

Republic of Rwanda



Ministry of Health

Community Performance-Based Financing User Guide

Final Version, January 2009

www.pbfrwanda.org.rw

Community Performance-Based Financing Guide

Acronyms

BCC	Behavior Change Communication
BTC/CTB	Belgian Technical Cooperation
CAAC	Performance-Based Financing Support Cell (Cellule d'Appui a l'Approche Contractuelle)
CASC	Cooperation des Agents de Sante Communautaire (Community Health Worker Cooperative)
CBHI	Community Based Health Insurance
CORDAID	Dutch Non-Governmental Organization; a conglomeration of three Dutch NGO's: Memisa, Mensen in Nood, and Vastenactie
CDLS	Comité de District de Lutte contre le SIDA (District AIDS Control Committee)
CHW	Community Health Worker
FOSACOM	Community Funded Health Facility (FOSA Communautaire)
GF	Global Fund
GOR	Government of Rwanda
HNI-TPO	HealthNet International; a Dutch Non-Governmental Organization
IMCI/PECIME	Integrated Management of Childhood Illness
MOH	Ministry of Health
MSH	Management Sciences for Health
NORAD	Norwegian Agency for Development Cooperation
PBF	Performance-Based Financing
P4P	Pay for Performance
PMI	President's Malaria Initiative
TWG	Technical Working Group
USF	District Health Department (Unité Sante Famille et Protection des Droits de L'Enfant)
USG	United States Government
WB	World Bank
WB-MAP	World Bank Multicountry AIDS Program

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Executive Statement

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Executive Statement

Community Health performance based financing is an innovational approach aimed at accelerating health results focusing on high impact community level health interventions. Performance based financing is being implemented in a score of countries including Rwanda through different models and impressive results have been registered but much is still desired.

The main challenge for Rwanda to accelerate health results towards achieving health targets as envisaged in Vision 2020, EDPRS and MDGs is not only inadequate health financing resources, medical supplies, human resources for health but also poor utilization of available health services compounded by lack of awareness of the opportunities available.

In light of the above reflection and as envisaged in the National community health policy, a significant change in health results has to be based to individuals and communities on a health system where community driven approach is the common denominator. The Community Performance based financing user guide will ensure community ownership of high impact health interventions by ensuring further decentralization of health services and resources to health centers, health posts and the community. Community PBF is not direct payments to community health workers. But it is intended community health workers to increase the capital of their cooperatives. The cooperatives in turn will then start income generating activities to the benefit of the individual members. The remuneration of individual community health workers will be from the profit of the cooperative activities.

The Community PBF user guide also defines twenty community health indicators that all interveners in community health will focus on. Verification and reporting tools have been adapted to suit community level interventions and separation of functions is clearly provided for through purchaser-provider split mechanisms. The Community PBF conforms to the provisions of National community health policy statement, which calls for urgent formation of community health workers cooperatives as a key initiative aimed at motivating and increasing their financial capacity in a sustainable way.

Dr. Richard SEZIBERA
Minister of Health



Introduction

Performance-Based Financing is thoroughly embedded in the Rwandan Health System. It is practiced in health centers and district hospitals nationwide using common approaches. Ministry of Health Performance-Based Financing has started at the central ministerial level. Performance-Based Financing systems are being designed for the national Community Based Health Insurance system, and for the CDLS. A national model for Community Performance-Based Financing has been developed, using a broad consultative process. The model is based on experience gained during the implementation of the health center and hospital Performance-Based Financing models, and benefits from a close fit with these models.

The purpose of this Community Performance-Based Financing (PBF) Guide is to document the tools and processes used in Community PBF. This guide is primarily meant as a background document for trainers, sector PBF Steering Committee members, and the Community Health Worker Cooperatives. However, it will be used by all working in the Rwandan Health System.

1. Community PBF Administrative Model

Background

Performance-Based Financing was rolled out in Rwanda from January 2006 onwards, using a phased approach. During the second and third quarters of 2006, newly designed Performance-Based Financing (PBF) models were introduced in 23 Rwandan districts. These models concerned health centers and district hospitals and were based on experience gained from PBF pilot programs.¹ These two models differ in the way performance is defined and assessed. Whereas the health center model uses a case-based reimbursement/prospective payment type of financing, in which indicators which are measured monthly have unit values and to which a quarterly quality score is applied, the hospital model uses an evaluation checklist with 52 composite indicators, applied quarterly.² Strong leadership from the MOH/Cellule d'Appui a l'Approche Contractuelle (CAAC) and close collaboration with and support from partners (USG, BTC, Cordaid, HNI-TPO and MSH and other USG collaborating agencies) has led to impressive progress in policy and strategy development and the implementation of these policies and strategies in the field. Performance-based financing indicators were developed, tools were defined, training and capacity building at all levels (national; district; health center) of the health system was done and is ongoing, a website and a database which uses the internet for data-entry and retrieval were created (www.pbfrwanda.org.rw), and a special monthly implementation and coordination mechanism with formal proceedings, the Extended Team, was introduced. The latter coordination mechanism has been added in May 2007, to bridge the gap between policy and implementation. As of April 1, 2008, PBF has been rolled out nationwide, in all health centers and district hospitals.

Current Challenges to Community Performance-Based Financing

Community PBF was conceived in December 2005, and started in January 2006 in 23 districts.³ It is embedded in the National Community Health Policy.⁴ Whereas the Ministry of Health is providing policy direction, the Ministry of Local Administration is supposed to implement the policy. Ninety Million Francs have been deposited on each district account over the past nine quarters (January 2006 to December 2008). Six community health indicators were selected to be monitored under the Community PBF approach:

¹ 'Rwanda: Performance-Based Financing in Health', Louis Rusa and Gyuri Fritsche, Managing for Development Results Sourcebook, 2007 second edition, <http://www.mfdr.org/Sourcebook/index.html> (accessed 25 May 2007)

² A good description of these two models, and of the previous PBF pilot models, can be found in 'Provider Payment Mechanisms using Performance-based Financing/Performance-based Contracting'. Musango, L and Fritsche, G et al. Draft 22 Sept 2007.

³ Information obtained from a presentation from G. Gahenda to the PBF Technical Working Group 16 Oct 07.

⁴ 'National Community Health Policy', 2008, MOH.

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1. Mutuelle enrollment
2. Deliveries at health centers
3. Use of Insecticide Treated bed Nets
4. Management of dehydration due to diarrhea among under-fives
5. Personal hygiene
6. Reporting.

Following several sub-TWG meetings, some basic principles of a workable community PBF model were agreed. The following changes were suggested: (i) Community PBF funds ought to be further decentralized to sectors and health centers, (ii) a verification committee should be formed at the sector level, (iii) contracts between stakeholders should be developed, and (iv), data collection tools and reports ought to be standardized.

Determining performance standards

Performance standards imply that these need to be assessed. In normal programming, assessment of performance would be based on routine reporting systems, surveys and other studies. In Rwanda-style performance-based financing, strong emphasis is put on controlling data at the service delivery level, at the district level and at the national level prior to remunerating performance. In addition, client surveys are currently being piloted to add an additional element of control and of eliciting feedback from the community on services received. Various mechanisms are created in the system to encourage accurate reporting, such as written contracts between the sector and the health center management, auto-control by the health center management prior to submitting performance results, external control by the district (USF or Hospital staff) at the health facility level through verifying every single entry of each remunerable indicator in its appropriate registers, and ensuring functioning management systems through an elaborate quarterly quality checklist. Discussion of performance results, both quantity and quality of services, is done in quarterly PBF district steering committees in which health authorities from the district and the hospital, alongside with civil society, health providers and technical assistants. The PBF district steering committees are governed through multilateral contracts written between the Mayor and the members of the steering committee, and technical assistance is provided from the national level through a team of over 40 technical assistants drawn from 9 non-governmental agencies and 2 MOH departments. The performance standard in the Rwandan health center PBF model is a mix of quantitative outputs on which impacts a quarterly quality measure: $HC_{earnings} = \text{Quantity} * \% \text{Quality}$.

Transplanting a performance system such as used at the health center level to the community level is challenging. It would entail considerable costs in time and money to mount a system to verify each reported indicator at the level of the community. For instance, when we would pay let us say FRW 10 per 'BCC session' to each community health worker, we would, in case we were to use the health center PBF model, need to verify each and every single 'Behavior Change Communication (BCC) session' held in the community, or, at the least, make credible effort to verify that such active has occurred. However, even when we were to accurately determine that a certain amount of

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'BCC sessions' had taken place, then, in that case, nothing about the quality of this session let alone the impact of the BCC session (behavior change) would be known. Paying per case would introduce incentives to over report performance, which would necessitate credible and costly mechanisms to deter over reporting. From this analysis, it seems desirable that the deliverable should be a quarterly report, containing certain indicators on which community health workers need to routinely report on. A contract will be written with the community health workers 'cooperative', which would be the agency organizing data collection by the CHW's. The performance standard would be timely quarterly submission of the compiled quarterly data. Assessment of this performance standard will do at the sector level, in a committee which meets quarterly. This committee would also examine the content of the performance, and take further action where necessary.

Separation of functions

When paying for performance, and assessing results, a '*separation of functions*' is necessary. This is a 'purchaser-provider split'. In the 'separation of functions' attention is given to avoiding potential or easy to avoid conflict of interest situations, such as may occur when the controlling agency is also a provider agency (in which case it should not control itself) or when the purchaser is the provider, or on a slightly different take: when the Quality regulator (the district hospital) is also fulfilling the Quantity Control function and could possibly be 'too close' to the health center service provider leading to situations of conflict of interest and fraud. Issues of moral hazard from the controller might creep in, when the controller has sole authority to certify performance whilst he is not the one paying for performance.

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The current GOR strategy, as reflected in the Community Health Policy and Strategy is based on the voluntary nature of the Community Health Worker. These community health workers have recently been elected and newly trained with the underlying assumption that they would function as voluntary workers, chosen by their communities, to provide certain services which benefit local health and development

*The community PBF is **not** for individual performance remuneration. The purpose of the incentive is for community health workers to increase the capital of their cooperatives. The cooperatives on their turn will then start income generating activities to the benefit of the individual members. The remuneration of individual community health workers will be from the profit of the cooperative activities.*

The Community Health PBF Model

Creating a national community PBF model confronts us with challenges as well as with opportunities. Challenges are to create the administrative model, to introduce its institutional structures, and to hope that these will govern a closer look at data and results. A further challenge will be to create a governing structure that will allow both Sector level Community PBF funds from the different partners, to reach the grass root workers. Opportunities are to lay the foundations of the administrative model which, once it proves successful, can be a portal to sluice more money through to these important activities, so vital for reaching the Millennium Development Goals and Rwanda's Vision 2020.

We propose to create the institutional foundations, the building blocks of the Community Performance-based financing model, which will allow sluicing money to the grass root structures for one key deliverable only: the timely submission of a filled quarterly activity report by the CHW cooperative to the Sector Community PBF Steering Committee and its subsequent validation by this sector steering committee.

For the Community PBF model, the following roles are proposed:

- The **Purchaser(s)**: the 'sector PBF steering committee' composed by in charge of social affairs in the sector and the health center delegate, other public institutions, teachers, civil society (local NGO's, Faith based organizations, etc.) on behalf of GoR and its Partners. The budget is transferred in a health center sub-account.
- The **Provider**: the CHW's cooperative
- The **Controller(s)**: the health center under guidance from the 'sector PBF steering committee.

Figure 1: The Purchaser-Provider split in the National Community PBF Model.

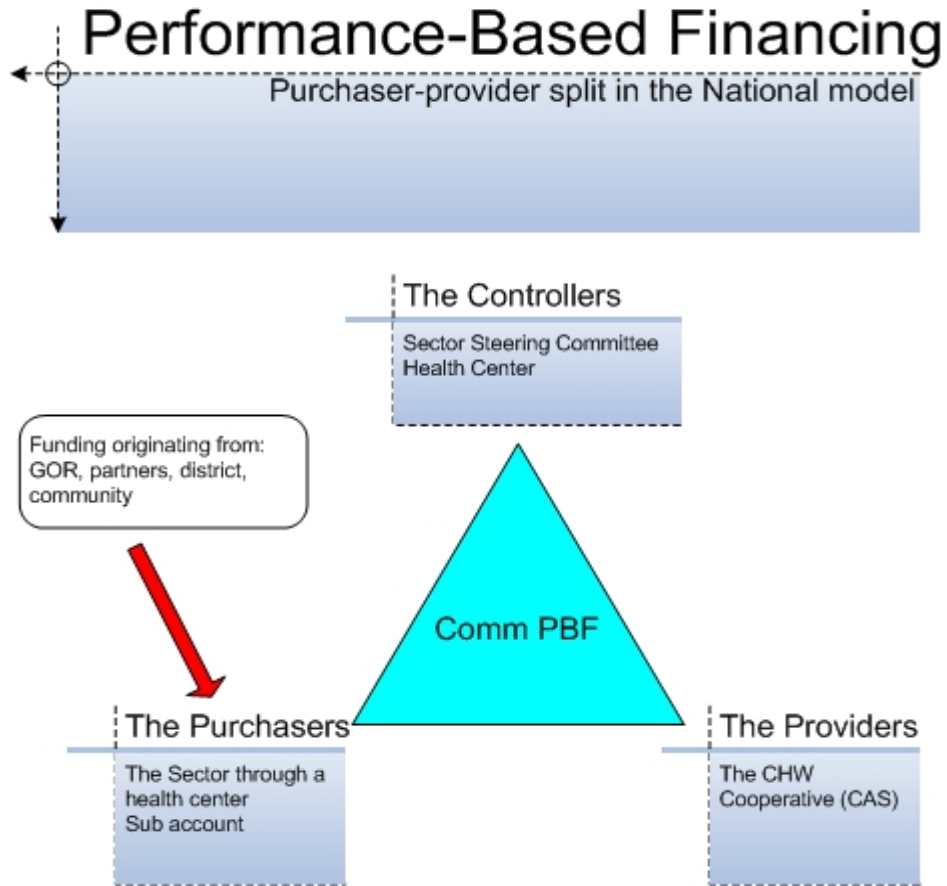
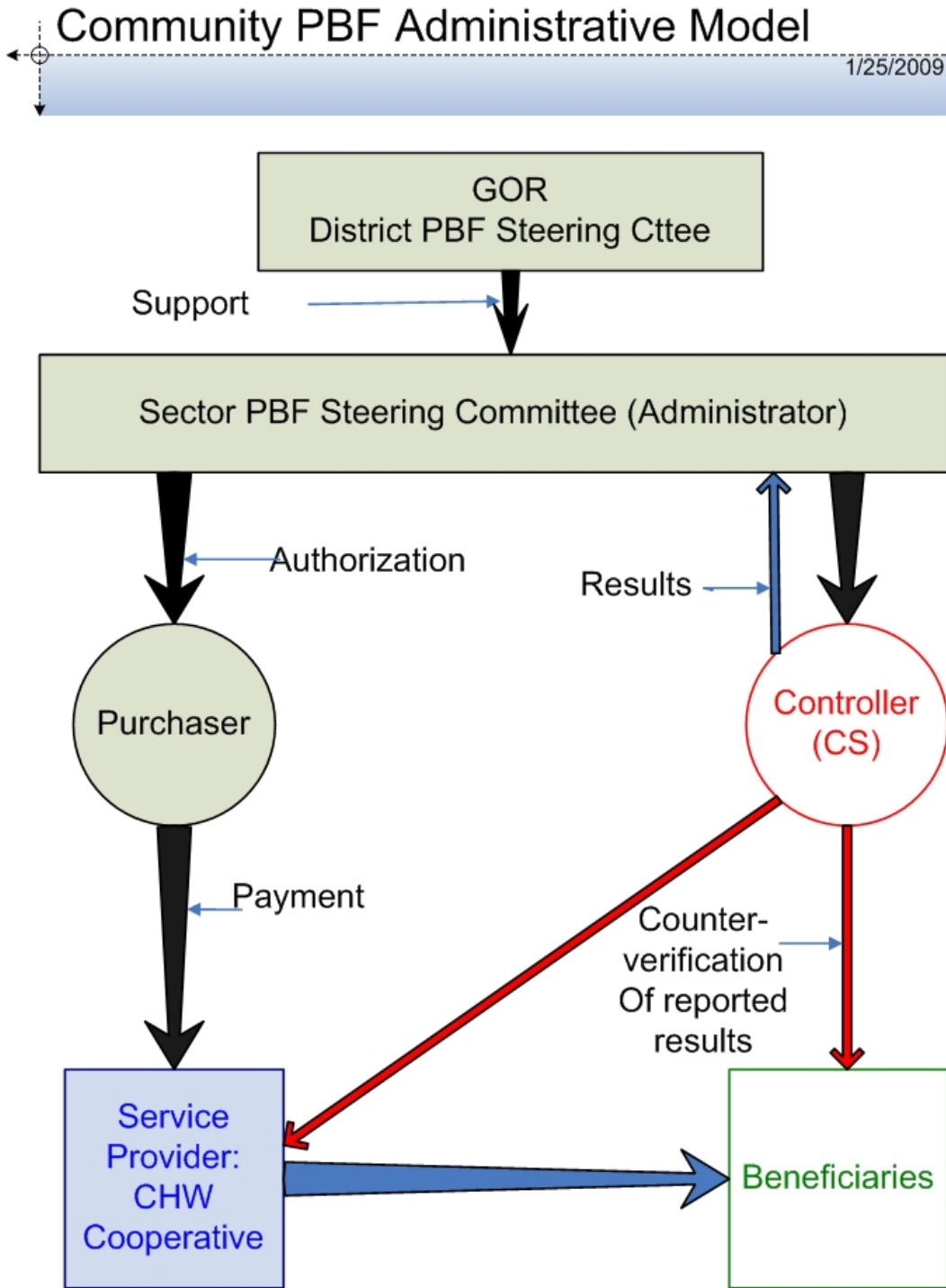


Figure 2: The Community PBF Administrative Model



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In the above figure:

1. The GoR , Partners and districts provide overall policy guidance and support to the national Community PBF system
2. The District health department and District hospital provides support to the sector steering committee;
 - a. General support and capacity building in the institutional mechanisms governing the Community PBF system
 - b. Organizing data input using the Web application
3. The Sector PBF Steering Committee decides on the level of achievement:
 - a. Discusses the quarterly sector community performance report and validates it;
 - b. Discusses any observations brought to the table by the Health Center
 - c. Approves the payment after determining successful performance based on the key performance indicators. The health center staff through traditional households visits (Visits a domicile) will do sampling and checking CHW's performance reports;
4. The Local Sector Administration signs a **contract** with the CHW's cooperative detailing the Community PBF performance indicators and the content of the reports that need to be submitted before a certain date. It compiles these reports from the CHW monthly reports. The partners (The Donor, the Purchasers, the Controller and the Provider) will sign an MOU with the Mayor. Money for paying the CHW cooperatives will be pooled in a special health center sub-account, the health center will act as the purchaser.

Institutional structures and payment

Funds for Community PBF are available through the Global Fund and through the GOR budget line for Community PBF, sector budget support, and World Bank and Norwegian grant monies. The health center must open a special bank account for community health. The PBF database contains an updated table with all Rwandan health facilities with their bank account details. Compiled and verified (verified through the 'sector PBF committees') quarterly CHW data will bring up to the district level by district controllers, and entered in the PBF database using the internet. A feed-back from this system will be created which should be presented to the 'sector PBF committees' for approval. By doing this, wrongly entered data would be intercepted by the sectors. Funds will flow from central level to the health center level, which would then be disbursed when performance standards have been met (as certified by the 'sector PBF committee'). A semi-automated 'payment order' for Community PBF funds will be created after a process at national level which would certify whether 'due diligence' has been met, i.e. whether reports have been entered timely in the PBF database.

Although sectors do have different characteristics related to poverty, geography and population size, it is advised to 'kick start' the system by allocating funds based on the size of the individual catchment populations. Later, when such data becomes available,

equity will be enhanced by introducing a specific index for disbursement/allocation of this budget, taking into account various variables (vertical equity).

2. Contract between the Mayor and the Sector PBF Steering Committee

There are two contracts in the Rwandan Community Performance-Based Financing Model. The first is an agreement between the Mayor, represented by the Local Sector Administration, and the Each Sector PBF Steering Committee. This agreement establishes the rules which govern the Sector PBF Steering Committee.

Members of the Sector Committee are: Members of the Sector Committee are: **(1)** The Sector in-charge of Health and social affairs (Chairperson), **(2)** The health center in-charge (V/Chairperson), **(3)** The president of the Community Health Worker Cooperative (**non-voting** Member), **(4)** The focal person at the health center in-charge of community health interventions (Secretary), and **(5)** One community member (*not member of any of the represented institutions*).

Catchment Populations of Health Centers and Sector Boundaries do not overlap. Some sectors have one or more health centers, whilst there are a few sectors which have no Health Center yet. The sector in which the Health Center is physically located, signs the contract with the Sector PBF Steering Committee. There can therefore only be one Sector PBF Steering Committee, however, there can be multiple Health Centers/Community Health Worker Cooperatives governed by the Contract/Agreement. However, membership of the Sector PBF Steering Committee will include these Health Centers, its Cooperative as non-voting representatives, and representatives of its communities.

For instance, in case there are two Health Centers in one Sector, the Sector PBF Steering Committee composition will be as follows:

Members of the Sector Committee, in the case of the Sector having two Health Centers are: **(1)** The Sector in-charge of Health and social affairs (Chairperson), **(2)** A health center in-charge (Vice-Chairperson), **(3)** the health center in charge of the second health center **(4)** The two presidents of the Community Health Worker Cooperatives (**non-voting** Members), **(5)** The two focal persons at the two health center in-charge of community health interventions (rotating secretary), and **(6)** Civil Society: one community member of the community surrounding the respective health centers (not member of any of the represented institutions).

Each of these members signs this Contract. The Contract is kept in a special file at the Local Sector Administration. A model Contract can be found in Annex 1.

3. Contract between the Sector Administration and the Community Health Worker Cooperative (CASC)

The second contract in the Rwandan Community Performance-Based Financing Model is the Purchase Contract. This Purchase Contract is signed between the Local Sector Administration and the Community Health Worker Cooperative (CASC). The Contract is governed by the Sector PBF Steering Committee. Payments, after approval in the Sector PBF Steering Committee, are made from the Health Center to the CASC. The Health Center has opened a sub-account, where funds from central level will be pre-positioned as to be able to pay the CASC as soon as its performance has been certified.

Each CASC surrounding each Health Center signs a contract with the Local Sector Administration. All CASC purchase contracts in any one specific sector are managed by the local PBF Sector Steering Committee.

The Contract is kept in a special file the Local Sector Administration. The Contract can be found in Annex 2.

4. Guidelines for the Sector PBF Steering Committee

The Contract of the Sector PBF Steering Committee in Annex 1 provides the essential information related to the terms of reference and the governance structure of the Sector PBF Steering Committee.

Additional Guidelines for the Sector PBF Steering Committee are as follows:

Participants and Quorum

- Participants are those that have been listed in the contract between the Mayor and the Sector PBF Steering Committee.
- The minimum QUORUM⁵ consists of at least one representative from three different institutions: (i) the representative of the local sector administration, (ii) the head of the health center or her deputy and (iii) representative from the community.

Procedures

- The one calling the meeting: the sector responsible for social affairs or her designate; the meeting should be called at least three working days before the actual meeting.
- Data entry in the PBF BDD: final responsible is the Director of USF (who can delegate responsibility). The collection of the monthly Sector Community

⁵ “In [law](#), a **quorum** is the minimum number of members of a [deliberative body](#) necessary to conduct the business of that group. Ordinarily, this is a majority of the people expected to be there, although many bodies may have a lower or higher quorum” definition from Wikipedia, <http://en.wikipedia.org/wiki/Quorum>, accessed 17 May 2007

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PBF/HMIS data is the responsibility of the CASC; however, transmission of the report to the district is the responsibility of the District Hospital, whose supervisors frequently visit the health center. The data entry in the PBF BDD will be under the authority of the President of the District PBF Steering Committee, who can allocate responsibility to somebody who manages the district PBF account.

Performance Measure for the Sector PBF Steering Committee

A quarterly budget will be allocated to the Sector PBF steering committee. This quarterly budget is performance based, and dependent on the correct execution of certain tasks. The District PBF Steering Committee will judge the performance of the Sector PBF Steering Committees. The performance funds will come from the district Community PBF budget. This quarterly performance budget has been put at FRW 50, 000.

	Item		Payment (Max)
1	Timeliness	The quarterly sector PBF steering committee meeting held prior to the 15 th of the fifth month and minutes have been made available to the local sector administration prior or on the 15 th of the fifth month. If criterion is met (40%) if not met (0%)	40% of available budget
2	Guidelines followed	The minutes are according to the templates in Annex 4. The Guidelines for the Sector PBF Steering Committee have been followed correctly. If criterion is met (40%) if not met (0%)	40% of available budget
3	Payment	Payment of the CASC executed latest 10 working days after the Sector PBF steering committee meeting. If criterion is met (20%), if not met (0%)	20% of available budget
Total			100%

5. Description ASC Cooperative, legal and other

Members of the cooperative are all community health workers operating within the catchment area of the health centre. Currently, health workers consist of the “binome” (1 female and 1 male) per village and 1 maternal health animator per village (the former Traditional Birth Attendant) and the person in charge of social affairs in the umudugudugu and cells level. The Ministry of Health assumes that only CHWs as defined above will form part of this CASC (Articles 13 and 14 of the Sector-CASC contract).

The community PBF is **not** for individual performance remuneration. The purpose of the incentive is for community health workers to increase the capital of their cooperatives. The cooperatives on their turn will then start income generating activities to the benefit of the individual members. The remuneration of individual community health workers will be from the profit of the cooperative activities (Article 19 of the CASC contract).

6. Template for the Monthly Data Collection Sheet of the CASC

The Monthly Data Collection Sheet of the Community Health Worker Cooperative can be found in Annex 7. These Monthly Data Collection sheets contain each month the compiled data of all Community Health Workers in the catchment area of the Health Center. These Monthly Data Collection Sheets need to be submitted to the Health Center, against a proof of reception, prior to the 10th of the month following the reporting period. These Data Collection Sheets are the same for the CHW Monthly Reports at the Village level. Each village compiles its CHW activity report, one village = one report. Then, all reports from villages belonging to a cell are compiled in a Cell Monthly Data Collection Sheet. All Cell reports are then compiled by the CASC into one Monthly CHW Sector Report. The level of compilation is indicated, by ticking the box on the left upper corner of the report.

7. Template for the Quarterly Consolidated Health Center PBF Report (printed from the PBF BDD)

The Quarterly Consolidated Health Center PBF Report is printed from the PBF BDD by the USF. After its printing, the Report should be brought to the Health Centers, in time for the Quarterly Sector PBF Steering Committee meetings, which are supposed to be held before the 15th of the fifth month. If there are more than one Health Centers in one sector, then there will be an equal number of Quarterly Consolidated Health Center PBF Reports each quarter.

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The above tasks fall under the supervisory authority of the President of the District PBF Steering Committee, who is also the District Director of Health/Director of the USF.

For the layout of the Report: see Annex 5.

8. Explanation of the Community Health Information System Flow Chart

Community Health Information System Indicators and Community Performance-Based Financing Indicators are the same. The twenty-two indicators, the registers and other recording tools, and reporting tools are the same. In addition, the Data Flow is the same, and is presented in detail in Annex 6. The steps are as follows:

- I. The CHWs in a village compile their monthly report, within three days of the end of each month using the reporting form in Annex 7. There will be one monthly CHW Village Report per village.
- II. The village CHW monthly report is compiled at the Cell level, within eight days of the end of each month, using the reporting form in Annex 7. There will be one monthly Cell Report per Cell.
- III. The monthly Cell CHW Reports are compiled at the Sector level by the Community Health Worker Cooperative, within 15 days of the end of each month, using the reporting form in Annex 7. There will be one monthly CASC CHW Report per Health Center. If, due to the next phase of decentralization, the Cell structure will disappear, it will be advisable for the CASC to retain some kind of organization of CHW report compilation along the lines of the former Cell, or any other organizational solution, for convenience sake. These reports are submitted to the Health Center by the CASC, and a written proof of reception is issued by the Health Center to the CASC.
- IV. The monthly compiled CASC CHW Reports are sent, as soon as possible, from the Health Center, through the Hospital Supervisor to the USF, for data entry in the PBF BDD. These data are entered before the end of the month in the PBF BDD, through the district PBF account. The responsible entity for this step is the District Hospital, and its execution will be checked through the Hospital PBF scheme.
- V. Once per quarter, a quarterly Consolidated Health Center PBF Report is printed by the USF, or under instructions of the District PBF Steering Committee by a third party, once such report for each Health Center. These reports will be brought to the Health Center, under the responsibility of the District Hospital, before the 5th of the fifth month.
- VI. Quarterly Consolidated Health Center PBF reports are validated by the Sector PBF Steering Committee meetings, once per quarter, prior to the 15h of the fifth month. Corrections, if any, are communicated to the daily committee of the District PBF Steering Committee (the USF), accompanied by detailed written instructions as documented in the minutes of the meeting. Corrections are executed forthwith in the PBF database by the USF, or a third party under mandate by the District PBF Steering Committee.

- VII. Health Centers, once per quarter at the least, will provide feedback to CHWs on their reported activities.

9. Indicators and Reporting Tools in use with Community Health

Community Performance Based Financing is based on the timeliness, completeness and correctness of the Community Health Reports. Community PBF is a tool to improve efficiency and effectiveness of data flows and the use of data for planning, at all levels but starting at the Sector level. In essence, Community PBF Indicators are at the core of the Community Health Management Information System. A significant part of the training in Community PBF will consist of training in the Community HMIS indicators and reporting tools. A separate Community HMIS Manual has been drafted.

This manual has annexed to this guide as Annex 7.

Annexes

Annex 1: Contract between the Mayor and the Sector PBF Steering Committee

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Contract

Between the Executive Secretary of the Sector Administration and the Sector PBF Steering Committee for the Community Performance-Based Financing Model

Context

The Ministry of Health has Performance-Based Financing at all levels of the health system. Performance-Based Financing, together with Quality Assurance and Community Based Health Insurance (Mutuelle de Santé), are the cornerstones of the new MOH Health Policy and Strategy. Community Health and a focus on Community Health Interventions are considered very important in order to reach the Health Targets of the Millennium Development Goals and Rwanda's Vision 2020. A new Community Performance-based Financing model has been accepted by the MOH. It consists of a decentralized control and decision making by a Sector PBF Steering Committee (after this called 'Sector Committee'), and payment of a Community Health Worker Cooperative by the Health Center after performance has been certified by the Sector Committee.

Purpose of this Contract

The purpose of this contract is to formalize the proceedings of the Sector PBF Committee, by signing a multilateral contract between the Mayor of the District, represented by its Local Administration, and the individuals who are members of the Sector PBF Committee, and those who represent their institutions. These institutions are the Health Center, the Community Health Worker Cooperative and the Sector Administration and the civil society from the community served.

Article 1: Members of the Sector PBF Steering Committee

Members of the Sector Committee are: **(1)** The Sector in-charge of Health and social affairs (Chairperson), **(2)** The health center in-charge (V/Chairperson), **(3)** The president of the Community Health Worker Cooperative (**non-voting** Member), **(4)** The focal

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person at the health center in-charge of community health interventions (Secretary), and (5) One community member (*not member of any of the represented institutions*).

Catchment Populations of Health Centers and Sector Boundaries do not overlap. Some sectors one or more health centers, whilst there are a few sectors which have at the time of writing, no Health Center yet. The sector in which the Health Center is physically located, signs the contract with the Sector PBF Steering Committee. There can therefore only be one Sector PBF Steering Committee, however, there can be multiple Health Centers/Community Health Worker Cooperatives governed by the Contract/Agreement. However, membership of the Sector PBF Steering Committee will include these Health Centers, its Cooperative non-voting representatives, and representatives of its communities.

For instance, in case there are two Health Centers in one Sector, the Sector PBF Steering Committee composition will be as follows:

Members of the Sector Committee, in the case of the Sector having two Health Centers are: (1) The Sector in-charge of Health and social affairs (Chairperson), (2) A health center in-charge (Vice-Chairperson), (3) the health center in charge of the second health center (4) The two presidents of the Community Health Worker Cooperatives (**non-voting** Members), (5) The two focal persons at the two health center in-charge of community health interventions (rotating secretary), and (6) Civil Society: one community member of the community surrounding the respective health centers (not member of any of the represented institutions).

Article 2: Frequency of Meetings of the Sector PBF Steering Committee

Meetings of the Sector Committee are once per quarter. These obligatory meetings should be held in the first or second week of the fifth month. For the first quarter, this should be in the month of May. For the second quarter this should be in the month of August. For the third quarter, this should be in the month of November. For the fourth quarter, this should be in the month of February. More frequent meetings can be held, as decided by the Sector Committee.

Article 3: Quorum

A quorum is the minimum representation of members representing specific institutions or stakeholders. Without a valid quorum, the meeting is not valid. The quorum for a valid quarterly sector PBF meeting consist of (i) the representative of the local sector administration, (ii) the head of the health center or her deputy and (iii) representative from the community.

Article 4: Tasks of the Sector PBF Steering Committee

Tasks of the Sector PBF Steering Committee are: (i) to scrutinize the quarterly Community PBF printout. See Annex 3. This printout will be done by the district responsible for data entry, (ii) Compare these figures to the monthly totals which have been submitted by the CASC to the Health Center, (iv) Correct any errors and create a feedback to the district responsible for data entry to correct any errors, and (v) discuss

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content of the indicators and make recommendations which are relevant to Community Health and, (vi) order for payments to the CHW Cooperative by the health center.

Article 5: The Printed Quarterly Community PBF Cumulative Report

A printed quarterly Community PBF cumulative report originates from the national PBF database. A Sector PBF Committee cannot approve the monthly CASC invoices without such a printed quarterly Community PBF cumulative report.

Article 6: Meeting Chair

The Meeting Chair is the sector in-charge of health and social affairs or his or her deputy (the Health Center in-charge).

Article 7: Meeting Secretary

The Meeting Secretary is the health center in charge of community health.

Article 8: Meeting Minutes

The Meeting minutes are produced and signed during, or straight after the Sector Committee Meeting. In the absence of a computer, a register can be used for this, and data, time, and those present should be noted. In addition, the participants should sign off on the minutes. This register should be kept in a secure location at the Health Center by the Head of the Health Center.

Article 9: Data transfer to the district (prior to the Sector Committee Meeting)

The CASC is bound, through a contract with the Local Sector Administration, to submit three monthly reports summarizing their Community Health Worker Monthly Reports to the Health Center. These three monthly reports should reflect the three months of the preceding quarter. These three reports should be along the format in Annex 2. These reports should be submitted, latest, by the 10th day of the first month following the end of the quarter, to the Health Center Management. The Health Center will issue a 'proof of reception' (« accusé de réception ») attesting that it received these reports. The Health Center is responsible to pass on these reports to the district, by way of the Hospital Supervisor. The Hospital Supervisor is responsible to pass on these reports to the one responsible to enter data in the PBF database (PBF BDD) at the district level.

Article 10: Data transfer from the district to the sector (prior to the Sector Committee Meeting)

Data entry in the PBF BDD is the responsibility of the one designated by the District PBF Steering Committee to do data entry in the PBF BDD (called the 'PBF BDD Responsible'). The PBF BDD Responsible will enter these data, and print out the Quarterly Reports, one for each Sector.

Article 11: Data transfer from the district to the sector (after the meeting)

These quarterly reports are returned to the Health Center Management. The Health Center Management Issues a 'proof of reception' after receiving this quarterly report. The responsibility of bringing these reports to the health center lies with the Hospital Director (through his Hospital Supervisory Team).

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Article 12: Per Diems and Other Expenses of the Sector PBF Steering Committee

The Local Sector Administration will pay, based on government rules, eventual per diems and other expenses related to eventual counter verification exercises. The Local Sector Administration receives a specific 'Community PBF Budget' out of which it can pay these items.

Signatories to this contract:

Date:

Sector Executive Secretary

Head of the Health Center

Health Center in Charge of CHW Supervision

President of the CASC

Local Community Representative

Annex 1: Community PBF indicators

Annex 2: Monthly Data Submission Form (CASC)

Annex 3: Quarterly Community PBF printout form

Annex 2: Contract between the Sector Administration and the Community Health Worker Cooperative

Republic of Rwanda



Ministry of Local Administration Contract

**Between the Local Sector Administration and the CHW Cooperative (CASC) for
the Community Performance-based Financing Model**

Context

The Ministry of Health has Performance-Based Financing at all levels of the health system. Performance-Based Financing (PBF), together with Quality Assurance and Community Based Health Insurance (Mutuelle de santé), are the cornerstones of the new MOH Health Policy and Strategy. Community Health and a focus on Community Health Interventions are considered very important in order to reach the Health Targets of the Millennium Development Goals and Rwanda's Vision 2020. A new Community Performance-Based Financing model has been accepted by the MOH. It consists of a decentralized control and decision making by a Sector PBF Steering Committee (after this called 'Sector Committee'), and payment of a Community Health Worker Cooperative by the Health Center after performance has been certified by the Sector Committee.

Purpose of this Contract

The purpose of this contract is to define the relationship between the Purchaser and the Provider, in the Community Performance-based Financing model. This contract will be signed between the Local Sector Administration and the president of the CHWs' Cooperative on behalf of all the cooperative members. This contract is governed by the Sector PBF Steering Committee.

Part A:

Articles related to the Institutional Framework of the Sector PBF Steering Committee

Article 1: Members of the Sector PBF Steering Committee

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Members of the Sector Committee are: (1) The Sector in-charge of Health and social affairs (Chairperson), (2) The health center in-charge (V/Chairperson), (3) The president of the Community Health Worker Cooperative (**non-voting** Member), (4) The focal person at the health center in-charge of community health interventions (Secretary), and (5) One community member (*not member of any of the represented institutions*).

Catchment Populations of Health Centers and Sector Boundaries do not overlap. Some sectors one or more health centers, whilst there are a few sectors which have at the time of writing, no Health Center yet. The sector in which the Health Center is physically located, signs the contract with the Sector PBF Steering Committee. There can therefore only be one Sector PBF Steering Committee, however, there can be multiple Health Centers/Community Health Worker Cooperatives governed by the Contract/Agreement. However, membership of the Sector PBF Steering Committee will include these Health Centers, its Cooperative non-voting representatives, and representatives of its communities.

For instance, in case there are two Health Centers in one Sector, the Sector PBF Steering Committee composition will be as follows:

Members of the Sector Committee, in the case of the Sector having two Health Centers are: (1) The Sector in-charge of Health and social affairs (Chairperson), (2) A health center in-charge (Vice-Chairperson), (3) the health center in charge of the second health center (4) The two presidents of the Community Health Worker Cooperatives (**non-voting** Members), (5) The two focal persons at the two health center in-charge of community health interventions (rotating secretary), and (6) Civil Society: one community member of the community surrounding the respective health centers (not member of any of the represented institutions).

Article 2: Frequency of Meetings of the Sector PBF Steering Committee

Meetings of the Sector Committee are once per quarter. These obligatory meetings should be held in the first or second week of the fifth month. For the first quarter, this should be in the month of May. For the second quarter this should be in the month of August. For the third quarter, this should be in the month of November. For the fourth quarter, this should be in the month of February. More frequent meetings can be held, as decided by the Sector Committee.

Article 3: Quorum

A quorum is the minimum representation of members representing specific institutions or stakeholders. Without a valid quorum, the meeting is not valid. The quorum for a valid quarterly sector PBF meeting consist of (i) the representative of the local sector administration, (ii) the head of the health center or her deputy and (iii) representative from the community.

Article 4: Tasks of the Sector PBF Steering Committee

Tasks of the Sector PBF Steering Committee are: (i) to scrutinize the quarterly Community PBF printout. See Annex 3. This printout will be done by the district

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responsible for data entry, (ii) Compare these figures to the monthly totals which have been submitted by the CASC to the Health Center, (iv) Correct any errors and create a feedback to the district responsible for data entry to correct any errors, and (v) discuss content of the indicators and make recommendations which are relevant to Community Health and, (vi) order for payments to the CHW Cooperative by the health center.

Article 5: The Printed Quarterly Community PBF Cumulative Report

A printed quarterly Community PBF cumulative report originates from the national PBF database. A Sector PBF Committee cannot approve the monthly CASC invoices without such a printed quarterly Community PBF cumulative report.

Article 6: Meeting Chair

The Meeting Chair is the sector in-charge of health and social affairs or his or her deputy (the Health Center in-charge).

Article 7: Meeting Secretary

The Meeting Secretary is the health center in charge of community health.

Article 8: Meeting Minutes

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Article 9: Data transfer to the district (prior to the Sector Committee Meeting)

The CASC is bound, through a contract with the Local Sector Administration, to submit three monthly reports summarizing their Community Health Worker Monthly Reports to the Health Center. These three monthly reports should reflect the three months of the preceding quarter. These three reports should be along the format in Annex 2. These reports should be submitted, latest, by the 10th day of the first month following the end of the quarter, to the Health Center Management. The Health Center will issue a 'proof of reception' (« accusé de réception ») attesting that it received these reports. The Health Center is responsible to pass on these reports to the district, by way of the Hospital Supervisor. The Hospital Supervisor is responsible to pass on these reports to the one responsible to enter data in the PBF database (PBF BDD) at the district level.

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Article 11: Data transfer from the district to the sector (after the meeting)

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These quarterly reports are returned to the Health Center Management. The Health Center Management Issues a ‘proof of reception’ after receiving this quarterly report. The responsibility of bringing these reports to the health center lies with the Hospital Director (through his Hospital Supervisory Team).

Article 12: Per Diems and Other Expenses of the Sector PBF Steering Committee

The Local Sector Administration will pay, based on government rules, eventual per diems and other expenses related to eventual counter verification exercises. The Local Sector Administration receives a specific ‘Community PBF Budget’ out of which it can pay these items.

Part B:

Articles related to the CHW Cooperative (CASC)

Article 13: Members of the CHW Cooperative

Members of the cooperative are all community health workers operating within the catchment area of the health centre. Currently, health workers consist of the “binome” (1 female and 1 male) per village and 1 maternal health animator per village (the former Traditional Birth Attendant).

Article 14: The Community Health Worker’s Cooperative

The Community Health Worker Cooperative (« Cooperation des Agents de Sante Communautaire (CASC) ») consists of Community Health Workers in the catchment area of the Health Center. The Ministry of Health assumes that only CHWs as defined above will form part of this CASC.

Article 15: Nature of the Performance Measure

The CHWs’ Cooperative shall report on 22 contracted Community health indicators. These indicators are the same as those from the Community Health Management Information System.

Using the national monthly reporting format for the Community PBF indicators, the cooperative under its leadership shall fill out the report format monthly and submit it to the health centre. The CASC monthly report uses the same monthly reporting format as the village monthly Community Health report; however, it consists of a compilation of all information from all CHWs in its catchment area. A copy of the report shall be properly filed in the cooperative’s archive. Also, the village monthly CHW reports are filed in the cooperative’s archive. Monthly compiled reports shall be submitted to the health centre not later than the 10th day of the month following the month for which the report shall be made.

The originals of the monthly cell reports shall also be submitted to the health center each month, together with the monthly compiled report.

Article 16: Determining Level of Performance

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The level of performance for each cooperative shall be determined based on three conditions; first, timeliness in submitting the monthly CASC reports, second, completeness of the monthly CASC report, and third, accuracy (internal logic) of the Monthly CASC report. The reports judged are the ones submitted to the health center. A proof of reception (« Accusé de réception ») of the monthly CASC report, issued by the Health Center, is mandatory. The performance level is determined in the quarterly Sector PBF Steering Committee meetings. The printed out quarterly Sector CHW report, is compared against the original monthly CASC reports.

If the performance is less than desirable, the following penalties will be applied:

	Item		Payment (Max)
1	Timeliness	If all three monthly reports submitted to the HC prior or on the 10 th of the month = 1 (40%), if one report is delayed = ½ (20%), if two or more reports delayed = ¼ (10%)	40% of available budget
2	Completeness	If all three monthly reports, including its monthly cell reports submitted to the HC are complete = 1 (40%), if one report (including one or any of its cell reports) is incomplete or absent = ½ (20%), if two or more reports (including any of its cell reports) are incomplete or absent = ¼ (10%)	40% of available budget
3	Accuracy	If internal logic in all three monthly reports submitted to the HC are correct = 1 (20%), if one report is faulty = ½ (10%), if two or more reports are faulty = ¼ (5%)	20% of available budget
Total			100%

Article 17: Counter-verification of Reported Data

The Sector PBF Steering Committee retains the right to counter-verify reported data, and delay or withhold payment in case of doubt of the veracity of the information provided. A counter-verification needs to be carried out within 30 days after the Sector PBF Steering

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Committee Meeting which decided on such a counter-verification. A new Sector PBF Steering Committee Meeting will have to be called to review the evidence provided by the counter-verification within 15 days of the end of the counter-verification.

Article 18: Payment for Performance of the CASC

Payment for Performance occurs once per quarter, after determining satisfactory performance according to article 15. Payment will be transferred into the CASC bank account, and the CASC will have to provide a proof of payment to the Health Center for the funds received, detailing the amount received. Amounts transferred may depend on the amounts available centrally from combined basket funds (GOR; GF; WB etc).

Article 19: Payment of the CHWs

The community PBF is **not** for individual performance remuneration. The purpose of the incentive is for community health workers to increase the capital of their cooperatives. The cooperatives on their turn will then start income generating activities to the benefit of the individual members. The remuneration of individual community health workers will be from the profit of the cooperative activities.

Article 20: Feedback meetings between the Health Center and the CASC

The health centre shall organize, at least, quarterly meetings with cooperative members to discuss results of the reported indicators. Members of the Sector PBF Steering Committee shall be invited to participate in the meetings.

Article 21: Unsatisfactory Performance by the CASC

In case of unsatisfactory performance by the CASC related to its primary task of collecting reliable and timely information from its members, the Sector PBF Steering Committee retains the right to end this contract.

Signatories to this contract:

Date:

Health Center Head (Health centre in-charge)

Management of the CHW Cooperative

Annex 1: The monthly report form

Annex 2: Community PBF indicators

Annex 3: Quarterly Community PBF printout form

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Annex 3: Agenda Template and Time Limits of Agenda Items

Agenda

Agenda ITEM	Time allocated
a. Opening	5 min
b. Approval of previous meeting minutes.	15 min
c. Follow up on action points decided during previous meeting.	15 min
d. CASC(s) presents report on the past quarter's CHW activities	15 min
e. Quarterly Sector Consolidated CHW Report presented and discussed; compared with actual physical monthly provisory invoices, and amended eventually. Keep note of discrepancies for later amendment.	60 min
f. Discuss indicator trends	30 min
g. Discuss activities for next quarter	30 min
h. Recap activities/decisions.	5 min
i. Closure and tentative date of next meeting.	5 min

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Annex 4: Template and Format for Minutes of steering committee Meeting

Template and Format

- Minutes should be in Microsoft Word. In case there is no computer available, minutes can be recorded in a special Meeting Register
- In case of the use of a computer: filename should follow the convention: [yrmonthdate_DistrictName_SectorName_HCname] for instance, 090430_Gicumbi_Bwisige_Bwisige.doc

**Sector PBF Steering Committee [District Name-Sector Name-Health
Center(s) Name-Times New Roman font 14 Bold Centralized]
070517 [Date –Times New Roman font 12 Bold]**

Meeting start and end time [Times New Roman font 12]

Chair: [name]

Secretary: [name]

Timekeeper: [name]

List of Participants [Times New Roman font 12]

No	Name	Institution	email	mobile
1	A			
2	B			
etc				

Agenda

Agenda ITEM	Time allocated
a. Opening	5 min
b. Approval of previous meeting minutes.	15 min
c. Follow up on action points decided during previous meeting.	15 min
d. CASC(s) presents report on the past quarter's CHW activities	15 min
e. Quarterly Sector Consolidated CHW Report presented and discussed; compared with actual physical monthly provisory invoices, and amended eventually. Keep note of discrepancies for later amendment.	60 min
f. Discuss indicator trends	30 min
g. Discuss activities for next quarter	30 min

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h. Recap activities/decisions.	5 min
i. Closure and tentative date of next meeting.	5 min

- (a) [report]
- (b) [report]
- (c) [etc]

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Annex 5: Template for the Quarterly Consolidated Health Center PBF Report



District: [Name]

Health Center: [Name]

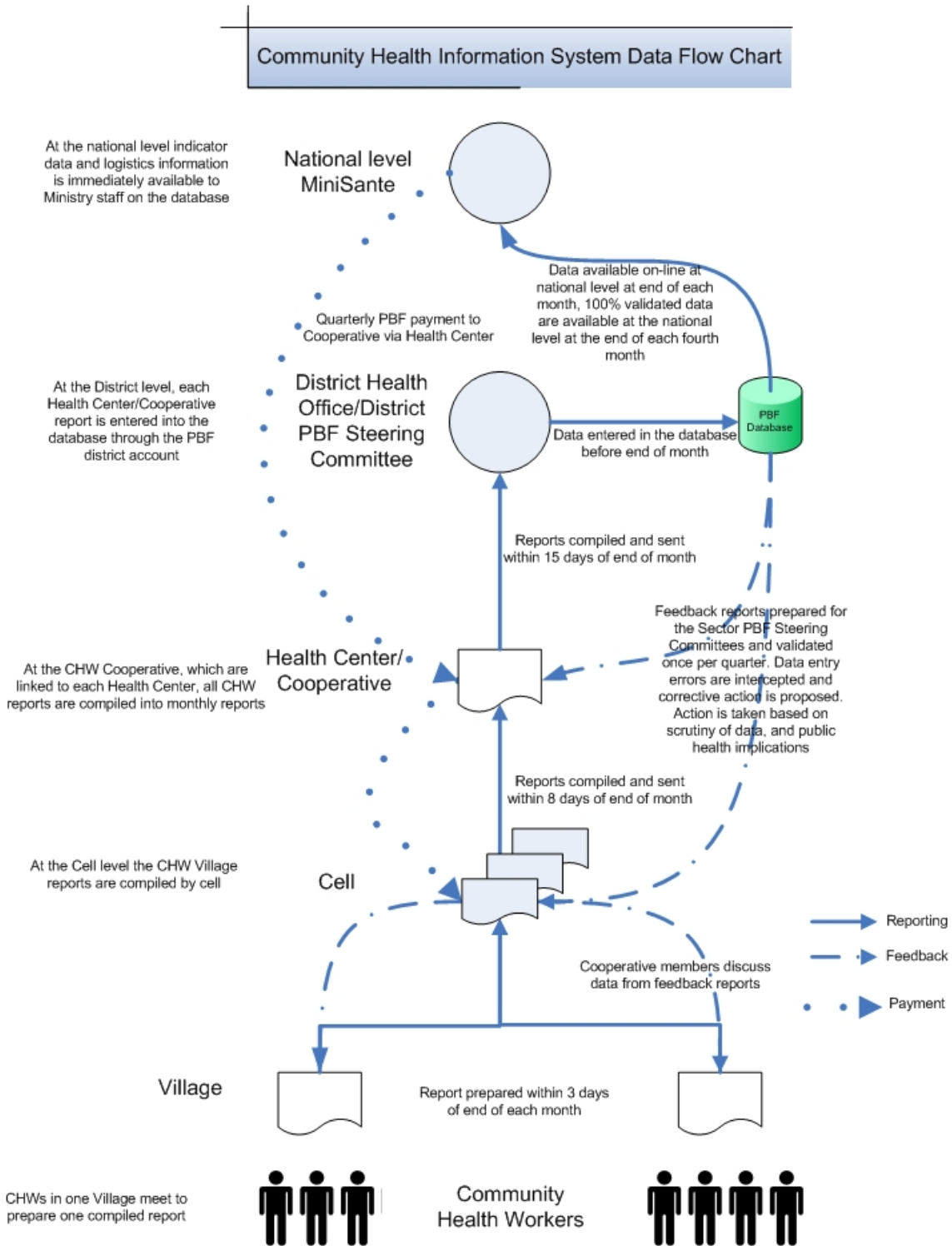
Report on Community Health Activities of HC [Name]

Health Facility [Name]	Quarter/year			
------------------------	--------------	--	--	--

Indicator	Jan	Feb	March	Total
<i>Child Health/IMCI</i>				
1. Number of children < 5 years screened for nutritional status				
2. Number of malnourished children (in yellow or red zone during screening) who were treated or referred				
3. etc				

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Annex 6: Community Health Information System Data Flow Chart



Community Performance-Based Financing Guide

Annex 7: Procedures Manual for Rwanda Community Health Information System



Procedures Manual for the Rwanda Community Health Information System (SISCom)

Section I: Data Recording & Reporting

Version 1.1
December 2008

Acknowledgements

This document was developed by the M&E Task Force and Community Health Desk of the Rwanda Ministry of Health with Technical Assistance from Management Sciences for Health (under PEPFAR funding: CONTRACT NO. GHS- I-00-03-00030-00 Task Order No. GHS- I-02-03-00030-00). The data collection formats were adapted from models used by a variety of implementation partners, including: Twubukane, ICAP and Partners in Health during a workshop organized at Bambino Conference center on December 2nd and 3rd.

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Introduction

Background

The Rwanda Community Health Information System (SISCom) has been developed to support the national community health worker program. This cadre of volunteer health workers is estimated to be around 30,000 in nearly every village in the country and is expected to double within the next few years.

A variety of pilot projects were undertaken by partner agencies since – some training staff in very specific tasks to support vertical programs. Over time the roles of these community health agents (ASC) has evolved and the following are their key responsibilities (according to the INTRAH Health Information Systems Assessment of 2006).

- Conscientizing the population on the benefits of health mutuelle membership, family planning, hygiene, prevention of HIV/AIDS and malaria;
- Supplying bednets, contraceptives and ORS/zinc to prevent dehydration in children with diarrhea ;
- Distributing anti-malarials, antipyretics, and other medicines to treat respiratory infections and diarrhea;
- Conscientizing pregnant women to attend ante-natal consultations (ANC), to deliver in health facilities and to have their children vaccinated;
- Track and report on vital events in the village, in particular births and maternal and child deaths

Given the enormous scale of the ASC program, it is crucial to have good data to support program monitoring & evaluation as well as the logistical challenge of keeping the agents supplied with contraceptives, bednets, and other basic medicines.

According to the INTRAHealth evaluation report ACSs will be responsible for performing the following data collection activities:

- Registering families (filling out the « *fiche de famille* » at the household)
- Filling out registers of children 0–5 years and women 15–49 years
- Updating registers during visits to household (vital events, last vaccinations etc.)
- Filling out the monthly “*fiche de compilation*” for the cell monthly during cell committee meetings
- Creating graphs/charts to provide analysis and feedback for informing Communities

Several partners, notably INTRAHealth’s Twubakane project and Partners in Health, have pioneered the development of some community-based recording and reporting tools.

When the MOH decided to add a performance-based financing (PBF) component to the program in 2008, the SISCom indicators were reviewed and a minimum set of indicators was selected. In light of this reduced set of indicators and observations that the existing tools were too complex and

expensive to reproduce for nearly 60,000 ASCs, a workshop was held in October 2008 to generate consensus on a revised set of SISCom tools.

This procedures manual has been produced to document the SISCom system by the M&E task force and the Community Health Desk, with support from partner organizations including INTRAHealth, ICAP/CU, MSH, Partners in Health

Purpose of this Manual

This manual is primarily intended for use by MOH staff in the training, orientation of Health Workers at all levels who are involved in supporting the community health worker program, and as a stand-alone reference. The document provides an overview of the System d'Information Sanitaire Communautaire (SISCom), describes the procedures to be used for data collection, processing, use as well as feedback mechanisms. The manual also includes samples of each of the principal recording and reporting formats, describes the priority indicators selected and provides detailed instructions for their completion and use. Given the dynamic nature of effective information systems it is important that this reference document be updated as and when information systems procedures change.

Organisation of this Manual

This manual is organised in two sections. The first section provides an overview of the system, defines the principal indicators that are collected by the system, and describes general data management procedures. Section two describes in detail each of the formats, which are used for data recording, planning, reporting and analysis purposes, including feedback.

Table of HMIS Formats

This manual considers three main types of formats:

Recording formats: These are forms, cards and registers that are maintained on a day to day basis at the village level by the community health workers to collect data about individual patients and ASC activities. These documents are usually not transmitted from one level to another.

Tally sheets: These are special forms that are used to simplify data aggregation and reduce errors.

Reporting formats: A range of documents that are prepared to transmit information between levels (eg. ACS to FOSA) on a periodic basis. In addition, these include feedback reports that are used to communicate information systematically from higher levels to the ASC's and their supervisors.

Below are the main recording and reporting formats envisioned as part of SISCom, some of which remain to be developed once there is a clearer understanding of ASC responsibilities to support HIV/AIDS and other community level interventions (these are highlighted in **bold**).

RECORDING FORMATS¹		
	Maintained by Family/Client	ID.
1	Maternal Card/Child immunization/Nutrition card	CC-1
2	Family planning card	CC-2
3	Vaccination card	CC-3
	Maintained by ASCs	
4	Maternal Health Register/IMCI Register	CR-1a & 1b
5	Child Vaccination/Nutrition register	CR-2
6	TB Treatment form (for patients who are being monitored by ASCs)	CF-1
7	Household Form	CF-2
8	IMCI Form (Prise en charge d'enfant malade)	CF-3
	District Hospital level only	
9	Report reception/transmission register	CR-2

REPORTING FORMATS		
	CHW level	ID
1	Monthly Report of CHW activities (Same format for Village, Cell and FOSA/Cooperative levels)	CMR-1
2	Referral/counter-referral form	CIR-1
3	Annual Household Survey Summary Sheet	CAR-1
4	Quarterly Consolidated Community PBF report	CQR-1

TALLY SHEETS		
	BHU & Hospital	ID
4	Annual Household Survey Village Summary Tally Sheet	CT-1

¹ Formats listed in **Bold** are not yet developed or still need to be standardized.

Overview of the Health Management Information System

Rwanda's Community Health Information System (SISCom) has been designed in order to:

- Provide data for individual case management (patient or client forms, records and registers)
- Help community health workers better manage their services
- Ensure an adequate supply of essential drugs and supplies required by ASCs.
- Help health workers in their efforts to organise and monitor development work in their communities
- Provide data to FOSA level supervisors for supervision and other supportive action
- Provide data to district, national program staff, and donors for planning, monitoring and evaluation

The content and key processes of the SISCom are described in the following sections.

The Content

It is important to appreciate the fact that numbers, ratios and percentages are not the only components of an information system. Statistical indicators are not the end measure but actually trigger further questions. Experiences and perceptions of the community, patients, and health workers at all levels are equally important indicators of health service performance. Well-designed information systems will collect many types of data both qualitative and quantitative and ensure its review

The HMIS contains the following components:

1. Records, cards, registers and tickler file systems for the management of individual patients and clients
2. Immediate reports to communicate information about particular events, such as cases of notifiable disease that require immediate action, or take place on an ad hoc basis, such as training courses.
3. Periodic Reports (Monthly, Quarterly, Semi-Annual, Annual) to transmit data between levels.
4. Results of periodic surveys (eg. Household Survey, National Health Survey), record reviews and evaluations conducted by MOHE staff and its partners
5. Qualitative information collected from communities, health workers and programme staff both through formal and informal channels.

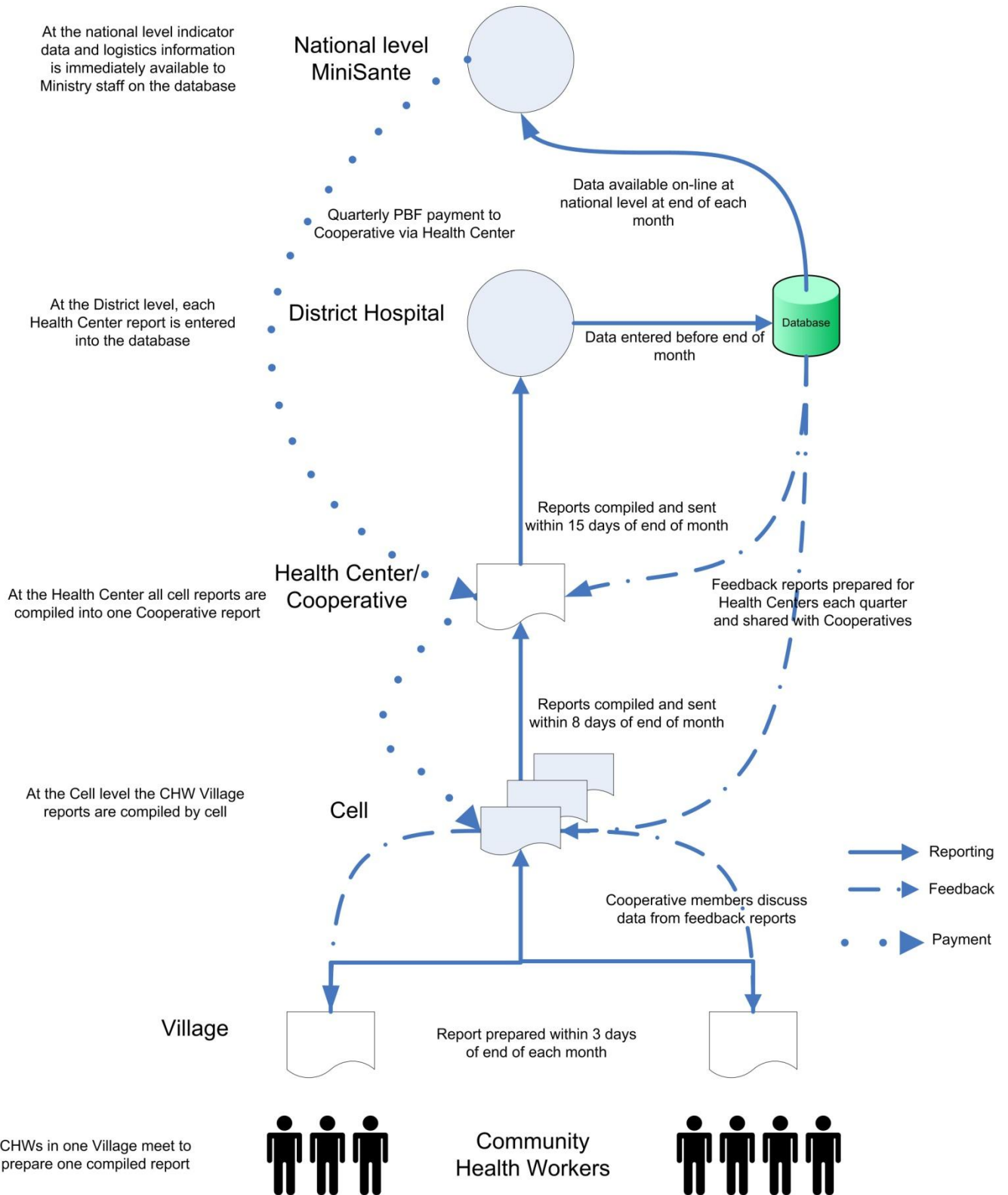
The Process

The SISCom should not be seen only as a mechanism for collecting information and passing it to successively higher levels. Information should be used at the level at which it is collected. The SISCom merges with the health facility SIS at the FOSA level and involves the following processes: collection of data, processing it to convert it into useful information, analysing and discussing it to assess the current status of services and using it to set appropriate strategies and targets.

The flow chart on the next page illustrates the flow of information between different organisational units at different levels of the hierarchy. The broken arrow line depicts the mechanisms for feedback. Feedback must occur at all levels, including from community health workers to their own communities. The feedback is provided not only through structured reports, but also through periodic meetings, reviews and supervision. The dotted lines represent the flow of PBF funds from the national level to the community health worker cooperatives – via the FOSAs.

The SISCom requires the following mechanisms for information analysis, reporting, feedback and sharing information within and outside the health sector.

Community Health Information System Data Flow Chart



Flow of Information

1. CHWs collect data on population, vital events, sanitation, immunisation and family planning service coverage on an annual basis. This data is aggregated at the village level using the Household Survey Tally sheet to provide population denominator data and measure other health program performance. This data is reported to the DHSO using the Village Level Household Survey Summary Form every year by 15th of March.
2. Community Health workers (ASC) provide services to the community during household visits and when they assist Nurses providing vaccinations and pre-natal services through Outreach Clinics within the FOSA's target zone. These encounters are recorded in registers (Maternal, Vaccination/Nutrition, IMCI register) and on cards maintained by the client/patient. Separate registers are maintained by each ASC.
3. If cases when unusual diseases are discovered in the community, the ACS must notify the FOSA that supports them and assist in the FOSA-led effort to investigate each case to identify any other possible cases and take action to manage the existing cases and prevent the further spread of the disease.
4. At the end of each month, the ASCs who work together in the same village, meet to consolidate data from their individual registers and fill out a village level ASC Monthly report form.
5. This information is transferred to the cell level by the 3rd day of the month, where the ACS monthly reports from each village are compiled into a cell level report and sent to the FOSA responsible for health services in that cell by the 8th day of the month.
6. The ACS supervisor at the FOSA compiles all of the Cell level reports together and sends a FOSA level monthly report form to the District Hospital by the 15th day of the month.
7. At the District level, the DHSO, DMO and (if available) the Statistical Officer, review the reports submitted from each health facility. They also maintain a report submission register to monitor the completeness, timely arrival and dispatch of reports. If reports are missing after the due date, they contact the health facilities concerned to remind them that reports are due. If there are errors in the reports, they also follow up with the ASC supervisors at the health facilities who in turn follow up with the cells and individual ASCs.
8. Before the end of each month the Data manager at the District Hospital enters each FOSA-level consolidated monthly report form into their computers where it joins the regular electronic data submission process of the GESIS.
9. At least twice a year, the District Level Data Manager and Supervisor analyse the performance of all ACS cooperatives and prepare written feedback reports that are sent to each health facility. *(Note: Once the computer system is in place, most of the content for these feedback reports can be produced automatically).* Before each supervisory tour, the district supervisor and FOSA-level ACS supervisors should also review data from the SISCom to help determine the performance of the cells and individual agents scheduled to be visited. This information should be discussed with staff during the visits.
10. In each district, all FOSA incharges and ASC supervisors should meet once a year for an Annual District Health planning meeting.² During this meeting, health workers should analyse their data, interpret key trends, plan priority activities and set targets for the following year. District-level staff

² Budgetary provisions should be made to cover the cost of this meeting each year.

from other sectors (e.g. Rural Water Supply & Sanitation, Education) should also participate in this meeting.

11. The National SIS Unit, merges the data from all districts and maintains a national database of health statistics. This database is used to prepare the Annual Health Bulletin and to respond to ad hoc requests for information from health programme staff, other Ministry of Health Departments and donors. Staff within the Health Department use this data to monitor disease trends and for planning purposes. Analysis of all data from the previous year must be ready by the 1st of May, so that key trends can be presented and discussed at the Annual Health Conference.

Indicators and Data Elements Selected for the HMIS

The following pages describe the indicators that will be used by health workers and Ministry of Health staff at all levels to monitor and evaluate health status, health services and critical resources related to priority health problems. In addition, a set of administrative indicators have been selected to support functions and activities managed by district and national level staff.

These indicators are designed to monitor activities at the following levels:

- ◆ The community (beneficiaries of health services, and the activities of the ASCs)
- ◆ Case management (patients whose care is being delegated to the ACS as well as clients for family planning and other preventive and health promotional services)
- ◆ Logistics management (distribution and numbers of ACSs and status of drugs & supplies)

The following table lists the core indicators selected. Aside from the indicators, additional data are also reported to help monitor the over stock situation for the small range of essential drugs and commodities that are distributed by the ASCs.

Proposed Community Health Worker Priority Indicators

	Indicator	Definition	Primary data source
Child Health/IMCI			
1.	Number of children < 5 years screened for nutritional status	Number of children <5 years screened for nutritional status using MUAC or baby scale during the past month.	Child Vaccination/Nutrition register
2.	Number of malnourished children (in yellow or red zone during screening) who were treated or referred	Number of children screened for nutrition status during the last month whose MUAC scores or weights for age were in the yellow or red zones.	Child Vaccination/Nutrition register
3.	Vaccination defaulters: Number of children between 9 and 12 months whose vaccination status is not up to date.	Number of children aged between 9 and 12 months who had not yet been completely immunized during the past month.	Child Vaccination/Nutrition register
4.	Number of children 2-59 months treated for Pneumonia	Number of children aged 2 to 59 months, with a suspicion of Pneumonia, treated according to protocol, during the past month.	IMCI Register
5.	Number of children 2-59 months treated for diarrhea	Number of children aged 2 to 59 months with diarrhea treated with ORS and Zinc during the past month.	IMCI Register
6.	Number of children 2-59 months with fever treated within 24 hours of the onset of fever	Number of children aged 2 to 59 months with fever who were treated by the CHW with an anti-malarial drug within 24 hours of the onset of their fever.	IMCI Register
7.	Number of children 2-59 months with fever treated more than 24 hours after the onset of fever.	Number of children aged 2 to 59 months with fever who were treated by the CHW with an anti-malarial drug more than 24 hours after the onset of fever	IMCI Register
Maternal Health			
8.	New: Number of home deliveries recorded by CHW.	Number of home deliveries recorded in the CHW's maternal health register by type.	Maternal Health Register
9.	Number of women and child pairs who delivered at home and were referred to the Health Center	Number of women and child-pairs who delivered at home and were referred to the Health Center <7 days after delivery, during the past month. This is a transitional indicator, once FOSA deliveries increase beyond 90%, the numbers should be quite small and it may no longer be relevant.	Maternal Health Register
10.	Number of women accompanied for delivery at the Health Center	Number of women who have been accompanied to deliver in a health center during the past month.	Maternal Health Register
11.	Number of pregnant women accompanied to FOSA due to specific risk factors.	Number of pregnant women accompanied to FOSA due to specific risk factors (including miscarriage, spotting,)	Maternal Health Register
12.	Number of New Family Planning users sent to the Health Center	Number of new Family Planning Clients who reached the Health Center during the past month. New client defined as using any FP method for the first time (modern or cycle beads)	Maternal Health Register
13.	Number FP methods distributed during the past month by type (condom, pills, injectables, cycle beads)	Number of FP methods distributed during the past month by type (condom, pills, injectables, cycle beads). Used to calculate the CYP at FOSA and national level, and for stock management purposes.	Maternal Health Register
14.	Number of couples accompanied to the Health Center for PMTCT	Number of couples accompanied to the Health Center for PMTCT	Maternal Health Register

	Indicator	Definition	Primary data source
		Due to high ANC attendance frequently the same as no 15.	
15.	Number of women accompanied to the Health Center for ANC within first 4 months of pregnancy.	Number of women accompanied to the Health Center for ANC within first 4 months of pregnancy.	Maternal Health Register
Surveillance/IEC			
16.	Number of IEC sessions	Number of Information, Education and Communication sessions with large groups (mass) with preparation that were held in the community by either the CHW and/or the local leader, during the past month. Comments: for instance add type of 'mass meeting' e.g. Umuganda, district campaigns, Umudugudu meeting'	Minutes of Umudugugu meetings or CHW agenda/calendar
17.	Number of suspected cases of TB referred to the health center	Number of suspected cases of TB referred to the Health Center by the CHW during the past month. Comment: add to definition something like 'A suspect case is somebody who has been coughing for over three weeks.'	Referral – Counter-referral forms
18.	Number of suspected cases of polio (AFP) or measles referred to the Health Center	Number of suspected cases of polio (acute flaccid paralysis) or measles referred to the Health Center during the past month.	Referral – Counter-referral forms
19.	Number of child deaths < 5 years declared in the community	All child deaths < 5 years declared in the community during the past month.	IMCI Register – Children who died without seeking CHW care will be entered as a new line on this register with only the identification, age and death columns filled in.
20.	Number of maternal deaths (related to pregnancy or delivery) in the community	Number of maternal deaths >2 months after conception to one month after delivery declared in the community during the past month.	Maternal Health Register – Women who died without seeking CHW ANC care will be entered as a new line on this register with only the identification, age and maternal death columns filled in.
21.	Number of new TB cases followed in the community	All new TB cases who started their treatment in the community during the past month	CHW TB register
22.	Number of households referred to the health center for voluntary HIV/AIDS counseling and testing (VCT)	All households to which the CHW has provided a Referral –counter-referral form to go to the health center for VCT testing	Referral – Counter-referral forms

SECTION B

Maternal Health Register (CR-1a)

Purpose of the Format

This recording format has been designed to assist health workers record visits with women of child-bearing age to monitor the status of their pregnancies and to provide family planning services. Since the community health workers do not maintain individual patient record cards, this format also helps staff maintain a history of visits and treatment prescribed for individual case management.

Presentation of the Format

The format is a large table, with each row designed to store information about a single visit – either by the CHW to a woman’s home or when a woman visits the CHW. The column headings include patient identification, pregnancy related events and services, maternal or infant deaths, childbirth, and family planning. The register is pre-printed as part of a combined Maternal and IMCI register for children so that the community health worker does not need to carry around as many registers and formats. Many of the columns are completed by simply entering a check mark , or tick, in the corresponding cell if a condition is present or true.

Data Sources

The data for this report come from the community health worker’s consultations during visits with women and their caretakers.

Preparation and Submission

This form is maintained at by each community health worker on a continuous basis. Notes should be taken during the course of patient visits, so that key observations are not forgotten. This format is not transmitted, but it is used to tally data for monthly reports.

Definition of Terms & Indicators

1. **Maternal death:** A maternal death is a woman who dies from pregnancy-related causes (from >2 months after conception to one month after delivery). CHWs should only declare deaths that took place within the community. Maternal deaths in Hospitals or FOSA will be reported by that level.
2. **Infant death or still-birth:** An infant death is any pregnancy outcome that results in the death of the child (either still born or death within 10 days due to complications of childbirth or foetal distress). CHWs should only declare deaths that took place within the community. Infant deaths in Hospitals or FOSA will be reported by that level.
3. **New FP user referred:** A new family planning user is someone – male or female who accepts a family planning method for the first time in their life. CHWs must refer individuals to the FOSA for initial counselling and prescription of a family planning method after which they are re-supplied by the CHW in the village.

Detailed Instructions for Completing Format

During each consultation

1. **Date:** Enter the date of the encounter with the patient, client
2. **Name:** Write the full name of the patient.
3. **National ID No:** Write the national ID number or other unique identifier for the patient
4. **Date of Birth:** Note the birth date of the woman.

Pregnancy:

5. **Women accompanied to the FOSA for CPN <=4 months after onset of pregnancy:** Place a check in this cell if the CHW accompanied a pregnant woman to the FOSA for her first CPN visit before the 5th month of pregnancy..
6. **Women accompanied to the FOSA because of pregnancy-related risk:** Place a check in this cell if the CHW accompanied a pregnant woman to the FOSA due to an identified high risk condition.

Delivery/Childbirth:

7. **Date of delivery:** note the date of the delivery – whether it was in a FOSA or delivered at home.
8. **Delivery in the Hospital/Health Center:** Check this field if the woman delivered in a health facility.
9. **Accompanied to the maternity:** Check this field if the CHW accompanied the patient to the health center for the delivery at the health center.
10. **Delivery at home:** Check this field if the woman delivered at home.
11. **Mother and child referred to the FOSA:** Check this field if the mother and child were referred to the FOSA within 7 days of delivery

12. Maternal Death: Check this column if a woman died in the community due to complications of pregnancy or childbirth. Do not record deaths that happened in a health center or hospital.

13. & 14. Status of the child: Check the appropriate column that reflects that status of the child at delivery: Live birth or still-born/neonatal death.

Family planning:

15. New FP user: Check this column if the woman (or her spouse) became a new family planning user

16-19: Contraceptive methods distributed: In the remaining columns, enter the number of units of contraceptives (or cycle beads) distributed to the woman.

HIV:

20. Couples referred for PMTCT: Tick this column if you referred a couple to the FOSA for prevention of mother to child transmission of HIV services.

21. Households accompanied for VCT: Tick this column if you accompanied household members to a FOSA for voluntary counselling and testing for HIV/AIDS.

22. Other service or care: Note any other service provided by the CHW to the mother or child in this last column.

Child IMCI Register (CR-1b)

Purpose of the Format

This reporting format has been designed to assist health workers record data about sick children who have been consulted either in their homes or at the CHW's home. This register is in addition to the IMCI form that is completed for each sick child. Only limited information is included in the register in order to reduce duplication. The register is intended mainly to simplify the aggregation of data – which very difficult to do using the forms themselves.

Presentation of the Format

The format is a large table, with each row designed to store information about a single visit. The column headings include date, child identification, risk factors, treatment dispensed and remarks. The register is pre-printed, on the reverse side of the Maternal Health Register to limit the size and number of documents that the community health workers must carry with them in the community.

Data Sources

The data for this report comes from the health worker's consultation with sick children in the community.

Preparation and Submission

This form is maintained by the CHW on a continuous basis. Notes should be taken during the course of patient visits, so that key observations are not forgotten. This format is not transmitted, but it is used to tally data for monthly reports.

Definition of Terms & Indicators

Nutritional Surveillance up-to-date: Sick children whose nutritional status has been assessed by a health worker within the last month.

Vitamin A supplementation up-to-date: This refers to children who have received vitamin A supplement within the last 6 months. It is the national policy is for children to receive vitamin A supplements twice a year.

Vaccination Status Up-to-date: This column should be checked for children who have had all of the required immunizations for their age.

Detailed Instructions for Completing Format

During each visit with a sick child begin a new line in the register by entering the date, the name of the child and other identification data. This register captures selected data that is gathered on the IMCI form, so it can be completed at the end of the day from the copies of forms that the CHW collects.

During each consultation

1. Date: Write the date that the child was seen in format DD/MM/YYYY.

2. No.: At the beginning of each month, re-start numbering at 1. Then assign each child visited the next serial number. This is a quick way for the CHW to track how many children consulted each month.

3. Name and first names: Write the names of the child consulted with the family name first (e.g. KAGUBARE Marie)

4. Age: Write the age of the child on the date of the visit. If it is less than one year write the age in months, if it is 1 year or older, note the age in years (e.g. 10 m. or 3 y.)

5. Sex: Record the gender of the child as M for Male and F for Female.

6. Mother/Father: Record here the name of the child's mother or father – or whoever is the child's guardian.

Prevention Status: During each sick child visit, the CHW is supposed to verify the status of key preventive services that all children are supposed to receive and tick the check box if these services are up to date. This information should be available from the child's growth chart and vaccination card.

7. Nutrition Surveillance up to date: Place a tick in the box if the child has been weighed within the last month.

8. Vitamin A up to date: Check this box if the child has received Vitamin A supplementation within the past 2 years.

9. Vaccinations up to date: Check this box if the child has received all of the vaccinations required for his or her age group. The vaccination schedule is below:

Danger signs: Tick off the boxes in these columns if any of these danger signs exist:

10. Fever seen by CHW less than 24 hours after onset: Check this box if the child presents a fever that the CHW saw within the first 24 hours after onset.

11. Fever seen more than 24 hours after onset: Check this box if the child presents a fever that began more than 24 hours before the CHW visit.

12. Diarrhea: Check this box if the child presents signs of diarrhea (defined as ??????)

13. Cough or Cold: Tick this box if the child presents symptoms of a cough or cold.

14. Mother/Father: Tick this box if the child presents symptoms of pneumonia (defined as ??????)

15. Nutritional Status: The CHW should assess the nutritional status using the MUAC (middle-upper arm circumference) or weight for age (using the child's growth chart) and enter the initial for the color of the zone in which the child falls: R= red, J=yellow, V=Green.

Treatment provided: The columns in this section are designed to capture information about both the type of treatment provided to the child and the quantity of medicines distributed. In each case write the number of units of the products provided to the child.

16. Coartem: Write the number of tablets of coartem provided to the child.

17. Zinc: Write the number of zinc tablets provided to the child

18. ORS: Write the number of ORS tablets provided to the child

19. Amoxycycline: Write the number and initial of the color of the pre-packed amoxyciline packets provided to the child, for example “1 J” = 1 yellow packet.

20. Mebendazole: Write the number of mebendazole tablets given to the child.

21. Vitamin A: Write the numbr of Vitamin A tablets provided to the child.

22. Other: Write the name and quantity of any other items provided to the child or guardian for prevention or treatment related to this visit. For example if a bednet is provide to the family write “bednet 1”, or if 2 bottles of water purification solution are provided write “SurEau 2”

Evolution: Health workers are supposed to actively monitor the status of the sick children they have seen. In these columns please tick the status of the child in relation to the specific episode of sickness seen registered on each line.

23. Referred: Check this box if the CHW referred the child for care at the FOSA.

24. Counter-References: Check this box if the CHW received a counter-referral note from the FOSA after having referred the child for care.

25. Cured: Check this box if the child has fully recovered from this episode of illness.

26. Died: Check this box if the child died shortly after being cared for by the CHW.

At the end of each month

At the end of each month draw a line under the last child seen and leave a space in which you can record totals for the ticked columns as well as the number of units of each product distributed. This information can then be transferred to the Village level monthly report. See the example in the text box at the right:

Dépistage malnutrition à jour	Vit A à jour	Vaccination à jour	Fièvre		Diarrhée	Toux ou Rhume	Pneumonie
			Vu avant 24 h	Vu après 24 h			
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	9	4	3	2	2	1	3

Child Vaccination/Nutrition register (CR-2)

Purpose of the Format

This reporting format has been designed to assist community health workers track preventive and nutrition services provided to children under 1. The format is designed to be used together with the child's growth chart that is kept by the family on which more detailed information about the child's nutritional and preventive care history is maintained. The document is primarily used to help the CHW tally information about how many children have been seen during a given month and what their nutritional and vaccination status is.

Presentation of the Format

The format is a large table, with each row designed to store information about a single child. The column headings include patient identification, health problem diagnosis, disease coding, treatment prescribed and referral status. The register can be either pre-printed, or the columns can be traced on a standard register book by health workers themselves.

Data Sources

The data for this report come from Growth charts and immunization cards that are kept by the families.

Preparation and Submission

This register is currently maintained by each CHW. Records should be entered at the time the CHW visits the children. This format is not transmitted, but is used to tally data for monthly reports.

Definition of Terms & Indicators

Nutritional Status: CHWs are all provided with basic tools for assessing nutritional status. In most cases this is the middle-upper arm circumference (MUAC) measurement band. Nutrition status is determined as follows:

<i>Level of under nutrition</i>	<i>MUAC (mm)</i>
Normal Status - Green	≥ 185
Moderate – Yellow	< 185
Severe - Red	< 160

Immunization Schedule: CHWs should record information from the child's immunization chart that corresponds to the immunization schedule below. Typically CHWs assist with immunizations provided by the health workers.

Detailed Instructions for Completing Format

During each visit with a child

- 1. Date:** Write the current date
- 2. No. d'ordre:** Assign each child a registration number that consists of the current year and a serial number as follows: 2009/1, 2009/2, etc... This number should also be written on the child's immunization and growth charts so that it is easy to find them in the register during future visits.
- 3. Name of Child:** Enter the family name and first name of the child.
- 4. Mother/Father:** Write the name of the Mother and or Father (or guardian if the child is an orphan)
- 5. Village:** Write the name of the village and other details that will enable the CHW to find the child again easily.
- 6. Date of Birth:** Note the child's date of birth in the format DD/MM/YYYY. This is necessary, since the child's record must be revisited many times during the first 5 years and the age changes.
- 7-11. Vaccinations:** Enter the month and year that the various vaccines were given to the child according to the national vaccination schedule (e.g.11/2009). This should be transcribed from the child's vaccination certificate.
- 12. Remarks:** This column should be used to note any significant events that could explain gaps in immunizations or nutrition surveillance.
- 13. Nutrition Surveillance:** In this section, note the nutrition status of the child during each visit using the codes in the cell that corresponds with the month of the visit:
R= rouge (severe malnutrition)
J= jaune (moderate malnutrition)
V=verte (normal nutritional status)

If the first child registered is during the month of February, make sure to start with the column marked Feb.

At the top of each block of 12 months, enter the years beginning with the current year. As a new year begins, the health worker should skip a page and shift the year columns to the left so that columns are not wasted.

At the end of each month

The last 3 rows of each page have been left blank so to enter the totals for the nutrition surveillance visits. For the column that coincides with the month and year just completed, count the number of "R"s and write the number in the row labelled "R", then do the same for the "J" and "V" cells. After each page has been totalled, add up the numbers from each page from the column for the past month making sure to go back through all pages of the register to capture data on older children who were registered in previous years – and taking into account any shifts in columns that occur as you change from one year to the next.

IMCI Form (Prise en charge d'enfant malade) (F-6)

Purpose of the Format

The IMCI form is a form designed to assist the CHW with diagnosis and treatment of a sick child. This is the primary source of information that is used to complete the IMCI register. This is a multi-part form. After it has been completed the top copy is given to the child's parent or guardian and the second remains in the pad.

Presentation of the Format

The IMCI Form is distributed in a booklet of A4 size, 2-part, auto-copy forms. The form is divided in several sections, including: identification, nutrition, danger signs, treatment, explanations, prevention and outcome.

Data Sources

The data for the format is entered during the course of the CHW's visit with a sick child based upon questions posed to the child or parent/guardian and direct observation by the health worker.

Preparation and Submission

A new IMCI form is issued each time a sick child is seen by the CHW for a new health problem. The exception is when the CHW is conducting a follow-up visit to see a child diagnosed with a condition earlier. In that case, additional remarks are noted on the copy of the previously completed IMCI form that remains in the pad.

Definition of Terms & Indicators

MUAC: this is the measurement in centimetres of the child's middle-upper arm circumference.

Detailed Instructions for completing format:

Date: This is date that the sick child was seen by the CHW.

FOSA: Write the name of the health facility which supervises the CHW.

Village: Write the name of the village where the child lives.

ASC: Write the name of the CHW who is completing the form.

Patient Name, Parent, Birth date, Age, Gender, Duration of the illness: Gather this information while interviewing the patient.

Nutrition: After measuring the child's arm circumference or weighing the child record the measurements in the relevant cells and circle the child's nutrition status.

Danger signs: for each observation in the list, verify the presence of the danger sign and circle the "Y" if the condition exists or "O" if it doesn't.

Refer: If “Y” is circled for any of the danger signs, then the child must be referred to the health center. The health worker does not have adequate training and experience to handle such cases.

Symptoms/Treatment: Once a diagnosis has been determined, circle the “Yego” or “Oya” for each symptom identified as well as the treatment prescribed along with the number of tablets to be taken, the frequency per day and the number of days.

Other Signs or symptoms: Note any other health problems that the CHW observes.

Explication: The CHW should use this check-list to ensure that explanations are given to the parent for each topic: Explaining the sickness, explaining the treatment, explaining the 3 treatment rules and providing guidance in case the child’s condition gets worse.

Prevention: This part of the form is used to record details the prevention status of the child. Circle the “Y” or “O” depending based upon a review of the child’s growth chart and vaccination card.

Evolution of the illness: Circle “Y” or “O” if a follow-up visit was made to the household. Circle the final outcome of the case.



FICHE INDIVIDUELLE DE PRISE EN CHARGE DE L'ENFANT MALADE PAR L'ASC

Date: **FOSA:** **Village:**
Nom de l'enfant: **Parent:** **ASC :**
Date de naissance: **Age:** an(s) mois **Sexe:** F M **Durée de la maladie :** jours

NUTRITION

MUAC: cm ou **POIDS:** kg **Classification:** Verte Jaune Rouge

SIGNES DE DANGER (REFERER SI "YEGO")

Moins de 2 mois	<input type="checkbox"/> Y <input type="checkbox"/> O	Resp. difficile+Tirage ou sifflement	<input type="checkbox"/> Y <input type="checkbox"/> O
Statut nutritionnel rouge	<input type="checkbox"/> Y <input type="checkbox"/> O	Maladie de 14 jours ou plus	<input type="checkbox"/> Y <input type="checkbox"/> O
Œdème avec godet	<input type="checkbox"/> Y <input type="checkbox"/> O	Souvent malade	<input type="checkbox"/> Y <input type="checkbox"/> O
Incapable de boire, têter, manger	<input type="checkbox"/> Y <input type="checkbox"/> O	Prise de imiti sans amélioration	<input type="checkbox"/> Y <input type="checkbox"/> O
Vomit tout	<input type="checkbox"/> Y <input type="checkbox"/> O	Fièvre avec éruption	<input type="checkbox"/> Y <input type="checkbox"/> O
A convulsé / convulse	<input type="checkbox"/> Y <input type="checkbox"/> O	Déshydratation sévère	<input type="checkbox"/> Y <input type="checkbox"/> O
Inconscient	<input type="checkbox"/> Y <input type="checkbox"/> O	Sang dans les selles	<input type="checkbox"/> Y <input type="checkbox"/> O
Très affaiblie	<input type="checkbox"/> Y <input type="checkbox"/> O	Moins de 6 mois avec fièvre	<input type="checkbox"/> Y <input type="checkbox"/> O
Pâleur palmaire	<input type="checkbox"/> Y <input type="checkbox"/> O	Plus de 5 ans	<input type="checkbox"/> Y <input type="checkbox"/> O

REFERER Yego Oya

SYMPTOMES, TRAITEMENT & POSOLOGIE

<u>SYMPTOMES</u>		<u>TRAITEMENT</u>		<u>POSOLOGIE</u>		
				Cp/prise	Fois/jr	No. de jrs
Fièvre	<input type="checkbox"/> Yego <input type="checkbox"/> Oya	Coartem	<input type="text"/> Tuku <input type="text"/> Hondo	<input type="text"/>	<input type="text"/>	<input type="text"/>
Diarrhée	<input type="checkbox"/> Yego <input type="checkbox"/> Oya	Zinc	<input type="text"/> 5 cps <input type="text"/> 10 cps	<input type="text"/>	<input type="text"/>	<input type="text"/>
		ORS	<input type="text"/> Sachets			
Toux	<input type="checkbox"/> Yego <input type="checkbox"/> Oya	Miel/ jus de citron				
Pneumonie	<input type="checkbox"/> Yego <input type="checkbox"/> Oya	Amox	<input type="text"/> 2-4 mois <input type="text"/> 5 cps <input type="text"/> 13-30 mois <input type="text"/> 15 cps	<input type="text"/> 5-12 mois <input type="text"/> 10 cps	<input type="text"/>	<input type="text"/>
Malnutrition légère/Jaune	<input type="checkbox"/> Yego <input type="checkbox"/> Oya	Mebendazole (6 mois et +)	<input type="text"/> 6 cps	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Fer/Folat	<input type="text"/> 15 cps	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Conseils nutrition				

Autre(s) signe(s): _____

EXPLICATION à la mère ou au gardien de l'enfant

Explication de la maladie Y O Explication des 3 règles du traitement Y O
 Explication de la posologie Y O Conseils de revenir si aggravation Y O

PREVENTION

Vaccination à jour Y O Vitamine A à jour Y O
 Déparasitage à jour Y O Suivi de la croissance à jour Y O

EVOLUTION DE MALADIE

Visite de suivi à ménage Y O Evolution de maladie de l'enfant: Guéri Référé Décédé

Monthly Report of CHW activities (Same format for Village, Cell and FOSA/Cooperative levels) (CMR-1)

Purpose of the Format

The purpose of this format is report on the routine activities of community health workers at successive levels within the health system. In order simplify logistics and save costs, the same form is used for the original village-level report as well as for the consolidation reports at the cell and health sector levels. Data from the Cooperative level consolidated form is entered into the SIS database at the District level.

Presentation of the Format

The form is a single page form printed on 2-part, auto-copy paper. The top copy is submitted to the next level of the hierarchy while the 2nd remains in the archives at each level.

Data Sources

The data for the format comes from

1. IMCI Register
2. Maternal Register
3. Child Nutrition/Vaccination Register
4. Reference/Counter-Reference forms
5. Diary or minutes of meetings, IEC sessions, supervisions and other activities

Preparation and Submission

The CHWs meet at the beginning of each month within each village (Umudugudu), to consolidate the data from their registers and complete a single village-level report. This report is transmitted to the Cell, where it is cumulated with data from all villages within the cell onto a new, cell-level copy of the form. All cell level reports are then sent to the CHW cooperative base at the Health Sector (FOSA) level where the data are compiled again onto another identical form, but with aggregated data for the entire sector catchment area. This sector level report is transmitted to the District Hospital where it is entered into the database.

Definition of Terms & Indicators

MUAC: Middle-upper arm circumference

Level of Compilation: This is the level of the health system at which the data on a given form is aggregated. For the SISCom, the 3 levels are Village, Cell or Cooperative.

PMTCT: Prevention of Mother to Child Transmission of HIV/AIDS

VCT: Voluntary counselling and testing for HIV/AIDS

Detailed Instructions for Completing Format

Identification

Level of compilation: Check the appropriate box that represents the level at which the data in the report is compiled: Village, Cell or Cooperative.

Name of village/cell/cooperative: Write the name of the village/cell or cooperative for which the report is being compiled.

District: write the name of the district within which the CHWs are working.

No. of CHWs: Write the number of CHWs currently active in the zone included in the report, whether or not they all contributed data to the report.

No. who reported: Write the number of CHWs who provided data for the current reporting period in the zone included in the report.

Name of Responsible person: Write the name of the person who is responsible for completing this report at the current level of compilation.

Year: Write the year for which the report is being prepared. Note that this year is not necessarily the same as the year you are preparing the report. For example, if you are preparing the report in January of 2009, write 2008 here because the report you are preparing is for year 2008.

Month: Write the month in letters of the reporting period (e.g. Feb, Mar, etc..)

Total target Population: Enter the total population of the catchment area for the current level of compilation. At the village level this is the total population of the village, at the cell level, this is the sum of the village populations; at the Cooperative level, this is the sum of the cell populations.

Number of children 0 to 5 years: This is typically calculated by multiplying the total population by the national average proportion of the population that is under 5 years (established at ????)

Number of women 15 to 49 years: This is typically calculated by multiplying the total population by the national average proportion of the population that represents women of child-bearing age 15-49 years (established at 25.43% during the 2002 census).

A. Case Management of sick children (From IMCI register)

1. Total number of sick children seen: This includes the total number of children seen by the CHWs during the month – whether it is at the CHW's home, the child's home or other location. This data should be obtained by counting the number of IMCI forms completed during the month – or by counting the number of visits in the IMCI register.

2. Number cases under 2 months of age referred: CHWs are not trained to provide care to sick children under 2 months of age, so they must be referred. This information should be obtained from the referral/counter-referral forms.

3. Number of counter-references received: Count the number of counter references received from the referral FOSA's during the month. Some of these referrals may have

been for patients referred during earlier months, but you should still count them during the month they are received. Counter-reference forms should be filed by date in a folder, so that they can be counted easily.

4. Number of cases of fever in children from 6 to 59 months treated within 24 hours: Count the number of ticked cells in column 10 of the IMCI register during the month.

5. Number of cases of fever in children from 6 to 59 months treated after 24 hours: Count the number of ticked cells in column 11 of the IMCI register during the month.

6. Number of cases of diarrhoea treated: Count the number of ticked cells in column 12 of the IMCI register during the month.

7. Number of cases of pneumonia treated: Count the number of ticked cells in column 14 of the IMCI register during the month.

B. Nutritional Status and Vaccinations (from Child Vaccination/Nutrition surveillance Register)

1. Number of children assessed in the Green zone: Count the number of cells marked with a “V” for the reporting month in columns 13 to 18.

2. Number of children assessed in the Yellow zone: Count the number of cells marked with a “J” for the reporting month in columns 13 to 18.

3. Number of children assessed in the Red zone: Count the number of cells marked with a “R” for the reporting month in columns 13 to 18.

4. Number of children 9 – 12 months of age who have not yet been completely vaccinated: First determine the range of birth dates that fall within the range of 9 to 12 months of age. For example if you are doing the report for December 2009, subtract 9 months for the lowest age (e.g. March 2008) and 12 months for the highest age Jan 2008. Then go through your entire register to find children born within that 3 month period and count the ones for whom any of the 5 vaccination cells is empty.

In the example to the right, 2 children are within the correct age range (highlighted in yellow) while the second one (DOB: 3/3/2008) is not yet completely vaccinated.

6	7	8	9	10	11
Date de naissance	Vaccinations				
	VAP-Z & BCG	Pentavalent & VAP			Rougeole
		I	II	III	
12/1/2008	√	√	√	√	√
5/8/2008	√				
3/3/2008	√	√	√		
3/12/2008	√				

C. Supervisions and Meetings/IEC

1. Number of supervisions received from the CHW coordinator: Review your agenda or visitor’s log book and count the number of times that the CHW coordinator visited the CHWs during the reporting month.

2. Number of supervisions received from the cell level: Review your agenda or visitor's log book and count the number of times that the supervisor's from the cell visited the CHWs during the reporting month.

3. Number of CHW meetings held at the CS: Review your agenda and count the number of meetings that were held for CHWs at the health center during the month.

4. Number IEC sessions held with large groups: Review your agenda and count the number of IEC sessions that were held during the month. Do not include one-on-one IEC sessions

D. Maternal Health (from Maternal Register)

1. Number of women accompanied to the CS for CPN before or during the 4th month of pregnancy: Count the number of ticks in column 5 of the Maternal Register for the reporting month.

2. Number of women accompanied to the CS for pregnancy-related risk factors: Count the number of ticks in column 6 of the Maternal Register for the reporting month.

3. Total number of births: Count the number entries in the date of birth column (7) that fall within the reporting month.

4. Number of women accompanied to the maternity for delivery: Count the number entries in column 9 of the Maternal Register for the reporting month.

5. Number of women who delivered at home: Count the number ticks in column 10 of the Maternal Register for the reporting month.

6. Women who delivered at home who were referred to the FOSA: Count the number ticks in column 11 of the Maternal Register for the reporting month.

7. Number of couples referred to the FOSA for PMTCT: Count the number ticks in column 20 of the Maternal Register for the reporting month.

8. Number of new Family Planning users referred: Count the number ticks in column 15 of the Maternal Register for the reporting month.

E. Deaths at home (from Maternal Register and IMCI register)

1. Number of maternal deaths: Count the number ticks in column 16 of the Maternal Register for the reporting month. This should only include women who died due to causes related to pregnancy or childbirth and should not include women who died at a FOSA.

2. Number of deaths of children <5 years old in the community: Count the number ticks in column 17 of the Maternal Register for the reporting month and add to it any deaths recorded in the IMCI register for the same period. Do not report on children who died in a health center or hospital.

F. Disease Surveillance and HIV (from Maternal Register, TB register and Referral/Counter-referral forms)

1. Number new suspected TB cases referred: Count the number of referral tickets that were completed for people suspected to have TB symptoms during the reporting month.

2. Number of TB cases monitored at home: Count the number of TB patients whose care you monitored at home during the reporting month.

3. Number new suspected cases of flaccid paralysis or measles referred: Count the number of referral tickets that were completed for people who have either flaccid paralysis (suspected polio) or measles symptoms.

4. Number households accompanied to the health center for VCT: Count the number of ticks in column 20 of the Maternal register for the reporting month.

G. Stock

In this section, complete the number of units of each stock item distributed during the reporting month as well as the number of units of each item that remained in your stock at the end of the month.

The “distributed” column should be calculated by adding up the quantities noted in the IMCI Register (columns 16-22) and Maternal Register (columns 16-19) for the reporting period. Note: for Coartem, be sure to count separately the red and yellow packets.

The “remaining” column should be calculated by doing a physical inventory of the remaining items at the end of the month.

If the CHW is provided with additional types of drugs or consumables they should be listed and accounted for in the blank spaces at the end of section G.



RAPPORT MENSUEL D'ACTIVITE DES AGENTS DE SANTE COMMUNAUTAIRE

Niveau de compilation	<input type="checkbox"/> Village <input type="checkbox"/> Cellule <input type="checkbox"/> Coopérative			Année	
Nom du Village/Cellule/Coopérative				Mois	
District				Population cible totale	
Nombre d'ASC total		Nombre qui ont rapporté		Nombre d'enfants de 0 à 5 ans	
Nom du Responsable				Nombre de femmes de 15 à 49 ans	

A. Prise en charge d'enfants malades		Nombre	Guéris	Décès	Référés	
1	Nombre total de cas de 0 à 5 ans reçus					
2	Nombre de cas de moins de 2 mois référés					
3	Nombre de contre-références reçues					
4	Nombre de cas de 6 mois à 59 mois avec fièvre traités avant 24h.					
5	Nombre de cas de 6 mois à 59 mois avec fièvre traités après 24h.					
6	Nombre de cas diarrhée traités					
7	Nombre de cas pneumonie traités					
B. Etat Nutritionnelle (Poids ou MUAC) et Vaccination		Nombre	Guéris	Décès	Référés	
1	Nombre d'enfants Verts (V)					
2	Nombre d'enfants Jaunes (J)					
3	Nombre d'enfants Rouges (R)					
4	Nombre d'enfants de 9 à 12 mois qui ne sont pas encore complètement vaccinés					
C. Supervisions reçues et Participation aux réunions/IEC		Nombre	G. Stock		Distribué	Reste
1	Nombre de supervisions reçues du Coordinateur des ASC		Pilules			
2	Nombre de supervisions reçues de la cellule		Condoms			
3	Nombre de réunions des ASC au Centre de Santé		Cycle beads			
4	Nombre de sessions d'IEC de masse		Contraceptif injectable			
D. Santé Maternelle		Nombre	Coartem (rouge)			
1	Nombre de femmes accompagnés au CS par l'ASC pour CPN <= 4 mois de grossesse.		Coartem (jaune)			
2	Nombre de femmes enceintes accompagnées au CS par l'ASC pour facteur de risque		Zinc			
3	Nombre total d'Accouchements ce mois		SRO			
4	Nombre accompagnées par l'ASC pour l'accouchement au CS		Amoxyciline			
5	Nombre d'accouchements à domicile		Mebendazole			
6	Femmes accouchés à domicile et référés au CS/Hôpital		SurEau			
7	Nombre de couples référés pour PMTCT		Vitamine A			
8	Planning Familiale: Nouveaux utilisateurs référés ce mois		Bednets			
E. Mortalité a domicile		Nombre				
1	Nombre de décès maternel (liés à la grossesse ou l'accouchement)					
2	Nombre de décès des enfants <5 ans dans la communauté					
F. Surveillance et VIH		Nombre				
1	Nombre de nouveau cas de tuberculose suspect référés					
2	Nombre de cas de tuberculose suivi à la maison					
3	Nombre de cas suspect de paralysie flasque/rougeole référés					
4	Nombre de ménages accompagnés au CS pour VCT					