MINISTRY OF HEALTH
COMMUNITY HEALTH SERVICES UNIT

MONITORING AND EVALUATION PLAN

FOR COMMUNITY HEALTH SERVICES (2014-2018)

AUGUST 2014

Community
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"Afya Yetu, Jukumu Letu"

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Lastly I would like to appreciate the great support offered from the CHSU staff who provided valuable insights, helpful suggestions, and guidance to the CHIS- TWG and the Consultant during the development process of this document.

I hope this plan would be beneficial to all partners offering health services at level one.

Dr. Hussein Salim
Head, Community Health Services Unit

FOREWORD

To ensure real progress towards the Millennium Development Goals (MDGs), National development priorities and other programme objectives, a common programme tool, and a common budgetary and harmonized business practices have to be monitored and evaluated from a common premise.

This M&E plan for Community Health Services offers a good opportunity in establishing a well-coordinated, harmonized monitoring, evaluation and research system that provides timely and accurate strategic information to guide the planning of the Community Health Strategy (CHS) implementation in Kenya.

Successful implementation of the M&E plan will require

- Development of a clear, integrated planning and programme review cycle that ensures evidence, as well as lessons learned, are used to inform policy, undertake harmonization, implement strategy and strengthen programme planning at all levels of the response.
- A strengthened M&E system that facilitates the timely collection, analysis, and reporting of quality-assured data to inform decision-making at all levels.
- Dissemination of results to all-level to policy makers and programme planners in order to inform planning of the CHS implementation.
- Monitoring of national indicators and programme indicators in order to determine the progress made towards the set targets.
- Harmonization of M&E systems from public, private and community levels within the national response to strengthen the 'One M&E system'.
- Providing leadership and coordination of all the M&E sub-systems to attain CHS targets and results.
- Holding relevant partners to account for their agreed roles to ensure successful implementation of the CHS M&E plan.

It is my sincere hope that this M&E plan will guide in successful implementation of Community Health Services programme and guarantee quality information which will be used for evidence based planning in the Health sector. This would in turn hasten the pace to the realization of the MDGs and programme objectives.

Dr. Nicholas Muraguri
Director of Medical Services
Ministry of Health

ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
AOPs	Annual Operational Plans
APHIA	AIDS, Population and Health Integrated Assistance
AWP	Annual Work Plan
CBHIS	Community Based Health Information System
CBOs	Community Based Organizations
CHCs	Community Health Committees
CHEW	Community Health Extension Worker
CHIS	Community Health Information System
CHVs	Community Health Volunteers
CHS	Community Health Strategy
CHUs	Community Health Units
CHSU	Community Health Services Unit
DHIS	District Health Information Software
CHMT	County Health Management Team
GLUK	Great Lakes University of Kisumu
GoK	Government of Kenya
ICC	Interagency Coordinating Committee
IEC	Information, Education and Communication
IRs	Intermediate Results
C-IMCI	Community Integrated Management of Childhood illness
ITNs	Insecticide Treated Nets
JICA	Japan International Cooperation Agency
KDHS	Kenya Demographic Health Survey
KEPH	Kenya Essential Package for Health
LLITNS	Long Lasting Insecticide Treated Nets
MCUL	Master Community Unit List
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
MFL	Master Facility List
MoH	Ministry of Health
NTWG	National Technical Working Group
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

Chapter 1: INTRODUCTION

1.1 Background of the Development of M&E Plan

While progresses have been observed in CHS implementation since it was launched in 2006, the Government of Kenya has faced certain challenges in rolling out the CHS as the current single CHS model is not responding to the needs arising from diversity of the country. The model has not been satisfactorily examined to obtain evidences from the fields to give feedback to development of effective policy. There has been no M&E Plan on CHS which enables the Government to use evidence-based planning on CHS.

In the development of structures for the county and sub counties health plans, which in future will be based largely on the intelligence developed at Level 1, we defined M&E as a continuum of observation, information gathering, analysis, documentation, supervision and assessment. This applies equally at community level.

An effective M&E system needs monitoring structures with appropriate staff, a good information network system, and appropriate reporting formats/registers and procedures. Fundamentally, monitoring should be established from the beginning as part of the planned activities.

Classified either as routine or non-routine, identified data collection subsystems are further elaborated in terms of the data flow mechanisms, reporting schedules, as well as the data processing and quality assurance processes. A national integrated CHS information database is also planned as part of a comprehensive data management and dissemination plan. The document concludes by summarizing the institutional roles and structures for coordination of the planned CHS M&E efforts at national and decentralized levels, in addition to providing year summary budgets for implementation of this plan.

Intended users for this document include the CHSU and its coordination structures at all levels, key institutions responsible for the collection, management and reporting of CHS -related data, programme managers and others involved in planning and implementing CHS -related M&E and research, plus CHS implementers, development partners and the general public. Wide stakeholder adoption of this Plan will ensure a coordinated approach to M&E and research at all levels under the principle of one national M&E system.

1.2 Purpose of the M&E plan

The purpose of developing the M&E plan is to establish a well-coordinated and harmonized monitoring, evaluation and research system that guides the national response with timely and accurate strategic information towards the successful achievement of the CHS implementation process. This is to fill the existing gaps as outlined below:

- Lack of a nationally accepted and standardized M&E framework and plan for CHS leading to existence of multiple plans and systems by different implementing partners.
- Limited data use in planning at all levels leading to limited evidence-informed CHS planning and implementation at community level.
- Inadequate resource allocation to CHS M&E hence limited capacity.

- Lack of systematic and effective data management and quality assurance hence incomplete, untimely and unreliable data
- Lack of dynamic and comprehensive data collection and reporting tools responsive to emerging information and service needs.

The M&E plan will help tracking the implementation of programmatic objectives through provisional regular data to assist in evidence-based planning. This plan is crucial for generating the strategic information required to guide KEPH implementation. In addition to addressing key findings from the Strategic Review of KEPH, this Plan has been specifically designed to support the results-based management approach and to facilitate the coordination of stakeholders responsible for M&E and research at all levels.

1.3 Development of the Community Health Strategy M&E Plan

This CHS M&E Plan was developed through a participatory and consultative process. The consultant developed a zero draft document that was taken through various review processes including: Nakuru 1 and 2 (June and December 2012), Mombasa (June 2013) and Nairobi (July 2014) A multi-sectorial TWG, drawn from key government agencies, development partners, professional bodies and institutions and implementers, spearheaded the entire development process.

The Plan was developed with consideration of the following principles;

1. **Integration**
   CHS M&E Plan integrated into the health and management information system (HIS).

2. **Decentralization of data management**
   Analysis, storage and use of data takes place at all levels.

3. **Simplicity of data management**
   The methods of analysis are simplified according to the information demanded at the various levels.

4. **Action Oriented**
   M&E will collect and forward the necessary information to decision making, while providing feedbacks to the periphery.

The purpose of this document is to outline the structures and mechanisms for measuring the implementation of the CHS. As a supporting document to the Kenya Essential Package for Health (KEPH), this Plan covers the national core indicators, data sources, information products and institutions responsible for monitoring whether or not the expected impact, outcome and output results are achieved.

In addition to providing a brief overview of KEPH and its relationship to this plan, this document defines the goal, objectives, guiding principles and implementation approach for the CHS M&E framework. For each national core indicator for monitoring KEPH performance, this Plan defines the baseline value, targets, data source, responsible institution and frequency for data collection and reporting.

Chapter 2:
OVERVIEW OF THE COMMUNITY HEALTH STRATEGY

2.1 Background to the Community Health Strategy

A large proportion of Kenyans continues to bear the burden of preventable diseases partly due to poverty which dialectically compounds powerlessness and increases ill health. Both have worsened progressively since the 1990s, with glaring disparities within and between provinces. Despite having well defined national health policies and a health agenda whose overriding strategies are focused on improving health care delivery services and systems through efficient and effective health management systems and reform, there has not been sufficient improvement in the health situation of households entrapped in the vicious cycle of poverty and ill health. The situation is further complicated by the emergence of new and resurgence of old communicable diseases. The health service structures at different levels are faced with the challenge of coping with the growing demand for care, in the face of deepening poverty and dwindling resources.

Kenya's second National Health Sector Strategic Plan (NHSSP II – 2005–2010) defined a new approach to the way the sector will deliver health care services to Kenyans – the Kenya Essential Package for Health (KEPH) under which services were conceived and promoted in 6-level cohort strategy. Based on experiences and strategic realities, the KEPH has been restructured under the new NHSSP III 2013-2018 in a 5 life-cycle cohort model with corresponding 5 service delivery levels. The consistent key innovations of KEPH cutting across both NHSSP II and III is the recognition and introduction of Level 1 services, the Community Health Strategy (CHS), aimed at empowering Kenyan households and communities to take charge of improving their own health which in essence is the foundation of CHS.

2.2 Vision of Community Health Strategy

Driven by the motto: Afya Yetu, Jukumu Letu -Our Health, Our responsibility the CHS has a vision of *healthy people living healthy and good quality lives in robust and vibrant communities that make up a healthy and vibrant nation*. Through the CHS it is envisioned that households and communities will be actively and effectively involved and enabled to increase their control over their environment in order to improve their own health statuses.

2.3 Mission of the Community Health Strategy

To realize its Vision, the CHS has set its mission *to become the modality for social transformation for development from the community level by establishing equitable, effective and efficient community health services in community units all over Kenya*. In pursuit of this mission, CHS aims to build the capacity of communities to assess, analyze, plan, implement and manage health and health related development issues, so as to enable them to contribute effectively to the country's socio-economic development. This will result in empowered communities that can demand their rights and seek accountability from the formal system for the efficiency and effectiveness of health and other services.

2.4 Overview of the Community Health Strategy

The overall goal of the CHS is to enhance community access to health care in order to improve productivity and thus reduce poverty, hunger, child and maternal deaths, as well as improve education and performance across all

the stages of the life cycle. This will be accomplished by establishing sustainable community level services delivery systems aimed at promoting dignified livelihoods throughout the country through the decentralization of services and accountability. *The CHS is the mechanism through which households and communities take an active role in health and health-related issue*s. The mechanism also enhances the capacity of communities to assess, analyze, plan, implement and manage health and health related development issues, so as to enable them to contribute effectively to the country's socio-economic development. The outcome of the approach is that communities are empowered to demand their rights and seek accountability from the formal system for the efficiency and effectiveness of health and other services.

The CHS expects to achieve its goal through selective highly cost-effective service package interventions for each age cohort that are likely to result in health improvement in the overall population. This strategy takes the NHSSP II objectives to the community level by mobilizing communities towards their active and dynamic involvement in implementing the interventions that contribute to their own health and socio-economic development, to release themselves from the vicious cycle of poverty and ill-health. The KEPH is designed as an integrated collection of cost-effective interventions that address common diseases, injuries and risk factors, including diagnostic and health care services, to satisfy the demand for prevention and treatment of these conditions. Using an evidence-based plan, health committees organize actions for health grounded in their own capacities. The conditions identified and included in their plan are those in which the Level 1 services can make the most significant contribution to the improvement of the health and well-being of Kenyans.

However, the implementation of the CHS has been facing structural and systemic challenges in its endeavour to cope with the growing demand for health care services and information. There has been inadequate accounting for both health service demand and provision through CHS due to limited information crucial for decision-making and evidence-driven planning. This is exacerbated by the lack of robust and relevant information management; data use and feedback mechanisms throughout the system. For instance, there is apparent lack of updated baselines on key indicators and expected outcomes.

While progress has been observed in CHS implementation since it was launched in 2006, there has been an absence of systematically generated and monitored evidence from the community level to track the contribution of CHS to improvement of health status in the Kenya. This has also hindered evidence-based relevant policy adjustments and implementation strategy improvements. This is attributable to the absence of a national M&E Plan for CHS.

Presently there are critical gaps relating to the CHS which a standard M&E Plan will address. These are:

- Lack of a nationally accepted and standardized M&E Plan for CHS leading to existence of multiple plans and systems by different implementing partners
- Limited data use in planning at all levels leading to limited evidence-informed CHS planning and implementation at community level
- Inadequate resource allocation to CHS M&E hence limited capacity
- Lack of systematic and effective data management and quality assurance hence incomplete, untimely and unreliable data
- Lack of dynamic and comprehensive data collection and reporting tools responsive to emerging information and service needs.

A comprehensive standard national CHS M&E Plan will help in tracking the implementation of programmatic objectives through provision of timely and quality data from all levels to ensure evidence-based planning and implementation. It will also ensure that the strategy is dynamic and responsive to emerging realities facing health service provision in Kenya. This is the reason the Division of Community Health Services has led the initiative of developing this comprehensive M&E Plan through a participatory multi-level stakeholder consultative process.

2.5 Community Health Strategy Intervention Strategy

The CHS provides a mechanism for the delivery of the basic KEPH at the community level. The KEPH, which is designed as an integrated collection of cost-effective interventions, addresses common diseases, injuries and risk factors, including diagnostic and health care services, to satisfy the demand for prevention and treatment of these conditions. Using an evidence-based plan, health committees organize actions for health grounded in their own capacities. The conditions identified and included in their plan are those in which the community level services can make the most significant contribution to the improvement of the health and well-being of Kenyans. Community level activities focus on effective communication aimed at behaviour change, disease prevention, and access to safe water and basic care through focus on key intervention areas. These are detailed in the CHS as follows;

1. **Disease prevention and control to reduce morbidity, disability and mortality**
    - Communicable disease control: HIV/AIDS, STI, TB, malaria, epidemics
    - First aid and emergency preparedness/treatment of injuries/trauma
    - Information, Education and Communication (IEC) for community health promotion and disease prevention

2. **Family health services to expand family planning, maternal, child and youth services**
    - MCH/FP, maternal care/obstetric care, immunization, nutrition, Community Integrated Management of Childhood illness (C-IMCI)
    - Adolescent reproductive health
    - Non-communicable disease control: Cardiovascular diseases, diabetes, neoplasms, anaemia, nutritional deficiencies, mental health
    - Common diseases of local priorities within the sub-county, e.g. eye disease, oral health, etc.
    - Community-based day-care centers
    - Community-based referral system, particularly in emergencies
    - Paying for first-contact health services provided by Community Health Volunteers (CHVs)

3. **Hygiene and environmental sanitation**
    - IEC for water, hygiene, sanitation and school health
    - Excreta/solid waste disposal
    - Water supply and safety, including protection of springs
    - Food hygiene
    - Control of insects and rodents
    - Personal hygiene
    - Healthy home environment: environmental sanitation, development of kitchen gardens
    - Organizing community health day

2.6 Scope of the Community Health Strategy

The CHS puts prioritizes reaching vulnerable population groups and communities especially those living below the poverty line and key community segments with inadequate access to health services. It aims at enhancing access to health services for everyone by ensuring facility access within a radius of 5 kilometers. This way, strategy responds to challenges communities face due to inadequate availability, awareness and acceptability of health services on one hand, and limited access to the services due to distance and socio-economic inability. The strategy also seeks to enhance the performance of health service provision through strengthening of accountability mechanisms at the community level by setting a clear foundation through which communities will demand

accountability on health service provision based on the norms and standards. In essence *the strategy address 5As of health services demand and provision: awareness, acceptability, accessibility, affordability, accountability*.

As a people-centered service provision flagship mechanism of Vision 2030, the CHS scope envisages reaching all the people living below the poverty line by 2015. This constitutes 46 percent of the total population in Kenya. Further, the strategy anticipates to reach 100 percent of the population by 2030. The strategy aims to improve the health and wellbeing of all Kenyans, based on a life-cycle approach for ensuring that each age cohort receives health services according to its needs. The cohorts include pregnancy and the newborn (first 28 days of life), childhood (28 days to 5 years), childhood and youth (5 to 19 years), adult (20-59 years), elderly (over 60 years) *Kenya Health Sector Strategic Plan III -2012*. Building on the National Health Sector Strategy II, the Strategy pursues its objectives by mobilizing communities towards the active and responsive participation in the interventions that contribute to their own health and socio-economic development in order to prevent or ameliorate entry into dual-ended cycle of poverty and ill-health.

2.7 Duration of the Community Health Strategy

The CHS is envisioned as a dynamic National Health Service delivery mechanism to be reviewed at periodic interval of five years. The periodic review also built on the sub-county and community annual action plans which are in tandem with the respective sub-county and national plans. Furthermore, the CHS is dynamic and flexible for necessary adjustments and strategic modifications during implementation.

2.8 Goals and Objectives of M&E Plan

In the CHS, M&E is conceived and promoted as a continuum of observation, information gathering, analysis, documentation, supervision and assessment which applies in equal measure to all levels starting from the community level. The M&E as critical in order to keep activities on track towards the key health goals and objectives; and to support decision making and evidence-informed decision-making from the community to the national policy levels. Effective M&E further aims to enhance accountability on current activities (reporting and assessing impact) and while improving planning and implementation of future activities. The M&E Plan provides the structured mechanism and document of reference for realizing the CHS M&E goals and objectives. Thus, the goal of the M&E Plan is *to establish harmonized and standardized national M&E system to guide and track the implementation and achievement of the CHS*.

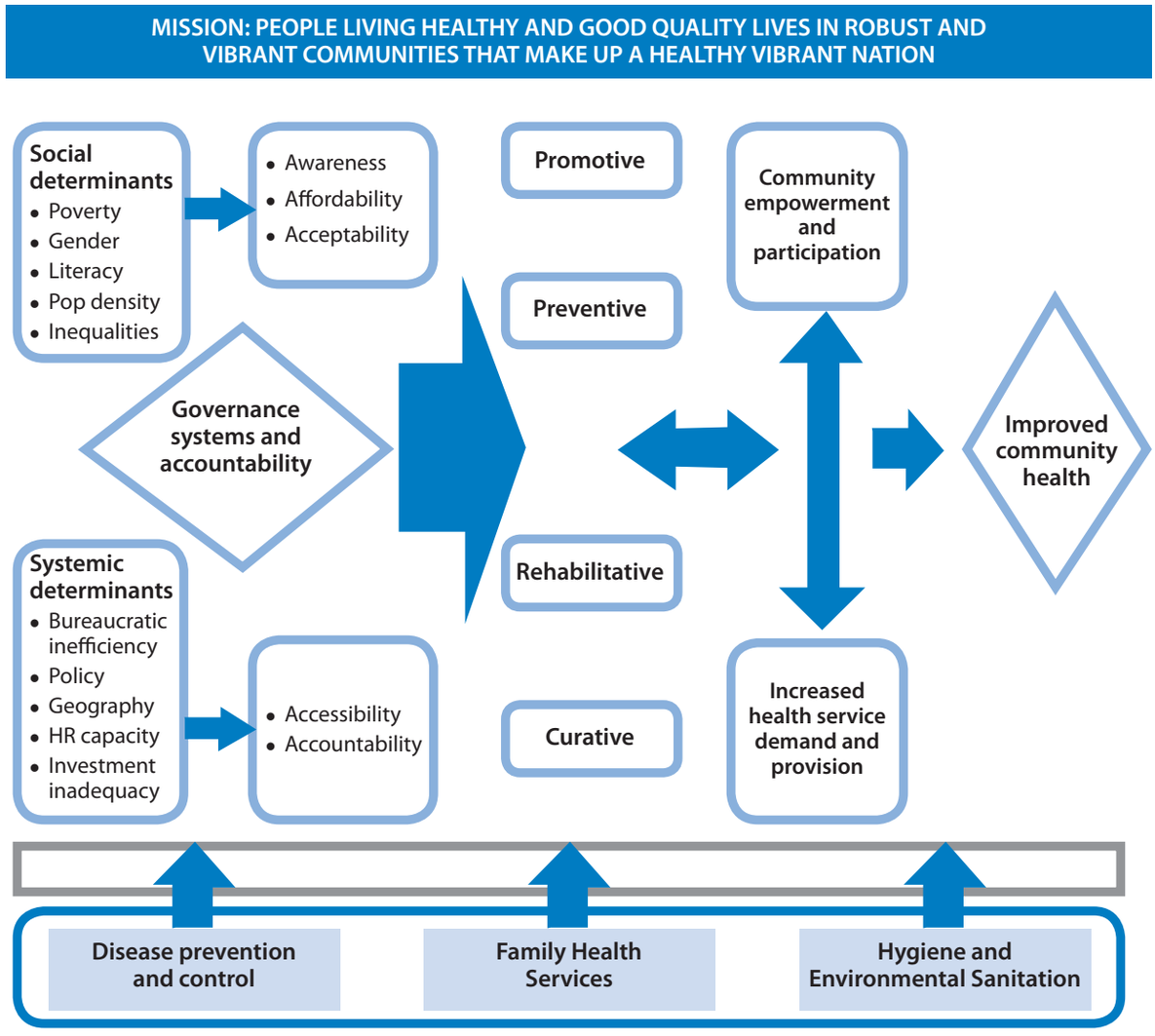
The goal will be pursued through the following specific objectives of the M&E Plan;

1. To establish a robust integrated CHS M&E Plan with capacity to adequately monitor implementation of interventions at Level 1 of the healthcare delivery system.
2. To provide a standard platform for strategic partnership and accountability among stakeholders at all levels and implementing partners as well as to those providing financial resources for the CHS.
3. To enhance the data use for informing evidence-based planning.
4. To identify and document emerging best practices and learnt lessons for improvement and scaling up of service provision.
5. To promote health system research, policy and innovation through documentation and information sharing
6. To provide a standard mechanism for tracking all relevant indicators to capture performance in disease prevention and control to reduce morbidity, disability and mortality; provision of family health services aimed at expanding family planning, maternal, child and youth services; and promotion of hygiene and environmental sanitation.

2.9 The Conceptual Framework of M&E Plan

The CHS aims at improving the overall health and wellbeing of the community. The CHS is conceptually framed to address various determinants of health at the community. These determinants include social and systemic factors which impact on awareness, affordability, acceptability, accessibility and accountability of preventive, promotive, curative and rehabilitative community health services. The CHS aims enhancing community empowerment and participation, increasing demand for health services as well as provision of health services. The conceptual framework below captures the linkages and interplay of these factors.

Figure 1: Conceptual framework for the CHS M&E Plan



On the overall, CHS aims at improving health services access in communities through linkages between community units and health workers with existing health facilities.

The basic results framework for the M&E Plan is given in flow chart below, and is adapted from the international standard logical framework for M&E of health programmes. This framework identifies inputs and process required to undertake comprehensive community health services. There are process indicators that measure these inputs and process. Undertaking of these services will contribute key outputs, outcomes and finally improved health status of Kenyan communities through reduction in morbidity and mortality attributable to preventable illnesses.

Chapter 3: INDICATORS

Table 1: Indicator Matrix

	Indicators	Indicator Definition	Frequency	Data Sources	Source Indicator	Responsible Party
Impact	Maternal mortality rate	N-Deaths among women reproductive age (15–49 years) that occurred during pregnancy, delivery, or within 42 days of delivery	3–5 years	KDHS, MoH 515		MoH KNBS
		D-Number of live births				
Impact	Infant mortality rate	N-Number of deaths within the first year of life (0–12 months)	3–5 years	KDHS, MoH 515		MoH KNBS
		D-Number of live births in the same year				
Impact	Under-five mortality rate	N-Number of all-cause deaths among children under age 5 in a given year	3–5 years	KDHS, MoH 515		MoH KNBS
		D-Number of live births in the same year				
IR1	Proportion of children age 0–6 months who were exclusively breastfed	N-Total number of children age 0–6 months surveyed exclusively breastfed in the day preceding the survey	Annually 5 years	KDHS/MICS/ MOH513	MOH 513 No. N	MoH KNBS
		D-Total number of children age 0–6 months surveyed			MOH 513 Nos. D	
IR1	Proportion of children age 6–59 months receiving at least two doses of Vitamin A supplementa -tion within one year	N-Number of children age 6–59 months supplemented with two doses of Vitamin A within one year in the catchment area	Annually 5 years	KDHS/MICS/ MOH 513	MOH 513 No. T	MoH KNBS
		D-Total number of children age 6–59 months in the catchment area			MOH 513 Nos. D	
IR1	Proportion of deliveries conducted by skilled attendant	N-Number of births in a given year attended by a skilled birth attendant such as doctor, nurse, or midwife	3–5 years	KDHS, MOH 513	MOH 513 No. M	MoH KNBS
		D-Total number of live births in the same year				
IR1	Proportion of women of reproductive age using a modern method of contraception	N-Number of women of reproductive age (15–49 years) currently using a modern method of contraception	3–5 years	KDHS, MOH 513, MOH 515	MOH 513 No. O	MoH KNBS
		D-Total number of women of reproductive age within the catchment population			MOH 515 No. 4	
IR1	Proportion of pregnant women attending at least four ANC visits	N-Number of pregnant women attending at least four ANC visits	3–5 years	KDHS, MOH 513, MOH 515	MOH 513 No. L	MoH KNBS
		D-Total number of pregnant women in the past 12 months			MOH 515 No.5 (Total for past 12 months)	
IR1	Proportion of children who are fully immunized	N-Number of children age 9–11 months who received age-specific vaccines before their second birthday	3–5 years	KDHS, MOH 513	MOH 513 No. S	MoH KNBS
		D-Total number of children age 9-11 months surveyed			MOH 513 Nos. D	

	Indicators	Indicator Definition	Frequency	Data Sources	Source Indicator	Responsible Party
IR1	Proportion of children under five sleeping under LLINs	N-Number of children under five reported to use LLITNs the night before the survey and confirmed by presence of net at the sleeping place D-Total number of children under five	3–5 years	KDHS, MOH 513, MOH 515	MOH 513 No. X with MOH 513 No. D MOH 515 Nos. 6-8	MoH KNBS
IR1	Proportion of pregnant women sleeping under LLITNs	N-Number of pregnant women who report the use of LLITNs the night before the interview and confirmed by presence of net at the sleeping place D-Total number of pregnant women who slept in surveyed households the previous night	Annually 3–5 years	DHIS KDHS MIS/ Quarterly Report. MOH 513	MOH 513 No. X with MOH 513 No. J MOH 513 No. X with MOH 513 No. J (sum of Y & N)	MoH KNBS
IR1	Number of defaulters traced and referred by CHVs for ANC, TB treatment, ART, immunization services	N-Total number of defaulters traced and referred by CHVs for ANC, TB treatment, ART, immunization services	Monthly	MOH 515, Treatment Register	MOH 515 Nos. 53-56 and Treatment register No. V-AC	CHEW
IR2	Proportion of CHUs receiving 25% of FIF and HSSF from the link facility	N-Number of CHUs receiving 25% of FIF and HSSF from the link facility D-Total number of CHUs	Quarterly	Quarterly Report		SCHMT
IR2	Proportion of successful referrals by CHVs	N-Number of referred clients received at link facility D-Total number of referred clients by CHVs	Monthly	DHIS, MOH 100, Treatment and tracking register	MOH 100 Section A Received MOH 100 Section A – Referral and Treatment register Nos. V-AC	CHEW, CHV
IR3	Proportion of community members satisfied with community health services	N-Number of community members who were satisfied with services D-Total number of community members interviewed	Annually	House- hold survey		SCHMT
IR3	Proportion of community members who can correctly cite the key health messages	N-Number of community members who can correctly cite the key health messages within the catchment population D-Catchment population surveyed	3-5 years	Survey		CHMT/ SCHMT
IR3	Proportion of CHUs with IGAs	N-Number of CHUs with IGAs D-Total number of CHUs	Annually	Annual Report		CHMT/ SCHMT
IR1.1	Proportion of households with functional latrines/toilets	N- Number of households with functional latrines/toilets D- Total number of households	Bi-annually	Quarterly Report, MOH 515	MOH 515 No. 18 MOH 515 No. 1	CHEW
IR1.1	Proportion of households with hand washing facilities	N- Number of households with hand washing facilities D- Total number of households with hand washing facilities	Bi-annually	Quarterly Report, MOH 515, MOH 513	MOH 513 No. 4 MOH 515 No.17	CHEW

	Indicators	Indicator Definition	Frequency	Data Sources	Source Indicator	Responsible Party
IR1.1	Proportion of households using treated water	N-Number of households using treated water (Treated water is defined as water treated by boiling and/or using chlorine)	Bi-annually	Quarterly Report, MOH 515	MOH 515 No. 16	CHEW
		D- Total number of households			MOH 515 No. 1	
IR1.1	Proportion of households with refuse disposal facilities	No. of households with refuse disposal facilities	Annually	MOH 513, MOH 513,	MOH 513 No. 6	CHEW
		D- Total number of households			MOH 515 No. 1	
IR1.1	Proportion of children age 0–59 months participating in GMP	No. of children age 0–59 months participating in GMP	Monthly	MOH 514, MOH 515	MOH 514 No. L	CHEW
		D- Total number of children age 0–59 months			MOH 515 Nos. 6-8	
IR1.1	Proportion of children age 12-59 months de-wormed	N-No. of children age 12-59 months de-wormed	Monthly	MOH 515. MOH 514	MOH 514 No. O	CHEW
		D-Total of children age 12-59 months			MOH 515 No. 8	
IR1.1	Proportion of women of reproductive age (15–49 years) provided with family planning commodities by CHVs	No. of women of reproductive age (15–49 years) provided with family planning commodities by CHVs	Monthly	MOH 515	MOH 514 No. K	CHEW
		Total number of women of reproductive age 15-49 years			MOH 515 No. 25	
IR1.1	No. of mothers with newborns counselled on exclusive breastfeeding	No. of mothers with newborns counselled on exclusive breastfeeding	Monthly	MOH 515	MOH 515 No. 20	CHEW
IR1.1	Proportion of children 6-59 months severely malnourished	N-No. of children 6-59 months who are severely malnourished in the community	Monthly	MOH 513	MOH 513 No. M	CHEW
		D-Total number of children 6-59 months			MOH 513 No. D	
IR1.1	Proportion of children 6-59 months with MUAC moderately malnourished	N-No. of children 6-59 months with MUAC indicating moderate malnourished in the community	Monthly	MOH 513	MOH 513 No. N	CHEW
		D-Total number of children 6-59 months			MOH 513 No. D	
IR1.2	No. of children 0-59 months presenting with fast breathing	No. of children 0-59 months presenting with fast breathing	Monthly	MOH 515	MOH 515 No. 34	CHEW
IR1.2	No. of children 0-59 months presenting with fast breathing treated with Amoxicillin	No. of children 0-59 months presenting with fast breathing treated with Amoxicillin	Monthly	MOH 515	MOH 515 No. 35	CHEW
IR1.2	No. of children 2-59 months with diarrhoea treated with Zinc and ORS	No. of children 2-59 months with diarrhoea treated with Zinc and ORS	Monthly	MOH 515	MOH 515 No. 33	CHEW
IR1.2	No. of fever cases managed	No. of fever cases managed	Monthly	MOH 515	MOH 515 No. 27	CHEW

	Indicators	Indicator Definition	Frequency	Data Sources	Source Indicator	Responsible Party
IR1.2	No. of fever cases less than 7 days RDT done	No. of fever cases less than 7 days RDT done	Monthly	MOH 515	MOH 515 No. 28	CHEW
IR1.2	No. of fever cases less than 7 days RDT positive	No. of fever cases less than 7 days RDT positive	Monthly	MOH 515	MOH 515 No. 29	CHEW
IR1.2	No. of malaria cases (RDT +) treated with ACT (under 5 years)	No. of RDT positive cases treated with ACT	Monthly	MOH 515	MOH 515 No. 30	CHEW
IR1.2	No. of malaria cases (RDT +) treated with ACT (over 5 years)	No. of RDT positive cases treated with ACT	Monthly	MOH 515	MOH 515 No. 31	CHEW
IR1.3	Proportions of CHUs conducting quarterly dialogue days	N-No. of CHUs conducting quarterly dialogue days D- Total number of CHUs	Quarterly	Quarterly Report, Support super-visory checklist	SSC No. 8.1 SSC No. 8.1/ DHIS	SCHMT
IR1.3	Proportion of CHUs conducting monthly action days	N-No. of CHUs conducting monthly action days D- total number of CHUs	Quarterly	Quarterly Report	SSC No. 8.1 CHEW Record /DHIS	SCHMT
IR1.3	Proportion of CHUs reporting through DHIS	Number of CHUs reporting through DHIS	Monthly	DHIS	DHIS	SCHMT
IR1.3	No. of community members participating in action days	No. of community members participating in action day during the reporting quarter (disaggregated by target group)	Quarterly	Quarterly Report	CHEW Record	SCHMT
IR1.3	Proportion of CHUs supervised by SCHMT in the last quarter	No. of CHUs supervised by SCHMT in the last quarter Total number of CHUs in the catchment area	Quarterly	Super-vision Report	SSC No. Admin info at top/ CHEW Record CHEW Record	SCHMT/CHS focal person
IR1.4	Proportion of CHVs receiving supportive supervision from CHEWs	N-No. of CHVs who received at least one supportive visit every three months, using a structured checklist D-Total number of CHVs in the CHU	Quarterly	Super-vision Report, MOH 515	SSC No. 1-3 CHEW Record/ MOH 515 admin info at top	CHEW
IR1.4	Percentage of CHEWs in a sub-county who are trained as per national curricula	N-No. of CHEWs in the sub-county who are trained using CHEWs training manual approved by the MoH (e.g., CHEWs Training Manual, ICCM) D-Total number of CHEWs in the sub-county	Annually	SCHMT training inventory	SCHMT Record SCHMT Record/ MOH 515 admin info at top	SCHMT/ CHS focal person

	Indicators	Indicator Definition	Frequency	Data Sources	Source Indicator	Responsible Party
IR1.4	Proportion of CHVs who can identify at least four danger signs for newborns	N-CHVs who can identify at least four danger signs for newborns D-Total number of CHVs	Annually	Super-vision Report		CHEW
IR1.4	Proportion of CHVs who can identify at least four danger signs for pregnant women	N-CHVs who can identify at least four danger signs for pregnant women D-Total number of CHVs	Annually	Super-vision Report		CHEW
IR1.4	No. of CHUs participating in at least one exchange visit annually	No. of CHUs participating in at least one exchange visit annually	Annually	Annual Report		SCHMT
IR2.1	Proportion of CHCs holding quarterly meeting	N-No. of CHCs holding quarterly meetings D-Total number of CHCs	Quarterly	Quarterly Report/ Super-vision Report		SCHMT
IR2.1	Proportion of CHU with AWPs incorporated in the link facility AWPs	N-No. of CHUs with AWPs incorporated in the link facility AWPs D-Total number of CHUs	Annually	DHIS		SCHMT
IR3.1	CHS web site in place	CHS web site developed and updated with information	Quarterly	Quarterly Report		DCHS
IR3.1	No. of media spots (radio/TV spots, etc.) on CHS conducted	No. of media spots (radio/TV spots, etc.) on CHS conducted	Bi-annually	Quarterly Report		DCHS
IR3.1	No. of sub-county using local media	No. of sub-county people using local media	Bi-annually	Quarterly Report		SCHMT
IR3.1	No. of CHC trained according to national guideline	No. of CHC trained according to national guideline	Quarterly	Quarterly Report		SCHMT
IR3.2	No. of CHUs registered as legal entities with the relevant government body	No. of CHUs registered as legal entities with the relevant government body	Quarterly	Quarterly Report		SCHMT

Chapter 4:
PERFORMANCE MONITORING PLAN

The purpose of the monitoring plan is to serve as the basis for establishing the CHS's information systems. These systems will generate information that will allow strategy implementers to track achievement of project outputs (immediate results of project activities), and monitor progress towards achievement of objectives and desired outcomes (interim results created by outputs).The monitoring plan focuses on four broad areas whose indicators are detailed in the Indicator Matrix. The four areas are as follows;

4.1 Capacity building

The CHS proposes to build the capacities of Community Health Extension Workers (CHEWs), CHVs and infrastructure for the smooth implementation of interventions. Interventions targeting CHEWs and CHVs include training and provision of equipment, kits, materials and motor-bikes/bicycles. A set of indicators have been formulated to collect data that will inform the status of these capacity building elements. Data on these indicators will be collected on a bi-annual basis.

4.2 Service provision

The CHVs are expected to provide health promotion services to their assigned households. Monitoring and reporting of these services in essential to inform the strategy implementation processes. To this end, a number of indicators have been formulated to collect, analyze and report the status of service provision. On a monthly basis, a report of the number of households visited and the type of services provided will be summarized from the CHV log books and disseminated.

4.3 Linkages and referrals

Community–link facility linkages are essential strategies for provision of quality services. Referrals of new cases identified by the CHVs need to be referred and received at the health facilities. The performance of this (referral) system will be monitored on a monthly basis using a set of output indicators in the performance matrix.

4.4 Community empowerment

Community empowerment initiatives are critical in equipping communities with necessary skills to demand for their rights for accessible and quality services. Interventions include, consecutive monthly meeting and dialogue days and quarterly action days. The M&E Plan has formulated a set of indicators, including the proportion of functional Community Health Units (CHUs) that will inform the process of empowerment.

Table 2: Performance Monitoring Matrix

Policy Objective	Indicator	Targets			Sources of Data
		Baseline (2012)	Mid Term (2015)	Target (2017)	
IMPACT TARGETS					
Level of Health	Life Expectancy at birth	52	56	65	KNBS
	Maternal deaths per 100,000 live births	400	300	150	KNBS
	Neonatal deaths per 1,000 live births	31	25	15	KNBS
	Under five deaths per 1000	74	50	35	KNBS
HEALTH & RELATED SERVICE OUTCOME TARGETS					
Eliminate Communicable Conditions	% Fully immunized children at 12-23 months	79	90	90	KNBS
	% of default traced disaggregated by service type (e.g. TB, ART, Immunization)	85	90	90	HIS
	% of children under-5 provided with LLITN's	44	85	85	HIS
	% of targeted pregnant women provided with LLITN's	30	70	85	HIS
	% of under 5's treated for diarrhoea at community level	40	60	80	HIS
	% of HH with hand washing facilities				
	% of children below 14 years dewormed	49	85	90	HIS
	% of children under 5 with fever tested with RDT at community level				
Provide essential health services	% deliveries conducted by skilled health personnel	44	60	65	HIS/KNBS
	% of women of Reproductive age receiving family planning commodities	45	80	80	HIS
	% of pregnant women returning for at least at least 4th ANC visits	36	80	80	HIS
Minimize exposure to health risk factors	% infants under 6 months on exclusive breastfeeding	32			KNBS
	% of mothers with newborn reporting being counselled on exclusive breastfeeding.				HIS
Strengthen collaboration with health related sectors	% Households with access to treated water	60		85	KNBS
	% of children under-5 underweight	17		5	KNBS/HIS
	% of children under-5 participating in growth monitoring				HIS
	% of households with functional latrines	34		70	KNBS
HEALTH INVESTMENT OUTPUT TARGETS					
Health promotion	% of CUs conducting monthly action days				
	% of CUs conducting quarterly dialogue days				
Service delivery systems	% of functional community units	28	64	100	Annual reports
	% of referred clients reaching referral unit	25	70	85	HIS
Health Workforce	% of CHVs at sub-county who are trained according to the national guidelines				Annual reports
	% of CHEWS at sub-county who are trained according to the national guidelines				Annual reports
	% of CHCs at sub-county who are trained according to the national guidelines				Annual reports
	% of CUs who have received supportive supervision from SCHMT in the last quarter				HIS
	% of CHVs who have received supportive supervision from CHEWs in the last quarter				HIS
Health Products	% of CUs supplied with CHV Kit commodities				
Equipment	% of CHVs with functional motorcycles				SCHMT
	% of CHVs with functional bicycles				SCHMT
Health Information	% of CUs submitting timely, complete and accurate information	32	70	85	HIS
	% of Counties conducting DQAs for CS information	0	60	80	HIS
	% of CUs submitting complete plans	65	95	95	HIS

Chapter 5:
EVALUATION PLAN

This evaluation plan enables you to evaluate the why you have or have not achieved the objectives and goals that were set for the project. It allows you to look at consequence, intended or unintended as well as effectiveness, efficiency, impact and sustainability. The evaluation looks at the overall project: the operations, governance, deliverables, and helps you identify the lessons learned and what you would do better next time .

Table 3: Evaluation Plan

Level of evaluation	What to be evaluated	Activities	Methodology for evaluation	Responsible organization	Cost (Kshs.)
Linkages and referrals	Level of linkages for all CUs and their link facilities	Evaluating linkages and referral systems Analyze data and establish data and linkage Develop county profile	Supportive supervisory tool		10,392,000
Minimum standards of service	Quality of service offered at community	Develop standard guideline and determine minimum standards Pretest and validate the tools Conduct the survey Analyze and establish baseline data	Conduct interview	CHSU	
Percentage of population below poverty line accessing services through CUs	Demographic profile Scale up mechanisms for access of services	Conduct economic demographic profile Document and scale up access	FGDs and interviews	CHSU	
Policy guidelines that have been developed to enhance community survive delivery	Policy guidelines	Conduct desk reviews Develop tool for effectiveness of guidelines Document, report and document	Desk review	CHSU	
Capacity building	Number of CHVs, CHEWs, and CHCs fully trained using approved guidelines	Establish proportion trained and stager trainings as per need	KII	CHSU	
Percentage of population accessing health services from the link facility within 5 kilometers coverage	Proportion of population living within the distance and establish the gap	Assess proximity to link facility	Exit interviews/ surveys	CHSU	
M & E systems	Existence and functionality of M & E Systems and CU	Hire consultant Develop evaluation tools Design FGD guide	Key informant interview (KII) FGD	CHSU	4, 011,000
Midterm survey					
Scale up	Scale up of M & E system, M health, and centers of excellence	Resource mobilization Equipment supply and maintenance Increase support to CU centers of excellence Adjust programme according survey report	Fine tune system intelligence review for optimum output CU survey	CHSU	10,392,000
End term survey					
	Evaluate achievement of programme strategic objectives	Conduct interviews			10,392,000

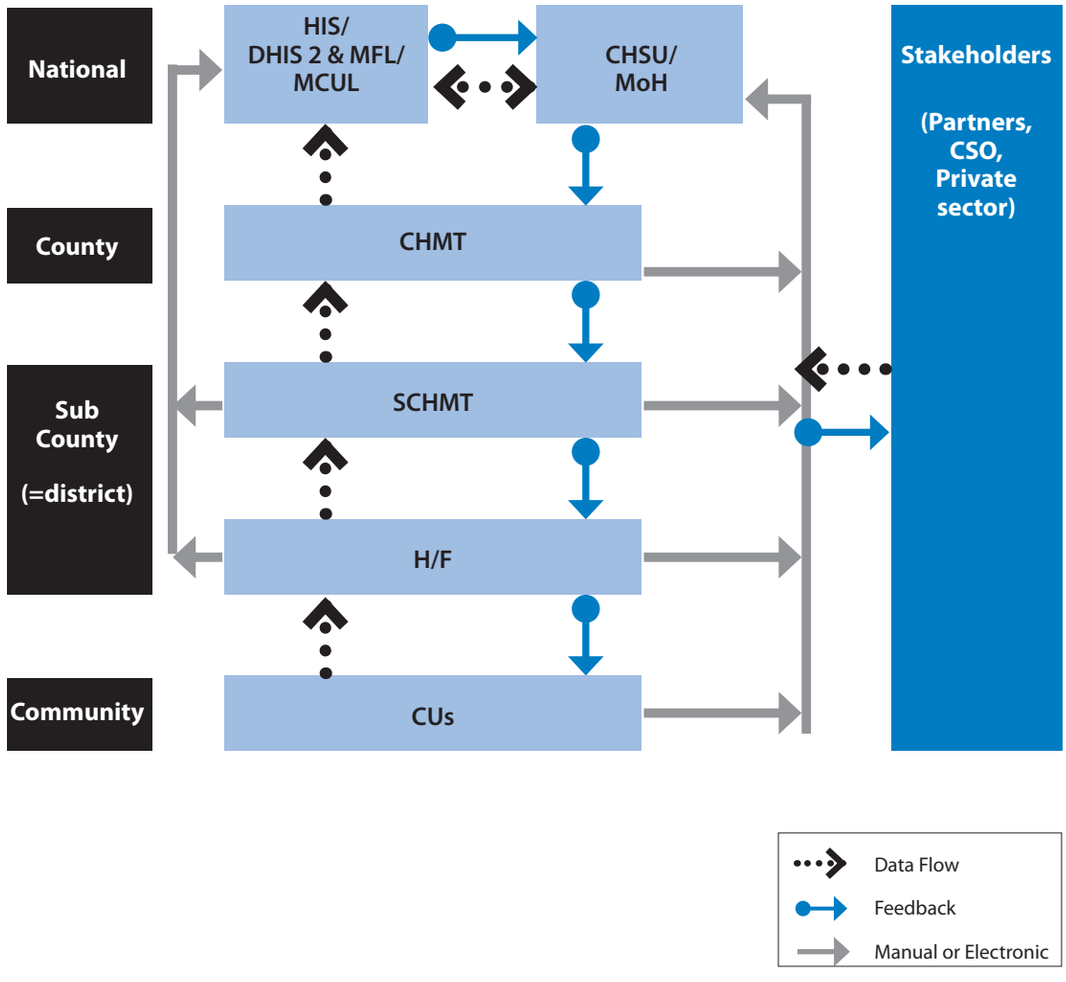
Chapter 6:
INFORMATION FLOW, DISSEMINATION AND USE

6.1 Introduction to Information Flow

Data flow under the CHS M&E Plan is envisioned to follow the structures of the CHS which begin from the community to the national level through the relevant platforms. At the community level, data will be collected by the CHVs and submitted to the CHEWs, who will summarize the data and submit the same vertically to link facility. From here information is submitted to the sub-county level to DHMT who will enter in the District Health Information Software (DHIS) electronically. CHUs that have resource centres should be able to enter their data directly into the DHIS. All the other units including the counties and national level should be able to access data by using the user rights at the various levels.

Figure 3 indicates information flow at various levels: national, county, sub-county and community levels. All core indicators, data and information have to be available and accessible through one point at each level.

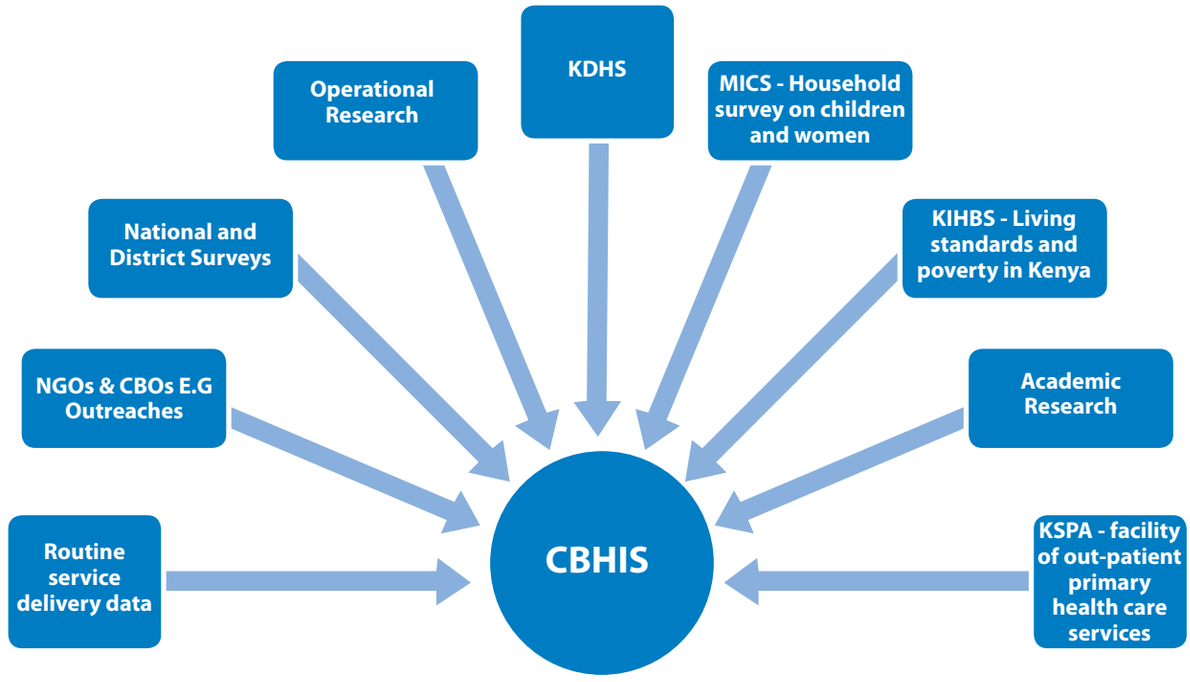
Figure 2: Proposed Information Flow



6.2 Proposed Data Flow for Non-Routine Data Sources

To enable timely capture of vital outcome and impact indicator information for community level services from identified non-routine data sources, individual reporting schedules will be developed with the responsible institutions and implementing partners through relevant TWG. It is proposed that within three months of completing the data collection and analysis for a particular study, a draft report will be submitted to the Community Health Services Unit (CHSU) for review. Within two months of receiving the final report, CHSU will enter relevant indicator information into the national information database. A summary of key findings will further be captured into a web-enabled research directory.

Figure 3: Proposed data flow for non-routine data sources



6.3 Data Quality

It is Important to Maintain data quality at each stage of the management process through;

- Integration of formal data quality assurance processes at every stage of data collection, management, and data dissemination
- Pay attention to the design and implementation of data management systems
- Provide written instructions for how to use data collection instruments and tools
- Document processes for data entry, cleaning, and management
- Conduct ongoing monitoring of data collection activities
- Take proactive steps to correct problems that compromise the quality of data

6.4 Ensuring Data Quality

Quality assurance of data is key to ensure the effectiveness of evidence-based decision making. At all levels from Community, Facility and, Sub-county, County and CHSU, relevant trained staff in charge of data and information

management will make sure that data validation is conducted regularly, data is interpreted and analyzed appropriately and the six principles of data are adhered to: precision, reliability, validity, integrity, completeness and timeliness. Efforts need to be made to identify and put mechanisms in place to ensure the quality of data from CHVs and CHEWs is maintained.

6.5 Linking of Data

All levels of health information including the community level are expected to be integrated into the HIS. For the CHS data, the sub-county office and health facility are expected to enter the relevant data into HIS online database. Data will be posted to the DHIS 2 website in abide to conclude the integration. The following points may be taken into account in the integration mechanism;

- Analysis of data from multiple sources can increase the validity and reliability of findings; it can corroborate findings and weakness of any one data source can be compensated for by the strengths of another
- Analysis of programme level data with outcome/impact level data can help substantiate the linkage between programme interventions and population-level outcomes/impacts
- Data can be linked from different sources, across different levels, or over time
- Linking data appropriately requires planning, preferably prior to data collection
- Understanding linked data can provide depth and continuity to enrich otherwise discrete points of information

6.6 Data Repository

The CHS database will be developed and managed at the CHSU. At the other levels, where it is applicable, the electronic repository of the information is advised to ensure the security, accessibility and timely use of the information at respective level. Information should be stored safely and appropriately.

- The manual data should be stored by the sub county focal person and at the CHU in the link facility in a lockable and secured fire proof cabinet as per Kenya Government regulations
- A set of logically and related data should be stored in a computer and should be backed up regularly
- Electronic data shall be handled by the DHIS software and maintain an external back up

6.7 Data Collection

The CHS draws information from several direct sources as well as from other information systems within and outside the health sector.

1. Routine data collection

Routine data sources include:

a. Health Information System (HIS)

The Ministry of Health (MoH) will manage this sub-system through the Division of Health Information monitoring and Evaluation (HIS) which is responsible for collection, processing, and reporting on all health and health related information from health facilities and communities. Existing standard data collection and reporting forms (such as the integrated registers MOH 511, 512, 513, 514) for reproductive health, HIV and AIDS, malaria, TB and child nutrition), relevant clinic registers, and individual patient cards will be improved to capture the requisite facility and sub-county level data for CHS. Also integrated reporting forms such as MOH 711, MOH 515 and MOH 516 shall be used to report and share aggregate data.

b. District Health Information Software (DHIS) 2

The DHIS 2, installed on a central server using the "cloud" based infrastructure, is a tool for collection, validation, analysis, and presentation of aggregate statistical data, tailored to integrated health information management activities. The system was rolled out in all provinces, enabling the users to access the system online through modems and LANS. The software becomes the main reporting system.

c. Community Health Information System (CHIS)

The system collects the information obtained through such tools as;

- CHIS Household Register (MOH 513) which gives the denominators for measuring the service delivery of the CHVs. It is filled out by CHVs every six months and reported to CHEWs
- CHVs Service Delivery Log Book (MOH 514), which is a diary that CHVs use to collect information from the household during their visitation as they give messages and services. The Log Book is submitted by CHVs to CHEWs for summary
- Community treatment and tracking register, which is a treatment register used by CHVs when offering integrated community case management
- CHEW Summary (MOH 515), which is filled monthly by CHVs using the information from the Community Service Log at the end of month and after six months, using the updated Household Register
- CHIS Chalk Board (MOH 516), which displays the general health status of the community unit, the demographic characteristics of the population update every six months served by CHU and service that are reported monthly by CHEWs. The information displayed outlines
- The action areas/displayed in the community dialogue days and action drawn by the community to improve the output

2. Non-routine data collection

Several of the CHS core indicators have information that come from non-routine information sources and have been harmonized accordingly with the information source. These information sources produce reports from which CHS will extract the required information and enter it into the CHSU data bank. Detailed information about these sources is available from the responsible agency. The Unit of Community Health Services will participate in the development of future non-routine information sources (particularly the DHS and the SPA) to ensure that the information required is collected in the manner that is most useful.

a. Demographic and Health Survey (DHS)

The DHS is a nationally representative household survey that is the source of impact and outcome indicators. If changes are made to the indicators in the matrix in future, these will also have to change accordingly). The Kenya National Bureau of Statistics is responsible for conducting the survey every 3 to 5 years. The DHS has been standardized and has been conducted in over 70 countries for cross-national comparison. The DHS has been conducted five times in Kenya (1987, 1993, 1998, and 2003 and 2008/9) offering trends over time.

b. Service Provision Assessment (SPA)

The SPA is a nationally representative facility survey that collects information on aspects of out-patient primary care (i.e., antenatal, family planning, and sexually transmitted infections) services and providers. The National Coordinating Agency for Planning and Development and MOH/CHSU are responsible for conducting the SPA. The SPA has been conducted thrice in Kenya: 1999, 2004 and 2010.

c. Census

Several of the CS core indicators require census information from the Kenya National Bureau of Statistics.

d. Auditor General Report

Auditor General produces a report on how different government ministries disburse and use the allocated resources from the Treasury annually. This is a source of proportion of MoH funds disbursed for CS activities.

e. Surveillance

Surveillance is the ongoing, systematic collection, analysis and interpretation of data on a disease or health condition from public health programmes, combined with feedback to all. It is vital for guiding the national and sub national response. In addition to informing whether collective efforts are being implemented on a large enough scale to impact on the morbidity and mortality.

f. Evaluations

Evaluations are conducted to gather evidences on whether the right interventions are being (or were) implemented with recommendations/lessons learnt. Evaluations also determine whether the identified long term effects and results can be attributed to specific interventions. Planned evaluations for CHS are;

- **Baseline Evaluation**

  CHSU shall conduct baseline surveys to establish baseline targets which will be used to calculate subsequent annual targets and stagger targets across the strategic period.

- **Mid-term evaluation and Final evaluations**

  The evaluations are conducted in collaboration with other stakeholders to synthesize data from multiple sources (routine monitoring, recent surveillance, surveys, and special studies including expenditure and resource flow surveys), and to strive to capture the perceptions of all stakeholders using a combination of quantitative and qualitative research methods.

- **Targeted programme evaluations**

  The evaluations are conducted to gather specific output indicator information for selected interventions. Some will be conducted at programme start to capture missing baseline data while others are scheduled much later to assess the outcome result for new interventions. A few targeted evaluations may be conducted ad hoc to assess the effectiveness of established programmes whose outcomes remain unknown or are in question.

g. Master Community Unit List (MCUL)

These are an added organisation structure for community units inventorying the Master Facility List (MFL) and the link will be made by the data field for the link facility. MCUL is established to provide an authoritative and reliable inventory of all community units established across the country.

6.8 Plans for Dissemination and Use of Information

The aim of undertaking CHS M&E is to disseminate the information generated for use by a wide range of stakeholders (from policy makers, programme managers, implementers, partners, health care providers, CHVs and community health extension workers as well as the beneficiary population).

Various information products are expected to be produced for the reporting and dissemination. Substantial efforts will be made to ensure that the right information products are developed at the right time for the right audience.

Substantial efforts will be made to ensure that the right information products are developed at the right time for the right audience. The following information products are expected under this plan;

1. Routine data

a. National Integrated CHS Report

CHSU will produce annual consolidated CHS report on the national core indicators as well as quarterly reports for the routine data and disseminate them to all the stakeholders. This annual report shall also include key activities and expenditures by different implementers, will inform the annual programme reviews.

b. Quarterly Programme Coverage Report

On a quarterly basis, CHSU will produce consolidated quarterly activity reports using data from the counties and sub-counties statistics and other routine monitoring systems using standard formats, these reports will be disseminated through the Inter-Agency Coordinating Committee meetings.

c. Sub-county report for routine data

Sub-county office will produce report with data required for CHS/or incorporate CHS data in the existing report and submit it to CHSU via County office.

2. Non-Routine data

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. The responsible TWG will determine the format of individual information products.

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 key findings reviewed, key issues addressed and lessons learnt. The M&E Sub-Unit will be responsible for documenting and forwarding the proceedings from planning and review meeting to the TWG within one month.

Dissemination Mechanisms

The aim of disseminating results of M&E efforts is for accountability and action from the various players in CHS. Multiple dissemination channels shall be used to ensure relevant information products achieve as wide coverage as possible. Some of these are listed as follows;

a. Consultative Annual Work Plan (AWP) planning and review forums with policy makers, development partners, implementers and other stakeholders.

b. Scientific conferences and journals including regional and national convention once in two years.

c. Print and broadcast media for the general population and special groups, which shall include journalists' orientation to CHS.

d. Pre- and in-service training for service providers at community level and its implementation components.

e. Print materials: A range of print materials shall be developed to disseminate information on CHS. These shall include CHS Fact Sheets, Bulletins/Newsletters and others, such as policy briefs.

f. CHS information website: As the world becomes increasingly connected via the internet, it has become essential CHSU shall post the programme progress reports, human interest stories and best practices among other issues on the CHS website.

6.9 Enhancing Data Use at all levels

At each level of data collection, information shall be used for decision making in policy formulation and review, resource allocation, advocating for resources, planning and programming. The responsible bodies/persons at each level will ensure that the information is available for all the stakeholders and accelerate its use.

- At the community level, data collected shall be shared and used with the community members through the displaying the data in the public place, community dialogues days or any other meetings feedback from CHVs during household visit and so on for planning and action.
- At the policy level, to enhance effective evidence based planning and reviews, M&E and research activities will be integrally linked with key planning and review processes to enable implementers to do the following: Review achievements against proposed work plans and intended targets and results; Identify key challenges and emerging issues; Determine programme priorities and targets for the coming period ; Recommend adjustments in programme interventions and resource allocation; Build consensus among all concerned stakeholders.

The following principles will be promoted for all CHS planning and review processes;

- National Ownership: The CHSU shall lead programme planning and reviews, supported by National TWG plus other relevant structures at the county and sub-county level.
- Relevance: Planning and reviews will be in keeping with the status of the implementation of CHS and the roll out of identified interventions in the different regions and the national response.

Chapter 7: IMPLEMENTATION STRATEGY FOR THE CHS M&E PLAN

7.1 Introduction

The CHSU, through the Monitoring and Evaluation Unit (CHSU M&E Unit), is responsible for designing, coordinating and supervising the implementation of the national CHS M&E Plan. Through the implementation, CHSU will facilitate evidence-based strategic review and planning, M&E leadership and advocacy; routine monitoring and programme review; strategic analysis and scientific writing and reporting; information documentation and dissemination; resource tracking and cost-effectiveness analysis. The magnitude and complexity of CHS M&E as proposed in this Plan demands for substantial commitment and support of all the stakeholders. CHSU will work closely with relevant divisions, departments, offices and units as well as partners to ensure the realization of commitment through strong leadership and effective coordination. One of the coordination forums for M&E implementation is the CHIS TWG through CHS Interagency Coordinating Committee (ICC). Functions and capacities of CHIS TWG need to be further strengthened to ensure the effective implementation of M&E Plan.

The proposed CHS M&E Plan will be implemented in order to assist stakeholders to monitor the performance and progress of the CHS activities in promoting healthy communities. The guiding assumption with regard to the implementation of the CHS M&E system is that there will be deliberate and systematic synchronization of the M&E Plan with annual CHS Plan and implementation process. To do this, all CHS M&E work planning should be done at the implementation processes, implying that CHS M&E reports will be available before periodic work plans are being developed. This will maximize opportunities for the CHS M&E results to be used for decision-making. The M&E Plan requires, therefore, a strategic integration with and within the activities of the CHS itself since it's aimed at improving the overall quality and efficiency of services provided and accessed through the CHS.

Implementation of the M&E Plan requires that at the different levels, the following issues are addressed and borne in mind at all times in order to ensure that the activities contribute towards the 5As. These issues affect the overall implementation of the CHS and therefore, will have significant contribution to the implementation process of the CHS M&E Plan.

- Local cultures, norms and prevailing patterns, population characteristics
- Existing state of health service infrastructure and needs in the region
- Significance, or not, of using different indicators at local, regional and environments
- Available information base
- Existing local disease burden
- Economic factors, demographic features and social developments
- The local connection between disease, health and local economy

7.2 M&E Plan Implementation Guiding Principles

The following principles are at the core of the CHS M&E Plan implementation strategy:

- Integration of the M&E activities into the overall CHS activities and work plans
- Establishing and maintenance of robust and working linkages with all health service provision units
- Enhancing community ownership through regular and coordinated feedback
- Structured engagement with stakeholders

- Focus on results: improved health outcomes
- Focus on overall development in the community

7.3 CHS M&E Work Planning and Budgeting

The CHS M&E system can only be operational with the development of a detailed work plan and budget for M&E. The CHS M&E budget should include funding for all data sources; staff costs; resource and administrative costs; costs for CHS M&E focal persons' supervision; and funding for periodic operational research. The annual CHS M&E work plan will be developed during the CHS work plan development for the following year.

7.4 Capacity Requirements for Implementing the CHS M&E System

For the CHS M&E Plan to become fully functional, everyone involved in the CHS needs to understand how it works to be able to use it by recognizing its capacity needs and status. Further, effective implementation of the CHS M&E strategy anchors on the following;

- Technical capacity (Knowledge and skills) – Strategically located individuals who are motivated, committed, competent and interested in M&E
- Availability of M&E supplies: tools and equipment
- Financial resources to meet M&E- related costs
- Physical infrastructure that provides a conducive and supportive working environment
- Organizational structure and culture (clear and agreed roles, incentives and rewards for supporting M&E; coordination, collaboration and networking as well as commitment to use and sharing of information)

Comprehensive and regular capacity assessments are necessary to ensure that the CHS implementation and its M&E are responsive to changing and emerging health needs. Capacity assessment tool will be developed to identify M&E capacity gaps. It will include key questions related to each of the capacity domains identified above. Based on the gaps identified, a capacity building action plan will be developed. Steps in developing the capacity building action plan are as follows;

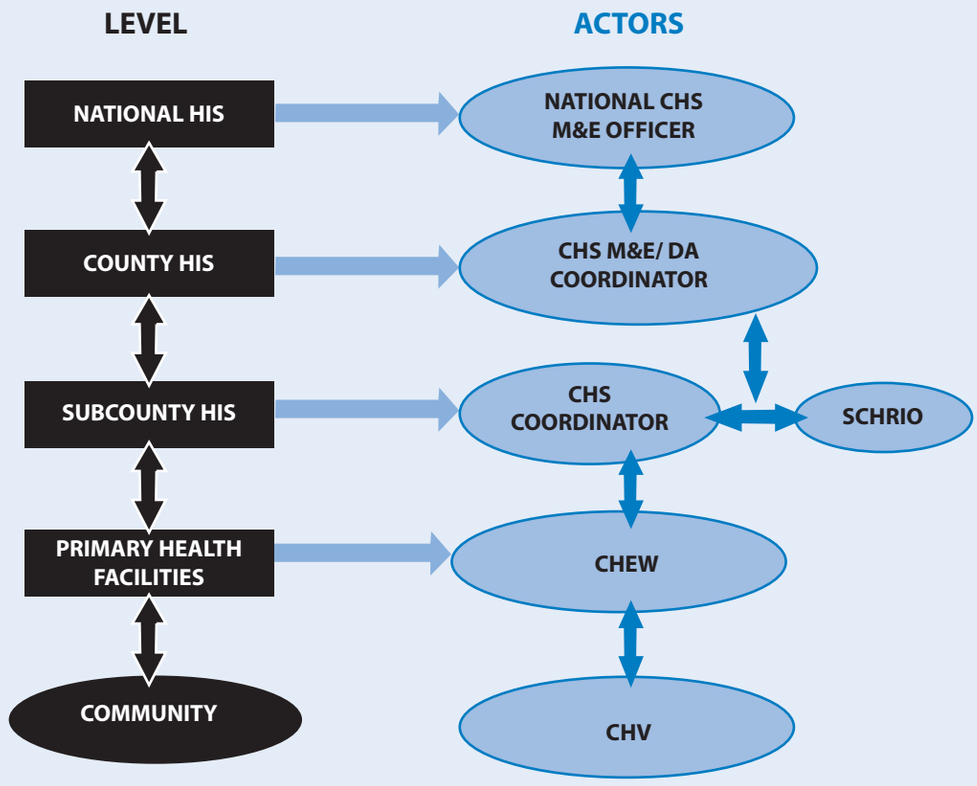
- Prioritise the capacity gaps to be addressed
- Determine the type of intervention for each of the gaps
- Develop an implementation plan
- Review the progress and re-plan as necessary

The existing capacity profile of the CHS implementers needs revamping structurally (to align it with the devolved governance structures under the New Constitution in Kenya). It also requires capacity assessments and subsequent building of the capacity to ensure fidelity during implementation. Therefore, given that the CHS's M&E Plan is a new system, the CHS Secretariat needs to build the capacity of stakeholders involved in managing and implementing CHS M&E activities. The specific capacity building plans can be developed after capacity assessments internal realignments within the of Community Health Services Unit.

7.5 Structure of CHS M&E Plan and Organogram

The structure of the CHS M&E Plan is linked and integrated such that the data and information collection from the community level is done by trained CHVs within structured community units. The overall national coordination of the CHS M&E Plan Implementation is vested with the national CHS M&E Officer; while the CHS M&E/QA Coordinator is in charge of the county level. The sub county levels will be under the CHS Focal Person who will work closely with the respective health record and information officers.

Figure 4: CHS M&E organogram



The responsibilities of the officers with regard to the M&E Plan implementation are detailed below;

1. **The national CHS M&E officer is responsible for:**
   - The overall coordination of CHS/M&E activities at the national level
   - Reviewing all the CHS information products which include progress reports, research reports, reviews, operation research reports, IEC materials and any promotion materials
   - Coordination of dissemination of information products to relevant stakeholders
   - Coordination of all relevant operations, researches, surveys and studies
   - Coordinate resource allocation for CHS M&E activities
   - Organizes annual work plan review meetings that are synchronized with CHS M&E plans
   - Coordinate TWG and other experts in development and standardization of supervision tools and guidelines

2. **The County M&E/QA coordinator will be to:**
   - Provide technical support for data quality at county level which includes ensuring data integrity, completeness and accuracy
   - Coordinate dissemination of information products to facilitate information use for decision making at the county
   - Coordinate capacity assessment, facilitates technical support and capacity building on M&E and QA for CHUs across the county

- Coordinate resource allocation for CHS M&E activities at the county level
- Organizes periodic review meetings and work plan development consultations to ensure synchronization with CHS M&E Plan and county sector plans

3. **Sub-county CHS Focal Person (Sub-county Community Health Coordinator)**
   - Coordinate the CHS M&E Plan implementation at the sub-county level
   - Provide technical support to the CHEW and CHU in implementing the M&E Plan
   - Conduct capacity building for CHEW and CHU on reporting and data capture at the sub-county level
   - Liaise with the health record and information officers to ensure that CHS data is entered in the DHIS and any other database
   - Disseminate data and information trends
   - Ensure availability of tools at the CHUs
   - Supervise CHEW's activities and reporting
   - Coordinate regular community data feedback sessions

4. **DHRIO**
   - Handle reports submitted by county community strategy coordinator
   - Validate and enter the data into DHIS in collaboration with the community strategy coordinator
   - Provide feedback to the SCHMT

5. **The role of the CHEW in monitoring and evaluation**
   - Supervise CHV and Community Health Committees (CHC) on data collection
   - Analyze data
   - Validate data
   - Submit data to link facility
   - Disseminate data to community through dialogue days

6. **Role of CHV in monitoring and evaluation**
   - Collect data
   - Report data

7.6 Mechanism for Updating the M&E Plan

A mechanism for reviewing and updating the M&E Plan is critical given that the M&E Plan is not cast on stone. Changes during the CHS implementation can affect the original plans for both M&E. When this occurs, appropriate modifications will be made and documented. Regular updates will be done and a review conducted every 5 years.

A checklist will be developed to inform reviewing and updating processes. It will seek to answer the following:

Does the M&E Plan;

- Focus on the key evaluation questions and the evaluation audience?
- Capture all that needs to be known in order to make a meaningful evaluation of the project?
- Only ask relevant monitoring questions and avoids the collection of unnecessary data?
- Know how data will be analysed, used and reported?
- Work within the budget and other resources?
- Identify the skills required to conduct the data collection and analysis?

While this plan proposes to work within the existing mechanism, it will require to further strengthen the capacities of all the actors to realize their roles and responsibilities. At the national level, major areas requiring further efforts will include maintaining of CHS database, appropriate interpretation and analysis of data for evidence based decision making, and provision of supportive supervision to the decentralized levels.

At the community level where the most of the routine data collection occur, it has been reported constantly in the different forums that the capacity of CHVs as well as CHEWs needs to be further strengthened for data collection, management and use.

Table 4: Scheduled Implementation Plan

Activity	Responsible Organization	2012/13	2013/14	2014/15	2015/16	2016/17	Cost (Kshs.)
I. Development of the M&E plan and operation manual							
1. Present the final draft plan to CHIS TWG	CHSU	x					0
2. Validate indicators	CHSU	x					1,100,000
3. Finalize the M&E plan	CHSU	x					957,500
4. Develop the draft operations manual	CHSU	x					4,000,000
5. Finalize the draft manual with stakeholders	CHSU	x					355,000
6. Disseminate/distribute of M&E plan and manual	CHSU		x				1,227,500
II. Strengthening the capacity							
1. Revise CHIS data collection, CU functionality assessment and reporting tools	CHSU/HMIS			X			0
2. Conduct assessment on the capacity in relation to CHS M&E	CHSU/HMIS		x	X			24,000,000
3. Train on data collection/ management/supervision etc	CHSU/HMIS		x	x	x	x	2,217,000
III. Development of data collection plan							
1. Revise CHIS data collection and reporting tools	CHSU		x				3,000,000
2. Pre-test tools	CHSU		x				2,100,000
3. Print& distribute tools	CHSU			x	x	x	1,624,200,000
4. Collect pilot electronic/mobile data	CHSU	x	x				13,600,000
5. Scale up of electronic/mobile data collection	CHSU			x	x	x	446,200,000
6. Develop SOPs for electronic/ mobile data collection	CHSU			x			0
IV. Strengthening data management and use							
1. Develop linkages for CHS database	CHSU			x			4,400,000
2. Train on the database management	CHSU			x	x		159,785,500
3. Update and maintain the databases	CHSU			x	x	x	3,600,000

Activity	Responsible Organization	2012/13	2013/14	2014/15	2015/16	2016/17	Cost (Kshs.)
V. Strengthening the supportive supervision							
1. Develop supportive supervision plan	CHSU		x				150,000
2. Review the support supervision tool	CHSU		x				450,000
3. Monitor the implementation of supportive supervision	CHSU		x	x	x	x	3,520,000
4. Compile and disseminate the SS report	CHSU		x	x	x	x	752,000
VI. Conduct evaluations , surveys and special studies							
1. Hire consultants and conduct baseline assessment	CHSU		x				10,392,000
2. Hire consultants and conduct for midline assessment	CHSU			x			10,392,000
3. Hire consultants and conduct for end of term assessment	CHSU					x	10,392,000
4. Compile a county profile on demographic, infrastructure and health services	CHSU		x				1,500,000
VII. Reporting							
1. Develop a annual reporting format for national, county and sub-county	CHSU/other levels' CHS focal points		x				0
2. Produce periodic report/ information product on CHS data			x	x	x	x	30,140,000
3. Disseminate reports and products to stakeholders through different means			x	x	x	x	1,200,000
VIII. Assessment of CHS M&E system and CU functionality							
1. Develop the assessment methodology/tool	CHSU		x				1,530,000
2. Conduct assessment of the CHS M&E system	CHSU		x				904,000
3. Conduct CU functionality assessments	CHSU		x	x	x	x	825,000
4. Compile the results and develop the plan to improve the M&E system and CU functionality	CHSU		x				752,000
IX. Data quality assurance							
1. Develop a data quality audit methodology	CHSU			x			825,000
2. Conduct data quality audit	CHSU			x	x	x	800,000
33. Prepare reports and feedback	CHSU			x	x	x	4,000,000
X. Maintenance of coordination and governance structures							
1. Quarterly update to the CHS ICC	CHSU	x	x	x	x	x	7,040,000
2. Hold quarterly M&E TWG	CHSU		x	x	x	x	4,800,000
3. Hold quarterly stakeholders meeting at County, sub county and CU level.	CHSU		x	x	x	x	6,750,000
4. Hold CHS convention every 2 years				x		x	30,000,000
				Sub-total (Kshs)			2,417,856,500
				5% Contingency			120,892,825
				Grand Total (Kshs.)			**2,538,749,325**
				Grand Total (USD)			**29,867,639**

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ANNEXES

Annex I
COSTED M&E IMPLEMENTATION PLAN

				Fiscal Year								
SN	**Component Area**	**Activities**	**Inputs**	**1**	**2**	**3**	**4**	**5**	**Unit Cost**	**Quantity**	**Total Cost (Kshs)**	**Source of Funds**
1	Develop the M&E plan and operation manual	1. Present the final draft plan to CHIS TWG		x							0	GoK, JICA, Measure Evaluation, AFYA Info
		2. Validate indicators	Customize validation tools								0	
			Conduct field visits	x					8,000	100	800,000	
			Fuel for field visits	x					60,000	5	300,000	
		3. Finalize the M&E plan	Hold taskforce meeting (conference package)	x					3,500	109	381,500	
			Per diem	x					8,000	47	376,000	
			Editing & Designer	x					200,000	1	200,000	
		4. Develop the draft operations manual	Printing of 2000 copies	x					2,000	2,000	4,000,000	
		5. Finalize the draft operation manual with stakeholders	Conference package for 1 day (Includes transport)	x					11,000	25	275,000	
			Per diem for 1 night		x				8,000	10	80,000	
		6. Dissemi-nate/distribute M&E plan and manual	Conference package						3,500	109	381,500	
			Per diem						8,000	47	376,000	
			Distribution (transport)		x				10,000	47	470,000	
2	Strengthen the capacity	1. Revision of CHIS data collection, CU functionality assessment and reporting tools	Office Meeting		x						0	
		2. Conduct assessment on the capacity in relation to CHS M&E	Site visits at district level		x	x	x	x	20,000	1,200	24,000,000	
		3. Train on data collection/ management/ supervision etc	CHMT 3 days training conf. package (47 from county and 3 national)		x				3,500	150	525,000	GoK, JICA, Measure Evaluation, AFYA Info, IntraHealth/ Capacity
			CHMT 3 days training per diem		x				12,000	141	1,692,000	GoK, JICA, Measure Evaluation, APHIA Plus, GF Round 10 (Malaria), Safaricom

				Fiscal Year								
SN	**Component Area**	**Activities**	**Inputs**	**1**	**2**	**3**	**4**	**5**	**Unit Cost**	**Quantity**	**Total Cost (Kshs)**	**Source of Funds**
3	Develop data collection plan	1. Revise CHIS data collection and reporting tools	Conduct a workshop (5 days)	x	x				3,000,000	1	3,000,000	
		2. Pre-test tools	Conduct field visits- fuel	x	x				60,000	5	300,000	
			Conduct field visits- 20 people*5 days						8,000	100	800,000	
			Hold consensus meeting- per diem for 50 people*2 days						8,000	100	800,000	
			Hold consensus meeting- transport						4,000	50	200,000	
		3. Print & distribute tools	Typesetting/editing		x				200,000	1	200,000	
			Printing CHS tools for 4 years for each CU						200,000	8000	1,600,000,000	
			Distributing tools annually						20,000	1200	24,000,000	
		4. Pilot electronic/ mobile data collection	Engage consultant		x				1,500,000	1	1,500,000	
			Purchase mobile phones for 1 county (40 CUs with 5 CHEWS each)		x				10,000	200	2,000,000	
			Establish communication centre (servers, computers, etc)		x				500,000	1	500,000	
			Maintenance costs (airtime, service contracts etc.)		x	x	x	x	1,000	9600	9,600,000	
		5. Scale up of electronic/ mobile data collection	Establish communication centres in the remaining 46 counties and maintenance costs for 3 years			x	x	x	9,700,000	46	446,200,000	
		6. Develop SOPs for electronic/ mobile data collection	Part of TOR for Consultant		x				0	0	0	

				Fiscal Year								
SN	**Component Area**	**Activities**	**Inputs**	**1**	**2**	**3**	**4**	**5**	**Unit Cost**	**Quantity**	**Total Cost (Kshs)**	**Source of Funds**
4	Strengthen data manage-ment and use	1. Develop linkages for CHS database	Carry out CHS database needs assessment								0	GoK, Measure Evaluation, APHIA Plus
			Stakeholder buy in meetings- per diem*3 days						24,000	100	2,400,000	
			Stakeholder buy in meetings- transport	x					5,000	100	500,000	
			IT consultant*30 days						50,000	30	1,500,000	
		2. Train on the database management	Review training manual, curriculum and SOPs- per diem for 10 experts*5 days						57,500	10	575,000	
			Review training manual, curriculum and SOPs-transport						5,000	10	50,000	
			Training 10 national TOTs by 3 facilitators for 3 days-per diem		x	x			34,500	13	448,500	
			Training 10 national TOTs by 3 facilitators for 3 days-fuel						40,000	13	520,000	
			TOTs train county focal persons- per diem TOT*3 days						34,500	3	103,500	
			TOTs train county focal persons- per diem participant*3 days						34,500	47	1,621,500	
			TOTs train county focal persons- transport for participants						5,000	47	235,000	
			TOTs train county focal persons- fuel for TOT						40,000	3	120,000	
			County roll out- per diem for 2 facilitators*3 days						24,000	3	72,000	
			County roll out- per diem for 165 participants per county for 3 days						846,000	165	139,590,000	
			County roll out- transport for 165 participants per county						94,000	165	15,510,000	
			County roll out- fuel for facilitators						470,000	2	940,000	
		3. Update and maintain the databases	Service contracts			x	x	x	1200,000	3	3,600,000	
5	Strengthen the supportive supervision	1. Develop supportive supervision plan	TWG meetings		x				150,000	1	150,000	FANIKISHA, MCHIP, MEASURE EVALUA-TION
		2. Review the support supervision tool	TF meetings		x				150,000	3	450,000	CHSU, MEASURE EVALUA-TION
		3. Monitor the implemen-tation of supportive supervision.	Fuel						240000	4	960,000	AFYA info, CHSU . UNICEF, MEASURE EVALUA-TION
			Per diems						640000	4	2,560,000	
			Report reviews						0	0	0	
		4. Compile and disseminate the SS report	Burn CD's with dissemination reports to the counties						100	7520	752,000	UNICEF, AFYA info, MEASURE EVALUA-TION, CHSU

				Fiscal Year								
SN	**Component Area**	**Activities**	**Inputs**	**1**	**2**	**3**	**4**	**5**	**Unit Cost**	**Quantity**	**Total Cost (Kshs)**	**Source of Funds**
6	Conduct evaluations, surveys and special studies	1. Hire consultants for baseline assessment	Hire Consultants for baseline assessment						1,500,000	1	1,500,000	CHSU and partners
		2. Conduct surveys (baseline, midline and end of term) and target setting	Training of enumerators(venue, logistics)		x				8,000	80	640,000	
			Pre-testing of tools		x				5,000	80	400,000	
			Transport- fuel		x				60,000	64	3,840,000	
			Per diems		x				8,000	64	512,000	
			Develop, pre-test and print survey/evaluation tools		x				500,000	1	500,000	
			Disseminate the results (Surveys/evaluations for 3 evaluations)			x			3,000,000	1	3,000,000	
		3. Hire consultants and conduct for midline assessment	Inputs same as for baseline survey						10,392,000	1	10,392,000	
		4. Hire consultants and conduct for end of term assessment	Inputs same as for baseline survey						10,392,000	1	10,392,000	
		5. Compile a county profile on demographic, infrastructure and health services	Consultant		x				1,500,000	1	1,500,000	
7	Reporting	1. Develop an annual and quarterly reporting format for national , county and sub-county	CHSU (TWG) develops reporting template		x				0	0	0	MEASURE EVALU-ATION, UNICEF, AFYA info, FANIKISHA, World Vision, MCHIP-USAID
			HIS customizes template into DHIS		x				0	0	0	
			CHSU reviews/evaluates reporting format and provides feedback to HIS			x			0	0	0	
		2. Produce periodic report/ information product on CHS data	Report compilation & editing (Annual report writing retreat- 10 pax for 5 days)		x	x	x	x	70,000	10	700,000	
			Quarterly printing of bulletins (2000 copies x 4 quarters X 8 pages X 40 kshs per page)		x	x	x	x	320	32,000	10,240,000	
			Printing of Annual Report (2000 copies X 60 pages X 40 kshs per page)		x	x	x	x	2,400	8,000	19,200,000	
		3. Disseminate reports and products to stakeholders through different means	Annual Report Dissemination Meeting (60 pax)		x	x	x	x	5,000	240	1,200,000	

				Fiscal Year								
SN	**Component Area**	**Activities**	**Inputs**	**1**	**2**	**3**	**4**	**5**	**Unit Cost**	**Quantity**	**Total Cost (Kshs)**	**Source of Funds**
8	Assess CHS M&E system	1. Develop the assessment methodology/ tool	TA develops assessment tool			x			1,500,000	1	1,500,000	GoK, JICA, MEASURE EVALUATION
			Meeting to review assessment tool			x			0	0	0	
			Pre-testing the tools (10 pax, 1 day)			x			3,000	10	30,000	
		2. Conduct assessment	Printing assessment tool						40	100	4,000	
			Per diem (10 pax, 5 nights)			x			8,000	50	400,000	
			Fuel						60,000	5	300,000	
			Drivers per diem (5 drivers, 5 nights)						8,000	25	200,000	
		3. Conduct CU functionality assessments	Report writing workshop (15 Pax X 5 days)			x			11,000	75	825,000	
			Monitor functionality of the 47 CU centres of Excellence (To be done as part of support supervision)		x	x	x	x	-	0	0	
		4. Compile the results and develop the plan to improve the M&E system and CU functionality	Burn CD's with dissemination reports to the counties		x	x	x	x	100	7520	752,000	
9	Assure data quality	1. Develop a data quality audit methodology	Developing data quality audit tool - Developing data quality audit methodology	x x					11,000	75	825,000	AFYA info, MEASURE EVALUATION, JICA
		2. Conduct data quality audit	Conduct data quality audits in the selected counties	x	x	x	x	x	160,000	5	800,000	
		3. Prepare reports and feedback	Dissemination of reports and feedback (includes travel costs)	x	x	x	x	x	200,000	20	4,000,000	
10	Maintain coordination and governance structures	1. Quarterly update to the CHS ICC	Quarterly CHS ICC update meetings	x	x	x	x	x	1,760,000	4	7,040,000	GoK, JICA, MEASURE EVALUATION
		2. Hold quarterly M&E TWG	Plan quarterly M&E TWG	x	x	x	x	x	1,200,000	4	4,800,000	
		3. Hold quarterly stakeholders meeting at County, sub-county, and CU level.	- quarterly stakeholders meeting at County, - sub county - CU level.	x	x	x	x	x	450,000	15	6,750,000	
		4. Hold CHS convention every 2 years	Plan CHS convention meetings		x		x		15,000,000	2	30,000,000	
										Subtotal	2,417,856,500	
										5% contingency	120,892,825	
										Total	**2,538,749,325**	
										USD	**29,867,639**	

Annex 2
HOUSEHOLD REGISTER
MOH 513

REPUBLIC OF KENYA – MINISTRY OF HEALTH

HOUSEHOLD REGISTER
MOH 513

Community Health Services
"Afya Yetu, Jukumu Letu"

NAME OF CHU:	
MCHUL CODE:	
LINK FACILITY:	
NAME OF CHV:	
NAME OF VILLAGE:	
START DATE:	
COUNTY:	
SUB COUNTY:	
DIVISION:	
LOCATION:	
SUB LOCATION:	
END DATE:	

INSTRUCTIONS ABOUT THE USE OF THE TOOL	
DESCRIPTION	The household register is a record where we write major household events or services at the household registration and after every six months. The Head of the Household should be able to respond and give detailed information about the household.
What type of information is collected?	The basic information collected is factual data on what was identified in the household. Basically the tool collects information for individual members as well as collective information for the entire household.
Who should fill?	The CHVs
When and to whom it should be submitted?	The Household register should be updated with information from the household at the beginning and after every SIX (6) Months. It should be submitted to the CHEW immediately after completion of household registration.

Household Level Indicators		
1	Household Number	Enter the number assigned to the current household - as determined during mapping
2	Access to Safe Water	Record by marking a tick (☑) when the household has access to safe water or (X) when the household does not have access to safe water
3	Use of Treated Water	Record by marking a tick (☑) when the household always uses water that is treated or (X) when the household does not use treated water.
4	Hand Washing Facilities	Record by marking a tick (☑) when the household has hand washing facilities such as Tippy Tap and leaky tin or hand wash basin or (X) when the household does not have hand washing facilities
5	Functional Latrine Use	Use a tick (☑) if the household uses a functional latrine or (X) if the household does not use a functional latrine. The description of functional latrine will depend on whether it is in an urban area (slum or not) or rural area
6	Refuse Disposal Facility	Record by marking a tick (☑) when the household has a refuse disposal facility or (X) when the household does not have a refuse disposal facility
Individual Level Indicators		
A	Date of Data Collection	Record Date when the Household member was registered. (Date is recorded as DD:MM:YY e.g. 31/07/14).
B	Individual Code	The number assigned by CHV that individually identifies a member of the household
C	Name of Household Member	Record the individual names that identify a household member - Record at least THREE names FOR EXAMPLE James Karani Bosire.
D	Age in Completed Years / Months/ Days	Record the age of the household member at the last birth day, expressed in numbers. Age here must be indicated in years or months or days (record Y for years if age is more than 1 year e.g. 7 Y for 7 years, M for months if age is less than 12 months e.g. 10 M for 10 months and D for days if age is less than 30 days e.g. 16 D for 16 days)
E	Sex (M/F)	This should be recorded as M for male and F for female
F	Relationship to HHH	This should be recorded using the key provided i.e. 1 for Household head, 2 for spouse, 3 for Child by Birth, 4 for Child by Registration, 5 for grand child , 6 for brother or sister, and 7 for others
G	Orphan	Record by marking a tick (☑) when household member is an orphan. Record (X) if the household member is not an orphan. An orphan is someone with one or both parents dead, and less than 18 years old. Record N/A if member is over 18 years
H	Has Birth Certificate	Record by marking a tick (☑) when household member has a birth certificate. Record (X) if the household member does not have a birth certificate
I	In School	Record by marking a tick (☑) when the household member is in school , or (X) when the household member is not going to school. The indicator refers to children of school age (for primary education). This is the age of 6-18 years (Ministry of Education of Kenya). Record N/A if member is below 6 years or over 18 years of age
J	Pregnant	Record by Indicating with a tick (☑) whether a household female member is pregnant or (X) if the household female member is not pregnant. The CHV should observe or ask the woman in the household. Record N/A if member is male
K	Mother and Child Health Booklet	Record with a tick (☑) if the household member has been issued with a mother and Child Health booklet. Record (X) if the household member has not been issued. Record N/A if member is not a pregnant mother or child of 0-59 months
L	ANC (at least 4 visits)	Record by marking with a tick (☑) if a household member who is a mother of a child of 0-11 months completed at least 4 Ante Natal Clinic (ANC) visits during the pregnancy period or mark with a (X) if a household member who is a mother of a child of 0-11 months did not complete at least 4 Ante Natal Clinic (ANC) visits during the pregnancy period. Record N/A if member is not a mother of a child of 0-11 months
M	Delivered by Skilled Birth Attendant	Record by marking with a tick (☑) if delivery within the past 6 months was through a Skilled Birth Attendant or (X) if delivery within the past 6 months was not through a Skilled Birth Attendant. Note that traditional birth attendants (TBA) are not considered Skilled Birth Attendants. Record N/A if a female member did not give birth over the past 6 months or the member is a male or a child
N	Exclusive Breastfeeding	Record by marking a tick (☑) when the child in the household is less than 6 months and is exclusively breastfed, or (X) when the child who is less than 6 months in the household is not exclusively breastfed. Record N/A if member is not a child of 0-6 months
O	Using Family Planning Methods	Record one of the provided numbers i.e. 1 for Modern, 2 for Traditional/ Natural, 3 for None to indicate the family planning method used. This applies to women of reproductive age (15-49 years). Record 4 for N/A if member is not a woman of reproductive age
P	Penta1 Given	Record by marking a tick (☑) when a child aged 6 weeks -11 months in the household was given Penta1 or (X) if the child was not given Penta1. Record N/A if member is not a child aged 6 weeks -11 months

Q	Penta 3 Given	Record by marking a tick (☑) when a child aged 14 weeks-11 months in the household was given Penta 3 or (X) if the child was not given Penta 3. Record N/A if member is not a child aged 14 weeks -11 months
R	Measles Given	Record by marking a tick (☑) when a child of 9-18 months age in the household was given Measles vaccination or (X) if the child was not given Measles vaccination. Record N/A if the member is not a child aged 9 -18 months
S	Fully Immunized	Record by marking a tick (☑) when a child of 9-11 months of age in the household was given ALL vaccinations required or (X) if the child was not given ALL vaccinations required. Record N/A if member is not a child aged 9 -11 months
T	Vitamin A given	Record by marking a tick (☑) when the child 6-59 months in the household was given Vitamin A in the last 6 months or (X) if the child was not given Vitamin A in the last 6 months. Record N/A if member is not a child aged 6-59 months
U	Children aged 6-23 Months receiving 3 or more food groups three times a day	Record by marking a tick (☑) when the child in the household aged 6-23 months receives 3 or more food groups per day or (X) if the child does not receive 3 or more food groups per day. Ask what food the child was given over the past 24 hours and determine the food groups in the food provided. Ask question where there are children of less than 24 months of age. Record N/A if member is not a child aged 6-23 months
V	Severely Malnourished (MUAC indicating Red)	Record by marking a tick (☑) when the household child's (6-59 months age) mid upper circumference (MUAC) is red or (X) when the child has MUAC that is not red. Record N/A if member is not a child aged 6-59 months
W	Moderately Malnourished (MUAC indicating Yellow)	Record by marking a tick (☑) when the household child's (6-59 months age) mid upper circumference (MUAC) is yellow or (X) when the child has MUAC that is not yellow. Record N/A if member is not a child aged 6-59 months
X	LLIN use	Record by marking with tick (☑) whether the household member slept under a Long Lasting Insecticide Net (LLIN) the night before or (X) when the household member did not sleep under LLIN the night before.
Y	Known Chronic Illness	Record one or more of the numbered illnesses for any known chronic illness observed: 0-None, 1=Diabetes, 2=Cancer, 3=Mental Illness, 4=Hypertension, 5=Chronic Respiratory Diseases, 6=Other. It is a chronic illness if someone has had a diagnosed illness for 1 year or more without healing
Z	Cough (2 Weeks and above)	Record by marking a tick (☑) when the household member has had cough for 2 weeks or longer or (X) when the household member has not had a cough or has had it for less than 2 weeks
AA	Knows HIV Status	Record by marking a tick (☑) when the household member knows his/her HIV status (checked during the past 6 months), or (X) when the household member does not know his/her HIV status. Record N/A for a small child
AB	Disability	Indicate any identified kind or type of disability for the household member by choosing one or more numbers out of the numbers given i.e. 0=None, 1=Visual, 2=Hearing, 3=Speech, 4=Physical, 5=Mental, 6=Other
	Others ()	Record here an indicator that is not part of the list of indicators, but which is of interest to the community e.g. jiggers. Enter the name of the indicator inside the brackets
AC	Other Specific Remarks	Write any other remark which you feel is important for follow-up
AD	Date of Death	Record date when the household member died (recorded as DD:MM:YY) for deaths within the last 6 months. An example of a date of death in the format is 31/07/14.
B*	Individual Code	The number assigned by a CHV that identifies an individual in the household (in this case, a dead member). The code might not be available in case of still births or deaths occurring before household registration. But the death should still be recorded
C*	Name of Household Member	Record the individual names that identify the dead household member - Record at least THREE names. For example James Karani Bosire.
D*	Age	Record the age of the dead household member at the last birth day, expressed in numbers. Age here must be indicated in years or months or days (record Y for years if age is more than 1 year e.g. 7 Y for 7 years, M for months if age is less than 12 months e.g. 10 M for 10 months and D for days if age is less than 30 days e.g. 16 D for 16 days)
E*	Sex	This should be recorded as M for male and F for female for the dead member
AE	Comments	Include comments e.g. stillbirths, neonates or death before registration and any other information to make the entry more understandable, for example the reason why there is no individual code. For a new household registration, no code is given for a member who died before 6 months before registration. NOTE: Include only deaths occurring within the last 6 months

HOUSEHOLD REGISTER **MOH 13**

"Date of Data Collection (Record as DD:MM:YY e.g. 31/07/14)"	Individual Code	Name of Household Member	Age in Completed Years/ Months /Days	No. of HH Members per Age Cohort 1=0-28 days 2= 29 days-11 months 3=12 -59 months, 4=5-12 years, 5=13-24 girls, 6=13-24 boys, 7=25-59 years, 8=60 years and above	Sex (M/F)	Relationship to HHH 1=HHH, 2=Spouse, 3=Child(B), 4= Child (R), 5=Grandchild, 6=Brother/Sister, 7=Others"	Orphan (✓/×/NA)	Birth Certificate (✓/×)	In School (✓/×/NA)	Pregnant (✓/×/NA)	Mother and Child Health Booklet (✓/×/ NA)	ANC (at least 4 visits) (✓/×/NA)	Delivered by Skilled Birth Attendant (✓/×/ NA)	Exclusive Breastfeeding (✓/×/NA)
A	B	C	D		E	F	G	H	I	J	K	L	M	N
TOTAL														

Household indicators	✓
1. Access to safe water (✓/×)	
2. Use of Treated Water (✓/×)	
3. Hand washing facilities (✓/×)	
4. Functional Latrine use (✓/×)	
5. Refuse Disposal Facility (✓/×)	

DEATHS					
Date of Death	Individual Code	Name of Household member	Age	Sex	Comments e.g. neonates or dead before household registration
AD	B*	C*	D*	E*	AE

B*, C*, D* and E* contain data similar to be B, C, D and E respectively.

HOUSEHOLD REGISTER **MOH 13**

Using Family Planning Methods 1=Modern, 2= Traditional/Natural 3=None 4=N/A	Penta1 Given (✓/×/NA)	Penta 3 Given (✓/×/NA)	Measles Given (✓/×/NA)	Fully Immunized (✓/×/NA)	Vitamin A Given (✓/×/NA)	Children 6-23 months receiving 3 or more food groups three times a day (✓/×/NA)	Severely Malnourished (MUAC indicating Red) (✓/×/NA)	Moderately Malnourished (MUAC indicating Yellow) (✓/×/NA)	LLIN use (✓/×)	Known chronic illness 0=None, 1=Diabetes, 2=Cancer, 3=Mental Illness, 4=Hypertension, 5=Chronic Respiratory Diseases, 6=Other	Cough (2 Weeks and above) (✓/×)	Knows HIV Status (✓/×/NA)	Disability 0=None, 1=Visual, 2=Hearing, 3=Speech, 4=Physical, 5=Mental, 6=Other	(Others)	Other specific remarks
O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB		AC
TOTAL															

Household indicators	✓
1. Access to safe water (✓/×)	
2. Use of Treated Water (✓/×)	
3. Hand washing facilities (✓/×)	
4. Functional Latrine use (✓/×)	
5. Refuse Disposal Facility (✓/×)	

DEATHS					
Date of Death	Individual Code	Name of Household member	Age	Sex	Comments e.g. neonates or dead before household registration
AD	B*	C*	D*	E*	AE

B*, C*, D* and E* contain data similar to be B, C, D and E respectively.

Annex 3
SERVICE DELIVERY LOG BOOK
MOH 514

REPUBLIC OF KENYA – MINISTRY OF HEALTH

SERVICE DELIVERY LOG BOOK
MOH 514

NAME OF CHU:	
MCHUL CODE:	
LINK FACILITY:	
NAME OF CHV:	
NUMBER OF HH:	
START DATE:	
COUNTY:	
SUB COUNTY:	
DIVISION:	
LOCATION:	
SUB LOCATION:	
END DATE:	

INSTRUCTIONS ABOUT THE USE OF THE TOOL	
DESCRIPTION	The Service Delivery Log Book is a diary that is used to collect information from the household during the period of offering a health service, health messages or defaulter traced. The Service Delivery Log Book gives the numerator for measuring the effort of the CHV.
What type of information is collected?	The basic information collected is factual data based on what was done or identified in the community, among households and/or individual (s) served. The Service Delivery Log Book measures the actual CHV's effort and should be written or filled during the household visitation.
Who should fill?	CHVs
When and to whom it should be submitted?	The Service Delivery Log Book should be submitted to the CHEW for summarization by 2nd of the following month.

Basic Information		
A	Date	The date when the household member receives a service from a Community Health Volunteer. It is recorded as DD/MM/YY, for example, 31/07/14
B	Village Name	The name of the village where the household is located
C	Household number	This is a unique identification number, which is assigned to a household during registration
D	Name of household member	Record the individual names that identify a household member - Record at least THREE names FOR EXAMPLE James Karani Bosire.
Mother Information		
E	Pregnant	Record by Indicating with a tick (☑) when a household female member is pregnant or (X) if the household female member is not pregnant. The CHV should observe or ask the woman in the household. Record N/A if the member is not a woman of reproductive age (15-49 years)
F	Pregnant woman counselled on Individual Birth Plan (IBP)	Record by Indicating with a tick (☑) when the pregnant woman has been counselled on Individual Birth Plan (IBP) or (X) if not. Record N/A if the member is not a pregnant woman
G	Woman delivered by unskilled attendant	Record by marking with a tick (☑) if delivery since the last visit was by an unskilled attendant. Note – traditional birth attendants (TBA) are considered unskilled. Record N/A if the member is not a woman who delivered since last visit
H	Woman delivered by skilled attendant	Record by marking with a tick (☑) if delivery since the last visit was by skilled attendant. Note – traditional birth attendants (TBA) are considered not skilled attendants. Record N/A if the member is not a woman who delivered since last visit
I	New-born visited at home within 48 hours of delivery	Record by Indicating with a tick (☑) if New-born (0-28 days) was visited at home within 48 hours of delivery or (X) if not. Record N/A if the member is not a new-born
J	Mother with new-born counselled on Exclusive Breast Feeding (EBF)	Record by Indicating with a tick (☑) if a mother with new-born (0-28 days) is counselled on Exclusive Breast Feeding (EBF) or (X) if not. Record N/A if the household member is not a mother of a new-born
K	Woman 15-49yrs provided with Family Planning commodities by CHVs	Record by Indicating with a tick (☑) if a Woman 15-49 years is provided with Family Planning commodities by CHVs or (X) if a woman of 15-49 years was not provided. Record N/A if the member is not a woman of reproductive age (15-49 years)
Child Information		
L	Child 0-59 months participating in growth monitoring	Record by Indicating with a tick (☑) if a child 0-59 months is participating in growth monitoring or (X) if not. Record N/A if the household member is not a child of 0-59 months
M	Child 6-59 months with MUAC (Red) indicating severe malnutrition	Record by Indicating with a tick (☑) if a child 6-59 months has MUAC (Red) indicating severe malnutrition or (X) if not. Record N/A if the household member is not a child of 6-59 months
N	Child 6-59 months with MUAC (Yellow) indicating moderate malnutrition	Record by Indicating with a tick (☑) if a child 6-59 months has MUAC (Yellow) indicating moderate malnutrition or (X) if not. Record N/A if the household member is not a child of 6-59 months
O	Child 12-59 months dewormed	Record by marking a tick (☑) when the child 12-59 months in the household was dewormed in the last 6 months or (X) if the child was not . Record N/A if the household member is not a child of 12-59 months
Referrals Information		
P	Pregnant woman referred for ANC	Record by marking a tick (☑) when the pregnant woman is referred for ANC or (X) if not. Record N/A if the household member is not a pregnant woman
Q	Pregnant women referred for skilled delivery	Record by marking a tick (☑) when the pregnant woman is referred for skilled delivery or (X) if not. Record N/A if the household member is not a pregnant woman
R	Woman referred for family planning services	Record by marking a tick (☑) when the woman of 15-49 years is referred for family planning services or (X) if not. Record N/A if the household member is not a woman of 15-49 years
R	Home delivery referred for Post Natal Care (PNC) Services	Record by marking a tick (☑) if a home delivery is referred for Post Natal Care (PNC) Services or (X) if not. Record N/A if the household member is not a mother who delivered at home
S	Child 0-11 months referred for immunization	Record by marking a tick (☑) if a child 0-11 months is referred for immunization services or (X) if not. Record N/A if the household member is not a child of 0-11 months
T	Child 6-59 months referred for Vitamin A supplementation	Record by marking a tick (☑) if a child between 6-59 months of age is referred for Vitamin A supplementation or (X) if not. Record N/A if the household member is not a child of 6-59 months

U	Cough more than 2 weeks referred	Record by marking a tick (☑) if a chronic cough for two or more weeks is referred to a health facility or (X) if not. Record N/A when the household member has not had chronic cough or has had it for less than 2 weeks
V	Referred for HIV Counselling and Testing (HCT)	Record by marking a tick (☑) if the household member is referred for HIV Counselling and Testing (HCT) or (X) if not. Record N/A for a small child
W	Elderly (60 +) referred for routine health check-ups	Record by marking a tick (☑) if elderly (60 years and above) is referred to a health facility for routine check-ups or (X) if not. Record N/A if the member is not elderly with 60 or more years
X	Known cases of chronic illness referred a=Diabetes, b=Cancer, c=Mental Illness, d=Hypertension, e=Others (specify in remarks), f=None	Indicate one or more numbers for a type of chronic illness with a corresponding tally of known cases of individuals referred to a health facility with that with illness: a=Diabetes, b=Cancer, c=Mental Illness, d=Hypertension, e=Other, f=None. For example, e.g. d-2 for two people suffering from hypertension in the household. It is a chronic illness if someone has been unwell for 1 year or more without healing
Defaulters Information		
Z	ANC defaulter referred	Record by marking a tick (☑) if an ANC defaulter is referred to a health facility or (X) if not. Record N/A if the member is not an ANC defaulter
AA	Immunization defaulter referred	Record by marking a tick (☑) if a child 0-59 months of age who defaulted on immunization has been referred for immunization or (X) if not. Record N/A if the member is not a child of 0-59 months or is a child of 0-59 months but did not default on immunization
AB	TB treatment defaulter traced and referred	Record by marking a tick (☑) if a Tuberculosis (TB) defaulter is referred to a health facility or (X) if not. Record N/A if the member has not had TB or has had TB but did not default
AC	ART defaulter traced and referred	Record by marking a tick (☑) if an ART defaulter is traced and referred to a health facility or (X) if not. Record N/A if the member has not been on ART or has been on ART but has not defaulted
AD	HIV exposed infant (HEI) defaulters traced and referred	Record by marking a tick (☑) if an HIV exposed infant (HEI) defaulter is traced and referred to a health facility or (X) if not. Record N/A if the member is not an HIV exposed infant (HEI) defaulter
Death Information		
AE	Number of deaths in the month	a: 0-28 days - Record all deaths between zero to 28 days of age which occurred in the month
		b: 29 days-11 months - Record all deaths between 29 days to 11 months of age which occurred in the month
		c: 12-59 months - Record all deaths between 12-59 months of age which occurred in the month
		d: Maternal - Record all deaths of women during pregnancy or child birth or within 42 days after delivery which occurred in the month
		e: Other deaths - Record all deaths in the household and not counted above which occurred in the month
Others		
AF	Remarks/other services provided	Write any remark which you think is important for follow-up or any other services provided not recorded among the indicators in the columns provided e.g. jigger management
Household Information		
AG*	Date of Data Collection (repeated from last page)	The date when the household member receives a service from a Community Health Volunteer, recorded as DD/MM/YY. For example, 31/07/14
AH*	Village Name (repeated from last page)	The name of the village where the household is located
AI*	Household Number	This is a unique identification number, which is assigned to a household during registration
AJ	Household has a functional latrine in use	Observe and record with a tick (☑) if the household has a functional latrine in use or (X) if the household does not have a functional latrine in use. This also includes all types of toilets and whether they are functional or not
AK	Household with hand washing facilities	Observe and record with a tick (☑) if the household has hand washing facilities (e.g. hand wash basin, tippy tap, leaky tin) or (X) if the household does not have hand washing facilities
AL	Household using treated water	Ask and record with a tick (☑) if the household is **always** using treated water for drinking or (X) if the household is not always using treated water for drinking

SERVICE DELIVERY LOG BOOK **MOH 514**

					MOTHER						CHILD			
Date of Data Collection (Record as DD:MM:YY e.g. 09/07/14)	Village name	Household number	Name of household member	Pregnant (✓/×/NA)	Counselled on Individual Birth Plan (IBP) (✓/×/NA)	Delivered by unskilled attendant (✓/×/NA)	Delivered by skilled attendant (✓/×/NA)	New-born visited at home within 48 hours of delivery (✓/×/NA)	Mother with newborns counselled Exclusive Breast Feeding (EBF) (✓/×/NA)	Woman 15-49yrs provided with Family Planning commodities by CHV (✓/×/NA)	Child 0-59 months participating in growth monitoring (✓/×/NA)	Child 6-59 months with MUAC (Red) indicating severe malnutrition (✓/×/NA)	Child 6-59 months with MUAC (Yellow) indicating moderate malnutrition (✓/×/NA)	Child 12-59 months dewormed (✓/×/NA)
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
TOTAL														

HOUSEHOLD LEVEL INDICATORS					
Date of Data Collection	Village Name	Household Number	Household has a functional latrine in use (✓/×)	Household with hand washing facilities (✓/×)	Household using treated water (✓/×)
AG*	AH*	AI*	AJ	AK	AL

AG*, AH*, AI* contain data similar to A, B and C respectively.

SERVICE DELIVERY LOG BOOK

MOH 514

REFERRALS										DEFAULTERS					DEATH	REMARKS
Pregnant woman referred for ANC (✓/×/NA)	Pregnant woman referred for skilled delivery(✓/×/NA)	Woman referred for family planning services (✓/×/NA)	Home delivery referred for Post Natal Care (PNC) Services (✓/×/NA)	Child 0-11 months referred for immunization (✓/×/NA)	Child 6-59 months referred for Vitamin A supplementation (✓/×/NA)	Cough more than 2 weeks referred (✓/×/NA)	Referred for HIV Counselling and Testing (HCT)(✓/×/NA)	Elderly (60 or more) referred for routine health check-ups(✓/×/NA)	Known cases of chronic illness referred a=Diabetes b=Cancer c=Mental Illness d=Hypertension e=Others (specify) f=None	ANC defaulter referred(✓/×/NA)	Immunization defaulter referred (✓/×/NA)	TB treatment defaulter traced and referred (✓/×/ NA)	ART defaulter traced and referred (✓/×/NA)	HIV exposed infant defaulters traced and referred (✓/×/NA)	No. of deaths in the month a=0-28 days b= 29 days-11 months c=12-59 months d=Maternal e=Other deaths	Remarks/ Other services
P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF

TOTAL

HOUSEHOLD LEVEL INDICATORS					
Date of Data Collection	Village Name	Household Number	Household has a functional latrine in use (✓/×)	Household with hand washing facilities (✓/×)	Household using treated water (✓/×)
AG*	AH*	AI*	AJ	AK	AL

AG*, AH*, AI* contain data similar to A, B and C respectively.

Annex 4
COMMUNITY TREATMENT AND TRACKING REGISTER

REPUBLIC OF KENYA – MINISTRY OF HEALTH

COMMUNITY TREATMENT AND TRACKING REGISTER

Community Health Services
"Afya Yetu, Jukumu Letu"

NAME OF CHU:	
MCHUL CODE:	
LINK FACILITY:	
NAME OF CHV:	
NUMBER OF HH:	
VILLAGE:	
START DATE:	
COUNTY:	
SUB COUNTY:	
DIVISION:	
LOCATION:	
SUB LOCATION:	
END DATE:	

INSTRUCTIONS ABOUT THE USE OF THE TOOL	
DESCRIPTION	The Community Treatment and Tracking Register is a diary that is used to record the information on ICCM and other service deliveries during the household visitation.
What type of information is collected?	The basic information recorded is factual data based on what was assessed or treated through the CHV kits in the community, among households and/or individual (s) served. The Community Treatment and Tracking Register should be written or filled during the household visitation. The register is treatment for under 5s during household visits. For those above 5 years, pre-referral treatment given should be documented.
Who should fill?	CHVs/CHEW
When and to whom it should be submitted?	The Community Treatment and Tracking Register should be submitted to the CHEW for summarization by 2nd of the following month.

Basic Information		
A	Date of Data Collection	Record as DD:MM:YY (e.g.) 31/07/14 the date when the household member receives a treatment service from a Community Health Volunteer
B	Name of Patient	Record at least THREE names of the patient (e.g.) James Karani Bosire.
C	Patient Contact - Phone No.	Indicate in this column the telephone number for the patient or closest person to enable tracing or follow-ups
D	Household Number	Record the household number
E	Sex	This should be recorded as M for male and F for female
F	Age in Completed Years / Months/ Days	Record the age of the household member at the last birth day, expressed in numbers. Age here must be indicated in years or months or days (record Y for years if age is more than 1 year e.g. 7 Y for 7 years, M for months if age is less than 12 months e.g. 10 M for 10 months and D for days if age is less than 30 days e.g. 16 D for 16 days)
G	Slept under LLINs last night	Indicate with a tick (☑) if the child slept under LLIN. Record (X) if not.
H	Exclusive Breastfeeding	Indicate with a tick (☑) if a child under 6 months is exclusively breastfed. Record (☑) if not. Record N/A if the member is not a child under 6 months
Assessment for treatment		
I	Duration of illness (days)	Indicate duration of illness in days
J	Diarrhoea less than 14 days	Indicate with a tick (☑) if the patient has had diarrhoea for less than 14 days. Record (X) if not.
K	Temperature	Record the temperature measured in degrees Celsius
L	Fever	Indicate with a tick (☑) if the patient has fever. Record (X) if not.
M	Fever less than 7 days RDT done	Indicate with a tick (☑) if the patient has had fever for less than 7 days with RDT done. Record (X) if not. Record N/A if the member has not had fever
N	Fever less than 7 days RDT +ve	Indicate with a tick (☑) if the patient has had fever for less than 7 days with RDT positive. Record (X) if RDT is not positive. Record N/A if the patient has not had fever or RDT has not been done
O	Fast breathing	Indicate with a tick (☑) if the patient (0-59 months) has fast breathing. Record (X) if not. Record N/A if patient is not of 0-59 months
Referrals		
P	Cough for 14 days or more	Indicate with a tick (☑) if the patient has been referred due to cough for 14 days or more. Record (X) if patient has had cough for 14 or more days but has not been referred. Record N/A if patient has not had cough or has had it for less than 14 days
Q	Diarrhoea for 14 days or more	Indicate with a tick (☑) if the patient has been referred due to diarrhoea for 14 days or more. Record (X) if patient has had diarrhoea for 14 or more days but has not been referred. Record N/A if patient has not had diarrhoea or has had diarrhoea for less than 14 days
R	Blood in stool	Indicate with a tick (☑) if the patient has been referred due to blood in stool. Record (X) if the patient has had blood in stool but has not been referred. Record N/A if patient has not had blood in stool
S	Fever for 7 days or more (RDT+or -or not done)	Indicate with a tick (☑) if the patient has been referred due to fever for 7 days or more (RDT positive or negative or not done). Record (X) if the patient has had fever for 7 days or more but has not been referred. Record N/A if the patient has not had fever or has had fever for less than 7 days
T	Convulsions	Indicate with a tick (☑) if the patient has been referred due to convulsions. Record (X) if the patient has had convulsions but has not been referred. Record N/A if the patient has not had convulsions.
U	Not able to drink or feed at all	Indicate with a tick (☑) if the patient has been referred due to inability to drink or feed. Record (X) if the patient has not been able to drink or feed at all but has not been referred. Record N/A if the patient has not experienced inability to drink or feed at all
V	Vomits everything	Indicate with a tick (☑) if the patient has been referred due to vomiting everything. Record (X) if the patient has had vomiting of everything but has not been referred. Record N/A if the patient has not experienced vomiting everything
W	Chest in-drawing	Indicate with a tick (☑) if the patient has been referred due to chest in-drawing. Record (X) if the patient has had chest in-drawing but has not been referred. Record N/A if the patient has not had chest in-drawing

X	Unusually sleepy or unconscious	Indicate with a tick (☑) if the patient has been referred due to being unusually sleepy or unconscious. Record (X) if the patient has been unusually sleepy or unconscious but has not been referred. Record N/A if the patient has not been unusually sleepy or unconscious
Y	Yellow on MUAC	Indicate with a tick (☑) if the child (6-59 months) has been referred due to moderate malnutrition (yellow). Record (X) if the child (6-59 months) has had moderate malnutrition but has not been referred. Record N/A if the patient is a child (6-59 months) but has not had moderate malnutrition or is not a child of that age
Z	Red on MUAC	Indicate with a tick (☑) if the child (6-59 months) has been referred due to severe malnutrition (red). Record (X) if the child (6-59 months) has had severe malnutrition but has not been referred. Record N/A if the patient is a child (6-59 months) but has not had severe malnutrition or is not a child of that age
AA	Swelling of both feet	Indicate with a tick (☑) if the patient has been referred due to swelling of both feet. Record (X) if the patient has had swelling of both feet but has not been referred. Record N/A if the patient has not had swelling of both feet
AB	Immunization required	Indicate with a tick (☑) if the child (0-11 months) was referred for immunization. Record (X) if the child (0-11 months) was not referred for immunization. Record N/A if the member is not a child of 0-11 months
AC	New-born danger signs present	Indicate with a tick (☑) if a new-born has been referred due to danger signs. Record (X) if a new-born has had danger signs but has not been referred. Record N/A if the member is not a new-born
Treatment/Management		
AD	ORS (20.5g/ltr); Sachets	Indicate with a tick (☑) if ORS has been given. Record (X) if not.
AE	ZINC (20mg)' Tabs	Indicate with a tick (☑) if zinc has been given. Record (X) if not.
AF	AMOXYCILLIN (125mg/5mls); Bottle	Indicate with a tick (☑) if amoxycillin has been given. Record (X) if not.
AG	ACTs (6s)	Indicate with a tick (☑) if ACTs (6s) has been given. Record (X) if not.
AH	ACTs (12s)	Indicate with a tick (☑) if ACTs (12s) has been given. Record (X) if not.
AI	ACTs (18s)	Indicate with a tick (☑) if ACTs (18s) has been given. Record (X) if not.
AJ	ACTs (24s)	Indicate with a tick (☑) if ACTs (24s) has been given. Record (X) if not.
AK	Albendazole (ABZ); Tabs	Indicate with a tick (☑) if albendazole has been given. Record (X) if not.
AL	Paracetamol; Tabs	Indicate with a tick (☑) if paracetamol has been given. Record (X) if not.
AM	Tetracycline Eye Ointment (TEO); 1%; tube	Indicate with a tick (☑) if tetracycline eye ointment (TEO) has been given. Record (X) if not.
AN	Injuries and wounds	Indicate with a tick (☑) if the patient had injuries or wounds and was treated. Record (X) if not.
AO	Counselled	Indicate with a tick (☑) if the patient was counselled. Record (X) if not.
AP	Treated within 24 hrs of illness onset	Indicate with a tick (☑) if the patient has been treated within 24 hours of onset of illness. Record (X) if not.
Outcome		
AQ	Date of 1st Follow up	Record the day of first follow-up as DD:MM:YY (e.g.) 31/07/14
AR	Referral compliance within 24 hours	Indicate with a tick (☑) if the patient has complied with the referral within 24 hours. Record (X) if not.
AS	Referral compliance more than 24hrs	Indicate with a tick (☑) if the patient has complied with the referral more than 24 hours. Record (X) if not.
AT	Adverse Drug Reaction (ADR)	Indicate with a tick (☑) if adverse drug reaction (ADR) occurred. Record (X) if not.
AU	Defaulted on: 1=Treatment; 2=referral	Indicate with "1" if the patient has defaulted on treatment and "2" if defaulted on referral
AV	Recovered	Indicate with a tick (☑) if the patient has recovered. Record (X) if not.
AW	Died	Indicate with a tick (☑) if the patient has died. Record (X) if not.
AX	Remarks	Any comments

COMMUNITY TREATMENT AND TRACKING REGISTER

Basic information								Assessment for treatment							Referrals					
Date of Data Collection (Record as DD:MM:YY e.g. 31/07/14)	Name of Patient	Patient Contact - Phone No.	Household Number	Sex (M/F)	Age in Completed Years / Months/ Days	Slept under LLINs last night (✓/✗)	Exclusive breastfeeding (✓/✗/NA)	Duration of illness (days)	Diarrhoea less than 14 days (✓/✗)	Temperature	Fever (✓)	Fever less than 7 days RDT done (✓/✗/ NA)	Fever less than 7 days RDT +ve(✓/✗/ NA)	Fast breathing (✓/✗/NA)	Cough for 14 days or more (✓/✗/NA)	Diarrhoea for 14 days or more (✓/✗/ NA)	Blood in stool (✓/✗/NA)	Fever for 7 days or more (RDT+or -or not done) (✓/✗/NA)	Convulsions (✓/✗/NA)	Not able to drink or feed at all (✓/✗/ NA)
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
TOTAL																				

	V	Vomits everything (✓)	Referrals
	W	Chest in-drawing (✓/×/NA)	
	X	Unusually sleepy or unconscious (✓/×/NA)	
	Y	Yellow on MUAC (✓/×/NA)	
	Z	Red on MUAC (✓/×/NA)	
	AA	Swelling of both feet (✓/×/NA)	
	AB	Immunization required (✓/×/NA)	
	AC	New-born danger signs present (✓/×/NA)	
	AD	ORS(20.5g/ltr); Sachets (✓/×)	Treatment/Management
	AE	ZINC (20mg)'Tabs (✓/×)	
	AF	AMOXYCILLIN (125mg/5mls); Bottle (✓/×)	
	AG	ACTs (6s) (✓/×)	
	AH	ACTs (12s) (✓/×)	
	AI	ACTs (18s) (✓/×)	
	AJ	ACTs (24s) (✓/×)	
	AK	Albendazole (ABZ); Tabs (✓/×)	
	AL	Paracetamol; Tabs (✓/×)	
	AM	Tetracycline Eye Ointment (TEO); 1%; tube (✓/×)	
	AN	Injuries and wounds (✓/×)	
	AO	Counselled (✓/×)	
	AP	Treated within 24 hrs of illness onset (✓/×)	
	AQ	Date of 1st Follow up (✓)	Outcome
	AR	Referral compliance within 24 hours (✓/×)	
	AS	Referral compliance more than 24hrs (✓/×)	
	AT	Adverse Drug Reaction (ADR) (✓/×)	
	AU	Defaulted on: 1=Treatment; 2=referral	
	AV	Recovered (✓/×)	
	AW	Died (✓/×)	
	AX	Remarks	

Annex 5
COMMUNITY HEALTH EXTENSION WORKERS SUMMARY MOH 515

REPUBLIC OF KENYA – MINISTRY OF HEALTH

COMMUNITY HEALTH EXTENSION WORKERS SUMMARY MOH 515

MINISTRY OF HEALTH

Community Health Services
"Afya Yetu, Jukumu Letu"

NAME OF CHU:	
MCHUL CODE:	
LINK FACILITY:	
NAME OF CHEW:	
NUMBER OF HH:	
COUNTY:	
SUB COUNTY:	
DIVISION:	
LOCATION:	
SUB LOCATION:	
START DATE:	
END DATE:	

INSTRUCTIONS ABOUT THE USE OF THE TOOL	
DESCRIPTION	This tool is the monthly summary of the CHVs efforts and services offered at the household levels. "
What type of information collected?	The information collected measures the CHV's efforts and services offered at the household level. It shows the Community Health Unit (CHU) Outputs.
Who should fill?	The tool is filled by the CHEW using the information from the Community Service Log Book, Treatment and Tracking Register and Commodity Register (at the end of every Month) and from the Household Register (after six months)."
When and to whom it should be submitted?	The tool is to be filled monthly. The information is submitted to the sub-county community health focal person by 5th of the following month. The information captured on the CHEW summary is used to fill the Chalk Board (MOH 516) for dialogue."

Demographic Information			
	Indicator Name	Indicator Description	Data Source
1	Total households	Total number of households in the Community Health Unit (CHU)	Household Register
2	Total number of households visited	Total number of households visited in the month	Service Delivery Log Book
3	Total population	Total number of people in the Community Health Unit (CHU)	Household Register
4	Total women 15-49 years	Total number of women aged 15 - 49 years in the CHU	Household Register
5	Total pregnant women	Total number of pregnant women in the CHU	Household Register
6	Total children 0-28 days	Total number of children 0-28 days in the CHU	Household Register
7	Total children 29 days -11 months	The number of children of 29 days -11 months in the CHU	Household Register
8	Total children 12-59 months	The number of children of 12-59 months in the CHU	Household Register
9	Total Children 5-12 years	The number of children of 5-12 years in the CHU	Household Register
10	Total adolescent and youth - Girls (13-24 years)	The number of adolescents and youths that are girls between the age of 13 - 24 years in the CHU	Household Register
11	Total adolescent and youth - Boys (13 - 24 years)	The number of adolescents and youths that are boys between the age of 13 - 24 years in the CHU	Household Register
12	Total females 25-59 years	The number of females in the CHU who are 25-59 years old	Household Register
13	Total males 25-59 years	The number of males in the CHU who are 25-59 years old	Household Register
14	Total of elderly females (60+ years)	The number of females in the CHU who are 60 and above	Household Register
15	Total of the elderly males (60+ years)	The number of males in the CHU who are 60 and above	Household Register
Household Information			
16	Number of households using treated water	Total number of Households using treated water in the CHU	Service Delivery Log Book
17	Number of households with hand washing facilities e.g. leaky tins in use	Total number of Households in the CHU having hand washing facilities	Service Delivery Log Book
18	Number of households with functional latrines	Total number of Households in the CHU that are having a functional latrine in use	Service Delivery Log Book
Mother and Child Health Information			
19	Number of newborns 0-28 days visited at home within 48 hours of delivery	Total number of newborns 0-28 days visited at home within 48 hours of birth	Service Delivery Log Book
20	Number of Mothers with newborns counselled on Exclusive Breastfeeding	Number of mothers with new born babies counselled on exclusive breastfeeding	Service Delivery Log Book
21	Number of children 0-59 months participating in growth monitoring	The number of children 0-59 months using growth monitoring services	Service Delivery Log Book
22	Total Deliveries	Record the total number of deliveries both attended to or not attended to by trained birth attendants	Household Register
23	Number of deliveries by Skilled Birth Attendants	Record the total number of deliveries attended to by skilled birth attendants	Service Delivery Log Book
24	Number of under-age pregnancies (under 18 years)	Record the total number of pregnancies for mothers under 18 year age. Refer to Age and Pregnancy status indicated in MOH 514	Service Delivery Log Book
25	Number of women (15-49 yrs) provided with FP commodities	The total number of women between 15 - 49 years provided with family planning commodities by CHVs	Service Delivery Log Book
26	Number of children 12-59 months dewormed	The total number of children of 12-59 months dewormed	Service Delivery Log Book
Treatment and Management Information			
27	Number of fever cases managed	The total number of fever cases managed	Treatment and Tracking Register
28	Number of Fever cases less than 7 days RDT done	Total number of fever cases of less than 7 days for which Rapid Diagnostic Test has been done	Treatment and Tracking Register
29	Number of Fever cases less than 7 days RDT +ve	Total number of fever cases of less than 7 days for which Rapid Diagnostic Test has been done and the result is positive	Treatment and Tracking Register

30	Number of 0-59 months Malaria Cases (RDT +ve) treated with ACT	Total number under 5 years malaria cases treated with ACT	Treatment and Tracking Register
31	Number of over 5 year old Malaria Cases (RDT +ve) treated with ACT	Total number of over 5 years malaria cases treated with ACT	Treatment and Tracking Register
32	Number of diarrhoea cases identified in children of 0-59 months	The total number of diarrhoea cases identified in children of 0-59 months	Treatment and Tracking Register
33	Number of children of 2-59 months with diarrhoea treated with ORS and Zinc	The total number of diarrhoea cases in children of 2-59 months managed by the CHV, by giving ORS and Zinc	Treatment and Tracking Register
34	Number of children of 0-59 months presenting with fast breathing	Total number of children of 0-59 months presenting with fast breathing	Treatment and Tracking Register
35	Number of children of 0-59 months presenting with fast breathing treated with Amoxycillin	Total number of children of 0-59 months presenting with fast breathing treated with Amoxycillin by the CHVs	Treatment and Tracking Register
36	Number of injuries and wounds managed	Total number of cases of injuries and wounds managed by the CHVs	Treatment and Tracking Register
Referrals Information			
37	Number of referrals for ANC	Total number of pregnant women in the CHU referred for ANC	Service Delivery Log Book
38	Number of referrals for skilled delivery	Total number of pregnant women referred for skilled delivery	Service Delivery Log Book
39	Number of newborns with danger signs referred	Total number of newborns with danger signs referred	Treatment and Tracking Register
40	Number of children of 0-11 months age referred for immunization	The number of children of 0-11 months age referred for immunization	Service Delivery Log Book
41	Number of children 6 - 59 Months referred for Vitamin A supplementation	The total number of children between the ages 6 months and 59 months referred for Vitamin A supplementation	Service Delivery Log Book
42	Number of referrals for severe malnutrition	Total number of referrals for severe malnutrition (red on MUAC)	Treatment and Tracking Register
43	Number of referrals for moderate malnutrition	Total number of referrals for moderate malnutrition (yellow on MUAC)	Treatment and Tracking Register
44	Number of referrals for cases with cough for 2 or more weeks	Total number of referrals for cases with cough for 2 or more weeks	Service Delivery Log Book
45	Number of referrals for HIV Counselling and Testing (HCT)	Total number of referrals for HIV Counselling and Testing (HCT)	Service Delivery Log Book
46	Number of referrals for routine health check-ups for the elderly (60+ years)	Total number of referrals for routine health check-ups for the elderly (60+ years)	Service Delivery Log Book
47	Cases of known chronic illness referred. It is a chronic illness if someone has been unwell for 1 year or more without healing	Diabetes - Total number of known cases of diabetes referred	Service Delivery Log Book
48		Cancer - Total number of known cases of cancer referred	Service Delivery Log Book
49		Mental Illness - Total number of known cases of mental illness referred	Service Delivery Log Book
50		Hypertension- Total number of known cases of hypertension referred	Service Delivery Log Book
51		Chronic Respiratory Diseases - Total number of known cases of Chronic Respiratory Diseases referred	Service Delivery Log Book
52		Others - Total number of known cases of other chronic illnesses referred	Service Delivery Log Book
Defaulters Information			
53	Number of defaulters traced and referred	ANC - Total number of defaulters for ANC traced and referred	Service Delivery Log Book
54		Immunization - Total number of defaulters for Immunization traced and referred	Service Delivery Log Book
55		ART - Total number of defaulters for ART traced and referred	Service Delivery Log Book
56		TB - Total number of defaulters for Tuberculosis treatment traced and referred	Service Delivery Log Book

Death Information			
57	Number of deaths in the month	0-28 days - Record all deaths between zero to 28 days of age	Service Delivery Log Book
58		29 days -11 months - Record all deaths between zero to 11 months of age	Service Delivery Log Book
59		12-59 months - Record all deaths between 12 - 59 months of age	Service Delivery Log Book
60		Maternal - Record all deaths of women during pregnancy or child birth or within 42 days after delivery	Service Delivery Log Book
61		Other deaths - Record all deaths in the household and not counted above	Service Delivery Log Book
62		Total deaths - Sum up all the deaths	Service Delivery Log Book
Community Health Unit (CHU) Activities			
63	Total number of community dialogue days held	The number of community dialogue days held in the previous month These days are held once per quarter. Therefore, in a year, there should be 4 community dialogue days	CHEW Record
64	Total number of community action days held	The number of action days held in the previous month. There should be one community action day per month, so a total of 12 such days per year	CHEW Record
65	Total number of community monthly meetings held	The number of monthly meetings between the CHEW and the CHV	CHEW Record
Commodities Information			
66	CHU issued with any commodities?	Record Yes or No to indicate whether or not the CHU was issued with any commodities	Commodity Register
67. a	Did the community unit experience stock-outs of more than 7 days for any of the following commodities	Record Yes, No or not applicable (N/A) to indicate whether or not Antimalarial (ACTs 6s and 12s) were out of stock for more than 7 days at the CHU during the past month	Commodity Register
b		Record Yes, No or not applicable (N/A) to indicate whether or not Oral Rehydration Salt (ORS) was out of stock for more than 7 days at the CHU during the past month	Commodity Register
c		Record Yes, No or not applicable (N/A) to indicate whether or not Zinc was out of stock for more than 7 days at the CHU during the past month	Commodity Register
d		Record Yes, No or not applicable (N/A) to indicate whether or not Rapid Diagnostic Test (RDT) Kit was out of stock for more than 7 days at the CHU during the past month	Commodity Register
e		Record Yes, No or not applicable (N/A) to indicate whether or not condoms were out of stock for more than 7 days at the CHU during the past month	Commodity Register
f		Record Yes, No or not applicable (N/A) to indicate whether or not oral contraceptives were out of stock for more than 7 days at the CHU during the past month	Commodity Register
g		Record Yes, No or not applicable (N/A) to indicate whether or not iodine solution was out of stock for more than 7 days at the CHU during the past month	Commodity Register
h		Record Yes, No or not applicable (N/A) to indicate whether or not chlorine tablets were out of stock for more than 7 days at the CHU during the past month	Commodity Register
i		Record Yes, No or not applicable (N/A) to indicate whether or not albedazole tablets were out of stock for more than 7 days at the CHU during the past month	Commodity Register
j		Record Yes, No or not applicable (N/A) to indicate whether or not tetracycline eye ointment was out of stock for more than 7 days at the CHU during the past month	Commodity Register
k		Record Yes, No or not applicable (N/A) to indicate whether or not paracetamol was out of stock for more than 7 days at the CHU during the past month	Commodity Register
Others			
	Remarks/Others	Enter any general or specific remarks about the summary of indicators or any other services rendered and not summarized in the indicators above e.g. Family Planning referrals, Intermittent Presumptive Treatment (IPT) for pregnant women	
	Signature and Date	The CHEW signs the report and provides the date of reporting	

Annex 6

COMMUNITY HEALTH UNIT CHALK BOARD MOH 516

COMMUNITY HEALTH UNIT CHALK BOARD

MOH 516

NAME OF CHU		DIVISION	
MCHUL CODE COUNTY		LOCATION	
SUB COUNTY		SUB LOCATION	

BI-ANNUAL BASELINE INDICATORS

Month: _____ Year:_____

Indicator	**No.**	Indicator	No.
Total population		Total adolescent and youth: Girls (13-24 years)	
Total households		Total adolescent and youth: Boys (13-24 years)	
Total villages		Total elderly (60+ years)	
Total women 15-49 years		No. of households without functional latrines	
Total pregnant women		No. of households without hand washing facilities	
Total children 0-6 months		No. of children not fully immunized	
Total children 0-11 months old		No. of pregnant women not using LLINs	
Total children 0-59 months old		No. of children 0-59 months not using LLINs	

ROUTINE INDICATORS - A

Indicators	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
No. of households visited												
No. of households not using treated water												
No. of households without hand washing facilities												
e.g. leaky tins in use, tippy tap, wash hand basin												
No. of household without functional latrines												
No. of deliveries												
No. of deliveries by unskilled attendants												
Number of newborns visited at home within 48 hours of birth												
No. of children 0-59 months not participating in growth monitoring												
Number of children of 12-59 months with diarrhoea treated with Zinc and ORS												
No. of children 6-59 months with moderate malnutrition (with MUAC indicating yellow)												
No. of children 6-59 months with severe malnutrition (with MUAC indicating Red)												
No. of children 12-59 months not dewormed												
No. of people with cough for more than 2 weeks referred												

ROUTINE INDICATORS - B

Indicators		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Defaulters referred	ANC													
	Immunization													
	Tuberculosis treatment													
	ART													
No. of people with known chronic illness	Diabetes													
	Cancer													
	Mental illness													
	Hypertension													
	Chronic Respiratory disease													
	Total of the others													
No. of deaths	0-28 Days													
	29 Days-11 months													
	12-59 months													
	Maternal													
	Other deaths													
	Total death													

COMMUNITY HEALTH UNIT (CHU) ACTIVITIES

	Q1	Q2	Q3	Q4	Total
No. of monthly CHV feedback meetings					
No. of community action days held					
No. of community dialogue days					

Annex 7

MOH 100: COMMUNITY REFERRAL FORM

REPUBLIC OF KENYA

MINISTRY OF HEALTH

Community Health Services
"Afya Yetu, Jukumu Letu"

MOH 100: 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:	
CHV 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:	Mobile No:
Name of CHV:	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 _____

Annex 8
SUPPORT SUPERVISION CHECKLIST

MINISTRY OF HEALTH

Community Health Services
"Afya Yetu, Jukumu Letu"

SUPPORT SUPERVISION CHECKLIST FOR COMMUNITY HEALTH SERVICES

SECTION 1: COMMUNITY HEALTH UNIT DETAILS

Name of County/Sub County	
Name of Community Health Unit (CHU)	
MCHUL Code	
Name of the link health facility	
Link health Facility (MFL) Code	
Name and phone number of the link health facility in charge	
Total population of the CHU	
Number of CHVs in the CHU	
Number of CHVs who have undergone basic module training	
Number of CHVs who have Undergone technical training (specify)	1. 2. 3. 4.
Number of CHEWs in the CHU	
Name (s) of CHEWs and Mobile Phone	Name _____No._____ Name _____No._____
Date of Supportive Supervision	
Name and title of Supervisor(s)	1.
	2.
	3.
	4.

SECTION 1: PERFORMANCE (CHEWs) as respondent

1-1: Do you have the following Plans?

Plans	Yes/No	Remarks
Annual Community Health Unit Work Plans		
Quarterly implementation plans		
Monthly Action Plans		

1-2: Targets for Key Priority Areas

i) Key achievements in high impact intervention areas in the last quarter (to be populated from MOH 515 in DHIS). Discuss the performance and areas of improvement

Performance Indicator	Target	Achieved	Achieve-ment (%)	Data Source	Make remarks
Proportion of pregnant women completing all four ANC visits within the catchment area					
Proportion of pregnant women receiving skilled care during delivery within the catchment area					
Proportion of children under 6 months who are exclusively breastfed					
Number of ART defaulters traced and referred by CHVs					
Number of TB defaulters traced and referred by CHVs					
Proportion of households with a functional latrine					
Proportion of households with a hand washing facilities					
Proportion of households with regular access to treated water for drinking					
Number of child immunization defaulters traced and referred					
Number of children less than 60 months with diarrhoea managed with ORS and zinc					
No of newborns 0-28 days visited within 48 hours of birth.					
Number of children 12 to 59 months receiving 2 doses of Vitamin A annually					
Number of children who are fully immunized					
Number of women of reproductive age receiving Family Planning commodities from CHVs					
Number of CHVs who update and submit their Service Log Book to the CHEW timely				CHEW Supervisory tool	
Number of CHVs correctly filling the treatment and Tracking Register.				CHEW Supervisory tool	
Average Performance (%)					

LEADERSHIP & GOVERNANCE

1-3: Meetings and Supervisory visits in the Last Quarter
(Respondent should be the CHEW on behalf of CHU)

Meetings/ Supervisory Visits	Number Reported	Date of Last Meeting/supervision	Number of reports/ visits Verified
How many supervisory visits have been made in the last quarter			
How many CHVs received at least one supervisory contact in the last 3 Months?			
How many focused community mobilization forums held and for what?			

1-4: What follow up measures have you taken on previous supervision recommendations?

1-5: What were the top three challenges encountered in bridging the previous supervision recommendations?

SECTION 2: STAFF MOTIVATION AND TRAINING

2-1: CHV Motivation

What are the motivation strategies put in place for CHVs? (Ask the CHEW and tick ☑ what applies)

Incentive	Yes	No	Specify/Comments
Basic Training			
Other training beyond basic (specify)			
Mentorship			
Recognition (e.g. Certificates, badges,…)			
Other non-cash incentive (specify)			
Cash incentive			

2 -2: CHC Motivation

Incentive	Yes	No	Specify/Comments
CHC Training			
Certificates			
Other incentives (Specify)			

SECTION 3: HEALTH INFORMATION (CHEW as respondent)

3-1: Is the CHU reporting monthly (☑ as appropriate)? Yes No

3-2: Did the CHU submit the last quarter report? (☑ as appropriate)? Yes No

3-3: Check for accuracy, completeness and timeliness of the last available reports and discuss.

Reporting parameter	Yes	No	Remarks
1. Accuracy			
2. Completeness			
3. Timeliness			

3-4 Utilization of Information

3-4-1: ☑ as appropriate to indicate whether last month's data was updated in the MOH 516 **Yes** **No**

3-4-2 : ☑ as appropriate to indicate whether MOH 516 is complete and up to date? **Yes** **No**

3-4-3: Ask whether the data displayed was discussed together with the CHC at least once in the last 3 months? Use ☑ as appropriate show the answer **Yes** **No**

3-4-4: Discuss and provide recommendations on utilization of information in the box below:

3-5: Information Resource Corner (CHEW as respondent)

3-5-1: Has the CHU established information Corner? (☑ as appropriate) **Yes** **No**

3-5-2: Discuss on the importance of the information corner in the box below:

3-5-3: If YES, is the information updated? (☑ as appropriate) **Yes** **No**

3-5-4: Use ☑ as appropriate to indicate the relevance of the displayed information **Yes** **No**

3-5-5: Provide further discussion on the relevance of the displayed information in the box below:

SECTION 4: SERVICE DELIVERY (CHEW as respondent)

4-1: Do all the CHVs have the Comprehensive CHS Job Aid? (☑ as appropriate) **Yes** **No**

4-2: What fraction of CHVs are demonstrating correct case management of childhood illnesses?

4-3: What proportions of children are followed up after treatment?

4-4: Discuss the responses and give recommendations in the box below:

SECTION 5: FINANCING

5-1: Ask for information on the following items to enable you complete the table on CHU finances (respondent CHEW)

Source of Funds	Amount Budgeted	Amount Received	Amount Utilised	Amount Accounted for
County Government				
Constituency Development Fund				
HSSF				
IGA				
Other (specify)				

5-2: Discuss on possible sources of finances for the CHU in the box below:

SECTION 6: TRANSPORT AND REFERRAL SYSTEM

6-1: Ask for information on the following items to enable you complete the table on CHU'S means of Transport and Referral

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

6-2: Do you use any standard referral form for referring patients in the community? (☑ as appropriate)
Yes No

6-3: Are the referral forms available presently? (☑ as appropriate) **Yes No**

6-4: What is the available communication system for referrals? ☐**Phone** ☐**Other**

6-5: If other, specify

SECTION 7: SUPPLIES AND COMMODITIES

7-1: Does the CHEW have an updated inventory of community health services kit (☑ as appropriate)
Yes No

7-2: Proportion of CHVs with no stock outs of key CHS kit commodities

7-3: Proportion of CHV with all the Basic Equipment
(Thermometer, MUAC Tape, Respiratory Timer and First Aid Kit)

7-4.: Make comments on the availability of supplies and commodities in the box below:

SECTION 8: FUNCTIONALITY OF COMMUNITY HEALTH UNITS

8-1: Fill in the following table with indicators to assess CHU functionality

Parameter	Expected Value	Actual Value	% Achieve-ment	Remarks
Active CHVs Reported				
Active CHC Members				
Dialogue days held in the last 3 months	1			
Number of Health action days held last 3 months	3			
CHC meetings held in the last 3 months	3			
CHIS tools available				
MOH 513				
MOH 514				
MOH 515				
MOH 516				
MOH 100				

ACTION POINTS FOR IMPROVEMENT BASED ON SUPPORTIVE SUPERVISORY VISIT

SUPERVISION CHECKLIST APPENDIX

SUPERVISORY CHECKLIST INDICATOR DEFINITIONS

INDICATOR	INDICATOR DEFINITION	SOURCE DOCUMENT
Proportion of pregnant women completing all four ANC visits within the catchment area	N-Number of pregnant women attending at least four ANC visits D-Total number of pregnant women in the past 12 months	MOH 513 No. L MOH 515 No.5 Total for past 12 months
Proportion of pregnant women receiving skilled care during delivery within the catchment area	N-Number of deliveries by skilled birth attendants D-Total pregnant women	MOH 515 No. 23 MOH 515 No.5 Total for past 12 months
Proportion of children under 6 months who are exclusively breastfed	N – Total number of children less than 6 months exclusive Breastfed D - Total number of children 0-6 moths	MOH 513 No. D MOH 513 No. N
Number of ART defaulters traced and referred by CHVs	N – Total number of ART traced defaulters referred by CHVs	MOH 515 No. 56
Number of TB defaulters traced and referred by CHVs	N- Number of TB defaulters traced and referred by CHVs	MOH 515 No. 55
Proportion of households with a functional latrine	N - Number of households with functional latrines/toilet D - Total number of households	MOH 515 No. 18 MOH 515 No. 1
Proportion of households with hand washing facilities	N- Number of households with hand washing facilities D - Total number of households	MOH 513 No. 4 MOH 515 No. 1
Proportion of households with regular access to treated water for drinking	N-Number of households using treated water (Treated water is defined as water treated by boiling and/or using chlorine) D - Total number of households	MOH 515 No. 16 MOH 515 No. 1
Number of child immunization defaulters traced and referred	N - Number of child immunization defaulters traced and referred	MOH 514 No. AA
Number of children 2-59 months with diarrhoea managed with ORS and zinc	N - Number of children 12-59 months with diarrhoea managed with ORS and zinc	Treatment register – treated with ORS, age indicator
No of newborns 0-28 days visited within 48 hours of birth.	No of neutrons 0-28 days visited within 48 hours of birth.	MOH 515 No. 19
Number of children 12 to 59 months receiving 2 doses of Vitamin A annually	Number of children 12 to 59 months receiving 2 doses of Vitamin A annually	MOH 513 No. T
Number of children who are fully immunized	Number of children who are fully immunized	MOH 513 No. S
Number of women of reproductive age receiving Family Planning commodities from CHVs	Number of women of reproductive age receiving Family Planning commodities from CHVs	MOH 514 No. K or MOH 515 No. 25
Number of CHVs who update and submit their Service Log Book to the CHEW timely	Number of CHVs who update and submit their Service Log Book to the CHEW timely	CHEW Record
Number of CHVs correctly filling the treatment and Tracking Register.	Number of CHVs correctly filling the treatment and Tracking Register.	CHEW Record

KEY PLAYERS

Name of Organization/ Institution	Role in the CHS
Community Strategy ICC	Monitoring of the strategy
Division of Community Health Services	Coordination
DHIS	Operational Research
CHIS Technical Working Group	Monitor implementation plan and strategy
Joint Inter-Coordinating Committee	Monitor M&E agenda in the strategic plan
County Health Management Committees	Coordination and oversight of county community health strategy monitoring systems
Community Health Coordinating Committee	Coordination of data collection and use at CU level and link facility
Kenya National Bureau of Statistics	Collection and dissemination of relevant household data
Ministry of Social Services	Registration of CSOs
Ministry of Education	Coordinate school health programmes
Ministry of Health and its health departments	Management of community health information systems
Ministry of Finance	Finance community health programmes
Ministry of Agriculture	Provide technical assistance on food security and community nutritional needs
Ministry of Water	Ensure community access to safe water
Civil Registration	Registration of births and deaths at community level
Development Partners and implementing partners	
USAID	Donor funding, technical assistance
APHIA Plus	Technical assistance, donor funding
Fanikisha	Systems strengthening
JICA	Funding and providing technical support to CHS
UNICEF	Funding and providing technical support to national programmes
Afya Info	Implementation, donor funding
Measure Evaluation	Donor funding, technical assistance
WHO	Donor funding
World Bank	Donor funding
African Development Bank	Donor funding
World Vision	Implementation
FHI 360	Implementation
AMREF	Implementation, donor funding
Intra Health Capacity	Implementation
AMPATH	Implementation
Marie Stopes	Implementation
MCHIP	Implementation
ICAP	Implementation
Global Fund Round 10 (Malaria)	Donor funding, technical support, implementation of community malaria interventions

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Strengthening Community Health Strategy in Kenya