MINISTRY OF HEALTH

INTEGRATED COMMUNITY CASE MANAGEMENT (iCCM), 2013-2018

MONITORING AND EVALUATION PLAN

AUGUST 2013 EDITION

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FOREWORD

The Government of Kenya is committed to the achievement of national, regional and international targets, including the Millennium Development Goals (MDGs), to improve maternal, newborn and child health and development indicators. Globally, most deaths in children are caused by preventable and easily treated diseases, namely pneumonia (18%), diarrhea (11%), malaria (7%) and newborn related conditions (pre-term birth complications – 14% and, intrapartum related complications - 9%).

It is estimated that in 2011, a total of 188,928 children under-five died in Kenya, and out of these, 21% deaths were caused by diarrhoea, 11% by malaria and (16%) by pneumonia. Neonatal deaths account for approximately 60% of the infant mortality in Kenya, as per the 2008/09 Kenya Demographic Health Survey (KDHS). Appropriate management of diarrhea, malaria, and pneumonia is one of the most cost effective interventions towards the reduction of the global burden of disease. There exist evidence-based high-impact interventions that can ensure a visible impact on reduction of childhood mortality.

The Integrated Community Case Management (iCCM) implementation plan presents a platform for acceleration of the control and management of childhood diarrhoea, malaria, pneumonia, neonatal mortality and malnutrition at the community level, thus contributing to the attainment of the MDG 4 by reducing significantly mortality attributed to the five conditions. The iCCM implementation plan addresses key areas including policy, coordination, case management, commodity logistics, advocacy, communication and social mobilization and monitoring and evaluation (M&E).

The iCCM M&E plan seeks to guide the tracking of the overall rollout of the national iCCM strategy. The plan will establish a well-coordinated, harmonized monitoring, evaluation and operational research system for iCCM that provides timely and accurate strategic information to guide the planning of iCCM implementation. The plan will feed into the existing Community Heath Strategy (CHS) M&E framework.

All stakeholders are urged to utilize this M&E plan to facilitate monitoring of the implementation process and the evaluation of effectiveness of iCCM towards improving access and quality of services at community level, where these services are most needed.

It is our sincere hope that implementation of this five-year plan, alongside other areas covered in the Community Health Strategy, will go a long way in reducing child morbidity and mortality in Kenya.

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ABBREVIATIONS

ACT	Artemisinin-based combination therapy
AL	Artemether-lumefantrine
AMREF	Africa Medical and Research Foundation
APHIA*PLUS*	AIDS, Population and Health Integrated Assistance Plus
CCM	Community case management
CDF	Constituency Development Fund
CHEW	Community Health Extension Worker
CHIS	Community Health Information System
CHW	Community Health Worker
CU	Community Unit
DCAH	Division of Child and Adolesent Health
DCHS	Division of Community Health Services
DHIS	District Health Information System
DHMT	District Health Management Team
DHP	Division of Health Promotion
DOMC	Division of Malaria Control
DON	Division of Nutrition
FGD	Focus Group Discussion
GoK	Government of Kenya
HMIS	Health Management Information System
HRIO	Health Records Information Officer
HSSF	Health Sector Services Fund
iCCM	Integrated Community Case Management
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
ITN	Insecticide treated nets
IYCN	Infant and Young Child Nutrition
JSI	John Snow Inc.
KAP	Knowledge Attitudes and Practices
KEMRI	Kenya Medical Research Institute
KEMSA	Kenya Medical Supply Agency
KHDS	Kenya Health Demographic Survey

KRCS	Kenya Red Cross Society
KSPA	Kenya Service Provision Assessment
LLITN	Long Lasting Insecticide Treated Net
LMIS	Logistics Management Information System
LQAS	Lot Quality Assuarance Sampling
MCHIP	Maternal and Child Health Integrated Program
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MIS	Malaria Indicator Survey
MOH	Ministry of Health
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
MUAC	Mid Upper Arm Circumference
NHIF	National Hospital Insurance Fund
NHSSP	National Health Sector Strategic Plan
ORS	Oral Rehydration Salt
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
RDT	Rapid diagnostic tests
RDQA	Rapid Data Quality Assesment
RUTF	Ready-to-use therapeutic food
SCUK	Save the Children United Kingdom
TWG	Technical Working Group
UNICEF	United Nations Children's Fund
USAID	Unites States Agency for International Development
WHO	World Health Organisation

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SECTION

1 INTRODUCTION

1.1 Background of the M&E Plan

The Division of Child and Adolescent Health services, in partnership with a wide range of stakeholders, developed the M&E Plan to coordinate stakeholders towards one agreed country-level monitoring and evaluation system for integrated Community Case Management (iCCM) for the period 2013 - 2018.

The process of developing the iCCM M&E plan was participatory through wide consultations with a wide range of stakeholders at community, district, provincial and national levels – which were the existing structures at the time this plan was developed. The process involved holding a series of workshop and consensus meetings to ensure that iCCM is grounded in the existing health delivery structures, bearing in mind the devolution of the governance and health systems to the county level that was to start in 2013.

The iCCM M&E plan seeks to establish a well-coordinated, harmonized monitoring, evaluation and operational research system for iCCM that provides timely and accurate strategic information to guide the planning of the iCCM implementation in Kenya. The plan will feed into the existing CHS M&E framework. Furthermore, the plan will help in tracking the implementation of programmatic objectives through provision of regular data to assist in evidence-based planning. Key intended users of this document include the DCAH and Division of Community Health Services (DCHS) in the Ministry of Health programme managers and others involved in planning and implementing iCCM, and development partners.

1.2 Goals and Objectives of the iCCM M&E Plan

The goal of the national iCCM M&E plan is to monitor the overall rollout of the national iCCM strategy. This strategy was developed to contribute to the reduction of morbidity and mortality among children under-5 by providing quality community case management for malaria, pneumonia, diarrhea and malnutrition, identification and referring of sick newborns. The plan will guide the measurement of achievement, implementation as well as preserving institutional memory.

Specific Objectives of the M&E Plan:

1. To monitor the implementation and adaption of the specific components of the national iCCM.
2. To monitor the rollout and scaling up of iCCM across Kenya
3. To monitor the quality of implementation of the different components of iCCM
4. To monitor the extent to which the national iCCM program is achieving targets that have been set in the overall iCCM implementation
5. To periodically measure the coverage of the iCCM across the different stages of scaling up
6. To evaluate the impact of the iCCM in improving coverage of prompt and appropriate treatment among children under five for the childhood illness as defined by iCCM

SECTION

2

NATIONAL ICCM FRAMEWORK AND PLAN FOR ACTION

Kenya adopted a Community Health Strategy (CHS) (MOH, 2007) as the overarching approach to health promotion in communities in line with the primary health care principles. The strategy is a flagship project aimed towards the attainment of Vision 2030 and the Millennium Development Goals (MDGs). It was initiated in 2006 based on the second National Health Sector Strategic Plan (NHSSP II), which aimed at reversing the decline in the health status of Kenyans through shifting the emphasis from a disease-centered approach to the promotion of individual and community health.

iCCM is a proven evidence-based strategy that trains, equips and supports various cadres of community health providers to deliver high-impact treatment interventions in the community. It is an important component of Integrated Management of Childhood Illness (IMCI), which was developed by WHO in the 1990s. It builds upon progress made and lessons learnt in the implementation of community IMCI and aims to augment health facility based case management.

The vision of the iCCM operational strategy is a Kenya where communities have zero tolerance for preventable deaths of children. A national framework and plan of action for the implementation of iCCM in Kenya has been developed to present a platform for acceleration of the control and management of childhood diarrhoea, malaria, pneumonia, neonatal mortality and malnutrition at the community level, thus contributing to the attainment of the MDG 4. It is anchored on the Ministry of Health (MOH) Community Health Strategy and Child Survival and Development Strategy as well as the Policy Guidelines on Control and Management of Diarrhoeal Diseases in Children below five years.

SECTION

3

INDICATORS

The iCCM M&E plan has 29 indicators. The full performance matrix for these indicators is presented in Annex 1. There are eight components, as per the global iCCM benchmark framework under which iCCM will be assessed. The components are: (i) policy and coordination, (ii) costing and financing, (iii) human resources, (iv) supply chain management, (v) service delivery and referral, (vi) communication and social mobilization, (vii) supervision and quality assurance, and (viii) M&E and Health Management Information System. A sub-set of the iCCM indicators have been included in the CHS M&E framework to ensure integration with the overall CHS strategy. These are outlined in Annex 2 (CHW perfomance matrix).

The iCCM indicators can be divided into several categories to measure the different aspects of the national iCCM program. These include:

i. **Indicators of implementation strength.** Implementation strength indicators are routine indicators that measure the critical program processes and outputs. They also help interpret results' indicators (e.g., utilization or coverage) by showing the "strength" of the program that is received as in a "dose-response relationship. The Catalytic Initiative (CI) has outlined generic indicators for five core elements in three supply side domains (human resources, commodities and quality of care) based on the minimum requirements for service delivery (a trained health worker is available and accessible to the population, equipped with required supplies, and regularly supervised and supported). These were reviewed and adapted for the Kenyan context, and additional indicators included capturing service delivery.

Table 1, in the next page lists the implementation strength indicators for the supply side domains and additional indicators which have been adapted for Kenya.

Table 1: List of Implementation Strength Indicators

Domain	iCCM Indicator
Human Resources	• Proportion of CHW/CHEWs targeted for iCCM who are trained in iCCM • Proportion of CHWs trained in iCCM who are providing iCCM services
Commodities	• Proportion of link facilities that had no stock out of recommended medicine and diagnostics during the day of assessment visit or last day of reporting period • Proportion of CU who had no stock out of recommended medicine and diagnostics during the day of assessment visit or last day of reporting period
Quality of Care	• Proportion of iCCM trained CHWs/CHEWs who received at least one administrative supervisory contact in the prior three months during which registers and/or reports were reviewed • Proportion of iCCM trained CHWs/CHEWs who received at least one supervisory contact during the prior three months where a sick child visit or scenario was assessed and coaching was provided
Service Delivery and Referral	• Number of iCCM conditions managed by CHWs per 1,000 children under five in target areas in a given time period (quarterly/annually) (reported by condition) • Proportion of newborns who received a home visit from a CHW within 48 hours of delivery

ii. **Indicators that can be potentially collected routinely, but through systems other than the Community Health Information System (CHIS)**: CHIS is part of the district health information system (DHIS). Since it may be difficult to add a longer list to the existing CHIS, other methods could include rapid, small scale CHW surveys using Lot Quality Assurance Sampling (LQAS) approaches.

Table 2: Selected Routine Indicators

Component	iCCM Indicator
Service Delivery and Referral	Proportion of children with fever who are tested with RDTs at community level (where RDTs are part of the package) Proportion of CHWs whose registers show completeness and consistency between classification and treatment
Supervision and Quality Assurance	Proportion of CHWs who correctly classify malnourished children using MUAC Proportion of CHWs who correctly count respiratory rate
M&E and HMIS	Proportion of counties/sub-counties reporting iCCM data on time and completely

iii. **Indicators that can be collected periodically through surveys or special studies.** These indicators can be used to periodically assess specific components of implementation and complement the routinely collected indicators listed above. Table 3 lists some of thyese indicators. They can be incorporated into existing periodic surveys such as DHS, Multi Indicator Cluster Survey (MICS), or can be captured through special survey/studies that are developed for evaluating the implementation of iCCM. Some indicators on quality of care (e.g. correct case management observed) require resource intensive special studies involving direct observation of CHWs with clinical re-examination.

Table 3: List of Periodic Indicators

Component	iCCM indicator
Service Delivery and Referral	• Percentage of sick children who received timely and appropriate treatment according to iCCM guidelines • Proportion of sick children under five in iCCM target areas taken to iCCM-trained CHWs as first source of care • Number and proportion of cases followed up after receiving treatment from CHW according to iCCM guidelines • Proportion of sick children recommended for referral who are received at the referral facility
Communication and Social Mobilization	• Proportion of caregivers in target areas who know the presence and role of their CHW. • Proportion of caregivers who know two or more signs of childhood illness that require immediate assessment and treatment, if appropriate
Supervision and Quality Assurance	• Proportion of CHWs who demonstrate correct knowledge of management of sick child case scenarios • Proportion of CHWs who demonstrate correct case management of a sick child under direct observation with clinical re-examination • Proportion of caregivers whose children received treatment from a CHW who were provided proper counseling

iv. **Indicators that represent national level milestones:** These indicators are qualitative and can be used to periodically assess progress towards an enabling environment for iCCM. (Refer to Table 4 below)

Table 4: List of National Milestone Indicators

Component	iCCM indicator

Policy and coordination	• iCCM is incorporated into national MNCH policy/guideline(s) to allow CHWs to give:
	  ○ *low osmolarity ORS and zinc supplements for diarrhoea*
	  ○ *antibiotics for pneumonia*
	  ○ *ACTs (and RDTs, where appropriate) for fever/malaria in malaria-endemic counties*
	• An iCCM stakeholder coordination group, working group or task force, led by the MOH and including key stakeholders, exists and meets regularly to coordinate iCCM activities.
	• List of iCCM partners, activities and locations available and up to date

Costing and Financing	• A costed operational plan for iCCM exists (or is part of a broader health operational plan) and is updated annually. • Percentage of the total annual iCCM budget which comes from Kenyan government funding sources
M&E and HMIS	• Existence of a comprehensive, integrated monitoring and evaluation (M&E) plan for iCCM • One or more indicators of community-based treatment for diarrhoea, pneumonia and/or malaria are included in the national HMIS system

The main data collection methods required to capture the iCCM indicators include:

a) routine sources (such as HMIS, project reports, government databases, supervision reports, etc);

b) periodic surveys such as household surveys, health facility assessments and CHW surveys; and

c) other complementary methods (special studies, document reviews, key informant interviews, etc).

SECTION

4

DATA COLLECTION METHODS

The three categories of data collection processes are described in this section:

4.1 Routine Data Collection

The routine indicators for iCCM can be collected through the CHW treatment and tracking register, CHW household register (MOH 513), CHEW supervision checklist and CHEW stock records. They are summarized by the monthly CHEW report (MOH 515), which is entered into the national CHIS/DHIS system. Other important sources of routine information include the DHMT supervision checklist and government databases on training. The information collected by these key tools is summarized in Table 5.

Table 5: Overview of Tools Used For Routine Data Collection

Tool	Information that can be collected
CHW iCCM Treatment and Tracking Register	• Captures information on sick child cases seen, treated and referred and on follow-up and outcomes. Also records amount of each commodity distributed. Data are summarized in the CHW report, which is then aggregated by the CHEW in the iCCM CHEW monthly report.
CHIS Household Register (MOH 513)	• Records data on household demographics that can be used to calculate the denominator for the routinely collected service delivery iCCM indicators. It is filled out by CHWs every six months and reported to CHEWs.
CHW Log Book (MOH 514)	• Collects information on daily CHW activities conducted as part of household visits. The Log Book is to be updated daily and submitted monthly by CHWs to CHEWs for summary.
CHEW Monthly Report (MOH 515)	• Summarizes data for the community unit in terms of service delivery (cases treated, referred, etc) and supervision and the main input into the CHIS/DHIS
CHEW Supervision Checklist	• Collects data on supervision of CHWs covering the full CHS package, including availability of medicines and supplies, record keeping, knowledge. Data related to indicators can be summarized on the CHEW monthly report and thus available through the CHIS/DHIS

Tool	Information that can be collected
CHEW Commodity Registers	• Collects data on receipt and consumption of CHS commodities, including those for iCCM.
CHEW Summary for CHW Treatment and Tracking Register	• Summarises data collected by CHWs on treatment of children and consumption of CHS commodities, including those for iCCM.
DHMT Support Supervision Tool	• Collects information on community units through interviews with CHEW. This is collected quarterly.
SCHMT Training Inventory	• Collects data on the training provided to CHEWs; It needs to be updated to reflect iCCM human resource training status
Resource Database on Community Health Program (to Assess CHW Training)	• Collects data on the training provided to CHWs; needs to be updated to reflect iCCM human resource training status
Other Logistics, Supply Chain Tools: *CHW Inventory control card; CHEW Stock control card; CHEW requisition, Issue and Order Voucher; CHEW re-Supply register*	• These are logistic and supply tools which allow the CHW and CHEW to keep track of the medicinal and diagnostic products they are using on sick children.

4.2 Periodic/Survey Data Collection

Several indicators for iCCM can be collected through periodic surveys. The main types of surveys and the information that can be gathered are highlighted in Table 6. These surveys are critical to help understand program coverage and provide an important source of information to help triangulate data collected through routine sources.

Table 6: Overview of Periodic Data Sources

Periodic Surveys/Tools for Special Studies	Information that can be collected
National Household Surveys (KDHS, Malaria Indicator Survey (MIS), MICS	Collect information on treatment coverage, caregiver knowledge of CHWs, caregiver knowledge on danger signs related to iCCM, caregiver care-seeking behaviours. As these surveys are large scale and resource intensive, they are only implemented every 3-5 years.
LQAS Survey	Can collect same information as national household surveys, but with less precision. It can be implemented in smaller geographic areas and with less resources and thus more frequently. It is possible to sample CHWs and capture information on activity levels, knowledge, availability of supplies, supervision coverage and aspects of quality of care.
Health Facility Surveys	Capture information on service delivery, availability of supplies and equipment, supervision coverage, knowledge and skills. Special studies to assess quality of care
CHW Surveys	Capture information on service delivery, availability of supplies and equipment, supervision coverage, knowledge and skills.
Census Data	Collect information on key denominators for children under 5
Qualitative Tools (Focus Group Discussions)	Can be used to assess care-seeking behaviours of caregivers, other special studies related to the research questions identified

4.3 Complementary Methods:

Several indicators, especially the qualitative national milestone indicators, require complimentary sources such as document reviews and key information interviews, as outlined in Table 7.

Table 7. Overview of Complementary Data Sources

Periodic Surveys/Tools for Special Studies	Information to be Collected
Document Review	Information on policies, plans, HMIS; etc
Key Informant Interviews	Information on policies, plans and the extent of their implementation; important source of triangulation for document review
Focus Group Discussions	Information to assess extent of implementation at the different levels; important source of triangulation for document review

SECTION

5

IMPLEMENTATION OF M&E FOR iCCM

5.1 Coordination of iCCM M&E Plan

Monitoring of the iCCM program at the national level will be embedded within the overarching CHS and coordinated by the M&E Unit of DCAH iCCM secretariat with support from an M&E sub-group of the National iCCM TWG and CHS. This M&E sub group will be part of the divisions/ Unit's M&E working group. The M&E sub-group will comprise representatives from relevant departments of the Ministry of Health and implementing partners such as UNICEF and non-governmental agencies (NGOs). The M&E subgroup will meet at least quarterly to help ensure that partner M&E plans and activities are shared early for inclusion into the MOH national M&E framework. This coordination mechanism will ensure that partner M&E resources contribute to the overall national iCCM M&E plan and avoid duplication of efforts.

At the county level, coordination of iCCM M&E will be led by County Director of Health with support from implementing partners active in the county.

5.2 Monitoring of the iCCM Implementation

The M&E Plan identifies several indicators for routine monitoring, with a focus on sub-set monitoring program implementation strength. Table 8 outlines these implementation strength indicators, the data sources, targets and required data elements. The majority of these indicators will be collected through the District Health Information System (DHIS) system as part of the overall CHS monitoring system, which captures monthly data from each community unit. Data for the existing CHS monitoring systems are generated through the CHEW monthly report, which summarizes data for all CHWs in the community unit.

The existing CHEW monthly report includes some required elements for iCCM, but several additional elements will need to be added to incorporate the minimal set of iCCM routine monitoring indicators. The required data elements represent the core required to measure implementation strength of the iCCM implementation. (see Annex 3a for the CHEW report with the required data elements added). Other elements should also be added based on CHW reports and CHEW supervision records. Program-focused, supportive supervision is critical for program monitoring and will be conducted regularly by all levels using standard supervision checklists. In addition, the supervision checklists will generate data on several indicators that

can be aggregated upwards and included within the CHIS/DHIS system. The sub county health management team shall be expected to conduct joint support supervision at least once per quarter to primary level health facilities. The CHEWs shall conduct monthly competency based skill reinforcing supportive supervision for all CHWs. Support will be provided to the CHWs to assess, classify and manage common childhood illnesses. The supervision will also assess CHWs counseling skills to ensure treatment adherence. An integrated supervision checklist for CHEWs to supervise CHWs is found in Annex 3b.

Table 8. Overview of Implementation Strength Indicators, Targets and Required Data Elements

Indicator	Definition	Data source & Frequency	Target by 2018	Data elements required in CHEW report DHIS
CHWs trained in CCM	Proportion of CHW/CHEWs targeted for iCCM who are trained in iCCM	Annual: work plans & training records	80%	No. of CHWs/CHEWs (by level) No. of CHWs in CU trained in iCCM
CHWs deployed for CCM and working	Proportion of CHWs trained in iCCM who are providing iCCM services (managing malaria, diarrhoea, pneumonia, malnutrition and newborn cases according to protocol)	Quarterly: DHIS (CHEW reports)	80% of trained CHWs	No. of CHWs trained in CCM who report providing iCCM services this month
Availability of CCM Supplies	Proportion of link facilities that had no stock out of recommended medicine and diagnostics during the day of assessment visit or last day of reporting period	Quarterly: DHMT supervision report;	80%	
	Proportion of CUs who had no stock out of recommended medicine and diagnostics during the day of assessment visit or last day of reporting period	Quarterly: DHIS (CHEW reports)	80%	Whether community unit experienced stock-outs of any key product for the reporting month
CHWs supervised	Proportion of CHWs/CHEWs who received at least one administrative supervisory contact in the prior 3 months during where a sick child or scenario was assessed*	Quarterly: DHIS (CHEW reports)	80%	No. of CHWs trained in CCM who were supervised using standard checklist this month
Service delivery	Number of CCM conditions managed per 1,000 children under five in target areas in a given time period (reported by condition: treatment of malaria/ diarrhoea; referral for malnutrition/ pneumonia/newborn)	Quarterly: DHIS (CHEW reports)	80%	No. of cases of malaria treated in U5 children No. of cases of diarrhoea treated in U5 children No. of cases of moderate/ severe malnutrition in U5 children referred* No. of cases of suspected pneumonia in U5 children referred No. of sick newborns referred No. of U5 children in community unit*
	Number and percent of newborns who received a home visit from a CHW within 48 hours of delivery	Quarterly: DHIS (CHEW reports)	80%	No. of newborns visited at home within the first 48 hours
* Data elements already included in the existing CHEW report/DHIS				

5.3 Data Flow

Data for iCCM will flow according to the existing system, starting with the CHWs reporting to the CHEWs, who report to the link facilities and then to the sub-county level (see Table 9). Community level data are entered into the online DHIS at sub-county level. In some cases, data are entered at the health facility level or even at the community unit level if computers and internets services are available. Once entered into the DHIS, the data are available for use at any level and can be analyzed by individual community unit, by sub-county, by county and nationally. Details on the data flow for commodities are provided in the supply chain management section of the iCCM implementation guidelines.

Table 9. Overview of Data Flow, Roles and Responsibilities and Forms by System Level

Level/cadre	Main data collection & reporting responsibilities	Data collection & reporting forms
Community – CHW	Track services provided and commodities received and consumed Prepare monthly report and submit to CHEW	Existing: CHW logbook; Household registers; CHW report New: CHW Treatment and Tracking Register; stock records, Newborn Checklist (refer Annex 12)
Community unit - CHEW	Supervise CHWs according to schedule and document using standard checklist Review and compile CHW data, stock records and supervision records and submit report to link facility	Existing: CHEW report (+ iCCM elements) New: Supervision checklist for CHWs; stock records; stock report Add CHEW Summary for CHW treatment and Tracking Register
Link Facility – Facility in-Charge/HRIO	Supervise CHEWs according to schedule and document using DHMT checklist Review and compile CHEW data and submit to sub-county/enter into DHIS Provide feedback to CHWs	Existing: CHEW report (+ iCCM elements) New: Supervision checklist for CHWs; stock records; stock report
Sub-county – DMHT - CHS	Supervise link facilities and CHEWs Manage data compilation and entry into DHIS for the sub-county and provide to county Rapid data quality assessment(RDQA) Provide feedback to facilities and community units	Existing: SCHMT supervision checklist (+iCCM elements), other?; SCHMT training inventory New: Any reports
County – CHMT CHS focal person	Supervise sub-county level Review sub-county level data and maintain county level information and reports Prepare reports and provide feedback to sub-county	CBHIS linked to DHIS;
National – DCAHiCCM M&E Secretariat	Review county level data and Prepare reports and provide feedback to counties/ other departments	CBHIS linked to DHIS

5.4 Data Quality Assurance

Mechanisms to routinely assess and enhance data quality will be implemented at all levels of the system. CHWs will be trained on how to record data and report on management of iCCM conditions and how to maintain accurate and up-to-date stock records. The CHWs will be supervised regularly by CHEWs, who will review records and validate reports to ensure data quality and completeness and reinforce good practices. Similarly, link facilities will be oriented on how to review and validate monthly data reported by CHEWs so that errors and problem areas can be identified and resolved at the lowest levels. At the sub-county and county levels, staff responsible for monitoring iCCM will be trained to assess data submitted by facilities for completeness and perform basic quality checks.

In addition to routine data quality checks, efforts will be made to conduct periodic rapid data quality assessments (RDQA). These RDQAs will help determine the availability, completeness and quality of the data and assess the use of iCCM data in program management and decision making.

Monitoring data for iCCM will be entered into the DHIS as part of the overall CHS M&E framework. Data captured on community units, including that related to iCCM, will be integrated into the existing DHIS web-based system. Data will be entered into the DHIS at the lowest level that has the required resources (computers, internet accessand staff for entry). Guidelines on appropriate information storage and measures to protect information security will be provided through DHIS.

The CHS database will be updated to incorporate iCCM information requirements by the DCHS. As part of the database development, it will be possible to include dashboards to display key indicators that will aid data use and interpretation by all users.

Use of program monitoring data for decision-making will also be encouraged through regular review meetings at multiple levels to assess the progress of iCCM implementation by identifying opportunities, challenges and looking for solutions. Experience sharing and dissemination of success stories, good practices and lessons learnt are addressed in such meetings. Review meetings will be held at national and county level at least once a year and at sub-county level at least twice in a year involving relevant stakeholders. The DCAH in conjunction with Community health services, County Health Management teams and Sub-county Health Management Teams shall be responsible to organize review meetings at their respective level. In order to make the review meetings effective and feasible, iCCM review meetings will be conducted by integrating with other health review meetings. Proceedings of the reviews are expected to be disseminated to all levels timely.

5.5 Evaluation Plan

Outcome indicators: The main indicators to assess the outcome of the iCCM program in Kenya are outlined in Table 10, along with the data source and targets. Most of these indicators pertain to care-seeking and treatment for childhood illness and can be measured through a household survey with interviews of mothers/caretakers of children who have experienced iCCM conditions in the previous two weeks. Measuring compliance with referral from a CHW will require a special study to track those referred and determine whether they receive care at the referral facility.

Table 10. Outcome Indicators for iCCM and Targets

Indicator	Definition	Data source & Frequency of reporting	Target By 2017
Treatment Coverage (overall)	Percentage of sick children who received timely and appropriate treatment according to specific protocol (reported separately by iCCM condition) ▪ Malaria (ACTs within 24 hours) ▪ Diarrhoea (ORS and zinc within 24 hours) ▪ Pneumonia (amoxicillin within 24 hours) ▪ Malnutrition (RUTF;) ▪ Newborn illness (injectable antibiotic;)	Household survey; episodic (baseline, 2-3 years later)	80%
Treatment Coverage by CHW*	Percentage of sick children who received timely and appropriate treatment according to specific protocol provided by CHWs ▪ Malaria (ACTs within 24 hours) ▪ Diarrhoea (ORS and zinc within 24 hours)	Household survey; episodic (baseline, 2-3 years later)	80%
First Source of Care	Proportion of sick children under five in iCCM target areas taken to iCCM-trained CHWs as first source of care.	Household survey; episodic (baseline, 2-3 years later)	TBD
Successful Referral	Proportion of sick children recommended for referral who were received at the referral facility (based on the CHW referral form-Annex 5)	Routine data & Special study of referrals	TBD
**Note that in the detailed indicator matrix this indicator is included as a disaggregation of the first indicator (treatment coverage overall), but has been listed separately here to provide further clarification*			

Evaluation questions: Table 11 outlines several key evaluation questions for the iCCM program in Kenya as well as proposed data collection methods. These evaluation questions can be answered in part through national level surveys such as DHS, MICS, MIS but others will require special studies. In addition, it is recommended that qualitative methods be included to help provide context and to illuminate the underlying factors and issues. These special studies will require additional resources and implementing partners should coordinate through the M&E sub-group of the iCCM TWG to address them in their evaluation plans as part of any program funding proposal.

Table 11. Evaluation Questions and Data Collection Methods

Evaluation question	Data collection methods
▪ What was the impact of the iCCM program on coverage of treatment for iCCM conditions? What was the coverage of early Post Natal Care home visits for newborn? Equity?	▪ Representative household survey comparing baseline to endline - ideally with comparison area ▪ Qualitative interviews with families to assess perceptions of iCCM services
▪ What was the use of iCCM services? How did it vary by iCCM condition and age group (child vs. newborn) and why?	
▪ What was the demand of iCCM services? Were there changes in care-seeking for newborn and child illness? How effective were the behavior change strategies?	
▪ How well did referral work for children and newborns? What was the range of experience? What were the challenges?	▪ Special study tracking referrals made by CHWs to assess referral compliance and outcomes ▪ Qualitative interviews with CHWs and families to understand referral barriers and facilitators
▪ What was the quality of iCCM services provided by CHWs? What was the quality of case management services provided at link facilities?	▪ Special study of CHWs with direct observation and clinical re-examination ▪ Qualitative interviews with families to assess perceived quality of care
▪ How was the supply of commodities at various levels (CHW, community unit, link facility)? What was the range of stock-outs and the reasons for stock-outs?	▪ Review of routine records and reports on commodity supplies at CHW, community unit, and link facility levels ▪ Periodic CHW/link facility surveys to assess availability of supplies and stock-outs
▪ What are the major factors that are critical to expand or scale up iCCM at various levels?	▪ Qualitative interviews with staff at various levels (community, facility, sub-county, county, national)

5.6 Implementation Capacity

There is need to assess capacity to implement iCCM M&E. Some considerations to make for this assessment include: Human resource, Infrastructure hardware and software, Tools and Staff readiness for M&E and financial support. iCCM focusses on the community level, and as such the immediate priority will be to strengthen the capacity of CHWs and CHEWs to collect, manage and use data to improve the delivery of community-based services. In addition, the CHS M&E framework also outlines the need to strengthen capacity at the national level to:

- Maintain the CHS database
- Analyse and interprete data for evidence based decision making
- Provide supportive supervision to the decentralized levels

5.7 Operations/Implementation Research and Special Studies

The research component in the iCCM implementation shall be used to improve access to cost effective high impact newborn and child health interventions. It will also be used to developing practical solutions to critical problems in the implementation of these interventions. The objectives to be addressed within the framework shall include the following:

- Identify common implementation problems, and their main determinants, which prevent effective access to interventions, and determine which of these problems are susceptible to research;
- Develop practical solutions to these problems and test whether new implementation strategies based on these solutions can significantly improve access to interventions
- Introduce these new implementation strategies into the programmes and facilitate their full-scale implementation, evaluate them, and modify as required.

Twenty-four research questions were identified for iCCM in Kenya during an implementation research consultative meeting led by WHO and UNICEF in 2011. These were prioritized based on the following criterion: answerability by research; likeliness to reduce maternal and child mortality; addresses the main barriers to scaling up; innovativeness and originality; likely to promote equity; and likeliness of use of the research results by policy makers. Table 12 highlights the list of ten implementation/operations research questions prioritized by iCCM stakeholders Several of the priority implementation research questions (Rank #1, 3, 9) could be feasibly embedded within iCCM programs as part of an evaluation. Programs should allocate at least two years, with about six months for planning and preparation, one full year of run-time and another six months for assessment and analysis. Other questions are directly related to indicators in the national iCCM M&E Plan, but would require special studies.

Table 12. Priority Implementation Research Questions for iCCM in Kenya

Research Question	Rank
How can care seeking for sick newborns be improved?	1
What is the effectiveness of different approaches for scaling up CHW perinatal home visits?	2
How can care seeking for child with cough or difficult breathing, fever and diarrhoea be improved?	3
How can we improve early postnatal care for mothers and newborns?	4
How can care seeking for early antenatal care be improved?	5
Can the use of different technological modalities (mobile phones-based algorithm, computer-based algorithm, treatment charts, etc.) improve health worker performance and increase compliance with standard management guidelines?	6
What is the effectiveness of different options (financial and non-financial) to attract, and retain skilled doctors, nurses, technicians and community health workers in rural areas and in hard to reach areas?	7
What is the effectiveness of different approaches (e.g. health facility boards, village health committees) to enhance community-health facility linkage for improving Maternal Newborn and Child Health service utilization?	8
Can trained, supervised and well supplied community health workers perform iCCM correctly, including pneumonia management with antibiotics, in hard to reach areas in order to increase coverage with effective interventions, within the context of the MOH community strategy?	9
What is the appropriate delivery channel of health service to ensure equity of service for hard to reach populations (urban and rural)?	10

The M&E subgroup of the iCCM TWG will be responsible for coordination of the overall research agenda to avoid duplication of efforts. Implementing partner agencies with research capacity should be encouraged to include these questions in their proposals for research and/or program funds and to explore how they can address these research questions by embedding them within already funded programs/studies where feasible or within upcoming studies. As with the M&E plan, the research agenda and questions should be reviewed and updated annually.

5.8 Dissemination and Use

A wide range of stakeholders, including policy makers, donors, program managers, implementing partners, facility staff, CHWs, and the target communities, constitute the main audience for dissemination of iCCM M&E information. Dissemination of iCCM information will be embedded within the existing CHS program and will include publication and distribution of quarterly and annual reports, program newsletters, and information sharing through national and international meetings and workshops. In addition, routine iCCM data captured through the DHIS will be available online for real-time access and analysis at the desired level of disaggregation.

Anticipated information products related to iCCM include, but not limited to:

Integrated CHS Reports: DCHS will produce annual consolidated CHS M&E report on the national core indicators as well as quarterly reports for the routine data and disseminate them to all the stakeholders.

District report for routine data: District office will produce report with data required for CHS/or incorporate CHS data in the existing report and submit it to DCHS via County office.

Information Products for Non-Routine Data Sources: The report of non-routine data will be generated by the respective responsible organization/body. Special requests for additional information products will require documentation for future appraisal of dissemination efforts.

Planning and Review Reports: To ensure all formal Planning and Review meetings contribute to evidence-based programme planning, budgeting and implementation, comprehensive meeting reports will be compiled that highlight M&E and research findings reviewed, key issues addressed and lessons learnt. The respective Technical Coordination Group or M&E sub-committee will be responsible for documenting and forwarding the proceedings from planning and review meeting to DCHS.

5.9 Detailed M&E Action Plan and Resources

The Plan of Action found in the National iCCM framework provides an overview of main activities, timelines and budget for iCCM M&E at national, county and sub-county levels. This M&E Action plan will be reviewed and updated under the leadership of the iCCM TWG.

5.10 Review of the M&E plan

The M&E plan for iCCM will be updated regularly and reviewed every three years . The M&E sub-group of the National iCCM TWG will be responsible for bringing MOH and implementing partners together to share data, update the indicator matrix with available data, revise and refine indicators and M&E activities and workplan as needed.

ANNEX 1: NATIONAL iCCM INDICATORS

No.	Indicator Area	Indicator	Definition	Type of Indicator	Target	Roles and responsibilities	Frequency of data collection	Data sources	Disaggregation
Component 1: Policy & Coordination									
1	ICCM Policy (Global)	ICCM is incorporated into national MNCH policy/guideline(s) to allow CHWs to give: • low osmolarity ORS and zinc supplements for diarrhea • antibiotics for pneumonia • ACTs (and RDTs, where appropriate) for fever/ malaria in malaria-endemic countries	Yes: National policy guidelines have been adopted to allow CHWs to provide treatment in line with WHO recommendations, for all relevant conditions (diarrhea, pneumonia and malaria in countries with malaria) Partial: National policy guidelines have been adopted to allow CHWs to provide treatment in line with WHO recommendations, for at least one but not all relevant conditions No: No national policy guidelines exist that support CCM in line with WHO recommendations	Input	Yes (by 2014)	ICCM TWG	Annual	MOH policy, strategy or guideline	National
2	ICCM coordination	An ICCM stakeholder coordination group, working group or task force, led by the MOH and including key stakeholders, exists and meets regularly to coordinate ICCM activities.	Yes: MOH-led ICCM stakeholder group established and meeting as outlined in terms of reference (TOR), or if no TOR exists, at a minimum of twice per year Partial: MOH-led ICCM stakeholder group established but meets less than twice per year (0-1 meetings) No: MOH-led ICCM stakeholder group not established	Input	Yes (quarterly mtgs)	Nat'l: Secretariate (DCAH)	Annual	TWG meeting minutes	County level forums addressing iCCM should also be formed/ integrated into existing county level forums once roll-out begins

No.	Indicator Area	Indicator	Definition	Type of Indicator	Target	Roles and responsibilities	Frequency of data collection	Data sources	Disaggregation
3	ICCM partner map	List of ICCM partners, activities and locations available and up to date	Yes: List/map of all known sites wherel CCM is being implemented, by whom and for which condition (diarrhea, pneumonia, or malaria) is available and updated within the last year Partial: List/map of some or all known ICCM partners, activities and locations available but not updated within the last year No: List/map of ICCM partners, activities and locations not available	Input	Yes (national & county)	National; DCAH-County: CHMT	Annual	DCAH & CHMT partner mapping matrix	County
Component 2: Costing and Financing									
4	Annual ICCM costed operational plan (Global)	A costed operational plan for CCM exists (or is part of a broader health operational plan) and is updated annually.	Yes: A costed CCM operational plan/ work plan for all relevant CCM conditions (as specified by country policy or implementation status) exists (or is part of a broader health operational plan) and has been updated within the past year Partial; a) A costed CCM operational plan exists (or is part of a broader health operational plan), including at least one but not all relevant CCM conditions, and has been updated within the past year; OR b) A costed CCM work plan exists (or is part of a broader health operational plan) including at least one relevant CCM condition, but is not updated within the past year No: No costed plans for CCM are available for any relevant health condition	Input	Yes (national, county & sub-county)	Nat'l: DCAH County: CHMT District: DHMT	Annual	Annual workplans	County, sub-county

No.	Indicator Area	Indicator	Definition	Type of Indicator	Target	Roles and responsibilities	Frequency of data collection	Data sources	Disaggregation
5	ICCM government financial contribution	Percentage of the total annual CCM budget which comes from Kenyan government funding sources	Numerator : Total annual public budgeted funding (MOH, county, and sub-county budgets) allocated to CCM Denominator: Total annual budgeted funding allocated to CCM program (public plus international donors)	Input	N/A	Nat'l: DCAH Cnty: CHMT Dist: DHMT	Annual	AWP and gap analysis tool; Annual Expenditure Reports	County, sub-county
Component 3: Human Resources									
6	Targeted CHWs/ CHEWs trained in ICCM	Proportion of CHW/ CHEWs targeted for ICCM who are trained in ICCM	Numerator: Number of CHWs/ CHEWs targeted for iCCM who have completed training in iCCM Denominator: Number of CHWs targeted for iCCM	Output	a) 80% of established CUs by 2015	DCHS/DCAH/ DOMC	Annual	AWPs Training reports	County, sub-county CHW, CHEWs
7	Trained CHWs providing ICCM (Global)	Proportion of CHWs trained in ICCM who are providing ICCM services	Numerator: Number of CHWs trained in iCCM who have provided iCCM services (managing malaria, diarrhea, pneumonia, malnutrition and newborn cases according to protocol) in the last 3 months Denominator: Number of CHWs trained in iCCM	Output	>80%	DCHS/DCAH/ DOMC	Quarterly/ Annual	DHIS (CHEW reports) CHW survey	County, sub-county CHW, CHEWs

No.	Indicator Area	Indicator	Definition	Type of Indicator	Target	Roles and responsibilities	Frequency of data collection	Data sources	Disaggregation
Component 4: Supply Chain Management									
8	Medicine and diagnostic availability – Link facilities	Proportion of link facilities that had no stock out of recommended medicine and diagnostics during the day of assessment visit or last day of reporting period, (key products defined by country policy)	Numerator: Number of link facilities with all key ICCM medicines and diagnostics in stock (antimalarials, antibiotics, ORS, zinc, RDTs, timer, RUTF, antibiotic for newborn infection) during the last assessment/observation visit or the last day of a reporting period. Denominator: Number of link facilities assessed in target areas	Output	80%	Collection: CHEWs; facility in-charge; pharmaceutical Compile: sub-county pharmacists	Monthly/ quarterly/ episodic	Supportive supervision (DHMT), direct observation and surveys	County, sub-county Commodity
9	Medicine and diagnostic availability - CU (Global)	Proportion of CU who had no stock out of recommended medicine and diagnostics during the day of assessment visit or last day of reporting period, (key products defined by country policy).	Numerator: Number of CUs with all key medicines and diagnostics (ACTs, ORS, zinc, RDTs) in stock during the last assessment/observation visit or the last day of a reporting period. Denominator: Total number of CUs assessed	Output	80%	Collection: CHEWs; facility in-charge; pharmaceutical Compile: sub-county pharmacists	Monthly/ quarterly/ episodic	Supportive supervision (DHMT), direct observation and surveys	County, sub-county Commodity
Component 5: Service Delivery and Referral									
10	Treatment coverage	Percentage of sick children who received timely and appropriate treatment according to specific protocol	Numerator: Number of children under five with a CCM condition (diarrhea, suspected pneumonia, or malaria in malaria-endemic areas, acute malnutrition) that received timely and appropriate treatment during the last two we eks Denominator: Number of children under five with a CCM condition in the last two weeks	Outcome	80% by 2017	DCHS/DCAH/ DOMC Varies at county level	Episodic	Household surveys (DHS, MICS, MIS, other)	County Point of service (community, facility, etc) CCM condition Sociodemographics

No.	Indicator Area	Indicator	Definition	Type of Indicator	Target	Roles and responsibilities	Frequency of data collection	Data sources	Disaggregation
11	ICCM case managment rate	Number of ICCM conditions managed by CHWs per 1,000 children under five in target areas in a given time period (quarterly/annually) (reported by condition)	Numerator: Number of cases of sick children under five managed by CHWs in a given time period (quarterly/annually) in target area Denominator: Number of children under five in target areas at a given time (quarterly /annually) divided by 1,000	Output	TBD	DCHS/DCAH/ DOMC Varies at county level	Quarterly/ Annually	DHIS (CHW register and CHEW report) Household surveys	County, sub-county Point of service (community, facility, etc) CCM condition
12	RDT use at community level	Proportion of children with fever who are tested with RDTs at community level (where RDTs are part of the package)	Numerator: Number of sick children under five in target areas who present with fever and who are tested with an RDT at the community level (in a given time period) Denominator: Number of sick children under five in target areas presenting with fever at the community level in a given time period	Output	TBD	DCHS/DCAH/ DOMC CHEWs	Quarterly/ Annual/ Episodic	DHIS (CHW treatment register and CHEW report) Direct observation	County, sub-county, health facility, CU
13	First source of care	Proportion of sick children under five in CCM target areas taken to CCM-trained CHWs as first source of care	Numerator: Number of sick children under five in the target area whose caregivers sought care from CCM-trained CHWs as first source of care for the child Denominator: Number of sick children under five in the target area	Outcome	TBD	DCHS/DCAH/ DOMC Varies at county level	Episodic	Household surveys (DHS, MICS, MIS, other)	County, sub-county, health facility, CU By CCM condition By child age (newborn, child)

No.	Indicator Area	Indicator	Definition	Type of Indicator	Target	Roles and responsibilities	Frequency of data collection	Data sources	Disaggregation
14	Complete and consistent registration	Proportion of CHWs whose registers show completeness and consistency between classification and treatment	Numerator: Number of CHWs whose registers show completeness and consistency between classification and treatment for at least four out of five cases reviewed Denominator: Number of CHWs assessed	Output	TBD	CHEWs, facility in-charge	Quarterly	DHIS (CHW supervision checklist/ CHEW report) CHW survey	County, sub-county, health facility, CU
15	Follow up rate	Number and proportion of cases followed up after receiving treatment from CHW according to country protocol	Numerator: Number of cases followed up according to protocol after receiving treatment from CHW in target area Denominator: Total number of cases receiving treatment from CHW in target area	Output	>80%	CHEWs, facility in-charge, other	Quarterly; Episodic	DHIS (CHW supervision checklist/ CHEW report), interviews with caregivers	County, sub-county, health facility, CU Child age (newborn; child)
16	Successful referral	Proportion of sick children recommended for referral who are received at the referral facility	Numerator: Number of sick children with danger signs who are referred by CHW and who are received at the referral facility Denominator: Total number of sick children with danger signs recommended for referral by CHW	Outcome	TBD	CHEWs, facility in-charge, other	Quarterly; Episodic	CHW Referral/counter referral forms; CHEW reports Special study	County, sub-county, health facility, CU CCM condition Child age (newborn; child)
17	Newborn care	Proportion of newborns who received a home visit from a CHW within 48 hours of delivery	Numerator: Number of newborns who received a home visit from a CHW within 48 hours of delivery Denominator: Total number of newborns	Output	80%	CHEWs	Quarterly/ Episodic	DHIS (CHW register and CHEW report) Household surveys	County, sub-county, health facility, CU
Component 6: Communication and Social Mobilization									

No.	Indicator Area	Indicator	Definition	Type of Indicator	Target	Roles and responsibilities	Frequency of data collection	Data sources	Disaggregation
18	Caregiver knowledge of CHW	Proportion of caregivers in target areas who know the presence and role of their CHW.	Numerator: Number of caregivers of children under five from target communities who can describe the location of a CHW in their community, and the role and CCM services provided by that CHW Denominator: Total number of caregivers of children under five interviewed from target communities	Output	>80%	DCHS/DCAH/ DOMC Varies at county level	Episodic	Household surveys (MIS, MICS, other)	County, sub-county, health facility, CU
19	Caregiver knowledge of illness signs (Global)	Proportion of caregivers who know two or more signs of childhood illness that require immediate assessment and treatment, if appropriate	Numerator: Number of caregivers of children under five interviewed who can correctly state 2 or more signs of childhood illness that require immediate assessment and treatment, if appropriate. Denominator: Number of caregivers of children under five interviewed	Output	80% by 2017	DCHS/DCAH/ DOMC Varies at county level	Episodic	Household surveys (MIS, MICS, other)	County, sub-county, health facility, CU
Component 7: Supervision and Quality Assurance									
20	Routine supervision coverage (Global)	Proportion of CHWs/ CHEWs who received at least one administrative supervisory contact in the prior three months during which registers and/or reports were reviewed	Numerator: Number of CHWs who received at least one administrative supervisory contact in the prior 3 months during which registers and/or reports were reviewed Denominator: Number of CHWs trained or number of CHWs interviewed (if survey used for measurement)	Output	TBD	CHEWs; sub-county staff	Quarterly/ Annual	DHIS (CHW supervision checklist/ CHEW report) CHW surveys	County, sub-county CHEWs/CHWs

No.	Indicator Area	Indicator	Definition	Type of Indicator	Target	Roles and responsibilities	Frequency of data collection	Data sources	Disaggregation
21	Clinical supervision coverage	Proportion of CHWs who received at least one supervisory contact during the prior three months where a sick child visit or scenario was assessed and coaching was provided	Numerator: Number of CHWs receiving at least one supervisory contact in the prior three months where a sick child visit was observed or scenario was assessed and coaching provided Denominator: Number of CCM-trained CHWs, or number of CHWs interviewed (if survey used for measurement)	Output	TBD	CHEWs; sub-county staff	Quarterly/ Annual	DHIS (CHW supervision checklist/ CHEW report) CHW surveys	County, sub-county
22	Correct case management (knowledge) (Global)	Proportion of CHWs who demonstrate correct knowledge of management of sick child case scenarios	Numerator: Number of CHWs who demonstrate correct management of sick child case scenarios Denominator: Number of CHWs assessed	Output	TBD	DCHS/DCAH/ DOMC Varies at county level	Episodic	Supportive supervision CHW survey	County, sub-county, CU ICCM condition
23	Correct case management (observed)	Proportion of CHWs who demonstrate correct case management of a sick child under direct observation with clinical re-examination (Note: can also be analyzed with sick child as unit)	Numerator: Number of CHWs who correctly managed sick child case(s) under direct observation with clinical re-examination Denominator: Number of CHWs observed with clinical re-examination	Output	TBD	DCHS/DCAH/ DOMC Varies at county level	Episodic	CHW survey with direct observation, clinical re-examination	County, sub-county ICCM condition
24	Correct classification of malnutrition	Proportion of CHWs who correctly classify malnourished children using MUAC	Numerator: Number of CHWs who demonstrate correct use of MUAC Denominator: Number of CHWs assessed	Output	TBD	CHEWs	Quarterly/Episodic	DHIS (CHW supervision checklist/ CHEW report) IMAM tools	County, sub-county, health facility, CU
25	Respiratory rate	Proportion of CHWs who correctly count respiratory rate	Numerator: Number of CHWs who correctly count the respiratory rate of live case, supervisor, community infant, or video Denominator: Number of CHWs assessed	Output	TBD	CHEWs; sub-county staff	Quarterly/ Episodic	DHIS (CHW supervision checklist/ CHEW report) CHW survey	County, sub-county, health facility, CU

No.	Indicator Area	Indicator	Definition	Type of Indicator	Target	Roles and responsibilities	Frequency of data collection	Data sources	Disaggregation
26	Counselling quality	Proportion of caregivers whose children received treatment from a CHW who were provided proper counselling	Numerator: Number of children provided medicines where caregivers were provided proper counseling for provision of treatments (dose, duration, frequency and follow-up) Denominator: Number of cases of children prescribed medicines	Output	TBD	CHEWs Other (for surveys)	Quarterly/ Episodic	DHIS (CHW supervision checklist/ CHEW report) CHW surveys with clinical re-examination	County, sub-county, CU CCM condition
Component 8: Monitoring and Evaluation and HMIS									
27	National Monitoring and Evaluation Plan for ICCM (Global)	Existence of a comprehensive, integrated monitoring and evaluation (M&E) plan for ICCM	Yes: An M & E plan for ICCM has all the critical components (listed below) and covers all relevant CCM conditions. Components may be country defined but should ideally include the following: - Program goals and objectives; - Indicators to be measured; - How (tools), how often(frequency) and where the indicator data(at what level) will be collected (methodologies); - Dissemination/use of information (how often and to what levels); Partial: M&E plan exists but has only some of the above critical components or does not cover all ICCM conditions No: Plan has no critical components or there is no written M & E plan that covers ICCM	Input	Yes (by 2012)	DCAH/DCHS	Annual	M&E plans and documents	NA

No.	Indicator Area	Indicator	Definition	Type of Indicator	Target	Roles and responsibilities	Frequency of data collection	Data sources	Disaggregation
28	ICCM utilization indicators included in HMIS	One or more indicators of community-based treatment for diarrhea, pneumonia and/or malaria are included in the national HMIS system	Yes: One or more ICCM indicator is included in the national HMIS system and disaggregated by level No: No recommended ICCM indicators are included in national HMIS, or are included but not disaggregated by level..	Input	Yes	DCAH/DCHS/ HMIS	Annual	HMIS tools and reports	CCM condition
29	County & sub-county monitoring	Proportion of counties/ sub-counties reporting ICCM data on time and completely	Numerator: Number of implementing counties and sub-counties reporting complete ICCM monitoring data on time Denominator: Number of counties and sub-counties implementing ICCM	Input	80%	DCHS/DCAH	Quarterly/ Annual	County & sub-county monitoring reports	County, sub-county

ANNEX 2: CHW PERFORMANCE MATRIX

Indicator Area	Indicator	Indicator Definition	Roles and Responsibilities	Frequency of Data Collection	Data Sources
Trained CHWs/CHEWs providing ICCM	Proportion of CHWs/CHEWs trained in ICCM who are providing ICCM services (malaria and diarrhoea)	Numerator: Number of CHWs/CHEWs trained in iCCM who have provided iCCM services (managing malaria, diarrhoea, pneumonia, malnutrition and newborn cases according to protocol) in the last 3 months Denominator: Number of CHWs/CHEWs trained in iCCM	DCHS/DCAH/ DOMC	Quarterly/ Annual	Routine: DHIS (CHEW reports)
Medicine and diagnostic availability - CHW/CU	Proportion of CU who had no stock out of recommended medicine and disgnostics during the day of assessment visit or last day of reporting period, (key products defined by country policy).	Numerator: Number of CUs with all key medicines and diagnostics (ACTs, ORS, zinc) in stock during the last assessment/observation visit or the last day of a reporting period. Denominator: Total number of CUs assessed	Collection: CHEWs; facility in-charge; pharmaceutical Compile: sub-county pharmacists	Monthly/quarterly/ episodic	Supportive supervision, LMIS, direct observation and surveys
Complete and consistent registration	Proportion of CHWs whose registers show completeness and consistency between classification and treatment	Numerator: Number of CHWs whose registers show completeness and consistency between classification and treatment for at least four out of five cases reviewed Denominator: Number of CHWs assessed	CHEWs, facility in-charge	Quarterly	Supportive supervision CHW survey
Follow up rate	Number and proportion of cases followed up after receiving treatment from CHW according to country protocol	Numerator: Number of cases followed up according to protocol after receiving treatment from CHW in target area Denominator: Total number of cases receiving treatment from CHW in target area	CHEWs, facility in-charge, other	Quarterly; Episodic	Supportive supervision, CHIS, interviews with caregivers

Indicator Area	Indicator	Indicator Definition	Roles and Responsibilities	Frequency of Data Collection	Data Sources
Correct classification of malnutrition	Proportion of CHWs who correctly classify malnourished children using MUAC	Numerator: Number of CHWs who demonstrate correct use of MUAC Denominator: Number of CHWs assessed	CHEWs	Quarterly/Episodic	Supportive Supervision, CHIS, IMAM tools
Respiratory rate	Proportion of CHWs who correctly count respiratory rate	Numerator: Number of CHWs who correctly count the respiratory rate of live case, supervisor, community infant, or video Denominator: Number of CHWs assessed	CHEWs; sub-county staff	Quarterly/ Episodic	Supportive supervision CHW survey
Counseling quality	Proportion of caregivers whose children received treatment from a CHW who were provided proper counselling	Numerator: Number of children provided medicines where caregivers were provided proper counseling for provision of treatments (dose, duration, frequency and follow-up) Denominator: Number of cases of children prescribed medicines	CHEWs Other (for surveys)	Quarterly/ Episodic	Supervisory reports CHW surveys with clinical re-examination
Correct case management (knowledge) – (Global)	Proportion of CHWs who demonstrate correct knowledge of management of sick child case scenarios	Numerator: Number of CHWs who demonstrate correct management of sick child case scenarios Denominator: Number of CHWs assessed	DCHS/DCAH/ DOMC Varies at county level	Episodic	Supportive supervision CHW survey

ANNEX 3A: CHEW MONTHLY SUMMARY WITH ICCM INDICATORS

COMMUNITY HEALTH EXTENTION WORKER SUMMARY **MOH 515**

Province:……

DISTRICT:……..……..……..……..…… DIVISION:……..……

LOCATION:……..……..……..…….. SUB LOCATION: ……..……..…. Total Villages:……

NAME OF CU:. ……..……..……..……..…… NUMBER OF CHWs:……..…… Total Reported:……..

ICCM trained CHWs:……CHWs providing ICCM:……..

CHEW Name: ……..……..……..…… Month:……..…… Year:……..…..

Sno.	Indicators	Total
1	Number of households	
2	Total population	
3	Total women 15-49 years	
4	Total children 0- 6 months	
5	Total children under one year old	
6	Total children under five years old	
7	Adolencent and youth - Girls (13 - 24 years)	
8	Adolescent and youth - Boys (13 - 24 years)	
9	Total population of the elderly (60+ years)	
10	Number of household using treated water	
12	Number of household with hand washing facilities e.g. leaky tins in use	
13	Number of households with functional latrines	
14	Total pregnant women	
15	Number of pregnant women reffered for ANC care	
16	Number pregnant women referred for ANC	
17	Number of newborns visited at home within 48 hours of delivery	
	Number of Mothers with newborns counselled on Exclusive Breastfeeding	
18	Children <5 years participating in growth monitoring	
	children < 5 years with MUAC indicating moderate malnutrition.	
	children < 5 years with MUAC indicating severe malnutrition.	
19	Number of deliveries by skilled delivery	
20	Number of newborn referred to a health facility	
21	Number of women(15-49yrs) provided with FP commodities by CHWs	
22	Number of children under one year referred for immunization	
23	Number of children 6 to 59 Months referred for Vitamin A supplementation	
24	Number of immunization defaulters traced	
25	Number of children 2-14 years dewormed	
26	Number of fever cases seen by CHWs	
27	Number of Fever cases < 7 days RDT done	
	Number of Fever cases < 7 days RDT +ve	
	Number of under 5 Malaria Cases (RDT +ve) treated with ACT	
28	Number of over 5 years Malaria Cases (RDT +ve) treated with ACT	
	Number of cases of diarrhea identified in children under five	
29	Number of under 5 children with diarrhoea treated with Zinc and ORS	

Sno	Indicator		Total
39	Number of deaths	< 1yrs	
		1-5 yrs	
		Maternal	
		Other deaths	
		Total deaths	
40	Number of Households without staple food		
42	Number of school drop out	Male	
		Female	

Did the community unit experience stock-outs of more than 7 days for any of the following commodities

#	COMMODITY	YES	NO
a	Antimalarials (child dosages)		
b	ORS		
c	Zinc		
d	RDTs		

……..……..……

Signature:……

Remarks ……

……..……..……

……..……..……

Signature:……

ANNEXT 3B: SUPPORT SUPERVISION CHECKLIST FOR DISTRICT/SUB COUNTY LEVEL SUPERVISION TO LEVEL 1 (COMMUNITY)

(Source: Division of Community Health Services, MOPHS, 2012)

Name of County/District	
Name of Community Health Unit	
Total population of the CHU	
Total number of CHWs under the CHU	
Name (s) of the Community Health Extension Worker	
Name of the link facility	
Name of the link facility in charge	
Phone number of the link facility in charge	
Date of Supportive Supervision	
Name of Supervisor(s)	

SECTION 1: LEADERSHIP & GOVERNANCE (CHEW as respondent)

1-2 Do you have the following plans?

Plans	Check and make remarks
Annual Community Work Plans	
Quarterly implementation plans	
Monthly Action Plans	

1-3 AWP Targets for Key priority areas

i) Key achievements in high impact intervention areas (CHEW as respondent for the CHU)

Performance indicator	Target	Achieved	Achievement (%)	Make remarks
Proportion of pregnant women completing all four ANC visits within the catchment area				
Proportion of women receiving skilled care during delivery within the catchment area				
Proportion of children under 6 months who are exclusively breastfed				
Number of ARV defaulters traced and referred by CHWs				
Number of TB defaulters traced and referred by CHWs				
Proportion of households with a serviceable latrine				
Proportion of households with a hand washing facility				
Proportion of households with access to regular safe water for drinking				
Number of child immunization defaulters traced and referred				
Number of children <5yrs with diarrhoea managed with ORS and zinc				
No of new-borns visited within 48 hours of birth.				
Proportion of children beyond one year receiving 2 doses of Vitamin A				
Number of women of reproductive age who are new family planning users				
Proportion of CHWs who provide timely (by the 5th of the month) monthly reports to the CHEW.				
Proportion of CHWs correctly applying the Treatment Registers				
Proportion of CHWs correctly maintaining commodities stock and inventory cards.				

I) CHU on track in performance of the specific priority areas (Rating):

1-3 AWP Targets for Key priority areas

Q1. Are the CHWs and CHEWs reporting on key priority areas (as per MOH513/514/515/516)?
Yes ☐ No ☐

Remarks _____

1-4 Meetings in the Last Quarter (respondent should be the CHEW on behalf of CHU)

Meetings	Number	Date of Last Meeting or supervision	Availability of Minutes-write [Yes/No]
How many supervisory visits have been made in the last quarter			
How many Stakeholder Forums held?			
How many CHWs received at least one supervisory contact?			

SECTION 2: CHW MOTIVATION AND TRAINING

2-3: Staff Motivation

What are the motivation strategies put in place for CHWs and CHCs? (List the different types of motivation strategies and ask the CHEW to mark/tick that apply)

Continuous training beyond basic (specify)
Mentorship
Recognition (Certificates)
Cash incentive (specify amounts)
Non-cash incentive (specify)
Other (specify)

2-4: Staff Training and Update

Q1: Has Training Needs Assessment for CHEWs, CHC and CHWs been done for the FY? Yes/No. Show report. Yes/No

(CHWs need to be given a logbook for recording trainings)

SECTION 3: HEALTH INFORMATION

Q1. Is the CHU reporting monthly? Yes ☐ No ☐

Is the CHU reporting quarterly? Yes ☐ No ☐

Q2. What is the level of accuracy, completeness and timeliness of reports?

(Circle the most appropriate rating e.g. (3) with 1 being the lowest and 5 the highest)

	Reporting parameter	Level/status (Rating scale)					Remarks
1	Accuracy	1	2	3	4	5	
2	Completeness	1	2	3	4	5	
3	Timeliness	1	2	3	4	5	

2-4 Utilization of Information

Q1: (Observe) whether last month's data was updated in the chalkboard Yes ☐ No ☐

Q2: (Observe) whether the update for key indicators was displayed on MOH 516?

Yes ☐ No ☐

Q3: Was the data displayed discussed by the CHC? Yes ☐ No ☐

Q4: If No, please explain (1, 2, 3)

2-5 Information Resource Corner (CHEW as respondent)

Q1: Has the CHU established an Information Resource Corner/Centre ? _____

Q2: How many written feedbacks did the DHMT provide to the supervisee? _____

Q3: What follow up have you done on previous recommendations? Explain in the space below.

Q4. What were top three challenges encountered in bridging the previous recommendations?

Challenges: 1. 2. 3.

SECTION 4: SERVICE DELIVERY (CHEW as respondent)

Q1. How many CHWs conducted house visits as per the number assigned? _____

Q2. How many CHWs filled and returned the MOH513 and MOH514 within the stipulated requirements? Yes ☐ No ☐

Q3. How many cases of sick children under five were managed by CHW in the last month?

Yes ☐ No ☐

Q4. How many newborns received a home visit from CHWs within 48 hours of delivery?

Yes ☐ No ☐

Q5. Does the CHW have a Job Aid? Yes ☐ No ☐

SECTION 5: FINANCING

Q1. What was the CHC budget? KES _____

Q2. How much of the budget was funded? _____

Q3. Does the CHC have with safe custody of finances and financial facilities e.g. bank account?

Yes ☐ No ☐

Comments:

SECTION 6: TRANSPORT AND REFERRAL SYSTEM

Q1. Means of transport

S/N	Available Means of Transport	Number	Remarks
1	Ambulance		
2	Motor bikes		
3	Bicycles		
4	Others (donkey carts, etc.)		

Q2. Do you use any standard referral form for referring Patients in the community?

Yes ☐ No ☐

Q3. What is the available communication system for referrals?

Phone Yes ☐ No ☐

Other Yes ☐ No ☐

If other (specify) _____

_____

SECTION 7: SUPPLIES AND COMMODITIES

Q1. Does the CHU have an updated inventory of?

CHW kit contents Yes ☐ No ☐

Data collection tools Yes ☐ No ☐

Q2. Proportion of CHW kits with ***Expired Drugs in the Quarter***

_____

Q3. Proportion of CHW kits with no stock outs of key commodities

_____

Q4. Proportion of CHW with all Basic Equipment

_____

Comments:

SECTION 8: FUNCTIONALITY OF COMMUNITY HEALTH UNITS

8.1 Functional Status

	Number	Remarks
Active CHWs Reported		
CHC Members		
Dialogue days held in the last quarter		
Health action days held last six months		
CHC meeting held in the last quarter		
CHIS tools available MOH 513 MOH 514 MOH 515 MOH 516		

Comments:

ANNEX 4: CHEW SUPERVISION CHECKLIST

KENYA COMMUNITY HEALTH STRATEGY CHW SUPERVISION CHECKLIST					
Supervisor Name:			Date:		
Supervisor Designation:			County:		
CHW name:			SubCounty:		
Name and code of community unit :			Health facility code:		
#	Item	Yes	No	NA	Comment
A	AVAILABILITY OF MEDICINES (Check medicines and ask about availability.)				
1	ORS (At least 12 Sachets)				
2	Did you have ORS everyday last month? If no, for about how many days were you without ORS last month?.....				
3	AL 1X6 (At least 10 blister packs)				
4	AL 2X6 (At least 10 blister packs)				
5	AL 3X6 (At least 10 blister packs)				
6	AL 4X6 (At least 10 blister packs)				
7	Did you have AL everyday last month? If no, for about how many days were you without AL last month?.....				
8	Zinc sulfate 20mg (Approximately 60 tablets)				
9	Did you have a continuous supply of AL, ORS and zinc for the last 3 months without any stock-out of those products?				
10	Albendazole 400mg (approximately (20 tablets)				
11	Paracetamol 500mg (Approximately 36 tablets)				
12	Tetracycline Eye ointment 1% (At least 6 tubes)				
13	Combined oral contraceptives (at least 25 packs)				
14	Povidone Iodine Solution (At least a bottle in use)				
AI	CHW HAS ALL KEY ICCM MEDICINES (AL/ORS/ZINC) [yes for 1,3,4&8]				
A2	CHW HAD NO STOCK-OUTS OF MORE THAN 7 DAYS FOR KEY iCCM MEDICINES				
A3	CHW HAS ALL KEY CHS MEDICINES [yes to all]				
B	MEDICINE STORAGE AND QUALITY	Yes	No	NA	Comment
1	Medicines are stored appropriately (as per guidelines)				
2	All medicines are valid (unexpired).				
B1	CHW DEMONSTRATES APPROPRIATE DRUG MANAGEMENT				
C	AVAILABILITY OF SUPPLIES (Observe availability of the following supplies)	Yes	No	NA	Comment
1	Appropriate timer (measures seconds) available and functioning				
2	Mid upper arm circumference (MUAC) tape				
3	Rapid diagnostic test kits (RDTs)				
4	Digital thermometer				
5	Salter scale/Colour coded salter scale				
6	Medical dispensing envelopes				
7	First aid kit				
8	Water quality supplies (Chlorine / flocculant (coagulant and disinfectant); Lavibond Comparator; DPD tablets)				
9	Male condoms				
11	Community treatment and tracking register with blank pages (for at least 10 cases)				
	Sick Child Recording Form				
12	CHS Job aids/counselling cards				
13	Blank referral Slips (at least 3)				
14	Service Log Book (MOH 514)				
C1	CHW HAS ALL KEY JOB AIDS (Sick Child Recording Form and CHS Job Aid)				
C2	CHW HAS ALL KEY ICCM SUPPLIES (MUAC, TIMER, RDTS)				
C3	CHW HAS FULL CHS KIT				

D.	PROVISION OF ICCM SERVICES (Ask to see CHW register and record below)	Yes	No	NA	Comment
D1	CHW HAS MANAGED ICCM CASES IN LAST 3 MONTHS				IF NO, describe why and skip to section H
E.	CLASSIFICATION-TREATMENT CONSISTENCY (Review the 2 most recent cases of fever, diarrhea and malnutrition in the Register.)	Yes	No	NA	Comment
1	Case 1: correct classification-treatment/referral				
2	Case 2: correct classification-treatment/referral				
3	Case 3: correct classification-treatment/referral				
4	Case 4: correct classification-treatment/referral				
5	Case 5: correct classification-treatment/referral				
5	Case 6: correct classification-treatment/referral				
E1	CHW REGISTER SHOWS CLASSIFICATION-TREATMENT CONSISTENCY (4/6 OR 6/6 'YES')				
F.	CASE FOLLOW-UP (Review 2 cases managed in the previous month and tick if follow up for each case was completed within 3 days)	Yes	No	N/A	Comment (describe condition)
1	Case 1: follow up complete				
2	Case 2: follow up complete				
3	Case 3: follow up complete				
4	Case 4: follow up complete				
	Case 5: follow up complete				
5	Case 6: follow up complete				
F1	CHW COMPLETING FOLLOW-UP FOR ICCM CASES (4/6 OR 6/6 'YES')				
G	REGISTER AND REPORT COMPLETENESS	Yes	No	NA	Comment
1	Treatment Register filled completely (all blanks filled and all boxes appropriately filled or ticked) for last full sheet				
2	Household register updated in the last 6 months				
3	Log book updated in the past week				
G1	CHW REGISTERS AND REPORTS COMPLETE AND UP TO DATE				
H	CASE MANAGEMENT AND COUNSELLING (Administer case scenario or simulation)	Yes	No	NA	Comment(Give
1	Takes child's identification (name AND age AND sex)?				
2	Assesses for all danger signs correctly				
2b	Identifies danger sign(s) correctly				
3	Counts respiratory rate correctly (+/- 2 breaths)				
4	Decides to treat or refer child's illness correctly				
5	Gives correct treatment				
6	Demonstrates how to administer treatment correctly				
7	Counsels (correct messages on feeding, increased fluids and when to return)				
8	Explains how to administer medicines correctly				
9	Asks mother to repeat back how to administer				
10	Asks caregiver to return for follow-up visit				
11	Refers if child has danger sign or condition he/she cannot treat				
12	Facilitates referral (provides referral slip AND first dose)				
H1	CHW DEMONSTRATES CORRECT COUNSELING ("Yes" for 6, 7, 8, and 9)				
H2	CHW DEMONSTRATES CORRECT CASE MANAGEMENT ("Yes" for 2, 4, 5 and 7)				
I	ASSESSMENT SKILLS (Refer to instructions)	Yes	No	NA	Comment
I1	CHW DEMONSTRATES CORRECT USE OF MUAC TAPES				
J	KNOWLEDGE OF DANGER SIGNS	Yes	No	NA	Comment
1	CHW can state at least **4** newborn danger signs				
2	CHW can state at least 4 danger signs in pregnancy				
3	CHW can state at least 4 danger signs in child under 5				
J1	CHW DEMONSTRATES KNOWLEDGE OF DANGER SIGNS ("Yes" for any 2 cohorts)				
L	MATERNAL AND NEWBORN CARE HOME VISITS AND COUNSELLING	Yes	No	NA	Comment
1	CHW has counselled one or more pregnant women in the last month				
2	CHW has conducted home visit within 48 hours to newborn (at least one in past two months)				
L1	CHW CONDUCTING MATERNAL AND NEWBORN ACTIVITIES ("Yes" for 1 & 2)				
	GENERAL COMMENTS				
	What were the CHW's most important concerns (and your responses)? Number by priority.				
	Observations and recommendations? Also record in Supervision Log Book at Community Unit				
	PERFORMANCE RATING OF THE CHW				

CHW Performance Scoring

Indicator	No	Yes
CHW HAS ALL KEY ICCM MEDICINES (AL/ORS/ZINC) [yes for 1,3,4&8]	0	1
CHW HAD NO STOCK-OUTS OF MORE THAN 7 DAYS FOR KEY iCCM MEDICINES	0	1
CHW HAS ALL KEY CHS MEDICINES [yes to all]	0	1
CHW DEMONSTRATES APPROPRIATE DRUG MANAGEMENT (criteria TBD)	0	1
CHW HAS ALL KEY JOB AIDS (Sick Child Recording Form and CHS Job Aid)	0	1
CHW HAS ALL KEY ICCM SUPPLIES (MUAC, TIMER, RDTS)	0	2
CHW HAS FULL CHS KIT	0	2
CHW HAS MANAGED ICCM CASES IN LAST 3 MONTHS	0	2
CHW REGISTER SHOWS CLASSIFICATION-TREATMENT CONSISTENCY (4/6 OR 6/6 'YES')	0	2
CHW COMPLETING FOLLOW-UP FOR ICCM CASES (4/6 OR 6/6 'YES')	0	2
CHW REGISTERS AND REPORTS COMPLETE AND UP TO DATE	0	1
CHW DEMONSTRATES CORRECT COUNSELING ("Yes" for 6, 7, 8, and 9)	0	2
CHW DEMONSTRATES CORRECT CASE MANAGEMENT ("Yes" for 2, 4, 5 and 7)	0	2
CHW DEMONSTRATES CORRECT USE OF MUAC TAPES	0	1
CHW DEMONSTRATES KNOWLEDGE OF DANGER SIGNS ("Yes" for any 2 cohorts)	0	2
CHW CONDUCTING MATERNAL AND NEWBORN ACTIVITIES ("Yes" for 1 & 2)	0	2
Total	**0**	**25**
Excellent performance(full incentives)	18 and above	
good performance(80% incentives)	From 14 - 17	
Average performance(50% incentives)	from 9 - 13	
Poor performance(No incentives)	Below 9	

ANNEX 5: CHW REFERRAL FORM

MINISTRY OF HEALTH

REPUBLIC OF KENYA

MINISTRY OF HEALTH - MOH:100

Division of Community Health Services
"Afya Yetu, Jukumu Letu"

COMMUNITY REFERRAL FORM

SECTION A: Patient /Client Data	
Date:	Time of referral:
Name of the patient:	
Sex: Male Female	Age:
Name of Community Health Unit:	
Name of Link Health Facility:	
Reason(s) for Referral	
Main problem(s):	
Treatment given:	
Comments:	
CHW Referring the Patient	
Name:	Mobile No:
Village/Estate:	Sub location:
Location:	
Name of the community unit:	
Receiving Officer	
Date:	Time:
Name of the officer:	
Profession:	
Name of the Health facility:	
Action taken:	
SECTION B : Referral back to the Community	
Name of the officer:	
Name of CHW:	Mobile No:
Name of the community unit:	
Call made by referring officer: Yes: ☐ No: ☐	
Kindly do the following to the patient: 1. 2. 3.	

Official Rubber Stamp & Signature: .....

Sick Child Recording Form

(for community-based treatment of child age 2 months up to 5 years)

Date:____/____/20___ **CHW's Name:** _____ **Tel:** _____

Child's name: First _____ Family _____ **Age:** ____Years/____Months. **Boy / Girl**

Caregiver's Name: _____ **Relationship:** Mother / Father / Other: _____

Name of Community Unit: _____ **Name of Link Facility:** _____

House Hold Number: _____ **Caregiver's Phone Number:** _____

1. Identify problems

ASK and LOOK		Any DANGER SIGN	SICK but NO Danger Sign?
ASK: What are the child's problems? If not reported, then ask to be sure. **YES,** sign present → Tick ☑ **NO** sign → Circle ⓞ			
☐	Cough? If yes, for how long? __ days	☐ Cough for 14 days or more	
☐	Diarrhoea (3 or more loose stools in 24 hrs)? IF YES, for how long? ____days.	☐ Diarrhoea for 14 days or more	☐ Diarrhoea (less than 14 days AND no blood in stool)
☐	IF DIARRHOEA, blood in stool?	☐ Blood in stool	
☐	Fever (reported or now)? If yes, started ____ days ago.	☐ Fever for last 7 days or more	☐ Fever (less than 7 days) in a malaria area
☐	Convulsions?	☐ Convulsions	
☐	Difficulty drinking or feeding? IF YES, ☐ not able to drink or feed anything?	☐ Not able to drink or feed anything	
☐	Vomiting? If yes, ☐ vomits everything?	☐ Vomits everything	
LOOK:			
☐	Chest indrawing? (FOR ALL CHILDREN)	☐ Chest indrawing	
☐	**IF COUGH, count breaths in 1 minute:** _____breaths per minute (bpm) Fast breathing: Age 2 months up to 12 months: 50 bpm or more Age 12 months up to 5 years: 40 bpm or more		☐ Fast breathing
☐	Unusually sleepy or unconscious?	☐ Unusually sleepy or unconscious	
☐	**For child 6 months up to 5 years, MUAC strap colour: red__ yellow__ green__**	☐ Red on MUAC strap	☐ Yellow on MUAC strap
☐	Swelling of both feet?	☐ Swelling of both feet	

2. Decide: Refer or treat child

(tick decision)

☐ **If ANY Danger Sign, REFER URGENTLY to health facility**

☐ **If NO Danger Sign, treat at home and advise caregiver**

GO TO PAGE 2 →

Child's name: _____ **Age:**_____

3. Refer or treat child

(tick treatments given and other actions)

☐ **If ANY Danger Sign, REFER URGENTLY to health facility**

☐ **If NO Danger Sign, treat at home and advise caregiver**

If any danger sign, REFER URGENTLY to health facility:

ASSIST REFERRAL to health facility:

☐ **Explain why child needs to go to health facility. GIVE FIRST DOSE OF TREATMENT:**

☐ If **Diarrhoea**	☐ If child can drink, **begin giving ORS solution** right away.
☐ If **Fever AND** ☐ **Convulsions** or ☐ **Unusually sleepy or unconscious** or ☐ **Not able to drink or feed anything** ☐ **Vomits everything** ---------- ☐ If **Fever AND** danger sign other than the 3 above	☐ **Give rectal artesunate suppository** (100 mg) ☐ Age 2 months up to 3 years—1 suppository ☐ Age 3 years up to 5 years—2 suppositories ---------- ☐ **Give first dose of oral antimalarial AL.** ☐ Age 2 months up to 3 years—1 tablet ☐ Age 3 years up to 5 years—2 tablets
☐ If **Chest indrawing,** or ☐ **Fast breathing**	☐ If child can drink, **give first dose of oral antibiotic** (amoxicillin tablet—250 mg) ☐ Age 2 months up to 12 months—1 tablet ☐ Age 12 months up to 5 years—2 tablets

☐ **For any sick child who can drink, advise to give fluids and continue feeding.**

☐ **Advise to keep child warm, if child is NOT hot with fever.**

☐ **Write a referral note.**

☐ **Arrange transportation, and help solve other difficulties in referral.**

→**FOLLOW UP child on return at least once a week until child is well.**

If no danger sign, TREAT at home and ADVISE on home care:

☐ If **Diarrhoea** (less than 14 days AND no blood in stool)	☐ **Give ORS.** Help caregiver give child ORS solution in front of you until child is no longer thirsty. ☐ **Give caregiver 4 ORS packets to take home.** Advise to give as much as child wants, but **at least** 1/2 cup ORS solution after each loose stool. ☐ **Give zinc supplement.** Give 1 dose daily for 10 days: ☐ Age 2 months up to 6 months—1/2 tablet (total 5 tabs) ☐ Age 6 months up to 5 years—1 tablet (total 10 tabs) Help caregiver to give first dose now.
☐ If **Fever** (less than 7 days) in a malaria area	☐ **Do a rapid diagnostic test (RDT).** __Positive __Negative ☐ **If RDT is positive, give oral antimalarial AL** (Artemether-Lumefantrine). **Give twice daily for 3 days:** ☐ Age 2 months up to 5 months -1/2 tablet (total 3 tabs) ☐ Age 5 months up to 3 years—1 tablet (total 6 tabs) ☐ Age 3 years up to 5 years—2 tablets (total 12 tabs) Help caregiver give first dose now. Advise to give 2nd dose after 8 hours, and to give dose twice daily for 2 more days.
☐ If **Fast breathing**	☐ **Give oral antibiotic (Amoxicillin tablet—250 mg).Give twice daily for 5 days:** ☐ Age 2 months up to 12 months—1 tablet (total 10 tabs) ☐ Age 12 months up to 5 years—2 tablets (total 20 tabs) Help caregiver give first dose now.
☐ If **Yellow on MUAC strap**	☐ **Counsel caregiver on feeding** or refer the child to a supplementary feeding programme, if available
☐ For **ALL children treated at home, advise on home care**	☐ **Advise caregiver to give more fluids and continue feeding.** ☐ **Advise on when to return. Go to nearest health facility immediately** or if not possible return if child ☐ Cannot drink or feed ☐ Becomes sicker ☐ Has blood in the stool ☐ **Advise caregiver on use of a bednet (ITN).** ☐ **Follow up child in 3 days** (schedule appointment in item 6 below).

4. CHECK VACCINES, DEWORMING & VITAMIN A STATUS

(Tick ☐ deworming drug or or vitamin A doses completed; Circle ⓞ those missed):

Advise caregiver, if needed: WHEN and WHERE to get the next dose.

✻ only in selected districts

Age	Vaccine			
Birth	☐ BCG			☐ OPV-0 (upto 2wks)
6 weeks	☐ DPT—Hib + HepB 1	☐ ROTA 1	☐ Pneumo 1	☐ OPV-1
10 weeks	☐ DPT—Hib + HepB 2	☐ ROTA 2	☐ Pneumo 2	☐ OPV-2
14 weeks	☐ DPT—Hib + HepB 3		☐ Pneumo 2	☐ OPV-3
9 Months	☐ Measles 1		☐ Yellow fever*	
18 Months	☐ Measles 2			

Vitamin A for age given?

☐ 6 months
☐ 12 months (1 year)
☐ 18 months (1 ½ years)
☐ 24 months (2 years)
☐ 30 months (2 ½ years)
☐ 36 months (3 years)
☐ 42 months (3 ½ years)
☐ 48 months (4 years)
☐ 54 months (4 ½ years)
☐ 60 months (5 years)

DEWORMING FROM 1 YEAR

Give once every six months to all children one year and above:
If Mebendazole 500mg or Albendazole 200mg for children 1 to 2 years and 400mg for children 2years and above.

Age	Drug	Dosage	Date of next visit
12 months (1Year)			
18 months (11/2Years)			
24 months (2Years)			
30 months (21/2Years)			
36 months (3Years)			
42 months (31/2Years)			
48 months (4years)			
54 months (41/2Years)			
60 months (5Years)			

5. If any OTHER PROBLEM or condition you cannot treat, refer child to health facility, write referral note.

Describe problem: _____

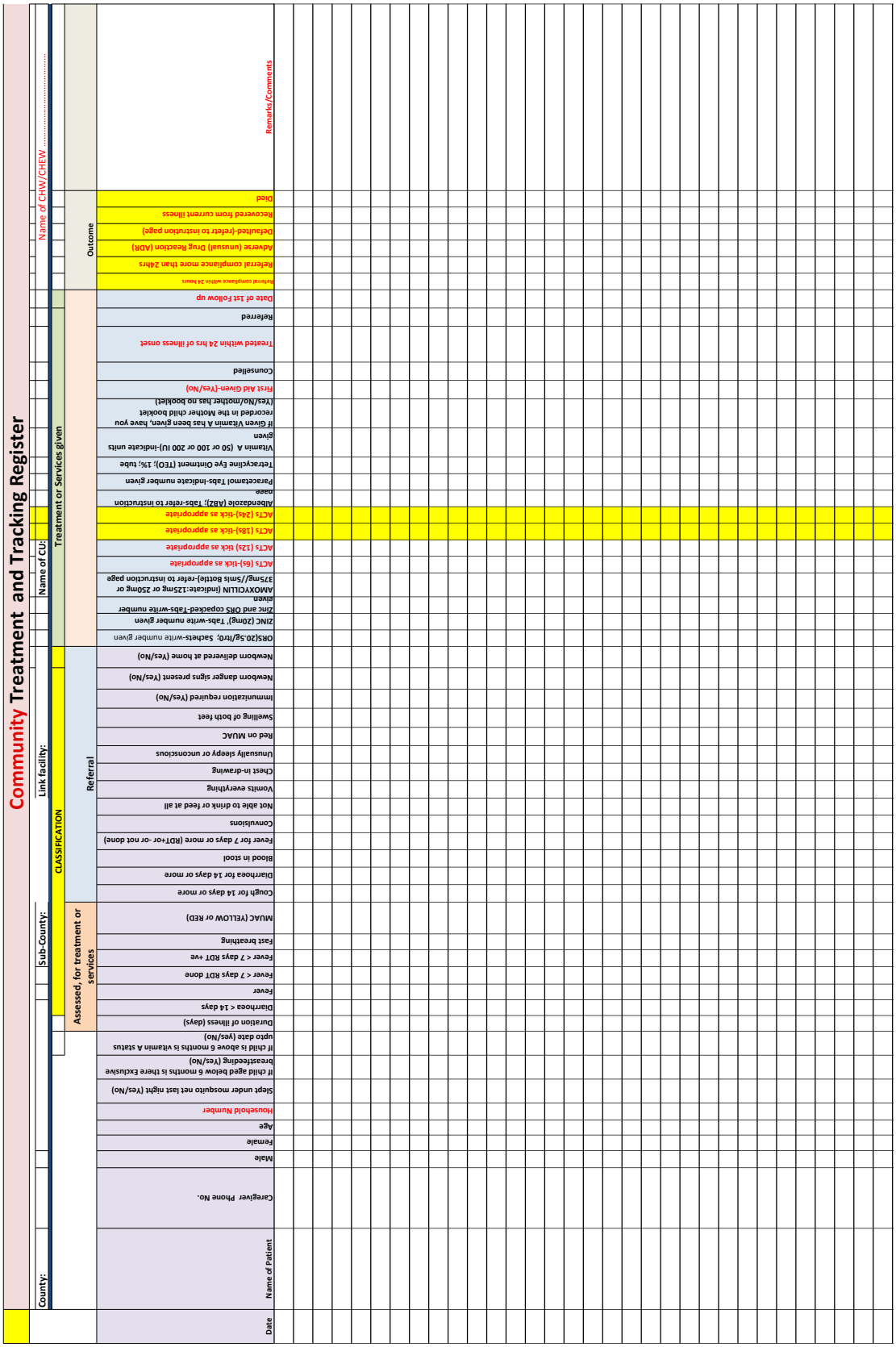
6. When to return for FOLLOW UP (circle):

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

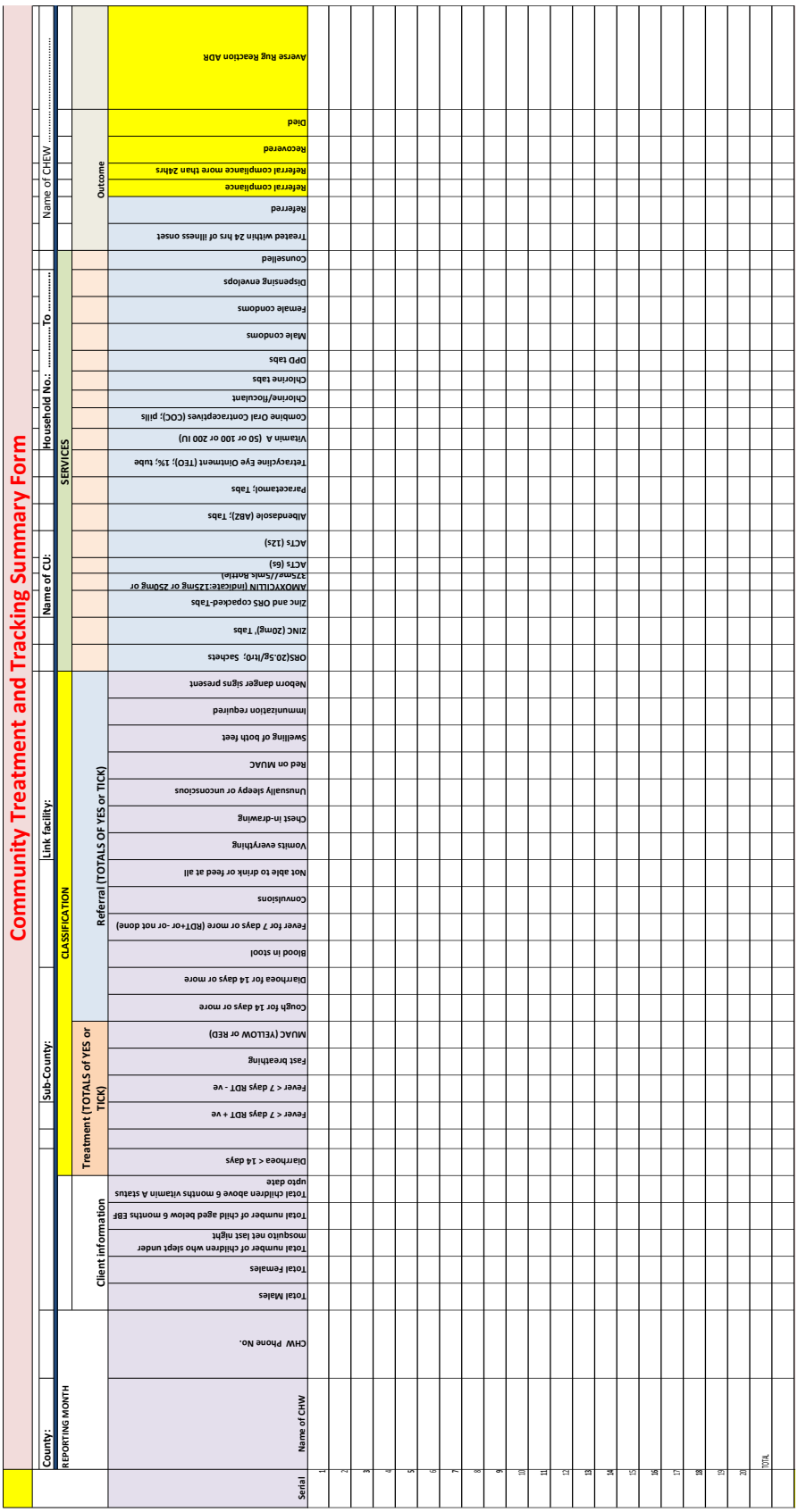
7. Note on follow up:

☐ Child is better—continue to treat at home.
Day of next follow up:_____.
☐ Child is not better—refer URGENTLY to health facility.
☐ Child has danger sign—refer URGENTLY to health facility.

ANNEX 7A: COMMUNITY TREATMENT AND TRACKING REGISTER



ANNEX 7B: CHEW iCCM MONTHLY SUMMARYFORM



ANNEX 8: CHW INVETORY CARD

Product Name:	
Strength/Presentation:	
Counting unit	

Max months of stock (MMS): _____
Max quantity (AMC*MMS): _____
Max quantity (AMC*MMS): _____
Emergency order point (EOP): _____
Emr. Ord.Qty (AMC*EOP): _____
Emr. Ord.Qty (AMC*EOP): _____
Average monthly consumptiom (AMC): _____

Date	Batch no./Serial No	Beginning balance	Quantities						Remarks/Initials
			Quantity requested	Received	Issued	Losses	Adjustments	Balance	
A	B	C	D	E	F	G	H	I	

ANNEX 9: CHEW REQUISITION, ISSUE AND RECEIPT VOUCHER

CHEW Requisition, Issue and Receipt Voucher

Name of CHEW:		Requisition number:	
Phone no (CHEW):		Facility MFL code:	
Facility name:		Facility phone number:	

		Request						Receipt			
Item No.	Date	Commodity name /description	Unit of issue	Balance brought forward	Quantity issued	Quantity on hand	Quantity requested	Quantity received	Batch No.	Current Balance	Remarks

Name of Store Manager _____ Date _____

Health Worker of Link Facility _____ Date _____

Name of CHEW _____ Date _____

CHEW/CHW stock control card

Product name:	
Strength:	
Formulation	
Presentation	

	Commodity name	Batch no./Serial No	Expiry date	Balance BF	Quantities						Remarks/Initials
					Received	DN no.	Issued	Losses	Adjustments	Balance	
A	B	C	D	E	F	G	H	I	J	K	K= (E+F)-(H+I+J)

NB: Adjustment = Gains or loss after physical stock count

DN =Delivery Note

ANNEX 11: CHEW RE-SUPPLY REGISTER

Supply Worksheet

County: _____ Sub-County:Link _____ Facility: _____ Name of CU: _____

	Key: D=Dispensed; B=Balance (stock on hand); QR=Quantity required QS=Quantity supplied	ORS				ZINC(20mg)				AMOXYCILLIN (125mg/5mls)				ACTs(6s)				ACTs(12s)				RDTs				Albendazole(400mg)				Paracetamol				Tetracycline Eye ointment (TEO)(1%)				Combined Oral Contraceptives (COC)			
		Sachets				Tablets				Bottles				Tablets				Tablets								Tablets				Tablets				Tubes				Pills			
Date	Name of CHW	D	B	QR	QS	D	B	QR	QS	D	B	QR	QS	D	B	QR	QS	D	B	QR	QS	D	B	QR	QS	D	B	QR	QS	D	B	QR	QS	D	B	QR	QS	D	B	QR	QS
	Totals																																								

ANNEX 12: NEWBORN CHECKLIST FOR COMMUNITY LEVEL

Name of the Baby:	
Age in Days:	
Name of CU:	
Date/month/year:	
Name of CHW:	
Refer to the link facility IF ANY of the following danger signs (From number 1-11) are there.	
1. Not able to feed since birth, or stopped feeding well.	Yes ☐ No ☐
2. Convulsed or fitted since birth.	Yes ☐ No ☐
3. Fast breathing: Two counts of 60 breaths or more in one minute (Use a watch)	Yes ☐ No ☐
4. Severe chest in drawing (chest draws in as the baby breathes)	Yes ☐ No ☐
5. High temperature: 37.5°C or more or by touch or mother's report	Yes ☐ No ☐
6. Very low temperature: 35.4°C or less (check extremities feet, hand and body)	Yes ☐ No ☐
7. Only moves when stimulated, or does not move even on stimulation.	Yes ☐ No ☐
8. Yellow sole	Yes ☐ No ☐
9. Bleeding from the umbilical stump	Yes ☐ No ☐
10. Signs of local infection: umbilicus red or draining pus, skin boils, or eyes draining pus	Yes ☐ No ☐
11. Weight chart using color coded scales if RED or Yellow (refer < 2.5kgs or those born less than 36 weeks of age)	Yes ☐ No ☐
12. Follow up and check if baby taken to hospital (if any of the above signs noted)	Yes ☐ No ☐

NB/Postnatal visits to be conducted on day 1, 3 and 7 of life of all newborns and postnatal register used for cross reference.

Tick as appropriate.

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