World Vision

Timed And Targeted Counselling For Health And Nutrition

A Guideline for ttC Data Collection and Reporting

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ABBREVIATIONS

ADP	Area development programme
ANC	Antenatal care
CHW	Community health worker/volunteer
COMM	Community health committee
c-PMTCT	Community prevention of mother-to-child transmission
CVA	Citizen Voice and Action
CWB	Child well-being
DHMT	District Health Management Team
DME	Design, monitoring and evaluation
EmOC	Emergency obstetric care
EWGR	Eligible Women and Girls Register
HIV	Human Immunodeficiency virus
HH	Household
HMIS	Health Management Information Systems
H/N	Health and nutrition
HSS	Health system strengthening
ICCM	Integrated community case management
HV	Home visitor
IDS	Immunisation, Deparasitisation and Supplementation
IFA	Iron and folic acid
IMCI	Integrated Management of Childhood Illnesses
IPTp1	Intermittent preventative treatment during pregnancy
LBW	Low birth weight (baby)
LEAP	Learning through Evaluation with Accountability and Planning
LLIN	Long-lasting insecticide treated net
MNCH	Maternal, newborn and child health
MoH	Ministry of Health
NO	National office
PHU	Primary healthcare unit
SBA	Skilled birth attendant
TBA	Traditional birth attendant
TT	Tetanus toxoid
TT1	Tetanus toxoid dose given at first contact
ttC	Timed and Targeted Counselling
ttC-HVs	ttC-Home visitors
WASH	Water, Sanitation and Hygiene

ICONS

 *Ask the group*

 *Technical information*

 *Summarise*

 *Recap the key messages and objective*

 *Use job aids (materials)*

 *Activity*

 *Discussion topic*

PART ONE: A GUIDELINE FOR TTC DATA COLLECTION AND REPORTING

1. INTRODUCTION TO DATA MONITORING FOR ttC

PURPOSE OF THIS SECTION

This section is intended to provide an overview of the timed and targeted counselling (ttC) data collection and data utilisation process for project managers; design, monitoring and evaluation (DME) staff; and Ministry of Health (MoH) facility-based staff or District Health Management Teams (DHMT) who are involved in the design of data monitoring systems for ttC. It starts with a rationale for monitoring as a programme-management tool, identifies the key audiences for the data and reports themselves and then briefly introduces the main tools of the system described in this guidance document. (Note: This guidance document does not cover tools that are appropriate for periodic baseline and evaluation exercises.)

1.1 Purpose and intent of programme monitoring

The primary goal of programme monitoring is to provide an ongoing information stream that **drives practical decisions about how to execute a ttC programme at the front lines**. Some examples of these kinds of decisions involved are listed in Box 1, and you can probably think of others.

Another goal of programme monitoring is to **facilitate planning processes at different levels of a health system or programme.** District health authorities may wish to anticipate changes in patient-flow levels based on the pace of scale-up of a ttC programme, for example; World Vision, together with partners, may need to make annual or multi-annual plans to support such programmes. This type of planning activity should be based on information about processes going on in the field and their immediate effects on household members.

Finally, monitoring systems reveal our 'programming footprint' to those who consider whether or not to financially support our programmes in the field or provide some other type of support. This type of accountability for the use of funds and other resources is a fundamental element of good practice in the management of programmes no matter where those resources come from. In this guidance document, this purpose for monitoring information is intentionally downplayed because we feel that if the first 2 focuses of monitoring are addressed, this focus can readily be addressed by managers who typically have a clear understanding of these expectations.

Box 1. Examples of programming questions that can be informed by monitoring information

- Is the corps of trained home visitors reaching the entire 'vulnerable population' however that is defined? (adequate coverage)
- Are there community- and programme-level barriers to health practices which are limiting the success of the programme and therefore need to be addressed through other activities?
- How many clients can home visitors handle in a certain time frame? Do I have the right number of home visitors for my community? Do I need more or fewer? (manpower management)
- Did the ttC training we did appear to work well? What should be improved and when do we need refresher training?
- Are supervisors able to perform their supervisory tasks adequately? What adjustments may be needed?
- What are the most challenging aspects of the programme for home visitors to discuss with families to achieve behaviour change? Do these have to do with barriers or the home visitor skills or both? How can we address this?

1.2 Audiences for monitoring information

Focusing on the goal of continuous programme improvement and on planning as the programme is scaled up and maintained, a set of prioritised audiences can be considered.

1. ttC-home visitors

ttC-home visitors (ttC-HVs) themselves will find it helpful to keep a record of their visits, referrals and the health practices that women and families have achieved. This will help them to continue to provide support and feedback to the families. With the support of a supervisor or during supervisory meetings, they can also compare progress across all households, looking for patterns that seem to match with the practices that are least and most practised in their communities and use this to improve the focus of their counselling. Sharing the 'big picture' from monitoring information in a way that is helpful to home visitors is critical to the success and the quality of the monitoring system.

2. ttC-HV supervisors

Supervision is concerned with ensuring that all home visitors are making maximum use of programme resources and their own skills in their encounters with families, and ensuring that the activities meet the quality-of-care standards defined by the programme. Guided by the collection of data and the review of progress during supervisory field visits or meetings, supervisors can identify gaps in counselling support and start to understand and help address those practices that are the most challenging for families in their community.

3. COMMs, CVA and community leaders

Community health committees (COMM), Citizen Voice and Action (CVA), and community leaders are concerned about common or particularly acute community-level barriers to achieving improved health status. They can support changes that will reduce these barriers and help enable families and communities to overcome them, or they can represent the community in taking up these issues with the health authorities or local government where necessary.

4. Primary health units and district health management teams

These audiences will make the greatest use of ttC programme monitoring information for planning purposes. In some cases they will use the information to assess the need for supervisory manpower for the programme, if that is their role. They will always be interested to understand progress towards broad coverage of the families that they serve. An additional important function is that the data can serve to help them plan and justify requests so that adequate resources, human and material, can be made available at the health facility to meet the increasing demand that the programme hopefully stimulates.

1.3 Available monitoring tools

Various tools have been made available as the starting point for developing contextualised DME tools for ttC. The ttC model encompasses the ongoing monitoring of the uptake of many household health practices. Table 1 in section 2.2 provides a description of existing monitoring tools which can be accessed through WV Central. Consistent with WV monitoring guidance, all these tools are intended as *examples that need to be adapted to local context*; during the adaptation process, the MoH will need to be consulted and alternative data collection tools compared side by side before deciding on the option best for the country. In some cases, a systematic process to examine the strengths and weaknesses of these and other existing tools can lead to an improved and appropriate measurement approach.

Available tools

- The **illustrative logframe**[1] for ttC is not a measurement tool; rather, it is a measurement framework and a programme design tool that includes indicators, some of which will be tracked by your monitoring system. The logframe includes an exhaustive list of core and optional indicators which can be used for monitoring (output level) and evaluation (outcome level) indicators. This logframe also highlights which of these indicators are child well-being (CWB) target indicators or related to them at the monitoring level. We hope that this framework will be consulted during the design or redesign process not only to assign indicators that are most appropriate to include for the programme but also to help programme designers to think through activities relevant to each outcome as is recommended through the Learning through Evaluation with Accountability and Planning (LEAP) standards.[2] Appendix B provides a list of selected core and optional indicators.
- The **Eligible Women and Girls Register** (EWGR) is a generic measurement tool that can be used at project start-up, and potentially periodically thereafter, to identify all women ages 15 to 49 years[3] who reside in an area served by an individual home visitor.
- The **Referral/Counter-Referral Form** is a generic tool designed to be used to transmit information between health facilities and ttC-HVs or community health workers (CHW) to enhance the beneficiary's experience with the health system and the follow up from a home visitor. It also tracks the specific timeframes around referrals and follow up.
- The **ttC Register and Tally Sheet** is a generic measurement tool designed with a multiple purpose. It tracks the home visiting of each visitor compared to the visit schedule, tracks basic information about urgent referrals, records maternal and newborn/child death events and captures a limited number of preventive health practices. The health practice information, when tracked accurately, can pinpoint areas of the programme where ttC has limited impact on behaviour change, and it can provide early signs of progress during the period between baseline and endline. The paper version of the tool[4] is structured to yield summary information for each beneficiary at the close of each of four life-cycle intervals (pregnancy, newborn 0–1m, infant aged 1–<6m and child aged 6–24m.) Paper tallying forms for this system are also available for supervisor's use in the field collection and feedback of data, and an MS Excel-based data repository and reporting tool, called the ttC Tracker, is under preparation. The Excel spreadsheet is for the purpose of data entry at the level of the health facility, area development programme (ADP) staff or district health authority, depending on the context and types of supervisors used.
- **The ttC-HV Diary** is essentially just a notebook or diary that literate ttC-HVs can use to mark visits planned and also note key outcomes of the visits, such as qualitative information about the barriers identified and reported by households.

[1] 'Logframe' refers to a logical framework. Sometimes the logframe is referred to as programme logic or as a performance measurement framework.

[2] The LEAP guidance and toolkit constitute the universal framework for performance measurement at World Vision. As of this writing the pilot testing phase for the latest version of this guidance, LEAP 3, is drawing to a close. Access to the full set of most current LEAP-related resources can be found at https://www.wvcentral.org/community/pe/pages/leap.aspx.

[3] This is the standard age range for women of childbearing age. However, in contexts where early marriage or adolescent pregnancies are very high, programmes might consider early registration in consultation with the MoH.

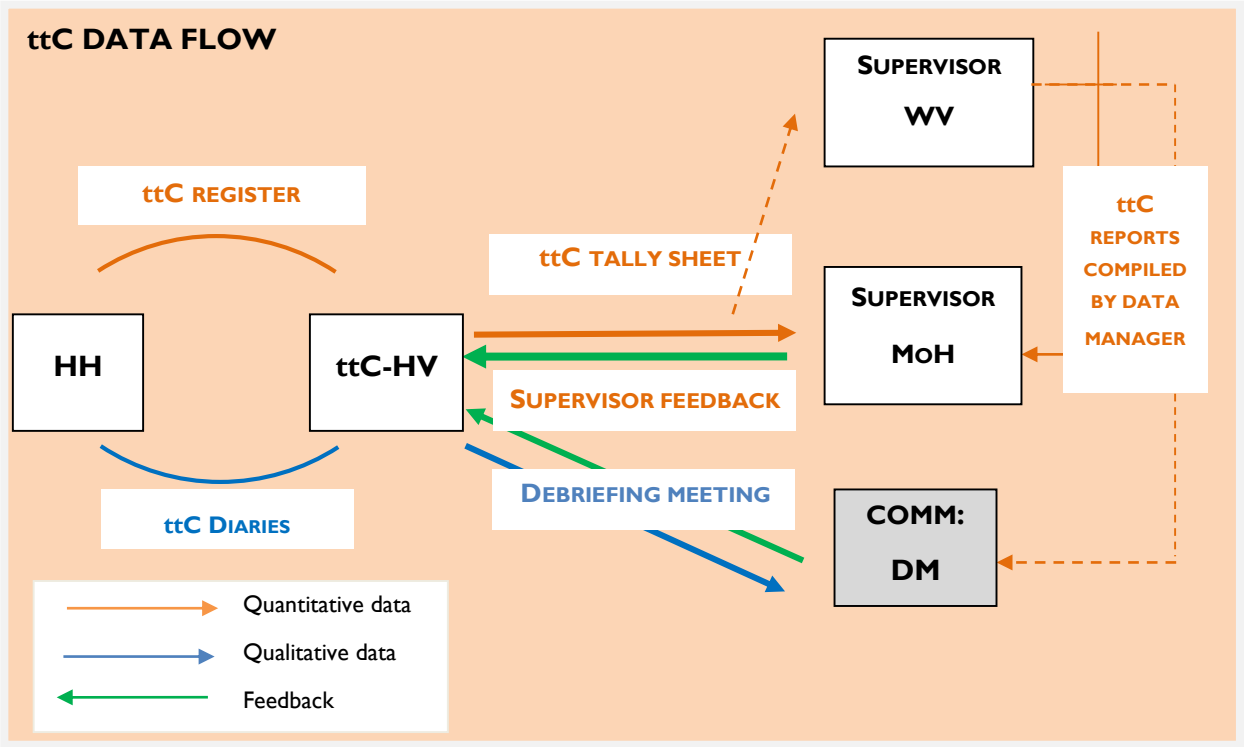
[4] A mobile ttC application is currently being piloted in a number of countries. Mobile systems can aggregate data automatically according to the programme preference.

2. OVERVIEW OF TTC DATA MONITORING

In this section we provide a more detailed overview of the ttC monitoring, beginning with the flow of information between different entities and a description of the different components of the system and how they can be contextualised.

2.1 The system of data flow

Figure 1: Recommended data flow pattern for ttC Registers and Diaries



Reporting flow of quantitative information

- **First-level quantitative: ttC-HV Register** The ttC-HV collects quantitative information during household visits, using forms especially developed for this purpose. (Programmes will either use the ttC-HV Registers distributed as part of this package or modify these to align with data collection instruments in use by MoH at the field level, if any.)
- **Second-level quantitative: ttC Tally Sheets** The supervisor collects the data from the ttC Registers, once the client has completed the life-cycle stage for that form. They manage quality control by completing the final outcome for the client, and then completing the ttC Tally Forms for that supervision period. **Note:** Under this model we are assuming that a ttC-HV supervisor may be someone with only basic literacy such as a lead ttC-HV, a CHW, a COMM representative or a low-level health professional (health extension or auxiliary health worker).
- **Third-level quantitative: ttC Reports** The ttC supervisors deliver the ttC Tally Forms to their superior – a WV project manager or an MoH technical supervisor. As not all supervisors have computers, and supervisors may have diverse capabilities, the system allows for data entry to occur at the health-facility or project-manager level. At this level there must be a person identified who is trained to enter the information from the ttC-HV Registers into a specially designed data spreadsheet system that enables various levels of aggregation. This information serves to contribute to WV upward

reporting requirements, and/or to MoH information management systems. More importantly, the aggregated data provides information as to programmatic and behavioural trends, enabling programming analysis, follow-up action, and 'mid-course corrections' to project design, as needed. As it is understood that data entry and analysis typically happens remotely from the field, the training materials for supervisors in Part 2 include training on how to analyse the data using tallies and threshold values that will enable real-time feedback during a field supervision, group supervision or debriefing meeting, depending on the supervision strategy.

Feedback flow of quantitative data

- **First-level feedback (direct to ttC-HV from the supervisor**) This important part of the feedback step needs to happen in real time (i.e. as the supervisor collects and reviews the data, pointing out key health barriers that emerge from the data and making suggestions for how the ttC-HVs can work with families to overcome these barriers and issues that need additional support from community leaders or COMMs). This can happen on a one-to-one basis during individual supervision or during a group data tallying exercise as part of group supervision, detailed in Part 2.
- **Second-level feedback (from supervisor's aggregated data to project staff and health authorities)** The WV or MoH supervisors present the aggregated data to all stakeholders, including the project staff and health authorities involved in ttC programme management. The reports will also be shared through the COMM group during periodic 'debriefing meetings' attended by COMM members, ttC-HVs, MoH representative(s) and WV staff. The COMM thereby gains experience in understanding the purpose of quantitative data collection and is empowered to use this data to inform its community responses. WV's involvement in this process should phase out over time, with this function remaining with the MoH. During these meeting the COMMs will also have a chance to share feedback with the supervisors (if the COMMs members are not supervisors) and for project managers to highlight gross changes in data or programme-wide issues that need to be addressed.

Feedback flow for qualitative information

- **First-level qualitative: ttC-HV Diary (plain notebook)** Through the 'dialogue counselling approach' the ttC-HV comes to understand the real-life situations of the families he or she visits, including many of the constraints or barriers that households may face when attempting to practise new recommended behaviours. This qualitative information provides some of the 'why' behind the quantitative figures collected. Literate ttC-HVs will record their observations in a ttC-HV Diary, while non-literate ttC-HVs should be able to remember the most salient stories. Supervisors will be able to provide real-time feedback during supervision and use this information captured through comments on the supervision tool itself.
- **Second-level qualitative: ttC-HV Debrief** During the periodic debriefing meetings the ttC-HVs share their learning gained as a result of engaging in dialogue counselling. Common themes/issues/barriers may emerge as all the ttC-HVs share their learning (i.e. second-level trends). The discussion of these common issues may lead to additional community action in response to identified barriers, may inform the COMM's advocacy agenda and/or may result in some changes to project design.

2.2 Components of the monitoring system

Table 1. Components of the monitoring systems and tools

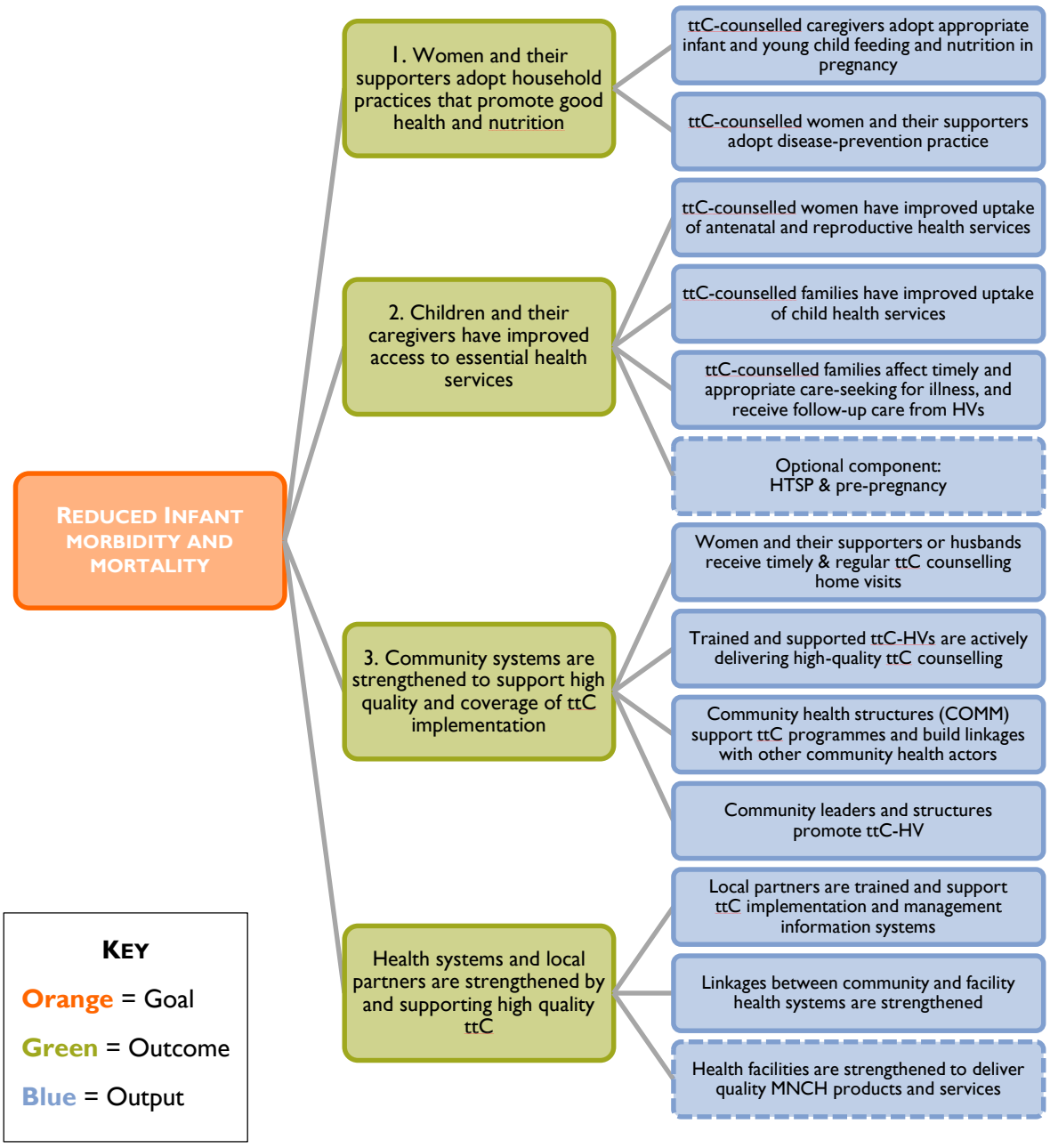
Name of tool	Description
Guidance on ttC Collection and Reporting	This document
Illustrative Logframe	An Excel version of the ttC generic logframe including a complete list of possible indicators for use alongside the strategic framework
Eligible Women and Girls Register	A simple form for ttC-HVs to identify all eligible women and girls in their coverage areas and regularly track women for new pregnancies, births and deaths
Referral/Counter-Referral Form	A simple double-sided form that enables information to be sent with the mother to the clinic; the reverse side is completed by the clinic and returned with the patients after discharge. This is to be adapted locally.
ttC Registers & Tally Sheets	Pictorial forms for the collection of data at the household level by the ttC-HVs. Each worksheet in the file includes 2 forms similar in appearance but with quite distinct functions as follows: • ttC Register (first-level quantitative): one for ttC-HV to collect data at the household level • ttC Tally Sheets: for the supervisor to collate the results from multiple ttC-HVs under her or his supervision
ttC Tracker	An Excel-based data repository and reporting tool that can be used for the ongoing management of ttC regular data collection and analysis at the ADP or at the district health management team level.

ttC strategic framework

The strategic framework for ttC, also called a measurement framework, is organised under four primary outcomes which reflect the 360° approach considered fundamental to the 7-11 strategy. The 360° approach is a simple idea. It suggests that working to achieve favourable changes related to health amongst family members at the household level, within health systems and community structures and in the broader policy environment, we can achieve far more than if we focused on just one or even 2 of these elements. These basic ideas from the 7-11 strategy should be familiar to project staff.

This framework is reflected in the ttC illustrative logframe, and is designed to be adaptable and to make it easier to clearly show linkages with other core models or approaches. COMM, for example, can be viewed as an extension of the community outcome of the ttC model, CVA under health systems strengthening (HSS). C-PMTCT and integrated community case management (ICCM) have stronger emphases on programme technical quality assurance elements, and they also group outcomes according to individual, community and environmental levels. Thus, whatever project modes are being integrated with ttC, this framework is 'expandable' or 'reducible' to accommodate them.

Figure 2. Overview of the ttC logic model or strategic framework



*where COMM is being deployed alongside ttC.

Description of strategic objectives

Outcome 1 Women and their supporters adopt household practices that promote good health and nutrition

In ttC nutrition and health practices are promoted by counselling activities. Importantly ttC data monitoring reports the immediate 'outcomes' of the counselling (i.e. reported uptake of practices by counselled women). At outcome levels, household surveys monitor the extent to which these activities have changed the practices at the population level, regardless of whether the household had enrolled in ttC. The illustrative logframe includes all optional practices, but the 'core' monitoring and evaluation indicators should not be omitted. Key outputs pertain to the adoption of household-level practices (or household *uptake*) related to child feeding and the prevention of diseases.

Outcome 2 Children and their caregivers have improved access to essential health services

Access to essential health services can be separated from the household practices outcomes under the model because, while they are promoted alongside home-based care, they may be limited by different factors than household practices such as service availability, cost and quality-of-care issues. There are 3 outputs under this outcome, including women's access to the full range of reproductive (antenatal, delivery, family planning and postpartum) services available to them; children's access to preventive care services (vaccination, supplementation, deworming, and growth monitoring and promotion); and household access to appropriate services in a timely manner in the event of a health problem. The ttC-HVs may not always be the person to make a referral; if they refer after a home visit, it is recommended they ensure the referral was followed and that they make a follow-up visit to check on the client. There is an option for a project to include counselling on birth spacing and family planning amongst women and girls pre-pregnancy rather than postpartum; although the ttC-core curriculum does not capture this, it may be considered as a local adaptation.

Outcome 3 Community systems are strengthened to support high quality and coverage of ttC implementation

Community systems strengthening is an integral part of ttC. This outcome aims to ensure that projects prioritise ttC community support in terms of programme reach, participation and quality. All activities related to training, supervision, integration of community health activities, community participation, sensitisation of communities and links to COMMs can be covered under this outcome.

The first output under this outcome relates to programme reach, which in turn has 3 elements – early enrolment during pregnancy, completion of planned visits, and husband/partner or family participation – which are key performance indicators for assessing ttC-HVs. The option of registration of eligible women and girls may increase likelihood that women are identified earlier and may promote the programme amongst those at risk or planning a pregnancy.

The second output encompasses the various efforts to train, equip, support and motivate the community actors to do their work.

The third output relates to linkages and support provided by COMMs, their supervision and their active involvement in promoting ttC.

Outcome 4 Health systems and local partners have increased operational structures to support ttC and maternal, newborn and child health (MNCH)

To ensure adequate support within the local health authorities, the ttC model should be implemented alongside appropriate primary health system strengthening activities. ttC programming should foster linkages with health services through communication, transportation and supervision, as well as the sharing of data (contribution to Health Management Information Systems [HMIS] of the ttC data). However, in some but not

all contexts, including fragile contexts and very isolated regions, structuring outcomes this way creates the space for deeper HSS activities to be included. Many pilot ttC projects, especially those developed within a grant system, have undertaken specific HSS training activities as they start up ttC (for example, refresher trainings for Integrated Management of Childhood Illnesses, emergency obstetric care [EmOC], Baby Friendly Hospital Initiative, improved support supervision and HMIS or data management). A full list of HSS activities is provided in the ttC Toolkit. There are core indicators for health systems to be collected (e.g. stocks, patient uptake and satisfaction) which may underlie ttC programme success; therefore, collecting this data is highly recommended.

Illustrative logframe for ttC

The ttC illustrative logframe includes a comprehensive list of the indicators used for both monitoring and evaluation of ttC programmes, and can be downloaded from wvcentral.[5] The list of possible output indicators is provided in **Appendix A**.

Table 2. A summary of output indicators for ttC monitoring

	Number of output indicators		
	Core	**Optional**	**Total**
Outcome 1: Home-based practices	6	8	14
Outcome 2: Access to services	10	12	22
Outcome 3: Community systems	14	4	18
Outcome 4: Health systems	4	5	9
Total indicators	34	29	63

The ttC illustrative logframe has evolved in consideration of the following points:

- **Comprehensive:** ttC is comprehensive of all 7-11 key messages and practices and therefore the list of indicators for ttC is also comprehensive of key 7-11 messages. It is also comprehensive both of those which need to be reporting for Standard Monitoring purposes for World Vision Health programmes and those commonly reported to the MoH systems.
- **Streamlined:** Earlier versions of this monitoring system systematically collected information on all behavioural targets at each specific household visit. This led to a system that was widely felt to be unrealistically burdensome to the home visitor and impractical to aggregate and tally using a set of paper forms. The data that is collected at each time point has been judiciously pruned to collect the minimum amount of information possible, to ideally assess behavioural targets only once when we expect the behaviour to be established, and to aggregate an individual beneficiary's information only at the end of each life-cycle interval.
- **Aligned with the WV Compendium of Indicators and Standard Monitoring Indicators:** In cases where decisions had to be made in terms of wording or choice of age ranges for some indicators, priority was given to aligning with the specifications for comparable indicators in the WV Compendium

[5] See wvcentral.org.

of Indicators.[6] For monitoring indicators, this exercise focused on alignment to as many of the new Health and Water, Sanitation and Hygiene (WASH) Standard Monitoring Indicators as possible.

- **Aligned with regional health and nutrition (H/N) monitoring indicators:** The process to develop the Health and WASH Standard Monitoring Indicators currently in effect took into consideration existing core indicators in place in each region. We therefore did not align to regional indicator sets in the design of this monitoring system.
- **Context-specific:** There are a number of indicators in this list that are relevant to some contexts but not to others (for example, indicators related to malaria). All of these context-specific indicators have been classified under the ttC measurement framework as 'optional'.

Working with generic logframe

Step 1. Review the logframe indicators with the MoH.

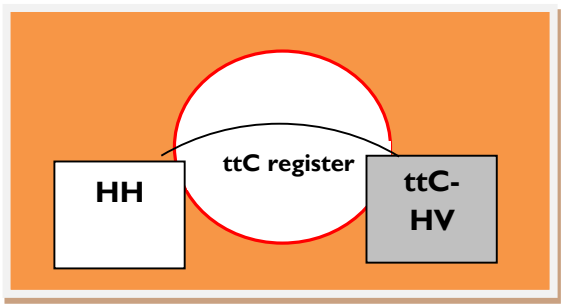
Step 2. Delete the rows that correspond to the optional indicators that you do not wish to collect for your context.

Step 3. Add rows under appropriate outcomes for any additional behaviours that the ttC-HVs will promote.

Step 4. Align your logframe to the appropriate accompanying project models that you are doing alongside ttC – typically this would be COMM and CVA.

Step 5. Under outcomes 3 and 4, add 'activity' rows for all relevant areas of health and community systems strengthening that you intend to undertake in the project (for example, training, supervision, incentives, communications support, emergency transport, health-facility–level trainings and technical or logistic support to supervision).

ttC Registers: First-level quantitative data collection



Appendix D contains an Excel spreadsheet copy of the ttC-HV Register and Tally Sheets. The data that the ttC-HV collects from the family during household visits comprises the first level of data collection. It is the raw data upon which all subsequent data aggregation and analysis is built. The ttC-HV uses a ttC-HV Register for this purpose, with spaces to record ✓or ✗ against the health practices of interest. Each image shown on the register corresponds to the health practice negotiated during the counselling. During their normal training courses, ttC-HVs are trained in how to complete the ttC Register, learning to correctly ask questions of household members to obtain the needed information. Cross-checking against the symbols recorded in the Household Handbook is a way to verify information with the families, and supervisors are also trained to do this.

ttC Register design considerations

A. **Life-cycle stage data collection.** Appendix B lists each indicator, along with the time it will be collected. There are four life-cycle stages at which data will be collected:

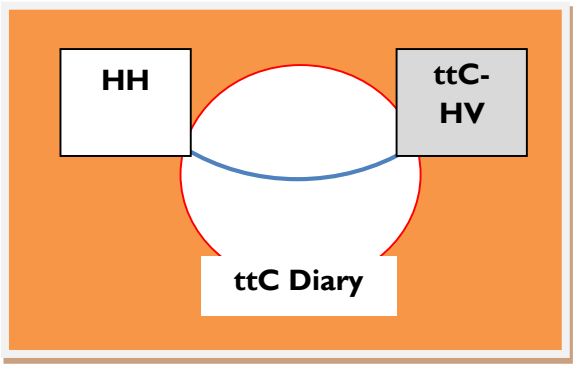
[6] The WV Compendium of Indicators is a tool focused at the level of **evaluation**, which means it is not equivalent to systems set up for the purpose of **monitoring**. Nevertheless, there is a good deal of alignment that can be achieved, and this alignment of the ttC monitoring system with the WV Compendium was always kept in mind.

Code	Life-cycle stage	When collected
P	Pregnancy	when the woman has given birth
N	Newborn	when the newborn has completed 30 days of life
I	Infant (corresponding to the exclusive breastfeeding phase of infancy 1–6 months)	when the child has completed 6 months
C	Child	when the child has completed 24 months of life

B. **Each life-cycle stage has a different page in the register** (or different form if they are to be printed separately). Supervisors may review this data for completeness, validate it using the 'spot check' supervision tool and capture information on performance indicators at any time.

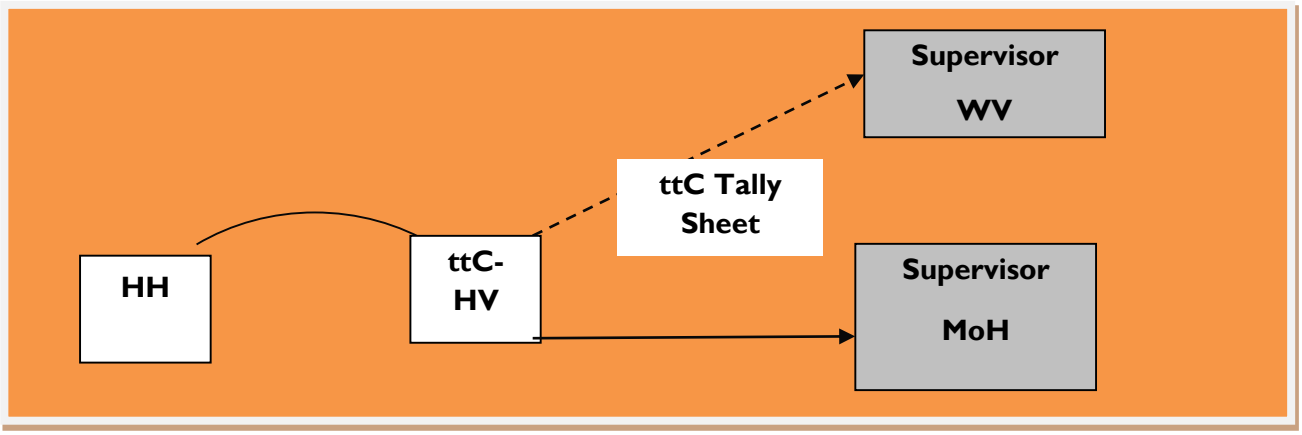
ttC-HV Diaries: First-level qualitative data collection

During dialogues with families, the ttC-HV encounters factors that influence behaviours and how they evolve over time through negotiations. ttC-HVs will be encouraged to record such qualitative findings, as insignificant as they may seem at first, in the **ttC-HV Diary**. The ttC-HV Diary need not be anything more complex than a blank notebook. As such, no appendix is provided.



ttC Tally Sheets: Second-level quantitative data collection

The ttC Tally Sheet is a printable form in which data from each ttC-HV Register is entered *manually* in the form of tally counts. Counts from each ttC-HV's completed ttC Registers must be entered into a different column in each Tally Sheet, which accommodates up to 10 ttC-HV's data per supervision period (e.g. quarterly/monthly) per sheet.



Tally Sheet design considerations

A. Retrospective data tallying. Health practice uptake is tallied only after that life-cycle stage has been completed (i.e. the data collection is retrospective). For example, information about whether the mother achieved 6 months of exclusive breastfeeding before she introduced complementary foods or water can be collected only after the child is 6 months old. Information on maternal and newborn mortality, completion of four antenatal consultations and iron-tablet consumption in pregnancy are also time-sensitive (i.e. it would result in double-counting if it were collected before the life-cycle stage is completed). Tallying time-sensitive and non-time–sensitive data separately would be too complex for supervisors to collect accurately, so the decision was taken to only tally at end-points. The performance indicators for the ongoing monitoring of the progress of each ttC-HV can be collected at any time. This decision was also made to reduce the complexity and to minimise data collection burden in the field.

B. Data verification of forms before tallying. While the ttC-HV makes ticks and crosses on the forms at all visits, the final decision about whether the desired behaviour had been practised or not during the life cycle is made at the end of the life-cycle stage. The supervisor will review the form and in the right hand column place a single ✓/× to indicate that the threshold for the practice of that indicator was reached.

a. Example 1: If 3 ticks are made for antenatal care (ANC), then the final result is × because the woman did not complete four ANC visits.
b. Example 2: If the woman breastfed without complementary food/water to four months, then the final result is × because she did not exclusively breastfeed to 6 months.

As such, the data is conservative, or stricter than the indicators collected for evaluation purposes, but arguably it will give wider variance for the use in assessment of ttC programme success and for the feedback at community level.

C. Identical layout and appearance of form. Instead of having different versions of forms for literate and non-literate users, we have opted to include pictures in both the supervisor's Tally Sheets and the ttC-HV Registers. The reason is that we may work with supervisors of low literacy, and because visually it aids the rapid tallying of forms if the page layouts and formats are identical.

D. Pictorial format for both supervisor and ttC-HV forms. Many supervisors in the field have a low education; they may be auxiliary nurses, health extension workers, CHWs or literate peer ttC-HVs who have been selected for the role of supervisor due to their success and achievements.

ttC Spreadsheet and reporting: Responsibility of supervisor/data manager

The third level of data collection involves feeding data from the ttC-HV supervisor's Tally Sheet into the **ttC Tracker Spreadsheet**. This enables aggregation at the level of supervisors, ADPs and health facilities (according to your needs), and at the level of the programme as a whole (multiple supervisors). The reports generated by the system provide a snapshot of the status and quality of implementation of ttC and its outcomes in terms of changes in behaviour and accessing of services. The responsibility for the introduction of the data into the spreadsheets and producing reports lies with the person delegated to do this within the project office or the health facility. This could be:

a. MoH data manager or data entry officer
b. MoH supervisor
c. MoH supervisor of supervisor (e.g. in peer supervision systems)

d. World Vision project staff

This data entry exercise can be done at several convenient times for the project:

- During group supervision (all in one session)
- During quarterly debriefings (all in one session)
- Following individual supervision in the field (one by one)

The advantage of having this done at the beginning or end of a debriefing meeting is that potentially the quarterly results can be available for some provisional analysis at the time, depending on how quickly automated reports can be generated.

Automated report design considerations

- **Automated threshold value analysis.** The reports generated from the ttC Tracker systems need to be interpreted by various audiences, most of whom will not have a high level of statistical education (for example COMM members, supervisors and perhaps also community leaders). Quantities of numbers need to be automatically interpreted in terms of what the programme deems to be an acceptable value for that indicator. For World Vision monitoring purposes, the values can be analysed in depth and actions taken; but at the project, ADP, primary healthcare unit (PHU) or community level, the automatic assignment to 3 possible ratings of 'good', 'needs improvement' or 'poor' should be part of the reporting structure. These thresholds are defined as default values but can be locally contextualised by the project.
- **Colour/contrast shade printing.** According to the threshold systems above, we aim to use green, orange and red colour coding as it is a well-recognised system globally. As the reports are intended to be shared, printing in colour or contrasting shades will enable interpretation by illiterate participants.
- **Short format.** The automated reporting systems aim to deliver brief reports with the basic statistics required at one page per ttC-HV and 2 to four pages per ADP/PHU area.
- **Grouping of indicator 'types' and life-cycle stages.** The indicators are to be grouped according to appropriate action to be taken (i.e. types of indicators).
- **Simple graphics.** Where possible, generate graphics of the current status of colour-coded indicators or show a difference between the current and desired outcome that can easily be interpreted.

2.3 ttC reporting framework

A. Supervisor-level report for each quarter

The ttC Summary Sheets (one for each supervisor) are used by the supervisors to enter data from all of their respective ttC-HV Registers. This data is entered directly into the ttC Tracker, and totals and percentages are calculated automatically.

B. ADP- or PHU-level quarterly compilation

These sheets automatically calculate totals for the quarter, from all the supervisor-level reports for the quarter. No data entry is required in these sheets. For your context you can decide whether to group data by ADP/PHU.

C. Supervisor annual compilation

These sheets also automatically calculate totals for each supervisor's four quarterly compilation sheets. No data entry is required in these sheets. In these sheets, *coverage* indicators are calculated in addition to performance indicators.

D. ADP/PHU annual compilation

This sheet automatically calculates data from five supervisors' annual compilations into one programme-wide compilation for each year. No data entry is required in this sheet. This sheet also contains both coverage and performance indicators.

E. Project-wide quarterly compilation

This will be possible using compiled reports from multiple ADPs or PHUs.

Types of indicators collected and calculated

Three types of indicators and related data are included in the ttC Tracker, as follows:

Community case statistics

These are indicators related to pregnancies, live births and still births, and deaths of pregnant and postpartum women, newborns, infants and children, recorded during each quarter. These are recorded as numbers, which are counted off ttC-HV registers and compiled at the supervisor and programme levels, both for the quarter and for the year.

Total population covered
of eligible women and girls registered (15–49 years and caregivers)
of eligible women and girls using a contraceptive method
of current pregnancies
of completed pregnancies
of deaths of pregnant women
of miscarriages, abortions
of women delivered since last supervision
of babies born (live and still born)
of deaths of women during labour and in postpartum (up to 6 weeks)
of still births (rate per 1,000 live births)
of live births
of deaths of newborns (up to 1 month of age, rate per 1,000 live births)
of total infants (1–6 months)
of total infants completed 6 months (forms collected this supervision)
of deaths of post-neonatal infants (1 to 6 months of age)
of children aged 6–23 months currently registered
of children aged 12–23 months
of ttC-completed children (now >24 months old)
of deaths of children (6–23 months or one day short of second birthday)

Performance indicators

Performance indicators are related to behaviours and utilisation of services, including referrals, and are calculated as proportions of all pregnant women/infants/children registered in ttC-HV registers and covered by ttC-HV home visits.

$$\text{Performance Indicator} = \frac{\text{\# clients reaching an outcome}}{\text{\# counselled clients}} \times 100$$

Key Performance Indicators for ttC	**Threshold Values**
• % completed ttC visits • % male/partner participation • % referral/follow up completion • % early registration in pregnancy	• <50% = poor • 50–75 % = needs improvement • 76–90% =good • >90% excellent

These indicators measure the extent of change amongst those being reached through ttC, with the caveat that all due ttC visits were made during the quarter. These indicators can be considered valid if at least 70 per cent of due visits were made during the quarter. Performance indicators are calculated at the supervisor and programme level every quarter and for the year.

Health practice uptake indicators (Appendix B)

Coverage indicators are calculated as proportions of all pregnant women/infants/children in the population. The set of indicators is the same as the set of performance indicators. These are based on estimates of pregnancies and births in the population, calculated from country-level birth rates. According to WHO estimates, approximately 63 per cent of all pregnancies end in a live birth, or, there are 1.58 pregnancies for every live birth. Deaths in pregnancy and the postpartum period, still births and deaths of newborns and infants are excluded from the appropriate denominators.

$$\text{Uptake Indicator} = \frac{\#\text{ reaching an outcome, as recorded in ttC visits}}{\#\text{ completed that life-cycle stage}} \times 100$$

When calculating uptake indicators, neonatal deaths have been deducted from the denominator for indicators for infants, and infant deaths deducted from those for children. However, it should be noted that the numerators for indicators for children aged 12-23 months are drawn from actual numbers of children born 1 to 2 years before, while the denominator contains deductions for infant deaths that took place during the current year.

Table 3. Reporting framework for ttC

Reporting level	**Individual ttC-HV-level reports** or community-level report for ttC-HV teams	**PHU or ADP level**	**DHMT LEVEL**
Frequency	Annually/biannually	Quarterly and annually Activities can be reported monthly	Biannually or annually.
Function	Individual level Performance reports Performance appraisal	Achieving expected numbers of supervision for ttC-HVs ttC programme is operational and having impact Show linkage between PHU and ttC-HVs	Combined data from all PHU/ADPs is aggregated by PHU or ADP
Description of decisions to be made using report	*Poor individual performance* • Replacement of the ttC-HV • Assessment of ttC-HV learning and support needs • Identify what refresher training needs to be done *Good individual performance* • Performance-based incentives • Giving rewards/recognition to top performers • Promotion: advanced training or as a peer counsellor	*Community health outcomes* • Identify which communities have lowest coverage of health. • Support Immunization, Deparasitization and Supplementation (IDS) campaign planning and outreach services. • Identify which communities and ttC-HVs to prioritise supervision efforts. • Monitor the number of referrals received and counter-referrals made (linkages). • Identify where most referrals are being received from.	Programme-management decisions Large-scale decisions
Indicators to include	*Community Case Statistics (per reporting period) e.g.* • # of eligible women population • # of completed cases per life-cycle stage (# total births/deliveries; # newborns; # children aged 1-<6m; # children aged 6-23m) • # of deaths by life-cycle stage (# total births/deliveries; # newborns; # children aged 1-<6m; # children aged 6-23m)	*Community Case Statistics (per reporting period)* e.g. • # of eligible women population • # of completed cases per life-cycle stage (# total births/deliveries; # newborns; # children aged 1–<6m; # children aged 6–23m) • # of deaths by life-cycle stage (# total births/deliveries; # newborns; # children aged 1–<6m; # children aged 6–23m)	As per PHU/ADP

	Performance-based indicators: • % completed ttC visits • % male/partner participation • % referral/follow up completion • % early registration in pregnancy *Health Practice Indicators* • Pregnancy core indicators • Newborn core indicators • Infant core indicators • Child core indicators • Optional or added indicators according to country requirements	*Performance-based indicators:* • % completed ttC visits • % male/partner participation • % referral/follow up completion • % early registration in pregnancy *Health Practice Indicators* • Pregnancy core indicators • Newborn core indicators • Infant core indicators • Child core indicators • Optional or added indicators according to country requirements	
Audiences	ttC-HV; supervisors; COMMs; chief and community leaders;	PHU staff; supervisors; DHMT staff; ADP managers; COMMs	MoH; DHMT; World Vision managers; Horizons

Data aggregation and feedback to stakeholders

Qualitative learnings

ttC-HVs share their learning that they have recorded in their ttC-HV Diaries during the periodic debriefing meetings organised by the COMMs as well as directly with their supervisors. The meetings present an opportunity to identify common themes, issues, and barriers and enablers to behaviour change as all the ttC-HVs share their learning. This identification of commonalities is the second level of compilation of qualitative trends. Supervisors participating in the debriefing meetings should record these common themes in their second-level version supervisor diaries, and report findings from data analysis. The discussion of these common issues may lead to additional community action in response to identified barriers, may inform the COMM's advocacy agenda and/or may result in some changes to project design.

ttC reports

The ttC Tracker will aggregate data at the PHU or ADP level and at the programme level, providing a picture of overall numbers of registered clients and the percent of those practising the recommended behaviours (per the indicators selected by the project). Aggregating data in this way enables the programme or DHMT to assess the extent to which behaviour change is taking place, and to identify those practices that are lagging.

During the debriefing meetings the WV or MoH data manager should present the aggregated data and reports to all stakeholders, including the ttC-HVs, supervisors, COMMs and health facility representatives. As noted, the data report ('snapshot picture') should be supplemented by the ttC-HVs' debriefs on the qualitative trends in their communities. It is only through such qualitative analysis that the programme can learn more about the reasons that households are or are not practising the recommended behaviours.

1.1. Contextualising the indicator list

Contextualisation: Each country will conduct this exercise once at the national level and then review following field testing and consultation with partners and MoH.

Project-specific decisions will need to be made as to **contextualisation** of the comprehensive list of indicators. In much the same way that not all of the messages and topics in the ttC curriculum will be relevant to every project area, so too not all indicators will be relevant. The indicator list for each project will need to be reviewed to identify which indicators are relevant to collect data against and which are not. There are 2 levels of decision-making when contextualising the indicator list: core and optional decisions.

Core indicator decisions

All projects must refer to the table in **Appendix B** and select or deselect the indicators listed therein, following the guidance provided and based on the project context. Core indicators include those which are target related (Standard Monitoring Indicators) and those which are central to ttC programming.

Optional indicator decisions

Projects may additionally choose to modify the indicator list, as follows:

- **Remove indicators:** Projects may determine that they do not wish to collect information related to certain indicators, if the behaviour or the practice is not an assessed priority in their project area.
- **Add indicators:** Projects will wish to add one or more indicators related to behaviours or practices that are not included in the list (shown as optional indicators in the ttC Registers). If

household practices are added, the project must ensure that *counselling related to the chosen practice is sufficiently covered in the ttC curriculum, and ideally added to the Household Handbook*.

Ministry of Health HMIS alignment

Projects may also choose to modify the list of indicators, if doing so will help to align to MoH reporting systems. If so, WV staff should determine what degree of reporting is required within WV itself (i.e. Standard Monitoring Indicators) and the extent to which the modified system will satisfy both the WV and the MoH reporting requirements. Increasingly, the guidance around annual reporting against the Child Well-Being Outcomes will emphasise the use of standard monitoring and outcome indicators.

Locations of contextualisation changes

When projects make changes to the indicator lists, these changes need to be reflected in all the following locations in the ttC-HV/ttC package of materials:

1. ttC Tracker spreadsheet, all tabs
2. ttC Registers and Tally Forms, through the deletion and addition of optional indicator rows
3. ttC Facilitator's Manual – changes to training sessions on completing ttC-HV Registers, as needed
4. ttC-HV Manual – corresponding changes (identical to changes made in facilitator's manual)
5. Household Handbook, if new practices are to be negotiated with families
6. Part 2 of this document – 'A Facilitators Guide to Training Supervisors in ttC Data Monitoring'

Adaptations to ttC Registers and Tally Sheets

- **Use available data.** Adopt and use any available information on pregnant women and infants/children already being recorded in MoH facilities or by CHW, such as reference numbers, expected delivery date and birth date.
- **Align with existing protocol of MoH** in areas such as the required number of antenatal visits, Human Immunodeficiency Virus (HIV) testing, malaria prevention and deworming during pregnancy and vitamin A and iron supplementation for infants and children.
- **Cross-reference the ttC and MoH lists** of indicators to bring overlapping indicators into alignment as far as possible.
- **Adjust forms for home visit numbers.** The current number of ttC home visits has been decided, taking several factors into consideration, including the number of messages that a visit can cover within a realistic time frame without overwhelming the family. However, the number of visits can be revised, considering the existing workload of ttC-HVs and their area of operation. The ttC Register should be able to accommodate any number of home visits determined, with small changes to the ttC Child Register column number.
- **Define the reporting period.** Negotiate and finalise the optimal frequency of supervisory visits to a ttC-HV, particularly if the supervisors are an MoH cadre and have to perform a host of other duties.
- **Check tallying methods.** Discuss the procedure for tallying information from registers, and ensure that the final counts will yield the required data (e.g. if the norm is 6 ANC visits in pregnancy, and 6 months of iron and folic acid (IFA), then adjust these tally columns in the ttC Registers).
  2.4

1.3. Contextualisation of the tools

Steps in adaptation

a. Selection of project activities and tools

During this process there should be a review of any existing tools used by the existing cadres/programmes for data collection at the community level. Where possible, use existing versions, and if there are gaps, negotiate adjustments within those tools. If the gaps are substantial, consider using the provided tools, ensuring that the adjustments are made to ensure HMIS alignment.

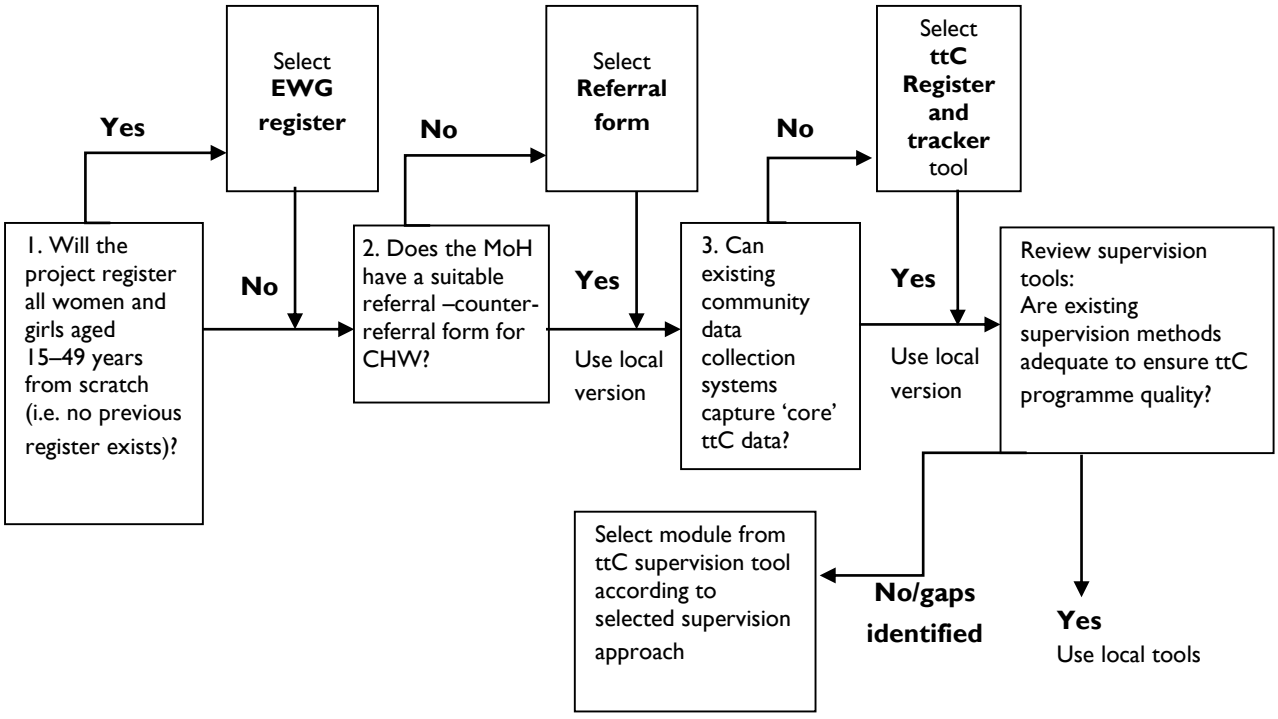
b. Selection of indicators

During national office adaptation of the tools, key household outcomes should be selected which will enable the best monitoring of the programme. All offices are to include the 'core' indicators and Health Target monitoring indicators, as well as certain aspects which are key to the programme methodology. 'Optional' indicators incorporate those that are specific to epidemiological context or the requirement of the programme to integrate with other activities. It is recommended that indicator selection *limits* the number of data points to those *most informative* (e.g. those that have high variance) or are required by HMIS systems. Remember to follow the principle of not collecting data that is unlikely to be used to improve programming.

c. Adjustment of tools

Once indicator selection is done, complete the adjustment of tools, which may be adding indicators to local MoH forms, or if using WV forms, deleting rows from the ttC Registers. This should be a straightforward process, and aim to do this only once during a project. Any HMIS required indicators not listed on the Global Centre sample ttC Registers can be added in the 'optional indicators' rows and given suitable icons. For adapting the back-end data base, this process will involve selecting and 'de-selecting' indicators required by your project. More information is given in the user guide.

Figure 3. Process flow for monitoring and supervision tools



PART TWO: A FACILITATOR'S GUIDE FOR TRAINING SUPERVISORS IN TTC DATA MONITORING

UNIT 1: COMPLETING THE TTC REGISTERS

Contextualisation: Your national office will have contextualised the monitoring systems. This involves making changes to the list of indicators and to the ttC Registers, adding or removing indicators for your context. Make sure you are working with the final versions of the ttC Registers as adapted by your NO or your project.

Note: If you have completed ttC training using ttC Curriculum 1st edition, then you will require these sessions for supervisors to understand how the ttC-HVs should complete the forms. You can use these sessions to train the ttC-HVs during the first possible debriefing meeting when you introduce the monitoring tools. If you are working from ttC Curriculum 2nd edition then these training sessions are included there, and supervisors ideally would have been fully trained on that, in which case you can use this unit.

All Worksheets referred to in this training manual are found in the TTC Trainer's CD as a separate Annex: 'TTC Data Collection and Reporting – Worksheets.doc'

Session 1. Registration of eligible women and girls (optional)

Contextualisation: ttC projects may opt to register all women and girls of childbearing age at start-up. The advantage of this is that the register can be used to record births and deaths, and to identify women who become pregnant. It can also be used to assign unique identifier codes in the mobile and paper applications. Use 'Eligible Women and Girls Register.xls', adapted for your country context.

If your project has protocols for promoting family planning in pre-pregnancy, provide that information in this session. You may want to develop additional activities for this.

Session plan Time: 1hr 30min	Activity 1: Completing the Eligible Women and Girls Register 60 min Activity 2: Practising and planning the registration visit 30 min
Learning objectives	At the end of this session, participants will be able to: • complete the Eligible Women and Girls Register (EWGR) at ttC project start-up • explain how and when to update the EWGR.
Key messages	• Women and girls ages 15–49 years,* and primary carers of children under 2 years are all eligible for registration in the project. Regular updating of the register (every 3–6 months) can help to sensitise the community, identify early pregnancy and monitor vital events (births and deaths). *Contextual adaptation – some places may wish to register earlier depending on MoH or project emphasis on preventing pregnancies under 18 years.
Preparation and materials	*Materials* • Eligible Women and Girls Register (adapted for country context) *Preparation* • Distribute cases and registers amongst the tables.

Activity 1: Completing the Eligible Women and Girls Register

Ask the group: Which people in our community are eligible to access ttC services?

Ensure they list mothers or carers of children under 2 years, pregnant women, women of childbearing age (i.e. those who may become pregnant during the programme).

Ask: Why might we decide to maintain a register of eligible women and girls?

- It can be used to guide us when we conduct home visits to check for new pregnancies
- It can be used to identify new births and deaths and families new to the area
- It can be shared with COMM and the health facility to capture population information

WHO IS ELIGIBLE FOR REGISTRATION?

Women and girls ages 15 to 49 years[7] and primary carers of a child under 2 years are all eligible for registration in the project. Regular updating of the register (every 3–6 months) can help to sensitise the community and identify early pregnancy and monitor vital events (births and deaths).

Ask: Present the form and explain what is to be written in each column, then ask participants to fill out a sample form.

Information about the CHW or HV	
Data	***Additional instructions***
ADP	Area development programme or project area they are working in.
Community ID	Identity number of community (should be assigned by the programme manager or health authority)
Community Name	Name of the community
CHW Name/ID	Name of CHW/home visitor (HV) and identity number assigned at the start of the programme.

Information about each woman	
Woman's ID	Either given at the start of the project or assigned during registration
Name of woman	Full name as it is given on any health record she holds. Do not give household or nicknames.
Age	At time of registration
Name of husband/household head	The name of the head of the household if she is unmarried. This is only for the purposes of finding her if she should move or the ttC-HV cannot find the home.
House no. or location	If houses are numbered, give the door number. If not, write something to remind the ttC-HV of the location of the house. (*This is optional and serves only to find the house for updating the register.)*
Date of birth of woman	Per any health records she has
No. of children under 24 months	Number of children currently living with her in her care that are under 2 years (without recording previous child deaths or maternal history)
Currently pregnant Y/N	Currently pregnant or any possibility she might be? It is advisable to refer suspected pregnancies for ANC even if they're not sure yet. Register *all* pregnancies at start-up. When updating the register, adjust this mark.

[7] Women of child-bearing age 15–49 years, however some contexts may decide to register earlier if, for example, early marriage is an issue in that context.

Names of children under 24 months	Per child health record
Date of birth	Per child health record
Sex	Per child health record
Alive?	Record only live children at start-up. When updating the register, confirm all previously registered children.

Distribute the cases or write on the flipchart

Ask the group to fill in EWGR forms with the following information. When they have finished each case, they can discuss in groups. Make sure you check the forms against the example shown below.

Contextualisation: Alter names in the table below to fit to your context

Case 0001 **Mariama Djau**	Her husband's name is Braima Dane. Mariama and Braima live at house number 12. Her date of birth is 1 May 1991, so she is 23 years old. She has one son whose name is Mahmoud Dane born 2 of December 2012. She is pregnant.
Case 0002 **Binta Balde**	Binta is 34 years old and married to Abram Kande. Her date of birth is in November 1980, but doesn't know which day. They live in a red painted house near the river, without a door number. She has twin girls born 3 of June 2013 named Ami and Adama Kande, and is not pregnant *now.*
Case 0003 **Mary Ialá**	Mary is married to Babu Ialá although she is only 17 years old. They live in a small hut with an iron roof, near to the market place. Mary *is not pregnant yet.*
Case 0004 **Djenabu Ndjai**	Djenabu is 15 year old and lives in her father's (Touba Djalo) house, 324 High Street. She is not married yet, but with difficulty she reveals that she suspects she is pregnant.

Having reviewed the cases, ask the group:

- How frequently should they update the register? (Every 3–4 months)
- Which women/families should be receiving ttC visits? (Cases 1, 2 & 4)
- When should the ttC-HV visit case 3? (Married adolescent, at least every 3 months, or sooner if possible).

Activity 2: Planning and practising registration visits

Discuss with the group:

- How will the ttC-HV reach all houses to conduct registration visits when the ttC-HV returns from training? (Discuss logistics and time to ensure full coverage.)
- How many households can the ttC-HV reach in one day? (Discuss.)
- Which houses should the ttC-HV aim to visit first? (Try to visit the most vulnerable or furthest away first, and those closest to the centre last.)

- Who needs to be present in the household registration meeting? (All eligible women and girls, male partners, other key decision makers in the household.)

HOW TO CONDUCT A REGISTRATION VISIT

1. Introduce yourself.
2. Ask to speak to members of the household, especially women ages 15–49 years old, grandmothers, husbands and carers of children under 2 years old.
3. Explain what ttC is, who is it for, and how can it help the family.
4. Explain why it is important to register for ttC as soon as a woman thinks she might be pregnant using the key message above.
5. Register all the eligible women and girls. (Ensure you have the names per their health cards.)
6. Let them know where they can find you or contact you to register for ttC.
7. Let the family know when you plan to come and check on them again.
8. Ask if anyone has any question or concerns.

Lastly, discuss who should store the EWGR:

- The Eligible Women and Girls Register should be kept safely until it needs to be updated.
- It can be stored by the COMM, in the health unit, or at home if there is no COMM close by.

Summarise the main points of the session

- Women and girls ages 15 to 49 years, and primary carers of a child under 2 years are all eligible for registration in the project.
- Regular updating of the register (every 3–6 months) can help to sensitise the community and identify early pregnancy and monitor vital events (births and deaths).

Eligible Women and Child Register

World Vision

[COUNTRY NAME]

Community ttC
Eligible Women and Girls List

ADP	
Community ID	
Community Name	
CHW Name/ID	

Contraceptive usage data can be collected here if integrating HTSP programming

Woman's ID	Name of woman	Age	Name of husband/ household head	House no. or location	Date of birth of woman			No. of children under 24 months	Currently pregnant? Y/N	Names of children under 24 months	Date of birth			Sex	Alive?
					D	M	Y				D	M	Y		
0001	*Mariama Djau*	*23*	*Braima Dane*	*#12*	*1*	*5*	*1991*	*1*	✓	*Mahmoud Dane*	*2*	*12*	*12*	*M*	✓
0002	*Binta Balde*	*34*	*Abram Kande*	*Red house by river*	*-*	*11*	*1980*	*2*	✗	*Ami Kande*	*3*	*6*	*13*	*F*	✓
										Adama Kande	*3*	*6*	*13*	*F*	✓
0003	*Mary Ialá*	*17*	*Babu Ialá*	*Beside market place, hut with iron roof*	*3*	*1*	*1997*	*0*	✗						
0004	*…enabu Ndjai*	*15*	*Touba Djalo*	*324, high street*	*16*	*4*	*1998*	*0*	✓						

Unique identity numbers might be needed; they can be assigned using this form, using mobile registration, or use existing codes if they exist.

Insert any information that prompts the ttC-HV to know where the house is.

During follow-up tracking the ttC-HV can confirm births and deaths by updating this data.

Session 2. Completing the ttC Register – Pregnancy

Contextualisation: High-risk pregnancy includes those with identified risk factors defined in the ttC Curriculum 2nd edition. If you do not have training on this, it will be excluded.

Session plan	Total time = 2 hr Activity 1: Review of the forms 15 min Activity 2: Example cases and completing the forms 60 min Activity 3: Validating information using the maternal health record 15 min Activity 4: Discussion and Q&A 30 min
Learning objectives	At the end of this session participants should be able to: • complete the Pregnancy Register for the first registration of pregnancy • complete the Pregnancy Register for all consecutive follow-up visits in pregnancy
Materials and preparation	*Materials* • Pregnancy registers (3 per participant) • Example registers – printed or projected on screen
Key messages	• The Pregnancy Register serves as a record of all important health practices being done by the household at the time of the visit, and can be used to report progress. • For all practices the ttC-HVs should mark a tick for a positive answer and a cross for a negative answer, aligned to the gestational age at the time of the home visit.

Activity 1: Review of the forms

Distribute a copy of the 'ttC Register – Pregnancy' to each participant. ***Note:*** *It is intended that the same register be used for both literate and non-literate ttC-HVs. Non-literate participants may require help with written portions of registers but should be able to complete the pictorial sections with support.*

- The Pregnancy Register serves as a record of all important health practices being done by the household at the time of the visit, and can be used to report progress.
- For all practices the ttC-HVs should mark a tick for a positive answer and a cross for a negative answer, aligned to the gestational age at the time of the home visit.

Explain the structure of the forms:

Universal register information: This section shows where the project is, the ID numbers of the ttC-HVs, the community and nearest health district and facility, mother's name and ID (if assigned).

Contextualisation: Items in this section will be modified as part of contextualisation.

Column structure and timing: Each register has a column structure. Fill in each visit in a vertical column aligned to gestational age at the time of the visit, and complete the register *downwards*. Look at the gestational ages (*pregnant mother symbols, with months across the bottom).* There are 2 columns – one for visits in months 1–4 of pregnancy (early pregnancy visits) and one column for visits occurring in months 5–9. In the worked example, see how ticks and crosses are all aligned under four months.

The ttC-HVs can find out the gestational age in 3 ways:

- Check the antenatal card for her expected date of delivery.
- Ask the mother, *if she knows*, or calculate from the last menstrual period.
- Confirm gestational age by palpation, if the ttC-HVs are trained to do this (e.g. ttC-HV/trained traditional birth attendant [TBA] only).

How to mark planned and completed visits: In the 'visits planned' row write the date of the next planned visit. In the row below, literate ttC-HVs can write the date the visit was completed. If they are not literate, they could mark the visit with a tick to show they have done the visit.

Indicators: Each row corresponds to one of the health practices the ttC-HVs will have promoted using the stories and Household Handbook. In completing the register they will tick (✓) for when the mother has already started or completed the practice. The ttC-HVs will put a cross (×) when the practice has not yet been completed. (Unlike in the Household Handbook, do not mark intention to try). In the worked example, the data shows that Lara's husband didn't participate, and that she was using a mosquito net. Take the participants through all indicators, beginning with the first one on the husband/partner's participation through to the row on referral completion.

- Some indicators relate to health practices that happen only once during pregnancy (e.g. 'HIV test done', 'HIV results obtained' and 'Birth plan made'). Once these actions are completed, the ttC-HV will not ask the pregnant woman those questions again.
- Other indicators are asked in every visit. The ttC-HV will place a ✓for every ANC visit completed. If for instance, the ttC-HV finds out that the pregnant woman had 2 ANC visits between the previous ttC visit and the current one, she will place 2 tick marks.
- When it comes to tallying, the supervisor will ensure that the final column is filled out correctly, corresponding to the indicators (e.g. four ticks under ANC = ✓ 4 ANC completed, and anything less would be marked ×).

Danger signs and referral: At the start of household visits the ttC-HVs will inquire about danger signs and will not continue with the visit if referral is needed.

- If there is a danger sign and the ttC-HVs recommend referral, they could write the date of referral (or use a tick if the ttC-HVs are not literate). If they must refer immediately, then they should come back and complete the ttC visit on another day.
- If there is no danger sign, enter a cross. If they have referred the woman, they should confirm that she was seen at the health facility before marking referral as completed.

In the following worked example, show how Lara was referred on the day of the ttC visit but that they have not yet confirmed the referral was done. (The ttC-HV is not required to record what the danger sign was.)

ttC Register – Pregnancy

This information to be added at registration.

TCC REGISTER - PREGNANCY

U - UNIVERSAL REGISTER INFORMATION

Health Authority >>> _____ Community Name >> _____

Health Centre >>> _____ ID>> CHW ID >>> _____ CHW Name >>> _____

CHW Supervisor >>> _____ Mother's Name >>> _____ Mother's ID number >> _____

ADP >>> _____ Mother's age >>> _____ First Recording Date >>> _____

COMPLETE THE REGISTER IN EVERY HOME VISIT	Pregnancy V1 V2 (1m 2m 3m 4m)	Pregnancy V3 V4 (5m 6m 7m 8m 9m)	data code	Totals ✓/X completed by the supervisor when case is complete
Death in pregnancy *(write date)*			D1	*Maternal Death? Yes or no*
Miscarriage			D2	*Woman experienced miscarriage?*
Visits Planned (*write date for planned visit*)			*	*verify date against gestation*
Home ttC Visits *(write date of visit)*			P1A	*1st visit before 16 weeks?*
			P1B	*4 visits in pregnancy?*
Husband/partner participated in ttC visit?			P2	*Husband/partner participation in most of ttC visits?*
High risk pregnancies			P3	*Woman was high risk at any point in pregnancy?*
Bednet use consistently since last visit			P4	*Did the woman sleep under a net during most of the pregnancy?*
Antenatal visits completed			P5A	*1st ANC before 16 weeks?*
			P5B	*4 ANC during pregnancy?*
HIV test done			P6	*Woman did HIV test during this pregnancy?*
Obtained HIV test result			P6	*Woman obtained test result during this pregnancy?*
Woman has taken iron tablets regularly during last month	*Mother has started taking IFA?*	*Mother has taken IFA for more than 4 months?*	P7	*Mother took at least 4 months of IFA during this pregnancy?*
Woman has eaten more than usual			P8	*Woman reported eating more than usual (3 meals + snack) at all visits?*
Birth plan			P9	*Woman had developed a birth plan at any point?*
Danger signs in pregnancy			E1	*Total events*
Referral completed			E1A	*Total events*
Post referral home visit completed			E1B	*Total events*
optional indicator				
optional indicator				

Enter in this column when the woman is under 4 months pregnant.

This column to be completed by supervisor during tallying.

Under each indicator the ttC-HV should mark ✓= yes (the woman reported that she has or is doing this practice) or ✗ = no (she has not done or is not doing at this time).

Activity 2: Example cases and completing the forms

Explain that 3 examples/storylines will be used to help participants learn how to fill out the registers: Lara, Sheila and Satumina. Clarify these are **not** stories used during home visits (and so not found in the Household Handbook or ttC job aids) but will be used only during the training.

Contextualisation: You will need to cross-check the story examples below with the final versions of the ttC Register they are using. Include information or data in the examples below only if it is also found on the ttC-HV Register for the first visit during pregnancy.

Review the cases of Lara and Sheila (below). Have several participants read parts of the section aloud. Explain that the example refers to the ttC-HV as 'you'.

EXAMPLE 1: LARA (FIGURE 3.1A IN WORKSHEETS)

- You visit Lara on 15 May. Lara is four months pregnant and lives on the outskirts of the village, next to the primary school. Her husband, Hussein, does not participate in the visit.
- She has already been to the health centre for her first ANC visit. She has no signs indicating she has a high-risk pregnancy. She was offered an HIV test but did not take it yet.
- She has started taking iron and folate tablets every day, and she reports that she always sleeps under a mosquito net at night. She doesn't have a birth plan yet.
- You have just completed counselling her on antenatal visits, home care, nutrition and danger signs in pregnancy. Lara reports that due to morning sickness she is eating less than usual.
- Lara is not feeling well, and you recommend that she goes to the health facility. You will follow up in 2 days to find out if she went and if she is feeling better.
- Lara and her family want you to visit them again about 2 months from now for the second ttC counselling visit.

EXAMPLE 2: SHEILA

Visit 1

- Sheila is four months pregnant and lives next to your friend Pinky's house near the weekly market. Sheila's husband's name is Aman, and he participated in the visit.
- She has already been to the health centre for one ANC. You check her health card and confirm the ANC was done. She was not told that she was high risk.
- She has had her HIV test and has received the results.
- Sheila's health card shows her expected date of delivery to be 20 August, 2010. You have just completed counselling her on antenatal visits, home care, nutrition and danger signs in pregnancy. She is using her mosquito net at all times.
- Sheila is feeling well and does not have any danger signs.
- Sheila's family would like to have you visit them again about one month from now.

Visit 2

- You visit Sheila one month later for her second visit, but her husband is away. You find that she has had one more ANC visit; she is still eating well and using her mosquito net. She is also taking her iron tablets regularly.

- She reports that she has been feeling very faint and exhausted all the time, and you refer her to go back to the health facility. Two days later you follow up to confirm that she has gone. She has gone to the clinic and has been given some extra iron tablets and is feeling better.

EXAMPLE 3: SATUMINA

- Satumina is in the sixth month of her pregnancy; her husband's name is Manuel and he is not home when you visit.
- She has already been to the health centre for one ANC and has had one TT vaccination. You check her health card and confirm the ANC. She had an HIV test but has not returned for the results.
- During the consultation she was told that she is high risk. This is her fourth child; she has suffered with hypertension in previous pregnancies and in this one. She has been given some tablets and told to come for a check-up more regularly.
- You have completed counselling her on antenatal visits, home care, nutrition and danger signs in pregnancy. She does not have a mosquito net for her bed as she says she finds it too hot. She reports that she is eating well, taking her iron tablets and is feeling well today.
- Her family would like to have you visit them again about one month from now.

Activity 3: Validating information using the maternal health record (for literate ttC-HV)

Contextualisation: Provide examples of maternal health records from your country.

The information that the mother or family reports during the home visit needs to be validated against the existing records at the health facility. Using the examples provided from your area, show where on the records to find the following information:

- Antenatal clinic attendance
- Expected date of delivery or date of last menstrual period
- HIV test results, if consent given (contextual)
- Any complication or observations during antenatal care

Activity 4: Discussion and Q&A

Allow 10 minutes for the participants to go over the examples they worked on, and answer any questions they may have. Allow extra time for participants who still have difficulties with the forms.

Discuss: Do they find the form complicated to understand? Which parts are difficult?

Will the illiterate/older ttC-HVs have any challenges completing these forms? Why/why not?

Summarise the session

- The Pregnancy Register serves as a record of all important health practices being done by the household at the time of the visit, and can be used to report progress.
- For all practices the ttC-HVs should mark a tick for a positive answer and a cross for a negative answer, aligned to the gestational age at the time of the home visit.

Session 3. Completing the ttC Register – Newborn

Contextualisation: Your national office will have contextualised the monitoring systems. This process involves making changes to the list of indicators and to the ttC Registers, adding or removing indicators for your context. Make sure you are working with the final versions of the ttC Register for newborns as adapted by your NO or your project.

'High-risk newborns' includes those with identified risk factors defined in the ttC Curriculum 2nd edition. If you do not have training on this, it will be excluded.

Session plan	Total time = 2 hr Activity 1: Review of the forms 15 min Activity 2: Example cases and completing the forms 60 min Activity 3: Validating information using mother-and-baby health records 15 min Activity 4: Discussion and Q&A 30 min
Learning objectives	At the end of this session participants should be able to: • complete the Newborn Register for the 3 newborn visits
Materials and preparation	*Materials* • Newborn Registers (3 per participant) • Example registers – printed or projected on screen
Key messages	• The Newborn Register serves as a record of vital information regarding the newborn and all important health practices being done by the household during the first week of life, and can be used to report progress. • For all practices, the ttC-HVs should mark a tick for a positive answer and a cross for a negative answer, aligned to the age of the newborn at the time of the home visit.

Activity 1: Review of the forms

Distribute a copy of the 'ttC Register – Newborn' to each participant.

Contextualisation: Discuss in-country how you wish to handle twin births at this point. The register encompasses twin births, but the supervisor needs to understand that when completing the tallying sections. Some countries provide one copy of the register per birth.

Note: *It is intended that the same register be used for both literate and illiterate ttC-HVs. Illiterate participants may require help completing written portions of registers, but should be able to complete the pictorial portion of the register with training and support.*

- The Newborn Register serves as a record of all important health practices being done by the household during the first week of life, and can be used to report progress.
- For all practices, the ttC-HVs should mark a tick for a positive answer and a cross for a negative answer, aligned to the age of newborn at the time of the home visit.

Explain the structure of the forms

- **Universal register information:** This is similar to the corresponding section in the Pregnancy Register, and the details will have to be copied from the latter. The 'First Recording Date' is the day when the ttC-HV makes the first newborn visit.

Contextualisation: Items in this section will be modified as part of contextualisation.

- **Column structure and timing:** As with the Pregnancy Register, each register has a column structure. Fill in each visit in a vertical column aligned to the age of the newborn at the time of the visit, and complete the register *downwards*. Look at the age of the newborn in weeks (denoted by baby symbols that are progressively larger for each of the four weeks). There are 2 columns – one for the 3 visits in the first week of the newborn period, and one column for the remaining 3 weeks, when the ttC-HV might visit to follow up on a baby who was referred. In the worked example, see how ticks and crosses are all aligned under the first week. **Note:** It is important that, during the fourth pregnancy visit, the ttC-HVs plan with the family how they will inform them of the birth.
- **Marking planned and completed visits:** In the 'visits planned' row, write the date of the next planned visit. In the row below, literate ttC-HVs can write the date the visit was completed. If they are not literate, they could mark the visit with a tick to show they have done the visit. **Note:** This will make it impossible to determine timeliness as a performance indicator. In the worked example of Lara, see how the dates of the 3 visits are marked under the column for the first week.
- **Indicators**: Each row corresponds to one of the health practices the ttC-HVs will have promoted using the stories and Household Handbook.

  They will tick (✓) for when the mother has already started or completed the practice. They will put a cross (×) when the practice has not yet been completed.

  In the worked example, the data shows that Lara's husband participated in the first newborn visit but not the other 2, and that she and the baby were sleeping under a mosquito net. Take the participants through all indicators, beginning with the first one on the husband/partner's participation through to the row on referral completion.

  Some indicators are related to health practices or services that happen only once during the newborn period. These are 'Baby was wiped and wrapped', 'Baby was put to the breast within the first hour' and 'Baby received early vaccines'.

  Once these actions are completed, the ttC-HVs will not ask the mother those questions in subsequent visits. There are other indicators such as 'Baby sleeps under a bed net at all times' that the ttC-HV needs to check/ask for during every visit and record the mother's responses or her observations in each visit. At the end, the supervisor will determine if the baby slept under a net for most of the newborn period, and complete the final column.

- **Danger signs and referral:** At the start of each household visit ttC-HVs will inquire about danger signs. If the mother or the baby has a danger sign and the ttC-HVs recommend referral – they could write the date of referral, or put a tick if the ttC-HVs are not literate. If they must refer immediately, come back and complete the ttC visit another day. If there is no danger sign, write a cross. If they have referred her, wait until confirmation that she *went to the health facility* before marking referral as completed.

  In the worked example below they will find that Lara and the baby did not show any danger signs.

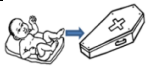
ttC Register – Newborn

Transfer registration info from the pregnancy form.

TTC REGISTER - NEWBORN

U - UNIVERSAL REGISTER INFORMATION

Health Authority >>> _____ ID>> Community Name >> _____
Health Centre >>> _____ CHW ID >>> _____ CHW Name >>> _____
CHW Supervisor >>> _____ Mother's Name >>> _____ Mother's ID number >> _____
ADP >>> _____ Mother's age >>> _____ First Recording Date >>> _____

Instructions: Record information EVERY VISIT		Newborn		Data code	✓/X completed by the supervisor when case is complete
		Week 1	week 2 3 4		
Date of birth		18/10/2014			
Visits Planned (*write data planned*)		V1 V2 V3	V4		
Maternal death 0-45d *(date of death)*				D2	*Number of maternal deaths*
Still birth *(No. of babies still born)*				D3	*Number of stillborn*
Live births *(No.babies born alive)*				ND2	*Number of babies born alive*
Newborn death *(date of death)*				D4	*Number of newborn deaths*
ttC Home Visits post- partum *(date of visit)*				N1	*Woman received at least 4 visits?*
Husband/partner participation in ttC visit				N2	*Husband/partner present for most of visits?*
High risk newborn				N3	*Number of high risk newborns?*
Skilled birth attendance in a facility				N4	*Number of women who delivered in facility with skilled attendant?*
Birthweight Baby 1				N5	*Number of babies that are LBW = <2.5kg*
Birthweight Baby 2					
Birthweight Baby 3					
Baby is receiving Kangaroo Mother Care				N6	*Number of babies receiving KMC*
Baby was breastfeed in first hour of life				N7	*Was the baby/babies breastfeed in the first hour?*
Baby was wiped and wrapped in the first hour of life				N8	*Was baby/babies wrapped and wiped not bathed in 1st hour?*
Baby sleeps under a mosquito net at all times				N9	*Baby slept under net at all visits?*
Babies who received early vaccines (BCG and OPV-0)				N10	*Received both BCG and OPV-0?*
Post-partum danger sign identified				E2	*Total number of events*
Newborn danger sign identified				E3	*Total number of events*
Referral completed				E4A	*Total number of events*
Post referral home visit completed				E4B	*Total number of events*
optional indicator					
optional indicator					

Enter in this column for visits in the first week of life.

This column to be completed by supervisor during tallying.

Activity 2: Example cases and completing the forms

Explain that 3 examples/storylines will be used to help participants learn how to fill out the registers: Lara, Sheila and Satumina. Clarify these are **not** stories that will be used during home visits (and so not found in the Household Handbook or the ttC job aids) but will be used only during the training.

Contextualisation: You will need to cross-check the story examples below with the final versions of the ttC Register they are using. Include information or data in the examples below only if it is also found on the 'ttC Register – Newborn.'

EXAMPLE 1: LARA (FIGURE 3.2A IN WORKSHEETS)

Newborn Visit 1

- Lara gives birth on 18 October, and Lara's husband gives you a call about it the same evening. He also informs you that Lara and the baby will be discharged from the facility the next day and will reach home by evening.
- You visit Lara on 19 October when the baby is a day old. It is a healthy girl baby, who weighed 3.7 kilos at birth. You get to know of it through the mother-baby card.
- Lara is happy to inform you that the nurse at the facility wiped the baby right after birth, wrapped the baby in the clothes Lara had with her and helped Lara put her to the breast within about 20 minutes after she was born.
- The baby has received BCG and OPV-0 vaccines.
- Lara continues to give the baby only breast milk.
- This is the baby's first night in her home, but both Lara and the baby are already resting under a bed net.
- You have examined the baby and observed a breastfeed. She has no danger signs and is able to latch to the breast and suck well. You ask Lara for postpartum danger signs, and she has none.
- You inform Lara and her family that you will return in 2 days.
- Lara's husband is present with the mother and baby throughout your time there, and participates in the discussions.

Newborn Visits 2 and 3

- You return to Lara's house on the 21st and again on the 23rd for the remaining newborn visits.
- Lara's husband was not at home during these 2 visits.
- Both Lara and the baby are doing well and do not have any danger signs.
- Both sleep under a bed net.

EXAMPLE 2: SHEILA

Newborn Visit 1

- Sheila has given birth in the health centre on 25 October to a baby girl. You get to know of it through Sheila's neighbour.
- You visit Sheila in her home on 27 October, when the baby is 2 days old. You learn that Sheila had a normal delivery and that the baby cried soon after birth. The nurse at the health centre wiped and wrapped the baby soon after birth.

- Sheila put the baby to the breast about 3 hours after she was born. The baby was given water prior to that.
- Sheila has since been breastfeeding the baby.
- Sheila and the baby have been sleeping under a bed net.
- Both Sheila and the baby are doing well and do not have any danger signs.
- The baby has not had any vaccinations, and Sheila plans to return to the health centre next week to get them.
- Sheila's husband is not at home during your visit.
- You inform Sheila and her family that you will visit again after 2 days.

Newborn Visits 2 and 3

- You planned to visit Sheila's home after 2 days but get called to their home the day after the first visit.
- Sheila informs you that the baby has been dull and sleepy and has not fed well since that morning. You examine the baby and find that she has fast breathing. You refer them to the health centre.
- Sheila's husband is present and prepares to take the mother and baby to the health centre immediately.
- You remind Sheila to pack the bed net, as you are not sure if the health centre has sufficient nets.
- At the facility, the nurse examines the baby and confirms that she has acute respiratory infection (ARI), and starts the baby on antibiotics. The nurse advises the family to stay overnight to see how the baby responds to treatment.
- You visit the health centre the following day to check on the mother and baby. The baby is doing well and is now able to breastfeed. The nurse informs you that they will be discharged in the evening.
- You visit Sheila and the baby in their home the following day. (This is both the third newborn visit as well as a follow up after the illness.)
- Sheila and the baby are doing well. The baby is feeding well.
- Both baby and the mother sleep under a bed net.
- Sheila's husband is present during the discussions.

EXAMPLE 3: SATUMINA

Newborn Visit 1

- Satumina has delivered a baby girl on 20 October at her home. Manuel informs you of the birth.
- You visit Satumina's home the same evening.
- You find that the baby cried at birth, and that the local TBA assisted the birth.
- The TBA wiped and wrapped the baby, and Satumina put her to the breast half an hour after birth.
- The baby has since been breastfeeding well.
- You ask Satumina about danger signs in her or the baby, and there are none.
- Satumina and the baby do not sleep under a bed net.
- Satumina's husband was present during your discussions.
- The baby has not had its early vaccinations.
- You inform the family that you will visit them again in a couple of days.

Newborn Visits 2 and 3

- You visit Satumina 2 days later.
- You find that Satumina and the baby had been to the health centre the day before and had weighed the baby. You find the birth weight mentioned in the baby health card as 2.5 kg.
- You also note that the baby has received BCG and OPV-0 vaccinations
- The baby is feeding well.
- Satumina and the baby have been sleeping under a net since your first visit.
- Neither has any danger signs.
- Satumina's husband was not present during the discussions

Activity 3: Validating information using mother-baby health record (literate HV)

Contextualisation: Provide examples of mother-baby health records from your country.

The information the mother or family reports during the home visit needs to be validated against the existing records at the health facility. Using the examples provided from your area, show where on the records to find the following information:

- Skilled attendance at birth
- Date of birth
- Birth weight
- HIV test results (if consent given)
- BCG and OPV doses given
- Any complication or observations during delivery and postpartum

Activity 4: Discussion and Q&A

Allow 10 minutes for the participants to go over the examples that they worked on, and answer any questions they may have. Allow extra time in case any participant still has difficulties with the forms.

Discuss:

Do they find the newborn form complicated to understand? Which parts are difficult?
Will the illiterate/older ttC-HVs have challenges completing these forms? Why/why not?
How can we give support to those struggling to complete them?

Summarise the session

- Include a recap of the key messages.

Session 4. Completing the ttC Register – Infant

Contextualisation: Your national office will have contextualised the monitoring systems. This process involves making changes to the list of indicators and to the ttC Registers, adding or removing indicators for your context. Make sure you are working with the final versions of the ttC Register for infants as adapted by your NO or your project.

High-risk infant includes all those with identified risk factors defined in the ttC 2nd edition. If you do not have training on this it will be excluded.

Session plan	Total time = 2 hr Activity 1: Review of the forms 15 min Activity 2: Example cases and completing the forms 60 min Activity 3: Validating information using mother-and-baby health records 15 min Activity 4: Discussion and Q&A 30 min
Learning objectives	At the end of this session participants should be able to: • complete the infant register for the one-month and six-month visits (visits 6 and 7)
Materials and preparation	*Materials* • Infant ttC registers (3 per participant) • Example registers – printed or projected on screen
Key messages	• The infant register serves as a record of vital information regarding the infant and all important health practices being done by the household from the first week to 6 months, and can be used to report progress. • For all practices the ttC-HVs should mark a tick for a positive answer and a cross for a negative answer, aligned to the age of the infant at the time of the home visit.

Activity 1: Review of the forms

Distribute a copy of the 'ttC Register – Infant' to each participant.

Note: *It is intended that the same register be used for both literate and illiterate ttC-HVs. Illiterate participants may require help completing written portions of registers but should be able to complete the pictorial portion of the register with training and support.*

- The infant register serves as a record of all important health practices being done by the household for the baby from its first week to 6 months, and can be used to report progress.
- For all practices the ttC-HVs should mark a tick for a positive answer and a cross for a negative answer, aligned to the age of infant at the time of the home visit.

Explain the structure of the forms

- **Universal register information:** This is similar to the corresponding section in the Pregnancy Register, and the details will have to be copied from the latter. The 'First Recording Date' is the day when the ttC-HV makes the one-month visit (visit 6). Also point out that the gender of the child is to be noted in the space provided in the top left corner.

Contextualisation: Items in this section will be modified as part of contextualisation.

- **Column structure and timing:** Fill in each visit in a vertical column aligned to the age of the infant at the time of the visit and complete the register *downwards*. Look at the age of the infant in months (denoted by baby symbols that denote a growing and developing baby). There are 2 columns titled V6 and V7 that correspond to the one-month and six-month visits. The intervening columns can be used when the ttC-HV might do additional visits to follow up on a baby who was referred. In the worked example, see how ticks and crosses are all aligned under the six-month visit.
- **How to mark planned and completed visits:** In the 'visits planned' row write the date of the next planned visit. In the row below, literate ttC-HVs can write the date the visit was completed. If they are not literate, they could mark the visit with a tick to show they have done the visit. In the worked example of Lara, see how the planned and actual home visit dates for the six-month visit are marked under the column V7.
- **Indicators**: Each row corresponds to one of the health practices the ttC-HVs will have promoted using the stories and Household Handbook. In completing the register they will tick (✓) for when the mother has already started or completed the practice. They will put a cross (×) when the practice has not yet been completed. (Unlike in the Household Handbook, do not mark intention to try.) In the worked example, the data shows that Lara's husband participated in the first newborn visit but not the other 2, and that she and the baby were sleeping under a mosquito net. Take the participants through all indicators, beginning with the first one on the husband/partner's participation through to the row on referral completion.
  - Some indicators are related to health practices or services that happen only once during this period, such as the baby receiving a birth certificate. Once these actions are completed, the ttC-HV will not ask the mother those questions in subsequent visits.
  - There are other indicators such as exclusive breastfeeding which need to be checked/asked for during every visit and the responses/observations recorded in each visit. The supervisor will then determine if the indicator condition was met (e.g. if the baby was exclusively breastfed to 6 months without introducing foods or water), and complete the final column on the register as ✓or ×.

A note about the indicators:

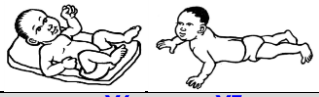
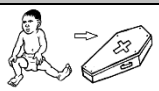
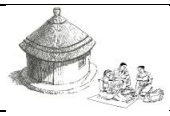
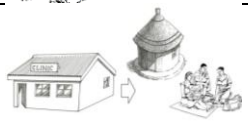
- **Exclusive breastfeeding to 6 months:** There are 2 questions in this section, the combined result of which shows whether the mother is exclusively breastfeeding. The first question is 'Are you still breastfeeding?' The second is 'Have you introduced any foods or water into the baby's diet yet?' In field testing this was found to be a more accurate answer, as women sometimes were found to answer yes to both questions and the ttC-HV will need to clarify.
- **Contraceptive methods:** We do not include traditional methods or Lactation Amenorrhoea Method (LAM), and this indicator applies only to modern contraception from a clinic.
- **Danger signs and referral:** If the baby has a danger sign and the ttC-HVs recommend referral, they could write the date of referral, or tick if they are not literate. If they have referred her, wait until they have confirmed that she *went to the health facility* before marking referral as completed. In the worked example on the next page they will find that Lara and the baby did not show any danger signs.

ttC Register – Infant

Circle baby's gender here.

Gender of child (circle): ♀ ♂

TTC REGISTER - INFANT

Instructions: Record information EVERY VISIT		Infant  V6 V7	DATA CODE	✓/X completed by the supervisor when case is complete
Visits Planned *(write date)*				
Infant Death *(date of death)*			D5	
Home Visits			i1	*5 month visit?*
Husband/partner participation in ttC visit			i2	*Husband/partner attend most of ttC visit?*
High Risk Infants			i3	*Infant identified as high risk at any time?*
Infant has a birth certificate			i4	*Infant received a birth certificate ?*
DTP/PENTA (1-3) vaccines given			i5	*Did the child complete 3 Penta and 3 OPV for this period?*
OPV vaccines given (1-3)				
Exclusive breastfeeding 6 months			i6	*Baby breastfeed exclusively to 6 months?*
Mother is already giving complementary foods or water at this time?				
Mother is currently using contraceptive method?			i7	
Infant is sleeping under a mosquito net every night?			i8	
Infant danger sign identified			E5	*Total events*
Referral completed			E5A	*Total events*
Post referral home visit completed			E5B	*Total events*
optional indicator				
optional indicator				

This column to be completed by supervisor during tallying.

Activity 2: Example cases and completing the forms

Explain that 3 examples/storylines will be used to help participants learn to fill out the registers: Lara, Sheila and Satumina. The examples given below pertain to the six-month visit, or visit 7.

Contextualisation: You will need to cross-check the story examples below with the final versions of the ttC Register they are using. Include information or data in the examples below only if it is also found on the 'ttC-HV Register – Infant'.

EXAMPLE 1: LARA (FIGURE 3.3A IN WORKSHEETS)

Six-Month Visit (V7)

- You had planned to visit Lara's house on 22 March but actually carry out the visit on 23 March.
- Lara's husband is present with the mother and baby throughout your home visit and participates in the discussions.
- The baby has received her birth certificate. Lara informs you that they have named her Esther.
- You check Esther's health card and find she has been given 3 doses of DPT/Penta and OPV vaccinations.
- You ask Lara what she is feeding the baby and you find that she has been giving Esther some water every day, in addition to breast feeding.
- The baby sleeps under a bed net.
- The baby does not have any danger signs.
- Lara and her husband have not begun using any contraceptive method.

EXAMPLE 2: SHEILA

Six-Month Visit (V7)

- You plan to visit Sheila's household on 25 March and actually make the visit on 2 April.
- Sheila's husband is present during the discussions.
- Sheila's baby is 6 months old now and Sheila gives her only breast milk. Sheila has not yet started the baby on water or any other foods.
- Both baby and the mother sleep under a bed net.
- The baby has not yet received its birth certificate.
- The baby has received 2 DPT/Penta vaccinations (✓✓) and 2 OPV doses (marked as ✓✓).
- The baby's parents have not begun using any modern contraceptives yet.
- The baby does not have any danger signs.

EXAMPLE 3: SATUMINA

- You plan to visit Satumina's house on 27 March, and you visit as planned.
- Satumina's husband is not present during the discussions.
- Satumina has taken her baby for vaccinations, and the baby has received 3 doses of DPT and 3 doses of OPV. You verify it from the baby's health card.
- The baby has also received her birth certificate.
- Both mother and baby sleep under a net.
- Satumina has been giving the baby only breast milk. She has not given water or other fluids/foods.
- The baby does not have any danger signs.

Activity 3: Validating information using mother-baby health record (literate ttC-HV)

Contextualisation: Provide examples of mother-baby health records from your country.

The information the mother or family reports during the home visit needs to be validated against the existing records at the health facility. Using the examples provided from your area, show where on the records to find the following information:

- Vaccinations given
- Any high-risk feature in the baby
- HIV results (if consent given)

Activity 4: Discussion and Q&A

Allow 10 minutes for the participants to go over the examples that they worked on, and answer any questions they may have. Allow extra time for any participant who still has difficulties with the forms.

Discuss:

- Do they find the Infant form complicated to understand? Which parts are difficult?
- Will the illiterate/older ttC-HVs have any challenges completing these forms? Why/why not?
- Any issues around determining exclusive breastfeeding?
- How can we give support to those struggling to complete them?

Summarise the session

- The infant register serves as a record of vital information regarding the infant and all important health practices being done by the household from the first week to 6 months, and can be used to report progress.
- For all practices the ttC-HVs should mark a tick for a positive answer and a cross for a negative answer, aligned to the age of the infant at the time of the home visit.

Session 5. Completing the ttC Register – Child

Contextualisation: Your national office will have contextualised the monitoring systems. This process involves making changes to the list of indicators and to the ttC Registers, adding or removing indicators for your context. Make sure you are working with the final versions of the ttC Register for children as adapted by your NO or your project.

'High-risk child' includes all those with identified risk factors defined in the ttC 2nd edition, in particular HIV-positive children and those who have suffered from malnutrition. If you do not have training on this it will be excluded for now.

Session plan	Total time = 1 hr 10 min Activity 1: Review of the forms — 15 min Activity 2: Review example case 4 — 30 min Activity 3: Validating information using mother-and-baby health records — 15 min Activity 4: Discussion and Q&A — 10 min
Learning objectives	At the end of this session participants should be able to: • complete the Child Register for visits 8 through 11 (at 9, 12, 18 and 24 months respectively).
Materials and preparation	*Materials* • Child registers (3 per participant) • Example registers – printed or projected on screen
Key messages	• The child register serves as a record of vital information regarding the infant and all important health practices being done by the household from 6 months to 2 years of the child's age, and can be used to report progress. • For all practices the ttC-HVs should mark a tick for a positive answer and a cross for a negative answer, aligned to the age of the child at the time of the home visit.

Activity 1: Review of the forms

Distribute a copy of the 'ttC Register – Child' to each participant.

Tell the participants that the structure of the forms is similar to that of forms discussed earlier.

Contextualisation: Items in this section will be modified as part of contextualisation.

By this point participants will be very clear about the style of the forms. Use the following questions to initiate a discussion around the form:

- What features in this form enable a non-literate ttC-HV to use it?
- What are the main purposes of this form? (Refer to key messages above.)
- How will the ttC-HV fill the universal register information? What is the first recording date? Where is the gender of the child recorded?
- Direct participants' attention to the column structure. What do the baby symbols denote? How will the ttC-HV complete the form for each visit? (Go down the vertical column for that visit.)
- How will the ttC-HV mark the planned and actual visit dates?

- What are the indicator items that these visits cover? Go over them one by one. Remind participants not to mark intention to try, but the actual completion of the practice. Draw attention to the fact that all indicators need to be asked at each visit
- Where will the ttC-HV record any danger sign and referral?

Activity 2: Reviewing example case 4

- Distribute the worked example of Lara or project on screen (Figure 3.4a in Worksheets).
- Divide participants into groups of 3 or four and ask them to discuss what they observe in the worked example. This example is a record of certain actions that the ttC-HV did well and those that can be improved. It also has a record of the family practising some recommended behaviours and not practising others.
- In plenary, have each group present its findings and planned approach to the issue.

Contextualisation: You will need to cross-check the story examples below with the final versions of the ttC Register you are using. Include information or data in the examples below only if it is also found on the 'ttC-HV Register – Child'.

Activity 3: Validating information using mother-baby health record (literate ttC-HV)

Contextualisation: Provide examples of mother-baby health records from your country.

The information the mother or family reports during the home visit needs to be validated against the existing records at the health facility. Using the examples provided from your area, show where on the records to find the following information:

- Vaccinations given
- Vitamin A supplementation and deworming doses given
- Any high-risk feature in the baby
- HIV results (if consent given)

Activity 4: Discussion and Q&A

Allow 10 minutes for the participants to go over the examples they worked on, and answer any questions they may have. Allow extra time if any participant still has difficulties with the forms.

Discuss:

- Do they find the Child Register complicated to understand? Which parts are difficult?
- Will the illiterate/older ttC-HVs have any challenges completing these forms? Why/why not?
- How can we give support to those struggling to complete them?

Summarise the session

- The Child Register serves as a record of vital information regarding the infant and all important health practices being done by the household from 6 months to 2 years of the child's age, and can be used to report progress.
- For all practices the ttC-HVs should mark a tick for a positive answer and a cross for a negative answer, aligned to the age of the child at the time of the home visit.

UNIT 2: COLLECTING, TALLYING AND ANALYSING TTC REGISTERS

Session 6. Collecting and tallying ttC Registers for pregnancy

Contextualisation: Your national office will have contextualised the monitoring systems. This process involves making changes to the list of indicators and to the ttC Registers, adding or removing indicators for your context. Make sure you are working with the final versions of the 'Summary Register – Pregnancy' and 'Totals by ttC-HV – Pregnancy' for your project.

Session plan	Total time = 2 h Activity 1: Overview of tally column in 'ttC Register – Pregnancy' 15min Activity 2: Discussion of worked example 30 min Activity 3: Working with other examples 60 min Activity 4: Discussion and Q&A 15 min
Learning objectives	At the end of this session participants should be able to: • complete the tally column of the ttC Register • tally the collected 'ttC Registers – Pregnancy' on an individual or a group supervision setting
Materials and preparation	*Materials* • One copy of the 'ttC Tally Sheet – Pregnancy' per participant • Example sheets – set of 3 per participant
Key messages	• The totals column in the 'ttC Register – Pregnancy' provides data on every pregnant woman served through ttC; each tally should be a Yes or a No response, and the last 3 rows should have number totals. • The totals column is completed only when the pregnancy is completed and the pregnant woman gives birth.

Activity 1: Overview of the tally column in 'ttC Register – Pregnancy'

Ask participants to return to open a 'ttC Register – Pregnancy' from Session 2.1. Point them to the totals column in the far right.

When and how to complete the tally column: The supervisor will complete this column only when the pregnancy is completed and the woman has given birth.

Explain that during every meeting the ttC-HVs will submit their Pregnancy Registers. The supervisor will work with each ttC-HV in turn, *identifying women in the Pregnancy Register who gave birth during the reporting period and completing the totals column for those women.*

Emphasise that data is not collected from all Pregnancy Registers during every reporting period, but only from those pregnant women who gave birth during the reporting period.

Each item in the totals column reads like a question. For each row, barring the last 3, the supervisor will review the information that the ttC-HV has entered for that row and determine whether the response in the totals

column will be a Yes or a No (✓ or ×). For the last 3 rows (danger signs, referral, post-referral home visits), the number of events is recorded.

Explain that for indicators that are checked every month (husband present during discussions, sleeping under a bed net, eating an extra meal), the total will be a ✓only if there are tick (✓) marks for at least 3 visits. For ANC visits, the total for item '4 ANC visits completed' will be a ✓ only if there are four tick marks in the row.

Activity 2: Discussion of worked example

Distribute the set of 3 examples of ttC Registers – Pregnancy, those of Tara, Fatuma and Amina. Their households are reached by the ttC-HV Mariam. These are Figures 3.5a, 3.5b and 3.5c in the Worksheets.

Ask participants to open Tara's Pregnancy Register and work through the totals in plenary. Explain the reason why the total is ✓or × or a number as recorded in the example.

Activity 3: Working with other examples

Distribute the other 2 examples (Fatuma and Amina) to all participants. Divide the participants into groups of four each and ask them to work through the 2 examples and complete the totals column.

Activity 4: Discussion and Q&A

In plenary, ask each group to share their experiences in working with the example sheets.

Summarise the session

- Respond to any questions the participants may have. Summarise using the key points of the session.
- The totals column in the 'ttC Register – Pregnancy' provides data on every pregnant woman served through ttC; each tally should be a Yes or a No response and the last 3 rows should have number totals.
- The totals column is completed only when the pregnancy is completed and the woman gives birth.

Session 7. Completing the Summary Register – Pregnancy

Contextualisation: Your national office will have contextualised the monitoring systems. This process involves making changes to the list of indicators and to the ttC Registers, adding or removing indicators for your context. Make sure you are working with the final versions of the ttC Register – Pregnancy and Totals by ttC-HV – Pregnancy as adapted by your NO or your project.

Session plan	Total time = 2 hr Activity 1: Overview of the 'ttC Summary Register – Pregnancy' 15 min Activity 2: Discussion of worked example 30 min Activity 3: Working with other examples 60 min Activity 4: Discussion and Q&A 15 min
Learning objectives	At the end of this session participants should be able to: • explain the parts of the 'ttC Summary Register – Pregnancy' • complete the 'ttC Summary Register – Pregnancy'
Materials and preparation	• ttC Summary Register (Per ttC-HV tally) – Pregnancy (one per participant) • Example sheets completed in previous session (set of 3 per participant) • Example worksheets for this session (set of 3 per participant)
Key messages	• The 'ttC Summary Register – Pregnancy' provides the totals for all pregnancies in all ttC-HV areas in the supervisor's area. • The supervisor completes ttC Summary Register using data from completed totals column of the 'ttC Register – Pregnancy' for pregnant women who have given birth during the reporting period.

Activity 1: Overview of the 'ttC Summary Register – Pregnancy'

Distribute the 'ttC Summary Register – Pregnancy' to all participants.

Explain that each supervisor will fill in one Summary Register per reporting period, using data from Pregnancy Registers of all ttC-HVs in the supervisor's area.

Note: Minimum standard reporting period is once per 3 months (quarterly), although some projects may do this more frequently.

Universal register information: This is the section at the top of the form. Point out that this has different items than the section in the Pregnancy Register. As there is only one of these sheets for every supervisor, this section has information pertaining to the supervisor.

Denominators section: This section immediately follows the universal information section and has four data items that need to be filled in for every ttC-HV. These items are the number of current clients from the EWG register, the number of EWGs using a contraceptive method, the current number of pregnancies from the Pregnancy Register and the number of pregnancies that were completed during this reporting period. These would form the denominator to calculate the percentages for pregnancy-related indicators.

Indicators: Point out that the indicators (going down the far left column) are exactly the same as in the ttC Pregnancy Register, and that we keep the images so supervisors will have identical forms.

Totals from each ttC-HV: Point to the columns to the right of the indicators, each of which pertains to one ttC-HV.

Each ttC-HV might have a few to several pregnant women who gave birth during the reporting period. Details from the totals column of the Pregnancy Register of all of these women should be entered under the column for that ttC-HV.

When transferring details from the totals column of a Pregnancy Register to the Summary Register, go down the totals column and for every Yes result in the Pregnancy Register, place a tally mark against the corresponding indicator in the Summary Register. If the result is in numbers, note the number against the indicator under the ttC-HV.

Repeat this process for the next pregnant woman in the ttC-HV area who gave birth during the reporting period. Enter the data for this pregnant woman in the same column, next to the data from the register of the first pregnant woman. Repeat this until you have entered the data from all pregnant women in the ttC-HV area who gave birth during the reporting period.

Move to the next column, which is for the next ttC-HV in the supervisor's area, and repeat the process for the registers of those pregnant women in this ttC-HV's area who gave birth during this reporting period.

Continue this until you cover all pregnant women who gave birth in this reporting period, in all ttC-HVs' areas.

Activity 2: Discussion of worked example

Ask: participants to pick up the 3 examples they worked with in the previous session – those of Tara, Fatuma and Amina.

Let us assume that these women are being visited by ttC-HV Mariam and all 3 of them gave birth during this reporting period. Let us look at how the details from the registers of these 3 women have been transferred to the 'ttC Summary Register – Pregnancy'.

Let us also assume that Mariam has a total of 10 women registered in her EWG register, and four women are currently pregnant. Three gave birth during this reporting period – Tara, Fatuma and Amina.

Summary Register – Pregnancy

TALLY FOR TTC REGISTER - PREGNANCY

U - UNIVERSAL REGISTER INFORMATION

Health Authority >> _____ ID >> _____ Community Name >> _____

Health Sector >> _____ Supervisor Name & ID _____

MG Supervisor >> _____ Supervision period>> _____ from _____ to: _____

ADP >> _____ Recording Date >> _____

RECORD RESULT FROM ELIGIBLE WOMEN AND GIRLS' REGISTER			HV ID:	HV ID:	HV ID:	HV ID:	HV ID:	HV ID:	HV ID:	HV ID:	HV ID:	HV ID:	HV ID:	HV ID:	HV ID:	HV ID:	HV ID:	Totals-All Women
No. of TTC eligible women& girls registered (15-49 years/caregivers)		S2																
Total number of eligible women and girls using contraceptive method		S3																
Total number of current pregnancies		PD1																
Number of completed pregnancies (forms this supervision)		PD2																
USING "TTC REGISTER-PREGNANCY" FROM WOMEN WHO HAVE COMPLETED PREGNANCY		**Data code**																
# of deaths of pregnant women		D1																
# of Women who experienced a miscarriage		D2																
# of women who received 1st ttC visit within 4 months of pregnancy		P1A																
# of women who received at least 4 visits during entire pregnancy		P1B																
# of women whose husband/partner participated in most of the ttC visits		P2																
# of women who attended 1st ANC visit within 16 weeks		P5a																
# of women who attended 4 ANC visit during entire pregnancy		P5b																
# of women who took at least 100 IFA tablets during pregnancy (at least 4 months)		P8																
# of women who report eating more than usual during this pregnancy		P9																
# of women who have developed a birth plan before the end of their pregnancy		P10																
# of *cases* where danger signs in pregnancy were identified		E1																
# of *cases* with danger signs where referral was completed		E1A																
# of *referral cases* for which post referral home visit completed		E1B																
OPTIONAL INDICATOR 1																		
OPTIONAL INDICATOR 2																		

These are the denominator rows.

There is one column for all pregnancies in a ttC-HV area.

Add up the totals from all ttC-HV columns and record here.

Worked example: ttC-HV Mariam (Women: Tara, Fatuma and Amina)

Ask participants to pick up the register sheet for Tara and call out the indicators for which there is a ✓ response under totals column. For referrals and referral completion, ask them to call out the numbers. Record every ✓ in the Summary Sheet against the corresponding indicator. After completing Tara's register, repeat the process for Fatuma and Amina. The results are shown in Figure 3.6a in the Worksheets.

Point out to participants that Fatuma did not receive the first ttC visit by 16 weeks of pregnancy, while Tara and Amina did. Hence there are 2 ✓s recorded for this indicator. All 3 of them have ✓recorded for sleeping under a bed net, and hence the Summary Sheet has 3 ✓s recorded for this indicator, and so on. Move to the totals column and point out the numbers from the denominators section and also how the number of ✓s have been totalled.

Activity 3: Working with other examples

Distribute the example worksheets (Pregnancy Register sheets) for Fudia, Nancy and Jane, who gave birth during the reporting period and who are visited by ttC-HV Mary. These sheets are Figures 3.6b, 3.6c and 3.6d in the Worksheets.

Divide participants into groups of five and have each group transfer the totals from the 3 Pregnancy Registers to Mary's Summary Sheet and complete the totals.

Activity 4: Discussion and Q&A

In plenary, ask the groups to present key points and lessons from the group exercise.

Summarise the session

- Respond to any questions the participants may have. Summarise using the key points of the session.
- The 'ttC Summary Register – Pregnancy' provides the totals for all pregnancies in all ttC-HV areas in the supervisor's area.
- The supervisor completes the ttC Summary Register using data from the completed totals column of the 'ttC Register – Pregnancy' for pregnant women who have given birth during the reporting period.

Session 8. Calculating and assessing coverage levels

Contextualisation: Your national office will have contextualised the monitoring systems. This process involves making changes to the list of indicators and to the ttC Registers, adding or removing indicators for your context and adapting the threshold levels for indicators. Make sure you are working with the final versions of the Summary Sheet and indicator threshold levels for your NO.

Session plan	Total time = 2 hr 15 min Activity 1: Calculating coverage levels — 30 min Activity 2: Discussion and working with example — 30 min Activity 3: Assessing coverage using threshold values — 60 min Activity 4: Discussion and Q&A — 15 min
Learning objectives	At the end of this session participants should be able to: • calculate coverage levels for indicators using the Summary Sheet – Pregnancy • assess the coverage levels based on thresholds
Materials and preparation	*Materials* • Summary ttC Register – Pregnancy (one per participant) • Example sheet – one per participant
Key messages	• Coverage levels are calculated for each indicator using percentages or estimations. • Coverage levels are assessed for progress by comparing with threshold levels.

Activity 1: Calculating coverage levels

Contextualisation: Edit this section based on the numeracy skills of the supervisors. If the supervisors have adequate numeracy skills and can calculate percentages with some training, you will use those sections in this session that have to do with percentages. If the supervisors are of low numeracy or require significant training and coaching to do percentages, use those sections that have to do with estimations. These 2 scenarios may exist in the same NO.

This section has 2 parts – the first one deals with calculating percentages and categorising coverage levels based on threshold percentages. This is meant for use in settings where the supervisors would have adequate numeracy skills and can comfortably calculate percentages. The second part is meant for settings where supervisors would find calculation of percentages challenging, and hence thresholds have been simplified for them to assess indicators based on threshold levels without having to calculate percentages. These 2 settings may exist in the same NO.

For supervisors with adequate numeracy

Introduce the concept of percentages: Begin by stating that numbers do not mean much. We need to know how many of those who actually need to practise a behaviour or access a service actually did it. This is also called 'coverage'. For example, 10 pregnant women have slept under a bed net in a community. We first need to know how many pregnant women are in that community. If there are 20 pregnant women in that community, then the number 10 would be considered a fairly high figure (though we would want all 20 to have slept under a bed net). On the other hand, if there are 50 pregnant women in the community, then 10 out of 50 would be considered very low.

So we have 2 coverage levels: 10/20 and 10/50. In order to make these 'standard', we use percentages, or 'out of a hundred'. For these 2 scenarios, percentages would be as follows:

10/20*100 = 50%

10/50*100 = 20%

For some indicators, coverage below 25% will be considered insufficient, while for others, levels of 70% or below would be considered insufficient. This depends on several factors, such as how critical the intervention is to the health and survival of the mother and baby, and what the coverage levels are in the district, region or country.

For supervisors with lower numeracy skills

Now that we know how many pregnant women who gave birth during this reporting period practised a certain behaviour, we need to look at how many total pregnancies were completed during this period, of whom the above women are a part. For example, consider these scenarios:

Out of 20 pregnant women who gave birth during the past reporting period, 5 had slept under a bed net during pregnancy: this is a **quarter** of all pregnant women

Out of 20 pregnant women who gave birth during the past reporting period, 11 had slept under a bed net during pregnancy: this is about a **half** of all pregnant women

Out of 20 pregnant women who gave birth during the past reporting period, 17 had slept under a bed net during pregnancy: this is **almost all** pregnant women

The terms quarter, half, almost all, etc. are also called 'coverage levels', and they tell us how widespread a health practice is.

Point out that we need to have 6 such coverage estimations:

- Almost all (all but 1 or 2 out of the total number)
- More than half (but not all or almost all)
- Half or about half
- Less than half (but more than one quarter)
- Quarter or less
- Very few (only 1 or 2 out of the total number).

Activity 2: Discussion and working with example – Totals and coverage levels

Working on totals

Distribute the example of Summary Register – Pregnancy of ttC-HV Fatumata for this exercise. This is found in Figure 3.7a in the Worksheets.

In plenary, carry out the summing up for the Denominators section. Point out the item 'Number of completed pregnancies this supervision period' (answer: 30) and the indicator '# women who received a ttC visit within four months of pregnancy' (answer: 23).

Next, divide participants into groups of five and ask them to sum up the totals for the remaining indicators.

When the group work is completed, go around the groups, asking them to call out the answer for one indicator each. Repeat in rounds until you have completed all the indicators.

Answer key:

women who received four ttC visits during entire pregnancy = 30
women whose husband/partner participated in most ttC visits = 15
women identified as high risk at any point during pregnancy = 10
women who slept under a bed net for at least half of the pregnancy = 22
women who had the first ANC visit within 16 weeks = 20
women tested for HIV at some point in pregnancy = 20
women tested for HIV and received the result = 26
women who took IFA tablets for at least four months = 27
women who report eating more than usual during pregnancy = 17
women who developed a birth plan before the end of pregnancy = 8
cases where danger signs were identified = 14
cases with danger signs where referral was completed = 9
cases with danger signs where post-referral home visit was completed = 9

Working on coverage levels

While the participants are still in their groups, demonstrate the calculation of coverage for the first indicator.

If you are using percentages, do the following calculation:

% women who received a ttC visit within four months of pregnancy =

$$\frac{\text{\# women who received a ttC visit within 4 months of pregnancy}}{\text{\# } \textbf{current} \text{ pregnancies this reporting period}} \times 100$$

Note: *For this indicator it is better to measure against the total number of current pregnancies, as registration is a one-off event. You can then advise ttC-HVs how to encourage earlier enrolment, if it is low.*

In the example, it is 23/30 *100 = 76%

If you are using estimations, do the following:

All women who completed pregnancy this supervision period: 30

Women who completed pregnancy, who had a ttC visit within four months of pregnancy: 23

Ask participants what category this belongs to. (Answer: almost all.)

Ask the participants to complete the coverage levels for the remaining indicators. They should come up with either percentages or estimates for each indicator.

Answer key:

% women who received four ttC visits during entire pregnancy = 100% (almost all, in fact, all)
% women whose husband/partner participated in most ttC visits = 50% (half)
% women identified as high risk at any point during pregnancy = 33% (less than half)
% women who slept under a bed net for at least half of the pregnancy = 73% (more than half)
% women who had the first ANC visit within 16 weeks = 66% (more than half)
% women tested for HIV at some point in pregnancy = 33% (quarter)
% women tested for HIV and received the result = 86% (almost all)
% women who took IFA tablets for at least four months = 90% (almost all)
% women who report eating more than usual during pregnancy = 56% (more than half)
% women who developed a birth plan before the end of pregnancy = 26% (quarter)
% cases where danger signs were identified = 46% (half)
% cases with danger signs where referral was completed = 64% (more than half)
% cases with danger signs where post-referral home visit was completed = 64% (more than half)

Point out to participants that for the last 2 indicators, the denominator, or all women – is NOT all women who completed pregnancy in the supervision period, but it is all women who had a danger sign identified.

Indicators with low desired coverage

Point participants to the indicators 'Proportion of pregnant women identified as high risk' and 'Proportion of pregnant women with a complication' and explain that, unlike all the other indicators, these are not desirable outcomes. Therefore a low coverage will be considered good, and a high coverage will be considered critical.

Activity 3: Assessing coverage using threshold values

Ask: How much coverage is sufficient, or how low a coverage level should cause concern?

This varies with the health practice in question. For some, 25% coverage (or a quarter of all who were to adopt the practice) is considered sufficient. For others, 85% (nearly all of those who were expected to adopt the practice) is considered sufficient coverage. These are called threshold values. For each indicator, the ttC programme in this country has established 3 threshold levels: Good, Moderate and Critical. These are indicated by green, yellow and red colours respectively.

For **most of the indicators** in the Pregnancy Register, the following threshold values are used:

>70%	50–70%	<50%
Most	More than half	Less than half

For 2 indicators (# of pregnant women who had an HIV test done and obtained results, and # of pregnant women who took IFA tablets for at least four months during pregnancy), **the threshold values are higher:**

>90%	70–90%	<70%
Almost all	More than half	Less (than most)

Note: *<70% is defined as less than the acceptable range of 70–100 (i.e. less than most). This will need explanation.*

For one indicator (Proportion of eligible women and girls using a contraceptive method), the **threshold values are lower:**

>35%	25–35%	<25%
Less than half	About a quarter	Less than a quarter

High-risk/most vulnerable cases

As discussed earlier, the indicators on **high-risk/most vulnerable pregnancies** and on **complications in pregnancy** are instances where we desire low levels of coverage; however, at the level of the community, these thresholds are not very meaningful. The intention of 'high-risk case', as defined in the ttC Curriculum 2nd edition, is that a variety of risk factors may be taken into consideration, such as young age, HIV status, medical risks and socio-economic or psychosocial risks. The reasons for these risks may in fact remain confidential between the ttC-HV and the client *if that is appropriate.* Therefore, at the community level the supervisor should consider only the *number of high-risk cases* and the extent to which the ttC-HV is working to provide patient-centred care through giving additional support through additional home visits, ensuring health facility attendance, supporting medicine adherence or other. The important data on these cases will be qualitative.

Only at the population level might we consider analysis of high risk as given below.

<5%	5–15%	>15%
Very few	Less than a quarter	About a quarter

Ask participants to look up the coverage levels of all the indicators in the example worksheet and assess them against the threshold values listed above.

Activity 4: Discussion and Q&A

Facilitate a discussion on the possible causes of coverage at critical level (red flags) in the above examples and what steps they could take to address them.

Summarise the session

- Respond to any questions the participants may have. Summarise using the key points of the session.
- Coverage levels are calculated for each indicator using percentages or estimations.
- Coverage levels are assessed for progress by comparing with threshold levels.

Thresholds for pregnancy indicators

Indicators	Threshold Values for Red/Green Flagging					
	Percentages			Estimates		
	Good	Moderate	Critical	Good	Moderate	Critical
% of eligible women and girls using a contraceptive method	>35%	25–35%	<25%			
% of deaths of pregnant women				0	1–2 per 50 HH	3 or more per 50 HH
% of miscarriages, abortions						
% of women who received their first ttC visit within the first 18 weeks of pregnancy	>70%	50–70%	<50%	Most	More than half	Less than half
% of women who received at least four ttC visits during the entire pregnancy						
% of women whose husband/partner participated in most of the ttC visits						
% of women who were identified as high risk at any point during this pregnancy	<5%	5–15%	>15%			
% of women who slept under a bed net during at least half of the pregnancy	>70%	50–70%	<50%	Most	More than half	Less than half
% of women who attended first ANC visit within 16 weeks						
% of women who attended four ANC visits during entire pregnancy						
% of women who were tested for HIV at some point during pregnancy	>90%	70–90%	<70%	Almost all	Most	Less
% of women who were tested and obtained HIV test result during pregnancy						
% of women who took at least 100 IFA tablets during pregnancy (at least four months)						
% of women who mostly ate more than usual during this pregnancy	>70%	50–70%	<50%	Most	More than half	Less than half
% of women who have developed a birth plan before the end of their pregnancy						
% of cases of pregnant women with a possible complication						
% of cases of pregnant women with a possible complication referred to a facility						
% of referral cases who received a home-visit follow up						

Session 9. Collecting and tallying completed newborn registers

Contextualisation: Your national office will have contextualised the monitoring systems. This process involves making changes to the list of indicators and to the ttC Registers, adding or removing indicators for your context. Make sure you are working with the final versions of the 'ttC Register – Newborn' and Summary Register – Pregnancy as adapted by your NO or your project.

Session plan	Total time = 2 hr	
	Activity 1: Overview of tally column in 'ttC Register – Newborn'	15 min
	Activity 2: Discussion of worked example	30 min
	Activity 3: Working with other examples	60 min
	Activity 4: Discussion and Q&A	15 min
Learning objectives	At the end of this session participants should be able to: • tally the 'ttC Register – Newborn'	
Materials and preparation	*Materials* • one copy of 'ttC Register – Newborn' • example sheets – set of 3 per participant	
Key messages	• The totals column in the 'ttC Register – Newborn' provides data on every newborn served through ttC. • Each tally should either be a Yes or No response or a total of entries in the visits column. • The totals column is completed only when the newborn period is completed and the baby's name is entered in the 'ttC Register – Infant'.	

Activity 1: Overview of the tally column in 'ttC Register – Newborn'

Ask participants to return to the 'ttC Register – Newborn'. Point them to the totals column in the far right.

When and how to complete the tally column: The supervisor will complete this column only when the newborn period is completed and the baby 'graduates' to the 'ttC Register – Newborn'.

Explain that during every meeting, the ttC-HVs will submit their Newborn Registers. The supervisor will work with each ttC-HV in turn, *identifying babies in the register who completed their first month and entered the ttC Register – Infant during the reporting period and completing the totals column for those newborns.*

Emphasise that data is not collected from all Newborn Registers during every reporting period.

Read through the items in the totals column (far right). Point out that some of these are numbers, which the supervisor obtains by adding the entries in each visit, and others are Yes/No, which the supervisor determines based on the entries made in the visits columns.

The first four items in the totals column need to be filled in with numbers: number of maternal deaths, number of stillborn, number of babies born live and number of babies who died in the newborn period.

If you are using one sheet per newborn in the event of multiple births, then these can all be changed to Yes/No. If not, then this part of the form needs to be number of births.

The next four items in the totals column read like questions. For each row the supervisor will review the information that the ttC-HV has entered for that row, and determine whether the response in the totals column will be a Yes or a No (Y or N).

The next four rows, entries from visits, are totalled and entered in numbers. The next four rows again read like questions and will be filled using Yes/No, based on entries made during the visits. The last four rows are to be completed in numbers.

Activity 2: Discussion of worked example

Distribute the set of 3 examples of 'ttC Registers – Newborn', those of the babies of Tara, Fatuma and Amina. Their households are reached by the ttC-HV Mariam. These are Figures 3.8a, 3.8b and 3.8c in the Worksheets.

Ask participants to open the Pregnancy Register of Tara and work through the totals in plenary. Explain the reason why the total is ✓ or ✗ or a number as recorded in the example.

Activity 3: Working with other examples

Distribute the other 2 examples (Fatuma and Amina) to all participants

Divide the participants into groups of four and ask them to work through the 2 examples and complete the totals column.

Activity 4: Discussion and Q&A

In plenary, ask each group to share their experiences in working with the example sheets.

Summarise the session

- Respond to any questions the participants may have. Summarise using the key points of the session.
- The totals column in the 'ttC Register – Newborn' provides data on every newborn served through ttC; each tally should either be a Yes/No response or a total of entries in the visit columns.
- The totals column is completed only when the newborn period is completed and the baby's name is entered in the 'ttC Register – Infant'.

Session 10. Completing the Summary Register – Newborn

Contextualisation: Your national office will have contextualised the monitoring systems. This process involves making changes to the list of indicators and to the ttC Registers, adding or removing indicators for your context. Make sure you are working with the final versions of the 'ttC Register – Newborn' and Summary 'ttC Register – Newborn' as adapted by your NO or your project.

Session plan	Total time = 2 hr Activity 1: Overview of the 'ttC Summary Register – Newborn' 15min Activity 2: Discussion of worked example 30 min Activity 3: Working with other examples 60 min Activity 4: Discussion and Q&A 15 min
Learning objectives	At the end of this session participants should be able to: • explain the parts of the 'ttC Summary Register – Newborn' • complete the 'ttC Summary Register – Newborn'
Materials and preparation	*Materials* • ttC Summary Register (Per ttC-HV tally) – Newborn (one per participant) • Example sheets completed in previous session (set of 3 per participant) • Example worksheets for this session (set of 3 per participant)
Key messages	• The 'ttC Summary Register – Newborn' provides the totals for all newborns in all ttC-HV areas in the supervisor's area. • The supervisor completes ttC Summary Register using data from completed totals column of the 'ttC Register – Newborn' for babies who have completed their first month during the reporting period.

Activity 1: Overview of the 'ttC Summary Register – Newborn'

Distribute the 'ttC Summary Register – Newborn' to all participants.

Explain that each supervisor will fill one Summary Register per reporting period using data from Newborn Registers of all ttC-HVs in the supervisor's area.

- **Universal register information**: This is the section at the top of the form. Point out that this has different items from the section in the Newborn Register. As there is only one of these sheets for every supervisor, this section has information pertaining to the supervisor.
- **Denominators section:** This section immediately follows the universal information section and has 2 data items that need to be filled in for every ttC-HV. These items are the number of pregnant women who delivered during this supervision period and the total number of births during this supervision period. These would form the denominator to calculate the newborn-related indicators. Point out that if a woman gives birth to twins, the numbers for these 2 indicators would be different.
- **Indicators**: Point out that the indicators (going down the far left column) are exactly the same as in the ttC Newborn Register. Totals from each ttC-HV: Point to the columns to the right of the indicators, each of which pertains to one ttC-HV.

Each ttC-HV might have a few to several babies who completed their newborn period during the reporting period. Details from the totals column of the Newborn Register of all these babies should be entered under the column for that ttC-HV.

When transferring details from the totals column of a Newborn Register to the Summary Register, go down the totals column and for every Yes result in the Newborn Register, place a tally mark against the corresponding indicator in the Summary Register. If the result is in numbers, note the number against the indicator under the ttC-HV.

Repeat this process for the next newborn in the ttC-HV area that completed one month during the reporting period. Enter the data for this newborn in the same column, next to the data from the register of the first newborn. Repeat this until you have entered the data from all newborns in the ttC-HV area that were born during the reporting period.

Move to the next column, which is for the next ttC-HV in the supervisor area, and repeat the process for the registers of those newborns in this ttC-HV's area that completed one month of life during this reporting period.

Continue this until you cover all newborns that completed their newborn period in this reporting period, in all ttC-HV areas.

Summary register – newborn

TALLY FOR TTC REGISTER - NEWBORN

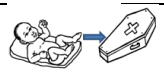
U - UNIVERSAL REGISTER INFORMATION

Health Authority >> _____ Community Name >> _____

Health Sector >> _____ Supervisor Name & ID >> _____

MG Supervisor >> _____ Supervision period >> from: _____ to: _____

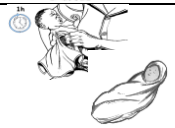
ADP >> _____ Recording Date >> _____

TALLY ALL RECORDS FOR ALL CASES, PER MG AMONGST CASES COMPLETED NEWBORN PHASE		Data code	HV ID:	HV ID:	HV ID:	HV ID:	HV ID:	HV ID:	HV ID:	HV ID:	HV ID:	HV ID:	HV ID:	HV ID:	HV ID:	HV ID:	HV ID:	Totals All Women
Total women delivered since last supervision, *cases completed 1 month*		**ND1**																
Total babies born (still and live births)		**ND2**																
Maternal deaths		**D2**																
# of still born babies		**D3**																
# of live born babies		**ND3**																
# of newborn deaths (0-1m)		**D4**																
# of women who received at least 4 ttC visits post partum		**N1**																
# of women whose husband/partner participated in most ttC visits		**N2**																
# of high risk/most vulnerable newborns		**N3**																
# of women who had skilled birth attendance in a facility		**N4**																
# of babies that were low birth weight (LBW) <2.5 kg		**N5**																

These are the denominator rows.

There is a column for each ttC-HV.

Totals from all ttC-HVs go here.

# of babies that received Kangaroo Mother Care		**N6**																	
# of babies breastfeed in first hour of life		**N7**																	
# of babies that were wiped and wrapped in the first hour of life (no bathing)		**N8**																	
# of babies that slept under bednet at all visits		**N9**																	
# of babies who received early vaccines (BCG and OPV-0)		**N10**																	
# of cases post-partum danger sign		**E2**																	
# of *cases* of newborns with danger signs		**E3**																	
# of newborns with danger signs referred to health facility		**E4A**																	
# of referral cases that received post-referral home visits		**E4B**																	
OPTIONAL INDICATOR 1																			
OPTIONAL INDICATOR 2																			

Activity 2: Discussion of worked example

Ask participants to pick up the 3 examples they worked with in the previous session – those of the babies of Tara, Fatuma and Amina.

Let us assume that these women are being visited by ttC-HV Mariam and all 3 of them gave birth during this reporting period. Let us look at how the details from the registers of these 3 women have been transferred to the 'ttC Summary Register – Newborn'. These 3 deliveries and the 3 live births will be entered in the denominators section.

Worked example: ttC-HV Mariam (women: Tara, Fatuma and Amina)

Ask participants to pick up the register sheet for Tara's newborn and call out the indicators for which there is a ✓ response under the totals column. For indicators with numbers, ask participants to call out the numbers from the totals column. After completing Tara's Newborn Register, repeat the process for Fatuma's and Amina's babies. The results are shown in Figure 3.9a in the Worksheets.

Point out to participants that all 3 newborns received 3 visits by the ttC-HV during the first week. Tara's and Amina's babies are of normal weight, but Fatuma's has low birth weight. Fatuma's husband was present during all the 3 visits but Amina's was not.

Ask participants to point out other differences and discuss how these will be reflected in the Summary Register.

Move to the totals column and point out the numbers from the denominator section and also how the number of Ys and numbers have been totalled up for each indicator.

Activity 3: Working with other examples

Distribute the example worksheets (Newborn Register sheets) for the babies of Fudia, Nancy and Jane, who completed their newborn period during this reporting period and who are visited by ttC-HV Mary. These sheets are Figures 3.9b, 3.9c and 3.9d in the Worksheets.

Divide participants into groups of five and get each group to transfer the totals from the 3 Pregnancy Registers on to Mary's Summary Sheet, and complete the totals.

Activity 4: Discussion and Q&A

In plenary, ask the groups to present key points and lessons from the group exercise.

Summarise the session

- Respond to any questions the participants may have. Summarise using the key points of the session.
- The 'ttC Summary Register – Newborn' provides the totals for all newborns in all ttC-HV areas in the supervisor's area.
- The supervisor completes ttC Summary Register using data from completed totals column of the 'ttC Register – Newborn' for those babies who have completed their first month during the reporting period.

Session 11. Calculating and assessing coverage levels

Contextualisation: Your national office will have contextualised the monitoring systems. This process involves making changes to the list of indicators and the ttC Registers, adding or removing indicators for your context and adapting the threshold levels for indicators. Make sure you are working with the final versions of the Summary Sheet and indicator threshold levels for your NO.

Edit this section based on the numeracy skills of the supervisors. If the supervisors have adequate numeracy skills and can calculate percentages with some training, you will use those sections in this session that have to do with percentages. If the supervisors are of low numeracy or require significant training and coaching to do percentages, use those sections that have to do with estimations. These 2 scenarios may exist in the same NO.

Session plan	Total time = 2 hr 15 min Activity 1: Calculating coverage levels — 30 min Activity 2: Discussion of worked example — 30 min Activity 3: Assessing coverage using threshold values — 60 min Activity 4: Discussion and Q&A — 15 min
Learning objectives	At the end of this session participants should be able to: • calculate coverage levels for indicators using the Summary Sheet – Pregnancy • assess the coverage levels based on thresholds
Materials and preparation	*Materials* • ttC Summary Register – Newborn (one per participant) • Example sheet - one per participant
Key messages	• Coverage levels are calculated for each indicator using percentages or estimations • Coverage levels are assessed for progress by comparing with threshold levels

Activity 1: Calculating coverage levels

This activity is similar to the one carried out with the 'Summary Register – Pregnancy'. Review the calculation of percentages or estimations that participants learnt in Session 8.

Activity 2: Discussion of worked example – Totals and coverage levels

Working on totals

Distribute the example of 'Summary Register – Newborn' of supervisor Alice for this exercise. This is found in Figure 3.10a in the Worksheet.

Divide participants into groups of five and ***ask them*** to carry out the totalling of data from the five ttC-HVs that Alice supervises. Point out the 2 types of data – ✓/× (for which only the responses have been tallied in the Summary Register) and numbers. This should not take long as they have already practised this with the Pregnancy Register.

Working on coverage levels

While the participants are still in their groups, demonstrate the calculation of coverage for the first indicator. Then ask the groups to calculate the coverage percentages for the rest of the indicators. Point out to participants that for the last four indicators, the denominator is NOT all newborns/mothers who completed one month in the supervision period; it is all newborns/mothers who had a danger sign identified. Similarly, the denominator for the indicator on skin-to-skin care is not all newborns but all those with low birth weight.

Indicators with low desired coverage

Point participants to the indicators '# of newborns identified as high risk' and '# of newborns with low birth weight' and explain that, unlike all the other indicators, these are not desirable outcomes. Therefore a low coverage will be considered good, and a high coverage will be considered critical.

Activity 3: Assessing coverage using threshold values

As with pregnancy indicators, the ttC programme in this country has established 3 threshold levels for each indicator: Good, Moderate and Critical. These are indicated by green, yellow and red colours respectively.

For **most** of the indicators, the following threshold values are used:

>70%	50–70%	<50%
Most	More than half	Less than half

For 2 indicators (# of newborns sleeping under a bed net and # of newborns who had early immunisations), the threshold values are **higher**:

>90%	70–90%	<70%
Almost all	Most	Less (i.e. than most)

High-risk newborns

As discussed earlier, the indicators on **high-risk newborns** and on **newborns with low birth weight** are instances where we desire low levels of coverage, but largely this should be considered at a population level rather than community. Again, the estimations are not sensitive here. For high-risk cases it is not so much the number that is important as that you can lead into discussions about what additional support they are considering in caring for the client and the high-risk baby.

<5%	5–15%	>15%
Very few	Less than a quarter	About a quarter

Ask participants to look up the coverage levels of all the indicators in the example worksheet and assess them against the threshold values listed above. Facilitate a discussion on possible causes of coverage at critical (red flags) in the above examples and what steps they could take to address them.

Summarise the session

- Respond to any questions the participants may have.
- Coverage levels are calculated for each indicator using percentages or estimations.
- Coverage levels are assessed for progress by comparing with threshold levels.

Threshold values for newborn registers						
Indicators	**Threshold Values for Red Flagging**					
	Percentages			**Estimates**		
	Good	**Moderate**	**Critical**	**Good**	**Moderate**	**Critical**
%/# of deaths of women during labour and in postpartum (up to 6 weeks)				0	1–2 per 50 HH	3 or more per 50 HH
% of stillbirths (rate per 1,000 live births)	<15%	15–20%	>20%			
% of deaths of newborns (up to one month of age) per 1,000 live births	<15%	15–20%	>20%	0	1–2 per 50 HH	3 or more per 50 HH
% of postpartum women who received at least four visits during the first month of life	>70%	50–70%	<50%	Most	More than half	less than half
% of women whose husband/partner was present during most ttC visits						
% of newborns reported as being high risk	<5%	5–15%	>15%			
% of births assisted by skilled health personnel in a health facility	>70%	50–70%	<50%	Most	More than half	less than half
% of births where the birth weight of the newborn was recorded and newborn weighed <2,500g OR % of newborns with low birth weight or premature identified by any other means	<10	10–15%	>15%			
% of low birth weight (LBW) babies who received skin-to-skin care	>70%	50–70%	<50%	Most	About half	less than half
% of newborns who were breastfed within one hour of life						
% of newborns who were wiped and wrapped soon after birth						
% of newborns who live in a home with a bed net, who sleep under the bed net	>90%	70–90%	<70%	Almost all	Most	Less than most
% of newborns who had early immunisations – BCG and OPV (zero dose) in the first month						
% of cases of postpartum mothers (up to 6 weeks) with a possible complication						
% of cases of newborns (0–28 days) with a possible complication						
% of cases of newborns with a possible complication referred to a facility	>70%	50-70%	<50%	Most	More than half	Less than half
% of cases of newborn referrals who received a follow-up home visit						
% of cases of pregnant women with a possible complication referred to a facility						
% of referral cases who received a home-visit follow up						

ttC TALLY REGISTER – INFANTS 1–6M (PER CHW)						
Indicators	**Threshold Values for Red Flagging**					
	Percentages			**Estimates**		
	Good	**Moderate**	**Critical**	**Good**	**Moderate**	**Critical**
%/# of deaths of post neonatal infants (1–6 months of age)	<15	15–20	>20	0	1–2 per 50 HH	3 or more per 50 HH
% of infants 1–6 months who received at least one home visit DURING one to 6 months	>70%	50–70	<50%	Most	More than half	less than half
% of home visits where male partner or chosen supporter was present						
% of infants identified as high-risk infants	<5%	5–15%	>15%			
% of infants 1–6 months who have a birth certificate	>70%	50-70%	<50%	Most	More than half	less than half
% of infants who completed both DTP/Penta and OPV vaccinations by 6 months	>90%	70–90%	<70%	Almost all	Most	Less
% of infants who were exclusively breastfed to 6 months of age (male)	>70%	50–70%	<50%	Most	More than half	less than half
% of infants who were exclusively breastfed to 6 months of age (female)						
% of women who are using a contraceptive method by 6 months postpartum						
% of infants aged 1–6 months who are sleeping under an LLIN						
% of cases of infants (1–6 months) with a possible complication	>70%	50–70%	<50%	Most	More than half	less than half
% of cases of infants (1–6 months) with a possible complication who were referred to a facility and who received a follow-up home visit post referral						
% of cases of infants (1–6 months) with referrals where a post-referral home visit was completed						

ttC REGISTER – CHILDREN 6–23M						
% of deaths of children (6–23 months or one day short of second birthday)	<15	15-20	>20	0	1–2 per 50 HH	3 or more per 50 HH
% of children visited twice in the first year of life (6 and 9 months)	>70%	50-70%	<50%	Most	More than half	less than half
% of children visited four times during 6–23 months (or one day short of second birthday)						
% of women whose husband/partner participated in most ttC visits						
% of children considered high risk at any point during 6–23 months	<5%	5-15%	>15%			
% of mothers of children aged 6–23 months who use a modern contraceptive method	>35%	25-35%	<25%	More than a third	More than a quarter	Less than a quarter
% of mothers who wash hands with soap or ash at appropriate times	>90%	70–90%	<70%	Almost all	Most	Less
% of children who continued to breastfeed up to 23 months						
% of infants who received complementary feeding from 6 months						
% of children aged 6–23 months who were given the minimum meal frequency						
% of children aged 6–23 months who regularly ate iron-rich and/or iron-fortified food daily	>70%	50–70%	<50%	Most	More than half	less than half
% of children aged 6–23 months who had iron supplements (syrup or tablets) at some point						
% of children who have received all essential vaccinations (Measles and DPT1, 2 and 3) by first birthday	>90%	70–90%	<70%	Almost all	Most	Less
% of children who have received at least 2 doses of vitamin A before second birthday						
% children who have received at least 2 doses of deworming medicine before second birthday						
% of children aged 6–23 months sleeping under a mosquito net regularly						
% of cases of children aged 6-23 months with a sign of illness	>70%	50–70%	<50%	Most	More than half	less than half
% of children (6–23 months) with a sign of illness taken to the health facility						
% of cases of referrals who received a follow-up home visit						

Session 12. Qualitative review, feedback and action planning

Session plan	Total time = 2 hours Activity 1: Introduction Activity 2: Analysing the data with the ttC-HVs Activity 3. Root-cause analysis Activity 4: A supervisor's response to community-level barriers Activity 5: Review and feedback process Activity 6: Practice in groups
Learning objectives	By the end of this session supervisor should be able to: • know how to debrief the ttC-HV following the data collections and provide feedback and help the ttC-HV make an action plan • identify root causes through discussion with ttC-HVs • explain and demonstrate good techniques for communicating that they can use during feedback.
Materials and preparation	*Materials* • ttC-HV Diary (notebooks or diaries) • Coloured paper • Coloured post-it notes
Key messages	Supervisor should conclude the supervisory session by summarising key findings, praising the ttC-HV on areas where improvements in health practices are evident and helping the ttC-HV make an action plan to improve on areas where uptake is still low.

Activity 1: Introduction

Begin by explaining that it is important for the supervisor to conclude the supervisory session by summarising key findings, praising the ttC-HV on areas where improvements in health practices are evident and helping the ttC-HV make an action plan to improve on areas where uptake is still low.

Remind participants to always remember to sign off the cases that they have supervised on the ttC Registers, so that they are not taken up again in a subsequent supervision session, and also to help cross-verify supervision findings with data in the registers.

Activity 2: Analysing the data with the ttC-HVs

Analysis steps	
Step 1.	**Tally the data** and enter into the form
Step 2.	**Identify threshold** of values that are good, need improvement or poor
Step 3.	**Check for trends** in the data compared to previous months; identify any improvements or declines in the health practices. Consider a change to be potentially important only if an

indicator has moved from one category to another or if it is a difference of more than 10% than a previous month. (Anything less than 10% with small numbers may not be important.)

Giving feedback and action planning

Step 4. **Identify and investigate success areas**. Ask the ttC-HVs to share how they think this result came about and take notes for the next debriefing meeting. **Give positive feedback** on what is going well.

Step 5. **Select 3 or four improvement focus areas.** To be really able to provide meaningful feedback and create a realistic action plan from the household data, do not try to do this with more than four data points at a time. Ideal range for action plans would be to address only 3 or four problem areas. When selecting problem areas/improvement focus areas, select from the list in order of priority:

a. Deaths or adverse events
b. Household practices in the 'poor' range
c. Household practices in the 'needs improvement' range
d. Any household practice indicator that has declined 10% or more since the previous month
e. Lower-than-expected ttC enrolment in coverage areas

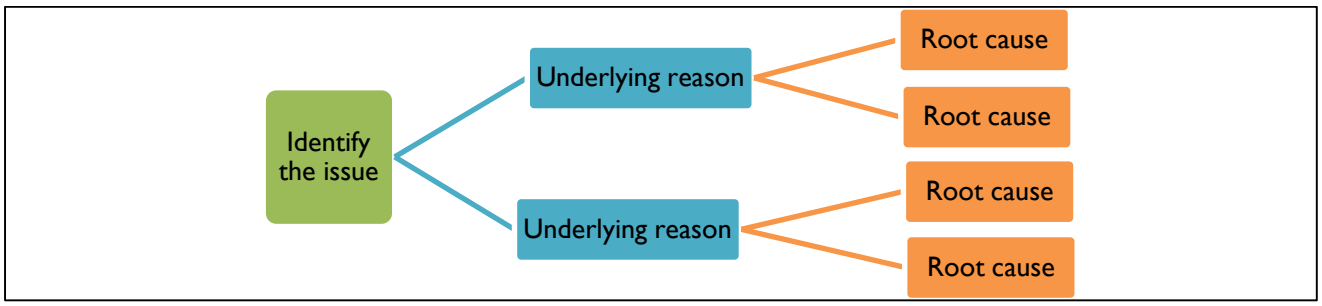
Step 6. **Use the 'root-cause' technique** to discuss the underlying barriers leading to these data findings, through discussion with the ttC-HVs.

Step 7. **Validate the data** by referring to the ttC-HV Diaries to identify most common barriers, and discuss these with the ttC-HVs.

Step 8. **Select an appropriate response**, and write this next to the barrier on the action plan. Agree on the action plan with the ttC-HV.

Step 9. **Feeding back to community representatives.** Before leaving the community, ensure that you report to the COMM/CHC (where they exist) or to the committee of elders/community chiefs. Share with them (if the ttC-HVs are willing for you to do so) the outcomes of the supervision and the actions you have agreed upon.

Activity 3. Root-cause analysis



Explain

When you speak to ttC-HVs about the identified improvement focus areas, you need to get to the root cause of the barrier; this means the real reason that indicator is poor in the community. Draw a diagram like the one shown on the next page (the Why-Why diagram) When we have identified an issue it often takes at least

2 steps to get to the root cause of the problem. A common way to do this in conversation would be to follow a 'Why–Why' route of questioning.

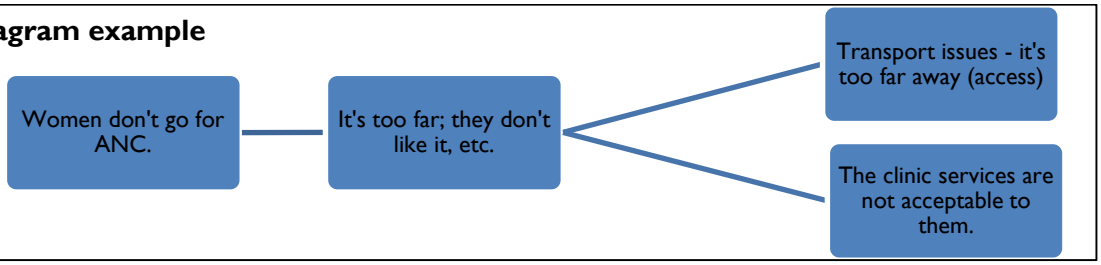
You continue until you find the root of the problems. It is this that you want to note and report during your COMM meetings.

Let's see this in practice. Two facilitators can role play the following

EXAMPLE 1	
Supervisor:	So, ANC uptake is very low in your community.
ttC-HV:	Yes, the women here don't like to go for ANC.
Supervisor:	Why don't they go? What makes it difficult for women here to go to ANC?
ttC-HV:	The women say it is too far and they don't like the clinic.
Supervisor:	Do you know why they don't like it at the clinic?

Enter these steps in the diagram on the flipchart and explain how the supervisor in the role play used a series of open questions to get to the root cause of the problem.

Why–Why diagram example



Work in pairs: Think of a community practice that is particularly low in your community. Turn to your partner and tell what it is, then let your partner try to get to the root cause with you, using the approach described above. Don't forget to check the ttC-HV Diary for the case examples to back up what the ttC-HV is saying.

Share experiences in plenary – did you get to the root cause? Did you find this technique useful?

Activity 4: A supervisor's response to community-level barriers

Ask: What types of steps can the ttC-HV take in response to low coverage or barriers at the community level?

If participants have experiences they can share, select one or 2. Discuss in plenary and note the ideas shared.

Explain

There is a range of appropriate responses a supervisor can take – too many to list in fact, but this is just to give participants an idea. The difficult barriers are to be addressed during the debriefing meetings, during a one-to-one discussion on areas the ttC-HV can influence.

WHEN TTC-HVS REPORT A BARRIER TO THE SUPERVISOR, THERE ARE SEVERAL ACTIONS TO BE TAKEN:

If the barrier pertains to only a few cases, do the following:

a. Help the ttC-HVs identify possible solutions.
b. Potentially help them speak to the families if there are difficult issues.

If the barriers are not solvable in the family and pertain to many cases, do the following:

c. Speak to community and women's groups leads about the common issues.
d. Give feedback to the COMM about common or difficult barriers.
e. Give feedback to the CVA or the health facility if the barriers pertain to them.

The table below shows some sample cases. Work through these and ask participants to determine a possible response. Then go back and review the examples they have given.

Example of problem	Supervisor's response
Low ANC coverage due to long distance travelled and transportation costs	a) and b)
Low health-facility deliveries because many women say they have had poor care at the facility	c) and/or d)
Low referral completing because of stock-outs of medicines	d) and/or e)

For each of the actions above, also ask the participants to think of examples from their own experience when they have taken these actions. Ask for volunteers to present their cases and how they addressed them. Ask them to explain what the outcomes were.

Activity 5: Review and feedback process

GIVING FEEDBACK

- Thank ttC-HVs for the work they have put in, and remember to give positive feedback. It's important to highlight the good things that they have done, while not losing the emphasis on incorrect treatment or evacuation.
- Ask them for their own ideas about weakness and improvements they could make.
- Be specific about where you have observed difficulties in their technique and, if possible, demonstrate how they can improve.
- Identify other sources of support nearby – another ttC-HV, or support with reading training guides.
- Before you leave, ensure that you have agreed on an action plan for how you wish to proceed, and how the action plan will be assessed.

Activity 6: Practise in groups

TTC-HV: SUPERVISION PERIOD 3 MONTHS

Positive areas:

- Exclusive breastfeeding to 6 months in recent cases has increased by 15% compared to previous months.
- Vaccination coverage is >90% in children; that's excellent.
- Male participation has increased from 20% to 50% in the last supervision period; well done!

Improvement focus areas:

- Less than 50% of pregnant women received their first ttC visit within 18 weeks.
- Less than 50% of newborns had early immunisations – BCG and OPV (zero dose) in the first month.
- Less than 50% of referrals received a follow-up visit afterwards.

Organise the participants into small groups. You could give them some practice data from the previous sessions to do the sequence from start to finish, identifying positive and improvement areas. Alternatively use the following examples.

Ask for 2 volunteers to role play the supervisor and the ttC-HV. First have one give the positive feedback, and then switch for the improvement areas. The supervisor should try to understand the root cause of the problem before proceeding to identify solutions and creating the action plan.

Summarise the session

- The feedback session helps the supervisor and the ttC-HV to recap key findings from the supervisory session, both positive and negative. It helps both to agree on a follow-up action plan in areas that need improvement.

APPENDICES

Appendix A. Illustrative Logframe and Output Monitoring Indicators

Hierarchy of objectives	Indicator	Recommended priority for ttC model*	Relevance to CWBT†	Means of verification or tool
Outcome 1. Women and their supporters adopt household practices that promote good health and nutrition				
Output 1.1 Caregivers who are counselled adopt appropriate infant and young child feeding and nutrition in pregnancy	Household-level uptake – early initiation of breastfeeding (within one hour of birth)	C	HR	ttC Register and supervision reports
	Household-level uptake – infants age 0–6 months exclusively breastfed	C	HR	
	Household-level uptake – children aged 6–24 months receiving continued breastfeeding	C	HR	
	Household-level uptake – children age 6–24 months receiving minimum meal frequency	O	A	
	Household-level uptake – women who report that they ate more than usual during current pregnancy	O	A	
	Household-level uptake – children aged 6–24 months consuming iron-rich or iron-fortified foods.	O	A	
Output 1.2 Women and their supporters who are counselled adopt disease-prevention practices	Household-level uptake – parents or caregivers of children aged 6–24 months with appropriate hand-washing behaviour	O	HR	
	Household-level uptake – children aged 0–1 month who received all 3 components of essential newborn care	C	HR	
	Household-level uptake – pregnant women who sleep under an insecticide-treated net	OL	A	
	Household-level uptake – children age 0–1 month who sleep under an insecticide-treated net	OL	T	
Outcome 2: Children and their caregivers have improved access to essential health services				
Output 2.1 ttC-counselled women have improved uptake of antenatal and reproductive health services	Household-level uptake – newborns 0–1 month of age whose births were attended by a skilled birth attendant	C	T	ttC Register and supervision report
	Household-level uptake – mothers of newborns 0–1 month of age who report that they had four or more antenatal visits during pregnancy	C	T	
	Household-level uptake – mothers of children 0–23 months who are using a modern contraceptive method	C	HR	

Hierarchy of objectives	Indicator	Recommended priority for ttC model*	Relevance to CWBT†	Means of verification or tool
	Referral rate for pregnant women – pregnant women who experienced a complication and were referred to a health facility and seen by a health provider	C	HR	
	Maternal death rate in programme beneficiaries	C	HR	
	Still birth or neonatal death rate in programme beneficiaries	C	HR	
	Household-level uptake – pregnant women who were counselled and tested for HIV and received their test results	OL	HR	
	Low birth weight in ttC registered live births	O	A	
	Household-level uptake – pregnant women who had a birth plan prior to delivery	O	A	
	Household-level uptake – pregnant women accessing antenatal care in the first 16 weeks of pregnancy	O	A	
	Household-level uptake – pregnant women who took iron/folate during pregnancy	OL	A	
Output 2.2 ttC-counselled families have improved uptake of child health services	Household-level uptake – coverage of all essential vaccines amongst registered children aged 1–12 months	C	T	
	Death rate in programme beneficiaries age 1–23 months	C	HR	
	Household-level uptake – children 6–23 months who received antihelminthic (deworming) treatment	O	A	
	Household-level uptake – children 6–23 months receiving vitamin A supplements	OL	A	
Output 2.3 ttC-counselled families affect timely and appropriate care-seeking for illness and receive follow-up care from HVs	Referral rate for children 0–23 months – children who experienced a danger sign and were referred to a health facility and seen by an appropriate provider	C	HR	
	Household-level uptake – children 0–23 months, with diarrhoea who were referred to an appropriate care provider for treatment	OL	T	ttC Referral Form
	Household-level uptake – children 0–23 months with fever who were referred to an appropriate medical provider for treatment	OL	T	
	Household-level uptake – children 0–23 months with presumed pneumonia who were referred to appropriate health provider	OL	T	
	Post-referral follow up of pregnant women by a ttC-HV	O	A	ttC Counter-Referral Form
	Post-referral follow up of children 0–23 months by a ttC-HV	O	A	

Hierarchy of objectives	Indicator	Recommended priority for ttC model*	Relevance to CWBT†	Means of verification or tool
Outcome 3. Community systems are strengthened to support high quality and coverage of ttC implementation				
Output 3.1 Women and their supporters or husbands receive timely and regular ttC counselling visits	Number of pregnant women registered by ttC-HV	C	HR	ttC Register
	Number of pregnant women served by ttC-HV	C	HR	
	Number of children 0–23 months registered by ttC-HV	C	HR	
	Number of children 0–23 months served by ttC-HV	C	HR	
	#/% of registered pregnant women who received their first home-based counselling visit within the first 16 weeks of pregnancy	C	HR	
	% of planned ttC-HV visits that were conducted	C	HR	
	#/% of programme beneficiaries who are accompanied by husband or birth partner during a household counselling	C	HR	
Output 3.2 Trained and supported ttC-HV (or appropriate implementers) are actively delivering high quality ttC counselling.	# & % of eligible CHWs who have completed the ttC competency-based training course using the standardised curriculum	C	HR	Training records supervision records
	# & % trained and functional ttC-HVs	C	HR	
	Ratio of active ttC-HVs per registered mother–infant pair	C	HR	
	#/% of ttC-HVs successfully undergoing supportive supervision	C	HR	
	#/% of ttC-HVs with adequate ttC support materials	O	A	
	Attrition rate among trained ttC-HVs	O	A	
Output 3.3 Community health structures (COMM) support ttC programmes and build linkages with other community health actors	# of COMMs that are functional and supporting ttC activities (please refer to COMM logframe)	C	HR	
	#/% of ttC-HVs undergoing COMM supervision events	C	HR	
	#/% of ttC-HVs who have received an individual performance-based evaluation including time-series assessment within the past year	O	A	
	# of formal interactions between ttC-HVs and other community health actors	O	A	
Output 3.4 Community leaders and other structures promote ttC in the community	# of ttC-related community sensitisation activities	C	HR	

Hierarchy of objectives	Indicator	Recommended priority for ttC model*	Relevance to CWBT†	Means of verification or tool
Outcome 4. Health systems and local partners have increased operational structures to support ttC and MNCH				
Output 4.1 Local partners are trained in and supporting ttC implementation and management-information systems	# ttC-HV supervisors trained	C	HR	Training records
	Ratio of trained ttC supervisors to ttC-HVs	C	HR	Training records
	#/% of appropriate local partners that report use of ttC community health data (please refer to COMM logframe)	C	HR	COMM debriefing tool
	#/% of ttC-HVs supervised by health facility staff	O	A	Supervision records
	#/% of appropriate local partners who have ready access to ttC monitoring data (please refer to COMM logframe)	O	A	COMM debriefing tool
Output 4.2 Linkages between community and facility health systems are strengthened	# of ttC-HV referrals received at health facilities	C	A	Referral records
	Improved communications and direct reporting events between CHWs and health facilities (qualitative indicator [please refer to COMM logframe])	O	A	COMM debriefing tool
	#/% of counter-referrals completed – programme beneficiaries who received appropriate ttC-HV visit following a referral event	O	A	Counter-referral records are preferred means of verification
Output 4.3 (HSS) Health facilities are strengthened to deliver quality MNCH products and services	# of health facilities and local partners with improved operational structures to deliver quality MNCH services	O	A	ADP project reports

*C=CORE, O= optional, OL= optional but usable for LiST †T=directly related to target, HR= highly recommended, A=additional

Appendix B. List of Indicators for Timed and Targeted Counselling Monitoring Forms

Note: *Core indictors are in bold. Case load data elements are denominators, health practice uptake data elements are the numerators for the calculation of indicators*

type	Data elements	Data form/time point	Core/ optional/ Target
Case load	**# of eligible women and girls registered (15–49 years and caregivers)**	**EWG**	**C**
Health practice uptake	# of eligible women and girls using a contraceptive method	EWG	O
ttC TALLY REGISTER – PREGNANCY (PER CHW)			
Case loads	**# of current pregnancies**	**P**	**C**
	# of completed pregnancies (forms collected this supervision)	**P**	**C**
Deaths	# of deaths of pregnant women	P	O
	# of miscarriages, abortions	P	O
Health practice uptake	**# of women who have received their first ttC visit within the first 18 weeks of pregnancy**	**P**	**C**
	# of women who received at least four ttC visits during the entire pregnancy	**P**	**C**
	# of women whose husband/partner participated in most of the ttC visits	P	O
	# of women who were identified as high risk at any point during this pregnancy	P	O
	# of women who slept under a bed net during at least half of the pregnancy	P	O
	# of women who attended first ANC visit within 16 weeks	**P**	**C**
	# of women who attended four ANC visits during entire pregnancy	**P**	**C**
	# of women who were tested for HIV at some point during pregnancy	P	O
	# of women who were tested and obtained HIV test result during pregnancy	P	O
	# of women who took at least 100 IFA tablets during pregnancy (at least four months)	**P**	**T**
	# of women who mostly ate more than usual during this pregnancy	P	O
	# of women who have developed a birth plan before the end of their pregnancy	P	O
Referrals	**# of cases of pregnant women with a possible complication**	**P**	**C**

type	Data elements	Data form/time point	Core/ optional/ Target
	# of cases of pregnant women with a possible complication referred to a facility	**P**	**C**
	# of referral cases who received a home-visit follow up	P	O
ttC TALLY REGISTER – NEWBORN (PER CHW)			
Case load	**# of total women delivered since last supervision**	**N**	**C**
	# of total babies born (live and still born)	**N**	**C**
Deaths	**# of deaths of women during labour and in postpartum period (up to 6 weeks after delivery)**	**N**	**C**
	# of still births	**N**	**C**
Case load	**# of live births**	**N**	**C**
Deaths	**# of deaths of newborns (up to 1 month of age)**	**N**	**C**
Health practice uptake	**# of postpartum women who received at least four visits during the first month of baby's life**	**N**	**C**
	# of women whose husband/partner was present during most of the ttC visits	**N**	**C**
	# of newborns reported as being high risk (LBW, premature, congenital malformation, other)	N	O
	# of births assisted by skilled health personnel in a health facility	**N**	**C**
	# of births where the birth weight of the newborn was recorded and newborn weighed less than 2,500g OR # of newborns with low birth weight or premature identified by any other means	N	O
	# of LBW babies who received skin-to-skin care (home-based or institutional)	N	O
	# of newborns who were breastfed within the hour of life	**N**	**C**
	# of newborns who were wiped and wrapped soon after birth	**N**	**C**
	# of newborns who live in a home with a bed net, who sleep under the long-lasting insecticide treated bed net (LLIN)	**N**	**T**
	# of newborns who had early immunisations – BCG and OPV (zero dose) in the first month	**N**	**C**
Referrals	**# of cases of postpartum mothers (up to 6 weeks) with a possible complication**	**N**	**C**
	# of cases of newborns (0–28 days) with a possible complication	**N**	**C**
	# of cases of newborns with a possible complication who were referred to a facility	**N**	**C**
	# of cases of newborn referrals who received a follow up home visit	**N**	**C**

type	Data elements	Data form/time point	Core/ optional/ Target
ttC TALLY REGISTER – INFANTS 1–6M (PER CHW)			
Case load	# (total) of infants in this stage (1–6 months of age)	I	C
	# (total) of infants completed 6 months of age (forms collected this supervision)	I	C
	# (total) of infants completed 6 months of age (FEMALE ONLY)	I	C
Deaths	# of deaths of post neonatal infants (1–6 months of age)	I	C
Health practice uptake	# of infants 1–6 months who received at least one home visit during 1–6 months	I	C
	# of home visits where male partner or chosen supporter was present	I	C
	# of infants identified as high-risk infants	I	O
	# of infants 1–6 months of age who have a birth certificate	I	O
	# of infants who completed both DTP/Penta and OPV vaccinations by 6 months	I	C
	# of infants who were exclusively breastfed to 6 months of age (male)	I	T
	# of infants who were exclusively breastfed to 6 months of age (female)	I	C
	# of women who are using a contraceptive method by 6 months postpartum	I	C
	# of infants aged 1–6 months of age who are sleeping under an LLIN	I	T
	# of cases of infants (1–6 months of age) with a possible complication	I	C
	# of cases of infants (1–6 months of age) with a possible complication who were referred to a facility and who received a home-visit follow up post referral	I	C
	# of cases of infants (1–6 months of age) with referrals where a post-referral home visit was completed	I	O

ttC REGISTER – CHILDREN 6–23 MONTHS OF AGE (PER CHW)			
Case load	**# of children aged 6–23 months of age currently registered**	**C**	**C**
	# of children aged 12 –23 months of age	**C**	**C**
	# of ttC-completed children (now >24 months old)	**C**	**C**
Deaths	**# of deaths of children (6–23 months or one day short of second birthday)**	**C**	**C**
Health practice uptake	**# of children visited twice in the first year of life (six and nine months)**	**C**	**C**
	# of children visited four times during 6–23 months (or one day short of second birthday)	C	O
	# of women whose husband/partner participated in most ttC visits	C	C
	# of children considered high risk at any point during 6–23 months	C	O
	# of mothers of children aged 6–23 months who use a modern contraceptive method	**C**	**C**
	# of mothers who wash hands with soap or ash at appropriate times	C	O
	# of children who continued to breastfeed up to 23 months	C	O
	# of infants who received complementary feeding from 6 months	**C**	**C**
	# of children ages 6–23 months who were given the minimum meal frequency	C	O
	# of children ages 6–23 months who regularly ate iron-rich and/or iron-fortified food daily	C	O
	# of children ages 6–23 months who had iron supplements (syrup or tablets) at some point	C	O
	# of children who have received all essential vaccinations (measles and DPT1, 2 and 3) by first birthday	**C**	**T**
	# of children who have received at least 2 doses of vitamin A before second birthday	**C**	**T**
	# children who have received at least 2 doses of deworming medicine before second birthday	**C**	**C**
	# of children ages 6–23 months sleeping under a mosquito net regularly	C	O
	# of cases of children ages 6–23 months with a sign of illness	**C**	**C**
	# of children (6–23 months) with a sign of illness taken to the health facility	**C**	**C**
	# of cases of referrals who received a follow-up home visit	C	O

Appendix C. Data Collection and Monitoring System Decisions Taken

Definitions	
Postpartum woman	Up to 6 weeks after birth
Newborns	0–30 days
Infants (exclusive breastfeeding stage)	1–6 months
Children (complementary feeding stage)	6–23 months (up to one day short of the second birthday)
Decision	**Reasoning**
1. Track deaths of (registered) women during pregnancy, labour and postpartum, but not thereafter.	• Aligns with global definition of maternal mortality due to pregnancy and childbirth • Aligns with 7-11 interventions
2. Disaggregate deaths of (registered) children by • Newborns • Infants (Note: Infant mortality *includes* also the subset of newborn deaths.) • Children	• Important for disaggregating periods of higher/lower neonatal, infant and child mortality • Aligns with global data collection
3. Choose life-cycle stage for reporting on indicators, as opposed to repeatedly tracking at multiple points in time.	• Avoids double-counting • Minimises data collection burden
4. Do not include indicators on HIV status, either for mother or baby. Do not include indicators that would indirectly reveal HIV status of mother (i.e. Neviripine for mother and baby, or baby tested for HIV)	• Confidentiality. ttC-HVs are members of same community as clients; confidentiality cannot be assured. • Global best practice is not to reveal HIV status on documents except in health facility.
5. Newborns who had 3 postnatal visits by the ttC-HV in the first week of birth	• WHO guidelines recommend that the newborn is visited by a trained health worker 3 times during the first week of life. • Our system only enables tracking of visits by ttC-trained ttC-HVs, who may or may not be *clinically trained* health workers.
6. Births assisted by skilled birth attendant	• General WHO definition does not include TBAs in the category of skilled birth attendant (SBA).

	• The definition of SBA must, however, be made on a project-by-project basis as some countries may have programmes to train TBAs to this level.
7. Disaggregate recording of danger signs/referrals for: • newborns and infants (0–6 months), and • infants and children (6–23 months)	• Aligns with global data collection where disease incidence rises at 6 months of age • Clumping 6–23 months aligns with global data collection/statistics
8. In contrast to *all other indicators*, the system tracks **numbers of illness episodes** as opposed to **absolute numbers of mothers/children** with illness episodes. Therefore, sentinel time points are not used for these indicators. *('Danger signs' are collected at every visit, meaning that totals can exceed the total numbers of registered mothers/children)*	• Given the length of time that registered mothers/children are tracked, it is *less interesting* to collect data on how many of these mothers/children are ever ill; as there is good probability that some pregnant women and many/most children will show signs of illness at least once over the nine-month/2-year period. • Typical MoH practice relates to episode, not to children.
9. Have excluded indicators related to TB, given the difficulties in collecting the data	• TB case finding indicators may encourage active case finding by ttC-HVs while MoH policy may disallow it. Or MoH may not have a policy on it, but it will be raised as an issue once our programmes begin to collect this data. Counterproductive to collect the data as it can cause strain on programme's relationship with MoH.

Appendix D. ttC Register and Tally Forms

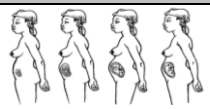
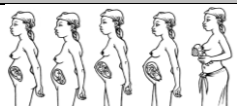
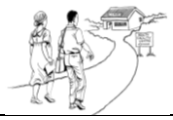
TTC Register and tally forms.xlsx

Appendix E. Additional Tools

ttC.DMEtools.FINAL.xlsx

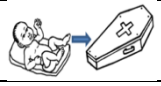
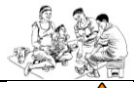
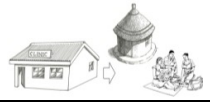
COMPLETING THE TTC REGISTER – PREGNANCY

Figure 3.1a Worked Example: Lara

COMPLETE THE REGISTER IN EVERY HOME VISIT		Pregnancy V1 V2  1m 2m 3m 4m	Pregnancy V3 V4  5m 6m 7m 8m 9m	data code	Totals
Death in pregnancy *(write date)*				D1	*Maternal Death? Yes or no*
Miscarriage				D2	*Woman experienced miscarriage?*
Visits Planned (*write date for planned visit*)		*14/5*	*17/6*	*	*verify date against gestation*
Home ttC Visits (*write date of visit*)		*15/ 5 or* ✓		P1A	*1st visit before 16 weeks?*
				P1B	*4 visits in pregnancy?*
Husband / partner participated in ttC visit?		✗		P2	*Husband / partner participation in most of ttC visits?*
High risk pregnancies		✗		P3	*Woman was high risk at any point in pregnancy?*
Bednet use consistently since last visit		✓		P4	*Did the woman sleep under a net during most of the pregnancy?*
Antenatal visits completed		✓		P5A	*1st ANC before 16 weeks?*
				P5B	*4 ANC during pregnancy?*
HIV test done		✗		P6	*Woman did HIV test during this pregnancy?*
Obtained HIV test result		✗		P6	*Woman obtained test result during this pregnancy?*
Woman has taken iron tablets regularly during last month		*Mother has started taking IFA?* ✓	*Mother has taken IFA for more than 4 months?*	P7	*Mother took at least 4 months of IFA during this pregnancy?*
Woman has eaten more than usual		✗		P8	*Woman reported eating more than usual (3 meals + snack) at all visits?*
Birth plan		✗		P9	*Woman had developed a birth plan at any point?*
Danger signs in pregnancy		*15/ 5 or* ✓		E1	*Total events*
Referral completed				E1A	*Total events*
Post referral home visit completed				E1B	*Total events*

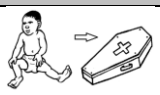
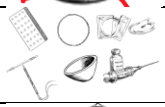
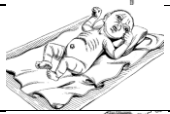
COMPLETING THE TTC REGISTER – NEWBORN

Figure 3.2a Worked Example: Lara

TTC REGISTER - NEWBORN					
Instructions: Record information EVERY VISIT		**Newborn** Week 1	**Newborn** week 2 3 4	**Data code**	**PX completed by the supervisor when case is complete**
Date of birth		*18 /10/2014*			
Visits Planned (*write data planned*)		**V1 V2 V3** *19th 21st 23rd*	**V4** *16th Nov*		
Maternal death 0-45d *(date of death)*		✗ ✗ ✗		D2	*Number of maternal deaths*
Still birth *(No. of babies still born)*		✗		D3	*Number of still borns*
Live births *(No.babies born alive)*		*1*		ND2	*Number of babies born alive*
Newborn death *(date of death)*		✗ ✗ ✗		D4	*Number of newborn deaths*
ttC Home Visits post- partum *(date of visit)*		*19/10 21/10 23/10*		N1	*Woman received at least 4 visits?*
Husband / partner participation in ttC visit		✓ ✗ ✗		N2	*Husband / partner present for most of visits?*
High risk newborn		✗		N3	*Number of high risk newborns?*
Skilled birth attendance in a facility		✓		N4	*Number of women who delivered in facility with skilled attendant?*
Birthweight Baby 1		*3.7 kilos*		N5	*Number of babies that are LBW = <2.5kg*
Birthweight Baby 2					
Birthweight Baby 3					
Baby is receiving Kangaroo Mother Care		✗		N6	*Number of babies receiving KMC*
Baby was breastfeed in first hour of life		✓		N7	*Was the baby / babies breastfeed in the first hour?*
Baby was wiped and wrapped in the first hour of life		✓		N8	*Was baby / babies wrapped and wiped not bathed in 1st hour?*
Baby sleeps under a mosquito net at all times		✓✓✓		N9	*Baby slept under net at all visits?*
Babies who received early vaccines (BCG and OPV-0)		✓		N10	*Received both BCG and OPV-0?*
Post-partum danger sign identified		✗ ✗ ✗		E2	*Total number of events*
Newborn danger sign identified		✗ ✗ ✗		E3	*Total number of events*
Referral completed				E4A	*Total number of events*
Post referral home visit completed				E4B	*Total number of events*

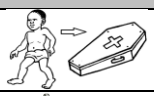
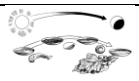
COMPLETING THE TTC REGISTER – INFANT

Figure 3.3a Worked Example: Lara

TTC REGISTER - INFANT				
Instructions: Record information EVERY VISIT		Infant 	DATA CODE	
Visits Planned (*write date*)		V6 / V7 22/3		
Infant Death (*date of death*)		✘	D5	
Home Visits		*23/3*	i1	*5 month visit?*
Husband / partner participation in ttC visit		✓	i2	*Husband / partner attend most of ttC visit?*
High Risk Infants		✘	i3	*Infant identified as high risk at any time?*
Infant has a birth certificate		✓	i4	*Infant received a birth certificate ?*
DTP / PENTA (1-3) vaccines given		✓	i5	*Did the child complete 3 Penta and 3 OPV for this period?*
OPV vaccines given (1-3)		✓		
Exclusive breastfeeding 6 months		✘	i6	*Baby breastfeed exclusively to 6 months?*
Mother is giving complementary foods or water at this time?		✓		
Mother is currently using contraceptive method?		✘	i7	
Infant is sleeping under a mosquito net every night?		✓	i8	
Infant danger sign identified		✘	E5	*Total events*
Referral completed		✘	E5A	*Total events*
Post referral home visit completed		✘	E5B	*Total events*

COMPLETING THE TTC REGISTER – CHILD

Figure 3.4a: Worked Example: Lara

Gender of child (circle): ♀ ♂		TTC REGISTER - CHILD					
		CHILD				DATA CODE	Totals completed by the supervisor when case is complete
		6m 9m	12m	18m	23m		
Visits Planned		V8 18/7	V9 18/10	V10 18/4	0V11 18/10		
Migrations / maternal death *(date of death)*		✗	✗	✗	✗		
Child death *(date of death)*		✗	✗	✗	✗	D6	
Home visits *(date of visit)*		19/7	18/10	30/4	18/10	C1 C2	
Husband / partner participated in ttC visit?		✓	✓	✓	✓		
High risk child?		✗	✗	✗		C4	*Child was considered at risk at any point?*
Mother is using contraceptive method		✓	✓	✗	✗	C5	
Handwashing		✓	✓	✓	✓		*Mother practices handwashing regularly at all visits?*
Continued breastfeeding		✓	✓	✗	✗	C7	
Complementary feeding from 6 months		✓	✓	✓	✓	C8	
Minimum meal frequency regularly eaten		✗	✓	✓	✓	C9	*Child is receiving minimum meal frequency during all visits?*
Iron rich foods regularly eaten?		✗	✗	✓	✓		
Iron supplements given		✗	✗	✗	✗	C11	
Completed all vaccinations		✓				C12	*before 12m*
Vitamin A given (6m, 12m, 18m, 24m)		✓	✗	✓	✓	C13	
Deworming tablets given (12m, 18m 24m)			✗	✓	✓	C14	
Child is sleeping under a mosquito net every night?		✓	✓	✓	✓	C15	*Children aged 6-23 months who used net consistently?*
Child with sign of illness?		✗	✓	✗	✗	E6	*Total events*
Child with illness was taken to the health facility		✗	✓	✗	✗	E6A	*Total events*
Post referral home visit completed		✗	✓	✗	✗	E6B	*Total events*

This visit was conducted late.

Lara stops taking the pill at 12 months because she wants to have another child

Lara stops breastfeeding at 18 months

Lara isn't giving enough meals per day in the 12 month visit, but after counselling she begins better practices.

Lara isn't giving chicken meat or eggs until the baby is 12 months, after this you counsel her and she begins giving iron rich foods

WOOPS! Lara missed a vitamin A and deworming dose at 12 months

Poor Esther was sick at visit 9. You referred her and followed up later – well done!

COLLECTING AND TALLYING COMPLETED TTC REGISTERS FOR PREGNANCY

Figure 3.5a Worked Example: Tara

COMPLETE THE REGISTER IN EVERY HOME VISIT	Pregnancy V1 V2 1m 2m 3m 4m	Pregnancy V3 V4 5m 6m 7m 8m 9m	data code	Totals
Death in pregnancy *(write date)*			D1	*Maternal Death? Yes or no* *N*
Miscarriage			D2	*Woman experienced miscarriage?* *N*
Visits Planned (*write date for planned visit*)	*14/5*	*17/6 18/8 17/10*	*	*verify date against gestation*
Home ttC Visits (*write date of visit*)	*15/ 5 or* ✓	✓ ✓	P1A	*1st visit before 16 weeks?* *Y*
			P1B	*4 visits in pregnancy?* *Y*
Husband / partner participated in ttC visit?	✗	✗ ✓ ✓	P2	*Husband / partner participation in most of ttC visits?* *N*
High risk pregnancies	✗	✗ ✗ ✗	P3	*Woman was high risk at any point in pregnancy?* *N*
Bednet use consistently since last visit	✓	✓ ✓ ✓	P4	*Did the woman sleep under a net during most of the pregnancy?* *Y*
Antenatal visits completed	✓	✓ ✓	P5A	*1st ANC before 16 weeks?* *Y*
			P5B	*4 ANC during pregnancy?* *N*
HIV test done	✗	✓	P6	*Woman did HIV test during this pregnancy?* *Y*
Obtained HIV test result	✗	✗ ✓	P6	*Woman obtained test result during this pregnancy?* *Y*
Woman has taken iron tablets regularly during last month	*Mother has started taking IFA?* ✓	*Mother has taken IFA for more than 4 months?* ✓ ✓ ✓	P7	*Mother took at least 4 months of IFA during this pregnancy?* *Y*
Woman has eaten more than usual	✗	✓ ✓ ✗	P8	*Woman reported eating more than usual (3 meals + snack) at all visits?* *N*
Birth plan	✗	✗ ✓	P9	*Woman had developed a birth plan at any point?* *Y*
Danger signs in pregnancy	*15/ 5 or* ✓	✗ ✗ ✗	E1	*Total events* *1*
Referral completed			E1A	*Total events* *0*
Post referral home visit completed			E1B	*Total events* *0*

Figure 3.5b – Example: Fatuma

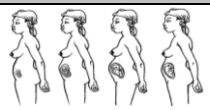
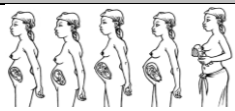
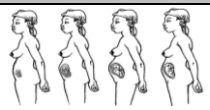
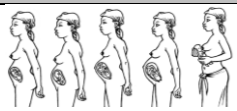
COMPLETE THE REGISTER IN EVERY HOME VISIT		Pregnancy V1 V2  1m 2m 3m 4m	Pregnancy V3 V4  5m 6m 7m 8m 9m	data code	Totals
Death in pregnancy *(write date)*				D1	*Maternal Death? Yes or no*
Miscarriage				D2	*Woman experienced miscarriage?*
Visits Planned (*write date for planned visit*)			*12/5 17/6 18/8 17/10*	*	*verify date against gestation*
Home ttC Visits (*write date of visit*)			✓ ✓ ✓ ✓	P1A	*1st visit before 16 weeks?*
				P1B	*4 visits in pregnancy?*
Husband / partner participated in ttC visit?			✗ ✓ ✓ ✓	P2	*Husband / partner participation in most of ttC visits?*
High risk pregnancies			✗ ✗ ✗ ✗	P3	*Woman was high risk at any point in pregnancy?*
Bednet use consistently since last visit			✓ ✓ ✓ ✓	P4	*Did the woman sleep under a net during most of the pregnancy?*
Antenatal visits completed			✓ ✓ ✓ ✓	P5A	*1st ANC before 16 weeks?*
				P5B	*4 ANC during pregnancy?*
HIV test done			✓	P6	*Woman did HIV test during this pregnancy?*
Obtained HIV test result			✗ ✓	P6	*Woman obtained test result during this pregnancy?*
Woman has taken iron tablets regularly during last month		*Mother has started taking IFA?*	*Mother has taken IFA for more than 4 months?* ✗ ✓ ✓ ✓	P7	*Mother took at least 4 months of IFA during this pregnancy?*
Woman has eaten more than usual			✓ ✓ ✗ ✗	P8	*Woman reported eating more than usual (3 meals + snack) at all visits?*
Birth plan			✗ ✓	P9	*Woman had developed a birth plan at any point?*
Danger signs in pregnancy			✗ ✗ ✓ ✗	E1	*Total events*
Referral completed			✓	E1A	*Total events*
Post referral home visit completed			✓	E1B	*Total events*

Figure 3.5c Example - Amina

COMPLETE THE REGISTER IN EVERY HOME VISIT		Pregnancy V1 V2  1m 2m 3m 4m	Pregnancy V3 V4  5m 6m 7m 8m 9m	data code	Totals
Death in pregnancy *(write date)*				D1	*Maternal Death? Yes or no* N
Miscarriage				D2	*Woman experienced miscarriage?* N
Visits Planned (*write date for planned visit*)		*10/5*	*11/6 14/8 19/10*	*	*verify date against gestation*
Home ttC Visits (*write date of visit*)		✓	✓ ✓ ✓	P1A	*1st visit before 16 weeks?*
				P1B	*4 visits in pregnancy?*
Husband / partner participated in ttC visit?		✗	✗ ✓ ✓	P2	*Husband / partner participation in most of ttC visits?*
High risk pregnancies		✗	✗ ✗ ✗	P3	*Woman was high risk at any point in pregnancy?*
Bednet use consistently since last visit		✓	✓ ✓ ✓	P4	*Did the woman sleep under a net during most of the pregnancy?*
Antenatal visits completed		✓	✓ ✓ ✓	P5A	*1st ANC before 16 weeks?*
				P5B	*4 ANC during pregnancy?*
HIV test done		✗	✗ ✓	P6	*Woman did HIV test during this pregnancy?*
Obtained HIV test result		✗	✗ ✓	P6	*Woman obtained test result during this pregnancy?*
Woman has taken iron tablets regularly during last month		*Mother has started taking IFA?* ✓	*Mother has taken IFA for more than 4 months?* ✓ ✓ ✓	P7	*Mother took at least 4 months of IFA during this pregnancy?*
Woman has eaten more than usual		✗	✓ ✓ ✗	P8	*Woman reported eating more than usual (3 meals + snack) at all visits?*
Birth plan		✗	✗ ✓	P9	*Woman had developed a birth plan at any point?*
Danger signs in pregnancy		✗	✗ ✗ ✗	E1	*Total events*
Referral completed				E1A	*Total events*
Post referral home visit completed				E1B	*Total events*

COMPLETING THE SUMMARY REGISTER – PREGNANCY

Figure 3.6a – Worked Example

TALLY FOR TTC REGISTER - PREGNANCY

U - UNIVERSAL REGISTER INFORMATION

uthority >> _____ Community Name >> _____

Health _____ ID pervisor Name & ID >> _____

pervisor >> _____ Supervision period >> from to:

ADP >> _____ Recording Date >> _____

RECORD RESULT FROM ELIGIBLE WOMEN AND GIRLS' REGISTER		CHW ID:	CHW ID:	CHW ID:	CHW ID:	CHW ID:	CHW ID:	CHW ID:	CHW ID:	CHW ID:	CHW ID:	Totals All Women
No. of TTC eligible women& girls registered (15-49 years & caregivers)	S2	10										10
Total number ofeligible women and girls using contraceptive method	S3	4										4
Total number of current pregnancies	PD1	6										6
Number of completed pregnancies (forms this supervision)	PD2	3										3
USING "TTC REGISTER-PREGNANCY" FROM WOMEN WHO HAVE COMPLETED PREGNANCY	Data code											
# of deaths of pregnant women	D1											
# of Women who experienced a miscarriage	D2											
# of women who received a ttC visit within 4 months of pregnancy	P1A	YY										2
# of women who received at least 4 visits during entire pregnancy	P1B	YYY										3
# of women whose husband / partner participated in most of the ttC visits	P2	Y										1
# of women who were identified as HIGH RISK at any point during this pregnancy	P3											0
# of women who slept under a bednet during at least *half of the pregnancy*	P4	YY										2
# of women who attended 1st ANC visit within 16 weeks	P5a	YY										2
# of women who attended 4 ANC visit during entire pregnancy	P5b	YY										2
# of women who were tested for HIV at some point during pregnancy	P6	YYY										3
# of women who were tested and obtained HIV test result during pregnancy	P7	YYY										3
# of women who took at least 100 IFA tablets during pregnancy (at least 4 months)	P8	YY										2
# of women who report eating more than usual during this pregnancy	P9											0
# of women who have developed a birth plan before the end of their pregnancy	P10	YYY										3
# of *cases* where danger signs in pregnancy were identified	E1	1+1+0										2
# of *cases* with danger signs where referral was completed	E1A	0+1+0										1
# of *referral cases* for which post referral home visit completed	E1B	0+1+0										1

Figure 3.6b Example: Fudia

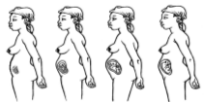
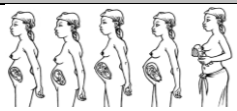
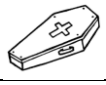
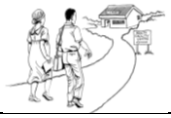
COMPLETE THE REGISTER IN EVERY HOME VISIT		Pregnancy V1 V2  1m 2m 3m 4m	Pregnancy V3 V4  5m 6m 7m 8m 9m	data code	Totals
Death in pregnancy *(write date)*				D1	*Maternal Death? Yes or no*
Miscarriage				D2	*Woman experienced miscarriage?*
Visits Planned (*write date for planned visit*)			*12/7 17/8 18/9 17/10*	*	*verify date against gestation*
Home ttC Visits (*write date of visit*)			✓ ✓ ✓ ✓	P1 A	*1st visit before 16 weeks?*
				P1 B	*4 visits in pregnancy?*
Husband / partner participated in ttC visit?			✗ ✓ ✓ ✗	P2	*Husband / partner participation in most of ttC visits?*
High risk pregnancies			✗ ✗ ✗ ✓	P3	*Woman was high risk at any point in pregnancy?*
Bednet use consistently since last visit			✓ ✓ ✗ ✗	P4	*Did the woman sleep under a net during most of the pregnancy?*
Antenatal visits completed			✓ ✓ ✓ ✓	P5 A	*1st ANC before 16 weeks?*
				P5 B	*4 ANC during pregnancy?*
HIV test done			✓	P6	*Woman did HIV test during this pregnancy?*
Obtained HIV test result			✗ ✓	P6	*Woman obtained test result during this pregnancy?*
Woman has taken iron tablets regularly during last month		*Mother has started taking IFA?*	*Mother has taken IFA for more than 4 months?* ✗ ✓ ✓ ✗	P7	*Mother took at least 4 months of IFA during this pregnancy?*
Woman has eaten more than usual			✓ ✗ ✗ ✗	P8	*Woman reported eating more than usual (3 meals + snack) at all visits?*
Birth plan			✗ ✗	P9	*Woman had developed a birth plan at any point?*
Danger signs in pregnancy			✗ ✗ ✗ ✗	E1	*Total events*
Referral completed				E1 A	*Total events*
Post referral home visit completed				E1 B	*Total events*

Figure 3.6c Example: Nancy

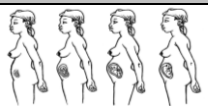
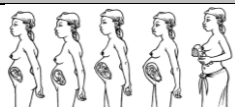
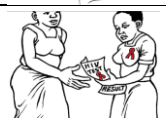
COMPLETE THE REGISTER IN EVERY HOME VISIT		Pregnancy V1 V2  1m 2m 3m 4m	Pregnancy V3 V4  5m 6m 7m 8m 9m	data code	Totals
Death in pregnancy *(write date)*				D1	*Maternal Death? Yes or no*
Miscarriage				D2	*Woman experienced miscarriage?*
Visits Planned (*write date for planned visit*)			*21/5 20/6 18/8 19/10*	*	*verify date against gestation*
Home ttC Visits (*write date of visit*)			✗ ✓ ✓ ✓	P1A	*1st visit before 16 weeks?*
				P1B	*4 visits in pregnancy?*
Husband / partner participated in ttC visit?			✗ ✗ ✓ ✓	P2	*Husband / partner participation in most of ttC visits?*
High risk pregnancies			✗ ✗ ✗ ✗	P3	*Woman was high risk at any point in pregnancy?*
Bednet use consistently since last visit			✓ ✗ ✓ ✓	P4	*Did the woman sleep under a net during most of the pregnancy?*
Antenatal visits completed			✓ ✓ ✓	P5A	*1st ANC before 16 weeks?*
				P5B	*4 ANC during pregnancy?*
HIV test done			✓	P6	*Woman did HIV test during this pregnancy?*
Obtained HIV test result			✗ ✓	P6	*Woman obtained test result during this pregnancy?*
Woman has taken iron tablets regularly during last month		*Mother has started taking IFA?*	*Mother has taken IFA for more than 4 months?* ✗ ✗ ✓ ✓	P7	*Mother took at least 4 months of IFA during this pregnancy?*
Woman has eaten more than usual			✓ ✓ ✗ ✗	P8	*Woman reported eating more than usual (3 meals + snack) at all visits?*
Birth plan			✗ ✓	P9	*Woman had developed a birth plan at any point?*
Danger signs in pregnancy			✗ ✗ ✓ ✗	E1	*Total events*
Referral completed			✓	E1A	*Total events*
Post referral home visit completed			✓	E1B	*Total events*

Figure 3.6d Example: Jane

COMPLETE THE REGISTER IN EVERY HOME VISIT	Pregnancy V1 V2 1m 2m 3m 4m	Pregnancy V3 V4 5m 6m 7m 8m 9m	data code	Totals
Death in pregnancy *(write date)*			D1	*Maternal Death? Yes or no*
Miscarriage			D2	*Woman experienced miscarriage?*
Visits Planned (*write date for planned visit*)		*2/5 7/6 6/8 1010*	*	*verify date against gestation*
Home ttC Visits (*write date of visit*)		✓ ✓ ✓ ✓	P1A	*1st visit before 16 weeks?*
			P1B	*4 visits in pregnancy?*
Husband / partner participated in ttC visit?		✗ ✓ ✗ ✓	P2	*Husband / partner participation in most of ttC visits?*
High risk pregnancies		✗ ✗ ✗	P3	*Woman was high risk at any point in pregnancy?*
Bednet use consistently since last visit		✓ ✓ ✓ ✓	P4	*Did the woman sleep under a net during most of the pregnancy?*
Antenatal visits completed		✓ ✓ ✓ ✗	P5A	*1st ANC before 16 weeks?*
			P5B	*4 ANC during pregnancy?*
HIV test done		✓	P6	*Woman did HIV test during this pregnancy?*
Obtained HIV test result		✗ ✓	P6	*Woman obtained test result during this pregnancy?*
Woman has taken iron tablets regularly during last month	*Mother has started taking IFA?*	*Mother has taken IFA for more than 4 months?* ✗ ✓ ✓ ✓	P7	*Mother took at least 4 months of IFA during this pregnancy?*
Woman has eaten more than usual		✓ ✓ ✗ ✗	P8	*Woman reported eating more than usual (3 meals + snack) at all visits?*
Birth plan		✗ ✓	P9	*Woman had developed a birth plan at any point?*
Danger signs in pregnancy		✗ ✗ ✗ ✗	E1	*Total events*
Referral completed			E1A	*Total events*
Post referral home visit completed			E1B	*Total events*

CALCULATING AND ASSESSING COVERAGE LEVELS

Figure 3.7a Example Supervisor Fatmata

TALLY FOR TTC REGISTER - PREGNANCY

U - UNIVERSAL REGISTER INFORMATION

uthority >> _____ Community Name >> _____

Health _____ ID pervisor Name & ID >> _____

pervisor >> _____ Supervision period >> from to:

ADP >> _____ Recording Date >> _____

RECORD RESULT FROM ELIGIBLE WOMEN AND GIRLS' REGISTER		CHW ID:	CHW ID:	CHW ID:	CHW ID:	CHW ID:	CHW ID:	CHW ID:	CHW ID:	CHW ID:	CHW ID:	Totals All Women
No. of TTC eligible women& girls registered (15-49 years & caregivers)	S2	10	12	8	8	9	11	12	7	10	11	
Total number ofeligible women and girls using contraceptive method	S3	4	5	4	3	6	4	5	3	4	4	
Total number of current pregnancies	PD1	6	5	4	3	4	4	5	4	4	5	
Number of completed pregnancies (forms this supervision)	PD2	3	3	2	4	3	3	3	2	3	4	
USING "TTC REGISTER-PREGNANCY" FROM WOMEN WHO HAVE COMPLETED PREGNANCY	Data code											
# of deaths of pregnant women	D1											
# of Women who experienced a miscarriage	D2								1			
# of women who received a ttC visit within 4 months of pregnancy	P1A	YY	YY	YY	YYY	YY	YYY	YY	YY	YY	YYY	
# of women who received at least 4 visits during entire pregnancy	P1B	YYY	YY	YY	YYYY	YYY	YYY	YYY	Y	YYY	YYYY	
# of women whose husband / partner participated in most of the ttC visits	P2	Y	YY	Y	YY	Y	YYY	Y	Y	Y	YY	
# of women who were identified as HIGH RISK at any point during this pregnancy	P3		Y	Y	YYY		Y		Y		YYY	
# of women who slept under a bednet during at least *half of the pregnancy*	P4	YY	YYY	YY	YYY	YY	Y	YY	YY	YY	YYY	
# of women who attended 1st ANC visit within 16 weeks	P5a	YY	Y	YY	YY	YY	YYY	YY	YY	YY	YY	
# of women who attended 4 ANC visit during entire pregnancy	P5b	YY	YYY	Y	YY	YY	YYY	YY	Y	YY	YY	
# of women who were tested for HIV at some point during pregnancy	P6	YYY	YYY	YY	YYYY	YYY	Y	YYY	Y	YYY	YYYY	
# of women who were tested and obtained HIV test result during pregnancy	P7	YYY	YY	YY	YYY	YYY	YYY	YYY	YY	YYY	YYY	
# of women who took at least 100 IFA tablets during pregnancy (at least 4 months)	P8	YY	Y		YYY	YY	Y	YY	Y	YY	YYY	
# of women who report eating more than usual during this pregnancy	P9		Y	Y	YY		Y		Y		YY	
# of women who have developed a birth plan before the end of their pregnancy	P10	YYY	YYY	YY	YYYY	YYY	YYY	YYY	YY	YYY	YYYY	
# of *cases* where danger signs in pregnancy were identified	E1	1+1+0	1,0,0	0,0	1,0,0,1	1+1+0	0,0,0	1+1+0	1,0	1+1+0	1,0,0,1	
# of *cases* with danger signs where referral was completed	E1A	0+1+0	0	0	1,0,0,1	0+1+0	0	0+1+0	1,0	0+1+0	1,0,0,1	
# of *referral cases* for which post referral home visit completed	E1B	0+1+0	0	0	1,0,0,1	0+1+0	0	0+1+0	1,0	0+1+0	1,0,0,1	1

TALLYING COMPLETED TTC REGISTERS - NEWBORN

Figure 3.8a Worked Example of Tara

TTC REGISTER - NEWBORN

U - UNIVERSAL REGISTER INFORMATION

Health Authority >>> _____ Community Name >>> _____

Health Centre >>> _____ ID >> CHW ID >>> _____ CHW Name >>> _____

CHW Supervisor >>> _____ Mother's Name >>> _____ Mother's ID >> _____

ADP >>> First Recording Date >>>

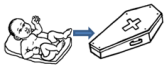
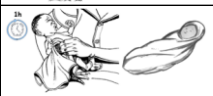
Instructions: Record information EVERY VISIT		Newborn				Data code	Totals
		Week 1	Week 2	Week 3	Week 4		✓✗ completed by the supervisor when case is complete
Date of birth		03-11-2013					
Visits Planned (*write data planned*)		V1	V2	V3	V4		
Maternal death 0-45d *(date of death)*		-				D2	*Number of maternal deaths*
Still birth *(No. of babies still born)*						D3	*Number of still borns* 0
Live births *(No.babies born alive)*		1				ND2	*Number of babies born alive* 1
Newborn death *(date of death)*		0				D4	*Number of newborn deaths* 0
ttC Home Visits post- partum *(date of visit)*		4/11	6/11	8/11		N1	*Woman received at least 3 visits?* Y
Husband / partner participation in ttC visit		✓	✓	✗		N2	*Husband / partner present for most of visits?* Y
High risk newborn		✗	✗	✗		N3	*Number of high risk newborns?* 0
Skilled birth attendance in a facility			✓			N4	*Delivered in facility with skilled attendant?* Y
Birthweight Baby 1		2.6 kg				N5	*Number of babies that are LBW = <2.5kg* 0
Birthweight Baby 2							
Birthweight Baby 3							
Baby is receiving Kangaroo Mother Care		✗	✗	✗		N6	*Number of babies receiving KMC* 0
Baby was breastfeed in first hour of life			✓			N7	*Was the baby / babies breastfeed in the first hour?* Y
Baby was wiped and wrapped in the first hour of life (no bathing)			✓			N8	*Was baby / babies wrapped and wiped not bathed in 1st hour?* Y
Baby sleeps under a mosquito net at all times		✓	✓	✗		N9	*Baby slept under net at all visits?* N
Babies who received early vaccines (BCG and OPV-0)			✓			N10	*Received both BCG and OPV-0?* Y
Post-partum danger sign identified		✗	✗	✗		E2	*Total number of events* 0
Newborn danger sign identified		✗	✗	✗		E3	*Total number of events* 0
Referral completed						E4A	*Total number of events* 0
Post referral home visit completed						E4B	*Total number of events* 0

Figure 3.8b – Example of Fatuma

TTC REGISTER - NEWBORN

U - UNIVERSAL REGISTER INFORMATION

Health Authority >>> _____ Community Name >>> _____

Health Centre >>> _____ ID >> CHW ID >>> _____ CHW Name >>> _____

CHW Supervisor >>> _____ Mother's Name >>> _____ Mother's ID >> _____

ADP >>> First Recording Date >>>

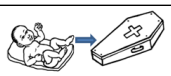
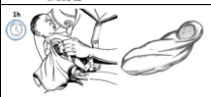
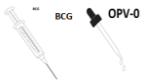
Instructions: Record information EVERY VISIT		Newborn				Data code	Totals
		Week 1	Week 2	Week 3	Week 4		✓✗ completed by the supervisor when case is complete
Date of birth		10-11-2013					
Visits Planned (*write data planned*)		V1 V2 V3	V4				
Maternal death 0-45d *(date of death)*		-				D2	*Number of maternal deaths*
Still birth *(No. of babies still born)*						D3	*Number of still borns*
Live births *(No.babies born alive)*		1				ND2	*Number of babies born alive*
Newborn death *(date of death)*		0				D4	*Number of newborn deaths*
ttC Home Visits post- partum *(date of visit)*		11/11 12/11 15/11				N1	*Woman received at least 3 visits?*
Husband / partner participation in ttC visit		✓ ✓ ✓				N2	*Husband / partner present for most of visits?*
High risk newborn		✗ ✗ ✗				N3	*Number of high risk newborns?*
Skilled birth attendance in a facility		✓				N4	*Delivered in facility with skilled attendant?*
Birthweight Baby 1		2.1 kg				N5	*Number of babies that are LBW = <2.5kg*
Birthweight Baby 2							
Birthweight Baby 3							
Baby is receiving Kangaroo Mother Care		✓ ✓ ✓				N6	*Number of babies receiving KMC*
Baby was breastfeed in first hour of life		✗				N7	*Was the baby / babies breastfeed in the first hour?*
Baby was wiped and wrapped in the first hour of life (no bathing)		✓				N8	*Was baby / babies wrapped and wiped not bathed in 1st hour?*
Baby sleeps under a mosquito net at all times		✓ ✓ ✓				N9	*Baby slept under net at all visits?*
Babies who received early vaccines (BCG and OPV-0)		✓				N10	*Received both BCG and OPV-0?*
Post-partum danger sign identified		✗ ✗ ✗				E2	*Total number of events*
Newborn danger sign identified		✗ ✗ ✓				E3	*Total number of events*
Referral completed		✓				E4A	*Total number of events*
Post referral home visit completed		✓				E4B	*Total number of events*

Figure 3.8c – Example of Amina

TTC REGISTER - NEWBORN

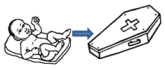
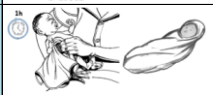
U - UNIVERSAL REGISTER INFORMATION

Health Authority >>> _____ Community Name >>> _____

Health Centre >>> _____ ID >> CHW ID >>> _____ CHW Name >>> _____

CHW Supervisor >>> _____ Mother's Name >>> _____ Mother's ID >> _____

ADP >>> First Recording Date >>>

Instructions: Record information EVERY VISIT		Newborn				Data code	Totals
		Week 1	Week 2	Week 3	Week 4		✓✗ completed by the supervisor when case is complete
Date of birth		18-11-2013					
Visits Planned (*write data planned*)		V1 V2 V3	V4				
Maternal death 0-45d *(date of death)*		-				D2	*Number of maternal deaths*
Still birth *(No. of babies still born)*						D3	*Number of still borns*
Live births *(No.babies born alive)*		1				ND2	*Number of babies born alive*
Newborn death *(date of death)*		0				D4	*Number of newborn deaths*
ttC Home Visits post- partum *(date of visit)*		19/11 21/11 23/11				N1	*Woman received at least 3 visits?*
Husband / partner participation in ttC visit		✗ ✗ ✗				N2	*Husband / partner present for most of visits?*
High risk newborn		✗ ✗ ✗				N3	*Number of high risk newborns?*
Skilled birth attendance in a facility		✓				N4	*Delivered in facility with skilled attendant?*
Birthweight Baby 1		3.1 kg				N5	*Number of babies that are LBW = <2.5kg*
Birthweight Baby 2							
Birthweight Baby 3							
Baby is receiving Kangaroo Mother Care		✗ ✗ ✗				N6	*Number of babies receiving KMC*
Baby was breastfeed in first hour of life		✗				N7	*Was the baby / babies breastfeed in the first hour?*
Baby was wiped and wrapped in the first hour of life (no bathing)		✓				N8	*Was baby / babies wrapped and wiped not bathed in 1st hour?*
Baby sleeps under a mosquito net at all times		✓ ✓ ✓				N9	*Baby slept under net at all visits?*
Babies who received early vaccines (BCG and OPV-0)		✓				N10	*Received both BCG and OPV-0?*
Post-partum danger sign identified		✗ ✗ ✗				E2	*Total number of events*
Newborn danger sign identified		✗ ✗ ✓				E3	*Total number of events*
Referral completed		✓				E4A	*Total number of events*
Post referral home visit completed		✓				E4B	*Total number of events*

COMPLETING THE SUMMARY REGISTER – NEWBORN

Figure 3.9a – Worked Example : Newborns of ttC-HV Mariam

SUMMARY TTC REGISTER - NEWBORN

U - UNIVERSAL REGISTER INFORMATION

Health Authority >> _____ Community Name >> _____

Health Sector >> _____ ID >> _____ Supervisor Name & ID >> _____

CHW Supervisor >> _____ Supervision period >> from: _____ to: _____

AOP >> Recording Date >>

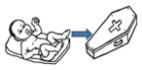
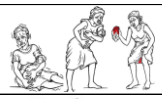
TALLY ALL RECORDS FOR ALL CASES, PER CHW AMONGST CASES COMPLETED NEWBORN PHASE		Data code	CHW ID:	CHW ID:	CHW ID:	CHW ID:	CHW ID:	CHW ID:	CHW ID:	CHW ID:	CHW ID:	CHW ID:	Totals All Women
Total women delivered since last supervision, *cases completed 1 month*		ND1	1+1+1										
Total babies born (still and live births)		ND2	1+1+1										
Maternal deaths		D2	0										
# of still born babies		D3	0										
# of live born babies		ND3	3										
# of newborn deaths (0-1m)		D4	0										
# of women who received at least 4 ttC visits post partum		N1	1+1+1										
# of women whose husband /partner participated in most ttC visits		N2	1+1+0										
# of high risk newborns		N3	0+0+0										
# of women who had skilled birth attendance in a facility		N4	1+1+1										
# of babies that were low birth weight (LBW) <2.5 kg		N5	0+1+0										
# of babies that received Kangaroo Mother Care		N6	0+1+0										
# of babies breastfeed in first hour of life		N7	1+0+0										
# of babies that were wiped and wrapped in the first hour of life (no bathing)		N8	1+1+1										
# of babies that slept under bednet at all visits		N9											
# of babies who received early vaccines (BCG and OPV-0)		N10	0+1+1										
# of cases post-partum danger sign		E2	0+0+0										
# of *cases* of newborns with danger signs		E3	0+1+1										
# of newborns with danger signs referred to health facility		E4A	0+1+1										
# of referral cases that received post-referral home visits		E4B	0+1+1										

Figure 3.9b – Example : Fudia's baby

TTC REGISTER - NEWBORN

U - UNIVERSAL REGISTER INFORMATION

Health Authority >>> _____ Community Name >>> _____

Health Centre >>> _____ ID >> CHW ID >>> _____ CHW Name >>> _____

CHW Supervisor >>> _____ Mother's Name >>> _____ Mother's ID >> _____

ADP >>> First Recording Date >>>

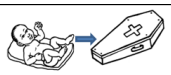
Instructions: Record information EVERY VISIT		Newborn				Data code	Totals
		Week 1	Week 2	Week 3	Week 4		✓✗ completed by the supervisor when case is complete
Date of birth		03-11-2013					
Visits Planned (*write data planned*)		V1 V2 V3	V4				
Maternal death 0-45d *(date of death)*		-				D2	*Number of maternal deaths*
Still birth *(No. of babies still born)*						D3	*Number of still borns* 0
Live births *(No.babies born alive)*		2				ND2	*Number of babies born alive* 2
Newborn death *(date of death)*		0				D4	*Number of newborn deaths* 0
ttC Home Visits post- partum *(date of visit)*		4/11 6/11				N1	*Woman received at least 3 visits?* N
Husband / partner participation in ttC visit		✓ ✓				N2	*Husband / partner present for most of visits?* Y
High risk newborn		✓ ✓				N3	*Number of high risk newborns?* 2
Skilled birth attendance in a facility		✓				N4	*Delivered in facility with skilled attendant?* Y
Birthweight Baby 1		1.9 kg				N5	*Number of babies that are LBW = <2.5kg* 1
Birthweight Baby 2		2.0 kg					
Birthweight Baby 3							
Baby is receiving Kangaroo Mother Care		✓ ✓				N6	*Number of babies receiving KMC* 2
Baby was breastfeed in first hour of life		✘				N7	*Was the baby / babies breastfeed in the first hour?* N
Baby was wiped and wrapped in the first hour of life (no bathing)		✓				N8	*Was baby / babies wrapped and wiped not bathed in 1st hour?* Y
Baby sleeps under a mosquito net at all times		✓ ✓				N9	*Baby slept under net at all visits?* Y
Babies who received early vaccines (BCG and OPV-0)		✓				N10	*Received both BCG and OPV-0?* Y
Post-partum danger sign identified		✘ ✘				E2	*Total number of events* 0
Newborn danger sign identified		✘ ✘				E3	*Total number of events* 0
Referral completed						E4A	*Total number of events* 0
Post referral home visit completed						E4B	*Total number of events* 0

Figure 3.9c – Nancy's Baby

TTC REGISTER - NEWBORN

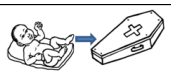
U - UNIVERSAL REGISTER INFORMATION

Health Authority >>> _____ Community Name >>> _____ _____

Health Centre >>> _____ ID >> CHW ID >>> _____ CHW Name >>> _____

CHW Supervisor >>> _____ Mother's Name >>> _____ Mother's ID >> _____

ADP >>> First Recording Date >>>

Instructions: Record information EVERY VISIT		Newborn				Data code	Totals
		Week 1	Week 2	Week 3	Week 4		✓✗ completed by the supervisor when case is complete
Date of birth		09-11-2013					
Visits Planned (*write data planned*)		V1 V2 V3	V4				
Maternal death 0-45d *(date of death)*		-				D2	*Number of maternal deaths*
Still birth *(No. of babies still born)*						D3	*Number of still borns* *0*
Live births *(No.babies born alive)*		1				ND2	*Number of babies born alive* *1*
Newborn death *(date of death)*		0				D4	*Number of newborn deaths* *0*
ttC Home Visits post- partum *(date of visit)*		10/11 13/11 14/11				N1	*Woman received at least 3 visits?* *Y*
Husband / partner participation in ttC visit		✓ ✓ ✓				N2	*Husband / partner present for most of visits?* *Y*
High risk newborn		✘ ✘ ✘				N3	*Number of high risk newborns?* *0*
Skilled birth attendance in a facility		✓				N4	*Delivered in facility with skilled attendant?* *Y*
Birthweight Baby 1		2.3 kg				N5	*Number of babies that are LBW = <2.5kg* *1*
Birthweight Baby 2							
Birthweight Baby 3							
Baby is receiving Kangaroo Mother Care		✓ ✓ ✓				N6	*Number of babies receiving KMC* *1*
Baby was breastfeed in first hour of life		✓				N7	*Was the baby / babies breastfeed in the first hour?* *Y*
Baby was wiped and wrapped in the first hour of life (no bathing)		✓				N8	*Was baby / babies wrapped and wiped not bathed in 1st hour?* *Y*
Baby sleeps under a mosquito net at all times		✓ ✓ ✓				N9	*Baby slept under net at all visits?* *Y*
Babies who received early vaccines (BCG and OPV-0)		✓				N10	*Received both BCG and OPV-0?* *Y*
Post-partum danger sign identified		✘ ✘ ✘				E2	*Total number of events* *0*
Newborn danger sign identified		✘ ✘ ✘				E3	*Total number of events* *0*
Referral completed						E4A	*Total number of events* *0*
Post referral home visit completed						E4B	*Total number of events* *0*

CALCULATING AND ASSESSING COVERAGE : NEWBORNS

Figure 3.10a : Summary Register of Supervisor Alice

U - UNIVERSAL REGISTER INFORMATION

Health Authority >> _____ Community Name >> _____

Health Sector >> _____ ID >> ____ Supervisor Name & ID >> _____

CHW Supervisor >> _____ Supervision period >> from: _____ to: _____

ADP >> Recording Date >>

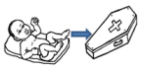
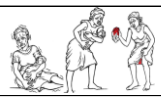
TALLY ALL RECORDS FOR ALL CASES, PER CHW AMONGST CASES COMPLETED NEWBORN PHASE		Data code	CHW ID:	CHW ID:	CHW ID:	CHW ID:	CHW ID:	CHW ID:	CHW ID:	CHW ID:	CHW ID:	CHW ID:	Totals All Women
Total women delivered since last supervision, *cases completed 1 month*		ND1	1+1+1	1+1	1+1+1	1+1+1	1+1+1						
Total babies born (still and live births)		ND2	1+2+1	1+1	1+1+1	1+1+1	1+1+1						
Maternal deaths		D2	0	0	0	0	0						
# of still born babies		D3	0	0	0	0	0						
# of live born babies		ND3	4	2	3	3	3						
# of newborn deaths (0-1m)		D4	0	0	0	0	0						
# of women who received at least 4 ttC visits post partum		N1	YYY	YY	YY	YY	YYY						
# of women whose husband /partner participated in most ttC visits		N2	YY	YY	YY	YY	YY						
# of high risk newborns		N3	0+2+0	0+0	0+0+0	0+0+0	0+0+0						
# of women who had skilled birth attendance in a facility		N4	YYY	YY	YYY	YYY	YYY						
# of babies that were low birth weight (LBW) <2.5 kg		N5	0+2+0	0+1	0+1+1	0+1+0	0+1+0						
# of babies that received Kangaroo Mother Care		N6	0+2+0	0+1	0+1+1	0+1+0	0+1+0						
# of babies breastfeed in first hour of life		N7	Y	Y	Y	Y	YY						
# of babies that were wiped and wrapped in the first hour of life (no bathing)		N8	YYY	YY	YYY	YYY	YYY						
# of babies that slept under bednet at all visits		N9	YY	Y	YY	YY	Y						
# of babies who received early vaccines (BCG and OPV-0)		N10	YY	YY	YYY	YY	YY						
# of cases post-partum danger sign		E2	0+0+0	0+0	0+0+0	0+0+0	0+0+0						
# of *cases* of newborns with danger signs		E3	0+1+1	0+1	0+1+1	0+1+1	0+1+1						
# of newborns with danger signs referred to health facility		E4A	0+1+1	0+1	0+1+1	0+1+1	0+1+1						
# of referral cases that received post-referral home visits		E4B	0+1+1	0+1	0+1+1	0+1+1	0+1+1						

Figure 3.9d – Jane's Baby

TTC REGISTER - NEWBORN

U - UNIVERSAL REGISTER INFORMATION

Health Authority >>> _____ Community Name >>> _____

Health Centre >>> _____ ID >> CHW ID >>> _____ CHW Name >>> _____

CHW Supervisor >>> _____ Mother's Name >>> _____ Mother's ID >> _____

ADP >>> First Recording Date >>>

Instructions: Record information EVERY VISIT		Newborn				Data code	Totals
		Week 1	Week 2	Week 3	Week 4		✓✗ completed by the supervisor when case is complete
Date of birth		12-11-2013					
Visits Planned (*write data planned*)		V1 V2 V3	V4				
Maternal death 0-45d *(date of death)*		-				D2	*Number of maternal deaths*
Still birth *(No. of babies still born)*						D3	*Number of still borns* 0
Live births *(No.babies born alive)*		1				ND2	*Number of babies born alive* 1
Newborn death *(date of death)*		0				D4	*Number of newborn deaths* 0
ttC Home Visits post- partum *(date of visit)*		13/11 16/11 17/11				N1	*Woman received at least 3 visits?* Y
Husband / partner participation in ttC visit		✓ ✓ ✓				N2	*Husband / partner present for most of visits?* Y
High risk newborn		✘ ✘ ✘				N3	*Number of high risk newborns?* 0
Skilled birth attendance in a facility		✓				N4	*Delivered in facility with skilled attendant?* Y
Birthweight Baby 1		2.8 kg				N5	*Number of babies that are LBW = <2.5kg* 1
Birthweight Baby 2							
Birthweight Baby 3							
Baby is receiving Kangaroo Mother Care		✘ ✘ ✘				N6	*Number of babies receiving KMC* 1
Baby was breastfeed in first hour of life		✓				N7	*Was the baby / babies breastfeed in the first hour?* Y
Baby was wiped and wrapped in the first hour of life (no bathing)		✘				N8	*Was baby / babies wrapped and wiped not bathed in 1st hour?* Y
Baby sleeps under a mosquito net at all times		✓ ✓ ✓				N9	*Baby slept under net at all visits?* Y
Babies who received early vaccines (BCG and OPV-0)		✓				N10	*Received both BCG and OPV-0?* Y
Post-partum danger sign identified		✘ ✘ ✘				E2	*Total number of events* 0
Newborn danger sign identified		✘ ✘ ✓				E3	*Total number of events* 0
Referral completed		✓				E4A	*Total number of events* 0
Post referral home visit completed		✓				E4B	*Total number of events* 0

OVERVIEW -- ttC logframe						
	Number of Outcome or Goal indicators			Number of output indicators		
	Core	Optional	Total	Core	Optional	Total
Goal level	3	4	7			
Outcome 1 Home based practices	6	10	16	6	8	14
Outcome 2 Access	7	5	12	10	12	22
Outcome 3 Community systems	1	2	3	14	4	18
Outcome 4 Health systems	1	4	5	4	5	9
TOTAL	**18**	**25**	**43**	**34**	**29**	**63**

Indicators	Threshold Values for Red / Green Flagging					
	Percentages			Estimates		
	Good	Moderate	Critical	Good	Moderate	Critical
Total population covered						
# of eligible women and girls registered (15-49 yrs & caregivers)						
# of eligible women and girls using a contraceptive method	>35%	25-35%	<25%			
# of current pregnancies						
# of completed pregnancies (forms this supervision)						
# of deaths of pregnant women				0	1-2 per 50 HH	3 or more per 50 HH
# of miscarriages, abortions						
# of women who have received their first ttC visit within the first 18 weeks of pregnancy	>70%	50-70%	<50%	Most	More than half	Less than half
# of women who received at least 4 ttC visits during the entire pregnancy						
# of women whose husband / partner participated in most of the ttC visits						
# of women who were identified as high risk at any point during this pregnancy	<5%	5-15%	>15%			
# of women who slept under a bednet during at least half of the pregnancy	>70%	50-70%	<50%	Most	More than half	Less than half
# of women who attended 1st ANC visit within 16 weeks						
# of women who attended 4 ANC visit during entire pregnancy						
# of women who were tested for HIV at some point during pregnancy	>90%	70-90%	<70%	Almost all	Most	Less
# of women who were tested and obtained HIV test result during pregnancy						
# of women who took at least 100 IFA tablets during pregnancy (at least 4 months)						
# of women who mostly ate more than usual during this pregnancy	>70%	50-70%	<50%	Most	More than half	Less than half
# of women who have developed a birth plan before the end of their pregnancy						
# of cases of pregnant women with a possible complication						
# of cases of pregnant women with a possible complication referred to a facility						
# of referral cases who received a home visit follow up						

Indicators	Threshold Values for Red Flagging					
	Percentages			Estimates		
	Good	Moderate	Critical	Good	Moderate	Critical
# of total women delivered since last supervision						
# of total babies born (live and still born)						
# of deaths of women during labour and in post partum (up to 6 weeks)				0	1-2 per 50 HH	3 or more per 50 HH
# of stillbirths (rate - per 1,000 live births)	<15%	15-20%	>20%			
# of live births						
# of deaths of newborns (up to 1 month of age) per 1,000 live births	<15%	15-20%	>20%	0	1-2 per 50 HH	3 or more per 50
# of post partum women who received at least 4 visits during the first month of life	>70%	50-70	<50%	Most	More than half	less than half
# of women whose husband / partner was present during most of the ttC visits						
# of of newborns reported as being high risk	<5%	5-15%	>15%			
# of births assisted by skilled health personnel in a health facility	>70%	50-70	<50%	Most	More than half	less than half
# of births where the birthweight of the newborn was recorded and newborn weighed <2,500g OR # of newborns with low birth weight or premature identified by any other means	<10	10-15%	>15%			
# of of LBW babies who received skin to skin	>70%	50-70	<50%	Most	About half	less than half
# of newborns who were breastfed within the hour of life						
# of newborns who were wiped and wrapped soon after birth						
# of newborns who live in a home with a bednet, who sleep under the bednet	>90%	70-90%	<70%	Almost all	Most	Less than most
# of newborns who had early immunizations - BCG and OPV (zero dose) in the first month						
# of cases of post partum mothers (up to 6 weeks) with a possible complication						
# of cases of newborns (0-28 days) with a possible complication						
# of cases of newborns with a possible complication who were referred to a facility	>70%	50-70	<50%	Most	More than half	Less than half
# of cases of newborn referrals who received a follow up home visit						
# of cases of pregnant women with a possible complication referred to a facility						
# of referral cases who received a home visit follow up						

TTC TALLY REGISTER - INFANTS 1-6M (PER CHW)						
# of total infants (1-6m)						
# of total infants completed 6m (forms collected this supervision)						
# of deaths of Post neonatal Infants (1 to 6 months of age)	<15	15-20	>20	0	1-2 per 50 HH	3 or more per 50 HH
# of infants 1 to 6 months who received at least one home visit DURING 1-6M	>70%	50-70	<50%	Most	More than half	less than half
# of home visits where male partner or chosen supporter was present						
# of infants identified as high risk infants	<5%	5-15%	>15%			
# of infants 1-6m who have a birth certificate	>70%	50-70	<50%	Most	More than half	less than half
# of infants who completed both dtp / penta and OPV vaccinations by 6 months	>90%	70-90%	<70%	Almost all	Most	Less
# of infants who were exclusively breastfed to six months of age (male)	>70%	50-70	<50%	Most	More than half	less than half
# of infants who were exclusively breastfed to six months of age (female)						
# of women who are using a contraceptive method by 6 months post partum						
# of infants aged 1-6months who are sleeping under a LLITN mosquito net						
# of cases of infants (1-6m) with a possible complication	>70%	50-70	<50%	Most	More than half	less than half
# of cases of infants (1-6m) with a possible complication who were referred to a facility and who received a home visit follow up post referral						
# of cases of infants (1-6m) with referrals where a post referral home visit was completed						

TTC REGISTER - CHILDREN 6-23M						
# of children aged 6-23 months currently registered						
# of Children aged 12 -23 months						
# of TTC completed children (now >24 months old)						
# of deaths of children (6 to 23 months or one day short of second birthday)	<15	15-20	>20	0	1-2 per 50 HH	3 or more per 50 HH
# of children visited twice in the first year of life (6 & 9 months)	>70%	50-70	<50%	Most	More than half	less than half
# of children visited 4 times during 6-23 months (or one day short of second birthday)						
# of women for whom husband / partner participated in most ttC visits						
# of children considered high risk at any point during 6-23 months	<5%	5-15%	>15%			
# of mothers of children aged 6 to 23 months who use a modern contraceptive method	>35%	25-35%	<25%	More than a third	More than a quarter	Less than a quarter
# of mothers who wash hands with soap or ash at appropriate times	>90%	70-90%	<70%	Almost all	Most	Less
# of children who continued to breastfeed up to 23 months						
# of infants who received complementary feeding from 6 months						
# of children aged 6-23 months who were given the minimum meal frequency						
# of children aged 6-23 months who regularly ate iron rich and/or iron-fortified food daily	>70%	50-70	<50%	Most	More than half	less than half
# of children aged 6-23 months who had iron supplements (syrup or tablets) at some point						
# of children who have received all essential vaccinations (Measles and DPT1, 2 and 3) by 1st birthday	>90%	70-90%	<70%	Almost all	Most	Less
# of children who received who have received at least two doses of Vitamin A before 2nd birthday						
# children who have received at least two doses of deworming medicine before 2nd birthday						
# of children aged 6-23 months sleeping under a mosquito net regularly						
# of cases of children aged 6-23 months with a sign of illness	>70%	50-70	<50%	Most	More than half	less than half
# of children (6-23 mos) with a sign of illness taken to the health facility						
# of cases of referrals who received a follow up home visit						

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