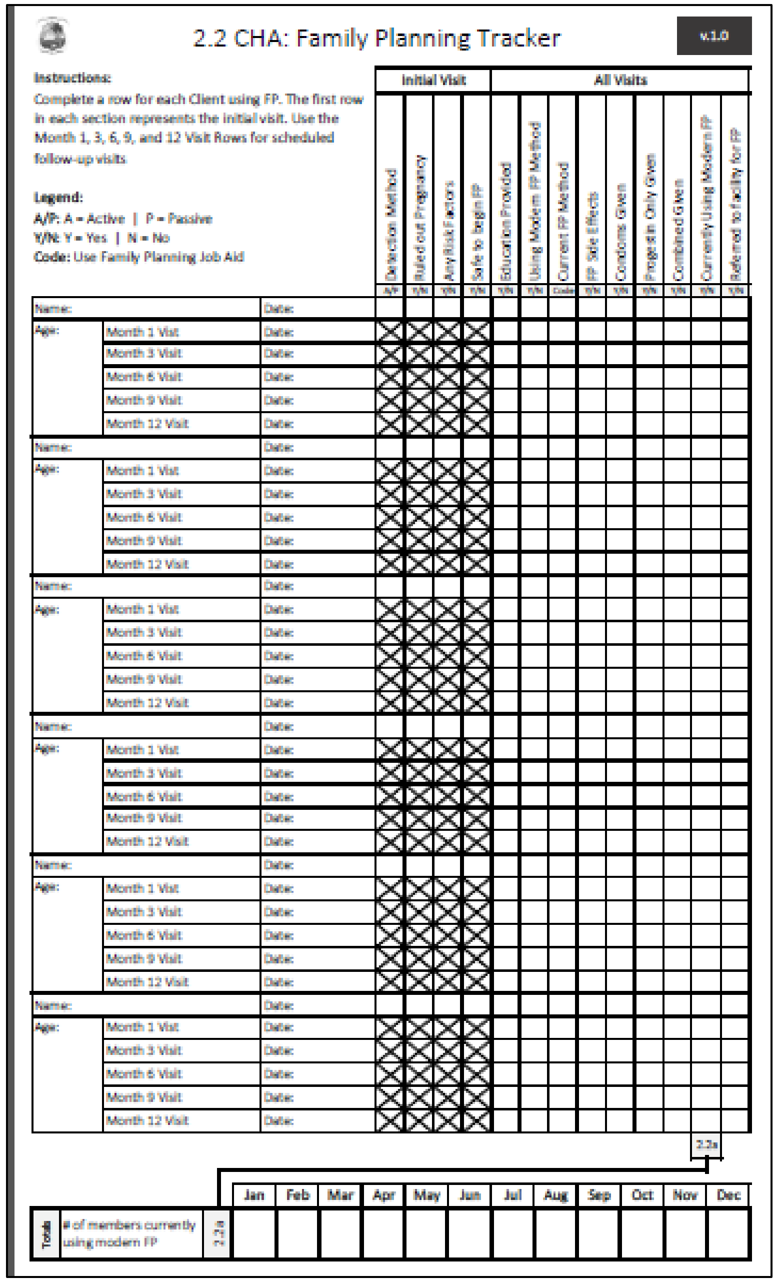
This form is used to track households and community members using family planning.

Frequency of Form

After the initial visit, the Family planning tracker should be filled out every three months. Data is collected monthly (women aged 15-49 using modern family planning method)

Data Collection

CHAs will record new women aged 15-49 who begin using modern family planning on the *5.1 CHA Monthly Service Report* on a monthly basis.



2.2 CHA: Family Planning Tracker

v.1.0

Instructions:
Complete a row for each Client using FP. The first row in each section represents the initial visit. Use the Month 1, 3, 6, 9, and 12 Visit Rows for scheduled follow-up visits

Legend:
A/P: A = Active | P = Passive
Y/N: Y = Yes | N = No
Code: Use Family Planning Job Aid

			Initial Visit				All Visits								
			Detection Method	Ruled out Pregnancy	Any Risk Factors	Safe to begin FP	Education Provided	Using Modern FP Method	Current FP Method	FP Side Effects	Condoms Given	Progestin Only Given	Combined Given	Currently Using Modern FP	Referred to Facility for FP
			A/P	Y/N	Y/N	Y/N	Y/N	Y/N	Code	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Name:		Date:													
Age:	Month 1 Visit	Date:	X	X	X	X									
	Month 3 Visit	Date:	X	X	X	X									
	Month 6 Visit	Date:	X	X	X	X									
	Month 9 Visit	Date:	X	X	X	X									
	Month 12 Visit	Date:	X	X	X	X									
Name:		Date:													
Age:	Month 1 Visit	Date:	X	X	X	X									
	Month 3 Visit	Date:	X	X	X	X									
	Month 6 Visit	Date:	X	X	X	X									
	Month 9 Visit	Date:	X	X	X	X									
	Month 12 Visit	Date:	X	X	X	X									
Name:		Date:													
Age:	Month 1 Visit	Date:	X	X	X	X									
	Month 3 Visit	Date:	X	X	X	X									
	Month 6 Visit	Date:	X	X	X	X									
	Month 9 Visit	Date:	X	X	X	X									
	Month 12 Visit	Date:	X	X	X	X									
Name:		Date:													
Age:	Month 1 Visit	Date:	X	X	X	X									
	Month 3 Visit	Date:	X	X	X	X									
	Month 6 Visit	Date:	X	X	X	X									
	Month 9 Visit	Date:	X	X	X	X									
	Month 12 Visit	Date:	X	X	X	X									
Name:		Date:													
Age:	Month 1 Visit	Date:	X	X	X	X									
	Month 3 Visit	Date:	X	X	X	X									
	Month 6 Visit	Date:	X	X	X	X									
	Month 9 Visit	Date:	X	X	X	X									
	Month 12 Visit	Date:	X	X	X	X									
Name:		Date:													
Age:	Month 1 Visit	Date:	X	X	X	X									
	Month 3 Visit	Date:	X	X	X	X									
	Month 6 Visit	Date:	X	X	X	X									
	Month 9 Visit	Date:	X	X	X	X									
	Month 12 Visit	Date:	X	X	X	X									

2.2a

			Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Totals	# of members currently using modern FP	2.2a												

Module 3 – iCCM

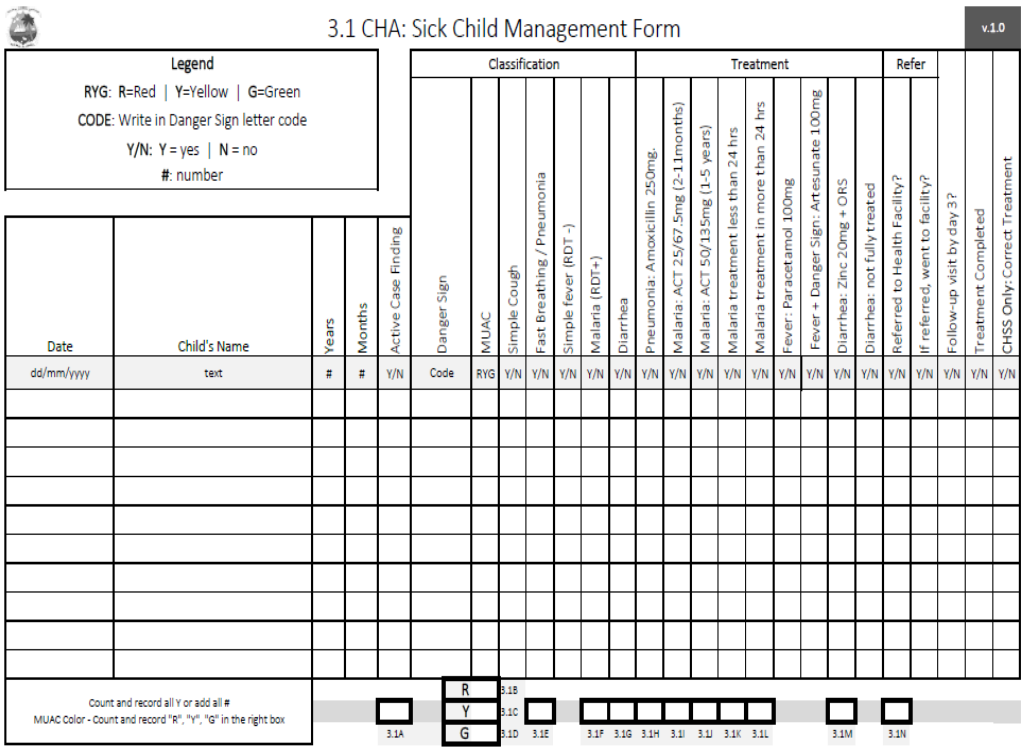
Sick Child Management Form
This form is used to track sick children visited in the community.

Frequency of Form

A row on this form is completed for every sick child that is visited by the CHA. Data is collected on a monthly basis, when the rows are summed, and a new form is begun.

Data Collection

- 3.1A Number of active case finds
- 3.1B Number of children with red MUAC strap recordings
- 3.1C Number of children with yellow MUAC strap recordings
- 3.1D Number of children with green MUAC strap recordings
- 3.1E Number of children identified with Pneumonia
- 3.1F Number of children identified with Malaria positive RDT
- 3.1G Number of children identified with Diarrhea
- 3.1H Number of Pneumonia cases treated with antibiotics
- 3.1I Number of Malaria cases treated (2-11 months old)
- 3.1J Number of Malaria cases treated (1-5 years old)
- 3.1K Number of Malaria cases treated within 24 hours of symptoms
- 3.1M Number of Malaria cases treated after 24 hours of symptoms
- 3.1N Diarrhea cases treated with Zinc tablets and ORS



3.1 CHA: Sick Child Management Form

v.1.0

Legend
RYG: R=Red | Y=Yellow | G=Green
CODE: Write in Danger Sign letter code
Y/N: Y = yes | N = no
#: number

					Classification							Treatment											Refer							
Date	Child's Name	Years	Months	Active Case Finding	Danger Sign	MUAC	Simple Cough	Fast Breathing / Pneumonia	Simple fever (RDT -)	Malaria (RDT+)	Diarrhea	Pneumonia: Amoxicillin 250mg.	Malaria: ACT 25/67.5mg (2-11months)	Malaria: ACT 50/135mg (1-5 years)	Malaria treatment less than 24 hrs	Malaria treatment in more than 24 hrs	Fever: Paracetamol 100mg	Fever + Danger Sign: Artesunate 100mg	Diarrhea: Zinc 20mg + ORS	Diarrhea: not fully treated	Referred to Health Facility?	If referred, went to facility?	Follow-up visit by day 3?	Treatment Completed	CHSS Only: Correct Treatment
dd/mm/yyyy	text	#	#	Y/N	Code	RYG	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	
Count and record all Y or add all # MUAC Color - Count and record "R", "Y", "G" in the right box				3.1A	R Y G	3.1B 3.1C 3.1D	3.1E					3.1F	3.1G	3.1H	3.1I	3.1J	3.1K	3.1L		3.1M		3.1N					

Module 4 – TB, HIV, Leprosy, and Mental Health

4.1 Case Management Ledger

The *4.1 Case Management Ledger* is used by the CHA to record indicators for HIV TB and NTD cases.

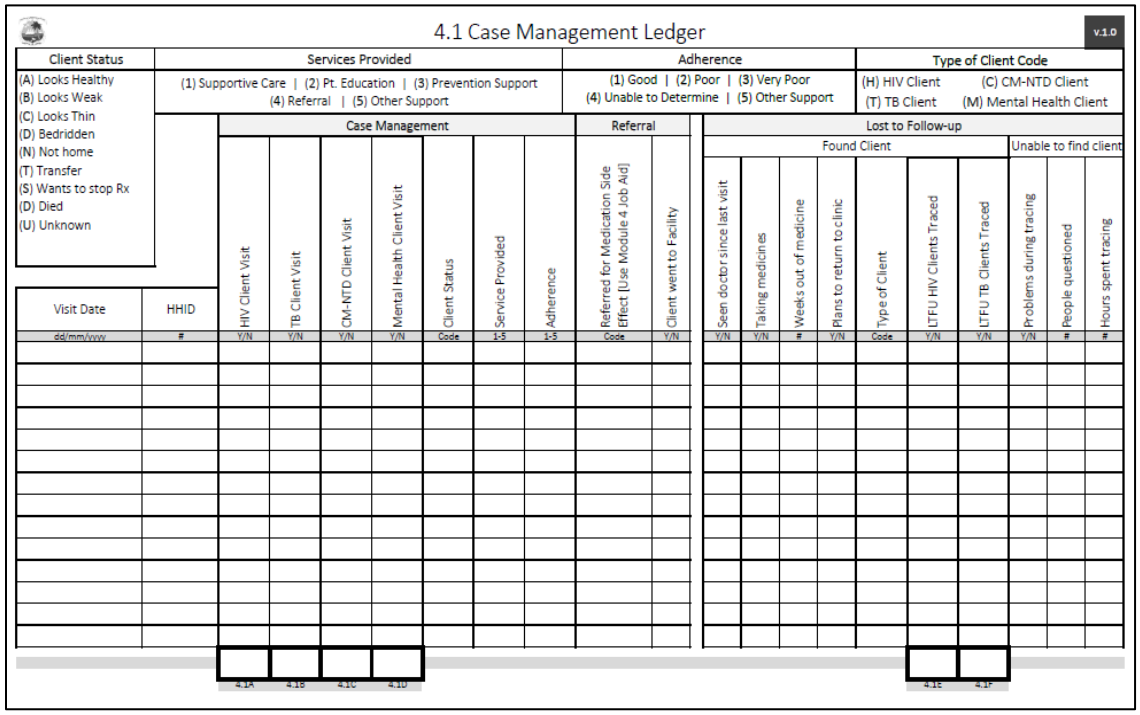
Frequency of Form

The form is used during routine visit and active case finds every month.

Data Collection

The numbered and bolded boxes on the *4.1 Case Management Ledger* correspond to the *5.1 CHA Monthly Service Report* indicators for module 4. These are collected monthly.

4.1A HIV Client visits
4.1B TB Client visits
4.1C CM NTD Client visits
4.1D Mental Health Client visits
4.1E LTFU HIV Clients Traced
4.1F LTFU TB Clients Traced



4.1 Case Management Ledger

v.1.0

Client Status	Services Provided	Adherence	Type of Client Code
(A) Looks Healthy (B) Looks Weak (C) Looks Thin (D) Bedridden (N) Not home (T) Transfer (S) Wants to stop Rx (D) Died (U) Unknown	(1) Supportive Care | (2) Pt. Education | (3) Prevention Support (4) Referral | (5) Other Support	(1) Good | (2) Poor | (3) Very Poor (4) Unable to Determine | (5) Other Support	(H) HIV Client (C) CM-NTD Client (T) TB Client (M) Mental Health Client

		Case Management							Referral		Lost to Follow-up										
											Found Client							Unable to find client			
Visit Date	HHID	HIV Client Visit	TB Client Visit	CM-NTD Client Visit	Mental Health Client Visit	Client Status	Service Provided	Adherence	Referred for Medication Side Effect [Use Module 4 Job Aid]	Client went to Facility	Seen doctor since last visit	Taking medicines	Weeks out of medicine	Plans to return to clinic	Type of Client	LTFU HIV Clients Traced	LTFU TB Clients Traced	Problems during tracing	People questioned	Hours spent tracing
dd/mm/yyyy	#	Y/N	Y/N	Y/N	Y/N	Code	1-5	1-5	Code	Y/N	Y/N	Y/N	#	Y/N	Code	Y/N	Y/N	Y/N	#	#
		4.1A	4.1B	4.1C	4.1D											4.1E	4.1F			

Supervision Tools

5.1 CHA Monthly Service Report

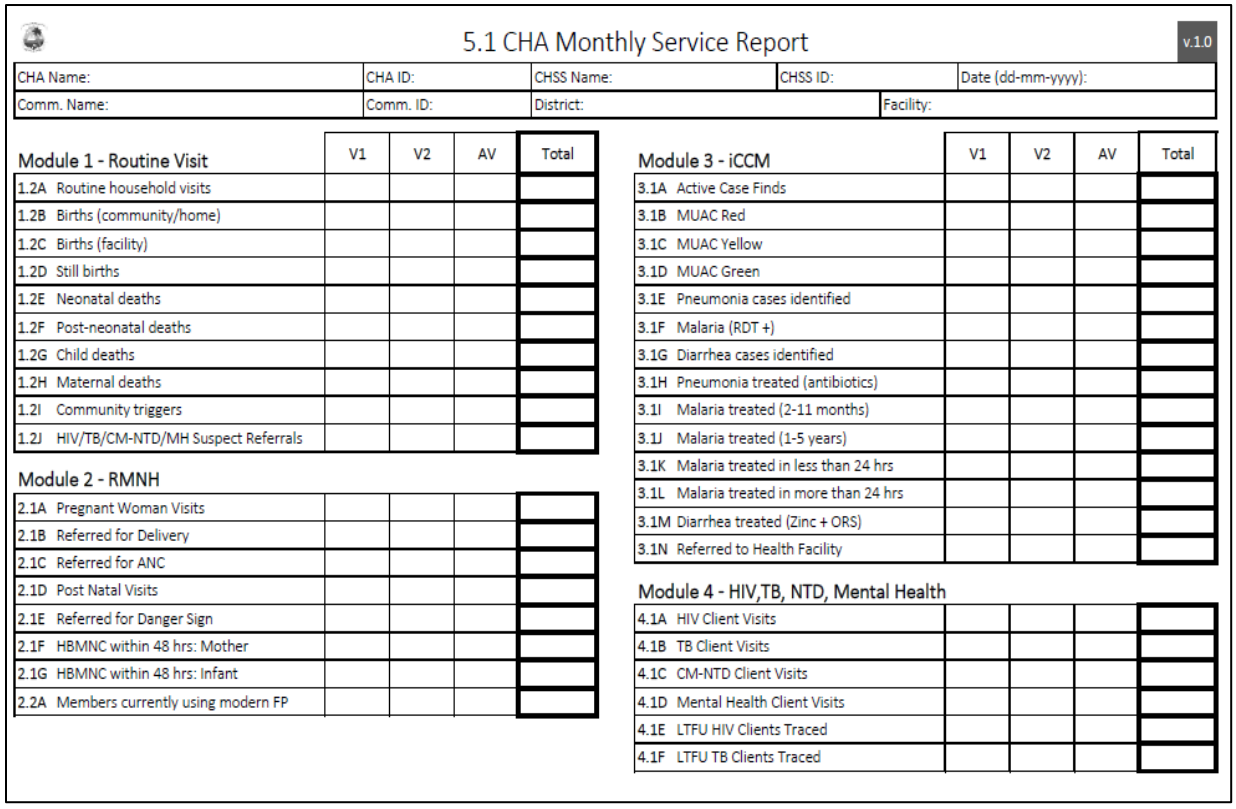
The *5.1 CHA Monthly Service Report* is used by the CHA. It Records vital statistics from each module.

Frequency of Form

The *5.1 CHA Monthly Service Report* is filled out by the CHA Monthly. The CHA uses the forms from each module to fill out the MSR.

Data Collection

The form should be completed by the CHA on the 1st of every month for the previous month. The CHSS will collect this form between the 1st and 5th of each month for the previous month.



5.1 CHA Monthly Service Report v.1.0

CHA Name:	CHA ID:	CHSS Name:	CHSS ID:	Date (dd-mm-yyyy):
Comm. Name:	Comm. ID:	District:	Facility:	

Module 1 - Routine Visit	V1	V2	AV	Total
1.2A Routine household visits				
1.2B Births (community/home)				
1.2C Births (facility)				
1.2D Still births				
1.2E Neonatal deaths				
1.2F Post-neonatal deaths				
1.2G Child deaths				
1.2H Maternal deaths				
1.2I Community triggers				
1.2J HIV/TB/CM-NTD/MH Suspect Referrals				

Module 2 - RMNH				
2.1A Pregnant Woman Visits				
2.1B Referred for Delivery				
2.1C Referred for ANC				
2.1D Post Natal Visits				
2.1E Referred for Danger Sign				
2.1F HBMNC within 48 hrs: Mother				
2.1G HBMNC within 48 hrs: Infant				
2.2A Members currently using modern FP				

Module 3 - iCCM	V1	V2	AV	Total
3.1A Active Case Finds				
3.1B MUAC Red				
3.1C MUAC Yellow				
3.1D MUAC Green				
3.1E Pneumonia cases identified				
3.1F Malaria (RDT +)				
3.1G Diarrhea cases identified				
3.1H Pneumonia treated (antibiotics)				
3.1I Malaria treated (2-11 months)				
3.1J Malaria treated (1-5 years)				
3.1K Malaria treated in less than 24 hrs				
3.1L Malaria treated in more than 24 hrs				
3.1M Diarrhea treated (Zinc + ORS)				
3.1N Referred to Health Facility				

Module 4 - HIV,TB, NTD, Mental Health				
4.1A HIV Client Visits				
4.1B TB Client Visits				
4.1C CM-NTD Client Visits				
4.1D Mental Health Client Visits				
4.1E LTFU HIV Clients Traced				
4.1F LTFU TB Clients Traced				

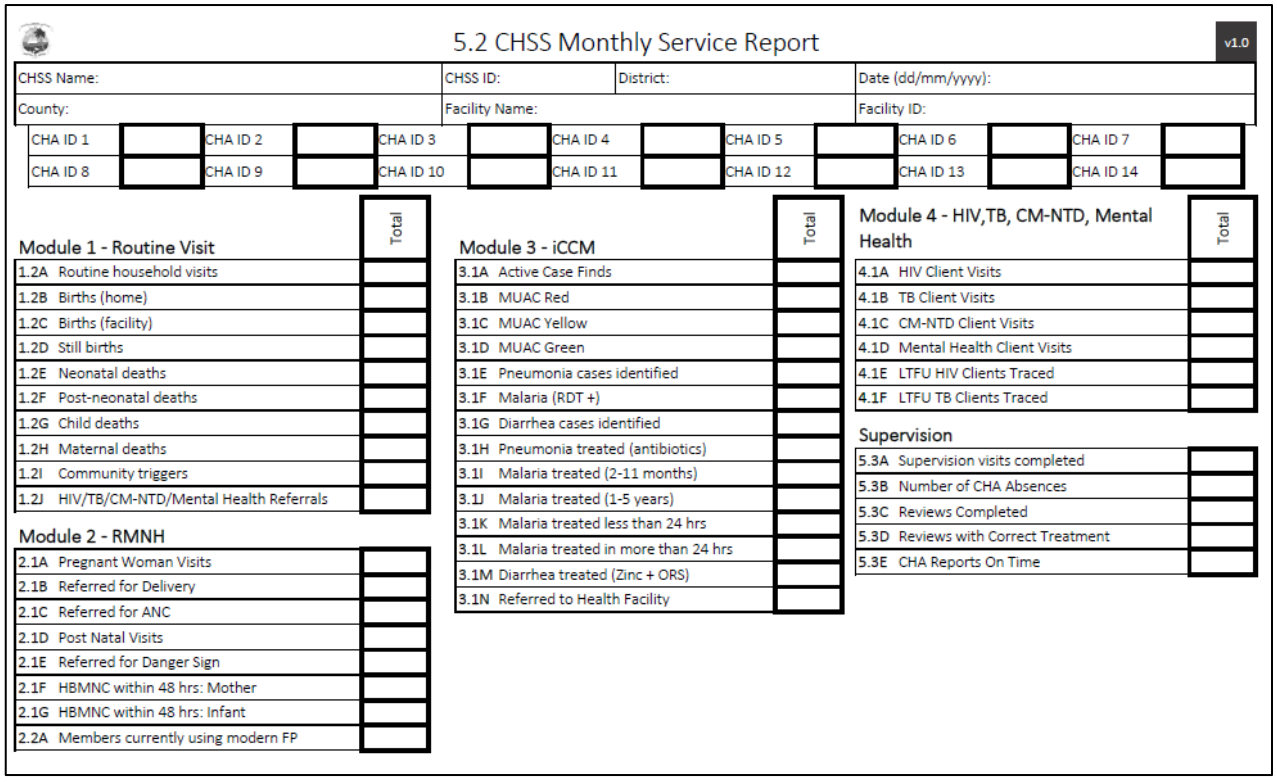
5.2 CHSS Monthly Service Report

Frequency of Form

The *5.2 CHSS Monthly Service Report* is used Monthly by the CHSS to collect data from the CHA.

Data Collection

The CHSS aggregates the 5.1 CHA Monthly Services Reports and records the totals on the 5.2 CHSS Monthly Service Report.



5.2 CHSS Monthly Service Report v1.0

CHSS Name:	CHSS ID:	District:	Date (dd/mm/yyyy):
County:	Facility Name:		Facility ID:

CHA ID 1		CHA ID 2		CHA ID 3		CHA ID 4		CHA ID 5		CHA ID 6		CHA ID 7	
CHA ID 8		CHA ID 9		CHA ID 10		CHA ID 11		CHA ID 12		CHA ID 13		CHA ID 14	

Module 1 - Routine Visit	Total
1.2A Routine household visits	
1.2B Births (home)	
1.2C Births (facility)	
1.2D Still births	
1.2E Neonatal deaths	
1.2F Post-neonatal deaths	
1.2G Child deaths	
1.2H Maternal deaths	
1.2I Community triggers	
1.2J HIV/TB/CM-NTD/Mental Health Referrals	

Module 2 - RMNH	
2.1A Pregnant Woman Visits	
2.1B Referred for Delivery	
2.1C Referred for ANC	
2.1D Post Natal Visits	
2.1E Referred for Danger Sign	
2.1F HBMNC within 48 hrs: Mother	
2.1G HBMNC within 48 hrs: Infant	
2.2A Members currently using modern FP	

Module 3 - iCCM	Total
3.1A Active Case Finds	
3.1B MUAC Red	
3.1C MUAC Yellow	
3.1D MUAC Green	
3.1E Pneumonia cases identified	
3.1F Malaria (RDT +)	
3.1G Diarrhea cases identified	
3.1H Pneumonia treated (antibiotics)	
3.1I Malaria treated (2-11 months)	
3.1J Malaria treated (1-5 years)	
3.1K Malaria treated less than 24 hrs	
3.1L Malaria treated in more than 24 hrs	
3.1M Diarrhea treated (Zinc + ORS)	
3.1N Referred to Health Facility	

Module 4 - HIV,TB, CM-NTD, Mental Health	Total
4.1A HIV Client Visits	
4.1B TB Client Visits	
4.1C CM-NTD Client Visits	
4.1D Mental Health Client Visits	
4.1E LTFU HIV Clients Traced	
4.1F LTFU TB Clients Traced	

Supervision	
5.3A Supervision visits completed	
5.3B Number of CHA Absences	
5.3C Reviews Completed	
5.3D Reviews with Correct Treatment	
5.3E CHA Reports On Time	

5.3 CHSS Supervision Report

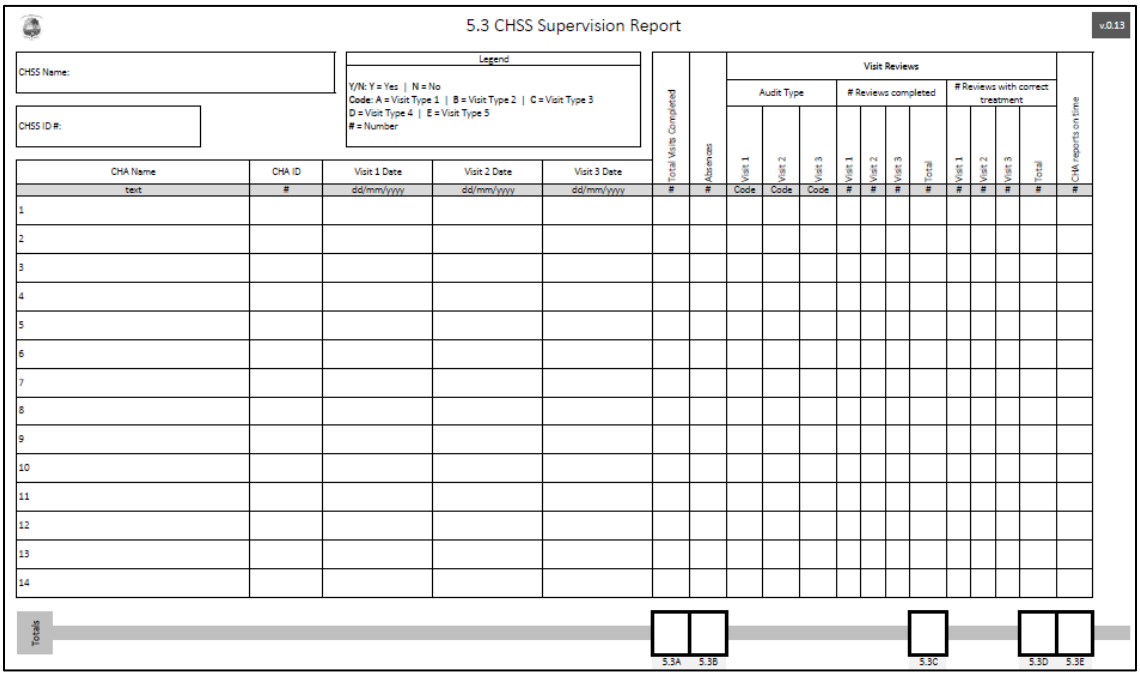
The *5.3 CHSS Supervision Report* is used by the CHSS to record CHA visit and audit information as well as reviews on correct treatment.

Frequency of Form

The form is used on routine supervision visits throughout the month.

Data Collection

The numbered and bolded boxes on the *5.3 CHSS Supervision Report* correspond to the numbered and bolded boxes on the *5.2 CHSS Monthly Supervision Report.*



5.3 CHSS Supervision Report

v.0.13

CHSS Name:

CHSS ID #:

Legend

Y/N: Y = Yes | N = No
Code: A = Visit Type 1 | B = Visit Type 2 | C = Visit Type 3
D = Visit Type 4 | E = Visit Type 5
# = Number

CHA Name	CHA ID	Visit 1 Date	Visit 2 Date	Visit 3 Date	Total Visits Completed	# Absences	Visit Reviews: Audit Type: Visit 1	Audit Type: Visit 2	Audit Type: Visit 3	# Reviews completed: Visit 1	# Reviews completed: Visit 2	# Reviews completed: Visit 3	# Reviews completed: Total	# Reviews with correct treatment: Visit 1	# Reviews with correct treatment: Visit 2	# Reviews with correct treatment: Visit 3	# Reviews with correct treatment: Total	# CHA reports on time
text	#	dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy	#	#	Code	Code	Code	#	#	#	#	#	#	#	#	#
1																		
2																		
3																		
4																		
5																		
6																		
7																		
8																		
9																		
10																		
11																		
12																		
13																		
14																		

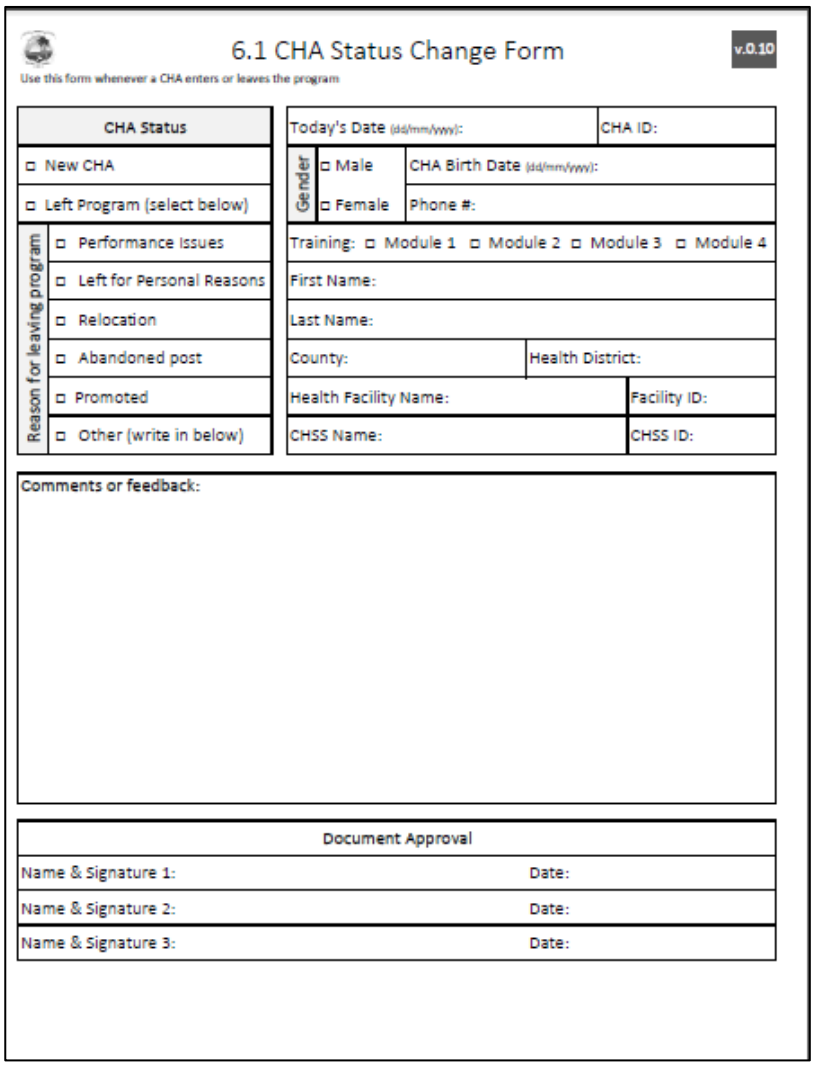
Totals

5.3A 5.3B 5.3C 5.3D 5.3E

Training and HR Tools

6.1 CHA Status Change Form

The *6.1 CHA Status Change Form* is to be used when selecting a CHA or when a CHA status has changed. It is intended to be used whenever a new CHA is selected or when a CHA is leaving the program. The form captures basic information on the CHA such as name, supervisor information, and training level. County-level Human Resource staff are responsible for completing this form whenever a change in CHA status occurs



6.1 CHA Status Change Form

v.0.10

Use this form whenever a CHA enters or leaves the program

CHA Status	Today's Date (dd/mm/yyyy):	CHA ID:
◻ New CHA	Gender ◻ Male	CHA Birth Date (dd/mm/yyyy):
◻ Left Program (select below)	Gender ◻ Female	Phone #:
Reason for leaving program: ◻ Performance Issues	Training: ◻ Module 1 ◻ Module 2 ◻ Module 3 ◻ Module 4	
◻ Left for Personal Reasons	First Name:	
◻ Relocation	Last Name:	
◻ Abandoned post	County:	Health District:
◻ Promoted	Health Facility Name:	Facility ID:
◻ Other (write in below)	CHSS Name:	CHSS ID:

Comments or feedback:

Document Approval	
Name & Signature 1:	Date:
Name & Signature 2:	Date:
Name & Signature 3:	Date:

6.2 CHA Training Ledger

The *6.2 CHA Training Ledger* is used during and immediately following CHA Training to track training participants and scores. The facilitators are responsible for completing this form. It is used to track which participants were successful in the training.

6.2 CHA Training Ledger

v.0.2

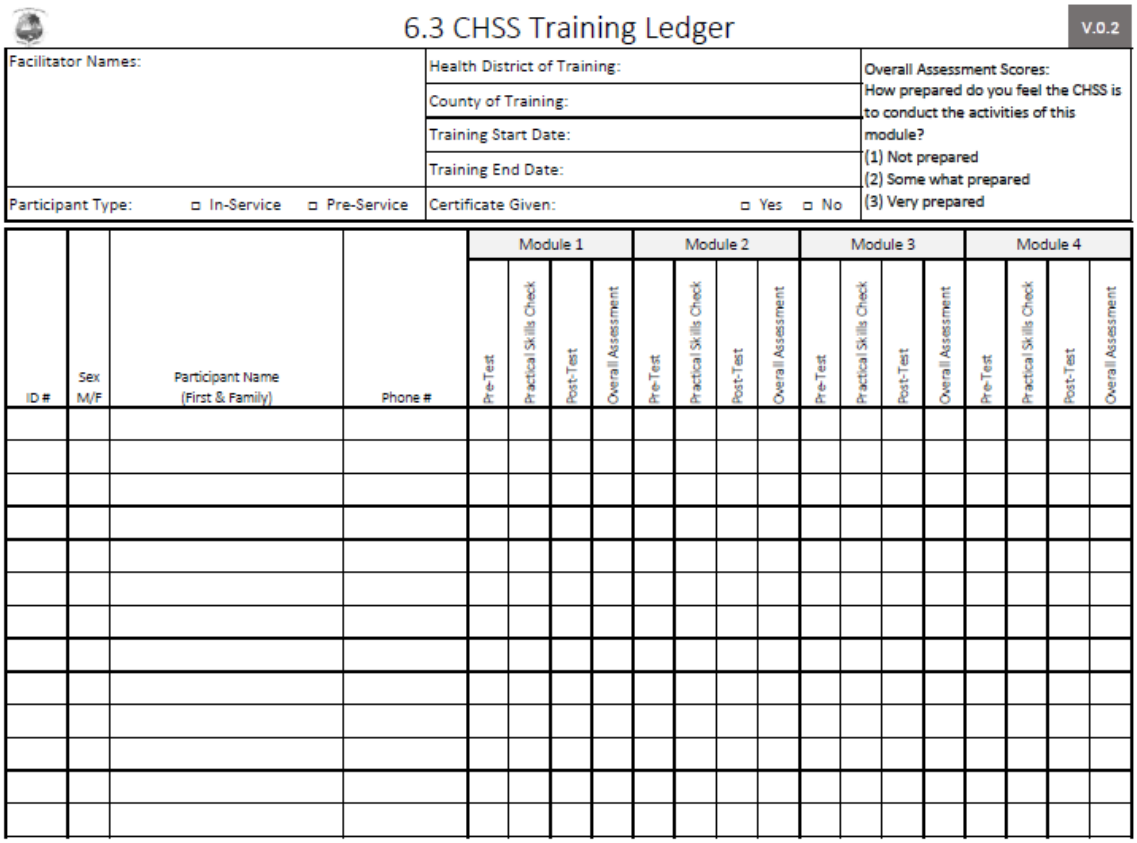
Facilitator Names:	Health District of Training:
	County of Training:
	Training Start Date:
	Training End Date:
☐ Module 1 ☐ Module 2 ☐ Module 3 ☐ Module 4	☐ Other (write in):
Training Participant Type: ☐ In-Service ☐ Pre-Service	Certificate Given: ☐ Yes ☐ No

Overall Assessment Score: *How prepared do you feel the CHA is to conduct the activities of this module?*
(1) Not prepared | (2) Somewhat prepared | (3) Very prepared

ID #	Sex M/F	Participant Name (First & Family)	Phone #	Pre-Test	Practical Skills Check	Post-Test	Overall Assessment

6.3 CHSS Training Ledger

The *6.3 CHSS Training Ledger* is used by the Training Team to record participants to the CHSS trainings and their subsequent scores. The facilitators of the training are responsible for filling this form. It is used to track which participants were successful in the training.



6.3 CHSS Training Ledger

V.0.2

Facilitator Names:	Health District of Training:	Overall Assessment Scores: How prepared do you feel the CHSS is to conduct the activities of this module? (1) Not prepared (2) Some what prepared (3) Very prepared
	County of Training:	
	Training Start Date:	
	Training End Date:	
Participant Type: ☐ In-Service ☐ Pre-Service	Certificate Given: ☐ Yes ☐ No	

ID #	Sex M/F	Participant Name (First & Family)	Phone #	Module 1				Module 2				Module 3				Module 4			
				Pre-Test	Practical Skills Check	Post-Test	Overall Assessment	Pre-Test	Practical Skills Check	Post-Test	Overall Assessment	Pre-Test	Practical Skills Check	Post-Test	Overall Assessment	Pre-Test	Practical Skills Check	Post-Test	Overall Assessment

Appendix III

M&E Framework

The M&E framework below shows the indicators that are collected for CBIS and where the indicators come from in the forms. Each KPI Code number corresponds to the number on the bolded boxes on the forms. For example, for Nutrition the KPI Code Numerator 3.1 b corresponds to the bolded box 3.1 b on the *3.1 Sick Child Management form*, which is then used to fill in the *5.1 CHA Monthly Service Report* with the same number and then used to aggregate the *5.2 CHSS Monthly Report.*

Category	Key Activities	Indicator	Numerator	Denominator	Disaggregation	Data Source	Frequency of Data Collection	Frequency of Data Reporting
Nutrition	MUAC screening	Number of children under 5 years assessed with MUAC	# of children under 5 years assessed with MUAC (3.1 b + 3.1c + 3.1d)	n/a	Red / yellow / green	CHSS Monthly Report	Weekly	Monthly
Reproductive Health	Postnatal care for mothers and newborns	Percent of mothers who received HBMNC within 2 days of child birth	# of mothers who received HBMNC within 2 days of child birth (2.1f)	# of mothers who gave birth (1.2b + 1.2c)	(none)	CHSS Monthly Report	Weekly	Monthly
		Percent of neonates who received HBMNC within 2 days of being in community after birth	# newborns who received HBMNC visit within 2 days of being in community after birth (2.1g)	# of newborns (1.2b + 1.2c)	(none)	CHSS Monthly Report	Weekly	Monthly

		Number of pregnant women referred to ANC	# of pregnant women referred to ANC (2.1c)	n/a		CHSS Monthly Report	Weekly	Monthly
		Number of pregnant women referred to facility for delivery	# of pregnant women referred to facility for delivery (2.1b)	n/a		CHSS Monthly Report	Weekly	Monthly
		Modern contraceptive prevalence rate	Women 15-49 using modern family planning (2.2a)	# of women 15-49 years old (1.1j)	(none)	CHSS Monthly Report and Registration Data	Weekly	Monthly
iCCM	Treatment of malaria, diarrhea, and pneumonia in children under five	Percent of children <5 years who tested positive for malaria (RDT) and were treated with ACT within 24 hours	# of children <5 years with malaria (confirmed with RDT) treated with ACT within 24 hours (3.1k)	Total # of children <5 years with malaria (confirmed with RDT) (3.1f)	Age (under-1 / 1-5 years	CHSS Monthly Report	Weekly	Monthly
		Percent of children <5 years treated for diarrhea with ORS and zinc	# of children <5 years with diarrhea treated with ORS / zinc (3.1m)	Total # of children <5 years with diarrhea identified by the CHA (3.1g)	Under 5 years	CHSS Monthly Report	Weekly	Monthly
		Percent of children <5 years treated for pneumonia with antibiotics	# of children <5 years with pneumonia treated with antibiotics (3.1h)	Total # of children <5 years with pneumonia identified by the CHA (3.1e)	Under 5 years	CHSS Monthly Report	Weekly	Monthly

HIV | TB | NTD | Mental Health	HIV, TB, NTD, MH Suspect Identification	Number of HIV, TB, NTD, MH suspects identified	Number of HIV, TB, NTD, MH suspects identified (1.2j)	n/a	(none)	CHSS Monthly Report	Weekly	Monthly
	Case Management	Number of HIV Client Visits	Number of HIV Client Visits (4.1a)	n/a	(none)	CHSS Monthly Report	Weekly	Monthly
		Number of TB Client Visits	Number of TB Client Visits (4.1b)	n/a	(none)	CHSS Monthly Report	Weekly	Monthly
		Number of Neglected Tropical Disease Client Visits	Number of Neglected Tropical Disease Client Visits (4.1c)	n/a	(none)	CHSS Monthly Report	Weekly	Monthly
		Number of Mental Health Client Visits	Number of Mental Health Client Visits (4.1d)	n/a	(none)	CHSS Monthly Report	Weekly	Monthly
	HIV and TB Lost to follow up tracing	Number of HIV Lost to follow up clients traced	Number of HIV Lost to follow up clients traced (4.1e)	n/a	(none)	CHSS Monthly Report	Weekly	Monthly
		Number of TB Lost to follow up clients traced	Number of TB Lost to follow up clients traced (4.1f)	n/a	(none)	CHSS Monthly Report	Weekly	Monthly
Surveillance	Priority disease surveillance and reporting	# priority disease events reported	# priority disease events reported (1.2i)	n/a	(none)	CHSS Monthly Report	Weekly	Monthly

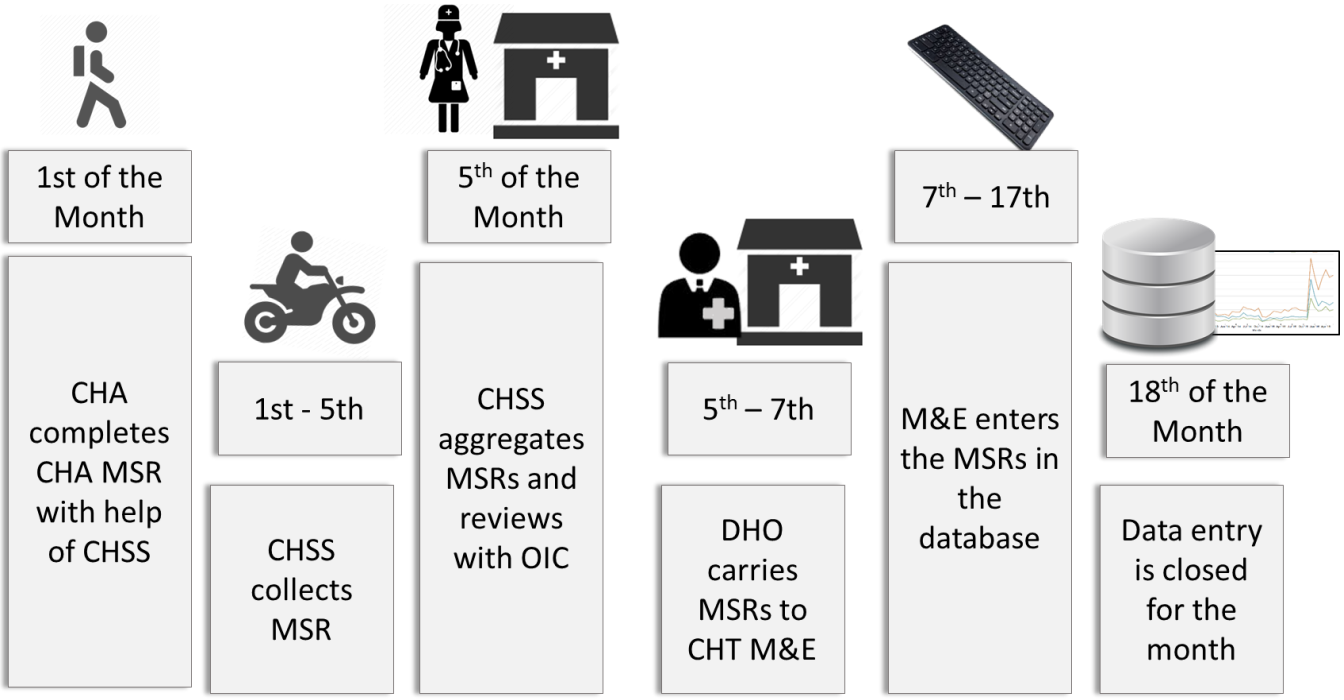
Supervision	High-quality supervision of CHAs by CHSSs	# of supervision visits received	# of supervision visits received (for which CHA was present) (5.3a)	n/a	CHA	CHSS monthly report	Monthly	Monthly
		# of CHAs supervised/ total active CHAs	# of CHAs who received at least one supervision visit (5.3a)	# of active CHAs	(none)	CHSS monthly report	Monthly	Monthly
		Correct treatment rate	# of patient reviews (audits) for which correct treatment was given (5.3d)	total # of patient reviews (5.3c)	Facilities, districts, counties	CHSS monthly report	Monthly	Monthly
		#/% of routine household visits conducted	# of routine household visits conducted (1.2a)	# of households in CHA catchment (1.1a)	CHA	Household Registration Form	Weekly	Monthly
		Number of active CHAs	# of CHAs who are receiving incentives, have received at least one training and have submitted their report	n/a	Age, gender	iHRIS records	Quarterly	Quarterly
Human resources	Recruitment and retention of health workers	Number of active CHSSs	# of CHSSs who are receiving incentives, have received at least one training have	n/a	Age, gender	iHRIS records	Quarterly	Quarterly

			submitted their report					
		Num/ % of CHAs trained	# of CHAs who have received a specific training module	# of active CHAs	Training module	iHRIS records	Monthly	Monthly
		Number of trainings conducted	# of distinct trainings conducted	n/a	Training module	iHRIS records	Monthly	Monthly
		Num/ % of communities served	# of geographically distinct clusters of houses served by an active CHA	# of communities >5km from a health facility	(none)	iHRIS records	Quarterly	Quarterly
		Num/ % of people served	# of people living in a community that is served by an active CHA	# of people living in communities >5km from a health facility	Age, gender	iHRIS records	Quarterly	Quarterly
		CHA: population ratio	# of active CHAs	# of people targeted (29% of the population)	By county	iHRIS records	Quarterly	Quarterly
		Annual retention rate	# of currently active health workers who were also active one year ago	# of health workers who were active one year ago	Health worker type, gender	iHRIS records	Quarterly	Quarterly
		Voluntary turnover rate	# of health workers who choose to leave in a given time period	Avg. number of health workers employed during that time	Health worker type, gender	iHRIS records	Quarterly	Quarterly

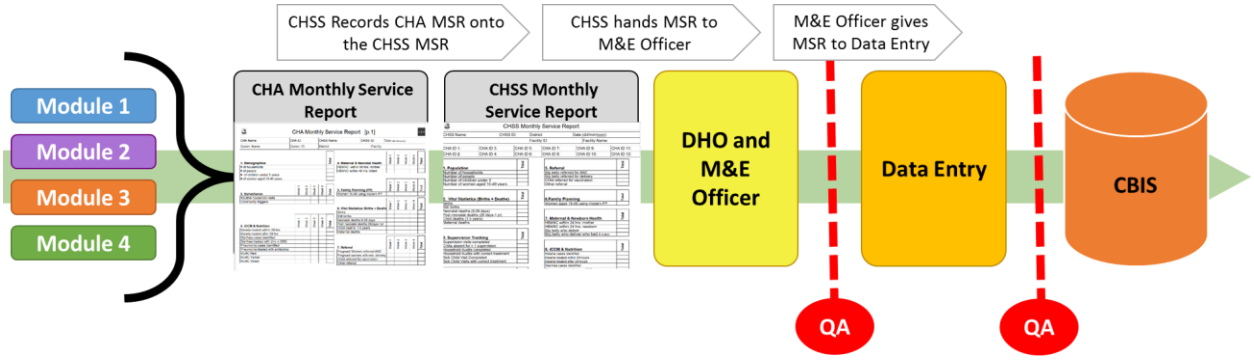
		Involuntary turnover rate	# of health workers who are forced to leave in a given time period	avg number of health workers employed during that time	Health worker type, gender	iHRIS records	Quarterly	Quarterly
		% of CHAs who submitted their monthly report on time	# of CHAs who submitted their monthly report on time (5.3e)	# of active CHAs (Total CHAs on CHSS Monthly Report)	CHSS	CHSS Monthly Report	Monthly	Monthly
Data Quality	Timely and high-quality data reporting	% of records entered into the database on time	# of records entered into the database on time	total # of records entered into the database	CHSS	DHIS2	Monthly	Monthly
		# of still births	# of still births (1.2d)	n/a	CHSS	CHSS Monthly Report	Monthly	Monthly
		# of deaths (under 1 month)	# of Neonatal deaths (1.2e)	n/a	CHSS	CHSS Monthly Report	Monthly	Monthly
		# of deaths (1mo-1 year)	# of Post neonatal deaths (1.2f)	n/a	CHSS	CHSS Monthly Report	Monthly	Monthly
Mortality	Monitor and document mortality	# of deaths (1-5 years)	# of child deaths (1.2g)	n/a	CHSS	CHSS Monthly Report	Monthly	Monthly
		# of maternal deaths	# of maternal deaths (1.2h)	n/a	CHSS	CHSS Monthly Report	Monthly	Monthly

Appendix IV – Process Schematics

Reporting Timeline



Reporting Process



Appendix V- Data Quality Framework

CHA Data Quality Assurance

CHAs will conduct daily data quality assurance (DQA) assessments. The CHA is the first point of data entry, it is important to conduct quality assurance daily at this level to verify the client information recorded is accurate. This prevents missing, blank data from being entered as data later on. The CHA will conduct daily data quality assurance accordingly:

1. Ensure that the appropriate MOH/CBIS standard forms and registers are being used and submitted by following curriculum, relevant job aids and instructions from the CHSS
2. Ensure timeliness in generation and submission of monthly reports to CHSS
3. Review all previously recorded data or processes on each CHA form
4. Check for inconsistencies or errors across the different data sources including use of appropriate data collection tools, accurate transcription of data from/to appropriate data sources
5. Check for the availability and use of recommended guidelines, procedures, and protocols
6. If the CHA has any questions or concerns about the forms or correct usages of an indicator, or about the data quality then the CHA is to defer to the CHSS.
7. Check for any missing data items. If there is missing data such as blank items, the CHA will correct this by filling in the missing data. He or she will record in the data in the appropriate data collection form and data sources
8. Check for any missing patient treatment records or data sets

CHSS Data Quality Assurance

During supervision visits and/or when reports are sent to the CHSS, the CHSS is to conduct data quality assurance observing the following:

1. Check for the availability and use of recommended guidelines, procedures, and/or protocols such as job aids
2. Check for the consistent and appropriate use of MOH/CBIS standard forms and registers. If forms are running low or the CHA is stocked out of forms, report this immediately to the OIC and work to replenish the forms immediately.
3. Check for any missing data items and ensure that the CHA is recording data in the appropriate data collection forms
4. Check for any missing client treatment records or data sets, ensure they have filled out the correct forms for all routine visits for the month
5. Check for inconsistencies or errors across the different data sources including use of appropriate data collection tools, accurate transcription of data to/from appropriate data sources, dates, and correct ID numbers. For example, verify that the same correct ID is on each of the forms used and

that the CHA correctly aggregated data from the modular forms to the *5.1 CHA Monthly Service Report.*

Check for timeliness in generation and submission of monthly reports to facility, in case of late or incomplete data the CHSS should request the missing data from the CHA and report the missing data to the OIC and DHO. For example, The CHSS must check with CHA to learn if any clients are not represented on the form or if any work days have not yet been recorded. This must be documented on paper and reviewed to pass on to the DHO

OIC Data Quality Assurance

The OIC along with the CHSS and other staff in the facility shall conduct a joint quality check before transmitting monthly data and reports. Any data that is missing when the DHO arrives to collect the *5.2 CHSS Monthly Service Reports* must be documented on paper and reported to the DHO. The documentation must clearly state what data elements are missing, who the data is missing from and what the reason is for the missing data.

DHO Data Quality Assurance

The DHO is responsible for checking the quality of the facility reports he receives. To do this, the DHO should complete spot checks on the 5.2 *CHSS Monthly Service Reports* against 5.1 *CHA Monthly Service Reports* to check for missing data. The DHO should randomly select at least 2 of the 5.1 *CHA Monthly Service Reports* each month to check for missing data. If the DHO does not trust the data, he or she may request the ledger forms from the community to be verified for accuracy.

CHT M&E Data Quality Assurance

The Data Clerk, Data Officer and M&E Officer are responsible for Data Quality Assurance. The Data Clerk and Data Officer are responsible for completing data quality assurance on at least 10 percent of all paper forms. This quality assurance is to check for errors in the Data Clerks work and to ensure a high level of accuracy is maintained when entering data. It is the responsibility of the Data Officer to verify that 10 percent quality assurance is done. It is at the discretion of the M&E Officer to do additional data quality assurance on the Data Clerk and Data Officers work.