# Best Practices in Strengthening Community Health Information Systems

**MEASURE** Evaluation PIMA

**March 2016**

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**Cover photo:**

Catherine Njambi, a community health worker from the Mututuini Community Health Unit in Machakos County, participated in the October 2015 launch of the Machakos County Monitoring and Evaluation Plan developed in collaboration with the Machakos Ministry of Health and the USAID-funded MEval-PIMA project. Ms. Njambi and her group were performing a skit to demonstrate the role of community health workers in addressing the challenges faced by women seeking to access maternal health care in rural areas.

## CONTENTS

## ABBREVIATIONS

| | |
|---|---|
| AWP | annual work plan |
| CHC | community health committee |
| CHEW | community health extension worker |
| CHIS | community health information system |
| CHSU | community health services unit |
| CHV | community health volunteer |
| CHW | community health worker |
| CoE | Center of Excellence |
| CU | community unit |
| DCHS | Division of Community Health Services |
| HIS | health information system |
| ICC | Interagency Coordination Committee |
| KEPH | Kenya Essential Program For Health |
| M&E | monitoring and evaluation |
| MEval-PIMA | MEASURE Evaluation PIMA |
| MOH | Ministry of Health |
| NHSSP | National Health Sector Strategic Plan |
| TWG | technical working group |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| USAID | United States Agency for International Development |
| WHO | World Health Organization |

## EXECUTIVE SUMMARY

This report describes the lessons learned and best practices towards strengthening the capacity of the community health information systems (CHIS) in Kenya to generate complete and quality data and promote data use for decision making. The work reported here was part of the support provided to the Community Health Services Unit (CHSU), (formerly the Division of Community Health Services) through the MEASURE Evaluation PIMA project (MEval-PIMA).

MEval-PIMA support to the DCHS was developed against the backdrop of a need to strengthen the national health information system, to respond to a growing need to provide good quality data on a timely basis, and to support county health information systems following devolution of responsibility to subnational government structures in 2010.

The MEval-PIMA support addressed the core capacities necessary for developing a functional monitoring and evaluation (M&E) system. These included developing a shared understanding of current capacity through a baseline assessment, establishment of broad partnerships to address the diverse needs of the DCHS, institutionalization of the capacity building efforts, and the development and implementation of a set of interventions to address the identified gaps.

The baseline assessment showed strengthening was needed to assure data quality, and to remedy late and untimely reporting and incomplete and inconsistent information. It further showed that DCHS needed technical assistance to assess and audit data quality and to train staff on use of data quality tools.

At the national level, MEval-PIMA supported the DCHS to coordinate and bring together stakeholders and implementing partners to spearhead the development of tools, standards, and guidelines for performance monitoring, while the support at the community level focused on developing a community unit (CU) functionality index, providing tools to aid reporting, skills building for community health committees (CHCs) and community health extension workers (CHEWs), structured learning visits, and supporting use of data through dialogue and community action days. At the national level, DCHS worked with MEval-PIMA to develop an M&E data-use plan, including mechanisms for producing routine and non-routine data reporting and quarterly reports. The national M&E plan would be crucial for setting the standard for generating strategic information at various levels of the health system to effectively guide the implementation of the Kenya Essential Program for Health (KEPH)—a national strategy for delivering health services at various levels of care.

The national M&E plan that resulted defined the processes by which the government would move toward strategy-driven, evidence-based planning. This national M&E plan has helped establish a well-coordinated, harmonized monitoring, evaluation, and research system that guides the national response through timely and accurate strategic information in line with the community health strategy.

It was essential, therefore, that the national plan and county and subcounty M&E plans be aligned in intent and reporting mechanisms in order to achieve a comprehensive and thorough flow of data throughout the various levels. MEval-PIMA supported this effort by involving key government agencies, stakeholders, and implementing partners through consensus-building workshops held at

DCHS M&E Technical Working Group (TWG) meetings, at client sites, and in a conference setting. The aim was to ensure integration among all systems, decentralization of data management, simplified data indicators appropriate for each level, and action-oriented practices to feed information through the system.

The Centers of Excellence (CoEs) were a central mechanism for MEval-PIMA's support to DCHS, which was limited to eight target counties. The task at the county level involved assessing existing capacity for generating quality health data and managing and using data for decision making at the community level. MEval-PIMA developed a package of support to transform selected community units into CoEs focused on M&E. The CoE concept leveraged organizational units that embodied a set of capabilities, such as efficient leadership, data collection, storage and analysis, best practices, research, and training in community health service provision. The CoEs were designed to be one-stop shops for community unit M&E needs for data demand and use.

Harmonizing tools emerged as a key challenge as M&E plans and data use goals were supported. Tools needed revision for fundamental concerns, for example, they did not take into consideration redefined key national policies and the devolved responsibility falling on community health strategies. And, tools were inadequate for quite specific reasons: they were not adequate to record population needs for health services at the lowest level; they did not facilitate data transfer from community units to health facilities; there were improvised tools that resulted in compromised data quality; there were too many tools that posed a burden on community health workers; there were parallel and duplicative tools used by various partners; and there was no master tool for MOH that captured all the necessary data.

To address these insufficiencies, MEval-PIMA worked with DCHS and other stakeholders to revise the CHIS tools at a series of meetings, subsequent county-level pretesting by CHVs and CHEWs for three months in the eight CoE sites, and revision based on user feedback.

Several important lessons were learned during the process of strengthening health information systems throughout the levels. These include the need to promote ownership and consensus-building with the beneficiaries, recognizing the value for locally-driven ideas to drive change, the centrality of community empowerment and data use, the importance of stakeholder engagement, leveraging, and joint planning, and the importance of institutionalizing capacity building support to gain institutional support.

The concept of CoEs demonstrated a modest-cost approach for strengthening community-based information systems. It centralized addressing gaps, monitoring progress, advocacy, and community participation to promote data use for change and community involvement. CoEs enabled enhanced feedback, information sharing, and identification of health problems, and were able to improve systems for local health programs, such as skilled deliveries and family planning. The models also encouraged peer learning and the implementation of health actions.

Just as the CoEs were the heart of learning and information exchange, the availability of usable data fed further improvement. During the project's two years, community units participated in exchange visits to promote cross-community learning in M&E. Further, the CoEs were implemented in eight regions with varied geographical and economic conditions, which revealed new ways to deal with disadvantaged groups, apply scalability, and help to bridge the equity gap among disadvantaged groups in the community.

Knowledge exchange visits to community units also revealed specific challenges in data collection, management, reporting, and use, and became laboratories for identifying, testing, and sharing innovations to overcome challenges. Innovations, such as mobile phone solutions, offered alternatives to paper-based CHIS tools, though results after testing were mixed. The need for more time for some activities and the need for more financial resources also posed some challenges.

Sustaining the gains made remains a challenge, especially after the community health strategy became a non-core priority for several partner organizations, and the MOH restructuring to a devolved system of governance strongly affected the knowledge base and reporting systems.

In sum, MEval-PIMA support was crucial to ensure achievement of the MOH goals set out in the community health strategy. Combined technical and logistical support will help ensure that DCHS has the capacity to learn and sustain the systems and tools for data collection, reporting, and use with minimum support.

# 1. INTRODUCTION AND BACKGROUND

## 1.1 Introduction

Since the inception of Kenya's community health strategy in 2006, the Ministry of Health (MOH) has had difficulty implementing a monitoring and evaluation (M&E) framework to assess the impact and efficacy of the strategy, compared to its intended results.

In 2007, MOH established the Division of Community Health Services (DCHS) to facilitate the strategy implementation. An assessment in 2010 indicated that areas that had implemented the strategy achieved better health-seeking behaviors in communities and better health outcomes, compared with other areas (Ministry of Health, *A Report on Community Health Strategy Evaluation*, 2010). The enactment of the new constitution in 2010, however, posed numerous and substantial organizational and legislative challenges in local government implementation of the strategy. For example, the new constitution called for devolution of the national government and recognized county governments as independent, which required a reassessment of the DCHS capacity to effectively execute its M&E mandate at the national and community levels and to provide policy and technical guidance to the independent local governmental structures.

At the national level, DCHS recognized that key elements were missing in its capacity to identify and respond to the need for quality health information and data. Other areas that the strategy addressed also needed support, such as the health care referral service system and the civil registration and vital statistics system. MEASURE Evaluation PIMA (MEval- PIMA), funded by the U.S. Agency for International Development (USAID), stepped in to provide support to DCHS as it identified data needs, improved information use, and institutionalized M&E strategy and implementation.

At the community level, the functions and responsibilities of the community units needed definition, which would, in turn, determine the scale of health services delivery. MEval-PIMA supported this defining process by helping to establish a concept of Centers of Excellence (CoEs) as a model for learning and increasing community unit capacity for M&E. Annex 1 provides the profiles of the

community units that were selected as candidate CoEs.

This report describes the contribution MEval-PIMA has made to M&E capacity building, as mandated in the DCHS Annual Work Plan (AWP, 2012–2013), in collaboration with other partners, through the M&E TWG. It also describes DCHS participation in program assessment and planning processes outlined in the DCHS AWP. This report documents best practices that have evolved through MEval-PIMA support provided to DCHS at the national and county levels to build M&E capacity (WHO Best Practice, 2008). The focus is on partners' collaboration in leveraging resources, empowering disadvantaged groups, involving the community in decision making, and on the MOH commitment to help achieve M&E capacity building. The report also documents challenges, best practices, and lessons learned during program implementation that could be useful for Kenya in the future and for other organizations interested in increasing M&E capacity.

## 1.2 Background

MEval-PIMA is a five-year USAID-funded project to provide support to the MOH for M&E capacity building for rigorous evaluations that can yield evidence-based data to guide decision making on health challenges in Kenya. The project also supports the development of tools and approaches to strengthen health information systems for effectiveness at the national and subnational levels.

MEval-PIMA conducted a baseline assessment in 2013 to gauge DCHS M&E capacity to design and implement interventions. The assessment had three objectives:

1. To understand, document, and clarify DCHS M&E performance objectives
2. To determine DCHS current M&E performance in key functional areas
3. To identify gaps in DCHS capacity to meet M&E performance expectations

The baseline assessment used adapted versions of the Monitoring and Evaluation System Strengthening Tool (MESST, 2010) and the Organizational Behavior Assessment Tool (OBAT) to understand the organizational, behavioral, and technical dimensions required to strengthen the M&E system at the DCHS. The assessment tools, designed through a participatory process among relevant stakeholders, were aimed to identify DCHS M&E capacity strengths and weaknesses. The baseline assessment sought answers to the following questions:

- What constitutes an acceptable level of M&E performance at DCHS?
- What are the decision-making process gaps that need to be bridged in the DCHS organizational structure and leadership?
- What is the demand for data and information?
- How are data and information shared and used? What are the constraints to data and information use? What tools and training could improve data and information sharing and use?

The baseline assessment resulted in these findings and recommendations:

- The M&E unit's human resource capacity is lean and needs continuous provision of basic M&E courses for all DCHS unit heads to increase M&E champions and to help the M&E unit reach full execution of its mandate.
- Routine monitoring needs to be strengthened. DCHS should not rely on stakeholders to revise the community health information system (CHIS) data collection tools. After revision, the tools need to be distributed to users to increase timely reporting.
- DCHS needs to lobby for more resources to enable routine data collection and reporting. Scale-up is needed for mobile reporting to alleviate poor data quality, delayed reporting, and a shortage of tools.
- DCHS needs to realign its guidelines with the constitutional mandate, including M&E strategies and plans to support activities at the subnational level.

- DCHS needs to strengthen supervision at the county and subcounty levels and address problems that result from unmet data needs for decision making at all levels.
- Quality data for decision making is a priority for evidence-based programming, and DCHS needs to train key personnel on how to meet data demand and to increase data use. Where possible, DCHS needs to appoint data demand and use champions, especially at the subnational level.
- M&E staff have limited skills in data analysis, especially in the use of statistical packages, such as SPSS and Stata. DCHS needs to provide training in data analysis and offer mentoring and supportive supervision for the M&E staff.
- Community units need a comprehensive package of essential CHIS elements to strengthen capacity so that they can become CoEs. These elements include providing refresher training on the use of CHIS data collection tools; offering training for community health workers (CHWs) and community health extension workers (CHEWs) on the integrated community case management module and other technical modules; and ensuring stakeholder engagement on other activities, such as the development of community unit infrastructure, that fall outside the mandate of MEval-PIMA.
- Other recommendations include developing routine data quality assurance checks on priority indicators to track progress among the designated community units over time; providing guidance on data quality issues, such as missing or unreported data in the tools; designing data tracking tools to determine the extent that community units use data for decision making; and encouraging the use of mHealth technology to capture Level 1 data for easier CHEW reporting, which can play a critical role in providing CHIS tools to ensure real-time data accessibility for decision making.
- The study also recommended further improvement in the quality of community health data, a clear scheme of service for Level 1 personnel, and development of standards with clear mechanisms for adherence.

In summary, the baseline assessment indicated key M&E gaps including; data quality, late and untimely reporting, and incomplete, inconsistent, and inaccurate information gathering. DCHS needs technical assistance to develop data quality assessments, to conduct routine data quality audits, and to train staff on the use of the tools. The report also recommended that DCHS, with support from various stakeholders, encourage county and subcounty health management teams to use the study findings to guide the development of AWPs.

## 2. THE PROJECT APPROACH AND RESPONSE

The MEval-PIMA strategy in support of DCHS covers four capacity areas:

1. Enhanced partnership and collaboration
2. Institutionalized M&E practices
3. Improved data use practices
4. Improved data quality through revised data collection tools

### 2.1 Enhanced Partnerships and Collaboration

The DCHS mandate changed with the enactment of the new constitution in 2010, which allowed devolution of the government. This shift in responsibility posed major organizational and legislative challenges in the implementation of the community health strategy. For example, the new constitution recognizes county governments as being independent, which required a reassessment of the DCHS capacity to execute its mandate to formulate policy and provide technical guidance to the counties, including capacity building.

The first step in designing an action plan to strengthen DCHS M&E capacity was to identify gaps in performance. The baseline assessment served as a mobilization tool to engage stakeholders in investing in DCHS M&E capacity building to execute its M&E mandate at the national and county levels (PIMA Baseline Capacity Assessment, 2013). Following the baseline assessment, the new DCHS staff members received on-the-job capacity-building support to provide them with the skills required to perform their roles and responsibilities.

The Community Health Services Unit recommended that the report be disseminated to various partners as part of a resource mapping, mobilization, and consensus-building effort.

Limited resources prevented widespread dissemination of the report, but plans are underway to share the report and its recommendations with all key stakeholders.

**Baseline Assessment Findings**

- The DCHS mission is developed through external support, with little staff involvement
- Staff is insufficient, and staff available lack adequate skills to support M&E activities
- DCHS has a clear governance structure, but engages irregularly with partners
- M&E plan is outdated and lacks a national M&E tool to track progress; M&E work plans have no tracking tools to monitor whether targets are met
- Communication strategy has no sustainability plan
- Indicators are inconsistent among different tools, resulting in compromised data quality
- No evaluation and research agenda is linked to other systemic areas

Source: Baseline Capacity Assessment Report 2013

## 2.2 Institutionalized M&E Practices

To create data demand and use, MEval-PIMA provided DCHS with technical and financial support to strengthen oversight, management, and coordination of M&E activities. With the project's support, DCHS established the M&E TWG, which included partner organizations with M&E interest and technical expertise in the membership. Through its quarterly meetings to discuss progress in implementing plans and to address emerging issues, the M&E TWG has advanced the DCHS M&E agenda.

Before establishment of the M&E TWG, DCHS M&E activities lacked direction in implementing and coordinating the M&E agenda. This lack of direction had numerous impacts, beginning with limited opportunities to leverage resources among partners. The community M&E tools lacked an agreed-upon framework and common guidelines and, therefore, the partners adapted their own sets of tools, based on their interest in specific regions.

MEval-PIMA supported DCHS through the M&E TWG for the following activities:

- Revision of CHIS data collection tools
- Development of a DCHS M&E plan
- Development of AWPs
- Revision of the community health strategy design and implementation at Level 1
- Transformation of selected community units into CoEs

The project also supported the revival of the Interagency Coordinating Committee (ICC), which is the highest decision-making body in the division. Its membership includes community health stakeholders and representatives from other government agencies. ICC ensures alignment of the DCHS strategic direction with the broader health sector.

## 2.3 Improved Data Use Practices

The lack of capacity for program-specific data analysis to inform evidenced-based planning and decision making was evident in several ways, such as a lack of data-based and evidence- informed program funding and planning. Since the inception of the community heath strategy in 2007, DCHS did not have an agreed-upon standardized plan to monitor and evaluate progress on the strategy, and different implementing partners used various M&E plans and systems. DCHS lacked systematic methods for reliable, effective data reporting and program M&E and also the necessary dynamic, comprehensive data collection and reporting tools to make the division responsive to emerging information and service needs.

DCHS worked with MEval-PIMA to develop a national M&E data-use plan, including mechanisms for producing routine and non-routine data reporting and quarterly coverage reports. The M&E plan defined the what, how, and by whom in the planning and implementation that enabled the government's move toward strategy-driven, evidence-based planning. The M&E plan has helped establish a well-coordinated, harmonized monitoring, evaluation, and research system that guides the national response with timely and accurate strategic information in line with the community health strategy.

Because DCHS had no means to measure its contribution to the priority health sector, the unit's M&E plans were short term and not coherently linked to national M&E plans that are so crucial for generating

strategic information at various levels to guide the implementation of the Kenya Essential Program for Health (KEPH)—a national strategy for delivering health services at various levels of care. In addition to addressing key findings from the KEPH strategic review, the new M&E plan also supports a results-based management approach that facilitates M&E stakeholder coordination at all levels.

The purpose of the M&E plan is to provide a standardized mechanism for tracking relevant indicators to capture performance in disease prevention and control; in reducing morbidity, mortality, and disability; in providing family health services aimed at expanding family planning and maternal, child, and youth services; and in promoting hygiene and environmental sanitation. Specifically, the M&E plan was designed to accomplish these objectives:

- Create a robust, integrated DCHS M&E system with the capacity to adequately monitor the implementation of interventions at Level 1, the lowest tier of Kenya's health system.
- Create a standard platform for strategic partnership and accountability among stakeholders and implementing partners at all levels.
- Enhance data use to inform evidence-based program planning.
- Identify and document emerging best practices and lessons learned for improving and scaling-up of service provision.
- Promote health research and innovation through health information documentation and sharing.

MEval-PIMA worked closely with partners to identify and engage stakeholders to build capacity in DCHS. The M&E plan was developed through a participatory consultative process that outlined clear Terms of Reference for the DCHS M&E TWG. The process began with two meetings and the development of a zero draft document that went through numerous reviews. To spearhead the development of the M&E plan, the multisectoral M&E TWG included key government agencies, stakeholders, and implementing partners. The M&E plan was developed through consensus-building workshops held at DCHS M&E TWG meetings, at client sites, and in a conference setting. The process considered the following principles:

- **Integration:** The M&E plan ensured full integration with the national health and management information system.
- **Decentralization of data management:** Analysis, storage, and data use takes place at all levels, from national to subnational.
- **User-friendly data management:** Data analysis methods were simplified according to the information demanded at various levels.
- **Action-oriented:** The M&E plan collects and provides the necessary information for decision making and feedback to the periphery.

## 2.4 Improved Data Availability through Revised Data Collection Tools

The CHIS tools needed a review to update them to emerging needs. Those needs included the community health strategy and redefined key policies, updates on the number of households and community unit catchment areas, tracking of household visits by community health volunteers (CHVs), and changes in Kenya's priority indicators. Previous tools failed to meet health program data needs, and some health programs at MOH and implementing partners previously used parallel tools to meet their needs. Tool integration became a high priority for stakeholders.

Health program decision making at the national and subnational levels and at the program- area level needed to be clearly aligned to population needs. For example, data on health services provided at Level 1 were inadequate because the CHIS tools were missing key details. Data access by health practitioners was insufficient because data were incomplete and tools to collect the information were inadequate to capture the required information.

The M&E TWG examined division capacity for a data collection and use strategy, availability of data tools and data management equipment, and the routine procedures for data transfer from community units to health facilities, including the Division of Health Information System (DHIS)—the central depository for MOH health data reported through the tool, MOH 515. The assessment showed that the tools were inadequate, which resulted in improvising means, such as using photocopies or exercise books to capture data.

Inconsistencies showed up in indicators across various tools, resulting in compromised data quality. Many Level 1 tools duplicated data collection efforts and differed only slightly in question wording and framing. The numerous tools used to measure similar indicators was burdensome for CHVs and CHEWs. A further complication was that various partners used parallel tools, and MOH lacked a master tool that captured all the data. In addition, the assessment noted numerous examples of under-reporting of data transmitted to DHIS.

To address these insufficiencies, MEval-PIMA worked with DCHS and other stakeholders through the M&E TWG to revise the CHIS tools. The project provided overall leadership in the tools revision and pretesting. The M&E TWG had the following objectives in revising the tools:

- Harmonize the tools used by various agencies working in health community.
- Create comprehensive datasets containing data elements required for decision making to meet the community health strategy.
- Create all-encompassing tools to monitor and evaluate health services.

The project supported DCHS in revising the tools through the M&E TWG up to the pretesting stage. The following revised tools were reviewed, presented, and approved by the DCHS M&E TWG:

- MOH 513 Household Register
- MOH 514 Service Delivery Log Book
- MOH 515 Community Health Extension Workers Summary
- MOH 516 Community Health Unit Chalkboard
- MOH 100 Community Referral Form
- Community Treatment and Tracking Register
- Support Supervisory Checklist

To begin the tool revision, the M&E TWG started with conceptualizing DCHS and building consensus among relevant MOH departments, including the health information system and national-level stakeholders. After an orientation meeting for focal MOH employees (CHVs) who were responsible for community health issues at Levels 1 and 2 was held, then those focal points coordinated the community health strategy at the regional level. Next the M&E TWG discussed the indicators that were missing in the CHIS tools and recommended forming a small task force to work on the proposed indicators. A series of meetings, mostly hosted by DCHS, resulted in draft tools for subsequent county-level pretesting by CHVs and CHEWs for three months in the eight CoE candidate community units: Eshibinga, Gikipa, Githioro, Karatina, Kotile Mutituni, Mwele, and Omia Diere. Annex 1 lists the profiles of the eight counties. This activity received support from MEval-PIMA, UNICEF, Japan International Cooperation Agency, and Kijabe African Inland Church Hospital.

Each tool was pretested for completeness and comprehensiveness. The pretest was followed by detailed qualitative feedback on outstanding issues, which later was summarized and analyzed qualitatively. At an M&E TWG meeting, the pretest findings were reviewed and discussed and then presented to ICC for input and finalization.

# 3 WORKING WITH COMMUNITY UNITS

## 3.1 Introduction

The community unit structure comprises CHCs, CHVs, CHEWs, households, and affiliate health facilities. The nearest health facility is the community's link for seeking all health services. The community unit, which draws its membership from the catchment area, is led by the CHC and office personnel to support the CHVs in their community-related health work. The community unit structure requires data for routine decision making at the community level. For example, during dialogue days, communities use the electronic chalkboard, MOH 516, to review and discuss key indicators that affect their lives. The CoEs represent outstanding community units that provide this type of information to bring equity in access for disadvantaged community members.

## 3.2 Support for Community Units and Centers of Excellence

For a long time, all levels of the Kenya CHIS lacked tools, such as standard guidelines and data collection forms, and a consistent system to ensure the availability of quality data for use in decision making. The problem was exacerbated by the high turnover of CHWs and the limited demand and use of CHIS information.

A functional community unit is a key component in the community-level structure to promote health activities, and therefore, constant assessment is needed to determine the functionality at Level 1. Community health services implementers, on the other hand, need to understand CHIS functionality and how it influences community health indicators. Before this project, the community unit functionality had no clear categorization in the DHIS Master Community Unit List.

MEval-PIMA support, limited to improvements in the functionality of selected community units in eight target counties, involved assessing existing capacity and developing profiles to depict current capacity for generating quality health data and managing and using data for decision making at the community level. Based on the assessment, MEval-PIMA developed and implemented a package of support to transform selected community units into CoEs focused on M&E so that these capabilities

could be leveraged by other community units. The CoE concept leveraged organizational units that embodied a set of capabilities, such as efficient leadership and governance, activity reporting, data collection, storage and analysis of data for decision making, best practices, research, and training in community health service provision and support. The CoEs were designed to be one-stop-shops for community unit M&E needs for data demand and use.

## 3.3 The Center of Excellence Establishment Process

The transformation of selected community units into CoEs had the following objectives:

- To identify gaps in community unit capacity and systems and inform interventions at the candidate CoEs.
- To gauge the level of CHIS functionality at the community level.
- To generate more M&E data for community use and decision making.
- To set and refine standards and practices for CoEs.

The project interventions included the following activities to transform community units into CoEs:

- Conduct a two-week training for CHWs using the DCHS CHW basic training module.
- Enter the information for every community unit in the Master Community Unit Listing.
- Map all households in the community unit catchment area.
- Form the governing structure—the CHC—and ensure that it meets at least quarterly.
- Ensure that the CoEs reported to the affiliate health facilities at least every six months.
- Provide support for community engagement days, including a monthly dialogue and action days for six months.
- Consult and engage with partners willing to support elements outside the mandate of the project.
- Fully engage the subcounty health management team that draws most of its members from the community unit, as evidenced by supportive supervision and documented feedback during the last six months of support.

A tool for assessing community unit M&E performance was developed to gain a clear picture of functionality and capacity gaps. Community health informational needs were also assessed, and a tailored package of support was established to address gaps. The support included building capacity, providing data collection tools, conducting peer learning visits, and supporting community meetings. The project intervention of regular supportive supervision was in place for 2013 and 2014. For comparison, another round of data collection followed the initial assessment two years after the intervention.

## 3.4 Community Support Package and Results

The targeted community units made progress in building capacity to generate quality data, empower the community to actively participate in health activities, and use data to influence decision making and interventions. The following project-supported activities ensured transformation of community units into CoEs.

**Provided CHIS tools.** CHIS tools were made available to the community units, which then reported that CHIS tools printed by MEval-PIMA were adequate, portable, and user- friendly, and that they facilitated the work of health workers, especially CHVs.

**Provided skills training.** All participants were offered training to improve their skills in community case management, such as identifying symptoms, conducting a rapid diagnostic test, and identifying treatment. Other training areas included understanding indicators and how to report them, changing attitudes, and motivating workers.

**Conducted structured learning visits**. The project encouraged community units to conduct exchange visits. Seven out of eight CoEs that participated in the structured learning visits reported that the visits provided them with an opportunity to learn best practices from other well-performing community units.

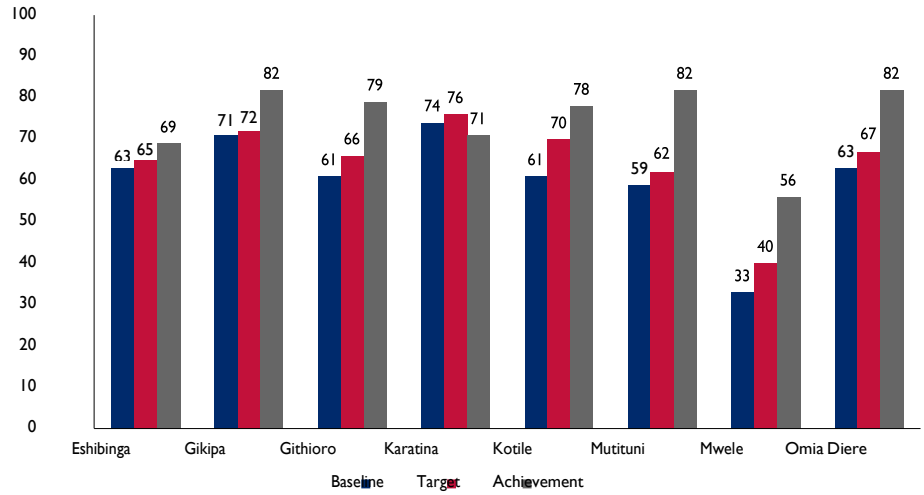
**Held dialogue days**. Dialogue days became the community forum to talk about health. The activity enhanced reporting, gained feedback, increased communication, and helped identify community health problems and data use difficulties. Dialogue days led to increased skilled deliveries, community referrals, and family planning use, and improved latrine coverage. They also enhanced positive relationships among the community unit, the link facility, and the community administration. Dialogue days raised community expectations on more incentives. It also became clear that financial motivation to facilitate the work at the community level is not sustainable.

**Held community action days**. Community action days are open forums where communities can interact and share their experiences in supporting community work and where well-performing units and individuals receive government or the host agency recognition. Community action days enhance participation, leading to behavior change; however, not all stakeholders participate in community action days and financial support is irregular and limited.

After the project supported these activities in the eight targeted community units to transform them into CoEs, the Year 1 baseline assessment was conducted in 2013, followed by the endline assessment in 2014 in Year 2. Achievements were compared to targets on different elements of CHIS, such as the availability of CHIS tools, data quality, reporting, data access, and data use for decision making. Figure 1 shows that all community units except Karatina surpassed the targets.

The most significant change exercise is an example of project achievements. The exercise involves an M&E participatory process that stakeholders use to decide the types of change to be recorded and analyzed. The exercise is used mostly in program evaluations, organizational reviews, and community ownership building. The results of the comparison of the baseline and endline assessments of community unit functionality indicated numerous changes over the two-year implementation period. Figure 1 shows that all eight community units were at the sustaining stage at the end of the two years.

**Figure 1. CHIS functionality at community units**

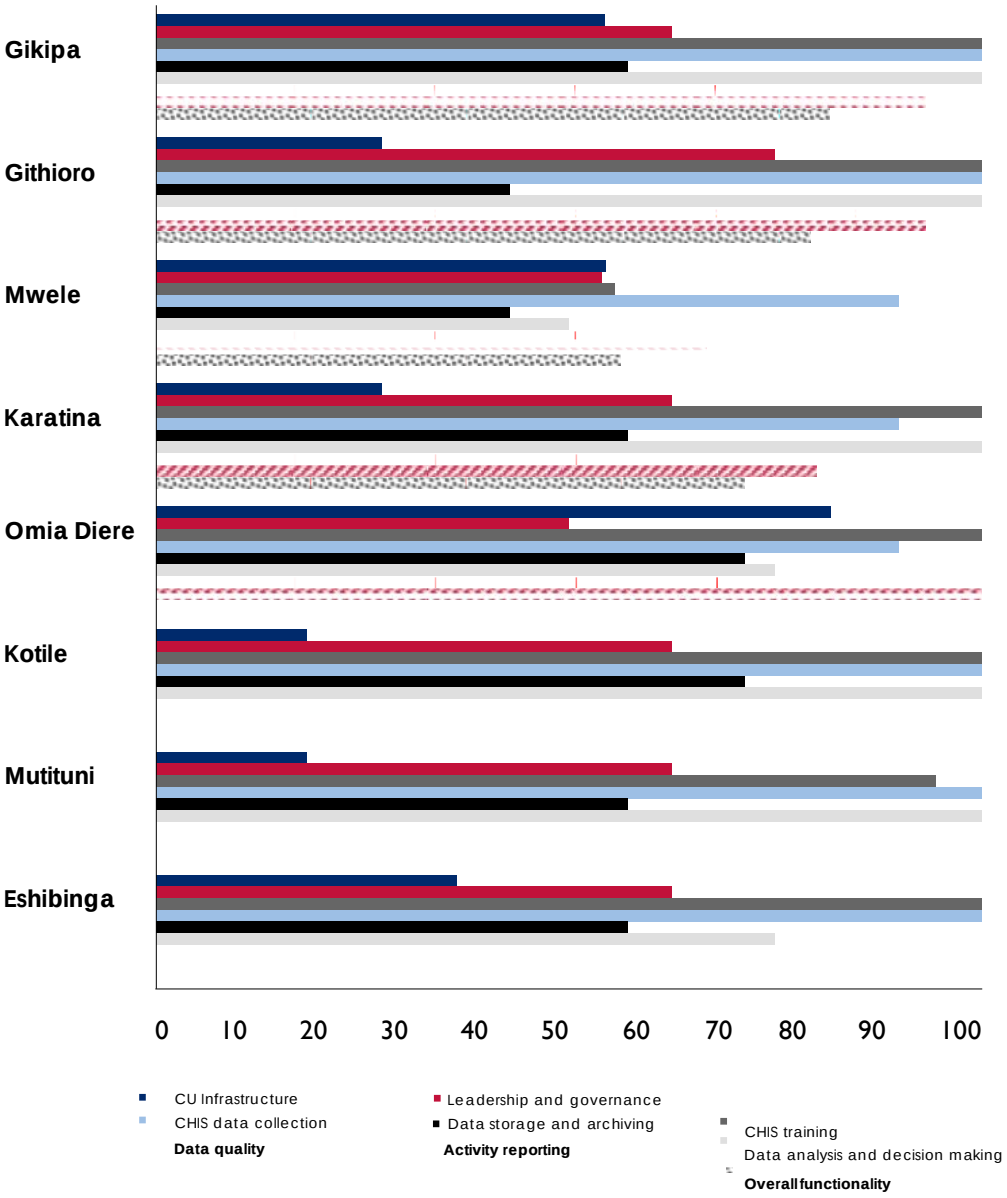



Source: Baseline and endline project assessments (2013)

Progress was measured through concrete outputs and outcomes. The assessments looked at functional areas of interest, including community unit infrastructure, leadership and governance, CHIS training, CHIS data collection, data storage and archiving, data analysis and decision making, data quality, activity reporting, and overall functionality.

Figure 2 shows that all eight community units that were transformed into CoEs had more than 50 percent overall functionality, with at least six of them rated at 70 percent and two of them at 80 percent functionality. Most of the eight community units did well in CHIS training, CHIS data collection, data analysis and decision making, data quality, and activity reporting. For example, the Mutituni community unit scored 100 percent in data analysis and decision making, data quality, and activity reporting, and 81.6 percent in overall functionality. Progress in these areas was attributed mostly to the MOH tool. Similar findings were observed for the Gikipa community unit.

**Figure 2. Community unit functional areas rated**




The assessment showed that CoEs were robust, integrated community units capable of M&E interventions at Level 1 of the health care delivery system. The assessment also showed that CoEs facilitated data sharing and integrated information systems for enhanced data use to inform evidence-based planning at the community level. Other performance areas included developing network and community partnerships, enabling identification and documentation of emerging best practices, providing lessons learned for improvement, and scaling up of service provision.

# 4 DISCUSSION

## 4.1 Introduction

The community health strategy goal is to improve the health status of Kenyan communities through the initiation and implementation of life cycle-focused health actions at Level 1.

The role played by community health strategy in improving health for all began in 1977 when the World Health Organization member states adopted the Health for All concept. A year later, during the Declaration of Alma-Ata in 1978, countries around the world recognized primary health care as the foundation for achieving Health for All by 2000. This declaration has since been ratified by WHO and several other reinforcement initiatives have been formed. The declaration recognized that (1) all people have a right to individually and collectively participate in the planning and implementation of their own health care and (2) primary health care is an integral part of the health care system.

Since its independence in 1963, Kenya has been an essential part of the group of countries that have ratified international health initiatives. Some initiatives include the primary health care recognition agenda laid out in the Declaration Alma-Ata on Health for All by 2000, the 1987 Bamako initiative, the structural adjustment program on health by the International Monetary Fund and The World Bank in the mid-1980s, and the implementation of the Millennium Development Goals. Despite Kenya's implementation of some of these initiatives, the results on health have been mixed.

Numerous policy changes have taken place in Kenya since the 1990s to revitalize the government's efforts to improve the nation's health. The establishment of the Kenya Health Policy Framework 1994–2010 ensured a comprehensive health approach that encompassed the primary health care approach and addressed issues of equity, social justice, and democracy. To implement the framework, MOH created the first National Health Sector Strategic Plan (NHSSP) 1999–2004 to address some of the pitfalls in Kenya's health system management and service delivery, including improving resource allocations to health, decentralizing health services and management and shifting resources from curative to preventive services, and strengthening governance. Despite these strategies, health indicators did not improve over time.

To address the lack of progress in Kenya's health trends, the government formulated NHSSP II 2005–2010. This strategy embraced the primary health care approach. The key principles driving this strategy included advocating increased equitable access to health services; improving quality, efficiency, and effectiveness of service delivery; enhancing the regulatory capacity of MOH; fostering partnerships in health; and improving health sector financing. As an improvement from NHSSP I, which did not achieve health outcomes improvement, the Kenyan Government strengthened the implementation framework of the strategy by creating the Joint Programme of Work and Funding to guide the investment decisions in providing health services at the community level. By 2010, clear improvements in various health indicators were evident. For example, infant and under-five mortality declined from 78 and 115 deaths per 1,000 live births in 2003 to 52 and 74 deaths per 1,000 live births,[1] respectively, in 2008–2009. Some of these improvements occurred when the Kenyan Government launched the community health strategy to provide Level 1 health services alongside other levels of the health care system, as stated in the KEPH framework. Vision 2030, Kenya's development program, also recognizes the implementation of the community strategy as a flagship project for the realization of the social pillar. Although formulated in 2006, community health strategy was not implemented until 2008, when MOH-developed CHIS to

implement the strategy and provide monitoring mechanisms.

Based on the community strategy implementation guidelines (MOH 2007), the community health strategy goal was to improve the health status of Kenyan communities by initiating and implementing health actions focused on Level 1 to accomplish these objectives:

- Provide Level 1 services for all population cohorts and socioeconomic groups, including "differently abled persons who also have a fundamental right to life."
- Build capacity of CHEWs and CHVs to provide Level 1 services and strengthen health facility community linkages through effective decentralization and partnerships to implement Level I services.
- Strengthen the community to realize its rights to accessible and quality health care and to seek accountability for facility-based health services.

## 4.2 Results of Implementing MEval-PIMA Support

To track progress toward achieving the goals of the community health strategy, MEval- PIMA initiated and supported efforts to enhance M&E functionality and make health information at the community level more available. One activity was to transform eight community units into CoEs as models to demonstrate best practices.

### 4.2.1 Collaboration and Partnerships

The M&E TWG worked on enhancing M&E functionality with the DCHS unit and various implementers, with DCHS as the lead, and collaborating with other MOH departments. The activities were supported financially and technically by partners that included MEval-PIMA, UNICEF, Japan International Cooperation Agency, African Medical Research Foundation and African Inland Church Kijabe, AfyaInfo, PATHFINDER, JPIEGO, and related MOH departments with similar interests.

The M&E TWG, which was responsible for revising the existing tools, used consensus- building as the cornerstone for this activity, relying on participatory and consultative processes. The multisectoral TWG comprised key government agencies, development partners, professional bodies, institutions, and implementers. The MEval-PIMA project contributed significant financial and technical resources, including hiring a technical expert. Partners contributed in other ways, such as providing logistical support for technical meetings and discussions.

#### 4.2.2 Ownership and Empowerment

The DCHS staff has demonstrated the capacity to prepare M&E plans, AWPs, and annual performance reviews, and the M&E plan has become a widely appreciated tool. DCHS is responsible for reviewing the M&E plan annually to remain responsive to the government's changing priorities. The M&E plan is the DCHS vehicle for routinely monitoring assessments and performance-based services, and it provides a standardized framework for addressing the previous issues of multiple M&E plans and systems.

The M&E plan has enabled partners to pool resources for M&E activities to measure accountability and performance and highlight engagement in diverse aspects. According to DCHS staff, stakeholders have been more responsive to participate in meetings and contribute than in previous initiatives. The support the M&E TWG has received exemplifies how stakeholders and implementing partners can work together to leverage their resources. DCHS staff members have been empowered through skills transfer and acquisition at the M&E TWG meetings and workshops, where M&E tools were revised or developed with staff participation. Other indications are the coordination among the many stakeholders to adopt a unified approach to take services to communities, leverage resources among implementing partners, and use the TWG as an advisory group on M&E issues.

Another indication is the creation of participatory processes where interested players collaborate, participate, and develop partnerships. An indication of the sustainability of the process has been in consensus among participants and in feedback from pilot testing on the revised tools. At every level, user involvement and the sensitization of CHVs and community health focal personnel to the importance of these initiatives have helped community members discern the quality of services being offered and encouraged participation and ownership.

The review of M&E tools for comprehensiveness resulted in numerous improvements. The MOH expressed satisfaction with the revised tools and partner use of parallel tools decreased. CHVs have commented positively on the standardized, integrated CHIS tools that reduced the number of tools they were required to use previously. A review of selected community units indicated marked improvement in reporting (MOH 515, DHIS December 2013). Training and regular internal reviews also have increased DCHS capacity and instituted mechanisms to ensure the transfer of knowledge and practices with minimum external assistance.

## 5 LESSONS LEARNED

The health care system in Kenya has focused on Level 1 services to correct disparities and empower households and communities to demand improved care and take an active role in influencing health services. The extent and quality of the services provided are based on how resources are allocated and the capacity of health workers and committees to organize and support community units.

Assessments based on information collected from the community units help gauge effectiveness, and these measurements are then used for planning. The MEval-PIMA project used selected community units as CoEs to demonstrate best practices that built on lessons learned. Following are summaries of some of the lessons learned during the transformation of community units into CoEs.

**Ownership, consensus-building, and partner engagement.** DCHS ownership and empowerment helped make the process work. The full engagement and commitment of the DCHS staff from the start and the consensus building among the various stakeholders were cornerstones for the success of the project. DCHS support was provided through a consultative engagement with all partners through the M&E TWG. The multisectoral TWG comprised of key government agencies, development partners, professional bodies and institutions, and implementers to spearhead the entire development process.

**Value for locally driven ideas to drive change.** Transforming the community units into CoEs provided local platforms for the units to explore their potential in planning and advocacy issues by

using health data. The CoEs also served as points for institutional learning through exchange visits.

**Investment compared to impact.** Major investments may not always be the cure-all to ensuring functional structure at the community level. The concept of CoEs, as implemented by the project, demonstrated a modest-cost approach by combining research into inequities and monitoring progress, advocacy, and community participation to promote the use of information for change and community involvement. CoEs enabled enhanced feedback, information sharing, identification of health problems, and data use. With this enhanced information, CoEs were able to improve systems for skilled deliveries and family planning, community referrals, and latrine facilities. The models also encouraged peer learning and the implementation of health actions.

**Community empowerment and data use.** The CoE concept brought community empowerment to use data for decision making. For example, the Omia Diere community unit embraced mobile technology, and consequently it became the center for visits by other community units. The community unit became the center for data generation, analysis, and quality assurance, which led to improved activity reporting (DHIS2 December 2013).

**Learning and exchange beyond the purpose.** Just as the CoEs were the heart of learning and information exchange, the availability of usable data fed further improvement. During the project's two years, community units participated in exchange visits to promote cross- community unit institutional learning in M&E, and the learning transcended to other areas of the health care community.

**Bridging the equity gap in information sharing.** The CoEs were implemented in eight regions that had varied geographical and economic conditions, such as nomadism, poor infrastructure, harsh climates, vastness, insecurity, and scarcity of human capital. For example, the Kotile community unit serves a typically nomadic population in the North Eastern region of Kenya. Through the other CoEs, Kotile was exposed to health information on new ways to deal with disadvantaged groups and apply scalability. The information helped to bridge the equity gap among disadvantaged groups in the community.

**Shared synergy among partners.** The CoEs brought partners and their experiences together in their implementation sites. The M&E TWG meetings provided an opportunity to share experiences and offered insights on how to mitigate issues that became clearer through the CoEs. This sharing revealed financial and technical resource contribution implications, and evoked partners' pride in their involvement at their respective sites. Through the project leadership, the DCHS, stakeholders, implementing partners, and the communities they served are all responsible for coordinating to support the CoEs. The result of the CoE model concept, captured in the most significant change exercise, was overwhelmingly positive and indicated that the support provided through the MEval-PIMA project enabled the community units to meet their objectives for effectiveness in monitoring and evaluation to provide evidence-based data for use in decision making.

**Information sharing and convergence of innovations.** Knowledge exchange visits to community units also revealed some of the specific challenges in data collection, management, reporting, and use. The CoE concept identified, tested, and shared innovations to overcome some of the most pressing challenges in data collection and use. Some of those innovations, such as mobile solutions, included alternative approaches to exclusive paper- based CHIS tools, and results after testing were mixed. CoEs became the epicenter in the attempt to address disparities in health services, especially

in areas that affected vulnerable societies. The disparities are the result of several factors, such as a lack of quality information to inform planning for health services and limited participation in decision making on health care provision and planning. The project was able to address inequity of access to health services by supporting the set-up and strengthening of the community voice through evidence-based decisions on health services provision and strengthened functionality and governance of community units.

**Inadequacy of funds.** During the implementation of the CoEs, some activities were not allocated adequate time. For example, three months were allotted for pretesting, but that proved to be inadequate, and as a result, data either were not reported to DHIS or DHIS did not record it. Another example was that in some cases, a lack of basic commodities in CHW kits prevented them from applying the skills they had gained during training. Sustaining the gains made remains a challenge, especially after the community health strategy became a non-core priority for several partner organizations, and the MOH restructuring to a devolved system of governance strongly affected the knowledge base and reporting systems.

Although the development of the M&E plan attracted wide stakeholder participation, subsectoral collaboration within MOH was minimal. M&E falls under the MOH department of planning, and the department's active participation during the development would have given a much needed impetus. This participation, however, resulted only partially by bridging the thinking process by using the sectorial blueprint. Progress would have been faster if the planning directorate had been involved earlier.

During the M&E TWG discussions on the tools revision, an agreement was reached that a test version of the revised tools would be available in the DHIS2 system for users to become familiar with them through practical use. It was evident that this was not achieved because few users navigated the site. Every time the TWG met, more updates were needed, which could have been done through the DHIS2, if it had been available.

Overall, MEval-PIMA support was crucial to ensure achievement of the MOH goals set out in the community health strategy. The support provided ranged from technical to logistical help to ensure that DCHS had the capacity to learn and sustain the systems and tools for data collection, reporting, and use with minimum support.

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## Annex 1: Candidate Center of Excellence Profiles

Eshibinga

Gikipa

Githioro

Karatina

Kotile

Mutituni

Mwele

Omia Diere

# Eshibinga Community Unit Functionality Summary

| | | | |
|---|---|---|---|
| | | | **Total Functionality Score: 69.0%** |
| Catchment population: | 4,874 | Date updated: | 08/25/14 |
| Current status of unit: | Fully functional | Households: | 1,159 |
| CHIS capacity score: | Sustaining | Number of active CHWs: | 10 |
| Information | | | |
| County: | Kakamega | MCUL code: | 600735 |
| Subcounty: | Khwisero | MFL code: | 15940 |
| Ward: | East Khwisero | Link facility name: | Khwisero Health Center |
| Established: | January 2009 | | |
| CHW Preparedness | | Partner Support | |
| CHW training conducted: | February 2009 | Names of partners: | MEASURE Evaluation PIMA, APHIAPLUS |
| CHW trained in national basic module: | 50 | Support received: | CHIS tools, monthly action days, monthly dialog days, training, transportation |
| CHW trained in technical modules: | 10 | Community unit reports to non-GOK: | PIMA |
| | | Community unit services: | Rearing of chickens |
| CU Infrastructure | | Overall Score: | 36.4% |
| Access to DHIS: | Yes | | |
| Motorcycle: | No | Badges: | No |
| Bicycle: | Yes | Monthly stipend: | No |
| Electricity: | Yes | Computer access: | Shared |
| Internet access: | Shared | Mobile phone: | No |
| Leadership and Governance | | Overall Score: | 62.5% |
| Number of CHC members: | 10 | Membership composition: | Partial |
| Monthly meeting conducted in last three months: | Yes | CHC meeting minutes exist: | Yes |
| Monthly supervision from CHEW: | Yes | Documentation of visit: | No |
| Reasons for no supervision: | N/A | Reasons for no documentation: | CHEW make rough notes but no formal report |
| CHIS | | Overall Score: | 69.0% |

*CHIS Training*

| | | | |
|---|---|---|---|
| Overall score: | 100% | | |
| | Collection | Collation and cleaning | Data use |
| CHW | Yes | Yes | Yes |
| CHEW | Yes | Yes | Yes |
| CHC | Yes | Yes | Yes |

*CHIS Data Collection*

| | | | |
|---|---|---|---|
| Overall score: | 100.0% | | |
| | Data available | | Data available |
| MOH 513 | Yes | MOH 515 | Yes |
| MOH 514 | Yes | MOH 516 | Yes |
| Collected according to national guideline: | Yes | | |

*mHealth Tools*

| | | | |
|---|---|---|---|
| Overall score: | 0.0% | | |
| Has mHealth tools for collection: | No | Using mHealth tools for collection: | No |

*Data Storage and Archiving*

| | | | |
|---|---|---|---|
| Overall score: | 57.1% | | |
| Link facility has dedicated storage space for CHIS storage: | Yes | Written policy in place on how source documents are to be archived and managed): | No |
| Policy in place to guide access to data: | No | Archived, stored data is accessible for routine use: | Yes |
| Storage space has security measures in place to limit access according to policy: | Yes | Method of data storage and archiving: | All manual |

*Data Analysis for Decision Making*

| | | | |
|---|---|---|---|
| Overall score: | 75.0% | | |
| The community has clearly documented data processing steps performed at each level of the system for quality: | No | CHIS data is accessible to Sub-CHMT through monthly reports from the community unit (MOH 515): | Yes |
| Supplemental analysis is conducted on the data for use in decision-making processes: | No | Does the subcommunity health management team use CHIS data to inform routine decision making: | Yes |

*Data Quality*

| | |
|---|---|
| Overall score: | 41.7% |
| The community unit has clearly documented data processing steps performed at each level of the system for quality purposes? | No |

| | | | |
|---|---|---|---|
| | Data quality reviewed: | | Data quality reviewed: |
| MOH 513 | Partial | MOH 515 | Yes |
| MOH 514 | Partial | MOH 516 | Partial |
| Written procedure on how to address late or missing (unreported) data: | No | Feedback is systematically provided to all subreporting levels on the quality of their reporting: | No |
| *Activity Reporting* | | | |
| Overall score: | 73.3% | | |
| Monthly dialog days conducted in last quarter: | Yes | Action days conducted in last quarter: | Yes |
| MOH 514 reported monthly: | Partial | MOH 516 reported monthly: | Partial |
| MOH 515 reported monthly: | Yes | MOH 515 entered into DHIS: | Yes |
| Data shared at subcounty forums: | Yes | Community unit receives feedback on monthly reports: | No |
| Unit has on-site access to DHIS: | Yes | Community unit reports to Non-GOK entities: | No |

## Gikipa Community Unit Functionality Summary

| | | | |
|---|---|---|---|
| | | **Total Functionality Score:** | **81.6%** |
| Catchment population: | 7,780 | Date updated: | 08/14/14 |
| Current status of unit: | Fully functional | Households: | 3,250 |
| CHIS capacity scale: | Sustaining | Number of active CHWs: | 45 |
| Information | | | |
| County: | Nairobi | MCUL code: | 601622 |
| Subcounty: | Embakasi | MFL code: | 13016 |
| Ward: | Savannah | Link facility name: | Kayole 2 subdistrict district |
| Established: | September 2011 | | |
| CHW Preparedness | | Partner Support | |
| CHW training conducted: | September 2011 | Names of partners: | MEASURE Evaluation |
| CHW trained in national basic module: | 50 | Support received: | CHIS tools, monthly dialog days, training |
| CHW trained in technical modules: | 50 | Community unit reports to non-GOK: | PIMA |
| | | Community unit services: | Unknown |
| Community Unit Infrastructure | | Overall score: | 54.4% |
| Access to DHIS: | No | | |
| Motorcycle: | Yes | Badges: | Yes |
| Bicycle: | Yes | Monthly stipend: | No |
| Electricity: | Yes | Computer access: | Shared |
| Internet access: | Shared | Mobile phone: | No |
| Leadership and Governance | | Overall score: | 62.5% |
| Number of CHC members: | 12 | Membership composition: | Partial |
| Monthly meeting conducted in last three months: | Yes | CHC meeting minutes exist: | Yes |
| Monthly supervision from CHEW: | No | Documentation of visit: | No |
| Reasons for no supervision: | CHEW supervision visit is done once a week | | |

| CHIS | | Overall Score: | 81.6% |
|---|---|---|---|
| *CHIS training* | | | |
| Overall score: | 100% | | |
| | Collection | Collation and cleaning | Data use |
| CHW | Yes | Partial | Yes |
| CHEW | Yes | Partial | Yes |
| CHC | Yes | Partial | Yes |
| *CHIS Data Collection* | | | |
| Overall score: | 100% | | |
| | Data available | | Data available |
| MOH 513 | Yes | MOH 515 | Yes |
| MOH 514 | Yes | MOH 516 | Yes |
| Collected according to national guideline: | Yes | | |
| *mHealth Tools* | | | |
| Overall score: | 0.0% | | |
| Has mHealth tools for collection: | No | Using mHealth tools for collection: | No |
| *Data Storage and Archiving* | | | |
| Overall score: | 57.1% | | |
| Link facility has dedicated storage space for CHIS storage: | Yes | Written policy in place on how source documents are to be archived and managed): | No |
| Policy in place to guide access to data: | No | Archived, stored data is accessible for routine use: | Yes |
| Storage space has security measures in place to limit access according to policy: | Yes | Method of data storage and archiving: | All manual |
| *Data Analysis for Decision Making* | | | |
| Overall score: | 100.0% | | |
| The community unit has clearly documented data processing steps performed at each level of the system for quality: | Yes | CHIS data is accessible to subcommunity health management team through monthly reports from the community unit (MOH) | Yes |
| Supplemental analysis is conducted on the data for use in decision-making processes: | Yes | Does the subcommunity health management team use CHIS data to inform routine decision making: | Yes |
| *Data Quality* | | | |
| Overall score: | 83.3% | | |

| | | | |
|---|---|---|---|
| Community unit has clearly documented data processing steps performed at each level of the system for quality? | | | Yes |
| | Data quality reviewed | | Data quality reviewed |
| MOH 513 | Yes | MOH 515 | Partial |
| MOH 514 | Yes | MOH 516 | Yes |
| Written procedure on how to address late or missing (unreported) data: | No | Feedback is systematically provided to all subreporting levels on the quality of their reporting : | Yes |
| *Activity Reporting* | | | |
| Overall score: | 93.3 % | | |
| Monthly dialog days conducted in last quarter: | Yes | Action days conducted in last quarter: | Yes |
| MOH 514 reported monthly: | Yes | MOH 516 reported monthly: | Yes |
| MOH 515 reported monthly: | Yes | MOH 515 entered into DHIS: | Yes |
| Data shared at subcounty forums: | Yes | Community unit receives feedback on monthly reports: | Yes |
| Unit has on-site access to DHIS: | No | Community unit reports to non-GOK entities: | Yes |

# Githioro Community Unit Functionality Summary

| | | | |
|---|---|---|---|
| | | **Total Functionality Score:** | **79.3** |
| Catchment population: | 5,000 | Date updated: | 09/12/14 |
| Current status of unit: | Fully functional | Households: | 960 |
| CHIS capacity scale: | Sustaining | Number of active CHWs: | 24 |
| Information | | | |
| County: | Nakuru | MCUL code: | 999905 |
| Subcounty: | Nakuru North | MFL code: | Unknown |
| Ward: | Dundori | Link facility name: | Dundori Health Center |
| Established: | February 2009 | | |
| CHW preparedness | | Partner support | |
| CHW training conducted: | October 2012 | Names of partners: | MEASURE Evaluation |
| CHW trained in national basic module: | 25 | Support received: | CHIS tools, monthly action days, monthly dialog days, training |
| CHW trained in technical modules: | 25 | Community unit reports to non- GOK: | PIMA |
| | | Community unit services: | Soap making, cake baking, and table banking |
| Community unit infrastructure | | Overall score: | 27.3% |
| Access to DHIS: | No | | |
| Motorcycle: | No | Badges: | Yes |
| Bicycle: | Yes | Monthly stipend: | No |
| Electricity: | Yes | Computer access: | No |
| Internet access: | No | Mobile phone: | No |
| Leadership and governance | | Overall score: | 75.0% |
| Number of CHC members: | 11 | Membership composition: | All |
| Monthly meeting conducted in last three months: | Yes | CHC meeting minutes exist: | Yes |
| Monthly supervision from CHEW: | No | Documentation of visit: | No |
| Reasons for no supervision: | Lack of facilitation by the link facility | | |

| CHIS | | | Overall score: | 79.3% |
|---|---|---|---|---|
| *CHIS Training* | | | | |
| Overall score: | 100% | | | |
| | Collection | Collation and cleaning | Data use | |
| CHW | Yes | Yes | Yes | |
| CHEW | Yes | No | Yes | |
| CHC | Yes | Unknown | Yes | |
| *CHIS Data Collection* | | | | |
| Overall score: | 100% | | | |
| | Data available | | | Data available |
| MOH 513 | Yes | | MOH 515 | Yes |
| MOH 514 | Yes | | MOH 516 | Yes |
| Collected according to national guideline: | Yes | | | |
| *mHealth Tools* | | | | |
| Overall score: | 0.0% | | | |
| Has mHealth tools for collection: | No | | Using mHealth tools for collection: | No |
| *Data Storage and Archiving* | | | | |
| Overall score: | 42.9% | | | |
| Link facility has dedicated storage space for CHIS storage: | No | | Written policy in place on how source documents are to be archived and managed): | Yes |
| Policy in place to guide access to data: | No | | Archived, stored data are accessible for routine use: | Yes |
| Storage space has security measures in place to limit access according to policy: | No | | Method of data storage and archiving: | All manual |
| *Data Analysis for Decision Making* | | | | |
| Overall score: | 100% | | | |
| The community unit has clearly documented data processing steps performed at each level of the system for quality: | Yes | | CHIS data is accessible to subcommunity health management team through monthly reports from the community unit (MOH 515): | Yes |

| | | | |
|---|---|---|---|
| Supplemental analysis is conducted on the data for use in decision-making processes: | Yes | Does the subcommunity health management team use CHIS data to inform routine decision making: | Yes |

*Data Quality*

| | |
|---|---|
| Overall score: | 91.7% |
| The community unit has clearly documented data processing steps performed at each level of the system for quality purposes? | Yes |

| | Data quality reviewed | | Data quality reviewed |
|---|---|---|---|
| MOH 513 | Yes | MOH 515 | Yes |
| MOH 514 | Yes | MOH 516 | Yes |
| Written procedure on how to address late or missing (unreported) data: | No | Feedback is systematically provided to all subreporting levels on the quality of their reporting: | Yes |

*Activity Reporting*

| | | | |
|---|---|---|---|
| Overall score: | 93.3% | | |
| Monthly dialog days conducted in last quarter: | Yes | Action days conducted in last quarter: | Yes |
| MOH 514 reported monthly: | Yes | MOH 516 reported monthly: | Yes |
| MOH 515 reported monthly: | Yes | MOH 515 entered into DHIS: | Yes |
| Data shared at subcounty forums: | Yes | Community unit receives feedback on monthly reports: | Yes |
| Community unit has on-site access to DHIS: | No | Community unit reports to non-GOK entities: | Yes |

## Kiratina Community Unit Functionality Summary

| | | | |
|---|---|---|---|
| | | **Total functionality score:** | **71.3%** |
| Catchment population: | 14,000 | Date updated: | 08/20/14 |
| Current status of unit: | Fully functional | Households: | 2,500 |
| CHIS capacity scale: | Sustaining | Number of active CHWs: | 42 |
| Information | | | |
| County: | Kirinyaga | MCUL code: | 601529 |
| Subcounty: | Kirinyaga North | MFL code: | 11092 |
| Ward: | Mwea | Link facility name: | Thiba Health Centre |
| Established: | September 2011 | | |
| CHW preparedness | | Partner support | |
| CHW training conducted: | September 2011 | Names of partners: | PIMA |
| CHW trained in national basic module: | 50 | Support received: | CHIS tools, monthly dialog days, other, training, transportation |
| CHW trained in technical modules: | 25 | Community unit reports to non-GOK: | NPIMA |
| | | Community unit services: | Pig rearing, growing sweet potatoes |
| Community unit infrastructure | | Overall score: | 27.3% |
| Access to DHIS: | Yes | | |
| Motorcycle: | No | Badges: | No |
| Bicycle: | No | Monthly stipend: | No |
| Electricity: | Yes | Computer access: | Shared |
| Internet Access: | Shared | Mobile phone: | No |
| Leadership and governance | | Overall score: | 62.5% |
| Number of CHC members: | 6 | Membership composition: | Partial |
| Monthly meeting conducted in last three months: | Yes | CHC meeting minutes exist: | Yes |
| Monthly supervision from CHEW: | Yes | Documentation of visit: | No |
| Reasons for no supervision: | Unknown | | |

## Kotile Community Unit Functionality Summary

| | | | | |
|---|---|---|---|---|
| | | | **Total Functionality Score:** | **78.2%** |
| Catchment Population: | 2,152 | | Date Updated: | 06/25/13 |
| Current Status of Unit: | Fully functional | Households: | 405 | |
| CHIS capacity scale: | sustaining | | Number of active CHWs: | 35 |
| Information | | | | |
| County: | Garissa | | MCUL code: | 601714 |
| Subcounty: | Ijara | | MFL code: | 13385 |
| Ward: | Masalani | | Link facility Name: | Kotile Health Centre |
| Established: | October 2010 | | | |
| CHW preparedness | | | Partner support | |
| CHW training conducted: | October 2010 | | Names of partners: | MEASURE Evaluation |
| | | | Support received: | CHIS tools, monthly action days, monthly dialog days, other, training, transportation |
| CHW trained in national basic module: | 35 | | | |
| CHW trained in technical modules: | 35 | | Community Unit reports to non-GOK: | PIMA |
| | | | Community unit services: | Rearing goats |
| Community unit infrastructure | | | Overall score: | 18.2% |
| Access to DHIS: | No | | | |
| Motorcycle: | No | | Badges: | Yes |
| Bicycle: | Yes | | Monthly stipend: | No |
| Electricity: | No | | Computer access: | No |
| Internet Access: | No | | Mobile phone: | No |
| Leadership and governance | | Overall Score: | 62.5% | |

| | | | |
|---|---|---|---|
| Number of CHC members: | 13 | Membership composition: | Partial |
| Monthly meeting conducted in last three months: | Yes | CHC meeting minutes exist: | Yes |
| Monthly supervision from CHEW: | Yes | Documentation of visit: | Yes |
| Reasons for no supervision: | N/A | | |

| CHIS | | | Overall score: | 78.2% |
|---|---|---|---|---|
| *CHIS Training* | | | | |
| Overall score: | 100% | | | |
| | Collection | Data use | Collation and cleaning | |
| CHW | Yes | Yes | Yes | |
| CHEW | Yes | Yes | Yes | |
| CHC | Yes | Yes | Yes | |
| *CHIS data collection* | | | | |
| Overall score: | 100.0% | | | |
| | Data available | | | Data available |
| MOH 513 | Yes | | MOH 515 | Yes |
| MOH 514 | Yes | | MOH 516 | Yes |
| Collected according to national guideline: | Yes | | | |
| *mHealth Tools* | | | | |
| Overall score: | 0.0% | | | |
| Has mHealth tools for collection: | No | | Using mHealth tools for collection: | No |
| *Data Storage and Archiving* | | | | |
| Overall score: | 71.4% | | | |
| Link facility has dedicated storage space for CHIS storage: | Yes | | Written policy in place on how source documents are to be archived and managed): | Yes |
| Policy in place to guide access to data: | No | | Archived, stored data is accessible for routine use: | Yes |
| Storage space has security measures in place to limit access according to policy: | Yes | | Method of data storage and archiving: | All manual |
| *Data analysis for decision making* | | | | |
| Overall score: | 100% | | | |

| | | | |
|---|---|---|---|
| Community unit has clearly documented data processing steps performed at each level of the system for quality purposes: | Yes | CHIS data is accessible to subcommunity health management team through monthly reports from the community unit (MOH 515): | Yes |
| Supplemental analysis is conducted on the data for use in decision-making processes: | Yes | Does the subcommunity health management team use CHIS data to inform routine decision making: | Yes |
| *Data Quality* | | | |
| Overall score: | 100% | | |
| Community unit has clearly documented data processing steps performed at each level of the system for quality purposes? | | | Yes |
| | Data quality reviewed | | Data quality reviewed |
| MOH 513 | Yes | MOH 515 | Yes |
| MOH 514 | Yes | MOH 516 | Yes |
| Written procedure on how to address late or missing (unreported) data: | Yes | Feedback is systematically provided to all sub-reporting levels on the quality of their reporting : | Yes |
| *Activity Reporting* | | | |
| Overall score: | 80.0% | | |
| Monthly dialog days conducted in last quarter: | Yes | Action days conducted in last quarter: | No |
| MOH 514 reported monthly: | Yes | MOH 516 reported monthly: | Yes |
| MOH 515 reported monthly: | Yes | MOH 515 entered into DHIS: | Yes |
| Data shared at subcounty forums: | Yes | Community unit receives feedback on monthly reports: | Yes |
| Unit has on-site access to DHIS: | No | Community unit reports to Non-GOK entities: | No |

## Mutituni Community Unit Functionality Summary

| | | | |
|---|---|---|---|
| | | **Total functionality score:** | **81.6%** |
| Catchment population: | 6,201 | Date updated: | 08/21/14 |
| Current status of unit: | Fully functional | Households: | 1,007 |
| CHIS capacity scale: | sustaining | Number of active CHWs: | 45 |
| Information | | | |
| County: | Machakos | MCUL code: | 602028 |
| Sub County: | Machakos | MFL code: | 12602 |
| Ward: | Mutituni | Link facility name: | Mutituni Health Centre |
| Established: | September 2007 | | |
| CHW preparedness | | Partner Support | |
| CHW training conducted: | September 2007 | Names of partners: | MEASURE Evaluation |
| CHW trained in national basic module: | 50 | Support received: | CHIS tools, monthly action days, monthly dialog days, training |
| CHW trained in technical modules: | 23 | CU reports to non-GOK: | PIMA |
| | | CU Services: | Unknown |
| Community unit infrastructure | | Overall score: | 18.2% |
| Access to DHIS: | Yes | | |
| Motorcycle: | Yes | Badges: | No |
| Bicycle: | No | Monthly stipend: | No |
| Electricity: | Yes | Computer access: | No |
| Internet Access: | No | Mobile phone: | No |
| Leadership and governance | | Overall score: | 62.5% |
| Number of CHC members: | 10 | Membership composition: | Partial |
| Monthly meeting conducted in last three months: | Yes | CHC meeting minutes exist: | Yes |
| Monthly supervision from CHEW: | Yes | Documentation of visit: | Yes |
| Reasons for no supervision: | Unknown | | |
| CHIS | | Overall score: | 81.6% |

*CHIS Training*

| | | | |
|---|---|---|---|
| Overall score: | 94.4% | | |
| | Collection | Collation and cleaning | Data use |
| CHW | Yes | Yes | Yes |

| | | | |
|---|---|---|---|
| CHEW | Yes | Yes | Yes |
| CHC | Yes | Partial | Yes |
| *CHIS data collection* | | | |
| Overall score: | 100% | | |
| | Data available | | Data available |
| MOH 513 | Yes | MOH 515 | Yes |
| MOH 514 | Yes | MOH 516 | Yes |
| Collected according to national guideline: | Yes | | |
| *mHealth Tools* | | | |
| Overall score: | 100% | | |
| Has mHealth tools for collection: | Yes | Using mHealth tools for collection: | Yes |
| *Data storage and archiving* | | | |
| Overall score: | 57.1% | | |
| Link facility has dedicated storage space for CHIS storage: | Yes | Written policy in place on how source documents are to be archived and managed): | No |
| Policy in place to guide access to data: | No | Archived, stored data is accessible for routine use: | Yes |
| Storage space has security measures in place to limit access according to policy: | Yes | Method of data storage and archiving: | All manual |
| *Data analysis for decision making* | | | |
| Overall score: | 100% | | |
| Community unit has clearly documented data processing steps performed at each level of the system for quality purposes: | Yes | CHIS data is accessible to subcommunity health management team through monthly reports from the community unit (MOH 515): | Yes |
| Supplemental analysis is conducted on the data for use in decision-making processes: | Yes | Does the subcommunity health management team use CHIS data to inform routine decision making: | Unknown |
| *Data Quality* | | | |
| Overall score: | 100% | | |
| Community unit has clearly documented data processing steps performed at each level of the system for quality purposes? | | | Yes |
| | Data quality reviewed | Data quality reviewed | |
| MOH 513 | Yes | MOH 515 | Yes |
| MOH 514 | Yes | MOH 516 | Yes |

| | | | |
|---|---|---|---|
| Written procedure on how to address late or missing (unreported) data: | Yes | Feedback is systematically provided to all sub-reporting levels on the quality of their reporting : | Yes |
| *Activity reporting* | | | |
| Overall score: | 100% | | |
| Monthly dialog days conducted in last quarter: | Yes | Action days conducted in last quarter: | Yes |
| MOH 514 reported monthly: | Yes | MOH 516 Reported Monthly: | Yes |
| MOH 515 reported monthly: | Yes | MOH 515 Entered into DHIS: | Yes |
| Data shared at subcounty forums: | Yes | Community unit receives feedback on monthly reports: | Yes |
| Community unit has on-site access to DHIS: | Yes | Community unit reports to non-GOK entities: | Yes |

## Mwele Community Unit Functionality Summary

| | | | |
|---|---|---|---|
| | | Total functionality score: | 56.3% |
| Catchment population: | 40,422 | Date updated: | 06/13/13 |
| Current status of unit: | Semi-functional | Households: | 1,341 |
| CHIS capacity scale: | Expanding | Number of active CHWs: | 50 |
| Information | | | |
| County: | Kilifi | MCUL code: | 601754 |
| Subcounty: | Rabai | MFL code: | 11748 |
| Ward: | Rabai | Link facility name: | Rabai Health Centre |
| Established: | September 2009 | | |
| CHW preparedness | | Partner support | |
| CHW training conducted: | October 2009 | Names of partners: | PIMA |
| CHW trained in national basic module: | 50 | Support received: | CHIS tools, CHW volunteer stipend, monthly action days, monthly dialog days, training |
| CHW trained in technical modules: | 0 | Community unit reports to non-GOK: | PIMA |
| | | Community unit services: | Unknown |
| CU Infrastructure | | Overall score: | 54.5% |
| Access to DHIS: | Yes | | |
| Motorcycle: | No | Badges: | Yes |
| Bicycle: | Yes | Monthly stipend: | Yes |
| Electricity: | Yes | Computer access: | Yes |
| Internet Access: | No | Mobile phone: | No |
| Leadership and governance | | Overall score: | 12.54 |
| Number of CHC members: | 9 | Membership composition: | Partial |
| Monthly meeting conducted in last three months: | No | CHC meeting minutes exist: | Unknown |
| Monthly supervision from CHEW: | Yes | Documentation of visit: | No |
| Reasons for no supervision: | Unknown | | |
| CHIS | | Overall score: | 56.3% |
| *CHIS training* | | | |

| | | | |
|---|---|---|---|
| Overall score: | 55.6% | | |
| | Collection | Collation and cleaning | Data use |
| CHW | Yes | Unknown | Yes |
| CHEW | Yes | Unknown | Yes |
| CHC | Yes | Unknown | No |
| *CHIS data collection* | | | |
| Overall score: | 90.0% | | |
| | Data available | | Data available |
| MOH 513 | Yes | MOH 515 | Yes |
| MOH 514 | Partial | MOH 516 | Yes |
| Collected according to national guideline: | Yes | | |
| *mHealth Tools* | | | |
| Overall Score: | 0.0% | | |
| Has mHealth tools for collection: | No | Using mHealth tools for collection: | No |
| *Data storage and archiving* | | | |
| Overall score: | 42.9% | | |
| Link facility has dedicated storage space for CHIS storage: | Yes | Written policy in place on how source documents are to be archived and managed): | No |
| Policy in place to guide access to data: | No | Archived, stored data is accessible for routine use: | Yes |
| Storage space has security measures in place to limit access according to policy: | No | Method of data storage and archiving: | All manual |
| *Data analysis for decision making* | | | |
| Overall score: | 50.0% | | |
| Community unit has clearly documented data processing steps performed at each level of the system for quality purposes: | Unknown | CHIS data is accessible to subcommunity health management team through monthly reports from the community unit (MOH 515): | Yes |
| Supplemental analysis is conducted on the data for use in decision-making processes: | Unknown | Does the subcommunity health management team use CHIS data to inform routine decision making: | Unknown |
| *Data quality* | | | |
| Overall score: | 66.7% | | |
| Community unit has clearly documented data processing steps performed at each level of the system for quality purposes? | | | No |

| | Data quality reviewed | | Data quality reviewed |
|---|---|---|---|
| MOH 513 | Yes | MOH 515 | Yes |
| MOH 514 | Yes | MOH 516 | Yes |
| Written procedure on how to address late or missing (unreported) data: | No | Feedback is systematically provided to all sub-reporting levels on the quality of their reporting : | Unknown |
| *Activity reporting* | | | |
| Overall score: | 66.7% | | |
| Monthly dialog days conducted in last quarter: | Yes | Action days conducted in last quarter: | Yes |
| MOH 514 reported monthly: | Partial | MOH 516 reported monthly: | Partial |
| MOH 515 reported monthly: | Partial | MOH 515 entered into DHIS: | Partial |
| Data shared at subcounty forums: | No | Community unit receives feedback on monthly reports: | Yes |
| Unit has on-site access to DHIS: | Yes | Community unit reports to non-GOK entities: | Yes |

## Omia Diere Community Unit Functionality Summary


| | | | |
|---|---|---|---|
| | | Total Functionality Score: | 81.6% |
| Catchment population: | 6,526 | Date updated: | 08/27/14 |
| Current status of unit: | Fully functional | Households: | 1,548 |
| CHIS capacity scale: | Sustaining | Number of active CHWs: | 17 |
| Information | | | |
| County: | Siaya | MCUL code: | 600409 |
| Subcounty: | Rarieda | MFL code: | 13461 |
| Ward: | Asembo East | Link facility name: | Abidha Health Centre |
| Established: | June 2011 | | |
| CHW preparedness | | Partner support | |
| CHW training conducted: | June 2011 | Names of partners: | MEASURE Evaluation PIMA, Impact Research and Development Organization, K- MET |
| CHW trained in national basic module: | 17 | Support received: | CHIS tools, CHW volunteer stipend, monthly action days, monthly dialog days, training, transportation |
| CHW trained in technical modules: | 17 | Community unit reports to non-GOK: | Unknown |

| | | | |
|---|---|---|---|
| | | Community unit services: | Table banking, selling water guard, every CHW has bought a goat |
| Community unit infrastructure | | Overall score: | 81.8% |
| Access to DHIS: | Yes | | |
| Motorcycle: | Yes | Badges: | Yes |
| Bicycle: | Yes | Monthly stipend: | Yes |
| Electricity: | Yes | Computer access: | Yes |
| Internet access: | Shard | Mobile phone: | Shared |
| Leadership and governance | | Overall score: | 50.0% |
| Number of CHC members: | 17 | Membership composition: | All |
| Monthly meeting conducted in last three months: | Yes | CHC meeting minutes exist: | Unknown |
| Monthly supervision from CHEW: | Yes | Documentation of visit: | Yes |
| Reasons for no supervision: | Unknown | | |
| CHIS | | Overall score: | 81.6% |
| *CHIS training* | | | |
| Overall score: | 100% | | |
| | Collection | Collation and cleaning | Data use |
| CHW | Yes | Yes | Yes |
| CHEW | Yes | Yes | Yes |
| CHC | Yes | Yes | Yes |
| *CHIS data collection* | | | |

| | | | |
|---|---|---|---|
| Overall score: | 90.0% | | |
| | Data available | | Data available |
| MOH 513 | Partial | MOH 515 | Yes |
| MOH 514 | Yes | MOH 516 | Yes |
| Collected according to national guideline: | Yes | | |
| *mHealth tools* | | | |
| Overall score: | 0.0% | | |
| Has mHealth tools for collection: | Partial | Using mHealth tools for collection: | Partial |
| *Data storage and archiving* | | | |
| Overall score: | 71.4% | | |
| Link facility has dedicated storage space for CHIS storage: | Yes | Written policy in place on how source documents are to be archived and managed: | No |
| Policy in place to guide access to data: | No | Archived, stored data are accessible for routine use: | Yes |
| Storage space has security measures in place to limit access according to policy: | Yes | Method of data storage and archiving: | Mixed |
| *Data analysis for decision making* | | | |
| Overall score: | 75.0% | | |
| Community unit has clearly documented data processing steps performed at each level of the system for quality: | No | CHIS data is accessible to subcommunity health management team through monthly reports from the community unit (MOH 515): | Yes |

| | | | |
|---|---|---|---|
| Supplemental analysis is conducted on the data for use in decision-making processes: | No | Does the subcommunity health management team use CHIS data to inform routine decision making: | Yes |

*Data quality*

| | |
|---|---|
| Overall score: | 75.0% |

| | |
|---|---|
| Community unit has clearly documented data processing steps performed at each level of the system for quality? | No |

| | Data quality reviewed | | Data quality reviewed |
|---|---|---|---|
| MOH 513 | Yes | MOH 515 | Yes |
| MOH 514 | Yes | MOH 516 | Yes |
| Written procedure on how to address late or missing (unreported) data: | No | Feedback is systematically provided to all subreporting levels on the quality of their reporting : | No |

*Activity reporting*

| | |
|---|---|
| Overall score: | 100% |

| | | | |
|---|---|---|---|
| Monthly dialog days conducted in last quarter: | Yes | Action days conducted in last quarter: | Yes |
| MOH 514 reported monthly: | Yes | MOH 516 reported monthly: | Yes |
| MOH 515 reported monthly: | Yes | MOH 515 entered into DHIS: | Yes |
| Data shared at subcounty forums: | Yes | Community unit receives feedback on monthly reports: | Yes |
| Unit has on-site access to DHIS: | Yes | Community unit reports to non-GOK entities: | Yes |

## Annex 2: Support Package for Centers of Excellence

1. Human Resources for Health
    a. Training
    b. Human resources requirements: community health committee, community health education workers, community health volunteers, according to the zoning guidelines, which are under deliberation
        - Community health committee: Seven days of training using an approved curriculum
        - Community health education workers: Six months of training using an approved curriculum
        - Community health volunteers: Ten days of basic training using an approved curriculum. Technical modules on maternal and newborn health; water and sanitation health; family planning; nutrition and integrated community case management, and knowledge management
    c. County and subcounty sensitization
    d. Recognition and motivation of the workforce, performance-based stipend
    e. Mentoring and coaching among the workforce, supervisory visits
2. Governance, leadership, and stewardship
    a. Linkages: data flow, how community health volunteers link with community health committees and community health education workers
    b. Health facility management committees
    c. Community health committee composition according to the guidelines
    d. Meetings and minutes
    e. Entry and selection criteria for community health committees and community health volunteers
    f. Stakeholder forums at the county, subcounty, and ward levels
    g. Support supervision for county health management teams to subcounty health management teams, subcounty health management teams to community health units, community health education workers to community health volunteers
    h. Quarterly community health committee meetings
3. Service delivery
    a. Community maternal and newborn health: at least four antenatal care visits, post- natal care, family planning, skilled deliveries, exclusive breastfeeding

b. Child health: immunization, deworming, nutrition

c. ICCM: pneumonia, diarrhea, malaria, malnutrition

d. Water and sanitation health: handwashing practices, availability and use of latrines, access to safe drinking water

e. Monthly action days and quarterly dialog days, monthly community health volunteer meetings with community health education workers

4. Supplies and commodities

   a. Community health volunteer and community health education worker kits, according to guidelines

   b. Rapid diagnostic tests

   c. Bicycles, motorbikes, and maintenance

   d. Stationery

   e. Information, education, and communication materials

   f. Identification items, such as badges and tee shirts

   g. Bags

5. Financing

   a. Access to Health Services Support Fund, National Health Insurance Fund, community-based health insurance, facility improvement fund

   b. Stipends

   c. Performance-based financing

   d. Revolving funds, income-generating activities

   e. Transportation reimbursements

6. Health informatics

   a. All community tools: MOH 513, 514, 515, 516, 100, community treatment and tracking register, inventory card, supervisory checklist

7. Infrastructure

   a. Information technology equipment, computers, Internet connection

   b. Community centers

   c. Data storage facilities, cabinets, shelves

8. Innovations, best practices, emerging issues, models

   a. Guidelines on documentation of self LVs

   b. Documentation of best practices in community health services programming

   c. Annual conference to share best practices in community health information service

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