FEDERAL MINISTRY OF HEALTH

STANDARD OPERATING PROCEDURE

FOR

COMMUNITY HEALTH MANAGEMENT INFORMATION SYSTEM

August 2020

Table of Contents

Abbreviation/Acronyms

ANC	-	Antenatal care
CBHC	-	Community based health committee
CBHV	-	Community based health volunteer
CEFP	-	Community engagement focal person
CHEW	-	Community health extension worker
CHIPS	-	Community health Influencers, Promoters and Services
CHMIS	-	Community Health Management Information System
DHIS	-	District Health Information System
EDD	-	Expected Date of Delivery
FMOH	-	Federal Ministry of Health
HDCC	-	Health Data Consultative Committee
HIS	-	Health Information System
iCCM	-	Integrated Community Case Management of Malaria
ISS	-	Joint Integrated Supportive Supervision
LGA	-	Local Government Area
LLIN	-	Long lasting Insecticide Treated Net
NBS	-	National Bureau of Statistics
NHMIS	-	National Health Management Information System
NPHCDA	-	National Primary Health Care Development Agency
NPopC	-	National Population Commission
OIC	-	Officer In Charge
PNC	-	Post Natal Care
PPMVs	-	Patent and Proprietary Medicine Vendors
PW	-	Pregnant Women
SMOH	-	State Ministry of Health
VCM	-	Voluntary Community Mobilizer
VHT	-	Village Health Team
WDC	-	Ward Development Committee

Target audience:

The Standard Operation procedure for Community Health Management Information System is designed primarily for stakeholders at the Federal, State and LGA levels. While there are a wide variety of stakeholders supporting CHMIS at different levels, it may be impossible to accommodate the interests and opinions of all stakeholders and a single recommendation may not be suitable to all. Importantly, this SOP will help the FMOH and her MDAs, State and LGA counterparts in coordinating the activities of community health programs and synchronize with the health facility HIS to promote and achieve national priorities, universal health coverage and sustainable development goals.

The CHMIS SOP is also intended for use by the following:

a. Community leaders, Ward and LGA chairpersons required to provide direct leadership and ownership of the operation of the Community health programs
b. Community health volunteers required to collect and report community health activities
c. Private sector practitioners, Community based organizations, Civil society organizations, Non-governmental organizations and other implementers supporting community level services and programs
d. The academic institutions and health facilities providing capacity building for health workers
e. Development partners and donors who provide technical assistance, oversight and financial support to community health programs

Definition of Terms

a. ***Community*** is a widely used term that has no single or fixed definition. Broadly, a community is considered a social unit, formed by a group of people who are connected to each other in distinct and varied ways, have something in common, such as norms, values, or identity. Communities are diverse and dynamic. One person may be part of more than one community. Community members may be connected by living in the same area/space or by shared experiences, demographic traits, health and other challenges, living situations, culture, religion, identity or values.

b. ***Key affected populations, people or communities*** are those who are most vulnerable to and affected by conditions such as malaria, tuberculosis and HIV. They are the most often marginalized and have the greatest difficulty achieving their rights to health. Key affected populations include children, youth and adults affected by specific diseases such as HIV, tuberculosis or malaria; women and girls; men who have sex with men; injecting and other drug users; sex workers; people living in poverty; street children and out-of-school youth; prisoners; migrants and migrant laborers; people in conflict and post-conflict situations; refugees and displaced persons[1].

c. ***Community health management information system (CHMIS)*** – refers to a collection of systems that links all community stakeholders—healthcare providers, clients, researchers, etc., in a given community with the purpose of providing better exchange of information across the community and enabling better performance in the health sector[2]. CHMIS is a combination of paper, software, hardware, people and process which seeks to support informed decision making and action taking of community health workers.

[1] Expanded from the UNAIDS definition of key populations: http://www.unaids.org/en/PolicyAndPractice/KeyPopulations/default.asp

[2] (2008) Community Health Management Information System (CHMIS). In:Kirch W. (eds) Encyclopedia of Public Health. Springer, Dordrecht. https://doi.org/10.1007/978-1-4020-5614-7_475

d. ***Community health worker or volunteer (CHW/CHV):*** Community health workers/volunteers are members of the communities where they work, should be selected by the communities, should be answerable to communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers (WHO Study Group, 1989).

e. ***Civil Society Organisations (CSO):*** The multitude of associations (usually Non Governmental Organisations and institutions) that reflect the interests and will of citizens through advocacy and represent the interests of the citizens

f. ***CHIPS Agent*** – refers to the community health influencers, promoters and services agent who is the community health worker providing promotive, preventive and curative services within the community
g. ***CBHVs*** – stands for the community health-based volunteer and refers to community volunteers who have been trained
h. **Community Data Tools** – refers to community both paper-based and electronic tally sheets (where available), monthly summary forms, guidelines, referral cards etc., that have been designed
i. **Confidentiality:** the ethical responsibility of keeping clients/patient's health information records professionally and used for only beneficial purposes to the clients/patient
j. **Data Access:** a user's ability to **access** or retrieve **data** stored within a database or other repository.
k. **Data Storage:** a way of keeping information in the memory storage for use by a computer.

CHAPTER 1

INTRODUCTION

1.1 Background

The management, access and use of health data and information is vital in the measurement of service utilization and quality of care provided to the population, which can lead to improved performance measures and outcomes. Therefore, health data management, access and use are key strategic functions of health institutions and health research organizations within the health system.

Community Health Information Management System (CHMIS) refers to the processes and mechanisms through which health-related data is produced at the community level and made accessible to users, through networking both within and outside the health sector. The CHMIS is a type of health information system that links all community stakeholders—healthcare providers, consumers, providers, purchasers, payers, and researchers—in a given community. Community HMIS thus entails the collection, collation, aggregation, analysis and archiving of health-related data not readily available at the health facilities but are obtained from informal service providers outside the orthodox health service. These non-facility-based data are often available at households, schools, community outreaches, maternity homes, PPMVs, TBA centres, and community campaigns.

While the HMIS concerns itself with information for services at the health facilities, the CHMIS is primarily focused on community health information and include data obtained from services provided to community members by the CHWs and community outreaches conducted from the health facility. Structurally, CHMIS and HMIS are inter-connected and by expectation and design, CHMIS will feed seamlessly into the HMIS to avoid duplications and redundancies.

CHMIS data is made up of both paper-based and electronic data generated from households, community service delivery outlets (such as PPMVs, maternity homes, TBAs), schools and community campaigns/outreaches conducted by health care workers

from the health facilities. The paper-based records serve as primary data sources and include client cards, registers, and tally forms while the electronic data is represented as CHMIS-DHIS2.0. Data entry into CHMIS-DHIS2.0 could either be case based data using the CHMIS tracker or aggregate summary reported at facility, ward or LGA level. Private and public services offered at community level are also captured in CHMIS. The integration of community services across RMNCHAH+N, HIV/AIDS, Tuberculosis, Malaria, Neglected Tropical Diseases, non-communicable diseases and vital registration in CHMIS is critical to achieve success of community response and accountability.

1.2 Description of the Community health system in Nigeria

The Nigeria's health system is organized in three tiers, namely, the primary, secondary and tertiary levels with a complex web of inter-connecting and referral network of health facilities. Additionally, the Ward level is now recognized as the fourth layer and incorporate the grassroot communities.

More than 70% of health facilities are primary health care and owned by the local government. Primary facilities are typically staffed by nurses, Community Health Officers (CHOs), Community Health Extension Workers (CHEWs), junior CHEWs, and environmental health officers. It is the responsibility of the Local Government Areas (LGAs) to finance and manage primary health care under the supervisory oversight of the state government.

The Ward level of care is under the ambit of the LGA is directly supervised by the PHC facility and there are about 10,000 Ward development committees organized to coordinate the activities within the ward level. These WDCs are local committees responsible for co-ownership, community participation, demand creation, ensuring client satisfaction, and engendering accountability for services delivered. The committees are made up of volunteer community members who can help to identify health and development problems within the community and promote demand for quality services by getting people to act and change their attitudes and behaviour.

WDCs help to ensure complete ownership by members of the community of all primary health issues such as health promotion and community mobilization, maternal and

newborn child health services, nutrition, control of communicable and non-communicable diseases and sexual and reproductive health.

Aside the established public health structures, there are private sector players at the community level responsible for providing a variety of service delivery. Of note is the role played by PPMVs, community pharmacies, maternity homes and traditional birth attendants in various public health programmes albeit with concerns over quality of care and treatment outcomes. Given their number and presence in rural communities, PPMVs represent an important opportunity to promoting access and delivery of primary health care commodities and services. PPMVs have long been recognized to provide and sell a limited range of pre-packaged and over-the-counter medicines including artemisinin-combination therapy (ACTs), condom, and other commodities.

In recognition of their role in reaching people in remote and hard to reach communities, PPMVs are now involved in TB case identification, case finding, referral and treatment support and in HIV provide opportunities for HIV testing, and referral for ART services. This SOP will provide guidance in how the activities of PPMVs are reported and strengthened to improve coverage of services.

1.3 Definition of Standard Operating Procedures

By definition, Standard Operating Procedures (SOPs) within the context of CHMIS, is a written description of steps for all significant activities relating to the practice of CHMIS management, that has been approved by the relevant authorities and program of the community based Primary Health Care interventions, linked to the activities within and related to the community health volunteer activities. SOPs should accurately reflect good information management practices, be sufficiently practical and be usable within the context of institutionalization of the community systems, such as the efforts of the community health volunteers and other programs such as CHIPS program, CORPS, etc. The good CHMIS management practices directly relate to and are linked to general aspects of Health Information System (HIS) management functions including data collection, compilation, analysis, storage, data processing, record storage, handling of urgent data requests/ needs, management of the devices/ tools/ appliances used to manage the data.

Terminology

For the ease of reference and uniformity of nomenclature in this SOP, the terminology – **Community Health Volunteer** shall be used to represent all community-based actors, service providers or implementers. This generalized nomenclature shall cover a myriad of community actors including but not limited to: CHIPS agents, Community drug distributors, CORPS, community volunteers, community-based health volunteers, community treatment supporters, PPMVs, mentor mothers working within communities, etc.

1.4 Purpose of CHMIS SOP

The Standard operation procedure for CHMIS is designed to strengthen the overall health management information system by ensuring an efficient M&E system within the community health structures. This system is built to ascertain the generation and use of high-quality community health data that will be fed into the larger health system. This has the added advantage of ensuring an all-inclusive process, accountability, promoting access to essential health services and promoting quality of care by care providers. Specifically, the purpose of the SOP are:

1. To improve the quality of data collection, collation, analysis and use at all levels
2. To improve data storage and retrieval systems at all levels
3. To promote usage of community health data by all relevant stakeholders
4. To provide guidance for addressing data quality issues, discrepancies, and errors.

1.5 Justification for Standard Operating Procedures

Based on Hon. Minister for Health's directive and stakeholder's call, the need to update and finalize CHMIS tools became imperative, hence two workshops were held in Kaduna. CHMIS tools review was done in November 2016 and March 2017

- The outcome of November 2016 meeting was as follows:

i. Wide consultation with departments, agencies and programmes along with implementing partners (DAP & IPs) e.g. NBS, NPHCDA, NPopC

ii. Review & update of tools

iii. Dissemination of draft of the community monthly summary form with all stakeholders
iv. Call to other partners for participation in the pilot

- The outcome of March 2017 meeting:

i. Draft indicator sheet, tally sheets/reporting Forms and data flow chart to be loaded on HMIS module created on National Instance (DHIS2.0)
ii. Agreed data flow chart
iii. Pilot to be undertaken in 4 States
iv. Community volunteers/Village Health Workers are responsible for data collection
v. Use of data for decision making by community leaders

However, the HMIS is faced with several challenges among which are;

- The majorly facility based DHIS 2.0 platform with little or no reporting of the community-based interventions and activities, hence the incomplete picture of the monthly reported activities.
- The poor coordination of the donor driven parallel community-based interventions and data information systems and tools, which has affected the efficiency of the data management across the three tiers of government.
- Use of non-standardized forms at the service delivery points in this case within the community; which has happened due to the absence of existing Standard Operating Procedures (SOPs) that guides the setting up and management of the CHMIS
- The poor capacity at the community level for quality reporting of intervention and activities.
- Lack of guidance on how to access health- related data from the producers and source.
- Lack of guidance on how to share the available data that is produced e.g. that is periodically generated through research and routinely generated through program implementation.

The following are the anticipated benefits of having generic SOPs for CHMIS;

1. Harmonization of CHMIS data management procedures of CHMIS sub-systems and components to ensure efficiency and effective coordination in the use of existing scare resources
2. Complete and good quality Community health-related data
3. To provide guidance on how to access Community health- related data from the producers of the data, in this case the CHIPS agents
4. To provide guidance on how to share the health- related data produced.

The procedures and guidelines contained in this document draw on guidance and advice available from good data management practices, data sharing policy and access to information law, experience in implementation of previous SOPs by the Federal Ministry of Health and implementing partners.

These guidelines and procedures provide a framework for consistent and effective collection, storage, analysis, use and sharing of data that is standards-based and fully integrated with other key information governance work areas. These procedures and guidelines apply to management of community health-related data in Nigeria. All producers and users of data related to community health in Nigeria, regardless of affiliation and irrespective of whether they access the data from within or outside of the country, should adhere to these guidelines and procedures. Managers of health sector institutions and organizations in Nigeria need to be able to demonstrate positive progress in enabling staff to conform to these standards, seeking additional resources if required and promoting organizational or systems changes that are required to implement them.

1.6 The Use of Community Health Management Information Systems

Community health management information systems (CHMIS) are those systems through which data is collected and reported directly from/by the community. Main purpose for establishing such systems are:

- For outbreaks notification: For early identification of outbreaks/ epidemics since people begin to fall sick while in the community, thereby establishing appropriate control and prevention measures.

- To reduce morbidity and mortality due to some of the common health conditions in the community by early detection and early response.
- For prompt initiation of treatment of cases
- To capture cases and deaths in the community since some people fall sick and seek treatment in the community, e.g. Village Health Teams (VHTs), traditional healers, herbalists.
- To ensure community participation in health matters / issues that affect them.
- To enable the surveillance system to capture/identify more patients who have not been captured by the current system that is based mainly on established health facilities (government/non-government).

❖ To capture information on health interventions that are carried out in the community in order to get a better estimate on coverage, e.g.: Deliveries by traditional birth attendants, village-based immunizers, family planning providers, referrals, minor malaria treatment, among others.

❖ Registration of births: in order to know the age of the child (for school entry), capture data on births including those in the community for more accurate estimates of population size (especially useful for planning purpose)

❖ Registration of deaths: in order to identify orphans in the community and plan for their support, get better estimates on deaths and Crude Mortality Rates.

NB: Registration of births and deaths is handled under the section on Vital Registration

1.7 Scope of services that CHMIS covers

1. Reproductive, maternal, newborn, child and adolescent health plus Nutrition services (RMNCAH+N):
    a. Routine immunization
    b. ANC, PNC, Emergency transport services and referral for Pregnant women
    c. IDSR/WASH
    d. Nutritional counselling and monitoring
2. HIV/AIDS

a. HIV testing services
b. HIV testing among Pregnant women and HEI
c. PMTCT and EID services (testing and referral)
d. ART adherence support
e. Care and support for Vulnerable children and households

3. Tuberculosis
    a. TB counselling, contact tracing and referral
    b. TB screening and referral of presumptive cases
    c. TB case finding
    d. Treatment support at community level
4. Malaria
    a. iCCM
    b. Routine LLIN distribution
    c. Seasonal chemoprophylaxis
    d. IPTp
5. Neglected Tropical Diseases
    a. Onchocerciasis (River blindness)
    b. Lymphatic filariasis (Elephantiasis)
    c. Schistosomiasis
    d. Soil-transmitted helminths
    e. Trachoma
6. Vital registration and statistics:
    a. Birth registration
    b. Death notification
7. Social and behavioural change communication (SBCC)

CHAPTER 2

STANDARD OPERATING PROCEDURES FOR DATA COLLECTION CHMIS-DHIS
(LINKING COMMUNITY-BASED INFORMATION SYSTEMS WITH THE MAINSTREAM HEALTH INFORMATION SYSTEM)

2.1. Purpose

- To standardize data collection at the community level to ensure data relevance and quality to facilitate continuity of care in the community and the health facility through referral linkages between both service delivery platforms
- To enable all stakeholders to have access to use quality information to reflect on their practice, to influence policy direction and implement changes based on available evidence

2.2. General principles

National/State

- All projects/programs must align with the harmonized system for community health data collection and reporting as specified in the CHMIS SOP
- Updates or Revisions to the CHMIS tools without the approval of the Honorable Minister of Health through the Director, Department of Health Planning, Research and Statistics is NOT permitted
- Introduction of parallel data collection and reporting tools without the approval of the Honorable Minister of Health through the Director, Department of Health Planning, Research, and Statistics is NOT permitted. Such tools must be harmonized with CHMIS tools.
- Harmonized CHMIS Data Collection tools should be reviewed periodically by stakeholders to ensure it is relevant to the countries Community Health Policy

- Whenever new CHMIS tools are introduced by DHPRS, FMOH, all old or obsolete data collection and reporting formats must be removed from circulation and use. Implementers and projects supporting community-based interventions must ensure strict compliance to use of new tool formats.

LGA/Ward/Community

- Community Health Volunteers who will be engaging in data collection and reporting should have adequate knowledge of the community they serve
- Each client receiving health care services must have a record initiated using the approved CHMIS data collection tools
- Records must be made immediately after the client is seen and services are provided
- Community health data should be recorded/collected using standardized CHMIS data collection tools approved by the Federal Ministry of Health as reflected in the CHMIS SOP
- Community health data should be collated using standardized harmonized CHMIS Data Reporting tools developed and produced by the Federal Ministry of Health as reflected in the CHMIS SOP
- All programmes/projects implemented using a community-based approach should be reported on the CHMIS platform for the Federal Ministry of Health to capture information on these services and activities

2.3 Data Collected at Community

The importance of data in empowering individuals, communities, and the government to make decisions underscores the type of data that should be collected. To bring about change in our communities, data collected should enable human resources at this level to identify and track individuals and households in need of support.

For community-level health data to be comprehensive and fulfill its purpose, the following areas should be contained within CHMIS Data collection tools:

- Service Utilization of community-based services
- Surveillance of key populations
- Surveillance of diseases of Public Health Importance
- Health related practices of community members
- Health seeking behavior of community members
- Morbidity and Mortality within the community

CHMIS Data collection tools should incorporate case-based information to enable them to fulfil the purpose stated above.

The linkages between the community-based and health facility-based activities and how these interactions can be monitored and evaluated are illustrated in the figure below. Examples of input and process indicators generated from community-based activities are enumerated. These results in the intermediate outputs, the community stakeholders can use for performance monitoring and accountability. As expected, community interventions and strategies should contribute to increased demand for and utilization of health services at the health facilities.

The overall goal of this interaction is to improve health outcomes, reduce maternal and child mortality through measures that promote disease prevention, early disease detection, identification, prompt referral, and linkage to effective treatment. Consequently, the success of the health system requires effective collaboration and coordination of efforts by community and health system actors.

2.4 Method of Data Collection

Whether a community intervention/programme utilizes either a paper and/or an electronic based system will be determined by various programmatic interventions and nature of support. Programmes/Projects should engage with stakeholders at all levels to determine the most suitable method of data collection.

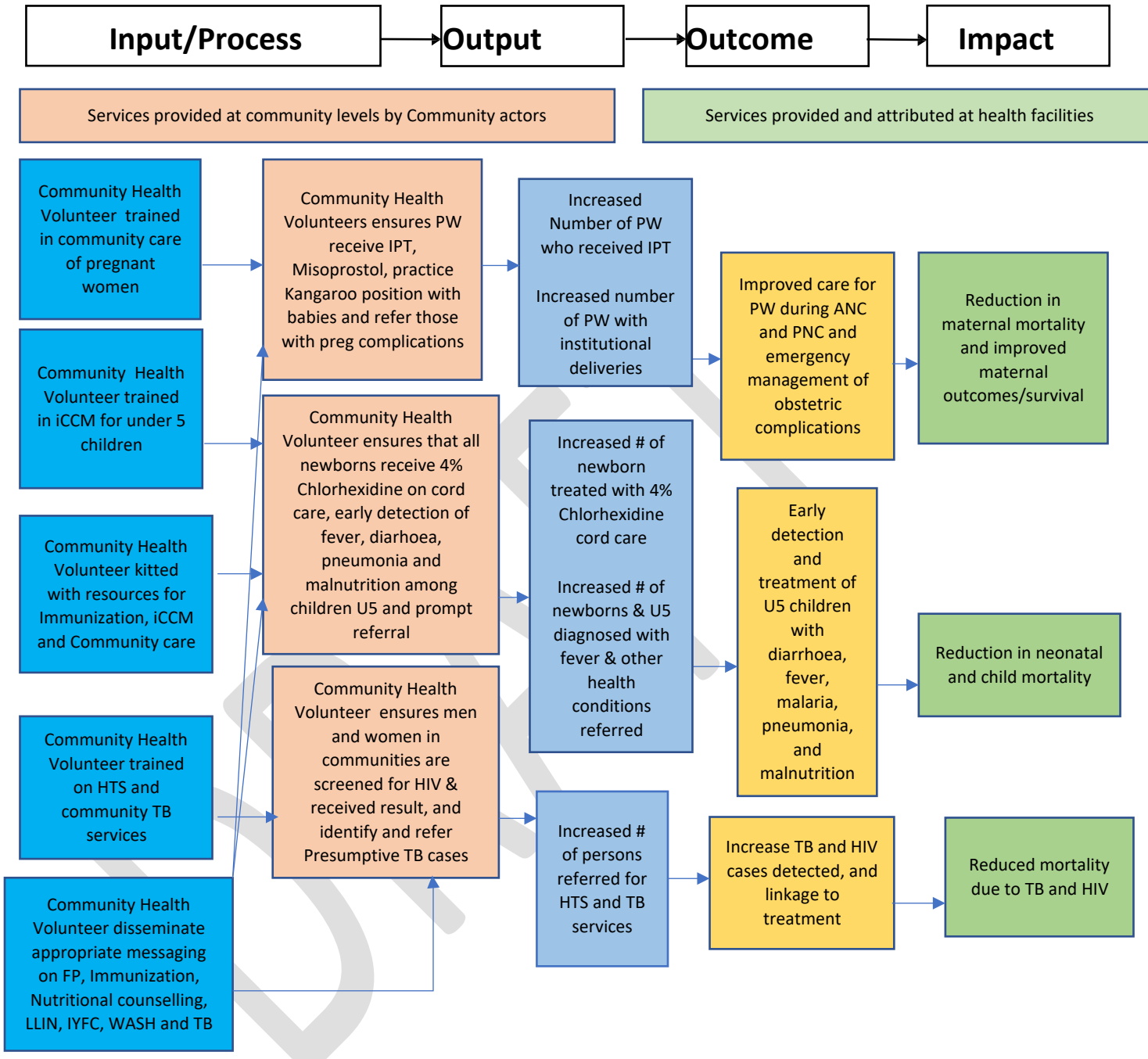
- **Paper-based data collection method**

The CHMIS tools will be printed in paper forms and used for data collection. Each booklet shall be stored securely at the health facility and distributed to CHVs as needed. Essentially, the design

of the tools should ensure that data collection and reporting forms are user-friendly, easy to handle and understood, and in some instances should include pictorial images to facilitate better comprehension by lower cadres of staff and volunteers. Training and mentoring in the use of the paper-based tools to end-users should be incorporated in the dissemination plan for these tools.

- **Electronic data collection method**

Data collection shall be done electronically using secure mobile devices/computer systems that are passworded and properly maintained to avoid data loss. The design of electronic data collection platforms should bear exact similarity with the paper-based forms in order to prevent discrepancies and minimize errors during data transcription. Also, capacity building of the CHV with respect to electronic data collection must be carried out


Input/Process
Output
Outcome
Impact
Services provided at community levels by Community actors
Services provided and attributed at health facilities
Community Health Volunteer trained in community care of pregnant women
Community Health Volunteer trained in iCCM for under 5 children
Community Health Volunteer kitted with resources for Immunization, iCCM and Community care
Community Health Volunteer trained on HTS and community TB services
Community Health Volunteer disseminate appropriate messaging on FP, Immunization, Nutritional counselling, LLIN, IYFC, WASH and TB
Community Health Volunteers ensures PW receive IPT, Misoprostol, practice Kangaroo position with babies and refer those with preg complications
Community Health Volunteer ensures that all newborns receive 4% Chlorhexidine on cord care, early detection of fever, diarhoea, pneumonia and malnutrition among children U5 and prompt referral
Community Health Volunteer ensures men and women in communities are screened for HIV & received result, and identify and refer Presumptive TB cases
Increased Number of PW who received IPT
Increased number of PW with institutional deliveries
Increased # of newborn treated with 4% Chlorhexidine cord care
Increased # of newborns & U5 diagnosed with fever & other health conditions referred
Increased # of persons referred for HTS and TB services
Improved care for PW during ANC and PNC and emergency management of obstetric complications
Early detection and treatment of U5 children with diarrhoea, fever, malaria, pneumonia, and malnutrition
Increase TB and HIV cases detected, and linkage to treatment
Reduction in maternal mortality and improved maternal outcomes/survival
Reduction in neonatal and child mortality
Reduced mortality due to TB and HIV

2.5. Summary of Roles and Responsibilities of Stakeholders

Federal Ministry of Health (FMOH)

Federal Ministry of Health (FMoH) in collaboration with states and stakeholders has the mandate of coordinating the development of tools and guidelines for data management in the country. FMOH is also responsible for managing the DHIS 2.0 platform where all health records various programme interventions from the communities, wards, LGAs and states are stored regularly. In addition to this, the DPHRS facilitates and coordinates the dissemination of the health information materials (both soft and hard copies), such as National health surveys.

In general, FMOH is responsible for the following as it relates to CHMIS data management :

- Coordinate the development of detailed guidelines and grant approvals for CHMIS-related activities including granting ethical approval for CHMIS pilots.
- Facilitate capacity building of all relevant actors at National and sub-national levels on related to CHMIS related activities
- Facilitate collaboration with other relevant Ministries, Departments, Agencies & other stakeholders
- Provide oversight functions for data management (collection, reporting, storage), dissemination and use.

National Primary Health Care Development Agency (NPHCDA)

- Leveraging the strengths and competencies of stakeholders in terms of human resources and technology to improve the functionality of the community level response
- Provide technical support on programme planning, management and implementation of PHC and the community response
- Facilitate community participation, ownership and responsibility for health service delivery through WDCs and other community structures and programmes

National Population Council (NPC)

- Facilitate coordination of community data gathering and reporting of births and deaths occurring at households and community levels
- Support capacity building of community health workers and volunteers in vital registration

.

State Primary Health Care Development Agency (SPHCDA)

- Facilitate collaboration with all relevant actors in the process of selection of CHIPS Agents
- Supervises LGA M&E officers
- Capacity building of community level human resource (e.g. CHIPS Agents) with the support of FMOH/NPHCDA

State M&E officer:

- Prepares and reviews community and health facility data for easy accessibility and sharing
- Ensures that data collected is complete, accurate, timely and of high quality
- Provides feedback to LGA, health facility and /community on data reporting and quality of community services
- Performs data analysis and prepares performance score cards for LGAs
- Responds to requests for health data access, sharing and release
- Ensures the confidentiality, privacy and security of health data sources

LGA M&E officer:

- Prepares and collates community and ward level summary reports
- Performs data quality checks and provides feedback to the ward level, CHWs and health facilities OICs
- Ensures data confidentiality, privacy and security of community data

- Supports capacity building process for CHIPS Agent, community health workers and volunteers

Community Leadership

Ward Development Committee (WDC)

- Facilitate the nomination and selection of Community health volunteers (CHVs), CHIPS Agents and Community Engagement Focal Persons (CEFPs)
- Review and endorse tools used by CHVs
- Randomly review consolidated ward level data during monthly meetings
- Monitor activities of the CHVs to ensure optimal performance of daily duties in line with the National Guidelines, SOPs and Job Aids
- Implement community accountability mechanism for monitoring CHVs' activities in line with community norms and values
- Mobilise funds and other resources for the community
- Put safety measures in place for the CHVs in security-compromised areas
- Endorse consolidated ward level data (by the Chairman or any other designated member)

Ward Focal person (WFP)

- Collates community health and non-health data and submits report to LGA
- Ensures timeliness and completeness of reports submitted by community health workers and volunteers
- Supports the effective implementation of community level activities and community accountability
- Provides feedback to WDC on community and health facility performance with data management
- Facilitates the operations of community health volunteers

- Collect community level data from CHVs
- Verify and reconcile data collected from CHIPS Agents
- Mentor CHVs on community data collection procedures

- Report data on CHMIS for the ward
- Collate and Report commodity usage by the CHVs
- Present the consolidated ward level data at the WDC meeting

Officer In-Charge (OIC)

- Is responsible for coordinating all health-related activities in the catchment communities of health facility
- Supervises activities of the the CHVs and provides regular feedback to the Facility health management, the WDC and the LGA health team.
- Ensures that nationally approved standard forms, registers and other tools used for medical recording, and staff files are always available in the facility
- Assumes overall management and approval of for all data collection, reporting, analysis and use for decision making
- Ensures that good data quality practices are implemented in all service areas as outlined in this SOP
- Ensures health facility that their staff have sufficient training and adequate knowledge understanding oin the use of data reporting systems (paper and electronic), used for recording patient data
- Adheres to data quality standards set out in thise SOP
- Facilitates planning, coordinating and conducting of all internal and external data quality assessment activities
- Ensures that the different types of health-related records are securely and appropriately maintained and stored
- Ensures that inactive or perpetual records are disposed of in accordance with this SOP
- Ensures that all services maintain a uniform filing system for health-related data and records

Community Health Extension Workers (CHEWs)

- Perform administrative functions including attending WDC meetings.
- Supervise the work of community health workers/CHIPS agents and volunteers to ensure compliance with quality standards
- Performs reviews and cross check on data reported by community health workers and volunteers
- Support collation of summary reports
- Visit communities regularly to assess community-based services.
- Ensure community participation in health and non health-related activities.
- Establish a two-way referral for clients/patientsclient.
- Ensure timelinessy, completeness and integrity of the community data generated at the community level

Community Health Volunteers

- Coordinate and facilitate collective community level activities involving the CHIPS Agents in the ward
- Serve as the spokesperson and advocate for the CHIPS Agents in the ward
- Conduct random and scheduled checks of CHIPS Agents' activities at the household level
- Transmit information received from OICs/CHEWs or designated health officer regarding community outreach programmes and other health activities to the CHIPS Agents in the ward
- Collect community level data from assigned CHIPS Agents
- Verify and reconcile data collected from CHIPS Agents
- Mentor CHIPS Agents on community data collection procedures
- Report data on CHMIS for the ward
- Collate and Report commodity usage by the CHIPS Agents
- Present the consolidated ward level data at the WDC meeting

Community Health Volunteer (CHV)

- Providing counselling, treatment, care and appropriate referral system for clients within the communities they serve
- Record community-level data during home visits and outreaches using Community Based data collection tools
- Record referrals from the community to the PHC facility using Referral Forms
- Provide updates on data collection and service implementation (including commodities usage) to supervisors during mentoring and supervision
- Ensures timely submission of community data to CHEWs
- Report notifiable diseases to the supervising CHEW or designated health officer who should report appropriately [Ward Focal Person (WFP), who would, in turn, report to the DSNO]

2.6 Stakeholders and related data elements contained in the CHMIS tools

NPHCDA	•**IDSR:** •Diarrhoea, Measles, Pneumonia, Malaria, Tetanus, Malnutrition, Accidents •Blinding Trachoma, Elephantiasis, Trypanosomiasis, Hookworm, Whipworm, Roundworm, Onchocerciasis, Schistosomiasis •PW referred for ANC, PW who took CIPT2 &3+, PW given Misoprostol, PW & Babies refer for PNC within 2 weeks, PW refer for preg complications, Premature and Stillbirths recorded/reported •**iCCM for under 5 children:**
NMEP	•Newborn care – newborn received 4% Chlorhexidine cord care, referred for immunization, Sick Newborn referred for treatment A.# Children aged 0-59 months who had fever in the last two weeks who received anti-malarial drugs B.# Children aged 0-59 months with diarrhea receiving ORS C.# Children aged 0-59 months with symptoms of pneumonia taken to an appropriate health provider •Newborn care – newborn received 4% Chlorhexidine cord care, referred for •IPT 1 uptake
NACA/NASCP	•**HIV Testing Services:** •# of indiv. CTRR, # of indiv. HIV+, # of indiv. referred for HTS •# of Condom distributed, # of indiv. tested for HBsAg, Syphilis, # of indiv. reactive for HBsAg, Syphilis •# of MARPS who received HIV CTRR, # of MARPS tested HIV+, referred for HTS services and MARPS provided with MPPI. •# of sexually assaulted persons referred for PEP •# of U5 & U18 VC provided with health, nutritional, educational &/or PSS
NTBLCP	•**Community TB Care:** •# of Presumptive TB cases referred by CV/TS, # of TB cases managed by TS/CV, # of persons referred for TB services, # of children U5 referred for TB services
SBCC	•# of PW & Men reached with messages of IPT & FP; •# of PW & Men reached with IYCF & key nutritional, WASH and LLIN messages; •# of indiv. who received messages on FP, Immunization, TB & Nutritional counselling, •# of MARPs reached with MPP

2.7 Who collects data in the community

Data from the community (Individuals and Households) are collected primarily by the Community Health Volunteers (CHVs). Community health volunteers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers.

Health workers from the health facility who conduct activities in the community will collect data relevant to their need, however, this does not constitute data that is entered into the CHMIS.

While CHVs are the primary collectors of CHMIS, there are other actors in the community who are the source of data but not necessarily the ones recording in the tools.

2.8 Standard Procedure for data collection and reporting

Data collection: It is the responsibility of the Community health volunteers to complete all individual and household forms, tally cards and registers at every contact with the clients. Once completed, the signed form/tally cards are submitted to the Ward Focal Person. Before records are collated at the Ward level, the community health volunteers must ensure that the summary reports are vetted and validated by the Supervising health officer (CHEW) at the health facility. All Monthly Summary forms (MSF) that have been countersigned by the Supervising health officer (CHEW) are then collated and submitted to the Ward level. The Ward Health focal person collates data for all the Community health volunteers in this catchment area/Ward. Upon verification, the Ward level health focal person, transmits the data to the LGA Health officer.

2.8a: Steps in the CHMIS data collection: Aggregate data reporting on DHIS2

Step 1:	Community based health related data is captured from the clients/patients within the community and recorded on the approved CHMIS data collection forms

Step 2:	Data recorded on the clients/patient forms is immediately entered in the CHMIS tally sheets/ register on a daily basis. *Both steps 1 and 2 above are done by the CHV who provided the services and supervised by the CHEWs to ensure that forms are available and rightly filled.*
Step 3:	The CHVs shall collate the data weekly and monthly from the registers and provide monthly summaries on the CHMIS monthly summary form
Step 4:	The CHV shall in company of the CHEW review registers and tally cards for quality, and he/she is expected to harmonize the collected data with health facility record and prepare the monthly summary by the 2nd day of the following month
Step 5:	The OIC at the supervising PHC must sign off on the validated MSF prepared by the CHW
Step 6:	The CHV shall submit the validated data on the monthly summary form to the Ward focal person
Step 7:	The Ward focal person should obtain the monthly summary forms from all the CHVs within the catchment area and upload on DHIS2.0
Step 8:	The LGA M&E officer should verify the monthly summary forms and conduct performance analysis

2.8c: Steps in the CHMIS data collection and reporting involving periodic data: Aggregate data reporting on DHIS2 (e.g. Malaria SMC, LLIN distribution, NTD Program)

Step 1:	Community based health related data is captured from the clients/patients within the community and recorded on the approved CHMIS data collection forms
Step 2:	CHV (e.g.CDD/CORPs) shall ensure data recorded on the clients/patient forms is immediately entered in the tally sheets/ register.
Step 3:	The CHVs shall collate the data from the registers and prepare appropriate community summary form and submit to head of supervising health facility (OIC)
Step 4:	The OIC at the supervising PHC shall collates all community summary forms and sign off on the Community summary forms prepared by the CHVs
Step 5:	The OIC at supervising health facility submits all community summary forms to the LGA Coordinator (e.g. LGA NTD Coordinator, LGA Malaria Coordinator)
Step 6:	The LGA Coordinator (e.g. LGA NTD Coordinator, LGA Malaria Coordinator) collates all summary forms from the health facilities (and School-based summary reports) and submit to the LGA M&E officer
Step 7:	The LGA M&E officer upload summary reports obtained from the NTD/Malaria LGA Coordinator to CHMIS-DHIS2.0

2.8d: **Steps in the CHMIS data collection and reporting related to disease outbreaks**

Step 1:	Any member of the community should alert the CHV responsible for collecting health-related data at community level, about any health issue that requires action by the health sector.

Step 2:	Once the CHV gets to know about the health issues, for which he/she is responsible for reporting, he/she should record the information according to the guidelines he/she was given.
Step 3:	CHV should submit data on the health issue/disease outbreak to the OIC at health facility and VHT
Step 3:	The VHT member, at the end of every quarter, should submit data gathered to the nearest government health facility. But in case of an outbreak, the data should be submitted immediately.
Step 4:	At the health facility, the data is received by the health facility in-charge. The in-charge ensures that it is compiled and incorporated into the Health Unit HMIS quarterly report as required. The report is then sent to the LGA level. Also, in case of an outbreak, the data should be submitted immediately.
Step 5:	The data from all the health facilities is collated and validated by the LGA M&E officer and sent on to the DHIS2.0 platform.

To avoid duplication of records, whenever it is discovered that a particular service was obtained by the clients (Pregnant woman or Baby) at the health facility prior to the encounter with the CHV, such information should be noted but not reported as new service rendered by the CHV.

CHAPTER 3

STANDARD OPERATING PROCEDURES FOR DATA REPORTING

3.1. Purpose

- To establish a process to be followed by health facilities in reporting program progress and achievements
- To provide guidelines on reporting timelines and roles and responsibilities of key stakeholders in the reporting process

3.2. General Practices

- All persons involved in the generation and compilation of community health facility report(s) must ensure that standard report formats and procedures are consistently used.
- Supervisors must routinely check for the completeness, accuracy and timely submission of all daily, weekly, monthly, quarterly and/or annual reports. If a report has not been submitted on time or has errors, the supervisor is required to take action and indicate in the supervisory report.
- Supervisors must ensure and follow up on all CHVs to collate monthly summary reports for all catchment areas under his/her jurisdiction. Missing report should immediately be flagged and follow up.
- Every facility must report immediately any identified outbreak or epidemic to the higher levels.
- Supervisors must ensure availability of standard forms and tool formats and are distributed to the community health volunteers responsible for generating and collating weekly and monthly reports

3.3. Procedures for data reporting

- Every facility must submit to the central level their electronic monthly report for the previous month's activities within the required timeframe

- Every facility must ensure that the weekly surveillance reports is submitted on time to the central level

- The OIC must ensure that the monthly report has been reviewed against source records for completeness, accuracy, consistency and integrity before submission

3.4. Data Reporting Schedules

The community health system accommodates a medley of interventions and programs with different target groups and reporting requirements. Most routine surveillance data are reported monthly while there are few exceptions requiring quarterly or less frequent timeframe depending on the nature of the disease and imperative of the specific program.

Monthly data reporting: Most disease programmes and community level activities require weekly and monthly reporting. In fact, more frequent data tracking such as daily reporting and real time data entry through mobile applications and electronic devices are been encouraged to aid program effectiveness and performance-driven actions. When preparing monthly report, CHV must conduct quality checks using source documents such as the individual/client records and registers and reconcile with commodities utilized/dispensed. Furthermore, harmonization of clients' referrals from communities to health facilities must be carried out to ascertain completed referrals and determine contribution to service uptake. Where discrepancies are observed, the CHV with support of their supervisors should collaborate to resolve it before a validated monthly summary form is generated and uploaded on the DHIS2.0.

Quarterly data reporting: There are community health data reporting requirements conducted every three-monthly (quarterly). The quarterly TB case finding, and cohort summaries are examples of quarterly reports.

Periodic data reporting: Periodic LLIN distribution, administration of mass drug administration (MDA) for NTD control and prevention have varying periodicity or cycle of administration and reporting. Yearly Seasonal Malaria chemoprophylaxis (SMC), LLIN mass distribution occurring every three years and mass administration of medicines (MAM) for NTD is twice yearly or annually depending on the prevalent disease condition.

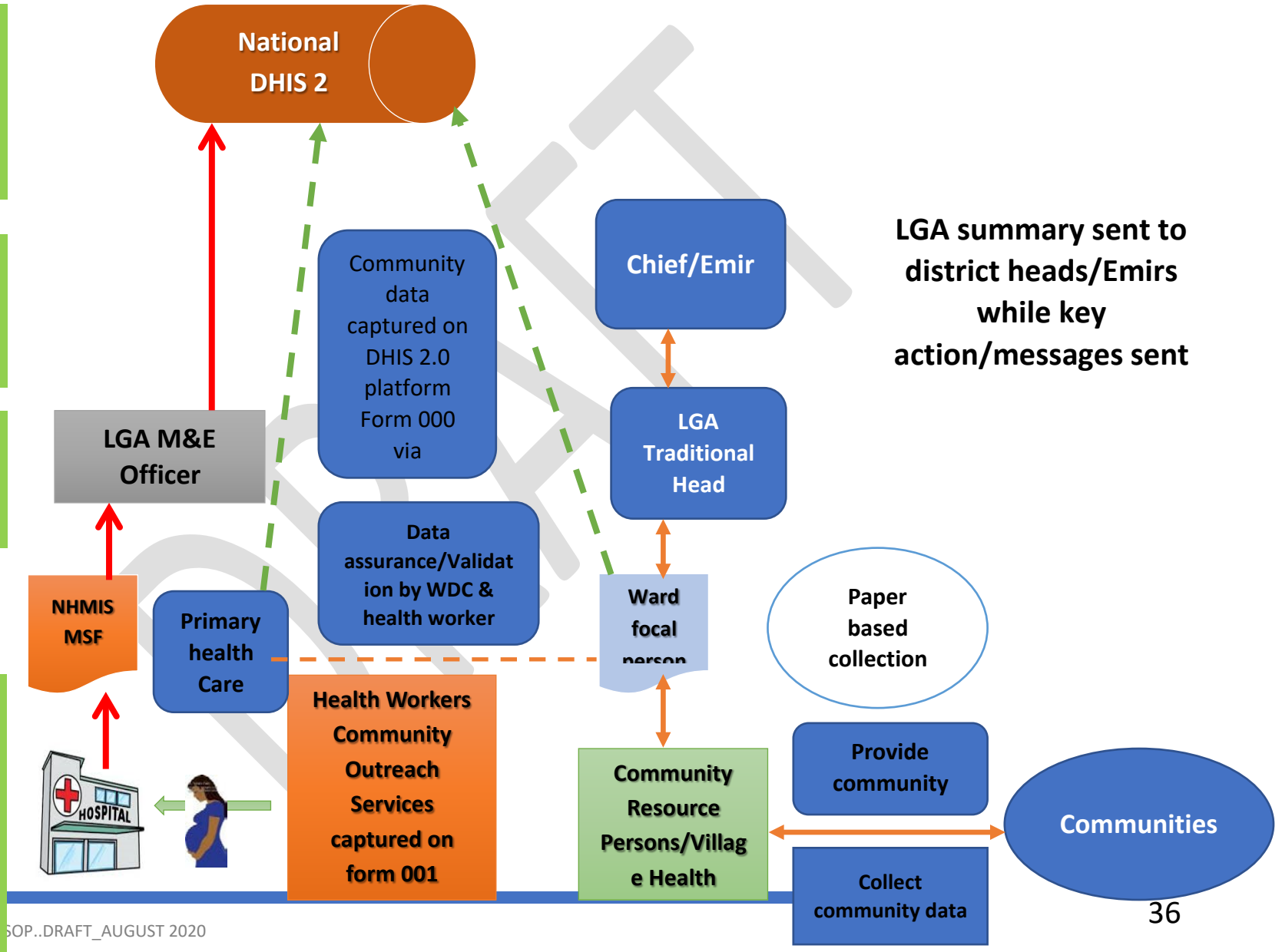
CHMIS Data Flow

National Level
- Data Quality Assurance
- Data Review and Analysis
- Data Feedback
- Progress Update

State Level
- Data Quality Assurance
- Data Feedback
- Data entry in

LGA-level
- Data Quality Assurance (DQA)
- Data Feedback

CHV/Service Provider-level
- Demand creation
- Community mobilization
- Service Provision
- Data Collection
- Data Collation
- Data Reporting
- Data entry



LGA summary sent to district heads/Emirs while key action/messages sent

3.5 CHMIS DATA FLOW

Data flow: Level 1 (Household, community, school based) - Daily

- Data collection begins at the household or community level by CHVs collecting individual clients records in appropriate CHMIS tools
- On a periodic basis, CHVs (e.g. Community Drug Distributors (CDD)) collects data at households on mass administration of medicines (MAM) for NTDs among children <5years and above
- School teachers collects data on administration of MAM for Schistosomiasis and STHs among school pupils aged 5-14years

Data flow: Level 2 (Health Facility) – Weekly and fortnightly

- CHEWs (or CEFPs) collect and reviews data collected by CHVs
- Supervising CHEWS verifies data records and registers collected by CHVs and verifies linkages with health facility records (referrals, commodities utilized)

Data flow: Level 3 (Ward level) - Monthly

- Facility OIC validates and signs off on the Monthly summary forms prepared by CHVs under the guidance of the CHEWs
- CHVs submit validated MSF to Ward focal person
- Ward FP collates all Community MSFs and upload on DHIS2 – CHMIS and shares information with Traditional heads at LGA and Community leaders (Chief/Emirs)
- CHV (e.g. CDD) submit Front line health facility (FLHF) Summary form to Ward FP
- CHV (e.g. CDD) collect copies of all School based MAM Summary forms within catchment area and submit to Ward FP

Data flow: Level 4 (LGA level) – Monthly

- LGA M&E officer collates and reviews all Monthly Summary Forms (MSFs) submitted by the Ward FPs on DHIS2
- LGA M&E officer conduct quality checks and performance analysis of the CHMIS data and provides feedback to the Ward FP, Supervising PHCs and CHVs

Data flow: Level 5 (State and National) – Monthly

- Submitted MSFs should be reviewed at the state and national levels
- State and National HMIS officers provide feedback to LGA and Facility OICs on data quality and performance analysis
- National HMIS officers generate state performance score card

CHAPTER 4

STANDARD OPERATING PROCEDURES FOR DATA QUALITY ASSURANCE

Data quality assurance is not a one-off or stand-alone activity, it must be embedded into all stages of the community HMIS data management process from tool production/printing, to data collection, collation, aggregation, reporting, analysis and use. Procedures for ensuring data quality should be communicated to and understood by all stakeholders involved in community health data management and incorporated into routine monitoring activities, supervision and reviews.

4.1. Purpose

1. To produce high quality community level data for decision making at that level and subsequent levels
2. To promote implementation of an M&E system at community level that can collect, transmit, document and report quality data

4.2. Data Quality Standards

Policy makers and planners require good quality data to make decisions. Good quality data should be accurate, valid, reliable, timely and complete. Data quality is achieved through monitoring and instituting procedures that are designed to identify common data quality errors (verification and validation).

This standard operating procedure identifies the following key aspects to good quality data with respect to patient dossiers, health records and reports: completeness, accuracy/validity, consistency/reliability, timeliness, precision and integrity.

Completeness of reporting:

The following information must be verified:

a. CHVs should ascertain that all reporting units have reported

b. All CHVs within the catchment area have submitted monthly report

c. In each report, all the required data elements have been reported

d. Where Zero is an actual output of a service, this should be recorded and not leave as blank spaces.

Correctness/Accuracy:

The following information must be verified:

a. Data reported is actual reflection of what is happening in the community

b. Correct values being reported in the appropriate boxes/spaces

c. Check for errors. Is this intentional, accidental or systematic (due to misunderstanding of the indicator definition or data element)?

d. Check for summation errors and correct it

Consistency:

The following must be verified:

a. The monthly report follows a consistent pattern of distribution or are there outliers/out-of-range/unexpected values being reported

b. When compared with previous months, is there a consistent pattern i.e. distribution pattern for age, gender or particular service or disease cases.

c. Compare pattern of distribution of cases among other CHVs

Timeliness of reporting:

The following information should be verified:

a. CHVs reports are submitted timely, in accordance with the reporting timeline of the FMOH

b. Penalty or sanction for late reporting are applied consistently across the country

4.3. General Principles

- This Standard Operating Procedure mandates that every health or non-health service rendered to clients at the community level must ensure an internal data quality assessment at least once a quarter. The results of these internal assessments must be summarized in a written report that is provided to the head of the supervisory health

facility and LGA health officer for follow up on resolving issues identified during the assessment.

- This standard operating procedure mandates that all community actors generating weekly and monthly reports should participate in the data quality assessment processes and activity should be coordinated by the head of the supervisory health facility under the guidance of the LGA Health Officer.

Data quality issues often present as data discrepancies. Data discrepancies are inconsistencies in data that must be corrected. Such errors can occur due to summation error, deliberation manipulation/alteration, poor understanding of data elements or missing data.

Where internal data quality errors or omissions are identified, they must be dealt with and corrected immediately.

- Where the community health worker receives queries on data quality from external sources, the queries must be logged and action be taken within 5 days.
- A standard data validation checklist should be developed and used by all responsible persons when conducting internal and external data quality assessment. This is to ensure uniformity in the depth and scope of assessment, and ensure uniform standard across the country
- A summary report detailing the key findings, strengths, observations, data gaps and quality issues identified, and recommended action plan for remediation. This should also include the responsible person to implement the agreed action plans and timeline.

NOTE: The following key consideration should be adhered to when addressing data quality issues and queries:

I. Corrections should be done on source documents without painting, cancellation or deleting

II. Avoid use of correction fluid (e.g. TipEx etc)

III. Only draw a line across on the item you are correcting.

IV. Redo a new/fresh reporting summary form and re-submit to the next higher level

V. Sign off on the page and include date when this correction was done

Irrespective of the level, data discrepancies observed on already reported data are to be rectified for a period not later than three (3) months after the reported quarter. For annual data, discrepancies observed are to be rectified within three (3) months of the next reporting year.

4.4. Procedures for Data Quality Assurance

General Principles:

- Selection of members must be from the cross section of relevant stakeholder involved in community response. Representatives from these organization are chosen to constitute the assessment team
- Use of standardized data validation or DQA tool must be available in either paper-based or electronic formats. Data validation tool which is limited in scope is to be applied routinely by supervisors at health facility, Ward and LGA level during routine data validation while the more comprehensive DQA checklist encompasses system review, human resource capacity, cocktail of data quality (availability, accuracy, completeness, timeliness and consistency) and analysis be applied for external DQA
- Orientation of participating team members should be undertaking before embarking on the DQA exercise
- Every assessment must incorporate mentorship and capacity building for personnel being visited
- Provide feedback and develop quality improvement action plan in collaboration with the community health worker and facility staff
- Where data errors are detected during the assessment, a new MSF should be generated following the appropriate change management procedure (CMP).

- Ensure all validated records and new MSFs are securely kept, archived and available for subsequent verification

4.5 Supervision, Monitoring and Assessment

4.5.1 Routine Data validation exercise

Ward Level:

- On a monthly basis, the Ward focal person with support of the health facility OIC shall conduct a thorough review of the records submitted by the CHVs and CHEWS.
- The review will entail checking for reporting rate, completion of data fields, error checks and correction, flag off outliers and inconsistencies, and incorrect summations.
- Automated excel forms or internal validation rules in-built in the CHMIS DHIS2.0 will be required to enhance the capacity of these officers in carrying out this task efficiently.

LGA Level:

- On a monthly or quarterly basis, the LGA team consisting of the focal persons for disease programmes, the LGA M&E officer, CSOs and implementing partners will conduct data quality check using the standard DQA checklist

4.5.2 External Data Quality Assessment

State Level:

- On a quarterly basis the SMOH, SPHCDA, implementing partners and CSOs operating in the state shall conduct data quality assessment to selected LGAs, Wards, health facilities and communities.
- This DQA should be integrated with the already established NHMIS DQA process and apply the same standard DQA checklist whether paper-based or electronic.

National:

- Representatives comprising of FMOH, NPHCDA, Disease programmes, NACA, NTD, NCD, NPC, NBS, NHRC, CSOs, bilateral and development agencies/partners and implementing partners shall undertake data quality assessment at least once or twice yearly to selected states and LGAs.
- The DQA exercise should synchronize with the established NHMIS DQA and processes.
- Use of standardized DQA checklist either paper-based or electronic shall be adapted to incorporate data elements for CHMIS

4.5.3 Supervision

Supervision will be done at the community/ward level by Health facility staff and Community health committee/WDCs carry out monthly supervisions to CHVs.

a. Quarterly Integrated joint Supportive Supervision (ISS)

Supervision should comprise a range of measures to ensure that staff carry out their activities effectively and become more competent at their work. It involves observing and guiding staff when carrying out their assigned tasks with the purpose of improving their performance against agreed standards.

Use of standard checklist especially the e-tool for the integrated supportive supervision (ISS) are available and should be applied at all levels. When conducted, both health facility and community-based supervisory visits should be harmonized. Importantly, feedback and follow up action plans must be jointly developed with the community health volunteers, CHIPS agents or PPMVs being supervised.

b. Quarterly National and State HDCC Meetings

The Health Data Consultative Committee (HDCC) is the technical body that deliberates on topical issues on health data and makes recommendations to the National Health Data Governance Council (HDGC) which is the highest oversight body for health data management in the country. Membership of the HDCC at the National level comprises officials and /or representatives of FMOH programmes, health related agencies, bilateral and multi-lateral agencies, National Bureau

of Statistics, National Population Commission, and HIS platform Administrators and Managers. Members are expected to meet quarterly to undertake the responsibilities as statutorily recommended by the National Health Information System (NHIS) policy 2014.

CHAPTER 5

STANDARD OPERATING PROCEDURES FOR DATA STORAGE AND RETENTION

5.1. Purpose

This SOP has been developed to promote improved records management practices within communities and health facilities so as:

- To ensure that health related records are retained and stored securely in an appropriate manner such that they are available for use as required.
- To ensure confidentiality of health-related records
- To prevent the premature destruction of records that need to be retained for a specified period to satisfy legal, financial and other requirements of public administration
- To avoid loss of, or missing data and information

5.2. General Principles

- All facilities are required to have and maintain a records centre for keeping inactive records until their cutoff date
- Every facility must have folders or files, shelves, filing cabinets, box files and/or lockable cupboards to enable secure active records
- Perpetual and/or inactive records must be accurate and appropriately kept.
- All staff with access to health-related records must respect the confidentiality issues

5.3. Procedures for health-related records storage and retention

- Collection, storage and processing of data should be done in accordance to international (General Data Protection Regulation (GDPR), Personal Information Protection and Electronic Documents Act (PIPEDA), etc) and local data protection laws
- All facilities must have an appropriate health related records filing and storage system that is easily understood and efficiently used by staff. The filing and storage system should facilitate easy tracing, retrieval and storage of health-related records.
- Active records must be stored in a secure location that is locked during non-clinic hours to safeguard against loss, tampering, or use by unauthorized personnel.
- Computers containing electronic records must be password protected including password protection of folders. Computers that are not being used should be logged off/locked/passworded.
- Data should be regularly backed up in external hard drives (HDD) and kept away in safe location. To minimize data loss, it is essential that a consistent backup schedule and logbook is kept, and depending on the volume of data generated, a monthly or quarterly backup is encouraged.
- Cloud storage of data is highly encouraged. However, cloud storage system should be flexible and there must be a in place mechanism for cloud security mechanism in place, data encryption, backups and data retrieval system

CHAPTER 6

STANDARD OPERATING PROCEDURES FOR DATA ANALYSIS, USE AND DISSEMINATION

6.1. Purpose

To describe procedures for health-related data analysis and dissemination including its interpretation and use

6.2. General Principles

- All community health data collection, analysis, use and reporting activities must protect the privacy and confidentiality of the individual patient(s).
- Data should only be used for the purposes it was intended for and consistent with relevant guidelines.
- All relevant staff should have training on how to interpret and use health related data.
- In analyzing and presentation of CHMIS data, selected indicators should be used to monitor the performance of the project/program
- Presentation of performance charts can be displayed at community/ward level using RUN chart, bar chart and frequency tables on White cardboards. This can be done with comparison by age and sex.
- When analyzing data, care must be taken to ensure that appropriate clinically and epidemiologically informed statistical and presentational techniques are employed so that accurate conclusions can be drawn. If not available within the health facility, competent statistical and analytical support should be sought when new analyses are undertaken.

6.3. Procedures for Data Analysis

- Questions should be developed that are measurable, clear and concise that clearly define the potential solutions for the specific problem or opportunity
- Clear measurement priorities need to be set by identifying what is going to be measured and how it is going to be measured
- The appropriate data analysis softwares for analysis need to be identified (i.e. Microsoft Excel)
- Data for analysis and use must be complete (above 95%) and accurate (error rate ±5%)
- Tables and charts must indicate the unit of measurement and the population being examined, and all internal labels (column headings, row stubs, and panel headings) must accurately describe the information they contain.
- Precaution must be taken when analyzing and reporting on sensitive data items through the anonymization of all identifiable information.

- Interpretation of data must consider all relevant contextual factors such as socioeconomic factors and data should be adjusted for these factors.

- Limitations that impacted or influenced the interpretation of the findings should be clearly communicated (i.e. limited access to data, time constraints, conflicts from cultural and personal bias)

6.4. Required Analyses

The following are some indicators that can be used to track the performance of community-based interventions. These and/or other relevant indicators should be used to monitor performance at the community, ward and facility level.

Community level performance tracking indicators:

1. Number of children <5 seen by the CHV
2. Number of under 5 cases of diarrhea treated with Lo-ORS/+Zinc tablet
3. Number of under 5 cases of cough treated with Amoxycillin
4. Number of pregnant women referred for further management

5. Number of pregnant women referred for ANC by CHV/CHIPS agent
6. Number of women accompanied to the health facility for deliveries
7. Number of women referred for family planning services
8. Number of newborns who received 4% Chlorhexidine gel for cord care
9. Number of newborns referred for immunization services
10. Number of under 5 tested with RDT
11. Number of confirmed Malaria cases among under 5 referred to HF
12. Number of persons tested for HIV (counselled, tested and received result)
13. Number of persons tested and are HIV+
14. Number of persons referred for HTS
15. Number of individuals referred for ART services
16. Number of HIV exposed infants (HEIs) tracked to HF
17. Number of HEIs exclusively breastfeed
18. Number of Vulnerable children (VC) provided with at a minimum of One support service
19. Number of MARPS reached with MPPI
20. Number of TB patients managed by Treatment supporter/Community volunteer
21. Number of Presumptive TB cases referred for TB diagnosis by CV
22. Number of persons referred for TB services by CV
23. Number of births registered by CV/CHIPS agents
24. Total number of births reported in catchment area
25. Number of deaths under 5 attributed to Pneumonia
26. Number of deaths under 5 attributed to Diarrhoea
27. Number of deaths under 5 attributed to malnutrition
28. Number of deaths under 5 attributed to Malaria

Analysis of Reporting rate:

- Percentage of CHVs/CHIPS agents (including PPMVs) reporting on time through the CHMIS
- Percentage of CHVs/CHIPS agents (including PPMVs) with complete (>= 95%) and accurate (error rate <=5%) data

6.5 Data sharing, analysis and decision making

a. Quarterly community data sharing meeting during town hall (analysis, decide, feedback)
b. Quarterly Technical Advisory Meetings
c. Bi-annual state steering committee meetings

APPENDIX

COMMUNITY/VILLAGE LEVEL HEALTH INFORMATION SYSTEM
COMMUNITY MONTHLY SUMMARY FORM

Identification

Political Ward:	Ward Code:
LGA:	Month :
State	Year :
Supervisory health facility:	Actual no. of reporting communities:
Estimated ward population:	Expected no of reporting communities:

Human Resources

	PPMVs	VHWs	CBHVs	CDDs	RMCs	CORPs	FBMs	(TBAs)
Male Community Health personnel engaged								
Female community health personnel engaged								
Number trained in reporting month female								
Number trained in reporting month male								
Number kitted female								
Number kitted male								
Number of people reporting female								
Number of people reporting male								
Number of clients attended to								

Community Integrated Disease Notification (Community IDSR)

	MALE					FEMALE				
	0 – 11mth	12mth – 59 mth	5 – 9 yrs	10 – 19 yrs	20 yrs above	0 – 11mth	12mth – 59 mth	5 – 9 yrs	10 – 19 yrs	20 yrs above
Diarrhoea new cases										
Suspected measles cases										
Suspected pneumonia cases										

Suspected malaria cases										
Confirmed malaria cases										
Suspected tetanus cases										
Suspected malnutrition cases (red muac or swollen feet)										
Road Traffic Accident										
Suspected skin condition cases										
Suspected oral condition cases										
Suspected mental condition cases										
Cough cases >=3 weeks										
Suspected STI cases										
Suspected pallor cases										
Blinding trachoma new cases										
Elephantiasis new cases										
Trypanosomiasis new cases										
Hookworm new cases										
Whipworm new cases										
Roundworm new cases										
Onchocerciasis new cases										
Schistosomiasis new cases										

Community Care of Pregnant Women and Deliveries

	Age Category	TBA (	FBM	SBA	CBHVs	Mothers who deliver independently at home	Total
Pregnant women identified (new)	Adolescent Girls						
	Adult						
Pregnant women followed up	Adolescent Girls						
	Adult						
Deliveries	Adolescent Girls						
	Adult						
Live births	M						
	F						
Still births							
Premature babies/small babies seen and referred (Low Birth Weight <2.5kg)	M						
	F						
Babies placed in skin to skin/kangaroo position & referred	M						
	F						
Clients that received family planning services	Adolescent female						
	Adult female						
	Adolescent Male						
	Adult Male						
Pregnant women referred for ANC for the first time by volunteer health worker	Adolescent Girls						
	Adult						
Pregnant women referred for tetanus toxoid	Adolescent Girls						
	Adult						
Number of women seeking care and treatment for Urine/Stool incontinence referred	Adolescent Girls						
	Adult						
Pregnant women referred for IPT	Adolescent female						
	Adult female						
	Adolescent Girls						

Pregnant women who took CIPT 1	Adult						
Pregnant women who took CIPT 2	Adolescent Girls						
	Adult						
Pregnant women who took CIPT3+	Adolescent Girls						
	Adult						
Pregnant women given Misoprostol	Adolescent Girls						
	Adult						
Women referred for postnatal care within 2days after delivery	Adolescent Girls						
	Adult						
Babies referred for postnatal care within 2days after delivery	M						
	F						
Persons referred for family planning services	Adolescent female						
	Adult female						
	Adolescent Male						
	Adult Male						
Pregnant women with fever referred for further treatment	Adolescent Girls						
	Adult						
Pregnant women with bleeding referred for further treatment	Adolescent Girls						
	Adult						
Pregnant women referred for other pregnancy complications	Adolescent Girls						
	Adult						
Pregnant women receiving Iron and Folic Acid	Adolescent Girls						
	Adult						
Pregnant women monitored for compliance with Iron and Folic acid regimen	Adolescent Girls						
	Adult						
Non-pregnant Adolescent girls who took weekly Iron and Folic acid supplementation							
	Adolescent Girls						

Number of Pregnant women with bleeding referred for further treatment	Adult						
Number of Pregnant women with prolonged labour (lasting more than 12 hours) referred	Adolescent Girls						
	Adult						
Number of Pregnant women referred with convulsion/fitting	Adolescent Girls						
	Adult						
Number of Pregnant Women with complication conveyed to HF through Emergency Transport System (ETS)	Adolescent Girls						
	Adult						
suspected intra-post partum depression	Adolescent female						
	Adult female						

XX

Integrated Community Case Management (ICCM)/Community Case Management of Malaria (CCM) for Children less than 5years (U5)

Newborn Care	female	male	TOTAL
0-28 days old who received 4% Chlorhexidine gel for cord care			
0-28 days old who is sick and referred			
0-28 days old referred for immunisation.			
Malaria			
Seen with fever			
Fever cases tested with RDT			
Fever cases tested RDT positive			
Confirmed malaria cases (RDT positives) treated with ACT			
Confirmed U5 malaria cases referred to facility for lack of improvement after treatment with ACT			
Fever cases with danger signs referred to facility for further management			
U5 Children followed up for Malaria in 3 days			
Pneumonia			TOTAL

U5 Suspect pneumonia cases seen			
U5 Suspect pneumonia cases with high respiratory rate given oral Amoxicillin			
U5 Suspected pneumonia cases referred for further treatment			
U5 Children followed up for Pneumonia in 3 days			
Diarrhoea			
U5 diarrhoea cases seen			
U5 diarrhoea cases given LO-ORS only			
U5 diarrhoea cases given Zinc tablet only			
U5 diarrhoea cases given Zinc+ORS			
U5 diarrhoea cases referred for further treatment			
U5 Children followed up for Diarrhoea in 3 days			
Nutrition			
Children with growth monitoring charts			
0-24 hours feeding on water, any milk or drink			
0-6 months not exclusively breastfed			
6-59 months whose mid upper arm circumference (MUAC) was measured			
6 – 59 months with Yellow MUAC			
6-59 months with red MUAC			
6 -59 SAM Cases treated and discharged			
6-59months who receive 5 or more feeds in the last 24hours			
6-59 months with red MUAC referred to Outpatient Therapeutic Programme (OTP) site			
6-59 months given Vitamin A supplement			
U5 cases with ADR outcome			
Total Number of Children Seen			
U5 children seen CORPs			
U5 Children followed Up			

HIV Prevention, Care and Support

	MALE		FEMALE		TOTAL
	Below 15yrs	Above 15yrs	Below 15yrs	Above 15yrs	
HIV Prevention – HTS					

No. of individuals 15+ who received HIV counselling, testing and received results					
No. of individuals tested HIV positive					
Number of persons referred for HTS					
No. of condoms distributed amongst the general population					
No. of individuals screened for HbsAg					
No. of individuals who were reactive to HbsAg screening and referred					
No. of individuals screened for Syphilis					
No. of individuals who were reactive to Syphilis screening and refered					
HIV Prevention – MARPs					
No. of MARPs who received HIV counselling, testing and received results					
No. of MARPS tested HIV positive					
Number of MARPs referred for HTS services					
No. of MARPS reached with MPPI					
Referral Services					
No. of HIV positive individuals referred for ART services					
No. of sexually assaulted persons referred for PEP					
FLHE					
No. of Teachers Sensitized					
No. of pupils/students reached with FLHE					
No. of schools providing FLHE					
Community-based PMTCT					
No. of Pregnant women referred for HTS					
No. of Pregnant women who received HIV counselling, testing and received results					
No. of Pregnant women tested HIV positive					

No. of HIV positive pregnant women with already known HIV status					
HIV exposed infants who were tracked for the first time					
HIV exposed infants 0-6months exclusively breastfed					
Care and Support					
	Male		Female		Total
No of PLHIV who receive one minimum community care service.					
No. of PLHIV who receive adherence services					
No. of eligible vulnerable children enlisted in care receiving social support services					
No. of PLHIV provided with Prevention with Positives (PHDP) services					

Community TB Care (CTBC)

	MALE		FEMALE		TOTAL
	Below 15yrs	Above 15yrs	Below 15yrs	Above 15yrs	
TB patients managed by Treatment Supporters/Community Volunteers					
Presumptive TB patients referred for TB diagnosis by volunteer health worker					
Persons referred for TB services by volunteer health worker					
Children Under 5 yrs referred for TB services by volunteer health worker					

OVC Care & Support

	MALE	FEMALE	TOTAL
No. of VC Under 5years provided with at least a minimum of one support service by the CBO (Note: CBO include all community level structures, FBO, NGO, etc.)			
No. of VC 5years and under 18 provided with at least a minimum of one support service by the CBO (Note: CBO include all community level structures, FBO, NGO, etc)			
No. of Households/Caregivers of OVC provided with livelihood/household economic strengthening support			
No. of VC Under 5years provided with nutritional support service by the CBO			
No. of VC 5years and Under 18years provided with nutritional support service by the CBO			
No. of VC Under 5years provided with educational support service by the CBO			
No. of VC 5years and Under 18years provided with educational support service by the CBO			
No. of VC under 5years provided with health support service by the CBO			
No. of VC 5years and Under 18years provided with health support service by the CBO			
No. of VC under 5 provided with child protection/Psychosocial support services			
No. of VC 5years and under 18 years provided with child protection/Psychosocial support services			

Deaths

	TOTAL	
Deaths in women related to pregnancy Adolescent female (15 – 19)		
Deaths in women related to pregnancy Adult female (20 - 49)		
	Male	Female
Deaths of babies aged 0 -28 days		
No. of deaths of babies aged 29 days - 11 months		
Deaths of children aged from 12 - 59months		
Deaths of U5 attributable to malaria		
Deaths of U5 attributable to pneumonia		
Deaths of U5 attributable to diarrhoea		
Deaths of U5 attributable to malnutrition		

Health Commodities Status and Distribution

	TOTAL
LLIN slip distributed through community volunteers	
LLIN distributed	
Deworming Tablets distributed	

Stock out of commodities/medicines

	Quantity distributed	STOCK OUT	STOCK OUT FOR 7 CONSECUTIVE DAYS
LLIN			
ACTs			
Amoxicillin (DT)			
LO – ORS			
Zinc tablet			
RDTs			
4% Chlorhexidine gel			
Rectal artesunate			
Misoprostol			
Micronutrient Powder			
Male Condom			
Female Condom			
Mectizan			
Praziquantel			
Albendazole			

Mebendazole			
Iron			
Folic acid			
RTKs			
Water purifiers			
Vaccines			
Sayana press			

Strategic Behaviour Change Communication activities

	Individuals		Total	Medium of Communication eg FGD, Electronic, print etc
	Adolescent 15-19	Adult 20 – 49 years		
No of Pregnant Women reached with messages on Intermittent Preventive Treatment of Malaria in Pregnancy (IPT)				
No of men reached with messages on Intermittent Preventive Treatment of Malaria in Pregnancy (IPT)				
No of Pregnant Women reached with messages on Family planning				
No of Men reached with messages on Family planning				
No of Pregnant Women reached with messages on 4% Chlorhexidine gel for Newborn cord care				
No of men reached with messages on 4% Chlorhexidine gel for Newborn cord care				
No of Pregnant Women reached with messages on Inject ible Antibiotics for prevention of sepsis in newborn				
No of men reached with messages on Inject ible Antibiotics for prevention of sepsis in newborn				

Pregnant women reached with IYCF and Key Nutrition messages				
men reached with IYCF and Key Nutrition messages				
	MALE	FEMALE		
No of Individuals reached with messages on LLIN				
No of Individuals reached with messages on prompt treatment for children under 5 with fever				
No of Individuals reached with messages on prompt treatment for children under 5 with cough or difficulty with breathing				
No of Individuals reached with messages on prompt treatment for children under 5 with diarrhoea				
No of Individuals reached with IYCF nutrition and WASH messages				
No of MARPs reached using the Minimum prevention package				
No of Individuals reached with messages on Antenatal care				
No of Individuals reached with messages on Post natal care				
No of Individuals reached with messages on Nutrition education and counselling				
No of Individuals reached with messages on Family planning				
No of Individuals reached with messages on Immunisation				
No of Individuals reached with messages on Tuberculosis (TB)				

Ward Development Committee (WDCs)/Community System Strengthening (CSS) Activities

	TOTAL	
No. of times Ward/Community Development Committee met		
No of community based outreached / Meetings conducted		
No of women on Ward/community development committee		
No of health related activities carried out in the community		
No of advocacy visit to key stakeholders		
No of functional mother to mother support groups		
No of CMAM sites that experience stock out of key nutrition commodities		

	TOTAL
No. of new wells/bore holes sunk during the month	
No of old water sources repaired/rehabilitated	
No. of new Latrines dug during the month	
No of self help projects initiatives during the month	

Completed by:

Designation: ..... Name: ..... Signature: .....Date: .....

Verified by:

Designation: ..... Name: ..... Signature: .....Date: .....

LIST OF CONTRIBUTORS

1. Dr. Chalres Nzelu (M&E Division DHPRS/FMOH)
2. Adeleke Balogun (M&E Division, FMOH/DHPRS)
3. Dr. Samuel Oyeniyi (FMOH/DFH)
4. Emmanuel Abatta (M&E Division, FMOH/DHPRS)
5. Aliyu Agwai (M&E Division, FMOH/DHPRS)
6. Dr. Anthony Adoghe (M&E Division, FMOH/DHPRS)
7. Dr. Adeyinka Adewemimo (M&E Division, FMOH/DHPRS)
8. Ajah Nwanne (M&E Division, FMOH/DHPRS)
9. Ogeh Ajirioghene (M&E Division, FMOH/DHPRS)
10. Ikechebelu Adaobi (M&E Division, FMOH/DHPRS)
11. Omisore Akinola (P&P Division, FMOH/DHPRS)
12. Adewumi Agbomola (M&E Division, FMOH/NMEP)
13. Olarewaju Adewumi (M&E Division, FMOH/NTBLCP)
14. Ayeni Dickson (DPRS, NPHCDA)
15. Ononuju Okonkwo (CHIPS, NPHCDA)
16. Bidemi Ayeni (PLAN International)
17. Fatima Cheshi (UNICEF)
18. Nkiruka Ukor (WHO)
19. Barnabas Akumba (HISP)
20. Charity Anoke (JHPIEGO)
21. Dr. Ibrahim Maikore (WHO)
22. Farahat Bello (CHAI)
23. Okoh
24. Abiodun (Consultant)
25. Pat Onnu
26. Gideon
27. Fasogbon Olasoji (AFENET)
28.
29.