REPUBLIC OF NAMIBIA
Ministry of Health and Social Services

Health Extension Program Routine Data Collection, Analysis & Reporting Guidelines

DIRECTORATE OF PRIMARY HEALTH CARE SERVICES
FAMILY HEALTH DIVISION
COMMUNITY BASED HEALTH CARE AND SCHOOL HEALTH SUB-DIVISION
Private Bag 13198
Windhoek
Namibia
Tel: (061) 203-2723
Fax: (061) 234-968
Email: docentre@mhss.gov.na
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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-retroviral Treatment
CBHC	Community Based Health Care
DDT	Dichlorodiphenyltrichloroethane
HIV	Human Immunodeficiency Virus
HEC	District Health Extension Coordinator
HEP	Health Extension Program
HEW	Health Extension Worker
HF	Health Facility
HH	Household
HIS	Health Information System
IPC	Interpersonal Communication
ITN	Insecticide Treated Net
LQAS	Lot Quality Assurance Sample
MoHSS	Ministry of Health and Social Services
M&E	Monitoring and Evaluation
PLHIV	People Living With HIV
RMT	Regional Management Team
TB	Tuberculosis
VHC	Village Health Committee

1. Introduction

This guideline details the key steps in Health Extension Program (HEP) routine data collection, analysis and reporting. It contains information on how HEP routine data is managed, reported and analyzed by HEWs, the health facility (HF) supervisor, District Health Extension Coordinator (HEC), Regional Health Management Team (RMT), and at Ministry of Health and Social Services (MoHSS) level. It expands on:

- the data flow
- how data will be collected and data source to be used
- how data will be compiled and analyzed
- the timing for reporting
- tools to be used for reporting
- feedback mechanisms
- data use and dissemination
- data quality assurance mechanisms

The data analysis and reporting should assess the performance of the HEP. As one of the performance monitoring processes, the routine data collection, reporting and analysis should identify opportunities, early signs of potential problems or success, and based on such an assessment, ascertain progress towards outcomes, and suggest practical recommendations on how to resolve problems or optimize initial gains.

The other performance monitoring and feedback processes such as participatory review meetings, supportive supervision, and documentation of good practices are thought to substantiate and complement the routine data collection, analysis and reporting process. There is a need to develop guidance notes for these important performance monitoring elements.

This guideline cannot be used in isolation, it is interlinked with the existing documents, including HEP indicators and definitions, and HEP routine data recording and reporting user guide.

2. Guiding Principles

The following overarching principles guide the HEP Monitoring and Evaluation (M&E) system:

Standardization
Common definitions of indicators, data collection instruments, and data processing and analysis procedures. Without consistent principles and definitions, performance cannot be systematically measured and improved across locations, or over time.

Integration
A single HIS/M&E plan, shared by all partners. Implementation of this principle requires integrating data from different programs into a shared channel from which all derive their information.

Reflection and Learning
On a continuous basis, employ and carry out participatory review and reflection. Primarily, the learning should be based on action, results and critical reflection.

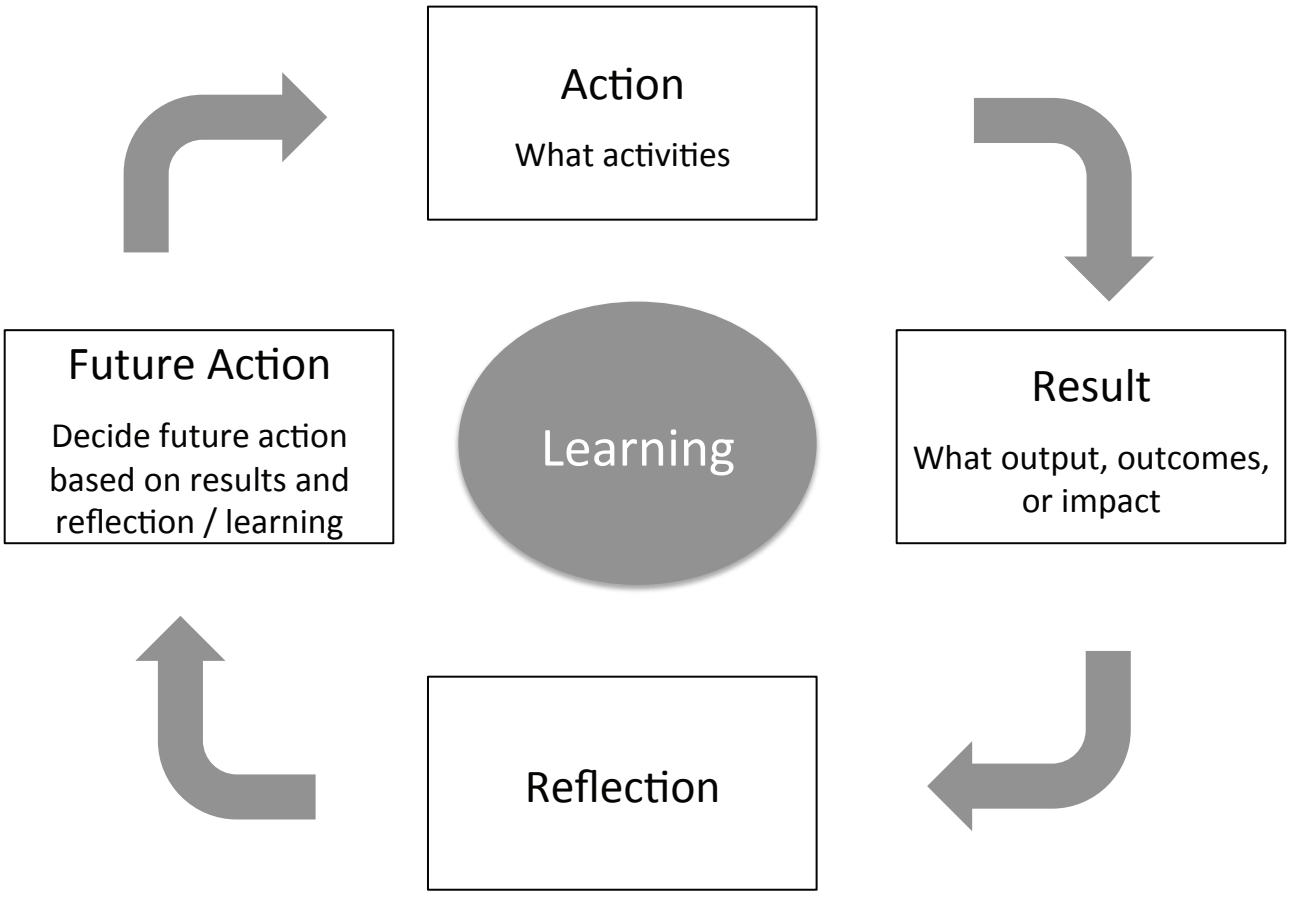

Figure 2.1. **Reflection and Learning**

Simplification
Collecting, analyzing, and interpreting only the information that is immediately relevant to performance improvement makes best use of scarce resources, especially human resources.

3. Data Flow and Management Process

In Figure 3.1, the data flow for programmatic activity reports is presented between the various entities that play a role in the HEP.

Regular review and reflection meetings at health facilities, district and regional level and supportive supervisions will be used to provide feedback to lower levels. Quality of care indicators are best reported through supportive supervision, which also provides the best means of addressing any shortcomings observed.

Every program in the MoHSS has a parallel system of recording and reporting. Health Information System (HIS) forms were developed in 1992, and are still in use. The current HIS did not include HEP, because the program pilot started in 2012. Activities in Community Based Health Care (CBHC) are reported as supportive health services by community health workers, traditional birth attendants, and traditional healers who are affiliated with health facilities.

The current exercise of developing HEP M&E is an opportunity to identify indicators that can be linked to National HIS. A discussion with MoHSS should continue on developing an integrated HIS that includes the HEP interventions.

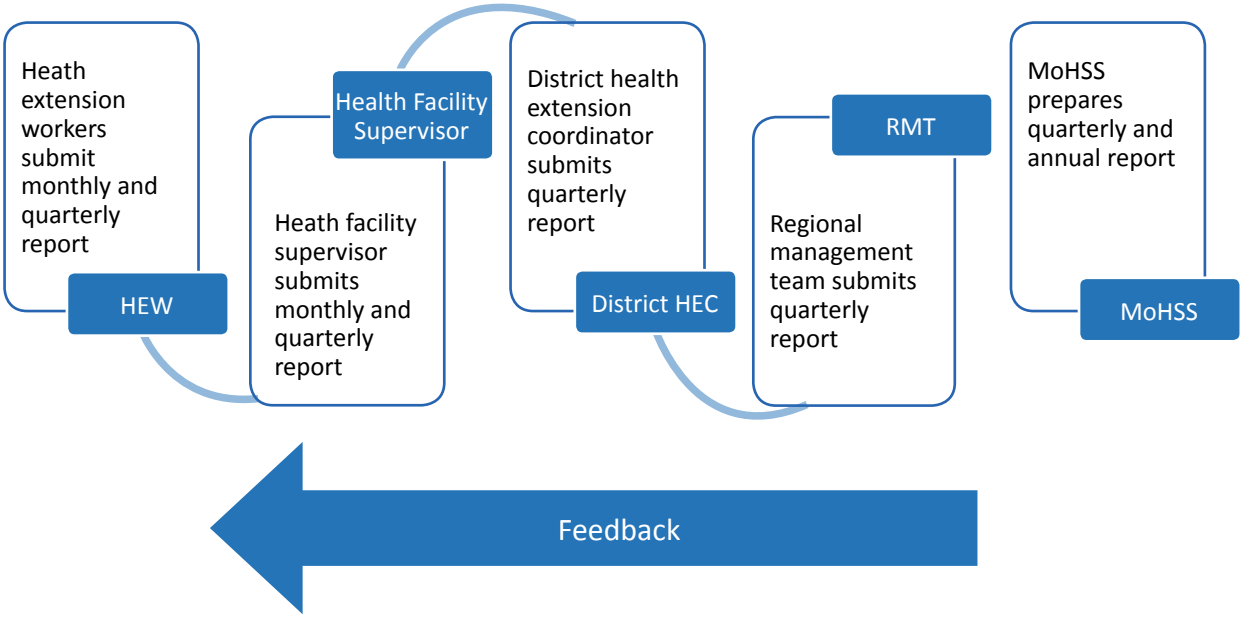

Figure 3.1. **HEP Data Flow**

Basic Assumptions:

- Integrated reporting: The data analysis and reporting beyond the health facility is a suggestion, and should follow through the National HIS policies and guidelines
- The importance of relatively detailed information for HEP use at the community level
- The suggested time line of reporting at all levels is intended to provide enough time for review of results to improve data quality, particularly at the catchment areas; the timeline presumes a manual system; introduction of electronic tr-ansmission from the health facility onwards should reduce the transmission time for reports

3.1. Data Collection, Analysis and Reporting by HEWs

3.1.1. Data Collection

Four types of recording and census forms are developed for routine recording of community based HIS data by HEWs. The purpose of the form, and how each form is used and completed is described in the HEP routine data recording and reporting user guide. The following table summarizes the formats used for daily recording and annual household (HH) and catchment area census.

Form Identification	Form Type	Purpose
HEP form 1	Recording form	Integrated daily activity register and client tracking tool
HEP form 2	Recording form	Maternal & neonatal health individual form; can also be used for client tracking
HEP form 3	HH Census form	Household census register
HEP form 4	Catchment area census form	Catchment area census register

Table 3.1. **HEP Recording and Census Forms for use by HEWs**

3.1.2. Reporting

Two types of reporting forms are developed for routine reporting of community based HIS data by HEWs. The purpose of the form, how each for is used and completed is described in the HEP routine data recording and reporting user guide. The following table summarizes the forms used for reporting.

Form Identification	Form Type	Purpose
HEP form 5	Reporting form	Monthly & quarterly vital event and activity reporting
HEP form 6	Reporting form	Monthly and quarterly disease and disability reporting

Table 3.2. **HEP Reporting Forms for use by HEWs**

When: The monthly and quarterly reporting will be submitted to a health facility within three days after the end of the reporting month. The annual reporting will be submitted within five days after the end of the fiscal year.

The week before the end of each month, the Health Extension Worker (HEW) will call a Village Health Committee (VHC) meeting to share a summary of what cases were found and what was done; and, to discuss problems or relevant topics.

Note: The HEWs will also submit the monthly, quarterly, and annual performance framework to facility supervisors together with the monthly and annual reports.

3.1.3. Data Analysis

Health extension workers will be encouraged to undertake analysis of achievements against the set targets for the specific period and trend analysis for service delivery and utilization.

The monthly and annual HEW plans are the basis for the data analysis. The plans should be developed during the monthly meeting at the facility level under the guidance of the facility supervisor. Analysis will be undertaken based on the achievement of the plan against the set targets on monthly, quarterly and annual basis.

The plan should not be complex, but rather highlight main targets to be accomplished during the month and annually, depending on the type of target. As the HEP evolves, and the HEW gains work experience at the community level, the structure and content of the HEW monthly plan can be adjusted and modified.

The household and catchment area census will be used to establish baseline data, as it provides detailed information about the household members, health conditions and demographic data. The baseline for some indicators that could not be captured on the household and community census could be generated in the first month of the start of the data collection. HEP routine M&E indicators guide the identification of indicators to be analyzed by HEWs on monthly or annual basis.

The following tables summarize the monthly, quarterly and annual performances of HEP at each catchment area.

Monthly performance framework
The purpose of this framework is to track progress in selected indicators on monthly basis. The monthly performance report can be aggregated quarterly and annually to look at trends and annual achievements respectively.

Catchment area:			Month:	
No.	Indicators Number of…	Target Quantity	Achievement Quantity	Remark
1	Pregnant mothers with birth plan			
2	Pregnant mothers visited in the month			
3	Children whose growth monitored			
4	Clients who received HIV counseling & testing			
5	PLHIV on ART visited by HEWs			
6	TB patients visited by HEW in the month			
7	Pregnant women sleeping under ITN			
8	Children under 5 sleeping under ITN			
9	Health promotion activities with groups[1]			
10	HH visited in the month			
11	Cases referred by[2] HEWs			
12	Referral cases who received services at referral facilities[2]			

Table 3.3. **Monthly Performance Framework for HEP at Village Level**

The facility supervisor will guide HEWs set targets by using the following assumptions:

- Review baseline
- Review trends and history
- Take account of VHC meeting inputs
- Take account of national, district and regional targets
- Expert opinion on what is possible or feasible with respect to a particular indicator and setting
- What is being accomplished elsewhere with similar program and setting

The following alternative approaches can be used when setting targets[3]:

1. **Establish a final performance target for the end of the planning period, and then plan progress from the baseline level**. This approach involves deciding on the program's performance target for the fiscal year, and then defining a path of progress for the months in between. When setting interim/monthly targets, remember that progress does not necessarily grow evenly. Final and interim targets should be based on an analysis of realistic achievements, given the stage of implementation, resources, country conditions, and technical constraints.
2. **Set monthly performance targets**. This approach is similar to the preceding, except it is based on judgments about what can be achieved each month, instead of starting with a final performance level and working backwards.

[1] For reporting purpose group education is defined as a health education involving groups other than household members. It could include education conducted in community or social gatherings, schools, etc. Health education during a household visit with an individual or more than one household member is considered IPC.
[2] For these indicators, target could be set after observing trends in the first three months of reporting
[3] USAID Center for Development Information and Evaluation. 1996. *Performance Monitoring and Evaluation Tips: Establishing performance targets.*

Quarterly and Annual Performance

A quarterly and annual performance will be assessed by aggregating the monthly performances. For some indicators whose performance can be assessed only on an annual basis, e.g. indicators #15 through #18, performances will be analyzed on annual basis.

Catchment area:								Year:			
No.	Indicators	Q1		Q2		Q3		Q4		Annual	
		Target	Ach.*	Target	Ach.	Target	Ach.	Target	Ach.	Target	Ach.
1	# of new latrines constructed										
2	# of new hand washing facilities in place										
3	# of pregnant mothers with birth plan										
4	# of pregnant mothers visited										
5	# of children whose growth monitored										
6	# of clients who received HIV counseling & testing										
7	# of PLHIV on ART visited by hews										
8	# of TB patients visited by HEW in the month										
9	# of pregnant women sleeping under ITN										
10	# of children under 5 sleeping under ITN										
11	# of health promotion activities with groups										
12	# of HH visited										
13	# of cases referred by HEW										
14	# of cases who received services at referral facilities										
15	# of HHs using latrine										
16	# of HHs with hand washing facility										
17	# of pregnant mothers who are visited by HEW at least 4 times before delivery										
18	# of HHs sprayed with residual DDT										

* Achievement Quantity

Figure 3.4. **Quarterly and Annual Performance at Village Level**

3.1.4. Data Storage and Confidentiality

Confidentiality means that clients are assured that their data will be maintained according to national and/or international standards. This means that personal information is not disclosed inappropriately, and that data in hard copy and electronic form are treated with appropriate levels of security.

HEWs need to respect confidentiality and not share confidential information with other clients.
To maintain confidentiality and safe storage:

- Keep paper records in locked cabinets
- Protect electronic files and databases (if available) with passwords
- Keep copies of monthly and quarterly reports
- Only allow access to personal data for the staff members who need it
- Train HEWs to respect confidentiality and not share confidential information with other clients
- Prepare a household folder for household census register and maternal and neonatal health individual forms

3.2. Data Management, Analysis and Reporting at Facility Level

3.2.1. Data Collection and Reporting

Three types of reporting forms are developed for routine reporting of community based HIS data by Facility Supervisors. The following table summarizes the purpose of each form and how each form is used and completed. Please refer to **Annex 1** for the details of the forms.

Form Identification	Purpose	Reporting Schedule
HEP summary form F1	To compile activities and vital events that are reported monthly and quarterly by HEWs from catchment areas supervised by the HF	The HF supervisor will submit to the district HEC within 8 days of the following month
HEP summary form F2	To compile monthly, quarterly and annual disease and disability reports of HEWS from catchment areas supervised by the HF	The HF supervisor will submit to the district HEC within 8 days of the following month

Table 3.5. **Facility Supervisor Monthly and Quarterly Reporting Forms**

The HF supervisor will also submit the quarterly and annual performance framework to the District HEC, together with the monthly and annual reports.

Upon receiving the HEW's monthly reports, HF supervisor should quality-check the data:

- Correct reporting period
- Inclusion of all relevant indicators due for reporting
- Complete submission of data sets (no blanks / gaps)
- Data (trends) make sense
- Data accuracy checks using Lot Quality Assurance Sampling technique (LQAS)

3.2.2. Data Analysis

The health facility supervisor will undertake analysis of achievements against the set targets by aggregating the performance frameworks of HEWs who are under his/her supervision, including trend analysis for service delivery and utilization. The aggregated performance framework will be presented and discussed during the monthly meeting with HEWs.

Monthly performance framework

The purpose of this framework is to track progress, in selected indicators, on a monthly basis in the catchment areas under the supervision of a HF supervisor. The monthly performance report can be aggregated quarterly and annually to look at trends and annual achievements respectively.

Please note that the monthly, quarterly, and annual performances will be presented per each catchment area, to see performances of each HEW, and compare areas. The tables below need to be adapted, depending on the number of catchment areas in each facility, and may need to be printed at A3 size (297mm X 420mm), to accommodate all areas. The catchment area name should be inserted before printing.

Catchment areas reporting to facility:								Month:			
No.	Catchment Area	CA1		CA2		CA3		CA4		CA5	
	Indicators	Target	Ach.	Target	Ach.	Target	Ach.	Target	Ach.	Target	Ach.
1	# of pregnant mothers with birth plan										
2	# of pregnant mothers visited in the month										
3	# of children whose growth monitored										
4	# of clients who received HIV counseling & testing										
5	# of PLHIV on ART visited by hews										
6	# of TB patients visited by HEW in the month										
7	# of pregnant women sleeping under ITN										
8	# of children under 5 sleeping under ITN										
9	# of health promotion activities with groups										
10	# of HH visited in the month										
11	# of cases referred by hews										
12	# of referral cases who received services at referral facilities										

Table 3.6. **Monthly Performance Framework by Catchment Area**

Quarterly and Annual Performance

A quarterly and annual performance will be assessed by aggregating the monthly performances. For some indicators, whose performance can be assessed only on an annual basis, e.g. indicators #15 through #21, performances will be analyzed on annual basis.

Catchment areas under the health facility:														Year:							
No	Quarter	Q1				Q2				Q3				Q4				Annual			
	Catchment Area	CA1		CA2		CA1		CA2		CA1		CA2		CA1		CA2		CA1		CA2	
	Indicators	T	A	T	A	T	A	T	A	T	A	T	A	T	A	T	A	T	A	T	A
1	# of new latrines completed in the quarter																				
2	# of new hand washing facilities in place in the quarter																				
3	# of pregnant mothers with birth plan																				
4	# of pregnant mothers visited in the month																				
5	# of children whose growth monitored																				
6	# of clients who received HIV counseling & testing																				
7	# of PLHIV on ART visited by hews																				
8	# of TB patients visited by HEW in the month																				
9	# of pregnant women sleeping under ITN																				
10	# of children under 5 sleeping under ITN																				
11	# of health promotion activities with groups																				
12	# of HH visited in the month																				
13	# of cases referred by HEWs																				
14	# of referred cases who received services at referral facilities																				
15	# of HHs using latrine																				
16	# of HHs with hand washing facility																				
17	# of pregnant mothers who are visited by HEW at least 4 times before delivery																				
18	# of HHs sprayed with residual DDT																				

T: Target A: Achievement

Table 3.7. **Quarterly and Annual Performance by Catchment Area**

3.2.3. Data Storage

To maintain safe storage of reports and performance frameworks:

- Keep reports and performance frameworks submitted by HEWs in a separate locked cabinet in the facility
- Keep copies of monthly and quarterly reports submitted to District
- Protect electronic files and databases (if available) with passwords

3.3. Data Management, Analysis and Reporting at District Level

3.3.1. Data Collection and Reporting

Three different types of reporting formats are developed for routine reporting of community based HIS data by District HEC to the Region. The following table summarizes the purpose, use, and completion for each form. Please refer to **Annex 2** for details on the forms.

Form Identification	Purpose	Reporting Schedule
HEP summary form D1	To compile activities and vital events that is monthly reported by HF supervisors in the District	The District HEC will submit to the (RMT) within 12 days of the following month after each quarter
HEP summary form D2	To compile monthly disease and disability reports of health facility supervisors in the District	The District HEC will submit to the RMT within 12 days of the following month after each quarter

Table 3.8. **District Health Extension Coordinator Reporting Forms**

Upon receiving the health facility supervisor's monthly reports the District HEC should quality-check the data:

- Correct reporting period
- Inclusion of all relevant indicators due for reporting
- Complete submission of data sets (no blanks / gaps)
- Data (trends) make sense

3.3.2. Data Compilation

On quarterly basis, the District HEC will compile facility reports and analyze data using the template below. The indicators definitions provided in the HEP M&E package will be used to calculate the required proportions or numbers for the selected indicators to be compiled on quarterly and annual basis. The denominators for the proportions should only cover health extension program catchment areas within the District, if all villages are not covered by HEP. The quarterly results can be aggregated to see the annual figures of the indicators. Data in the district will be aggregated by facility reports to see performances of each facility and compare results among them.

The tables below need to be adapted, depending on the number of facilities in each district, and may need to be printed at A3 size (297mm X 420mm), to accommodate all facility reports. The facility name should be inserted before printing.

No.	Indicator	Q1			Q2			Q3			Q4			Total Annual		
	Facility:	F1	F2	F3	F1	F2	F3	F1	F2	F3	F1	F2	F3	F1	F2	F3
1	**FIRST AID**															
1.1	# of accidents/injuries managed or referred															
2	**MATERNAL HEALTH**															
2.1	Proportion of mothers visited by HEW 3 times within one week after delivery															
2.2	Proportion of pregnant mothers with birth plan															
2.3	Proportion of home deliveries															
3	**NEONATAL HEALTH**															
3.1	Low birth weight proportion (for home deliveries)															
3.2	Proportion of still births (home delivery)															
3.3	Proportion of neonatal deaths (death occurred at home)															
4	**CHILD HEALTH**															
4.1	Proportion of children with malnutrition															
4.2	Proportion of babies exclusively breast fed															
4.3	# of new under 5 pneumonia cases identified by HEWs															
4.4	Proportion of under five years deaths (death occurred at home)															
5	**HIV & AIDS**															
5.1	HIV testing rate															
5.2	HIV positivity rate															
5.3	# of ART defaulters referred, followed up															
6	**TB**															
6.1	# of suspected TB cases identified															
6.2	# of TB treatment defaulters referred, followed up															
6.3	# of TB contacts traced and referred															
7	**MALARIA**															
7.1	# of new malaria cases identified by HEWs															
7.2	Proportion of pregnant women sleeping under ITN															
7.3	Proportion of children under 5 sleeping under ITN															
8	**SOCIAL WELFARE**															
8.1	# of family violence detected and referred															
8.2	Proportion of eligible HHs not receiving social grant															
8.3	# of substance abuse detected & referred															
8.4	# of suicidal thoughts/behavior detected & referred															
9	**DISABILITY PREVENTION AND REHABILITATION**															
9.1	# of people with disability identified and referred															
10	**HEALTH PROMOTION & REFERRAL SERVICES**															
10.1	# of group health education sessions conducted															
10.2	% of referral cases who received services at HFs															
11	**DATA THAT WILL BE REPORTED AND ANALYZED ANNUALLY**															
11.1	Proportion of HHs using latrine															
11.2	Proportion of HHs with hand washing facility															
11.3	Proportion of pregnant mothers who are visited by HEW at least 4 times before delivery															

Table 3.9. **Quarterly and Annual Data Aggregation Template at District level**

3.3.3. Data Analysis

The comprehensive National Performance Framework (please refer to the health extension program M&E framework) will guide the development of the performance of key community HIS indicators at the District level. The RMT will lead the development of the performance framework for the Regions and Districts.

At the Regional level, decisions will be made to set program performance target for the fiscal year, and then define a path of progress for the quarters between. When setting interim/ quarterly targets, that progress does not necessarily grow evenly. All targets, both final and interim, should be based on a careful analysis of what is realistic to achieve, given the stage of program implementation, resource availabilities, country and regional conditions, technical constraints, etc.

The following criteria will be considered when setting targets at regional and District level:

- Review baseline
- Review trends and history
- Take account of national targets
- Expert opinion on what is possible or feasible with respect to a particular indicator and setting
- What is being accomplished elsewhere with similar program and setting

A total of 16 indicators are selected to be able to track performance of HEP on quarterly and annual basis at District, Regional and National levels. The baselines data, including data sources and means of verifications for data for achievements are elaborated in the M&E framework (please refer to the *Health Extension Program M&E Framework* document).

No	Indicator	Q1		Q2		Q3		Q4		Annual	
		Target	Ach.	Target	Ach.	Target	Ach.	Target	Ach.	Target	Ach.
1	Proportion of mothers visited by HEW 3 times in one week after delivery										
2	Proportion of pregnant mothers with birth plan										
3	Proportion of home deliveries										
4	Proportion of children with malnutrition										
5	HIV testing rate										
6	HIV positivity rate										
7	Proportion of pregnant women sleeping under ITN										
8	Proportion of children under 5 sleeping under ITN										
9	Proportion of eligible HHs not receiving social grant										
10	# of health group education sessions conducted										
11	% of referral cases who received services at HFs										
12	Proportion of HHs using latrine										
13	Proportion of HHs with hand washing facility										
14	Proportion of pregnant mothers who are visited by HEW at least 4 times before delivery										

Table 3.10. **Quarterly and Annual Performance Framework at District Level**

3.4. Data Management and Reporting at Region Level

3.4.1. Data Collection and Reporting

Three different types of reporting formats are developed for routine reporting of community based HIS data by RMT to National MoHSS. The following table summarizes the purpose of each form and how each form is used and completed. Please refer to **Annex 3** for the details of the forms.

Form Identification	Purpose	Reporting Schedule
HEP summary form R1	To compile activities and vital events that is monthly reported by District HECs	The RMT will combine all of the HECs reports in the Region and submit to MoHSS within 16 days of the following month after each quarter
HEP summary form R2	To compile monthly disease and disability reports of HECs	The RMT will combine all of the HEC reports in the Region and submit to MoHSS within 16 days of the following month after each quarter

Table 3.11. **Regional Health Management Team Reporting Forms**

Upon receiving of the District HEC monthly reports the RMT should quality-check the data:

- Correct reporting period
- Inclusion of all relevant indicators due for reporting
- Complete submission of data sets (no blanks / gaps)
- Data (trends) make “sense”

3.4.2. Data Compilation

On quarterly basis the RMT will compile District reports and analyze data using the template below. The indicators definitions provided in the HEP M&E package will be used to calculate the required proportions or numbers for the selected indicators to be analyzed on quarterly and annual basis.

The denominators for the proportions should only cover health extension program catchment areas within the Region. The quarterly results can be aggregated to see the annual performances of the indicators in the Region. Data in the region will be aggregated by district to see performances of each district and compare results among them.

The tables below need to be adapted, depending on the number of districts in each region, and may need to be printed at A3 size (297mm X 420mm), to accommodate all district reports. The district name should be inserted before printing.

No.	Indicator	Q1			Q2			Q3			Q4			Total Annual		
	District:	D1	D2	D3	D1	D2	D3	D1	D2	D3	D1	D2	D3	D1	D2	D3
1	**MATERNAL HEALTH**															
1.1	Proportion of mothers visited by HEW 3 times in one week after delivery															
1.2	Proportion of pregnant mothers with birth plan															
1,3	Proportion of home deliveries															
2	**NEONATAL HEALTH**															
2.1	Low birth weight proportion (for home deliveries)															
2.2	Proportion of still births (for home deliveries)															
2.3	Proportion of neonatal deaths (death occurred at home)															
3	**CHILD HEALTH**															
3.1	Proportion of children with malnutrition															
3.2	Proportion of babies who are exclusively breast fed															
3.3	# of new under five pneumonia cases identified by HEWs															
3.4	Proportion of under five years deaths (death occurred at home)															
4	**HIV & AIDS**															
4.1	HIV testing rate															
4.2	HIV positivity rate															
4.3	# of ART defaulters referred and followed up															
5	**TB**															
5.1	# of suspected TB cases identified															
5.2	# of TB treatment defaulters referred and followed up															
5.3	# of TB contacts traced and referred															
6	**MALARIA**															
6.1	# of new malaria cases identified by HEWs															
6.2	Proportion of pregnant women sleeping under ITN															
6.3	Proportion of children under 5 sleeping under ITN															
7	**SOCIAL WELFARE**															
7.1	Proportion of eligible HHs not receiving social grant															
7.2	# of substance abuse detected and referred															
8	**DISABILITY PREVENTION AND REHABILITATION**															
8.1	# of people with disability identified and referred															
9	**REFERRAL SERVICES**															
9.1	Proportion of referral cases who received services at HFs															
10	**DATA THAT WILL BE REPORTED AND ANALYZED ANNUALLY**															
10.1	Proportion of HHs using latrine															
10.2	Proportion of pregnant mothers who are visited by HEW at least 4 times before delivery															

Table 3.12. **Quarterly Data Aggregation Template at Region Level**

3.4.3. Data Analysis

The comprehensive National level Performance Framework (please refer to health extension program M&E framework) will guide the development of the performance of key HIS indicators at Regional level. The RMTs in consultation with MoHSS will develop the performance framework for all Regions with HEP.

The RMT in consultation with MoHSS will set program's performance target for the fiscal year, and then defining a path of progress for the quarters in between. When setting interim/quarterly targets, remember that progress does not necessarily grow evenly. Final and interim targets should be based on an analysis of realistic achievements, given the stage of implementation, resources, country conditions, and technical constraints.

The following criteria will be considered when setting targets at regional and District level:

- Review baseline
- Review trends and history
- Take account of national targets
- Expert opinion on what is possible or feasible with respect to a particular indicator and setting
- What is being accomplished elsewhere with similar program and setting

A total of 17 indicators are selected to be able to track performance of HEP on quarterly and annual basis at District, Regional and National levels. The baselines data, including data sources and means of verifications for data for achievements are elaborated in the M&E framework (please refer to the health extension program M&E framework document).

No	Indicator	Q1		Q2		Q3		Q4		Annual	
		Target	Ach.	Target	Ach.	Target	Ach.	Target	Ach.	Target	Ach.
1	Proportion of mothers visited by HEW 3 times in one week after delivery										
2	Proportion of pregnant mothers with birth plan										
3	Proportion of home deliveries										
4	Proportion of children with malnutrition										
5	HIV testing rate										
6	HIV positivity rate										
7	Proportion of pregnant women sleeping under ITN										
8	Proportion of children under 5 sleeping under ITN										
9	Proportion of eligible HHs not receiving social grant										
10	# of Health education sessions conducted										
11	Proportion of referral cases who received services at HFs										
12	Proportion of HHs using latrine										
13	Proportion of HHs with hand washing facility										
14	Proportion of pregnant mothers who are visited by HEW at least 4 times before delivery										

Table 3.13. **Annual Performance Framework at Region Level**

3.5. Data Management at National Level

3.5.1. Data Compilation

On quarterly basis the MoHSS will compile District reports and analyze data using the template below. The indicators definitions provided in the HEP M&E package will be used to calculate the required proportions or numbers for the selected indicators to be analyzed on quarterly and annual basis. The denominators for the proportions should only cover health extension program catchment areas within the Country. The quarterly results can be aggregated to see the annual performances of the indicators at National level. Data at national level will be aggregated by region to see performances of each region and compare results among them.

The tables below need to be adopted depending on the number of regions and may need to be printed in A3 size paper to accommodate all regions. In the actual table format the region name should be specified.

No.	Indicators	Q1			Q2			Q3			Q4			Total Annual		
		R1	R2	R3	R1	R2	R3	R1	R2	R3	R1	R2	R3	R1	R2	R3
1	**MATERNAL HEALTH**															
1.1	Proportion of mothers who are visited by HEW 3 times in one week after delivery															
1.2	Proportion of pregnant mothers with birth plan															
1.3	Proportion of home deliveries															
2	**NEONATAL HEALTH**															
2.1	Low birth weight proportion (for home deliveries)															
2.2	Proportion of neonatal deaths (for death occurred at home)															
3	**CHILD HEALTH**															
3.1	Proportion of children with malnutrition															
3.2	Proportion of babies who are exclusively breast fed															
3.3	# of new under five pneumonia cases id'ed by HEWs															
3.4	Proportion of under five years deaths (for death occurred at home)															
4	**HIV & AIDS**															
4.1	HIV testing rate															
4.2	HIV positivity rate															
4.3	# of ART defaulters referred and followed up															
5	**TB**															
5.1	# of suspected TB cases identified															
5.2	# of TB treatment defaulters referred & followed up															
5.3	# of TB contacts traced and referred															
6	**MALARIA**															
6.1	# of new malaria cases identified by HEWs															
6.2	Proportion of pregnant women sleeping under ITN															
6.3	Proportion of children under 5 sleeping under ITN															
7	**SOCIAL WELFARE**															
7.1	Proportion of eligible HHs not receiving social grant															
7.2	# of substance abuse detected and referred															
8	**DISABILITY PREVENTION AND REHABILITATION**															
8.1	# of people with disability identified and referred															
9	**REFERRAL SERVICES**															
9.1	Proportion of referral cases who received services at HF															
10	**DATA THAT WILL BE REPORTED AND ANALYZED ANNUALLY**															
10.1	Proportion of HHs using latrine															
10.2	Proportion of pregnant mothers who are visited by HEW at least 4 times before delivery															

Table 3.14. **Quarterly Data Aggregation Template at National Level**

3.5.2. Data Analysis

The comprehensive National Performance Framework (please refer to the health extension program M&E framework) will guide the development of the performance of key HIS indicators at National Level. The MoHSS HEP coordinating unit will be responsible for developing the performance framework at National level.

The MoHSS HEP coordination unit will set program's performance target for the fiscal year, and then defining a path of progress for the quarters in between. When setting interim/quarterly targets, remember that progress does not necessarily grow evenly. Final and interim targets should be based on an analysis of realistic achievements, given the stage of implementation, resources, country conditions, and technical constraints.

The following criteria will be considered when setting targets at regional and District level:

- Review baseline
- Review trends and history
- Take account of national targets
- Expert opinion on what is possible or feasible with respect to a particular indicator and setting
- What is being accomplished elsewhere with similar program and setting

A total of 17 indicators are selected to be able to track performance of HEP on quarterly and annual basis at District, Regional and National levels. The baselines data, including data sources and means of verifications for data for achievements are elaborated in the M&E framework (please refer to the health extension program M&E framework document).

No	Indicator	Q1		Q2		Q3		Q4		Annual	
		Target	Ach.	Target	Ach.	Target	Ach.	Target	Ach.	Target	Ach.
1	Proportion of mothers visited by HEW 3 times in one week after delivery										
2	Proportion of pregnant mothers with birth plan										
3	Proportion of home deliveries										
4	Proportion of children with malnutrition										
5	HIV testing rate										
6	HIV positivity rate										
7	Proportion of pregnant women sleeping under ITN										
8	Proportion of children under 5 sleeping under ITN										
9	Proportion of eligible HHs not receiving social grant										
10	# of Health education sessions conducted										
11	% of referral cases who received services at health facilities										
12	Proportion of HHs using latrine										
13	Proportion of HHs with hand washing facility										

Table 3.15. **Annual Performance Framework at National Level**

4. Data Display

As HEWs work from home, facilities and District HEC should maintain a minimum set of standard charts and worksheets for data display. The purpose of minimum standard charts and worksheets is to ensure that:

- Basic HEP information is displayed where it will have the widest visibility to HEWs, health facility supervisors, HECs, managers and visitors
- Compare key performances among catchment areas, facilities and districts
- Basic HEP information is regularly updated and monitored

The table below summarizes the minimum display charts to be maintained at health facilities, districts and regions.

Name of chart	Where	Format	Frequency of update
Map of catchment area/s	HF, District, RMT	Map	Annual
Catchment Population Profile	HF, District, RMT	Table	Annual
Catchment areas quarterly and annual performance (Table 3.7)	HF	Table	Quarterly, annual
Maternal and Child Health Chart showing: 1. Proportion of mothers who are visited by HEWs within 24-48 hours after birth 2. Proportion of mothers with birth plan 3. Proportion of children who are malnourished	District, RMT, MoHSS	Line graph	Quarterly
HIV and TB HIV testing and positivity rate; TB contacts traced and referred	District, RMT, MoHSS	Line graph	Quarterly
Social welfare and disability proportion of eligible HHs not receiving social grant; People with disability identified and referred	District, RMT, MoHSS	Line graph	Quarterly
Referral Proportion of referral cases who received services at HF			

Table 4.1. **Minimum Display Charts to be Maintained at Health Facility, District and Region**

5. Data Use and Feedback

5.1. Data Use

Collecting data is only meaningful and worthwhile if it is subsequently used for evidence-based decision-making. The key to effective data use involves linking the data to the decisions that need to be made and to those making these decisions. The decision-maker needs to be aware of relevant information in order to make informed decisions. When decision-makers understand the kinds of information that can be used to inform decisions and improve results, they are more likely to seek out and use this information.

M&E is not only about collecting data, though people spend a lot of time thinking about data sources and data collection tools. HIS/M&E in the HEP context is about using data for:

- Program improvement
- Reporting and accountability
- Advocacy
- Resource mobilization
- Contributing to global knowledge

The term data refers to raw, unprocessed information while information, or strategic information, usually refers to processed data or data presented in some sort of context, such as report, or a performance framework.

The following table summarizes the use of strategic information in HEP, including the reports and performance frameworks, etc. at the different levels of reporting.

Data use	Example	Main user
To guide and enhance service delivery	• Monitor changes in client health seeking, service utilization, and risk behavior • Follow up with clients • Understand client needs • Assess whether services are culturally appropriate	HEWs, HF supervisor, HEC
To communicate program successes and challenges to the community	• Provide information on monthly performance, challenges and lessons learned for VHC • To mitigate challenges • To develop community action plan	HEWs
To discuss program performance and challenges in the facility monthly HEWs meetings	• Discussion on monthly performance, challenges and lessons learned • To mitigate challenges • To develop HEWs monthly plan	HEWs, HF supervisor
To manage and improve program processes and systems by comparing program planning data with actual implementation data	• Monitor activities and performances of catchment areas, facilities, districts and regions • Track and monitor supplies disseminated and expenditures	HF supervisor, District HEC, RMT, MoHSS
To make decisions about the future direction of the program	• Scale up services/expand coverage • Identify new geographical areas and/or other services to be added to the program	District HEC, RMT, MoHSS
To gain additional resources	• Raise funds	MoHSS
To be accountable to community, next level supervisor, donors and other stakeholders	• To report to VHC, next level supervisor, donors, policymakers	HEW, HF supervisor, District HEC, RMT, MoHSS

Table 5.1. **The Use of Strategic Information in Hep at Different Levels of Reporting**

5.2. Feedback

Starting from the HF, at every reporting level, feedback should be provided by the unit who received the report to the lower level who submitted the report. Regular review and reflection meetings at the HF, district, and regional levels, and supportive supervisions will be used as a forum to provide feedback to lower levels.

The feedback includes, but is not limited to the following key issues:

- Data quality, including completeness, timeliness and accuracy of the report
- Performance of key indicators against benchmarks/targets
- Data trends if make any sense
- Proposed solutions for implementation challenges

The following table summarizes the timeline for feedback at each reporting level:

Feedback to	How	When
HEWs	To be provided by HF supervisor during the monthly meeting with HEWs	Monthly
	To be provided during supportive supervisions by HF coordinator and/or District HEC	Quarterly
HF supervisor	To be provided by District HEC during quarterly review meeting with HF coordinators	Quarterly
District HEC	To be provided by RMT during quarterly review meeting with District HEC coordinators	Quarterly
RMT	To be provided by MoHSS during bi annual review meeting with RMT	Biannual

Table 5.2. **Timeline for Feedback at Each Reporting Level**

6. Data Quality

6.1. Checking data accuracy in monthly reports[4]

If data in the monthly report are not accurate, then decisions made based on those data may not produce intended effects. Lot Quality Assurance Sampling (LQAS) is a methodology that originated in manufacturing, as a low-cost way to assess, and assure quality. Based on a small sample size, one can estimate the level of quality. In recent years this methodology has been applied to assess the quality of various aspects of health services, including data quality.

The following steps show how the quality of HIS data can be estimated using a sample of twelve data elements, and comparing the results with a standard LQAS table. Selected data elements from HEWs monthly report submitted to the health facility are compared with the tallies and register sums that are the sources of these data elements. If a high proportion of the numbers are the same, then the quality of the data can be assumed to be high; if a low proportion is the same, then the quality of the data is low.

1. Selection of data elements is random, which means data elements are selected without any preference. A broad representation of the data elements from different sections of the monthly report form is required to assure all data elements are given equal opportunity for selection. A sample of twelve data elements is required based on LQAS table.
2. Select randomly at least one data element from each section of the previous monthly report (HEP form 6 and 7): two data elements from Maternal Health and one data element from the rest of each section. Write the selected data element in the first column of the data accuracy check sheet given below. Repeat the procedure until all data elements from different sections are entered in first column.
3. Copy the figures of the selected data elements as reported on the monthly report form in second column of data quality check sheet, under the heading of “figures from monthly report form”.
4. Pick the register (HEP form 1) which has the selected data element. Count the actual entries in the register related to a specific selected data element. Put the figure you counted in third column of check sheet, under the heading “figure from register”. Repeat this procedure for all data elements.
5. If the figures in column 2 and 3 are same, tick under YES in column four. If they are not the same (do not match), put a tick under NO in column four. Repeat this procedure for all data elements.
6. Count the total ticks under “YES” and write in row of total for “YES”. Repeat the procedure for “NO” column. The sum of YES and NO totals should be equal to the sample size of 12.

[4] Adapted from *LQAS MLE Toolkits* accessed at http:// toolkits.urbanreproductivehealth.org and *HMIS Procedures Manual*, MOH of Ethiopia, 2009

Data Accuracy Check Sheet

Month for which data accuracy is checked: ____M____/____Y____				
Randomly Selected Data Elements from monthly reporting form	Figures from Monthly report form (2)	Figures counted from register (3)	Do figures from columns 2 & 3 Match?	
			YES	NO
1. First Aid				
2. Maternal health (use two data elements) 2.1 2.2.				
3. Neonatal health				
4. Child Health				
5. HIV & AIDS				
6. TB				
7. Malaria				
8. Disability				
9. Social welfare				
10. Health promotion				
11. Health service management				
		Total		

Table 6.1. **Data Accuracy Check Sheet**

Use the following LQAS table to assess the level of data quality. The total in number in the "Yes" column corresponds to the percentage of data accuracy in the following LQAS table. For example, if total "yes" number is equal to 2, the accuracy level is between 30-35%; if total number in the "yes" column equals 7, the accuracy level is between 65-70%.

Circle the data accuracy percentage and write it in the monthly report and submit to the District HEC.

LQAS Table: Decisions Rules for Sample Sizes of 12 and Coverage Benchmarks/Average Coverage of 20-95%																	
Sample Size	Coverage Benchmarks or Average Coverage (For data quality)																
	Less than 20%	20%	25%	30%	35%	40%	45%	50%	55%	60%	65%	70%	75%	80%	85%	90%	95%
12	N/A	1	1	2	2	3	4	5	5	6	7	7	8	8	9	10	11

N/A= Not applicable- indicates that LQAS should not be used since coverage is too low for LQAS to detect

Table 6.2. **Decisions Rules for Sample Sizes of 12 and Coverage Benchmarks/Average Coverage of 20-95%**

N.B. Please note that with sample size of 12 data elements, the level of error is >15%. A sample size of 12 instead of the 19 (preferred sample size for LQAS with level of error <10%) is considered for easy application of LQAS by HF supervisor, in terms of selection of data elements and reduced time.

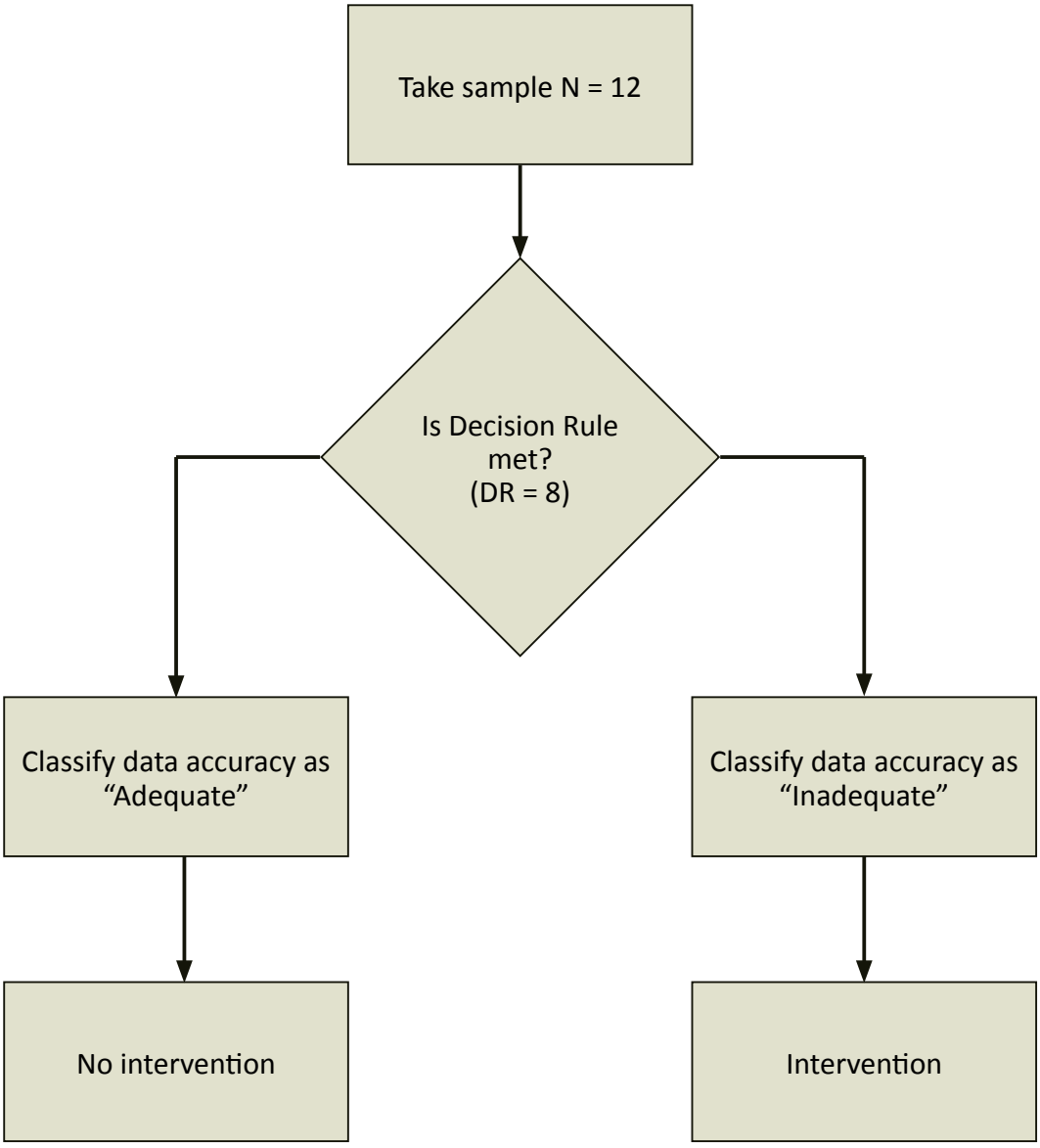

Figure 6.3. **LQAS Analysis Decisions**

Achievement of data accuracy level at 95% means a high level of accuracy and needs to be maintained at that level. You could set a cut of point for coverage benchmark at 75-80% (DR=8) for adequate data accuracy.

6.2. Completeness and Timeliness of Reporting

Reporting completeness (the proportion of reports expected that were received) and timeliness (the proportion of reports expected that were received on time) are important indicators of data quality. Completeness and timeliness are also HEP HIS indicators. If reports are incomplete, the data may give an inaccurate picture of performance, leading to poor decisions; if reports are late, then the information may not be available when needed to make a decision.

Every month, the HF supervisor will calculate the completeness and timeliness of reports received from HEWs under his catchment area and report to District HEC. The DHC will calculate the completeness and timeliness of reports received from HF supervisors and report to RMT on quarterly basis.

ANNEXES

Annex 1: Health Facility Supervisor Reporting Forms

HEP Summary Form F1:
Health Facility Supervisor Monthly & Quarterly Vital Event & Activity Report Form

Name of Health Facility: _____

Name of Facility Catchment Areas: _____

Reporting Month, Date & Year: ____/____/____ Quarter: _____

Name of Reporting Person: _____ Signature: _____

Name of Supervisor: _____ Signature: _____

No.	Vital Event/Activity	Number		
		Male	Female	Total
1	**MATERNAL HEALTH**			
1.1	Pregnant mothers			
1.2	Pregnant mothers with birth plan			
1.3	Prenatal danger sign			
1.4	Total births			
1.5	Home delivery			
1.5	Live birth (home delivery)			
1.6	Still birth (home delivery)			
1.7	Premature birth (home delivery)			
1.8	Mothers who are visited by HEW within 24-48 hours after birth			
1.9	Postnatal danger sign			
2	**NEONATAL HEALTH**			
2.1	Neonatal danger sign			
2.2	Low birth weight babies (for home delivery)			
2.3	Neonatal deaths (for death occurred at home)			
3	**CHILD HEALTH**			
3.1	Babies who are exclusively breast fed at six months of age			
3.2	Under five years deaths (death occurred at home)			
3.3	Pneumonia detected and treated			
3.4	Pneumonia referred			
3.5	Diarrhea detected and managed			
3.6	Serious diarrhea and dehydration			
3.7	Serious illness with fever			
3.8	Serious cough or difficulty of breathing			
3.9	Serious ear or throat problem			
3.10	Moderate malnutrition			
3.11	Severe malnutrition			
3.12	Serious nutrition problem			
4	**HIV & AIDS**			
4.1	Clients who received HIV counseling only			
4.2	Clients who received HIV counseling and testing			
4.3	Clients with positive HIV test			
4.4	HIV + clients on ART identified in the reporting month/quarter			
4.5	ART defaulters identified & referred in reporting month/quarter			
5	**TB**			
5.1	Suspected TB cases identified and referred			
5.2	TB treatment defaulters identified and referred			
5.3	Patients supported with DOT			
5.4	TB contacts traced and referred			

No.	Vital Event/Activity	Number		
		Male	Female	Total
6	**SOCIAL WELFARE**			
6.1	Family violence detected			
6.2	Family violence referred			
6.3	Violence against elderly detected			
6.4	Violence against elderly referred			
6.5	Eligible HHs not receiving social grant			
6.6	Substance abuse detected			
6.7	Substance abuse referred			
6.8	Suicidal thoughts/behavior detected			
6.9	Suicidal thoughts/behavior referred			
6.10	Parent-child relationship problem detected			
6.11	Parent-child relationship problem referred			
7	**MALARIA**			
7.1	HHs sprayed with residual DDT			
7.2	Children sleeping under ITN			
7.3	Pregnant mothers sleeping under ITN			
8	**DISABILITY PREVENTION AND REHABILITATION**			
8.1	People with disabilities detected			
8.2	People referred for assistive devices			
8.3	People referred for rehabilitation services			
9	**HEALTH PROMOTION**	**Individual**	**Group**	**Total**
9.1	Number of health promotion activities conducted			
10	**HEALTH SERVICE MANAGEMENT**			
10.1	Total referral cases			
10.2	Referral cases who received services at health facilities			
10.3	Household visits (First visits)			
10.4	Household visits (Follow up visits)			
10.5	Supportive supervisions received from DHO/HF			
10.6	Data accuracy using LQAS			
10.7	Data completeness			
10.8	Data timeliness			
11	**ACTIVITIES TO BE REPORTED QUARTERLY & ANNUALLY**			
11.1	Number of new hand washing facilities completed in the quarter			
11.2	Number of new latrines completed in the quarter			
11.3	Number of HHs using hand washing facility			
11.4	Number of HHs using latrine			
11.5	Number of pregnant mothers who are visited by HEW at least 4 times before delivery			
11.6	Number of other CHCPs in the catchment area (disaggregated by type)			
11.6.1				
11.6.2				
11.6.3				
11.6.4				
11.6.5				
11.6.6				

Observations, opinions and suggestions in the month:

Annex 1.1. **Health Facility Supervisor Monthly & Quarterly Vital Event & Activity Report Form**

HEP Summary Form F2: Health Facility Monthly & Quarterly Disease and Disability Report Form

Name of Health Facility: _____

Name of Facility Catchment Areas:

Reporting Month, Date & Year: ____/____/____ Quarter: _____

Name of Reporting Person: _____ Signature: _____

Name of Supervisor: _____ Signature: _____

Disease/Disability	Number of Cases						
	Male			Female			Total
	0-4 years	5-14 years	≥ 15 years	0-4 years	5-14 years	≥ 15 years	
FIRST AID							
Accidents/injuries detected							
Accidents/injuries managed							
Accidents/injuries referred							
MALARIA							
Malaria cases detected (RDT/clinical)							
Malaria cases treated							
Malaria cases referred							
DISABILITY							
Visual impairment							
Hearing difficulty							
Speech difficulty							
Movement difficulty							
Learning difficulty							
Observations, opinions and suggestions in the month:							

Annex 1.2. **Health Facility Monthly & Quarterly Disease and Disability Report Form**

Annex 2: District Health Extension Coordinator Reporting Form

HEP Summary Form D1: District HEC Quarterly Vital Event & Activity Report Form

Name of Health Facility: _____

Name of Facilities reporting to the District: _____

Reporting Month, Date & Year: ____/____/____

Reporting Quarter: _____

Name of Reporting Person: _____ Signature: _____

Name of Supervisor: _____ Signature: _____

S.N	Vital Event/Activity	Number		
		Male	Female	Total
1	**MATERNAL HEALTH**			
1.1	Pregnant mothers			
1.2	Pregnant mothers with birth plan			
1.3	Prenatal danger sign			
1.4	Total births			
1.5	Home delivery			
1.5	Live birth (home delivery)			
1.6	Still birth (home delivery)			
1.7	Premature birth (home delivery)			
1.8	Mothers who are visited by HEW within 24-48 hours after birth			
1.9	Postnatal danger sign			
2	**NEONATAL HEALTH**			
2.1	Neonatal danger sign			
2.2	Low birth weight babies (for home delivery)			
2.3	Neonatal deaths (for death occurred at home)			
3	**CHILD HEALTH**			
3.1	Babies who are exclusively breast fed at six months of age			
3.2	Under five years deaths (death occurred at home)			
3.3	Pneumonia detected and treated			
3.4	Pneumonia referred			
3.5	Serious diarrhea and dehydration			
3.6	Serious illness with fever			
3.7	Moderate malnutrition			
3.8	Severe malnutrition			
4	**HIV & AIDS**			
4.1	Clients who received HIV counseling only			
4.2	Clients who received HIV counseling and testing			
4.3	Clients with positive HIV test			
4.4	HIV + clients on ART identified in the reporting month/quarter			
4.5	ART defaulters identified and referred in the reporting month/quarter			
5	**TB**			
5.1	Suspected TB cases identified and referred			
5.2	TB treatment defaulters identified and referred			
5.3	Patients supported with DOT			
5.4	TB contacts traced and referred			
6	**SOCIAL WELFARE**			
6.1	Family violence detected			
6.2	Family violence referred			
6.3	Violence against elderly detected			
6.4	Violence against elderly referred			
6.5	Eligible HHs not receiving social grant			
6.6	Substance abuse detected			

S.N	Vital Event/Activity	Number		
		Male	Female	Total
6.7	Substance abuse referred			
6.8	Suicidal thoughts/behavior detected			
6.9	Suicidal thoughts/behavior referred			
6.10	Parent-child relationship problem detected			
6.11	Parent-child relationship problem referred			
7	**MALARIA**			
7.1	HHs sprayed with residual DDT			
7.2	Children sleeping under ITN			
7.3	Pregnant mothers sleeping under ITN			
8	**DISABILITY PREVENTION AND REHABILITATION**			
8.1	People with disabilities detected			
8.2	People referred for assistive devices			
8.3	People referred for rehabilitation services			
9	**HEALTH PROMOTION**	**Individual**	**Group**	**Total**
9.1	Number of health promotion activities conducted			
10	**HEALTH SERVICE MANAGEMENT**			
10.1	Total referral cases			
10.2	Referral cases who received services at health facilities			
10.3	Household visits (First visits)			
10.4	Household visits (Follow up visits)			
10.5	Supportive supervisions received from DHO/HF			
10.6	Data accuracy using LQAS			
10.7	Data completeness			
10.8	Data timeliness			
11	**ACTIVITIES TO BE REPORTED QUARTERLY & ANNUALLY**			
11.1	Number of new hand washing facilities completed in the quarter			
11.2	Number of new latrines completed in the quarter			
11.3	Number of HHs using hand washing facility			
11.4	Number of HHs using latrine			
11.5	Number of pregnant mothers who are visited by HEW at least 4 times before delivery			
11.6	Number of other community health care providers (CHCPs) in the catchment area (disaggregated by type)			
11.6.1				
11.6.2				
11.6.3				
11.6.4				
11.6.5				
11.6.6				

Observations, opinions and suggestions in the month:

Annex 2.1. **District HEC Quarterly Vital Event & Activity Report Form**

HEP Summary Form D2: District HEC Quarterly Disease and Disability Report Form

Name of Health Facility: _____

Name of Facilities reporting to the District: _____

Reporting Month, Date & Year: _____/_____/_____

Reporting Quarter:

Name of Reporting Person: _____ Signature: _____

Name of Supervisor: _____ Signature: _____

Disease/Disability	Number of Cases						
	Male			Female			Total
	0-4 years	5-14 years	>=15 years	0-4 years	5-14 years	>=15 years	
FIRST AID							
Accidents/injuries detected							
Accidents/injuries managed							
Accidents/injuries referred							
MALARIA							
Malaria cases detected (RDT/clinical)							
Malaria cases treated							
Malaria cases referred							
DISABILITY							
Visual impairment							
Hearing difficulty							
Speech difficulty							
Movement difficulty							
Learning difficulty							
Observations, opinions and suggestions in the month:							

Annex 2.2. **District HEC Quarterly Disease and Disability Report Form**

Annex 3: Regional Health Management Team Report Form

HEP Summary Form R: RMT Quarterly Vital Event & Activity Report Form

Name of Region: _____

Name of Districts reporting to the Region: _____

Reporting Month, Date & Year: ____/____/____

Reporting Quarter: _____

Name of Reporting Person: _____ Signature: _____

Name of Supervisor: _____ Signature: _____

S.N	Vital Event/Activity	Number		
		Male	Female	Total
1	**MATERNAL HEALTH**			
1.1	Pregnant mothers			
1.2	Pregnant mothers with birth plan			
1.3	Prenatal danger sign			
1.4	Total births			
1.5	Home delivery			
1.5	Live birth (home delivery)			
1.6	Still birth (home delivery)			
1.7	Premature birth (home delivery)			
1.8	Mothers who are visited by HEW within 24-48 hours after birth			
1.9	Postnatal danger sign			
2	**NEONATAL HEALTH**			
2.1	Neonatal danger sign			
2.2	Low birth weight babies (for home delivery)			
2.3	Neonatal deaths (for death occurred at home)			
3	**CHILD HEALTH**			
3.1	Babies who are exclusively breast fed at six months of age			
3.2	Under five years deaths (death occurred at home)			
3.3	Pneumonia detected and treated			
3.4	Pneumonia referred			
3.5	Serious diarrhea and dehydration			
3.6	Serious illness with fever			
3.7	Moderate malnutrition			
3.8	Severe malnutrition			
4	**HIV & AIDS**			
4.1	Clients who received HIV counseling only			
4.2	Clients who received HIV counseling and testing			
4.3	Clients with positive HIV test			
4.4	HIV + clients on ART identified in the reporting month/quarter			
4.5	ART defaulters identified and referred in the reporting month/ quarter			
5	**TB**			
5.1	Suspected TB cases identified and referred			
5.2	TB treatment defaulters identified and referred			
5.3	Patients supported with DOT			
5.4	TB contacts traced and referred			

S.N	Vital Event/Activity	Number		
		Male	Female	Total
6	**SOCIAL WELFARE**			
6.1	Family violence detected			
6.2	Family violence referred			
6.3	Violence against elderly detected			
6.4	Violence against elderly referred			
6.5	Eligible HHs not receiving social grant			
6.6	Substance abuse detected			
6.7	Substance abuse referred			
7	**MALARIA**			
7.1	HHs sprayed with residual DDT			
7.2	Children sleeping under ITN			
7.3	Pregnant mothers sleeping under ITN			
8	**DISABILITY PREVENTION AND REHABILITATION**			
8.1	People with disabilities detected			
8.2	People referred for assistive devices			
8.3	People referred for rehabilitation services			
9	**HEALTH PROMOTION**	**Individual**	**Group**	**Total**
9.1	Number of health promotion activities conducted			
10	**HEALTH SERVICE MANAGEMENT**			
10.1	Total referral cases			
10.2	Referral cases who received services at health facilities			
10.3	Household visits (First visits)			
10.4	Household visits (Follow up visits)			
11	**ACTIVITIES TO BE REPORTED ANNUALLY**			
11.1	Number of HHs using hand washing facility			
11.2	Number of HHs using latrine			
11.3	Number of pregnant mothers who are visited by HEW at least 4 times before delivery			

Annex 3.1. **RMT Quarterly Vital Event & Activity Report Form**

HEP Summary Form R2: RMT Quarterly Disease and Disability Report Form

Name of Region: _____

Name of Districts reporting to the Region: _____

Reporting Month, Date & Year: ____/____/____

Reporting Quarter:

Name of Reporting Person: _____ Signature: _____

Name of Supervisor: _____ Signature: _____

Disease/Disability	Number of Cases						
	Male			Female			
	0-4 years	5-14 years	>=15 years	0-4 years	5-14 years	>=15 years	Total
MALARIA							
Malaria cases detected (RDT/clinical)							
Malaria cases treated							
Malaria cases referred							
DISABILITY							
Visual impairment							
Hearing difficulty							
Speech difficulty							
Movement difficulty							
Learning difficulty							
Observations, opinions and suggestions in the month:							

Annex 3.2. **RMT Quarterly Disease and Disability Report Form**

READER'S NOTES