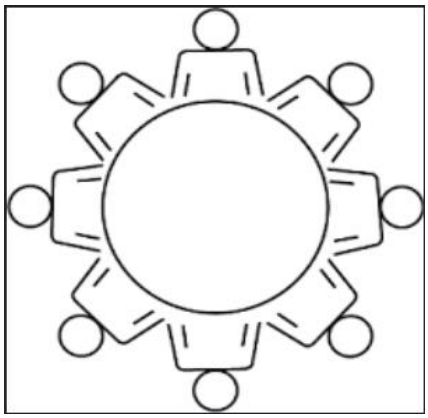
The Republic of The Gambia



National Integrated Community Case Management (iCCM+)
Monitoring and Evaluation Plan 2024 - 2030
The Gambia

Better Access to quality case management of key childhood illnesses (Malaria, pneumonia, diarrhea and malnutrition) at the community level

2024 - 2030

Contents

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Abbreviations

ACT	**Artemisinin-based Combination Therapy**
AL	Artemether/Lumefantrine
BHP	Basic Health Package
CBCS	Community Birth Companions
CHNS	Community Health Nurses
CCM	Community Case Management
CI	Childhood Illness
DCD	Department of Community Development
RHDS	Regional Health Directorates
DHS	Director of Health Services
DMP	Diarrhea, Malaria & Pneumonia
DPI	Director of Planning and Information
GBOS	Gambia Bureau of Statistics
GDP	Gross Domestic Product
HC	Health Centre
HF	Health Facility
HMIS	Health Management Information System
HSD	Health Sub-district
HW	Health Worker
ICCM	Integrated Community Case Management
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IPT	Intermittent Preventive
LC	Local Council
LCD	Liquid Crystal Display
MICS	Multiple Cluster Indicator
MOH	Ministry of Health
NGO	Non-Governmental Organization
NMCP	National Malaria Control Programme
OIC	Officer –in- Charge
ORS	Oral Rehydration Solution
PHC	Primary Health Care
RHD	Regional Health Directorates
RMNCAH	Reproductive
RPPHN	Regional Principal Public Health Nurse
SBCC	Social and Behavioral Change Communication
SC	Sub-county
SCHNT	Senior Community Health Nurse Tutor
SP	Sulfadoxine/Pyrimethamine (Fansidar)
TOR	Terms of Reference
TWG	Technical Working Group
U5	Under 5 years
UNICEF	United Nations Children's Fund
VHS	Village Health Services
WHO	World Health Organization

Foreword

The Government of The Gambia is committed to the achievement of national, regional and international targets, including the Sustainable Development Goals (SDGs), to improve maternal, new-born and child health and development indicators. In The Gambia, most deaths in children are caused by preventable and easily treated diseases, namely pneumonia, diarrhoea, malaria and new-born related conditions (pre-term birth complications and, intrapartum related complications. The population of children under-5 years of age is 15.4% and the mortality rate among this age group is about 57 per 1,000 live births[1].

Analysis of deaths identified within two Health and Demographic Surveillance Systems (HDSS) in rural Gambia, 49.5% occurred at home. Acute respiratory infection including pneumonia (ARIP) 33.7%, and diarrhoeal diseases 23.3%, were the commonest primary causes of death in the post-neonatal period. In the neonatal period, unspecified perinatal causes of death 34.0%, and deaths due to birth asphyxia 27.3%, were the commonest causes of death. Severe malnutrition 28.6%, was the commonest underlying cause of death[2].

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

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

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

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

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[1] *MICS 2018*
[2] *MRCG at LSHTM HDSS VA analysis of childhood deaths in rural Gambia PubMed Central 2023 Jul 6.*

The Quadrangle
Banjul

Acknowledgments

The Ministry of Health (MOH) wishes to thank all those organizations and individuals who contributed to the development and completion of the integrated Community Case Management (iCCM) national framework and plan of action and a Monitoring and evaluation (M&E) plan that guides the tracking of its implementation.

1. Introduction

1.1 Background of the Monitoring and Evaluation Plan

The Primary Health Care Unit, in partnership with a wide range of stakeholders, developed the iCCM M&E Plan to coordinate stakeholders towards one agreed country level monitoring and evaluation system for integrated Community Case Management (iCCM) for the period 2024 - 2030.

The process of developing the iCCM M&E plan was participatory through wide consultations with a wide range of stakeholders at national and regional levels. The process involved holding a series of consensus meetings to ensure that iCCM is grounded in the existing health delivery structures, bearing in mind the devolution of the governance and health systems to the county level that was to start in 2001.

The iCCM M&E plan seeks to establish a well-coordinated, harmonized monitoring, evaluation and operational system for iCCM that provides timely and accurate strategic information to guide the planning of the iCCM implementation in The Gambia. The plan will feed into the existing NHSP M&E framework. Furthermore, the plan will help in tracking the implementation of programmatic objectives through provision of regular data to assist in evidence-based planning. Key intended users of this document include the RHDs, Health Directorates, Program managers and others involved in planning and implementing iCCM, and development partners.

1.2 Goal and Objectives of the iCCM M&E Plan

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

1.3 Specific Objectives of the M&E Plan

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

2. National iCCM Framework and Plan of Action

The Gambia adopted Primary Health Care (PHC) in 1980/81 as the overarching approach to addressing the health needs of communities, integrating care, prevention, promotion and education in line with the Alma Ata Declaration. The primary health care strategy is essential to the attainment of Universal Health Coverage and the Sustainable Development Goals (SDGs). It is aligned to the National Health Sector Strategic Plan (NHSSP 2021-2025), which aimed at reversing the decline in the health status of The Gambians through shifting the emphasis from a disease-centered approach to the promotion of individual and community health.

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

The vision of the iCCM operational strategy is a Gambia where communities have zero tolerance for preventable deaths of children. A national framework and plan of action for the implementation of iCCM in The Gambia has been developed to present a platform for acceleration of the control and management of childhood diarrhoea, malaria, pneumonia, neonatal mortality and malnutrition at the community level, thus contributing to the attainment of the SDG 3. It is anchored on the Ministry of Health (MOH) National Health Strategic Plan and the Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) Strategy as well as the Child Survival and Development.

3. Indicators

The iCCM M&E plan has 9 indicators. The full performance matrix for these indicators is presented in Annex 1. There are eight components, as per the global iCCM benchmark framework under which iCCM will be assessed. The components are: (i) policy and coordination, (ii) costing and financing, (iii) human resources, (iv) supply chain management, (v) service delivery and referral, (vi) communication and social mobilization, (vii) supervision and quality assurance, and (viii) M&E and Health Management Information System.

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

i. Routine iCCM Indicators. Routine indicators that measure the critical program processes and outputs. They also help interpret results' indicators (e.g., utilization or coverage) by showing the "strength" of the program. The three supply side domains (human resources, commodities and quality of care) are based on the minimum requirements for service delivery (a trained health worker is available and accessible to the population, equipped with required supplies, and regularly supervised and supported).

Table 1, lists the implementation routine indicators for the supply side and additional indicators which have been adapted for The Gambia.

Table 1: Routine iCCM Indicators

Component	iCCM Indicator
Human Resources	• Proportion of VHWs targeted for iCCM who are trained in iCCM • Proportion of villages with at least one VHW distributing iCCM medicines • Proportion of VHWs with no stock outs of iCCM medicines during the last 1 month • Proportion of under five cases of diarrhea, malaria, pneumonia, HIV/AIDS, Tuberculosis and malnutrition seen by the VHWs
Commodities	• Proportion of VHS that had no stock out of iCCM medicine during the last 1 month • Proportion of health facilities with no stock outs of iCCM medicines during the last 3 months
Quality of Care	Proportion of iCCM trained VHWs who received at least one supervisory visit for iCCM in the last 3 month • Proportion of under five cases of diarrhea, malaria, pneumonia and malnutrition seen by the VHWs and appropriately treated • Proportion of children under five years who died in the last month • Proportion of VHWs who fail to submit iCCM reports for a period of 3 months
Service Delivery and Referral	• Proportion of under five children seen by the VHWS and referred • Number of iCCM conditions managed by VHWs in target areas in a given time period (quarterly/annually) (reported by condition) • Proportion of new-borns who received a home visit from a VHW within 48 hours of delivery

ii. Indicators that can be potentially collected routinely, but through District Health Information Software 2 Tracker (DHIS2) systems as part of the health management information system (HMIS).

Table 2. Selected Routine Indicators

Component	iCCM Indicator
Service Delivery and Referral	• **Proportion of children with fever who are tested with RDTs at community level** • **Proportion of VHWs whose registers show completeness and consistency between classification and treatment**

Supervision and Quality Assurance	• **Proportion of mothers, CHWs who correctly classify malnourished children using MUAC** • **Proportion of VHWs who correctly count respiratory rate**
M&E and HMIS	• **Proportion of VHS reporting iCCM data on time and completely**

iii. Indicators that can be collected periodically through surveys or special studies. These indicators can be used to periodically assess specific components of implementation and complement the routinely collected indicators listed above. Table 3 lists some of these indicators. They can be incorporated into existing periodic surveys such as DHS, Multi Indicator Cluster Survey (MICS), or can be captured through special survey/studies that are developed for evaluating the implementation of iCCM.

Table 3. List of Survey Indicators

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

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

Table 4. List of National Milestone Indicators

Component	iCCM indicator

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

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

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

1. routine sources (such as HMIS, project reports, supervision reports, etc);
2. periodic surveys such as household surveys, health facility assessments and VHW surveys; and
3. other complementary methods (special studies, document reviews, key informant interviews, etc).

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

4. Routine Data Collection

The routine indicators for iCCM can be collected through the VHW treatment register, VHW household register, VHW supervision checklist and VHW stock records. They are summarized by the monthly VHW report, which is entered into the national DHIS2 system. Other important sources of routine information include the RHDs supervision checklist and training reports. The information collected by these key tools is summarized in Table 5.

Table 5. Tools For Routine Data Collection

Tool	Information that can be collected
VHW iCCM Treatment Register	• Captures information on sick child cases seen, treated and referred and on follow-up and outcomes. Also, records amount of each commodity distributed. Data are summarized in the VHW report, which is then aggregated by the VHs CHN in the iCCM VHS CHN monthly report.
HMIS Household Register	• Records data on household demographics that can be used to calculate the denominator for the routinely collected service delivery iCCM indicators. It is filled out by VHWs every six months and reported to VHS CHNs.
VHW Log Book	• Collects information on daily VHW activities conducted as part of household visits. The Log Book is to be updated daily and submitted monthly by VHWs to VHS CHNs for summary.
VHS Monthly Report	• Summarizes data for the VHS in terms of service delivery (cases treated, referred, etc) and supervision and the main input into the DHIS2.
VHS Supervision Checklist	• Collects data on supervision of VHWs covering the full iCCM package, including availability of medicines and supplies, record keeping, knowledge. Data related to indicators can be summarized on the VHWs monthly report and thus available through the DHIS2.
VHS Commodity Registers	• Collects data on receipt and consumption of VHS commodities, including those for iCCM.
VHS Summary for VHW Treatment Register	• Summarises data collected by VHWs on treatment of children and consumption of CHS commodities, including those for iCCM.
RHDs Support Supervision Tool	• Collects information on VHS through interviews with VHWs. • This is collected quarterly.
VHS Training Inventory	• Collects data on the training provided to VHWs; It needs to be updated to reflect iCCM human resource training status
DHIS2 to Assess VHW Training	• Collects data on the training provided to VHWs; needs to be updated to reflect iCCM human resource training status

Other Logistics, Supply Chain Tools: VHS Inventory control card; VHS Stock control card; VHW requisition, Issue and Order Voucher; VHW re-Supply register	• These are logistics and supply tools which allow the VHW to keep track of the medicinal and diagnostic products they use on sick children.

4.1 Periodic/Survey Data Collection

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

Table 6. Periodic/Survey Data Collection

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

4.2 Complementary Methods:

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

Table 7. Complementary Data Sources

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

5. Coordination of iCCM M&E Plan

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

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

5.1 Monitoring of the iCCM Implementation

The M&E Plan identifies several indicators for routine monitoring, with a focus on sub-set monitoring program implementation strength. Table 8 outlines the implementation of these indicators, the data sources, targets and required data elements. The majority of these indicators will be collected through DHIS2 as part of the overall Primary Health Care monitoring system, which captures monthly data from each VHS. Data for the existing PHC monitoring systems are generated through the VHW monthly report, which summarizes data for all VHWs in the VHS.

The existing VHW monthly report includes some required elements for iCCM, but several additional elements will need to be added to incorporate the minimal set of iCCM routine monitoring indicators. The data represent the core elements required to measure implementation strength of the iCCM plan. Program-focused, supportive supervision is critical for program monitoring and will be conducted regularly by all levels using standard supervisory

checklists. In addition, the supervisory checklists will generate data on several indicators that can be aggregated upwards and included within the DHIS2 system. The RHDs shall be expected to conduct joint supportive supervision at least once per quarter to primary health care facilities. The VHS CHNs shall conduct monthly competency-based skill reinforcing supportive supervision for all VHWs. Support will be provided to the VHWs to assess, classify and manage common childhood illnesses. The supervision will also assess VHWs counseling skills to ensure treatment adherence. An integrated supervision checklist for VHS CHNs to supervise VHWs is found in Annex xx.

Table 8. Implementation Indicators, Targets and Required Data

Indicator	**Definition**	**Data source & Frequency**	**Target by 2030**	Data elements required in VHWs report DHIS2
VHWs trained in iCCM	Proportion of VHW targeted for iCCM who are trained in iCCM	Annual: work plans & training records	80%	No. of VHWs in VHS trained in iCCM
VHWs deployed for iCCM and working	Proportion of VHWs trained in CCM who are providing iCCM services (managing malaria, diarrhoea, pneumonia, malnutrition and newborn cases according to protocol)	Quarterly: DHIS2 (VHWs reports)	80% of trained VHWs	No. of VHWs trained in CCM who report providing iCCM services this month
Availability of iCCM Supplies	Proportion of link facilities that had no stock out of recommended medicines and diagnostics during the day of assessment visit or last day of reporting period	Quarterly: RHDs supervision report;	80%	
	Proportion of VHWs who had no stock out of recommended medicines and diagnostics during the day of assessment visit or last day of reporting period	Quarterly: DHIS2 (VHWs reports)	80%	Whether VHS experienced stock-outs of any key product for the reporting month
VHWs supervised	Proportion of VHWs who received at least one administrative supervisory contact in the prior 3 months during where a sick child or scenario was assessed*	Quarterly: DHIS (RHDs reports)	80%	No. of VHWs trained in CCM who were supervised using standard checklist this month

Service delivery	Number of iCCM conditions managed per 1,000 children under five in target areas in a given time period (reported by condition: treatment of malaria/ diarrhoea; referral for malnutrition/ pneumonia/newborn)	Quarterly: DHIS (VHS reports)	80%	No. of cases of malaria treated in U5 children No. of cases of diarrhoea treated in U5 children No. of cases of moderate/ severe malnutrition in U5 children referred* No. of cases of suspected pneumonia in U5 children referred No. of sick newborns referred
	Number and percent of newborns who received a home visit from a VHW within 48 hours of delivery	Quarterly: DHIS (VHW reports)	80%	No. of newborns visited at home within the first 48 hours

*** Data elements already included in the existing VHS report/DHIS2**

5.2 Data Flow

Data for iCCM will flow according to the existing system, starting with the VHWs reporting to the BHS link facilities and then to the RHDs (see Table 9). Community level data are entered into the online DHIS2 at RHDs. In some cases, data are entered at the health care facility level or even at the VHS level if computers and internets services are available. Once entered into the DHIS2, the data are available for use at any level and can be analyzed by health facilities, RHDs and nationally. Details on the data flow for commodities are provided in the supply chain management section of the iCCM implementation guidelines.

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

Level/cadre	Main data collection & reporting	Data collection & reporting
VHS VHW	Track services provided and commodities received and consumed Prepare monthly report and submit to VHS CHNs	Existing: VHW logbook; Household registers; VHW report New: VHW Treatment Register; stock records, Newborn Checklist (refer Annex xx)
PHC VHS CHN	Supervise VHWs according to schedule and document using standard checklist Review and compile VHW data, stock records and supervision records and entered directly into the DHIS2.	Existing: VHWs reports New: Supervision checklist for VHWs; stock records; stock report, plus VHWs treatment Registers.
BHS Facility – Facilities in-Charge of VHS	Supervise VHWs according to schedule and document using RHDs checklist Review and compile VHW's data and submit to RHDs for verification. Provide feedback to VHWs	Existing: VHW report New: Supervision checklist for VHWs; stock records; stock report
Regions – RHDs **- BHS Facilities**	Supervise linked facilities and VHS CHNs Manage data compilation and entry into DHIS2 for the BHS Facilities and submit to the RHDs Rapid data quality assessment (RDQA) Provide feedback to facilities and VHS	Existing: Monitoring supervision checklist (PHC Training reports New: Any other reports
Regions – RHDs - BHS Facilities OICs	Supervise VHS CHNs Review district level data and maintain RHDs information and reports. Prepare reports and provide feedback to BHS and VHS	RHDs linked to DHIS2
National – Planning Directorate M&E Unit	**Review Regional level data and** **Prepare reports and provide feedback to RHDs/other directorates**	RHDs linked to DHIS2

5.3 Data Quality Assurance

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

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

Monitoring data for iCCM will be entered into the DHIS2 as part of the overall HMIS M&E framework. Data captured at the community level, including that related to iCCM, will be integrated into the existing DHIS2 web-based system. Data will be entered into the DHIS2 at the lowest level that has the required resources (computers, internet access and staff for entry). Guidelines on appropriate information storage and measures to protect information security will be provided through DHIS2.

The DHIS2 database will be updated to incorporate iCCM information requirements by the HMIS unit. As part of the database development, it will be possible to include dashboards to display key indicators that will aid data use and interpretation by all users.

Use of program monitoring data for decision-making will also be encouraged through regular review meetings at multiple levels to assess the progress of iCCM implementation by identifying opportunities, challenges and looking for solutions. Experience sharing and dissemination of success stories, good practices and lessons learnt are addressed in such meetings. Review meetings will be held at national at least once a year and regional levels at least twice a year involving relevant stakeholders. The PHC Unit in conjunction with the RHDs, BHS facilities, and VHS shall be responsible for organizing review meetings at their respective levels. In order to make the review meetings effective and feasible, iCCM review meetings will be conducted by integrating with annual health sector joint review meetings. Proceedings of the reviews are expected to be disseminated to all levels on time.

5.4 Evaluation Plan

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

Table 10. Outcome indicators and Targets for iCCM

Indicator	Definition	Data source & Frequency of reporting	Target by 2030
Treatment Coverage (overall)	Percentage of sick children who received timely and appropriate treatment according to specific protocol (reported separately by iCCM condition) • Malaria (ACTs within 24 hours) • Diarrhoea (ORS and zinc within 24 hours) • Pneumonia (amoxicillin within 24 hours) • Malnutrition (RUTF;) • Newborn illness (injectable antibiotic;)	Household survey; (baseline, 2-3 years later)	**80%**
Treatment Coverage by VHW*	Percentage of sick children who received timely and appropriate treatment according to specific protocol provided by VHWs	Household survey; episodic (baseline, 2-3 years later)	**80%**
First Source of Care	Proportion of sick children under five in iCCM target areas taken to iCCM-trained VHWs as first point of care.	Household survey; episodic (baseline, 2-3 years later)	**TBD**
Successful Referral	Proportion of sick children recommended for referral who were received at the referral facility (based on the VHW referral form- Annex xx)	Routine data & Special study of referrals	**TBD**

Note that in the detailed indicator matrix this indicator is included as a disaggregation of the first indicator

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

Table 11. Evaluation Questions and Data Collection Methods

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

5.5 Implementation Capacity

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

- Maintain the DHIS2 database
- Analyse and interpret data for evidence-based decision making
- Provide supportive supervision to the decentralized levels

5.6 Operations/Implementation Research and Special Studies

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

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

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

Table 12. Priority Implementation Research Questions for iCCM

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

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

5.7 Dissemination and Use

A wide range of stakeholders, including policy makers, donors, program managers, implementing partners, facility staff, VHWs, and the target communities, constitute the main audience for dissemination of iCCM M&E information. Dissemination of iCCM information will be embedded within the existing PHC program and will include publication and distribution of quarterly and annual reports, program newsletters, and information sharing through national and international meetings and workshops. In addition, routine iCCM data captured through the DHIS2 will be available online for real-time access and analysis at the desired level of disaggregation.

Anticipated information products related to iCCM include, but not limited to:
Integrated DHIS2 Reports: PHC unit will produce annual consolidated national M&E report on the national core indicators as well as quarterly reports for the routine data and disseminate them to all the stakeholders.

Regional report for routine data: RHDs will produce quarterly report incorporating VHS data in the existing report and submit it to the PHC program.

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

5.8 Detailed M&E Action Plan and Resources

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

5.9 Review of the M&E plan

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

6. Monthly VHS CHNs Summary Report

MINISTRY OF HEALTH - THE GAMBIA

VILLAGE HEALTH SERVICES MONTHLY SUMMARY FORM

Circuit:		District:						Region:						Month:						Year: 20.....							
Villages:		Key		1		2		3		4		5		6		7		8		9		10		11		12	
Total Patients Seen		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Children < 5 and above 5		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Paediatric Paracetamol 100mg	<5																										
Paracetamol 500mg	>5																										
Suspected Measles	<5																										
	>5																										
Fast Breathing	<5																										
Dispersible amoxicillin 125mg	<5																										
Cough Less than two weeks	>5																										
Diarrhoea	<5																										
	>5																										
ORS	<5																										
ZINC	<5																										
Diarrhoea with Blood	<5																										
	>5																										
ORS	<5																										
Conjunctivitis	**>5**																										
Conjunctivitis	**<5**																										
Tetracycline Eye Ointment	<5																										
Malnutrition (MUAC)	**<5**																										
Number of Suspected Malaria Cases	<5																										
	>5																										
RDT Use	<5 Positive																										
	<5 Negative																										
	<5 Invalid																										
	>5																										

	Positive																												
	>5 Negative																												
	>5 Invalid																												
Uncomplicated Malaria Confirmed with RDT	<5																												
	>5																												
Pregnant women with Uncomplicated Malaria Confirmed with RDT																													
Coartem 6 tab Doses	**<5**																												
Coartem 12 tab Doses	**<5**																												
	>5																												
Coartem 18 tab Doses	**>5**																												
Coartem 24 tab Doses	**>5**																												

Others Family Planning

Villages		***Key***		***1***		***2***		***3***		***4***		***5***		***6***		***7***		**8**		**9**		**10**		**11**		**12**	
		M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Number of Clients given Condoms																											
Number of Condoms Issued																											

VHW Other Activities

Home Visits																											
Follow Up Visits																											
Referrals to Health Facility		**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
	<5																										
	>5																										
Infant Deaths (Less than 1 year)	**< 1 year**																										
Deaths 1 to 5 years	**<5**																										
Deaths above 5 years	**> 5**																										

CBCs Activities

Total Ante Natals visited																											
Total antenatal Counselled and referred for ANC booking																											
Ante Natals Counselled and referred for first trimester booking																											

Births at the Community		Births at the Community																									
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Live Births at the community																											
Stillbirths at the community																											
Women referred for institutional delivery																											
Maternal Deaths at the Community																											
Neonatal Death at the Community																											
Postnatal																											
Postnatal visits made																											
Post Natal women issued with Fefa																											
Neonatal Conjunctivitis																											
Neonatal Tetanus																											

Family Planning

Villages		*Key*		*1*		*2*		*3*		*4*		*5*		*6*		7		8		9		10		11		12	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Family Planning Motivations given																											
Women Given Pills at The Community																											
Cycles of Pills issued																											
Referrals for Family Planning																											
Referrals of mothers with Complications																											
Referrals of Neonates																											

Other Activities

		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Referrals to Health Facility	< 5																										
	> 5																										

CHN Activities Supervision

Supervisory visits																											
Children < 5 YRS.		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Moderate Acute Malnutrition																											
Severe Acute Malnutrition (SAM)																											
Severe Malnutrition with Anaemia																											

Severe Malnutrition with other medical complications																											
Number of SAM patients treated according to the protocol																											
Clinical Activities																											
RCH Clinics Attended																											
Mothers with identified problem visited																											
		M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
At risk children visited	**<5**																										
	> 5																										
		M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Presumptive TB cases	**<5**																										
	> 5																										
TB Patients receiving DOTS in the village	**<5**																										
	> 5																										
Suspected Leprosy	**<5**																										
	> 5																										

Other Activities

	Key	***1***	***2***	***3***	***4***	***5***	***6***	**7**	**8**	**9**	**10**	**11**	**12**
Villages													
Community meetings attended													
Others (Include all SBCC activities)													

Deaths Reported by VHW and CBCs

Name	**Village**	**Sex**	**Age**	**Suspected Cause of Death**	**Place of Death**	**Infant=I, Maternal =M**	**Date of Death**

Filled By		**Signature**			
Designation		**Date**			
Telephone					
Verified at the RHD by		**Signature**			
Designation		**Date**			
Telephone:					

7. iCCM Key Health Indicators

No.	Indicator	Total	No.	Indicator	Total
1.	Number of ANC first trimester visits		17.	Number of pregnant women with severe anaemia	
2.	Percentage of deliveries conducted by skilled health attendant in health facilities		18.	Number of households with at least one ITN and/or IRS during the last 12 months	
3.	Total number of antenatal counselled and referred for ANC booking		19.	Number of Fever cases < 7 days RDT done	
4.	Antenatal counselled and referred for first trimester booking		20.	Number of Fever cases < 7 days RDT +ve	
5.	Women referred for Institutional delivery		21.	Number of under 5 Malaria Cases (RDT +ve) treated with ACT	
6.	Total antenatal visited		22.	Number of household members using improved sanitation facilities which are not shared	
7.	Children <5 years participating in growth monitoring		23.	Number of household members with an improved drinking water source on premises	
8.	children < 5 years with MUAC indicating moderate malnutrition.		24.	Number of deaths < 1yrs	

9.	children < 5 years with MUAC indicating severe malnutrition.		25.	Number of deaths	1-5 yrs	
10.	Number of new-borns referred to a health facility		26.	Number of deaths	Maternal deaths	
11.	Number of women(15-49yrs) provided with FP commodities by CHWs		27.	Number of deaths	Other deaths	
12.	Number of children under one year referred for immunization		28.	Total deaths		
13.	Number of children 6 to 59 Months referred for Vitamin A					
14.	Number of immunization defaulters traced					
15.	Number of children 2-14 years dewormed					
16.	Number of fever cases seen by CHWs					

Did the community unit experience stock-outs of more than 7 days for any of the following commodities			
No.	COMMODITY	Yes	No
1.	Antimalarials (child dosages)		
2.	Zinc		
3.	ORS		
4.	RDT		

THE GAMBIA COMMUNITY HEALTH STRATEGY CHW SUPERVISION CHECKLIST					
Supervisor Name:		**Date:**			
Supervisor Designation:		**Region:**			
CHW name:		**District:**			
Name of community:		**Health facility:**			
#	**Item**	**Yes**	**No**	**NA**	**Comment**
A	**AVAILABILITY OF MEDICINES** (Check medicines and ask				
1	ORS (At least **12** Sachets)				
2	Did you have ORS everyday last month? If no, for about how many days were you without ORS last				
3	AL 1X6 (At least 10 blister packs)				
4	AL 2X6 (At least 10 blister packs)				
5	AL 3X6 (At least 10 blister packs)				
6	AL 4X6 (At least 10 blister packs)				
7	Did you have AL everyday last month? If no, for about how many days were you without				

8	Zinc sulfate 20mg (Approximately **60** tablets)				
9	Did you have a continuous supply of AL, ORS and zinc for the last 3 months without any stock-out of those products?				
10	Albendazole 400mg (approximately (20 tablets)				
11	Paracetamol 500mg (Approximately 36 tablets)				
12	Tetracycline Eye ointment 1% (At least 6 tubes)				
13	Combined oral contraceptives (at least 25 packs)				
14	Povidone Iodine Solution (At least a bottle in use)				
AI	**CHW HAS ALL KEY ICCM MEDICINES (AL/ORS/ZINC) [yes for 1,3,4&8]**				
A2	**CHW HAD NO STOCK-OUTS OF MORE THAN 7 DAYS FOR KEY iCCM MEDICINES**				
A3	**CHW HAS ALL KEY CHS MEDICINES [yes to all]**				
B	**MEDICINE STORAGE AND QUALITY**	**Yes**	**No**	**NA**	**Comment**
1	Medicines are stored appropriately (as per guidelines)				
2	All medicines are valid (unexpired).				
B1	**CHW DEMONSTRATES APPROPRIATE DRUG MANAGEMENT**				
C	**AVAILABILITY OF SUPPLIES (**Observe availability of the following supplies)	**Yes**	**No**	**NA**	**Comment**
1	Mid upper arm circumference (MUAC) tape				
2	RDTs				
3	Digital thermometer				
4	Salter scale/Colour coded salter scale				
5	Medical dispensing envelopes				
6	First aid kit				
7	Water quality supplies (Chlorine / flocculant (coagulant and				
8	Male condoms				
9	Community treatment and tracking register with blank				
11	Sick Child Recording Form				
12	CHWs Job aids/counselling cards				
13	Blank referral forms (at least 3)				
C1	**CHW HAS ALL KEY JOB AIDS (Sick Child Recording Form and CHS Job Aid)**				
C2	**CHW HAS ALL KEY iCCM SUPPLIES (MUAC, TIMER, RDTS)**				
C3	**CHWs HAS FULL CHWs KIT**				

D.	**PROVISION OF iCCM SERVICES (Ask to see CHWs register and record below)**	**Yes**	**No**	**NA**	**Comment**
D1	**CHWs HAS MANAGED iCCM CASES IN LAST 3 MONTHS**				IF NO, describe why and skip to section H
E.	**CLASSIFICATION-TREATMENT CONSISTENCY (**Review the 2 most recent cases of fever, diarrhoea and malnutrition in the Register.)	**Yes**	**No**	**NA**	**Comment**
1	Case 1: correct classification-treatment/referral				
2	Case 2: correct classification-treatment/referral				
3	Case 3: correct classification-treatment/referral				
4	Case 4: correct classification-treatment/referral				
5	Case 5: correct classification-treatment/referral				
5	Case 6: correct classification-treatment/referral				
E1	**CHWs REGISTER SHOWS CLASSIFICATION-TREATMENT CONSISTENCY (4/6 OR 6/6 'YES')**				
F.	**CASE FOLLOW-UP (**Review 2 cases managed in the previous month and tick if follow up for each case was completed within 3 days)	**Yes**	**No**	**N/A**	**Comment (describe condition)**
1	Case 1: follow up complete				
2	Case 2: follow up complete				
3	Case 3: follow up complete				
4	Case 4: follow up complete				
5	Case 5: follow up complete				
6	Case 6: follow up complete				
F1	**CHW COMPLETING FOLLOW-UP FOR iCCM CASES (4/6 OR 6/6 'YES')**				
G	**REGISTER AND REPORT COMPLETENESS**	**Yes**	**No**	**NA**	**Comment**
1	Treatment Register filled completely (all blanks filled and all				
2	Household register updated in the last 6 months				
3	Log book updated in the past week				
G1	**CHW REGISTERS AND REPORTS COMPLETE AND UP TO DATE**				

H	CASE MANAGEMENT AND COUNSELLING (Administer case scenario or simulation)	Yes	No	NA	Comment(Give
1	Takes child's identification (name AND age AND sex)?				
2	Assesses for all danger signs correctly				
2b	Identifies danger sign(s) correctly				
3	Counts respiratory rate correctly (+/- 2 breaths)				
4	Decides to treat or refer child's illness correctly				
5	Gives correct treatment				
6	Demonstrates how to administer treatment correctly				
7	Counsels (correct messages on feeding, increased fluids				
8	Explains how to administer medicines correctly				
9	Asks mother to repeat back how to administer				
10	Asks caregiver to return for follow-up visit				
11	Refers if child has danger sign or condition, he/she cannot				
12	Facilitates referral (provides referral slip AND first dose)				
H1	**CHW DEMONSTRATES CORRECT COUNSELING ("Yes" for 6, 7, 8, and 9)**				
H2	**CHW DEMONSTRATES CORRECT CASE MANAGEMENT ("Yes" for 2, 4, 5 and 7)**				

I	ASSESSMENT SKILLS (Refer to instructions)	Yes	No	NA	Comment
I1	**CHW DEMONSTRATES CORRECT USE OF MUAC TAPES**				
J	**KNOWLEDGE OF DANGER SIGNS**	**Yes**	**No**	**NA**	**Comment**
1	CHW can state at least **4** new-born danger signs				
2	CHW can state at least 4 danger signs in pregnancy				
3	CHW can state at least 4 danger signs in child under 5				
J1	**CHW DEMONSTRATES KNOWLEDGE OF DANGER SIGNS ("Yes" for any 2 cohorts)**				
L	**MATERNAL AND NEWBORN CARE HOME VISITS AND COUNSELLING**	**Yes**	**No**	**NA**	**Comment**
1	CHW has counselled one or more pregnant women in the last month				
2	CHW has conducted home visit within 48 hours to				
L1	**CHWs CONDUCTING MATERNAL AND NEWBORN ACTIVITIES ("Yes" for 1 & 2)**				
	GENERAL COMMENTS				

	What were the CHW's most important concerns (and your responses)? Number by priority.				
	Observations and recommendations? Also record in Supervision Log Book at VHS				
	PERFORMANCE RATING OF THE CHW				

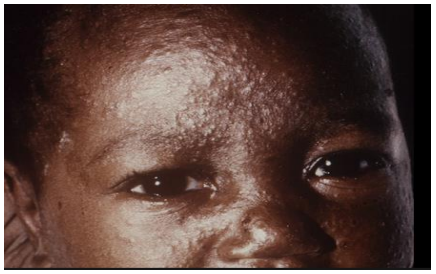
SECTION A: Patient /Client Data	
Date:	Time of referral:
Name of the patient:	
Sex: Male Female	Age:
Name of PHC Village: Name of Supervising Health Facility: Reason(s) for Referral Main problem(s): Treatment given: Comments: CHW Referring the Patient	
Name:	Mobile No:
Village/District:	Sub location: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

Official Rubber Stamp & Signature: ----------

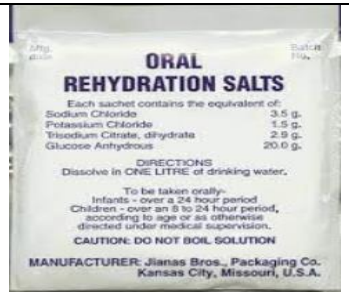
8. Village Health Worker Tally Form Under Five Years

Name of Village:	District:	Circuit
Name of VHW:	Region	Year:20

Conditions/Activities	 Months		 Months	
 **Total Patients Seen**	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000

 **Paediatric Paracetamol 100mg**	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000
 Child with Suspected Measles	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000
 **Child with Fast Breathing**	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000

 Amoxicillin Trihydrate Dispersible	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000
 **Child with Diarrhoea**	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000
 Diarrhoea with Blood	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000

 ORS	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000
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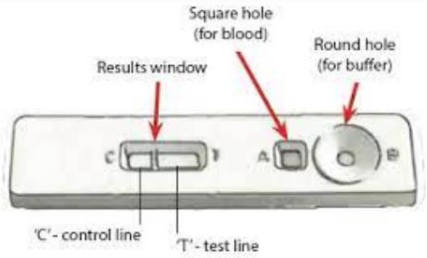
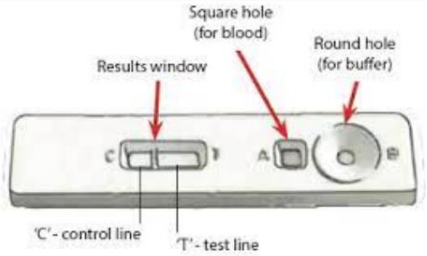
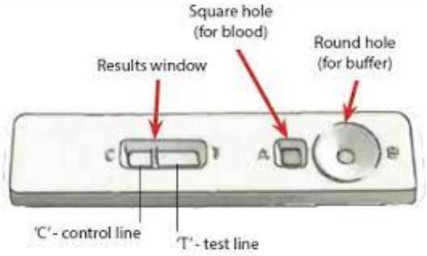
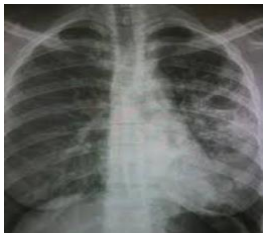
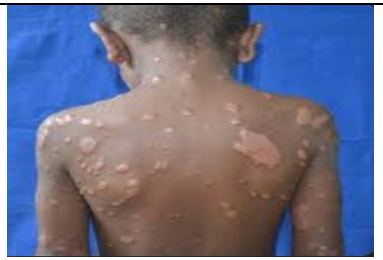
 RDT Positive	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000

 RDT Negative	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000
 RDT Invalid	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000
 **Child with Uncomplicated Malaria**	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000

 **Coartem 6**	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000
 **Coartem 12**	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000
 Presumptive TB Cases	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000

 **Number of TB Patients on DOT**	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000
 **Suspected Leprosy**	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000
 **Number of Referrals**	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000

 **Home visits**	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000
 Follow-up Home visits	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000
 Infant Deaths (Less than 1 Year)	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000

 **Deaths 1 – 5 Years**	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000