REPUBLIC OF RWANDA

MINISTRY OF HEALTH
P. O. Box 84 Kigali
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Procedures Manual for the Rwanda Health Management Information System (HMIS)

Section: Data Recording & Reporting

DRAFT
Version 2.C

October 2013

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Acronyms

ARDS	: Acute Respiratory Distress Syndrome
ARV	: Anti Retro Viral (Treatment)
ASC	: Animator of Health Community
BCG	: Bacillus Calmette–Guérin
BMI	: Body Mass Index
CDT	: Centre of Treatment and Diagnosis
CE	: Single
CF	: Female Condom
CL	: Cycle beads
CM	: Male Condom
CO	: Co-habiting
CQ	: Control of Quality
CS	: Cesaerian Section
CT	: Traitment Center
DBS	: Dried Blood Spot
DI	: Divorced
DOTS	: Directly Observed Treatment Short course chemotherapy
EBF	: Exclusive Breast Feeding
EDD	: Expected Date of Delivery
GBV	: Gender-Based Violence
HAART-	: Highly Active Antiretroviral Therapy
HIV	: Human Immunodeficiency Virus
HMIS	: Health Management Information System
ICD	: International Classification of Disease
IMCI	: Integrated Management of Childhood Illnesses
INH	: Izoniazid, drug to treat pulmonary TB
LMIS	: Logistics Management Information System
LMP	: Last Menstrual Period
M&E	: Monitoring and Evaluation
MA	: Married
MoH	: Ministry of Health
MSH	: Management Sciences for Health
MUAC	: Mid Upper Arm Circonference
NCHS	: National Center for Health Statistics
Neg	: Negative
OL	: Obstructed Labour
PCR	: Polymerase Chain reaction
Pos	: Positive
PPH	: Post Partum Hemorrhage
PS	: Puerpueral Sepsis
PVV	: Persons living with HIV
RDS	: Respiratory Distress Syndrome
RF	: Replacement Feeding
RP	: Return after abandonnment
RUTF	: Ready-to-use Therapeutic Food
SE	: Separated
SOP	: Standard Operating Procedures
SVD	: Spontaneous Vaginal Delivery,
TB	: Tuberculosis
TBMR	: Multi-Drug Resistant Tuberculosis
TEP	: Extra pulmonary TB
TP ou trad	: Traditional healers
TPM-	: Pulmonary TB Negative smears
TPM+	: Pulmonary TB with smear positive
TPM0	: Pulmonary TB with microscopy not done
VCT	: Voluntary Counseling and Testing
VE	: Vaginal Extraction
VE	:Widow
WHO	: World Health Organization

Acknowledgements

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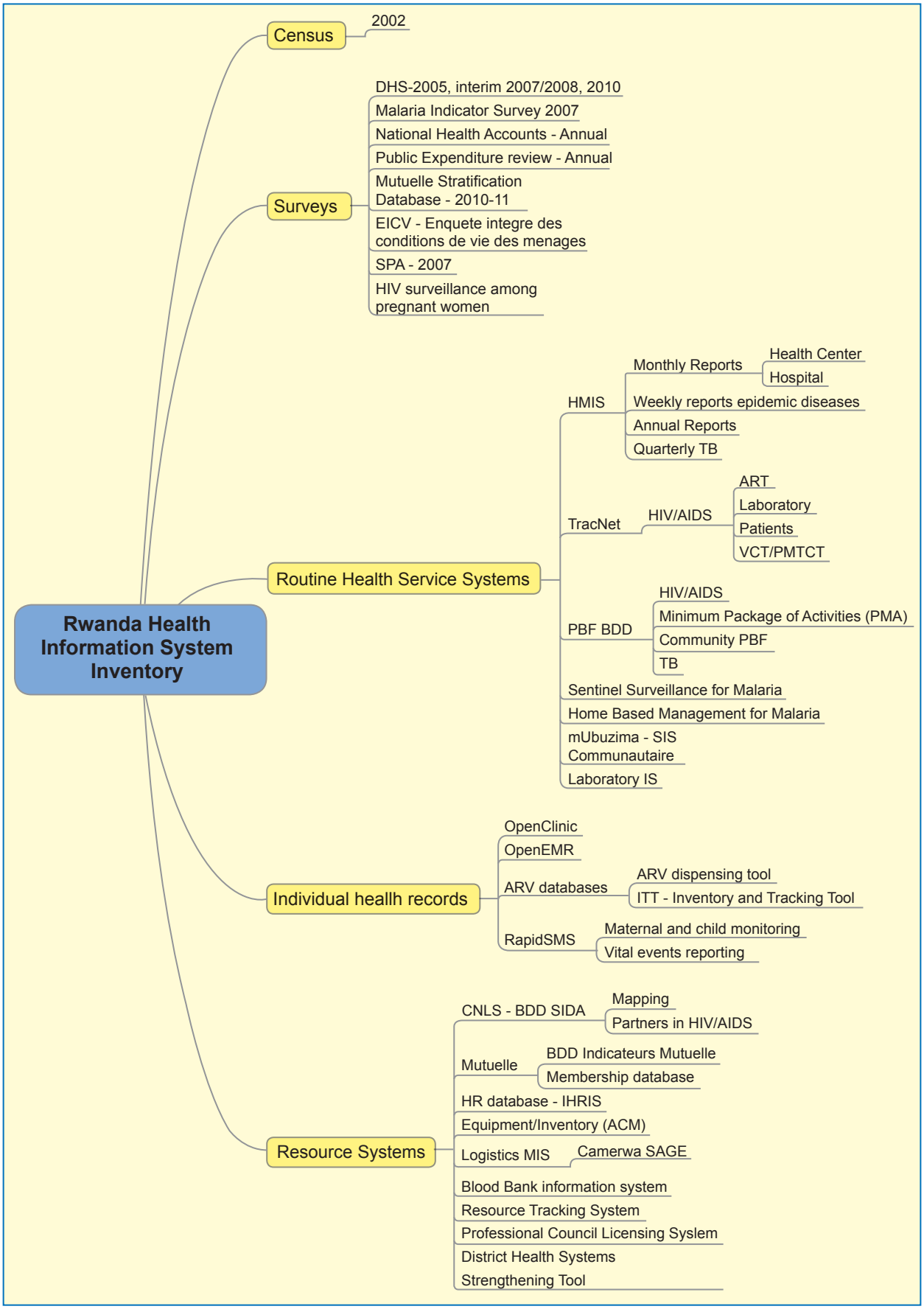
1. Introduction

1.1. Background

The Rwanda Health Management Information System (HMIS) has been developed to support the health service providers and Ministry of Health departments at all levels. In 2011 Rwanda had a network of over 600 health facilities and over 60,000 community health workers. After many years of proliferation of health information related systems in the late 1990s and early 2000s, many reporting systems were consolidated into a two monthly reporting formats in 2008.

The *Gestion du Système d'Information Sanitaire* (GESIS or Health MIS Information System), included structures, processes, and information flows set up and managed by the GoR to collect and provide national information on health in the country. The MoH is responsible for implementation and administration of the SIS, which includes paper records at facility levels, paper and electronic reporting to district and central levels, and electronic aggregation at the central (MoH) level. Rwanda defines its Health Information System in the broad sense along the lines of WHO/Health Metrics Network's framework that includes both routine and non-routine sources of information. Figure 1: below provides a high level overview of current health-related information systems.

Figure 1: Overview of Rwanda HIS sub-systems



The data for the HMIS is collected through a combination of paper and electronic procedures. At the service delivery point (health centers and district hospitals), data are recorded using a variety of registers and patient record forms. Many of these recording instruments are recently standardized, and most facilities maintain separate registers for each service (Outpatient registration, Hospital Registration, Ante-Natal Care, Laboratory tests, VCT, ARV, Maternity, Surgical Ward, health education, nutrition surveillance, vaccinations). In addition information is extracted from pharmacy stock cards and accounting registers.

Data are reported according to the following data flow chart. Currently the 'official' integrated reporting instruments are the following:

1. Monthly Health Center Report;
2. Monthly District Hospital Report;
3. Monthly Private Clinic Report;
4. Monthly Private Dispensary Report;
5. Monthly Referral Hospital Report;
6. Monthly Mutuelle Section Report;
7. Monthly Community Health Information System Report (SISCom);
8. Quarterly TB/HIV report: These reports are currently sent directly to the TB unit in the Ministry of Health. There are plans to integrate this into the DHIS soon;
9. Weekly Epidemic Diseases Report: this is currently compiled in the districts and sent to TracPlus, it has been integrated on the TracNet platform and data can be reported by phone or on-line;
10. Immediate report for Epidemic Diseases: This has also been integrated on the TracNet platform and data can be reported by phone or on-line.
11. Minister's Daily electronic report from District hospitals: these are entered on line and serve to alert the Minister of major health events in the districts.

Apart from the Minister's Daily report, most of these reports are compiled on paper forms that are completed with the health facilities and then sent to the District Hospitals for entry into the HMIS database software. In 2011 all health center data managers were trained to enter the data, so in nearly all of the facility the data entry has been decentralized to the health facility level (HC and DH).

Data managers are supposed to enter their reports on-line into the DHIS by the 5th day of each month or sent copies of the paper forms to the next level up so that by the 15th of each month the data can be checked and then exported or used on-line by programs and partners for M&E purposes.

A detailed set of Standard Operating Procedures (SOP) have been developed for health center and district hospital level staff involved in data management tasks – in particular those related to the HMIS.

This procedures manual has been produced to document the HMIS system by the HMIS department of the Ministry of Health, with support from most of the national level programs and departments (MCH, RBC units) and technical assistance from MSH, Futures Group, Partners in Health, and BTC.

1.2. 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 managing health-related data, and as a stand-alone reference. The document provides an overview of the HMIS, 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.

1.3. 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.

1.4. 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 facility level by the health workers to collect data about individual patients and activities within health facilities. 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 variety of documents that are prepared to transmit information between levels (eg. Health facility to District Hospital) on a periodic basis. In addition, these include feedback reports that are used to communicate information systematically from higher levels to the health facilities and their supervisors.

Below are the main recording and reporting formats that are included in this manual. A separate manual has been developed to document the Community Health Information (SISCom) and for the Minister's daily report (electronic format only). Similarly, the formats for GBV, Nutrition, Financial Management, HIV and TB are still undergoing design and harmonization, so they will be added to this guide when they are complete.

Table 1: Recording Formats & Reporting Formats

RECORDING FORMATS[1]		
	Maintained by Family/Client	***ID.***
1	Family planning client appointment card	CC-2
	Vaccination card	
	Under 5 growth monitoring chart	
	Maintained at the Health Facility	
1	***Outpatient – OPD register***	OPDR
2	Hospitalization register	HR
	MNCH	
3	Family planning register	FPR
4	Maternity register	MR
5	ANC register	ANCR
6	IMCI register	IMCIR
7	Family Planning Appointment Box	FPAPP
8	Family Planning Consultation form	FPC
9	IMCI Tally Sheet	IMCIT
	Nutrition Screening Register	
	Outpatient Nutrition Rehabilitation Register	
	Inpatient Nutrition Rehabilitation Register	
	Vaccination Register	
	OTHER HEALTH PROGRAMS	
	GBV Intake form	
	GBV Register	
	TB Register	
	ARV Register	
	PMTCT Register	
	VCT Register	
	PIT Register	
	RESOURCE MANAGEMENT	
	Stock card	
	Financial accounting register	

REPORTING FORMATS		
	Health Center Level	***ID***
1	Health Center HMIS Monthly Report	MR-1
2	Monthly CBHI/Mutuelle Section Indicator Report	CBHIS-1
3	TB Diagnostic and Treatment Center Monthly PBF Report	
4	TB Treatment Center Monthly PBF Report	
5	**TB Quarterly Report**	
6	**Maternal Death Audit Report**	
7	**Neonatal Death Audit Report**	
	District Hospital Level	
1	District Hospital HMIS Monthly Report	MR-2
2	Monthly District Hospital CBHI/Mutuelle Section Indicator Report	CBHIS-1
3	District CBHI Office Monthly Activity Report	CBHID-1
	National Referral Hospital Level	
1	Referral Hospital HMIS Monthly Report	MR-3
	Private health facility level	
1	Private Dispensary HMIS Monthly Report Form	MR-4
2	District Clinic HMIS Monthly Report	MR-5

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

2. Overview of the Health Management Information System

Rwanda's Health Management Information System has been designed in order to:

- Provide data for individual case management (patient or client forms, records and registers);
- Help health workers better manage their services;
- Ensure an adequate supply of essential drugs and supplies;
- Help health workers in their efforts to organise and monitor the effectiveness of the services they provide to their communities;
- Provide data to 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 HMIS are described in the following sections.

2.1. 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:

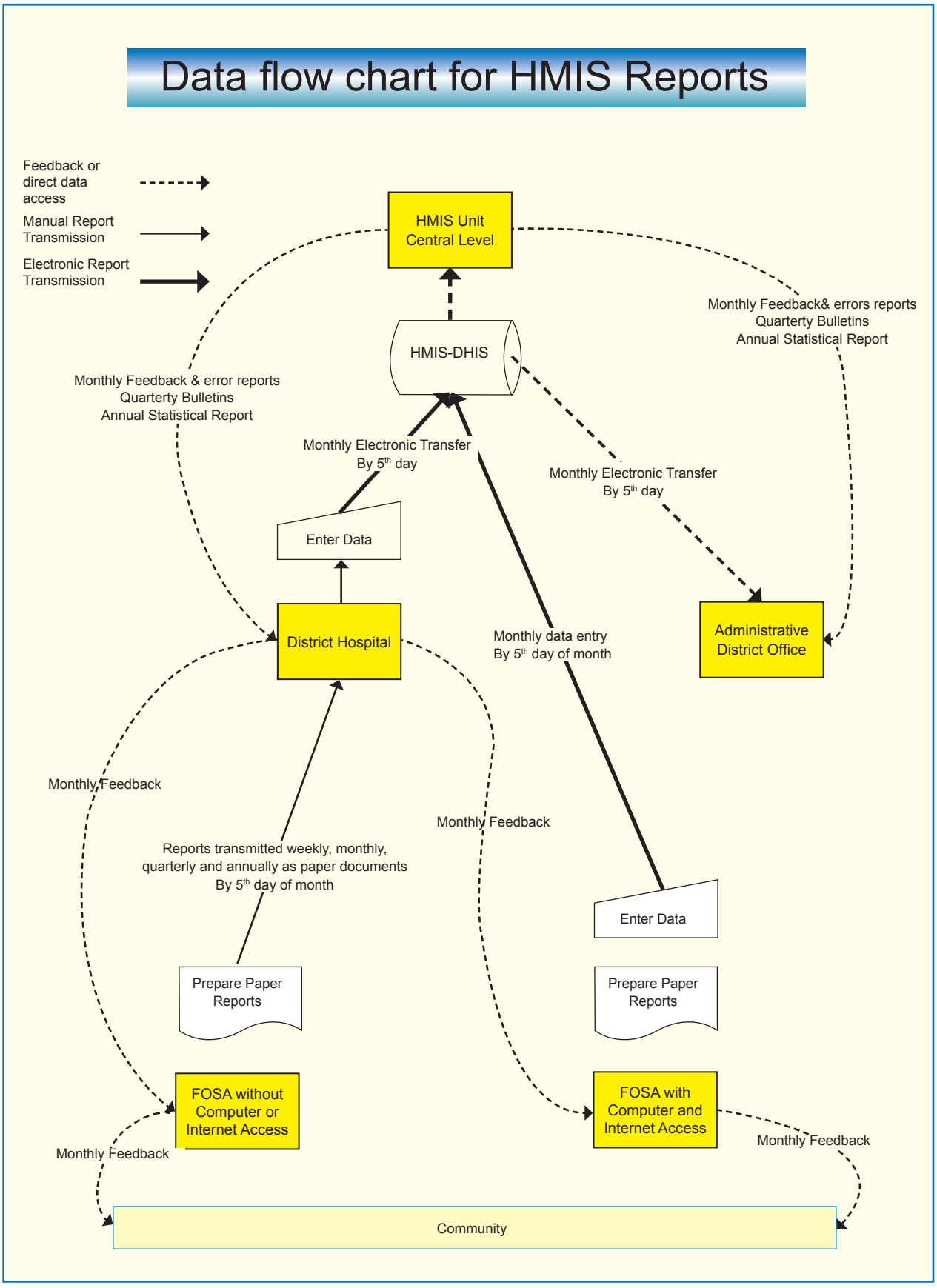
1. Records, cards, registers and tickler file systems for the management of individual patients and clients
2. Immediate reports to communicate information about particular events, such as cases of notifiable disease that require immediate action, or take place on an ad hoc basis, such as training courses.
3. Periodic Reports (Weekly, Monthly, Quarterly, 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.

2.2. The Process

The HMIS 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 HMIS also 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. At some levels certain of these processes are computerized, while others are paper based. As the implementation of OpenMRS medical records system progresses, some of the paper forms and reporting instruments may no longer be required.

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.

Figure 2: Data flow chart for HMIS Reports



2.3. Flow of Information

1. Health workers from each department record data on a daily basis using registers and patient files.
2. At the end of each reporting period, data are compiled by the head of each department with the assistance of the health facility data manager into each of the required reporting formats.
3. If the health facility has a computer and access to the internet, then the data are entered directly into the national database by the 5th of the month.
4. If a health facility does not have a computer or internet access, then a paper copy of the reporting forms are sent to the district hospital. The data manager at the district hospital enters the data for all facilities without computers.
5. The District Hospital data manager is responsible for ensuring that all reports have been entered into the DHIS database, if any facility has not yet completed their report the data manager must contact the facility to remind them by the 10th of each month.
6. Once data are in the data base, the District Data Manager and M&E officer review the data for data quality issues extreme values, missing data, etc... And communicate about any issues with the relevant the health facilities.
7. From the 15th to the end of each month feedback reports are prepared to each reporting unit and from the central level to the District hospitals.
8. At least twice a year, the District Level Data Manager and Supervisor analyse the performance of all health facilities and prepare written feedback reports that are sent to each health facility. (Note: Once the analysis module of the DHIS-2 is in place, most of the content for these feedback reports can be produced automatically). Before each supervisory tour, the district supervisors also review data from the HMIS to help determine the performance of the health facilities scheduled to be visited. This information should be discussed with staff during the visits.
9. In each district, all FOSA incharges and supervisors should meet once a year for an Annual District Health planning meeting.F[2]F 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 from other sectors (e.g. Rural Water Supply & Sanitation, Education) should also participate in this meeting.
10. The National HMIS 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.

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

2.4. 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. The entire list is too big to include in this document, but is available on the Ministry of Health Web site. This is a dynamic list, designed to change as health problems and priorities change.

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 provided by health facilities as well as clients for family planning and other preventive and health promotional services)
- Financial management (expenditures and receipts across major account categories and a monthly balance sheet)
- Logistics management (Only a short tracer list of drugs is included in the HMIS for the moment. A major effort is underway to develop a national logistics management information system or LMIS)

The following table lists a summary of the main categories and types of indicators selected.

Table 2: Initial Minimun Indicator list for the health sector in Rwanda – May 2011

No	Service Area/Indicators	Method of collection (Survey, Routine, etc)	Data source	Frequency
	Child health			
1	% measles vaccination-coverage for children 12-24 months	Survey	DHS	
2	% of children < 5 diagnosed with clinical Vitamin A deficiency (Bitot)	Survey	DHSR/CFNVA	
3	% of children < 5 underweight (weight for age)	Survey	DHS/CFSVA	
4	% of children < 5 with acute malnutrition (Weight for height and edema)	Survey	DHS/CFSVA	
5	% of children < 5 with stunting/chronic malnutrition (height for age)	Survey	DHS/CFSVA	
6	% of children 12-23 months who were fully immunized before reaching one year of age	Survey	DHS	
7	% of children aged 6-59 months who receive 2 doses of vitamin A every 6 month	MCH week	MCH Week report	6 monthly
8	% of children aged 6-59 months who received deworwing every 6 month	MCH week	MCH Week report	6 monthly
9	% of children aged 6-8 months fed with solid or semi solide complementary foods in addition to breast milk	Survey	DHSR/CFNVA	
10	% of children from 6-59 months of age who received vitamin A supplementation during the last 6 months	Survey	DHSR/CFNVA	
11	% of Children under 5 years treated correctly according IMCI protocol at all levels (disaggregated by hospital, health centre, CHW)	Survey	survey (specify)	
12	% of children with acute malnutrition who were treated	Routine	Child health (SISCOM/growth monitoring/OP screening/malnutrition register)	monthly
13	% of children with underweight who were treated	Routine	Child health (SISCOM and HF growth monitoring/ OP screening/malnutrition register)	monthly
14	% of estimated ARI cases < 5 treated by level (hospital, health centre, CHW)	Routine	HMIS (IP &OP register) /SISCOM (C-IMCI register)& DHS	monthly
15	% of estimated diarrhea cases < 5 treated by level (hospital, health centre, CHW)	Routine	HMIS/SISCOM/DHS	monthly
16	% of estimated malaria cases < 5 treated by level (hospital, health centre, CHW)	Routine	HMIS (IP &OP register) /SISCOM (C-IMCI register)& DHS	monthly
17	% of reported < 5 deaths of the expected deaths	Routine	HMIS (HF IP register)/SISCOM/N-CDA and verbal autopsy &DHS	monthly
18	BCG immunization coverage for children < 1 year	Routine	HMIS/PEV database (EPI register)	monthly
19	Case fatality rate for 5 main causes of morbidity among the under five (disaggregated by hospital and health facility)	Routine	HMIS (HF IP register)/N-CDA and verbal autopsy	monthly

No	Service Area/Indicators	Method of collection (Survey, Routine, etc)	Data source	Frequency
20	Cure rate of children who were treated for acute malnutrition	Routine	HMIS/MCH nutrition desk (Hospital and HC malnutrition register)	monthly
21	Defaulter rate of children who were treated for acute malnutrition	Routine	HMIS/MCH nutrition desk (Hospital and HC malnutrition register)	monthly
22	Infant mortality rate in the poorest quintile per 1000 live births	Survey	Survey, DHS/DHS+ (Demographic and Health Survey)	2 or 5 years
23	Infant mortality rate per 1000 live births	Survey	Survey, DHS/DHS+ (Demographic and Health Survey)	2 or 5 years
24	Measles Immunization coverage (under 1 year old)	Routine	HMIS/PEV database (EPI register)	monthly
25	Mortality rate of children who were treated for acute malnutrition	Routine	HMIS/MCH nutrition desk (Hospital and HC malnutrition register)	monthly
26	Neonatal mortality rate by cause	Routine	HMIS (maternity and IP register)/NDA and verbal autopsy	monthly
27	Neonatal mortality rate per 1000 live births	Survey	Survey, DHS/DHS+ (Demographic and Health Survey)	
28	Penta-3/Polio 3/Pneumococcal 3 immunization coverage for children < 1 year	Routine	HMIS/PEV database (EPI register)	monthly
29	Proportion of children who initiate early breastfeeding (within 1 hour after birth)	Survey	DHSR/CFNVA	
30	Proportion of children who receive exclusive breastfeeding up to 6 months	Survey	DHSR/CFNVA	
31	Proportion of newborn with Low birth weight (< 2.5 kg) (disaggregated by hospital and health center)	Routine	HMIS (delivery register)	monthly
32	Proportional morbidity (10 main causes) among the < 5 for OPD consultations in health facilities (healthcentres/hospitals)	Routine	HMIS (HC and Hops IP register)	monthly
33	Proportional Mortality (by 5 main causes) among the < 5 in health facilities (disaggregated for hospitals and health centers)	Routine	HMIS (HF IP register)/N-CDA and verbal autopsy	monthly
34	Reported Early neonatal mortality rate	Routine	HMIS/SISCOM/NDA (neonatal death audit)and verbal autopsy/DHS	monthly
35	Reported Neonatal mortality rate per 1000 live births in health facilities	Routine	HMIS/SISCOM/NDA (neonatal death audit)and verbal autopsy/DHS	monthly
36	Reported under 5 mortality rate per 1000 live births per level	Routine	HMIS (HF IP register)/SISCOM/N-CDA (Neonatal -child death audit)and verbal autopsy	monthly
37	Stillbirth ratio (from 22 weeks amenorrhea) (disaggregated in fresh and macerated) (disaggregated by hospital and health center)	Routine	HMIS (delivery register)	monthly
38	Under 5 child mortality rate per 1000 live births	Survey	Survey, DHS/DHS+ (Demographic and Health Survey)	2 or 5 years

No	Service Area/Indicators	Method of collection (Survey, Routine, etc)	Data source	Frequency
	Community Health Worker services			
1	# of children between 9 and 12 months whose vaccination status is not up to date	Routine	SISCOM through community register [enfants pre-scolaire TBD]	monthly
2	# of episodes of ARI treated per child per year at community level	Routine	SISCOM	Annual
3	# of episodes of fever treated per child per year at community level	Routine	SISCOM	Annual
4	# of episodes of diarrhea treated per child per year in the community	Routine	SISCOM	Annual
5	% fever cases in children 6-59 months treated within 24 hours	Routine	SISCOM	monthly
6	% of children < 5 years identified with oedema and referred to HC	Routine	SISCOM	monthly
7	% of children < 5 years identified with oedema	Routine	SISCOM	monthly
8	% of children 0-5 years screened for nutritional status by weight for age [community growth monitoring coverage]	Routine	SISCOM	monthly
9	% of children 6-59 months screened for acute malnutrition by MUAC [community MUAC screening coverage]	Routine	SISCOM	monthly
10	% of children U5 seen by CHWs per total U5 population	Routine	SISCom through cIMCI register	monthly
11	% of counter-referral forms received by CHW of all referrals recorded	Routine	SISCOM	monthly
12	% of households with kitchen gardens	Survey	Survey	Annually
13	% of moderately malnourished (MUAC yellow) children who are identified	Routine	(blank)	
14	% of moderately malnourished (MUAC yellow) children who are referred	Routine	(blank)	
15	% of moderately malnourished (W/A yellow) children who are identified	Routine	SISCOM	monthly
16	% of moderately malnourished (W/A yellow) children who are referred	Routine	SISCOM	monthly
17	% of severely malnourished (MUAC red) children who are identified	Routine	(blank)	
18	% of severely malnourished (MUAC red) children who are referred	Routine	(blank)	
19	% of severely malnourished (W/A red) children who are identified	Routine	(blank)	
20	% of severely malnourished (W/A red) children who are referred	Routine	(blank)	
21	% of total cases presenting with ARI	Routine	SISCOM	monthly
22	% of total cases presenting with diarrhoea	Routine	SISCOM	monthly
23	% of total cases presenting with fever	Routine	SISCOM	monthly
24	% CHW cooperatives covered by complete PBF package	Routine	PBF database	Twice a year
25	# of consultations for FP-clients continuing in the CBP program	Routine	(blank)	

No	Service Area/Indicators	Method of collection (Survey, Routine, etc)	Data source	Frequency
26	# of FP-clients new to the CBP (who initiated at FOSA a contraceptive method)	Routine	CBP register	
27	% of new FP users at health center level who are enrolled at the CBP program	Routine	(blank)	
28	% CHWs visited by cell level supervisor	Routine	SISCOM	monthly
29	% CHWs visited by health center in-charge of community health	Routine	SISCOM	monthly
30	# of maternal deaths in health facilities	Routine	(blank)	
31	# of maternal deaths in the community	Routine	SISCOM	monthly
32	# of neonatal deaths (up 28 days) in health facilities	Routine	(blank)	
33	# of neonatal deaths (up 28 days) in the community	Routine	(blank)	monthly
34	# of under-5 deaths in health facilities	Routine	(blank)	
35	# of under-5 deaths in the community	Routine	(blank)	monthly
36	% of fever cases seen tested with RDTs	Routine	SISCOM	monthly
37	% RDT positive cases treated with any Primo	Routine	SISCOM	monthly
38	# of months supply remaining (per drug)	Routine	SISCOM	monthly
39	% of RDTs found positive	Routine	SISCOM	monthly
40	% RDTs found invalid	Routine	SISCOM	monthly
41	% RDTs found negative	Routine	SISCOM	monthly
42	% of currently pregnant women using a bednet at last visit	Routine	SISCOm through ASM register of pregnant women	monthly
43	% of women accompanied by CHW to deliver at the Health Facility of all deliveries in the month	Routine	SISCOM	monthly
44	% of women and child pairs (if child alive) after home delivery who were referred to the Health Center for postnatal care within 3 days post partum	Routine	SISCOM	monthly
45	% women delivered at health facility as documented by CHWs	Routine	SISCOM	monthly
46	% women within 4 months of pregnancy referred by CHW to ANC of pregnant women newly identify by CHW	Routine	SISCOm through ASM register of pregnant women	monthly
	Epidemic and Infectious Diseases			
1	Proportion of cases of diseases targeted for elimination, eradication and any other diseases selected for case-based surveillance that were reported to the district using case-based definition	Routine	eIDSR: Routine summary reports and case-based	Weekly
2	Proportion of districts in which a current trend analysis (line graph or histogram) is available for selected priority diseases	Routine	eIDSR: Routine summary reports and case-based	Weekly

No	Service Area/Indicators	Method of collection (Survey, Routine, etc)	Data source	Frequency
3	Proportion of health facilities submitting weekly (or monthly) surveillance reports on time to the district	Routine	eIDSR: Monitoring chart for timely report submission	Weekly
4	Proportion of investigated outbreaks with laboratory results	Routine	eIDSR: Routine summary reports and case-based	semi-Annual
5	Proportion of reports of investigated outbreaks that include analyzed case-based data	Routine	eIDSR: Routine summary reports and case-based	semi-Annual
6	Proportion of suspected outbreaks of epidemic-prone diseases notified to the next higher level within 2 days of surpassing the epidemic threshold	Routine	eIDSR: Routine summary reports and case-based	Weekly
	Environmental Health			
1	% of Food establishments with hygienic food handling and storage conditions	Routine	Environmnental Health Inspection Reports	quarterly
2	% of Health Facilities reporting accidental needle stick Injuries	Routine	HMIS, environmental health reports	monthly
3	% of health facilities with appropriate facilities for proper disposal of Health care waste	Routine	Environmnental Health Inspection Reports	quarterly
4	% of health facilities with handwash facility, water and soap at the toilets/latrines	Routine	Environmnental Health Inspection Reports	Annually
5	% of households in permanent settlements with improved sanitation facilities constructed according to national standards	Survey	Community Hygiene Clubs registers/reports	quarterly
6	% of households using latrines/toilets with no Excreta on walls and Floors	Survey	Community Hygiene Clubs registers/reports	quarterly
7	% of Households with appropriate hand washing facilities with water and soap near latrine/Toilet	Survey	Community Hygiene Clubs registers/reports	quarterly
8	% of households with separate clean covered container for storage of safe drinking water	Survey	Community Hygiene Clubs registers/reports	quarterly
9	% of Hygiene clubs at Umudugudu level that are functioning regularly	Survey	Community Hygiene Clubs registers/reports	quarterly
	Essential drugs			
10	% of stockouts tracer pharmaceutical products	Survey	Health centers, District Hospital, District Pharmacy, Referral Hospitals, Camerwa	Monthly
11	Pharmacetical order fill rate	Survey	Health Facilities, District Pharmacy, Camerwa	Monthly
	Financing			
1	% health facilities covered by whole package of PBF	Routine	PBF database	Quarterly
2	% of Community Based Health Insurance members received in Out Patients Department	Routine	HMIS (Health Centers)	Annually
3	% population covered by health insurance	Survey	CBHI database, RAMA, SORAS, etc..	Every 2 years
4	Mutuelle Expenditure/ total recovery	Routine	Mutuelle Section of Health Centers, District Mutuelle section	quarterly

No	Service Area/Indicators	Method of collection (Survey, Routine, etc)	Data source	Frequency
5	Mutuelle funds Recovery Rate	Routine	Mutuelle Section of Health Centers	Annually
6	Proportion of population covered by Community health Insurance scheme	Routine	CBHI database	Annually
	Geographic Access			
1	% population within less than one hour walking distance of a Health Facility	Survey	Survey	Every 2 years
2	Primary curative health care utilisation rate (HC and private dispensaries)	Routine	HMIS	
	HIV			
1	% of adults aged 15-49 who had more than one sexual partner in the last 12 months, who say they used a condom with their last sexual partner	Survey	DHS, AIS	DHS: 5 years AIS: 5years
2	% of adults and children eligible for ART receiving it	Routine	Numerator:Pre-ART/ ART registers Denominator: HIV and AIDS Epidemiologic Update	Monthly (numerator) Denominator: EPP spectrum annually
3	% of adults and children with HIV known to be on treatment 12, 24, and 36 months after initiating anti-retroviral therapy	Survey	Cohort study	Annually
4	% of clinically malnurished HIV positive patients who received therapeutic or nutritional supplementation in the last 12 months	Routine	Nutritional registers, individual patient records; Child health register	numerator: monthly; denominator: annually
5	% of couples tested and counseled for HIV and whose test results are discordant	Routine	CDV Register, PMTCT Register	yearly
6	% of donated blood units screened for HIV	Routine	Routine Reporting	monthly
7	% of HIV positive patients initiating ART during a selected time period who are taking an apppropriate first line regimen 12 months later	Routine	TRACNet	Annually
8	% of HIV positive patients whose Viral load is undetectable 12 months after ARV initiation	Routine	TRACNet	Annually
9	% of HIV+ children born to known HIV+ mothers [at 6 weeks, 9 months and 18 months]	Routine	CN Register, HIV exposed child record	yearly
10	% of HIV+ pregnant women who received antiretroviral therapy to reduce the risk of mother to child transmission	Routine	Routine Reporting	Monthly (numerator) Denominator: EPP spectrum annually
11	% of HIV-positive patients who were screened for TB in HIV care or treatment settings at enrollement (at the end of the reporting period)	Routine	Pre-ART and ART registers	monthly

No	Service Area/Indicators	Method of collection (Survey, Routine, etc)	Data source	Frequency
12	% of hospitals and health centers offering full package of HIV services (VCT, PMTCT, PIT, ART)	Survey	UPDC Quarterl Reports; HIV Services Mapping Exercise (Cartographie de FOSA)	Monthly Reporting; compiled each quarter into a quarterly report
13	% of infants born to HIV Positive mothers who are started on cotrimoxazole prophilaxis within two months of birth	Routine	PMTCT register; infant follow-up register??? This needs to be decided later by TRACplus	monthly
14	% of partners of pregnant women attending ANC who were tested for HIV in the last 12 months and who know their results	Routine	TRACNet	monthly
15	% of people exposed to HIV provided with post-exposure prophylaxis	Routine	PEP registers at health facilities (though not yet standardized at national level)	Monthly
16	% of PLHIV in need benefiting from nutritional support in clinical settings in the last 12 months	Routine	Nutritional registers, individual patient records; Child health register	monthly
17	% of PLWHA who confronted, challenged, or educated someone who was stigmatizing and/or discriminating them	Survey	Rwanda Stigma Index	4 years
18	% of population aged 15-49 who had more than one sexual partner in the last 12 months (Higher risk sex)	Survey	DHS	5 years
19	% of pregnant women who were tested for HIV and who know their results	Routine	Numerator: ANC Register, Maternity Register, HIV-exposed infant register; PMTCT Register	Monthly (numerator) Denominator: NISR annual
20	% of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	Survey	Survey	5 years
21	Current school attendance among orphans and non-orphans aged 10-14	Survey	DHS+, R-AIS 2012	3-5 years
22	% of testing facilities (laboratories) that are accredited according to national or international standards	Survey	Accreditation Services	
	HR			
1	% health workers trained to deliver the basic package of services	Routine	Training Database	Annually
2	% of health care workers who successfully completed an in-service training program	Routine	Training Database	Monthly
3	% of health facilities with a midwife	Survey	HRIS	Annually
4	% of health staff outside Kigali	Survey	HRIS	Annually
5	Ratio of pharmacists to 10,000 inhabitants	Survey	HRIS	Annually
6	Ratio of medical doctor to 10,000 inhabitants	Survey	HRIS	Annually

No	Service Area/Indicators	Method of collection (Survey, Routine, etc)	Data source	Frequency
7	Ratio of new health care profesionals who graduated from pre-service training Institutions per 10,000 inhabitants (by specific type: Doctor, nurses, midwives, lab technicians,…)	Survey	Graduation Booklet and other sources from Academic Institutions	Annually
8	Ratio of qualified nurses to 10,000 inhabitants	Survey	HRIS	Annually
	Infrastructure			
1	% HF with a maintenance tracking system	Survey	DHSST	Twice a year
2	% HF with electricity	Survey	DHSST	Twice a year
3	% HF with water	Survey	DHSST	Twice a year
4	% of districts with operational SAMU	Survey	DHSST	Twice a year
	Laboratory			
1	Proportion of results available in 30-60 days after arrival at a testing site/ All samples arrived at a site for TB MDR testing	Routine	Clinical service and Lab registers	monthly
2	Proportion of results available in 7-14 days after arrival at a testing site/ All samples arrived at a site for CD4 testing	Routine	Clinical service and Lab registers	monthly
3	Proportion of results available in 7-14 days after arrival at a testing site/ All samples arrived at a site for DBS PCR testing	Routine	Clinical service and Lab registers	monthly
4	Proportion of results available in 7-14 days after arrival at a testing site/ All samples arrived at a site for Viral load testing	Routine	Clinical service and Lab registers	monthly
5	Proportion of true negatives: # of true negatives/Total of all negatives tested at a site	Routine	Clinical service and Lab registers	monthly
6	Proportion of true positives: # of confirmed positives/Total of all positives tested at a site	Routine	Clinical service and Lab registers	monthly
	MALARIA			
1	% of confirmed MALARIA admissions among all health facilities admissions	Routine	HMIS	monthly
2	% of drug samples that meet the stipulated original specifications	Routine	Quality Control Activity Report	quarterly
3	% of Health facilities with no stock outs of antiMALARIA drugs for more than a week during the last month	Routine	HMIS, LMIS, Health facility Survey	monthly
4	% of people with complete knowledge about malaria	Survey	Survey, Malaria BSS (Behavioral and Surveillance Survey)	2 years
5	All-cause under-five mortality rate	Survey	DHS survey, MIS survey	2 years (MIS) 5 years (DHS)
6	Case fatality rate at health facility for under 5	Routine	HMIS	Collected monthly, calculated annually
7	Incidence of confirmed malaria cases (all ages) per 1000 in habitants in a year	Routine	HMIS	monthly

No	Service Area/Indicators	Method of collection (Survey, Routine, etc)	Data source	Frequency
8	MALARIA parasite prevalence: % of children aged 6-59 months with MALARIA infection(detection of parasitemia by microscopy)	Survey	DHS MIS	2 or 5 years
9	MALARIA-attributed mortality rate for children under-five	Survey	Nationally representative VA survey as part of surveys large enough to estimate 5q0	5 years
10	Proportion of all cases of uncomplicated MALARIA in the health facilities that are treated in accordance with the national treatment policy;	Survey	Health facility survey	2 years
11	Proportion of cases of severe MALARIA in the health facilities that are treated in accordance with the national treatment guidelines/policy.	Survey	Health facility survey	2 years
12	Proportion of children under five years old who slept under an ITN the previous night	Survey	DHS survey, MIS survey,	2 and 5 years
13	Proportion of children under five years old with fever (in the last two weeks) who received antiMALARIA treatment according to national treatment policy within 24 hours of onset of fever	Survey	DHS survey, MIS survey	2 or 5 years
14	Proportion of children under five years old with fever (in the last two weeks) who received any antiMALARIA treatment according to national treatment policy	Survey	DHS survey, MIS survey	3 and 5 years
15	Proportion of households with at least one ITN	Survey	DHS survey, MIS survey, MICS survey	2 or 5 years
16	Proportion of malaria attributed deaths among under 5 at health facility	Routine	HMIS	Annually
17	Proportion of malaria attributed deaths in all ages at health facility	Routine	HMIS	Annually
18	Proportion of MALARIA epidemics that are detected and are controlled within the 2 weeks following detection.	???	Malaria Report from Health facilities	???
19	Proportion of pregnant women who slept under an ITN the previous night	Survey	DHS survey, MIS survey,	2 and 5 years
20	Proportion of targeted households sprayed with a residual insecticide	???	Activity reports	Annually
21	RDT postivity rate in fever cases at community level	Routine	SISCOM	monthly
22	RDT postivity rate in fever cases at health facility	Routine	HMIS	monthly
23	Slide postivity rate in fever cases	Routine	HMIS	monthly
	Quality Assurance			
1	% facilities involved in accreditation system by level	Survey	Accreditation database	Annually or every 2 years
2	% of accredited health facilities	Survey	Accreditation database	Annually or every 2 years
	Reproductive Health/MCH			
3	% of births among young women (< 20 years)	Routine	HMIS (delivery register)	monthly
4	% of hospitals that offer Comprehensive Emergency Obstetric and Neonatal Care (EONC)	Survey	Survey	Annually

No	Service Area/Indicators	Method of collection (Survey, Routine, etc)	Data source	Frequency
5	% of Districts with at least 50 % of Health facilities centers delivering services to youth (as defined in the PMA)	Routine	SRA district supervision reports	semestriel
6	% of districts with youth friendly centers with functional Reproductive health services (as according the PMA)	Routine	SRA district supervision reports	semestriel
7	% of eligible GBV survivors who received emergency contraception	Routine	HMIS (GBV register)	monthly
8	% of eligible GBV survivors who received PEP	Routine	HMIS (GBV register)	monthly
9	% of GBV survivors referred from health facilities to other services (disaggregate per service)	Routine	HMIS (GBV register)	monthly
10	% of maternal mortality < 20 years	Routine	HMIS/SISCOM/MDA and Verbal Autopsy	monthly
11	Contraceptive Prevalence rate among young people	Survey	DHS	2 years
12	Contraceptive utilisation rate among young people (disaggregated in 10-14 yrs, 15-19 yrs, 20-24 years)	Routine	HMIS (FP register)	monthly
13	Maternal mortality ratio	Survey	(blank)	2 or 5 years
14	Proportional abortion rate recorded among adolescents in health facilities	Routine	HMIS	monthly
	Resources			
1	% of health facilities using electronic medical records system	Survey	DHSST	Annual
2	% of health facilities using financial accounting software (Sage, Quickbooks, etc)	Survey	DHSST	Annual
3	% of health facilities using HMIS software	Survey	DHSST	Annual
4	% of health facilities using HRIS software	Survey	DHSST	Annual
5	% of health facilities with access to Electricity (by type)	Survey	DHSST	Annual
6	% of health facilities with access to Internet (by type)	Survey	DHSST	Annual
7	% of health facilities with local area network installed	Survey	DHSST	Annual
8	% of new private facilities registered that were inspected during the period	Survey	Inspection reports and Requests for registration	monthly
9	% of private health facilities that report requlary through the HMIS	Routine	HMIS, Health facility registry	monthly
10	% of private sites inspected that achieve minimum criteria for elegibility to practice	Survey	Inspection checklist	monthly
	TB			
1	% of CDT which reported a stock out in first line drugs during the reporting period out of all CDT.	Routine	stock cards and quarterly reports	Quarterly; annually
2	% of labs performing regular quality assurance (at least 3 times per year) for microscopy (ZN and Fluorescence)	Routine	Lab at HF	Quarterly; annually

No	Service Area/Indicators	Method of collection (Survey, Routine, etc)	Data source	Frequency
3	% of MDR-TB cases that have negative smears and cultures at 6 months of treatment (according to WHO definition)	Routine	Cohort study	Quarterly; annually
4	% of TB patients (all forms) tested for HIV (numerator) of all TB patients (all forms) registered (denominator)	Routine	TB registers; quarterly reports; annual reports	Quarterly; annually
5	% of TB/HIV patients receiving ART by the end of TB treatment out of all TB/HIV patients.	Routine	TB register; quarterly reports	Quarterly; annually
6	Proportion of New Sputum smear Positive TB cases successfully treated.	Routine	Quarterly reports of health facilities	Quarterly; annually
7	Treatment succes rate among MDR-TB cases	Routine	MDR TB register	Quarterly; annually
	MENTAL HEALTH			
1	% of psychiatric inpatient facilities in general hospital in which at least one psychotropic medicine of each therapeutic class is available in the facility throughout the year, according to the national essential drug list	Routine	HCS and DHs Mental Health Program Annul Report	monthly
2	Annual admissions to mental health services/100000 population	Routine	Mental Health Program Annul Report	annually
3	Global assessment of functioning (GAF) intake and discharge in mental health services of general hospitals and psychiatric hospital	Routine	registre HD and psychiatric hospital	monthly

3. Case Definitions

One of the issues affecting the quality of data in the previous versions of the HMIS was the lack of standard case definitions. Detailed case definitions for all data elements and indicators are now stored electronically using the DHIS metadata dictionary, but some of the key concepts about selected case definitions are highlighted below:

3.1. Outpatient/Ambulatory Care:

a. **New Cases:** A new case of a disease is a patient presenting with a particular diagnosis for the first time during a specific disease episode. Disease episodes differ depending upon the nature of the disease, below are some guidelines:

b. **Old Cases:** An old case of a disease is a patient presenting for follow-up care for a diagnosis that was previously recorded as a new case.

Table 3: Outpatient/Ambulatory Care

Diagnosis	Type	How to classify an episode
Malaria	Acute	Typical episode is brief (1 week or less), classify as new case unless clearly a follow-up visit.
Diarrhea	Acute	Typical episode is brief (1 week or less), classify as new case unless clearly a follow-up visit.
ARI	Acute	Typical episode is brief (1 week or less), classify as new case unless clearly a follow-up visit.
TB	Chronic	Initial contact is NC, all subsequent visits are OC until cured. Relapsed old case is counted as OC.
HIV	Chronic	Initial contact is NC, all subsequent visits are OC
HIV Opportunistic Infections	Chronic	
Fracture	Acute	Initial contact is NC, all subsequent visits are OC
Hypertension	Chronic	
Diabetes	Chronic	

3.2. Hospitalization

a. **Admission:** A patient admitted for inpatient hospital care during the month, typically the diagnosis is recorded at discharge. For example: a patient is admitted to the hospital with severe headache and fever, following positive lab test for malaria patient is treated successfully for severe malaria and released. The admission would be recorded as “malaria severe”.

b. **Death:** This is a recorded as the diagnosed primary cause of death at discharge regardless of the cause of admission. Deaths are recorded the month that they take place, regardless of the month of admission.

3.3. Family Planning

a. **New Acceptor:** Is an individual who adopts a family planning method for the first time in their life

b. **Defaulter:** Also know as a dropout or 'lost to follow-up'. A defaulter is a user of renewable family planning methods who does not return for his or her scheduled appointment within 1 month of the scheduled date for whatever reason. For example: a woman receives 3 cycles of pills in February. If she does not return for her scheduled appointment in May, she is counted as a defaulter in June. Patients who are lost to follow-up are also included. A client is only reported as a defaulter at the time their appointment is missed....not during future months.

c. **Family Planning user at end of month:** These are users of contraceptives who continue to be protected by a method during the reporting month. This is most easily determined by counting records in the tickler file box at the end of the month after having removed all defaulters. Users at end of month includes new acceptors at the facility during the month, it also includes all female users of permanent methods who have not yet reached the age of 50 years, all vasectomised males who are still alive.

3.4. Nutrition Rehabilitation

a. **Diagnoses**
   i. Acutely Malnourished Severe
   ii. Acutely Malnourished Moderate
   iii. Chronically Malnourished
   iv. Malnourished pregnant/lactating women

b. **Patient categorization**
   i. Present at beginning of month
   ii. Admitted
   iii. Discharged
   iv. Present at end of month

3.5. Obstetrics:

a. **Maternal death:** (as cited in International Classification of Disease [ICD]-10 [WHO, 1992]) is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy. Death can stem from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

b. **Preterm birth:** A preterm birth is defined as a live birth before 37 completed weeks of gestation

c. **Live birth:** A "live birth" is described by the United Nations (2001) as "the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which, after such separation, breathes or shows any other

evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered live born."

d. **Late fetal death:** is defined as death of a fetus after 28 weeks of gestation. The WHO definition of a "fetal death," also adopted by the United Nations and the National Center for Health Statistics (NCHS), is death before the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy. The terms stillbirth and fetal death are sometimes used interchangeably

e. **Fetal death:** is the death of a fetus weighing 500g or more or of 22 weeks gestation or more if weight is unavailable (ICD-10).

f. **Early neonatal death:** (END) is the death of a live newborn within the first 7 completed days (i.e., 0-6 days) of life. Note: The day of birth is counted as day 0, so that "within the first 7 completed days" or "within 1 week" includes babies 0-6 days old.

g. **Neonatal death**: is defined as a death within the first 28 completed days of life (0-27 days).

SECTION A

1. Maternity Register

1.1. Purpose of the Format

The Maternity, Labour and Delivery register records admissions and deliveries taking place within the health facility including deliveries before arrival, deliveries at home and referrals to the facility. This information serves the purpose of monitoring the number of deliveries in maternity as a national preventive target. If deliveries decline while ANC new clients do not, it is necessary to find out why and correct the situation. The information in the register also serves as a purpose of reviewing the obstetrical techniques used with the diagnosis made.

1.2. Presentation of the Format

Each row is one mother. In other words, the Maternity, Labour and Delivery (ML&D) register is similar to the antenatal care register for that particular pregnancy and delivery. This means that each row contains the name of one woman for a particular pregnancy and delivery and you go back to that row to complete the woman's entry during maternity, labour and delivery.

All deliveries should be recorded in this register including those outside the maternity ward. Deliveries at home, births before arrival (BBA) and births in referral facilities should be updated into the register using relevant data sources (e.g. CHW reports, referral hospital records, mother's card).

1.3. Data Sources

The information required to complete this register can be found in the ANC register, IPD register, and partogram chart.

1.4. Preparation and Submission

This form is maintained by the nurse or mid-wife during the process of managing a delivery. Notes should be taken during the evolution of the delivery – from admission to the maternity to release, so that key observations are not forgotten. This format is not transmitted, but it is used to tally data for monthly reports.

1.5. Definition of Terms & Indicators

Mode of delivery: Record "SVD" for Spontaneous Vaginal Delivery, 'VE' for Vaginal Extraction or 'CS' for Cesaerian Section

Apgar Score: score from 1 to 10 that indicates the health of the newborn infant taking into consideration 5 specific elements (see chart and table below for scoring)

Infant Feeding option chosen: Record the feeding option the mother has chosen for infant feeding. The following codes for the options have been suggested: EBF=Exclusive Breast Feeding, RF=Replacement Feeding, O: Others

Delivery Complication: Using the codes at the footnote of the page §, record the delivery complications. The following codes have been suggested: 'X' for No Complication, 'PPH' for Post Partum Hemorrhage, 'E' for Eclampsia, 'OL' for Obstructed Labour, 'T' for Third Degree tear, 'B' for Breech, 'PS' for Puerpueral Sepsis, 'CS' for Caesarian Section, and 'Ot' for Other Complications (specify the complication)

1.6. Detailed Instructions for Completing Format

Please note that the columns in the register are referred to as column 1, column 2, etc. even though they are not actually numbered on the register.

Maternity, Labour and Delivery register

1. **Serial number**: Record the patient's hospital serial number for the month. At the beginning of the month, restart numbering at 1. Then assign each woman in admission during that month the next serial number. This is a quick way of tracking how many women are admitted for each month.
2. **ANC N°**: Record the ANC number assigned to the woman from the ANC register or maternal health card or mother's card.
3. **Full Name**: Record full name of the woman with the family name written in the upper space and given name in lower space (e.g KAGUBARE / Marie).
4. **Sector :** record the sector in which the mother currently resides
5. **Cell**: record the cell in which the woman currently resides
6. **Village:** record the Village in which the woman currently resides
7. **Catchment area:** record 'Z' if patient currently resides within the health facility catchment area, 'HZ' if the patient currently resides outside the health facility catchment but within the district where the facility is located and 'HD' if patient currently resides outside the district where the facility is located
8. **Age**: Record the woman's completed age in years

Registration

1. **Admission Date:** Record the date of admission to maternity ward.
2. **Time of admission:** Record the time of admission in maternity
3. **HIV status at admission:** Record either 'P' for Positive or 'N' for Negative or 'NC' for Unknown the woman's HIV status at admission in maternity
4. **Previous HIV test date:** If the woman has ever had an HIV test before, record the date of the last HIV test
5. **Syphilis result:** Record 'P' for Positive or 'N' for Negative syphilis test results during ANC

Delivery information

1. **Date**: Record the date of delivery. Note that the field in this column is divided into two cells or rows. In case of multiple deliveries (i.e. twins), record the date for the first delivery in the upper row and the date for the second delivery in the lower row. It is not necessary that the dates for the twins are the same. One twin might be born before midnight and the other after midnight. In this case, the dates of delivery are different.
2. **Hour**: Likewise, record the time of delivery. In case of multiple deliveries, record the time as instructed above
3. **Mode of Delivery**: Record 'SVD' for Spontaneous Vaginal Delivery, 'VE' for Vaginal Extraction or 'CS' for Cesaerian Section delivery mode. In case of multiple deliveries, record as instructed above
4. **Location of Delivery**: Record 'F' if the delivery took place in a health facility, or 'H' from mother's or any other person's home. In case of multiple deliveries, record as instructed above
5. **Attended by skilled health worker**: Record whether the delivery was attended by a Doctor, Midwife or nurse. In case of multiple deliveries, record as instructed above

Delivery outcome

1. **Normal delivery**: For normal deliveries, record in the respective columns whether it was a Term or Preterm delivery. In case of multiple deliveries, record as instructed above
2. **Delivery Complications**: Using the codes at the footnote of the page §, record the delivery complications. The following codes have been suggested: 'X' for no complication, 'PPH' for PostPartum Hemorrhage, 'E' for Eclampsia, 'OL' for Obstructed Labour, 'T' for Third degree tear, 'B' for Breech, 'PS' for Puerpueral Sepsis, 'CS' for Caesarian Section, and 'OT' for Other Complications (specify the complication)
3. **Stillbirth:** If stillbirth, indicate whether macerated or fresh. In case of multiple deliveries, record as instructed above.
4. **Blood loss**: Indicate whether there was any blood loss (see labor and delivery guidelines)
5. **Perinuem status**: Using codes provided in the footnote, indicate the state of the perineum following birth. The following codes have been suggested: 1=Intact, 2=1st degree laceration/vaginal graze, 3=2nd degree laceration, 4=3rd degree laceration, 5=Episiotomy, 6=Combined laceration and episiotomy, 7=4th degree laceration, 8=Other
6. **Referred**: Indicate whether the woman was referred and possible reasons for referral
7. **Maternal Outcome:** Indicate the status of the mother after delivery; whether she is in a stable condition, referred for any complication or dead after birth.

Newborn

1. **Sex**: Record the sex of the newborn. In case of multiple deliveries, record as instructed above
2. **Physical Status**: **Apgar score***:* record Apgar score (1-10) of the newborn (refer to score sheet below). In case of multiple deliveries, record as instructed above
3. **Physical Status**: **Head circumference***:* record the head circumference measured in centimeters. In case of multiple deliveries, record as instructed above

4. **Physical Status**: **Size or height**: Record the height of newborn. In case of multiple deliveries, record as instructed above

5. **Physical Status**: **Anomalies**: Indicate whether there are any anomalies with the newborn. In case of multiple deliveries, record as instructed above

6. **Physical Status: Birth weight:** If the newborn's birth weight is less than 2500g, record the actual birth weight in the '<2500g' column. If is 2500g or more, record actual birth weight in '≥2500g' column. In case of multiple deliveries, record as instructed above

7. **Weighed <72 hrs:** Record 'Y' for Yes or 'N' for No if newborn was weighed within 72 hours of after birth.

ARV Prophylaxis

1. **ARV taken during ANC**: Record 1= Triple therapy prophylaxis or 2= Triple therapy treatment for the type of prophylaxis that the mother took during ANC

2. **ARV taken during labor**: Record 1=Triple therapy prophylaxis or 2= Triple therapy treatment or 3=Single dose TDF+3TC+EFV (for HIV negative discordant) for the type of prophylaxis that the mother took during labor.

3. **Received AZT+3TC after delivery**: Record 'Y' for Yes or 'N' for No if mother received AZT+3TC after delivery

4. **Received TDF+3TC during seven days after delivery**: Record 'Y' for Yes or 'N' for No if HIV negative discordant mother received a combination of ARV prophylaxis of TDF+3TC during seven days after delivery

5. **ARV Enfant**: Record the date and time when the infant received NVP

COUNSELED

1. **Breastfeeding**: Record 'Y' for Yes if the mother has been counseled on infant breastfeeding or 'N' for No if mother not counseled.
2. **Family planning**: Record 'Y' for Yes if the mother has been counseled on family planning or 'N' for No if mother not counseled.
3. **Feeding option chosen**: Record the feeding option the mother has chosen for infant feeding. The following codes for the options have been suggested: **EBF**=Exclusive Breastfeeding, **RF**=Replacement Feeding, **O**=Others
4. **Vitamin A**: Record in this column if the mother was given vitamin A after delivery
5. **Name of health worker**: Record the name of health worker who assisted with the delivery

Figure 3: APGAR Score sheet

Apgar Score	0	1	2	Score
Appearance	Bluish-gray or pale all over	Normal color (but hands and feet are bluish)	Normal color all over (hands and feet are pink)	
Pulse	Absent (no pulse)	Below 100 beats per minute	Normal (above 100 beats per minute)	
Grimace	Absent (no response to stimulation)	Facial movement only (grimace) with stimulation	Pulls away, sneezes, or coughs with stimulation	
Activity	No movement, "floppy" tone	Arms and legs flexed with little movement	Active, spontaneous movement	
Respirations	Absent (no breathing)	Slow or irregular breathing, weak cry	Normal rate and effort, good cry	
			Total Score (range 1-10)	

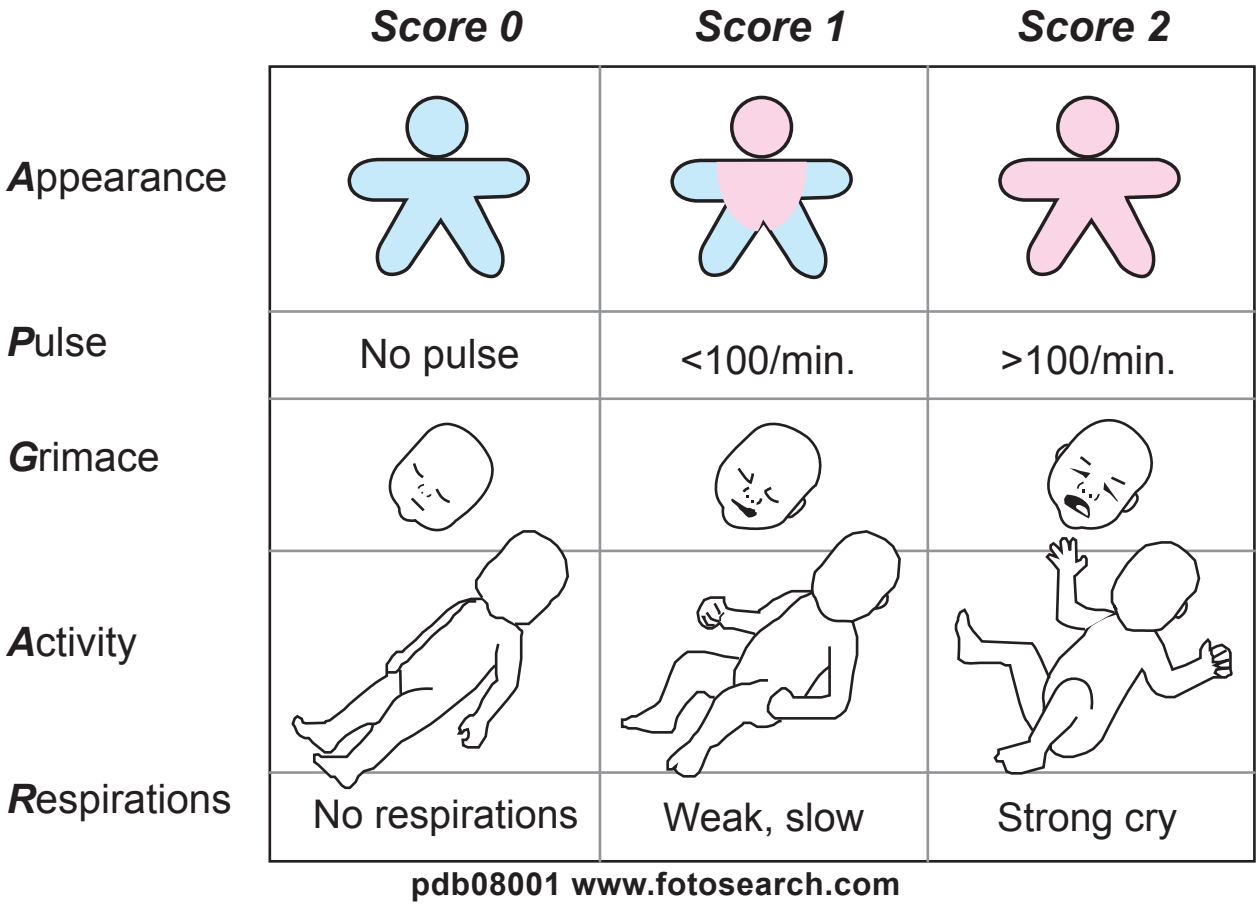


Table 4: Simple of Maternity Register: MATERNITY, LABOUR AND DELIVERY REGISTER)

Serial number	ANC Number	Name in Full Upper row: Surname Bottom row: given name	Address Upper row: District Bottom row: Sector	 Upper row: Cell Bottom row: village	Catchment area (Z, HZ,HD)	Age

MATERNITY, LABOUR AND DELIVERY REGISTER

REGISTRATION														
Admission date	Time of admission	Weight (Kg)	Gravidity	Parity	Number of alive children	DDR *LMP*	DPA *EDD*	*Gest. Age*	Blood pressure	BCF *Fetal Heart Rate*	*Time*	Presentation C=Cephalic B=Breech T=Trans-verse	HIV status at admission (P/N/NC) Upper: *HIV status* Bottom: Date of HIV previous test	*RPR result* (P/N)

MATERNITY, LABOUR AND DELIVERY REGISTER

OBSTETRIC HISTORY					HIV TESTING DURING LABOR		DELIVERY INFORMATION				
Number of Stillbirth	Number of abortions	Number of Caesarian sections	Last born *Birth date*	 *Alive/ dead*	Upper row: HIV result Bottom row: Date	Date of results received	Date and time of delivery Upper row: Date Bottom row: Time	Mode of delivery** (SVD/VE/ CS): Upper row first born Bottom row: second born	Complications (Specify)	Interventions	Avec personnel de santé qualifié *Attended by skilled hlth worker* *(D=Doct M=midwife N=Nurse O=Other)*

MATERNITY, LABOUR AND DELIVERY REGISTER

DELIVERY OUTCOME								ALIVE NEWBORN (*Upper row: first born/bottom row: second born*)													
Term/ -Premauture		Stillbirth		Blood loss within 15 mins after delivery 1=<500ml 2=≥500ml	Perinuem status*	*Maternal Outcome* 1. Stable 2. Referred 3. Died	Cause of maternal deaths	*Sex* (B/G)											Poids a la naissance*** *Birth weight (Préciser le poids)*		
Term	**Preterm (premature) (specify gestation age)**	macerated	Frais						APGAR			Cry at birth (Y/N)	Reanimes/resuscitated (Y/N)	Reanimes et cri dans 5 minutes/resuscitated and cried within 5 minutes	Perimètre cranien *Head circum-ference*	Taille Height	**malformations** congenitales/ congenital **malformations (Y/N)**	<2500g		≥2500g
									1st	5th	10th	**(Y/N)**						term	Premature	

MATERNITY, LABOUR AND DELIVERY REGISTER

		Mother and Child ARV during labour				*COUNSELED*						Observations
Death at birth (Y/N)	breastfed within 1 hour (Y/N	*ARV taken during ANC* (Y/N)	ARV taken during labor 1. Tritherapie 2. Sd-TDF+3TC+EFV (*discordant)*	Discordant Réception de TDF+3TC après l'accouchement pendant 7jours/ *TDF+3TC received for 7 days after delivery* (Y/N)	*Child ARV* *Date and time of receiving NVP*	*Breast-feeding* (Y/N)	Planific-ation familliale *Family planning* (Y/N)	Feeding option chosen B= Breastfeeding RF= Replacement Feeding	Vitamin K (Y/N)	Placed under observation for 72 hours (Y/N)	*Name of health worker*	

*** record the weight of child in respective column

B= Breastfeeding

RF=Replacement Feeding

2. ANC Register

2.1. Purpose of the Format

The ANC register records the pregnancy history of the mother including previous pregnancies and complications and also provides information on the current status of the pregnancies and any possible complications that are related to the pregnancy. This information serves the purpose of tracking the woman's pregnancy in order to improve maternal and perinatal health of the mother and newborn.

2.2. Presentation of the Format

Each row is one pregnant woman. In other words, the ANC register is similar to the chronic care registers (like pre-ART and ART registers) for that particular pregnancy under care. This means that each row contains the name of one pregnant woman for a particular pregnancy and you go back to that row to complete the patient's entry every time you see her during that pregnancy. You do not re-enter the patient into the same register twice until that current pregnancy ends. The columns contain information about the pregnant women, one piece of information per column.

2.3. Data Sources

The information required to complete this register can be found in the maternal health card or mother's card. Please note that the columns in the register are referred to as column 1, column 2, etc. even though they are not actually numbered on the register.

2.4. Preparation and Submission

This register is currently maintained by the nurses or doctors who provide antenatal care to pregnant women. Records should be entered at the time of each visit. This format is not transmitted, but is used to tally data for monthly reports and to support continuity of care.

2.5. Definitions of Terms & Indicators

Gravidity: Record the number of pregnancies the woman has had, including those that ended with an abortion

Parity: Record the number of previous deliveries. Kindly note that in some situations, women may not include stillbirths and early neonatal deaths as deliveries

LMP: Record the date of the Last Menstrual Period

EDD: Record the Expected Date of Delivery (as calculated from the LMP)

Gestational Age: record the gestational age in weeks. Gestational age, for this column, is the time measured in weeks from the day of the woman's last menstruation to the current date when she is visiting the facility.

Standard visit: The 4 ANC visits scheduled as part of monitoring of a normal delivery, it doesn't include ad hoc visits made by the women because of complications or other discomfort: The first standard visit should be during the first trimester,

Non-Standard Visit: An ad hoc visit to the maternity or obstetrical service by a pregnant women due to complications or other discomfort.

2.6. Detailed Instructions for Completing Format

1. **Serial number:** Record the patient's hospital serial number for the month. At the beginning of the month, restart numbering at 1. Then assign each woman attending ANC for the first time during that month the next serial number. This is a quick way of tracking how many women are attending ANC for the first time each month.

2. **ANC Number***:* Record the ANC number assigned to the woman from the maternal health card or mother's card.

3. **Date of visit**: Record the date of visit. This corresponds to the date when the pregnant came for antenatal care for the first time at the health facility.

4. **Name in Full:** Record full name of the woman with the family name written in the upper space and given name in lower space (e.g KAGUBARE / Marie).

5. **Addresse**: **sector:** record the sector in which the mother currently resides

6. **Addresse**: **cell:** record the cell in which the woman currently resides

7. **Addresse**: **village**: record the village in which the woman currently resides

8. **Catchment area**: Record 'Z' if patient currently resides within the health facility catchment area, 'HZ' if the patient currently resides outside the health facility catchment but within the district where the facility is located and 'HD' if patient currently resides outside the district where the facility is located

9. **Date of Birth**: record the date of birth of pregnant woman in the format DD/MM/YYYY

10. **Age**: Record the woman's completed age in years

Registration

1. **Marital status***: R*ecord the marital status of the woman during her first ANC visit. Marital status has been coded as CE=Single, MA=Married, DI=Divorced, SE= Separated, CO=Co-habiting and VE=Widow

2. **Pregnacy:** Record the number of pregnancies the woman has had, including those that ended with an abortion

3. **Parity:** Record the number of previous deliveries. Kindly note that in some situations, women may not include stillbirths and early neonatal deaths as deliveries unless they are directly asked about them.

4. **Number of children**: Record the number of surviving children born to the woman

5. **LMP**: Record the date of the Last Menstrual Period

6 **EDD**: Record the Expected Date of Delivery (as calculated from the LMP).

7 **Gestational Age**: record the gestational age in weeks. Gestational age, for this column, is the time measured in weeks from the day of the woman's last menstruation to the current date when she is visiting the facility.

Obstetric History

1. **Stillbirth child**: Record the total number of stillbirth the woman has had during her lifetime
2. **Abortion:** Record the total number of abortions the woman has had during her lifetime
3. **Caesarian section:** Record the total number of caesarian sections the woman has had during her lifetime
4. **Last born-Birth date**: If the woman has had a delivery before, irrespective of the outcome of that delivery, record the date of delivery for the last pregnancy that precedes the current pregnancy.
5. **Last born- Alive/ dead:** Record the outcome of the last delivery. The status of the last born can be classified as 'Alive' or 'Dead' at the time of delivery.

Risk Factors

1. **1st visit- Date**: Record the date the woman came to the facility the first time for ANC.
2. **1st visit- Gest age**: Record the gestational age in weeks from the day of the woman's last menstruation to the current date when she is visiting the facility for her first antenatal care visit.
3. **1st visit- ANC RF**: For the first antenatal visit, enter the antenatal risk factor associated with the pregnancy using the codes provided at the bottom of the register page.
4. **2nd visit- Date**: Record the date the woman came to the facility the second time for ANC.
5. **2nd visit- Gest age**: Record the gestational age in weeks from the day of the woman's last menstruation to the current date when she is visiting the facility for her second antenatal care visit.
6. **2nd visit- ANC RF***:* For the second antenatal visit, enter the antenatal risk factor associated with the pregnancy using the codes provided at the bottom of the register page.
7. **3rd visit- Date**: Record the date the woman came to the facility the third time for ANC.
8. **3rd visit- Gest age**: Record the gestational age in weeks from the day of the woman's last menstruation to the current date when she is visiting the facility for her third antenatal care visit.
9. **3rd visit- ANC RF**: For the third antenatal visit, enter the antenatal risk factor associated with the pregnancy using the codes provided at the bottom of the register page.
10. **4th visit- Date**: Record the date the woman came to the facility the fourth time for ANC.
11. **4th visit- Gest age**: Record the gestational age in weeks from the day of the woman's last menstruation to the current date when she is visiting the facility for her fourth antenatal care visit.

12. **4th visit- ANC RF:** For the fourth antenatal visit, enter the antenatal risk factor associated with the pregnancy using the codes provided at the bottom of the register page.

13. **Non-Standard Visit**: Record the date the woman came to the facility for any other ANC visit after the fourth standard visit.

14. **Reference- Antenatal Risk Factor:** Record 'Y' for Yes or 'N' for No if the woman was referred for any antenatal risk factor

15. **Previously known HIV status**: Record either 'P' for positive or 'N' for negative the woman's HIV status during enrolment in the ANC clinic. For those who have never tested or do not know their HIV status during enrolment for ANC, record 'NC' for 'Unknown' status

Services

HIV MONITORING

1. **HIV – Date of test**: Record the date the woman has been given an HIV test during ANC. This HIV test applies to women with unknown HIV status during enrolment or those with previously known HIV negative status during enrolment.

2. **HIV result**: Record 'P' for positive or 'N' for negative HIV test results. In some cases, the HIV test results may be inconclusive. In this case, subsequent tests might be taken until the final status is revealed. Use the date of the final test and results to update the register.

3. **Date of results submission**: Record the date when the woman received the test results in this column

4. **2nd HIV test-date**: If the pregnant woman is discordant HIV negative, record the date of the second HIV test

5. **2nd HIV test- results**: If the pregnant woman is discordant HIV negative, record the test results of the second HIV test

6. **3rd HIV test-date**: If the pregnant woman is discordant HIV negative, record the date of the third HIV test

7. **3rd HIV test- results**: If the pregnant woman is discordant HIV negative, record the test results of the third HIV test

HIV POSITIVE WOMEN

1. **Creatine test result** : Record the creatine test results (in mg/dL) and the date when done in the lower row

2. **CD4**: record the CD4 cell count in the upper row and date when the CD4 test was done in the lower row

3. **WHO clinical stage**: Record the WHO clinical stage of the pregnant mother

4. **Date of appointments for ARV**: record the date of appointment for ARVs

5. **ARV prophylaxis start date**: Record the date when the pregnant woman was started on ARV prophylaxis

6. **ARV préscrits**: record 1= Triple therapy prophylaxis or 2= Triple therapy treatment for the type of prophylaxis that the pregnant woman was started on during ANC in the upper row and the code of ARV regimen in the lower row e.g. 1a for TDF+3TC+NVP or 1b for TDF + 3TC + EFV.

7. **Cotrimoxazole start date:** record the date of start of Cotrimoxazole prophylaxis

8. **Screened for TB?:** Indicate with 'Y' for Yes or 'N' for No if the pregnant mother was screened for TB

9. **Lost to prophylaxis follow-up?:** Indicate with 'Y' for Yes or 'N"'for No if the pregnant mother is a lost to follow up for prophylaxis

TEST RPR

1. **RPR** – Date of test: Record the date the woman has been given a RPR test during ANC

2. **RPR result**: Record 'P' for positive or 'N' for negative RPR test results.

3. **Treatment:** Record either 'Y' for Yes or 'N' if the woman with Positive RPR results received treatment.

4. **Partner treatment**: Record either 'Y' for Yes or 'N' if the partner of the woman with Positive RPR results received treatment as a result of his wife/partner being positive for RPR

5. **Tetanus vaccination Dates:** To ensure that all antenatal care patients and their newborn babies are effectively protected against tetanus, women attending ANC are given tetanus doses until delivery. Record the date of vaccination in the appropriate column for each time the woman is given a tetanus dose until delivery. This information can be taken from the patient's tetanus card and not from her memory.

6. **Mosquito net**: Record 'Y' for Yes or 'N' for No if the pregnant woman received a mosquito net during ANC or after delivery.

SEXUAL PARTNER

1. **Partner visited ANC clinic?:** Record 'Y'for Yes or 'N' for No if the sexual partner visited the ANC clinic during the pregnancy to receive services offered to partners of pregnant women

2. **Date of partner HIV test:** Record the date when the sexual partner attending any ANC visit with the pregnant woman received testing for HIV

3. **Partner HIV result**: Record 'P' for positive or 'N' for negative partner HIV test results. In some cases, the HIV test results may be inconclusive. In this case, subsequent tests might be taken until the final status is revealed. Use the date of the final test and results to update the register

4. **Shared results**: Record 'Y' for Yes or 'N' for No if both sexual partners shared their HIV test results. This information should be updated after confirmation that both partners have shared their results in the presence of the health worker. In some instances, partners can test separately but share their results, update where applicable.

5. **Partner syphilis Test**: Record the syphilis test results for the partner in the upper row and the date when the test was done in the lower row.

PREGNANCY OUTCOME

1. **Abortion**: In case the pregnancy outcome was an abortion, tick with (√) in the respective column whether it was completed or not completed

2. **Date of delivery**: Record the date of delivery

3. **Location of delivery***:* Record 'F' if the delivery took place in a health facility, or 'H' from mother's or any other person's home.

4. **Normal delivery**: For normal deliveries, tick with (√) the respective columns whether it was a Term or Preterm delivery.

5. **Complication**: Using the codes at the footnote of the page, record any complications found and remember to update the same information on the mother's ANC card. The following codes have been suggested: 'X' for no complication, 'HPP' for postpartum hemorrhage, 'E'for eclampsia, 'OT' for obstructed labor, 'S' for third degree tier, 'D' for breech, "SP" for puerpueral sepsis, 'SC' for caesarian section, and 'A'for other complications (specify the complication)

6. **Stillbirth**: record in this column if the birth outcome was a stillbirth

7. **Vitamin A**: Record in this column if the mother was given vitamin A after delivery

Table 5: Sample of ANC REGISTER

ANC REGISTER

Serial number	ANC No	Date of Visit	Name in full Upper Space: surname Lower space: given name	Address		Catchment area (Z, HZ, HC)	Date of birth	Age	Marital status	Gravity	Parity	Number of children	Number of stillbirth	Number of abortion	Number of caesarian section	Last born		Last menstruation period LMP	Expected date of delivery	Gestational age	ANC STANDARD VISITS										Previously known HIV Status P: positive N: negative UN: Unknown
																					1st visit		2nd Visit		3rd Visit		4th visit				Reference for antenatal Risk Factor (Y/N)	
				Upper row: District Lower row: sector	Upper row: Cell Lower row: village											Birth date	alive/ deceased				Upper space: date Lower space: gestational age	ANC RF	Upper space: date Lower space: gestational age	ANC RF	Upper space: date Lower space: gestational age	ANC RF	Upper space: date Lower space: gestational age	ANC RF				

***Marital status**

CE: Single **MA:** Married **D:** Divorced **SE:** Separated **CO:** Co-habiting **VE:** Widow

***Antenatal Risk Factor**

X: No risk factor **A:** Anemia **O:** Oedema **P:** proteinurta **POS:** not gaining weigh **HAP:** ante partum haemorrage

ANC REGISTER

SERVICES																								SEXUAL PARTNER				PREGNANCY OUTCOME	
HIV MONITORING							HIV positive women							RPR TEST				Tetanus Vaccination dates					Date of receiving Mosquito net						
HIV Test Upper row: HIV Result Lower row: Date	Date of submission of result	HIV Test Upper row: HIV Result Lower row: Date	2nd HIV Test Upper row: HIV Result Lower row: Date	3rd HIV Test Upper row: HIV Result Lower row: Date	Creatine Upper row: Result Lower row: Date	CD4 Upper row: Result Lower row: Date	WHO Clinical Stage	Appointment Date of ARV	ARV prophylaxis start date	Upper row: 1= triple therapy prophylaxis 2= triple therapy treatment Lower row: ARV code regimen	Cotrimoxazole start date	Screened for TB? (Y/N)	Lost to prophylaxis follow-up? (Y/N)	Date of RPR screening	RPR Test Upper row: RPR Result Lower row: Date	Treatment (Y/N)	Partner treatment (Y/N)	Date TT1	Date TT2	Date TT3	Date TT4	Date TT5		Partner visited ANC clinic (Y/N)	Partner HIV test Upper row: HIV Result Lower row: Date	Shared results (Y/N)	Partner RPR Test Upper row: RPR Result Lower row: Date	Delivery outcome	Upper row: Location of delivery F: Health Facility H: Hospital

T= High blood pressure above 140/90 POS: Abnormal lle ..after 32 weeks NM= Multiple births Au= Other

** Tripletherapy prophylaxis

1a=TDF + 3TC + NVP 1b= TDF + 3TC + EFV 1c= ABC + 3TC + NVP 1d=ABC + 3TC + EFV 1e= TDF + 3TC + Lop/rlt 1f= ABC + 3TC + Lop/rlt 1g= others (specify)

** Tripletherapy TTT

2a=TDF + 3TC + NVP 2b= TDF + 3TC + EFV 2c= ABC + 3TC + NVP 2d=ABC + 3TC + EFV 2e= TDF + 3TC + Lop/rlt 2f= ABC + 3TC + Lop/rlt 2g= others (specify)

3. Family Planning Register

3.1. Purpose of the Format

The Family planning register records selected information about FP clients in health facilities. The register is designed to help service providers aggregate data for their monthly reports as well as to monitor continuity of care.

3.2. Presentation of the Format

Each row is one user. Data are initially recorded on the left side of the register during the first FP consultation visit. The register is pre-printed on A3 format with approximately 24 acceptors per page. The remaining columns contain space for recording a note on each monthly visit during 6 years as well as a column for recording HIV status during each year

At the bottom of the page is a place to total the number of dropouts, new users and users at the end of the month.

At the end of 6 years you should transfer your existing clients to a new section of the register and begin again with year 1.

The register is intended to be used in combination with other recording tools (Client Form, Client Appointment card and Appointment box) to compile data for the monthly health facility reports and ensure continuity of care.

3.3. Data Sources

The information required to complete this register can be found in the Family Planning Client Form, or through the initial interview with the client.

3.4. Preparation and Submission

This form is maintained by the Family Planning counselor or other health worker providing family planning services. Notes should be taken during the course of the initial visit, so that key observations are not forgotten. This format is not transmitted, but it is used to tally data for monthly reports.

At the end of each month, total the number of users by type and by method in these boxes. Drop-outs should be marked with an X the month that they missed their scheduled appointment and counted regardless of the reason for stopping contraception. You will do a separate analysis of dropouts using a tally sheet.

Once the total has been completed for the past month, transfer the numbers from each page to a tally sheet like the one on page and add them up for your all Family planning clients who were received or expected by the end of the month. Remember to skip clients who have dropped out during earlier months (blank cells).

If a user dropped out and returned for a contraceptive method again later on, do not count them as a new user, but count them instead with the continuing users at the end of the month.

3.5. Definition of Terms & Indicators

New acceptor: A new acceptor is an individual who adopts a family planning method for the first time in their life. This data element is useful for tracking the recruitment rate of new contraceptive users. This is different from a new registration which can be for either a new acceptor or someone who previously used contraceptives elsewhere and is re-registering for family planning services at your health facility.

Stopped using PF: A client who stopped using contraceptive (otherwise known as abandoned, drop-out, or lost to follow-up) is any user who decides to stop using their contraceptive method for whatever reason or who does not return for follow-up visits or re-supply of renewable contraceptive methods.

Continuing user at end of month: This is any user who is protected by one or more contraceptive methods at the end of the reporting period. Continuing users include previously registered individuals as well as new acceptors and new registrations during the month. Continuing users do not include clients who abandoned contraceptive use during the month.

Roaming users: These are contraceptive users visiting a different health facility because they are travelling. In order to encourage continuity of family planning services, roaming users should be welcomed in other health facilities. For recording puposes they should be added to the register and counted as users at the end of the month, but not given a serial number. For renewable methods, they should be provided with the usual number of units of contraceptives that they receive at their home facility. When they do not return for re-supply after their visit they should be marked with an X and counted as stopped using FP at this facility. Note: if they do not have their FP client appointment card that states the method prescribed, they should also complete an individual FP client form and case history in order to ensure they do not have any risk factors for the method they desire.

3.6. Detailed Instructions for Completing Format

Please note that the columns in the register are referred to as column 1, column 2, etc. even though they are not actually numbered on the register.

1. **Registration No:** Each newly registered family planning client, should receive a unique number for the health facility where they are registered. Registration numbers may be issued as a single serial number 0,1, 2, 3… etc.., or 2012/1, 2012/2, 2012/3, etc… New numbers are issued to clients whether they are new users (never used FP before) or have transferred from other FP clinics. This number should also be written on the FP planning client form.
2. **NID:** This is the 16 digit national ID number, for foreign clients, you can include passport number or other form of identification.

3. **Registration Date:** this is the date of initial registration at this health facility or family planning clinic.

4. **Name and First Names:** Enter the name of the client followed by first name and middle name. In some areas, individuals are known by nicknames, such as "Maman Alex". You could also record the more familiar nickname.

5. **Telephone Number:** Enter the client's telephone number so that you can contact the person if they miss an appointment or if you need to contact them for any other reason.

6. **Date of Birth** (DD/MM/AAAA): use the format Day/Month/Year for example 29/4/2012

7. **Sex** (M/F)**:** enter M for males or F for females

8. **History of FP use**:

   a) Used any family planning method previously? (Y/N)

   b) Methods previously used, enter the appropriate code(s) from the list of codes in the Family Planning Encounter monitoring sheets.

9. **HIV status at registration**:

   a) Date of last test: enter the date of the last HIV test done before registration

   b) HIV status: enter Pos or Neg result of the last HIV test done

   c) Was the client counselled about HIV> Enter Y for yes or N for no.

   d) If HIV positive

10. **FAMILY PLANNING ENCOUNTER MONITORING SHEET**

    a) **Year:** enter the year for which encounters are being monitored

    b) **Months** – Jan to December: enter the code corresponding to the method used during the month. If a person received 3 months of supply, write the code for the method for each of the months during which s/he is covered. If a person misses their appointment – a blank box, enter X the first month missed and record as a dropout.

In this sheet enter the following codes for the method currently being used:

P= Pill

S=DIU

I=Injectible

CM= Male Condom

CF= Female Condom

B= Other barrier method

A=Auto observation

CL= Cycle beads

M=Implants

T=Tubal Ligation

V=Vasectomy

If a patient becomes lost to follow-up or abandons a method for whatever reason, enter an X

X=Lost to follow up

In the column SRV, enter the result of the annual HIV teat **Neg** ou **Pos**

Reg #	Name	YEAR: 2012 **P**=pilule progestative **S=**DIU **I**=injectables **CM**= condom masculin **CF**=condom feminin **B**= Barriere autres **A**=Auto observation **CL**= Collier **M**=Implants **T**=Ligature des trompes **V**=Vasectomie **X**=Perdu de vue *SRV*: **Neg** ou **Pos**												
		Jan	*Feb*	*Mar*	*Apr*	*May*	*Jun*	*Jul*	*Aug*	*Sep*	*Oct*	*Nov*	*Dec*	**SRV**
13	*Marie*	C	C	P	P	P	P	P	P					Neg
14	*Jeanine*		P	P	P	X	-	-	-					Neg
15	*Florence*		C	I	I	I	I	I	I					Neg

11. **Observations:** Note any comments about the patient (Moved, died, had method failure, etc…), if this a roaming patient, record this here and write the name of the health facility that usually provides services.

Table 6: FAMILY PLANNING REGISTER

Serial No. (nn/YY/MM)	NID number	Date of registration	Name in Full	Origin (Zone=Z Hors Zone=H)	Telephone number	Date of birth (dd/mm/yyyy)	Sex (M/F)	Previous FP use		HIV Status			
								Used FP method previously? (Y/N)	Previously used methods	HIV status at registration (Pos,Neg, DNK)	Date of last HIV test	Counsel-led for HIV (Y/N)	Referred for HIV test (Y/N)

Suite du Registre de Planification Familiale/Continuation of Family Planning Register

FAMILY PLANNING ENCOUNTER MONITORING SHEET (Write in year)																									
YEAR: _____ **P**=pill **S**=DIU **I**=injectables **MC**= male condom **FC**=female condom **B**= other barreer **A**=Auto observation **CL**= Collar **M**=Implants **T**=Ligature of Fallopian tubes **V**=Vasectomy **X**=Disappeared *SRV*: **Neg** ou **Pos**													YEAR: _____ **P**=pilule **S**=DIU **I**=injectables **CM**= condom masculin **CF**=condom feminin **B**= Autre Barrieres **A**=Auto observation **CL**= Collier **M**=Implants **T**=Ligature des trompes **V**=Vasectomie **X**=Perdu de vue *SRV*: **Neg** ou **Pos**													
												SRV (Pos,Neg)													**SRV** (Pos,Neg)
Jan	*Feb*	*Mar*	*Apr*	*May*	*Jun*	*Jul*	*Aug*	*Sep*	*Oct*	*Nov*	*Dec*		*Jan*	*Feb*	*Mar*	*Apr*	*May*	*Jun*	*Jul*	*Aug*	*Sep*	*Oct*	*Nov*	*Dec*	

Suite du Registre de Planification Familiale Continuation of Family Planning Register

FAMILY PLANNING ENCOUNTER MONITORING SHEET (Write in year)

YEAR: _____ **P**=pilule/pill **S**=DIU **I**=injectables **MC**= male condom **FC**=female condom **B**= other barreer **A**=Auto observation **CL**= Collar **M**=Implants **T**=Ligature of Fallopian tubes **V**=Vasectomy **X**=Disappeared *SRV*: **Neg** ou **Pos**													**YEAR: _____** **P**=pilule **S**=DIU **I**=injectables **CM**= condom masculin **CF**=condom feminin **B**= Autre Barrieres **A**=Auto observation **CL**= Collier **M**=Implants **T**=Ligature des trompes **V**=Vasectomie **X**=Perdu de vue *SRV*: **Neg** ou **Pos**												
Jan	*Feb*	*Mar*	*Apr*	*May*	*Jun*	*Jul*	*Aug*	*Sep*	*Oct*	*Nov*	*Dec*	**SRV** (Pos,Neg)	*Jan*	*Feb*	*Mar*	*Apr*	*May*	*Jun*	*Jul*	*Aug*	*Sep*	*Oct*	*Nov*	*Dec*	**SRV** (Pos,Neg)

Suite du Registre de Planification Familiale Continuation of Family Planning Register

YEAR: _____ **P**=pilule/pill **S**=DIU **I**=injectables **MC**= male condom **FC**=female condom **B**= other barreer **A**=Auto observation **CL**= Collar **M**=Implants **T**=Ligature of Fallopian tubes **V**=Vasectomy **X**=Disappeared *SRV*: **Neg** ou **Pos**													**YEAR: _____** **P**=pilule **S**=DIU **I**=injectables **CM**= condom masculin **CF**=condom feminin **B**= Autre Barrieres **A**=Auto observation **CL**= Collier **M**=Implants **T**=Ligature des trompes **V**=Vasectomie **X**=Perdu de vue *SRV*: **Neg** ou **Pos**													**Observations**
Jan	*Feb*	*Mar*	*Apr*	*May*	*Jun*	*Jul*	*Aug*	*Sep*	*Oct*	*Nov*	*Dec*	**SRV** (Pos,Neg)	*Jan*	*Feb*	*Mar*	*Apr*	*May*	*Jun*	*Jul*	*Aug*	*Sep*	*Oct*	*Nov*	*Dec*	**SRV** (Pos,Neg)	

4. Family Planning Client Appointment Card

4.1. Purpose of the Format

The Family Planning Client Appointment Card is a small card on which key information about the client is kept including, Client Name, Health Facility Name, Registration Number, methods used and the dates of past and future appointments. The card is issued during the first visit for users of renewable methods (not needed for vasectomy or tubal ligation) and should be brought by the client to each appointment to facilitate finding the patient record and to note the date of the next appointment.

4.2. Presentation of the Format

This is a small card with identification information and then a table with appointment dates and observations. It is designed to be carried by the client as a reminder of future appointment dates. It also includes the method currently being used, in case the user is travelling and seeks to obtain contraceptives from a different health center. The table with appointment schedules should continue on the back of the card.

4.3. Data Sources

The information required to complete this form are entered during initial registration and then additional notes are added at the end of each FP appointment before returning it to the client.

4.4. Preparation and Submission

This form is maintained by the FP counsellor or other Health worker providing family planning services. Once the date of the next appointment is entered, the card is returned to the client as a reminder of the next appointment.

4.5. Definition of Terms & Indicators

FP appointment date: Appointments are typically set after different periods of time depending upon the method of contraception used:

Method	Date of next appointment
Pill – 1st visit	28 days after first visit – for status check and re-supply
Pill – all other visits	3 months after present visit assuming that the client is re-supplied with 3 cycles.
Injectible – Depo Provera	3 months after last injection
Implant – Norplant	7 days after insertion of implant. After that once per years for check-up
Condoms – male or female	Varies depending upon the individual – normally once a month.
Cycle beads	No follow-up appointments necessary, only request that they return to health facility if there is a method failure or if they have questions.
Vasectomy	Usually request follow-up visit for sperm count test after 3 months. After negative test, no need for future appointment
Tubal Ligation	Return 3 days after surgery to remove dressings and control for infections. No future appointments required
IUD	Return after the first menstruation following insertion to ensure IUD is still there. After that, 1 appointment per year.

Note that all clients are encouraged to return if they suffer and adverse effects, experience a method failure or have any questions about the method they have selected.

4.6. Detailed Instructions for Completing Format

When the client is first registered at the health facility, a new card is issued and identification data are entered. At the end of each appointment, additional notes are entered in the table by the FP counselor or health worker and returned to the client.

Complete the form as follows:

1. **Health Facility**: Write the name of the health facility where the card was issued.
2. **Client Name** : Write the name of the client
3. **FP Consultation Form Number**: Write the client's FP registration number, usually this is the number that was entered in the register the first time that the client came for family planning services and it is also written at the top of the individual FP consultation form.
4. **Revisit date**: Write the date that the client was seen
5. **Prescription:** Write the family planning method that was prescribed or continued during the visit
6. **Next appointment**: Write the date of the next appointment

Table 7: FP Monitoring Individual Form

REPUBLIC OF RWANDA
MINISTRY OF HEALTH
P.O. Box 84 KIGALI

Health Facility Name:

Client Name:

FP Consultation Form Number:

Revisit date	Prescription	Next Appointment	Revisit date	Prescription	Next Appointment

5. Family Planning Consultation Form

5.1. Purpose of the Format

The Family Planning Consultation Form is used to record the history of family planning use for all family planning users. It contains demographic information about the client, information about the eligibility criteria of the user and method selection during the first visit, then a history of all visits that the client makes. It is also used to record the date of the next appointment.

5.2. Presentation of the Format

The Family Planning Consultation form is used for individual case management of family planning clients. It should be printed on light card, so that it will stand upright and can be easily moved around in the appointment file box. If a client continues to use the system over many years, an additional form can be stapled to the original form.

Every client should be issued a client form during their initial registration at a health facility regardless of the method selected. If the client moves to a new location, they can request transfer of their form, or a new form can be entered for them in their new health facility.

At the top of the form is a space where the health worker can stick a small colored dot which corresponds to the method currently being used by the client.

Method	Color of dot
Pill	Blue
Injectable	Red
IUD	Yellow
Implant – Norplant	Green
Condom	Black
Gell or other barrier method	White
Cycle beads	

There is no need to put a dot on the client forms for those who select permanent methods (vasectomy or tubal), since those records are not maintained in the appointment box and can be easily counted in the permanent method file,

Similarly clients who have selected natural (non-renewable methods) such as cycle beads and auto-observation are not typically given follow up appointments, so they should be maintained in a separate file. If there is a temporary stockout of stickers, the marks can be applied with markers, but it is best to use stickers that can be pasted on top of each other to see the most recent method on top.

5.3. Data Sources

The information required to complete this form comes from the initial encounter with a newly registered client and the medical history taken at the time. In addition, notes are recorded during each follow-up appointment in the table designed for that purpose.

5.4. Preparation and Submission

This form is maintained by the Family Planning counsellor or Health Worker providing family planning services. Notes should be taken during the course of each visit, so that key observations are not forgotten. This format is not transmitted, but it is filed so that it can be counted to compile data on abandoned clients and continuing users at the end of the month.

Depending upon the method used, the forms are filed in different places:

Appointment Box: Client cards for all renewable methods (Condom, Pill, IUD, Implant, Gel) should be filed in the appointment box, according to the month and date of the next appointment.

Natural Family planning methods folder: Client cards for users of natural family planning methods should be filed in a separate folder as they do not have future appointments. If such a user decides to change to a renewable or permanent method, the card should be moved to the appropriate folder.

Permanent methods folder: Client cards for users of permanent family planning methods should also be filed in a separate folder as they do not have future appointments.

Abandon folder: Clients cards for those who are lost to follow-up or have decided to abandon contraception should be kept in a separate folder for follow-up action. CHW's can be informed to locate the missing user in their village and provide counselling.

Archive folder: Clients cards for those who have died or female adopters of permanent methods who reach 50 years of age should be

5.5. Definition of Terms & Indicators

Renewable family planning methods: Renewable family planning methods include contraceptive pills, condoms, implants, IUD, contraceptive jells and injectables.

Permanent family planning methods: Permanent family planning methods include

Natural family planning methods: Cycle beads

For other case definitions see above.

5.6. Detailed Instructions for Completing Format

During the initial family planning consultation, the health worker must complete the first sections of the family planning card. This includes:

1. Identification data: enter the data for each of the following fields:

Province: write the name of the province

District Hospital: write the name of the district hospital that supervises the health facility

Health Facility: write the name of the health facility where the service is being provided.

Consultation date: enter the date of the first consultation here, when the form is first filled out.

N°: enter the family planning registration number that corresponds with the next available number on the FP register.

2. **Patient identification: record the following patient identification data on the form**

Full Name:

Province:

Administrative District:

Sector:

Cell:

Village:

3. Patient demographics:

Sexe: (M for Males, F for Females)

Birth Date: date of birth in format dd/mm/yyyy

Maritial Status: marital status should be recorded as: S=Single, M=Married, D=Divorced

Telephone Number:

Education Level:

Profession:

Religion:

Gravidity: write the number of pregnancies the client has had

Parity: write the number of deliveries the client has had

Alive Children: how many live children there are

Desired children: what is the number of children the client desires

Date of last delivery: what was the date of the last delivery, if any

Date of last abortion: what was the date of the last abortion or miscarriage

Number of dead children: number of childred who diedWhat is the purpose of seeking family planning services:

Birth spacing: check this box if the primary reason for using family planning is for birth spacing

Birth Limitation: check this box if the primary reason for using family planning is for limiting births

Desired method: note the family planning method desired by the client during the initial contact

Date of Last Menatruation: Record the date of last menstruation

4. Previous use of Contraceptives: record for the woman and the woman's partner any previous use of contraceptives:

Last method used

How long the method was used

Reason for stopping the method

5. Table of eligibility criteria for contraceptive methods: Record Yes or No next to each question in the table. If all of the responses are No, then the client is eligible for all of the methods available. If there are any criteria for which the answer is Yes, the service provider should review each one to decide the client's eligibility for particular methods. The legend below indicates a client's eligibility for a method based upon a particular criterion:

+= Eligible (WHO category 1)

(-) = Relative eligibility (WHO category 2)

- = Not eligible (WHO categories 3 and 4)

A. MEDICAL HISTORY	**Yes/Not**
1. Never pregnant	
2. Post-partum < 6 weeks and breastfeeding	
3. Post-partum < 6 weeks not breastfeeding	
4. Post-abortion < 6 weeks	
5. Caesarian section< 6 months	
6. Diabetes not monitored	
7. Two of the following risk factors - Age > 35 ans (age >35 years) - Heavy smoker - Obesity	
8. Hypermenorrhea, Dysmenorrhea	
9. Metrorragies	
10. undergoing treatment that could interfere with hormonal contraceptives	
B. ANTECEDENTS	
1. Phlebitis, Thrombosis, Embolisms	
2. Ectopic pregnancy	
3. Genital infection	
4. Recent liver disease<6months	
C. EXAMEN GENERAL & GYNECOLOGIQUE / GENERAL & GYNECOLOGIC EXAMINATION	
1. Conjonctives jaunes (maladie du foie) (jaundice)/ Liver disease (jaundice)	
2. cardiovascular pathologies	
3. Poids (préciser le poids): Weight (specify weight):	
4. Blood Pressure > 14/9, specify BP	
5. Breast tumor	
6. Phlebitis, varicose veins	
7. pelvice tumor non-diagnosed	
8. Pelvic inflammatory disease	
9. genital infection	
10. HIV positive	
11. Under treatment with ARVs	
12. Pregnant	

6. **ADDITIONAL EXAMINATIONS** (if required): record here the results of any complementary medical exams or lab tests that may be required before recommending/selecting a method.

7. **CONCLUSION**

   a. **Client method selected**: record the method selected by the client:

   b. **Methods for which the client is eligible:** record the methods for which the client is eligible based upon the table of eligibility on the first page

   c. **Offered methods:** write the method offered by the health service provider.

8. **Control and Follow-up:** Use this table to record observations about each visit and schedule the next visit for clients:

   a. **Visit Date :** record the date of the visit

   b. **Specified or used method:** note the method used by the client

   c. **Complaints:** record any complaints that the client may have had

   d. **Exams:** record information about any physical or lab exams that were done

      i. Poids: weight in kilos

      ii. BP: Blood Pressure

      iii. Other Exams (Including gynecologixcal): note any other exams that were completed

   e. **Observations and treatments:** record any observations or treatments recommended

   f. **Next Appointment:** note the date of the next appointment and record this as well on the FP client form.

Table 8: FP Consultation Form

REPUBLIC OF RWANDA

MINISTRY OF HEALTH
P.O. Box : 84 KIGALI

FP CONSULTATION FORM

Province : District Hospital: Health Facility:	Consultation Date	**N°**
Full Name: Province : Administrative District: Sector : Cell: Village :	Sex : Birth date : Maritial status: Telephone number:	Education level : Profession : Religion :

Gravity: Parity:	Client objectif for using FP: ☐ Birth spacing ☐ Birth limitation	Previous use of Contraceptives		
Alive Children			For the woman	For the man
Desired children	Desired method:	Last used method		
Date of last delivery:	DDR :	How long used		
Date of last abortion:	Number of deceased children:	Reason for stopping		

Instructions for using the table eligibility criteria here below:

Reply by Yes or No to the criteria quated here below

- If all reply are 'No', then the client is eligible to all methods
- If there are 'No' replies to criterias, you would then go through them one by one to determine the eligibility or ineligibility of the client for the method considered (chosen).

D. ANAMNISIS	YES/ NO	PC	PP	Inject.	Implants	DIU	MAO	Collier	Barrier	CCV
1. Nulligeste		+	+	+	+	(-)	+	+	+	-
2. Post partum < 6 weeks and feeding		-	(-)	(-)	(-)	(-)	-	(-)	+	+
3. Post-partum < 6 weeks without feeding		(-)	+	+	+	(-)	(-)	(-)	+	+
4. Post abortum < 6 weeks		+				(-)	-	+	+	+
5. Caesarean <6 months		+	+	+	+	(-)	+	+	+	+
6. Unmonitored diabetes		(-)	+	+	+	(-)	+	+	+	+
7. Two signs from: - Age> 35 years - Heavy smoking - Obesity		-	+	+	+	+	+	+	+	+
8. Hypermenorrhea, Dysmenorrhea		+	+	+	+	(-)	+	+	+	+
9. Bleeding		-	-	-	-	-	+	+	+	+
10. Treatment may interfere with hormonal contraceptives		-	-	-	-	+	+	+	+	+

E. BACKGROUND										
1. Phlebitis, arterial thrombosis, embolism		-	(-)	(-)	(-)	+	+	+	+	+
2. Extra Uterine Pregnancy		+	+	+	+	(-)	+	+	+	+
3. Genital Infection		+	+	+	+	(-)	+	+	+	+
4. Recent liver disease (<at 6 months)		-	-	-	-	+	+	+	+	+
F. GENERAL & GYNAECOLOGICAL EXAM										
1. Yellow conjunctiva (liver disease)		-	-	-	-	+	+	+	+	+
2. Cardiovascular disease		-	-	-	-	+	+	+	+	+
3. Weight (specify weight):		+	+	+	+	+	+	+	+	+
4. TA> 14/9 (specify TA)		-	(-)	-	(-)	+	+	+	+	+
5. Mammary		-	-	-	-	+	+	+	+	+
6. Phlebitis, varicose large, deep		(-)	+	+	+	+	+	+	+	+
7. Undiagnosed pelvic tumor		-	-	-	-	-	+	+	+	(-)
8. Pelvic inflammatory disease		+	+	+	+	-	+	+	+	(-)
9. Genital Infection		+	+	+	+	-	+	+	+	-
10. HIV positive		+	+	+	+	(-)	+	+	+	+
11. ARV treatment		+	+	+	+	+	+	+	+	+
12. Pregnant		-	-	-	-	-	-	-	+	-
Legend: **+= Eligible (category 1 WHO)** **(-) = Eligibility relative (Category 2 WHO)** **- = Ineligible (Categories 3 and 4 WHO)**										

1. ADDITIONAL EXAM (if necessary)

Date	Type of examination requested	Results

2. CONCLUSION

Method chosen by the client:									
Methods for which the client is eligible:	☐ **PC**	☐ **PP**	☐ **Injectables**	☐ **Implants**	☐ **DIU**	☐ **MAO**	☐ **Cycle beads**	☐ **Other barrier methods**	☐ **CCV**
Method offered:									
Date of Prescription:	Provider Name:					Qualification of the service provider:			
Date of first monitoring appointment:	Signature:								

3. CONTROL AND MONITORING

Date of Visit	Method used or prescribed	Complaints	Exams			Observations and treatments	Event and RDV
			Weight	TA	Other Exams (including gynecological)		

6. Family Planning Appointment Box (Tickler file)

6.1. Purpose of the Format

The Family Planning Appointment Box is designed to improve family planning client management and to simplify aggregation of data.

6.2. Presentation of the Format

The Family Planning Appointment Box is a wooden or metal box with 12 dividers (one for each month) in which family planning client record cards are placed according to the month that the clients are due to return for their next rendezvous.

Only the records of clients choosing renewable methods, or those with follow-up appointments are to be kept in the appointment box. If they use a permanent method or were lost to follow-up, the records should be moved into separate folders.

6.3. Data Sources

The tickler file box contains the FP client consultation cards for all clients chosing renewable methods.

6.4. Preparation and Submission

The tickler file should be maintained by the family planning service providers in some central location where records can be found easily. After recording any observations on the client's form, the service provider should ensure that the correct colored sticker is on the front of the form to indicate the currently used method (see table below) and then place the client form in the divider according to the month of the next rendezvous or appointment.

6.5. Definition of Terms & Indicators

New acceptor: A new acceptor is an individual who adopts a family planning method for the first time in their life. This data element is useful for tracking the recruitment rate of new contraceptive users. This is different from a new registration which can be for either a new acceptor or someone who previously used contraceptives elsewhere and is re-registering for family planning services at your health facility.

Stopped using PF: A client who stopped using contraceptive (otherwise known as abandoned, drop-out, or lost to follow-up) is any user who decides to stop using their contraceptive method for whatever reason or who does not return for follow-up visits or re-supply of renewable contraceptive methods.

Continuing user at end of month: This is any user who is protected by one or more contraceptive methods at the end of the reporting period. Continuing users include previously registered individuals as well as new acceptors and new registrations during the month. Continuing users do not include clients who abandoned contraceptive use during the month.

Roaming users: These are contraceptive users visiting a different health facility because they are travelling. In order to encourage continuity of family planning services, roaming users should be welcomed in other health facilities. For recording puposes they should be added to the register and counted as users at the end of the month, but not given a serial number. For renewable methods, they should be provided with the usual number of units of contraceptives that they receive at their home facility. When they do not return for re-supply after their visit they should be marked with an X and counted as stopped using FP at this facility. Note: if they do not have their FP client appointment card that states the method prescribed, they should also complete an individual FP client form and case history in order to ensure they do not have any risk factors for the method they desire.

6.6. Detailed Instructions for maintaining the appointment box

During appointments: When a client comes for his or her appointment, the service provider should remove the client form from the appointment box and proceed with the indicated physical examination and/or counseling session. All observations should be noted on the client form in the section on follow-up.

After appointments: Once the consultation is complete, the service provider should ensure that the appropriate colored sticker is on the form representing the method currently used and return the client form to the appointment box according to the month of the next appointment. If the client has decided not to use a family planning method any longer, the form should be placed in the dropout folder.

At the beginning of each month: the family planning service provider should go through the appointment box to extract any forms that remain from the previous months, these should be put to the side to be used for the analysis of clients who stopped using FP.

a. Using a tally sheet like the one on the following page, place a mark in the appropriate box for each type of user by method.
b. Tally all of the forms for clients who stopped using FP (abandons or drop outs) that you removed earlier in the 'Stopped FP' column,
c. Then tally the patient cards remaining in the file box as 'Active users at the end of the month' for renewable methods.
d. Next find the folders for permanent methods and remove any records for women who are 50 years of age or older or for men who have died. Tally the remaining records as 'Active users at the end of the month" according to the permanent method selected.
e. Finally, find the natural family planning methods folder and remove any records for women who are 50 years of age or older or for men who have died. (Forms for those who have changed to a renewable or long term method, should already be moved to the tickler file box or the long term methods folder.) Tally the remaining records as 'Active users at the end of the month' according to the natural family planning method selected.

An analysis of New acceptors should be done by tallying the new acceptors who were registered in the Family Planning Register over the previous month.

Table 9: Sample tally sheet for compiling family planning acceptor data

Methods		From FP Register	Stopped PF	From FP Register or Appointment box and LT methods files
		New Acceptors		Active users at end of month
1	Oral Contraceptives			
2	Injectables (Depo-Provera)			
3	Implants			
4	IUD			
5	Male condoms			
6	Female condoms			
7	Other barrier methods (gel, diaphram)			
8	Auto observation or Cycle beads			
9	Tubal ligations			
10	Vasectomy			

7. Child Immunization Register

7.1. Purpose of the format

The child health register ensures that clinically useful, appropriate, up-to-date, and accurate health information is available at every contact between a child and a health professional. It also ensures that we have accurate denominator information so that trends in coverage (e.g. immunization level) can be measured.

7.2. Presentation of the format

Each row is a record of one child. This means that each row contains the name of one child until the child completes all vaccinations or immunizations. In other words, you do not re-enter the child into the same register twice.

7.3. Data Sources

The information required to complete this register is gathered during initial contact at birth and subsequent contacts or visits. Other information comes from the child health card (Ifishi y'ubuzima bw'umwana) that is updated at every consultation between the health professional and the parent(s) or child either at the community level or health facility level and sometimes during special immunization campaign days.

7.4. Preparation and submission

As previously indicated this register is kept at health facility and it is used to collect information on immunized children. It is used for the purpose of monitoring child health or progress of vaccination campain.

7.5. Definition of terms and Indicators

BCG: Bacillus Calmette–Guérin or BCG is a vaccine against tuberculosis that is prepared from a strain of the attenuated (weakened) live bovine tuberculosis bacillus, *Mycobacterium bovis*, that has lost its virulence in humans by being specially subcultured in a culture medium, usually Middlebrook 7H9. Because the living bacilli evolve to make the best use of the available nutrients, they become less well adapted to their traditional environment, human blood, and can no longer induce the disease when introduced into a human host. Still, they are similar enough to their wild ancestors to provide some degree of immunity against human tuberculosis. The BCG vaccine can be anywhere from 0 to 80% effective in preventing tuberculosis for a duration of 15 years; however, its protective effect appears to vary according to geography and the lab in which the vaccine strain was grown.

Polio-DTP-HepB/Hib: (Imbasa +Kokorishi + Gakwega+ Akaniga) Combination vaccine against diphtheria, tetanus and pertussis (DTP), hepatitis B, polio and Haemophilus influenzae type .

7.6. Detailed instructions to complete the format

Please note that the columns in the register are referred to as column 1, column 2, etc. even though they are not actually numbered on the register.

1. **Serial number**: Record the child's serial number for the register. At the beginning of the register, restart numbering at 1. Then assign each child vaccinated the next serial number.
2. **Child number**: Record the child's number from the child health card
3. **Child Name in Full**: Record full name of the child with the family name written in the upper space and given name in lower space (e.g NDUWIMANA / Kelly).
4. **Mother's Name in Full**: Record full name of the mother with the family name written in the upper space and given name in lower space (e.g MUTESI / Helene).
5. **Address:** family head: record the name of the family head. The family head is an individual in the household who provides support and maintenance to household members either related to him or her by blood, marriage or through adoption.
6. **Address:** sector: record the sector in which the family currently resides
7. **Address:** cell: record the cell in which the family currently resides
8. **Address:** village: record the village in which the family currently resides
9. **Catchment area**: Record "Z" if family currently resides within the health facility catchment area, "HZ" if the family currently resides outside the health facility catchment but within the district where the facility is located and "HD" if family currently resides outside the district where the facility is located.
10. **Sex:** record the gender of the child as "M" for male or "F" for female.
11. **Date of birth:** Record the child's date of birth. Use numbers for months (e.g. 23rd April 2009 should be written as 23/4/2009)
12. **Age:** Record the child's completed age in months
13. **Weight:** record the current weight of the child in kilograms
14. **Mother HIV status:** record the HIV status of the mother. If the mother was never tested before but testing is done during immunization, record the most recent HIV status
15. **Is child exposed to HIV**? Record "Y" for Yes if the child is exposed to HIV or "N" for No. Note that if the mother is HIV negative discordant (i.e. the father is HIV positive and mother is HIV negative), then the child is exposed to HIV
16. **Child HIV status:** record the HIV status of the child if known
17. **BCG Date:** Record the date that BCG was given. Use numbers for months (e.g. 23rd April 2009 should be written as 23/4/2009)

18. **Polio 0**: Record the date that first dose of Polio was administered

19. **Polio-DTP-HepB/Hib** [-1, -2, -3]: Record the date of each Polio-DTP-HepB/Hib dose was administered until all the three doses are completed

20. **GMP Zone:** For each vaccination visit, record the Growth Monitoring Program color zone corresponding for the age of the child during that visit

21. **Measles:** Record the date of measles vaccination and the weight during measles vaccination visit

22. **Vitamin A Administration Dates:** Record the month and year (e.g July 2009 as 4/09) for each supplement of Vitamin A that the child is receiving. Note that Vitamin A administration should continue up to 59 months of age. Also for each Vitamin A administration, record the GMP color zone of the child from the Growth Monitoring Program.

Table 10: Sample of Child Immunization Register

Catchment area (Z, HZ,HD)	Sex (M/F)	Date of Birth	AGE (months)	Weight	HIV status of mother (P/N)	Exposed to HIV? (Y/N)	HIV EXPOSED INFANT	BCG	Polio 0	Polio-Penta1-1PCV7	Polio-Penta2-2PCV7	Polio-Penta3-3PCV7	MEASLES
							Child HIV status (P/N)	Date: JJ/MM/YY	Date: JJ/MM/YY	Upper space: JJ/MM/YY Lower space: GMP Zone (V/J/R)	Upper space: JJ/MM/YY Lower space: GMP Zone (V/J/R)	Upper space: JJ/MM/YY Lower space: GMP Zone (V/J/R)	Upper space: JJ/MM/YY Lower space: GMP Zone (V/J/R)

8. GBV victim's file

8.1. Purpose of the format

The format is designed to document in details the gender based violence for a given client and its primary purpose is to enable health providers and decision makers establish a set of interventions to prevent and offer comprehensive and ethical response to survivors/victims,at individual and community levels.

8.2. Presentation of the format

The format is a questionnaire consisting of several parts, each of which contains information from the identification of the victim, the sequence of events, history, treatment and follow-up examinations. The format also contains diagrams where injuries due to violence can be shown.

8.3. Data sources

The victim of GBV is always referred to One Stop Centre and the social worker on duty at reception records all information needed. He (she) opens a file of the victim and the file should accompany the victim when referred to either physician or psychologist according to the need. However, each one of the members of Multidisciplinary Investigative and Intervention Team (a team of professionals assigned to the case) should add information to the file of victim according to the diagnosis, exams or prescriptions.

8.4. Preparation and submission

The file is kept by the social worker at One Stop Center but a Release of Information form must be signed if any information about the victim is to be shared with anyone outside the One Stop Centre. This applies to letting someone else know that the victim has sought services at the One Stop Center. Therefore, staff must obtain written consent from the victim to contact a spouse or family member to let them know that the victim is at the One Stop Center. However, if the victim is medically and mentally incapacitated and the staffs need important information about the victim's medical history etc., they can be contacted to aid in the victim's care. In this situation, the Social Worker makes every effort to keep in confidence the services sought at the One Stop Center and focus on the victim as a patient admitted to the hospital in general.

8.5. Definition of terms and indicators

One Stop Center: Victims of Gender based Violence and Child Abuse urgently require a variety of services ranging from medical care, protection from further violence, investigation of the crime, medical testing for evidence in courts of law, treatment for physical and psychological trauma and long term physical and mental health consequences. The One Stop Centres were created to provide these specialized services in a coordinated way at a single location. Such coordinated care requires high levels of collaboration among service providers across medical, mental health, social work, police and legal disciplines.

Sexual violence, physical violence, emergency contraception and post exposition prophylaxis (see definitions in GBV register format)

8.6. Detailed instructions for completing format

Identification of the victim

Name and surname :	Record full name of the victim with the family name and given name both written
National ID Code :	The national ID has a number of 16 figures, write the full number
Date of birth :	Record the victim's date of birth. Use numbers for months (e.g. 23rd April 2009 should be written as 23/4/2009)
Age :	Record the victim's completed age in months
Sex : M/F	Record the gender of the victim as "M" for male or "F" for female.
Matrimonial status:	Choose one appropriate and write "M" for married, "W" for widow, "S" for separated, "Sn" for Single and "D" for Divorced
Address	Write the names of District, Sector, Cell and Village
Contact person, name & surname	Record full name of the contact person with the family name and surname
Telephone :	Write tel number for contact person. If he has more than one, write all numbers, mobile and landline
Relationship with contact person	Write with required precision the exact relationship

Anamnesis and historical

Account of facts ++ :	Please, write in details what is told by the victim or the person accompanying the victim. Please mention if the victim took a bath or changed clothes before coming, if a condom has been used, the recidivism
Relationship with the perpetrator:	Write with required precision the exact relationship and put more details. If there is no relationship, please write it.
Date and time of assault:	Write date in format dd/mm/yy and try to get exact time when event occurred and write it
Place of aggression :	Write the place with details to allow to identify the exact place of aggression
The institution or the person who referred the victim:	Choose one appropriate and write it, if there is other information please give precision

Previous facts

a. medical history	Ask about medical history and write all details
b. surgical history	Ask about surgical history and write all details
c. psychiatric history	Ask about psychiatric history and write all details
d. Gynecological and obstetric history	Ask about Gynecological and obstetric history and write all details
e. Drug suffer from allergies	Ask about Drug suffer from allergies and write all details
f. the sexual history	Ask about the sexual history and write all details
g. The history associated with STIs	Ask about The history associated with STIs and write all details
h. history associated to violence	Ask about The history associated with violence and write all details

EXAMINATIONS

Date	The date on which the tests were conducted
Time	The time at which the tests were conducted
Medical examiner : Full Name and function	Write the full name of the examiner and his/her function
Persons accompanying the victim and their relationship with the victim	Write Y or N. If the victim is accompanied, write full names of all persons accompanying the victim, especially those who entered in the room. For each one please give the relationship with the victim
Clinical examination	For clinical examination, describe the general and mental state
Physical examination*	For physical examination, please identify physical symptoms on the scheme in next page (draw)
gynecological examination*	For gynecological examination, please identify physical symptoms on the scheme in next page (draw)
Additional examinations and results	Write Y or N. If yes , write those examinations and give results of additional examinations

DIAGNOSTIC

Diagnostic	Write the detailed diagnostic
Type of violence experienced	Write type of violence experienced by the victim in selecting ones appropriate
Prophylactic, (if eligible prescribed treatment)	Write Y or N. If Y select in proposed list which prophylactic treatment is prescribed. If it is other, please give details
Cure	Write Y or N. If Y write which cure is prescribed
Location of symptoms	Please give location of symptoms by describing the scheme on next page
Medical and biological monitoring	For medical and biological monitoring please indicate dates of appointment (or of home visits if appropriate), new treatment and next dates of appointment. In observations write any new fact related to his recovery.
Psychosocial monitoring	For psychosocial monitoring please indicate dates of appointment (or of home visits if appropriate), new treatment and next dates of appointment. In observations, write any new fact related to his recovery.
Referrals	Indicate Y or N. If Y write the service and location where the victim is referred to If it is several referrals, please indicate dates of referrals.
Counter- referrals	Indicate Y or N. If Y write the service and location where the victim is counter referred to. If it is several counter-referrals, please indicate dates

Table 11: GBV VICTIM'S FILE

GBV VICTIM'S FILE

1. Victim Identification

Name and surname:		National ID Code:	
Birth date:		Age :	
Sexe : M/F			
Matrimonial status:	☐Single ☐In union ☐Separated ☐Divorced ☐Widower		
Adress :	District : Sector : Cell: Village:		
Person of contact, name and surname		Telephone:	
Relationship with the person of contact:			

2. Anamnesis and history

Account of facts++ :			
Relationship with the perpetrator			
Date and time of assault		Place of aggression:	
The institution or the person who referred the victim	☐ASC ☐Police ☐C.S ☐Local authority ☐Family ☐Neigbour ☐Others (specify):		

++***Please mention if:*** the victim took a bath or changed clothes after assault, use of condom, the recidivism

3. Previous facts

a. Medical	
b. Surgical	
c. Psychiatric	
d. Gynecological and obstetric	- DDR *: - Normal lenght of the cycle* : - Use of contraceptives*: ☐No ☐Yes, which method? - Others...
e. Allergic to drugs	
f. Sexuals	Number of sexual partners (in life) : Sex of partner (s) (in life) : ☐Man ☐Woman ☐Man and Woman Date of the last volunteer sexual relation:
g. Associated with STIs	
h. Associated to violence	GBV: Other violences :

4. Examens:

Date		Hour	
Medical examiner : Full Name and function:			
Persons accompanying the victim and their relationship with the victim:			
Clinical exam : - General Status:			
- Mental Status:			
Physical Exam*			
Gynecological exam*			
Additional Exams and results			

** Identify phisical symtoms on the chart on page 3*

5. Diagnostic

Diagnostic	
Type of violence experienced	• Physical • Sexual ☐Vagina ☐With penetration ☐Without penetration ☐ Anus ☐With penetration ☐Without penetration ☐Mouth • Psychological

6. Treatment

Prophylactic treatment, (if eligible prescribed treatment)	Emergency contraception: ISTs: HIV (PEP) : Others (specify) :
Curative Treatment	

Figure 4: Symptoms Localisation

Symptoms Localisation

Sketch of person

Anterior view

Posterior view

Comments

Female Genitalia

Male Genitalia

7. Victim's medical and biological monitoring:

Date	Observations	Treatments/RDVZ

8. Psychosocial monitoring

Date	Observations	Treatments/RDVZ

9. References

References done :	
Counter-referral:	

9. Gender-based violence register

9.1. Purpose of the format

The purpose of the format is to collect and provide reliable data to informing the health care providers and authorities for appropriate response to gender-based violence.

9.2. Presentation of the format

The format documents general information on the victims of GBV, type of violence, the referral of GBV victim and the follow up of the GBV victim

9.3. Data source

Points of entry of GBV victims are One Stop Center and Health Facility when referred to. The GBV register is generally filled in by Social worker at the One Stop Center.

9.4. Preparation and submission

The register is kept at One Stop Center and it is used to generate different reports or to be consulted by authorized officials. It is confidential unless the victim authorizes its consultation.

9.5. Definition of terms and indicators

Sexual violence with penetration: A person/ persons commit(s) rape if they intentionally penetrate the vagina, anus or mouth of another person with their penis without consent.

Sexual violence without penetration: The crime deals with non-penetrative sexual contact.

Physical violence: Physical violence is the intentional use of physical force with the potential for causing death, disability, injury, or harm.

Psychological violence A form of mistreatment in which there is intent to cause mental or emotional pain or injury; Psychological violence includes verbal aggression, statements intended to humiliate or infantilize, insults, threats of abandonment or institutionalization; Psychological violence results in stress, social withdrawal, long-term or recalcitrant depression, anxiety.

Emergency contraception: Emergency contraception (EC), or emergency post coital contraception, are birth control measures that, if taken after sexual intercourse, may prevent pregnancy.

Post exposure prophylaxis (PEP): Post-exposure prophylaxis (PEP) is any preventive medical treatment started immediately after exposure to a pathogen (such as a disease-causing virus), in order to prevent infection by the pathogen and the development of disease.

9.6. Detailed instructions for completing the format

Serial number:	The number assigned to patient by order of registration
Date of 1st visit:	For victim already registered
Patient file number:	a number attributed to the patient's file for his 1st visit
Post intake victimization:	check the bottom of register
Vulnerability:	put the appropriate category from 1 to 8 as specified in the bottom of register
Date of assault:	when violence occurred
Type of violence:	violence could be sexual, physical or psychological, choose one appropriated. For sexual violence, it should be mentioned whether or not penetration was done.
Next columns:	you should respond by Y or N to the questions, please choose one appropriated. (Y/N questions)
Case management recommendations and other remarks:	For management of effects, there could be recommendations or other important point to recall for the wellbeing of the victim.

Table 12: GBV Register

Serial nbr	Date of first visit	Patient file nbr	New Victim (*)	Post intake victimization (*)	Age/ Date of birth	Sex (M=male F=Female)	Vulnerability (category 1-8)(*)	Date of assault	Type of violence				Referral of GBV victim			
									Sexual		Physical	Psychological	By community health workers or other community members	by Police	by Health facility (HC or DH)	Referred to higher level
									With penetration (anal and/or vaginal)	Without penetration (anal and/or vaginal)						

* new victim: victim presenting for the first time in his/her life
* post intake victimization: victim has become victim of GBV again (by same or different perpetrator) after having been received the first time at your centre
* Vulnerability: 1) sex workers 2) refugee/returnee/ 3) PLHIV 4) PLWDA 5) historically marginalized groups 6) OVC 7) LGBT (Lesbian, Gay, Bisexual, Transgender) 8) none
* Psychological: victim reports psychological violence and/or if care provider identifies/diagnoses psychological problems.

Follow up of GBV victim									
Pregnant at the first visit (Y/N or N/A)	Received emergency contraception within 72 hours (Y/N or N/A)	Pregnant 2 weeks after exposure (Y/N)	HIV + at the first visit (Y/N or N/A)	Received post exposure HIV prophylaxis within 48 hours (Y/N or N/A)	HIV+ 3 months after exposure (Y/N)	Preventive treatment received for STI (Y/N or N/A)	Irreversible disabilities due to GBV (Y/N)	Death due to effects of GBV (Y/N)	Case management recommendations and other remarks

10. Mother infant Pairs Register

10.1. Purpose of the format

Mother infant pairs register is designed to in order to evaluate whether women who initiate ART during pregnancy remain on ART and that infants receive clinical care, including determination of final HIV status.

10.2. Presentation of the format

The format allows to collect 3 types of information:

- The general information on the mother-infant pair;
- The child follow up information;
- The mother's follow up information.

This is a longitudinal register tracking HIV-exposed infants (0-18 months old) through the Early Infant Diagnosis process. There are a number of columns in each category according to information to be collected. For each exposed infant, there is only one line in the Register, which is used at every visit. No infant should ever be entered into the register more than once.
As the purpose of the format is the follow up of mother-infant pair, the most of information are composed of dates and HIV status at different steps of follow up.

10.3. Data sources

The mother-infant pair register is kept by PMTC service in Health facility where this service is already implemented (a PMTCT site).

10.4. Preparation and submission

The register is filled in by health providers in charge of PMTCT service at health facility.

10.5. Definition of terms and Indicators

DBS: (Dried Blood Spot) is a form of bio sampling where blood samples are blotted and dried on filter paper. The dried samples can easily be shipped to an analytical laboratory and analysed using various methods.

PCR: (Polymerase Chain reaction)The HIV PCR test is one the most accurate diagnostic tools in use to detect the presence of the human immunodeficiency virus in the blood, more commonly known as HIV. Aside from being considered more reliable in terms of accuracy than most other tests, the HIV PCR test is also one of the few screening procedures that can be used for early detection.

Nevirapine: Nevirapine is an oral medication that is used for the treatment of infections with the human immunodeficiency virus (HIV). Nevirapine is used together with other anti-HIV drugs for the treatment of HIV infection.

Tritherapy: Combination of 3 drugs for treatment of HIV. Tritherapy or HAART-Highly active antiretroviral therapy- is defined as any medication containing three active ingredients acting differently.

10.6. Detailed instructions for completing Format

MOTHER-INFANT PAIR REGISTRATION INFORMATION	
1. Date of child registration:	This is the date the child is first entered into this register for purposes of follow-up.
2. Serial number:	Since each site is expected to have their own register, the serial numbering starts from the first client to be enrolled, allocated serial number 1 and this increases subsequently until the last client allocated serial number.
3. HIV exposed infant registration number	Enter the infant personal identification of unique number
4. Child name in full	In Upper space put the Name and in lower space put the surname. When more than one person name records are stored, choose the preferred one. If there is no preferred marker, choose the latest one
5. Child date of birth	Put Childbirth date in the format of dd/mm/yyyy for date of birth. For age, calculate age at enrollment into the HEI program. Note that this should not be rounded off to the nearest year or month e.g avoid recording an 8 months old child as a 1year, instead record them as 8months. For those above one year, record age and round off to nearest month e.g record 1year and 4months instead of 1year and 1year 7months instead of 2years.
6. Date scheduled for screening (DBS/ PCR)	Record the date given to the mother for early detection of child HIV using DBS/PCR (see definition above)
7. Mother's ANC number	Record the mother's Antenatal clinic number as it appears on the ANC card or ANC Register.
8. Mother's HIV negative	Respond by "Y" if test for mother negative or by "N" if test is positive
9. Mother's TRACNet number	
10. Child Sex	Write M for male and F for female.
11. Child weight at birth	Indicate the weight in gms
12. Method of feeding (AA/AM)	Please indicate method by AA for exclusive breastfeeding and AM for mixed feeding
CHILD FOLLOW UP INFORMATION	
13. Received NVP up to 6 weeks?	Respond by "Y" or "N"
14.Date started CTX	This is the age at which the infant was started on Cotrimoxazole prophylaxis. Cotrimoxazole prophylaxis should be given starting at 6 weeks of age, and stopped only after the infant has been confirmed HIV-negative after stopping breastfeeding.
15.Date screened (DBS) (6 weeks)	Enter the date DBS was done
16.Results of screening	Put "P" for positive, "N" for negative and "NC" for not concluded
17.Date of receipt of result	Date that 1st DBS result arrived at the facility from the reference testing laboratory. Be sure to include the year.
18.Date scheduled for testing (9months)	Date given to the mother for 2nd test of child
19.Date tested	Effective date of 2nd test

20. Results of testing	Put “P” for positive, ”N” for negative and “NC” for not concluded
21. Date of receipt of result	Date that 2nd DBS result arrived from the reference testing lab.
22. Date scheduled for test (18 months)	Date given to the mother for 3rd test of child
23. Date tested (serology)	Effective date of 3rd test
24. Results of tested	Put “P” for positive, ”N” for negative and “NC” for not concluded
25. Date of weaning	Date breastfeeding was stopped
26. Date of final test	The confirmatory rapid test should be done starting at 18 months. If the mother is still breastfeeding, a second rapid test should be done 3 months after stopping.
27. Final HIV status	Confirmed status, Put “P” for positive, ”N” for negative and “NC” for not concluded
28. Date and reasons for exiting the program	Put in upper cell the date and the reason in lower cell. For reason,put “Dead” if child or mother is dead,”N” for negative test,”P” for positive test,”N/BF” for not breastfeeding and “LOST” for lost to follow up if reason is not known.
29. Date child registered in Pre-ART	Put the date the child is transferred to PRE-ART Register
30. Date of ART initiation	Date of starting ART treatment, in upper row write date and TRACnet ID in lower row
ARVs taken during breast-feeding **1. Tritherapie Prophylaxie** **2. Tritherapie TTT**	Put 1 if treatment was prophylaxis and 2. If it is tritherapy

MOTHER’S FOLLOW UP			
1st test	**Discordant HIV**	Upper row: HIV results	Record here the results of the test whether “Negative” or “Positive”
		Lower row: Date	Record here date of test
	CD4	Upper row: CD4 count	Record here the mother’s CD4 results. If not yet done, book mother for testing and record results later when the test is done
		Lower row: Date	Record here date of test
2nd test	**Discordant HIV**	Upper row: HIV results	Record here the results of the test whether “Negative” or “Positive”
		Lower row: Date	Record here date of test
	CD4	Upper row: CD4 count	Record here the mother’s CD4 results. If not yet done, book mother for testing and record results later when the test is done
		Lower row: Date	Record here date of test
3rd Test	**Discordant HIV**	Upper row: HIV results	Record here the results of the test whether “Negative” or “Positive”
		Lower row: Date	Record here date of test
	CD4	Upper row: CD4 count	Record here the mother’s CD4 results. If not yet done, book mother for testing and record results later when the test is done Record date of CD4 test
		Lower row: Date	Record here date of test
4th Test	**Discordant HIV**	Upper row: HIV results	Record here the results of the test whether “Negative” or “Positive”
		Lower row: Date	Record here date of test
	CD4	Upper row: CD4 count	Record here the mother’s CD4 results. If not yet done, book mother for testing and record results later when the test is done
		Lower row: Date	Record here date of test

5th Test	**Discordant HIV**	Upper row: HIV results	Record here the results of the test whether "Negative" or "Positive"
		Lower row: Date	Record here date of test
	CD4	Upper row: CD4 count	Record here the mother's CD4 results. If not yet done, book mother for testing and record results later when the test is done
		Lower row: Date	Record here date of test
6th Test	**Discordant HIV**	Upper row: HIV results	Record here the results of the test whether "Negative" or "Positive"
		Lower row: Date	Record here date of test
	CD4	Upper row: CD4 count	Record here the mother's CD4 results. If not yet done, book mother for testing and record results later when the test is done
		Lower row: Date	Record here date of test
Mother ARV		End date for ARV prophylaxis	Record date when the mother stopped Prophylaxis treatment
		Completed PMTCT ARV prophylaxis?	Put "Y" if the mother has completed prophylaxis treatment o"N"in case of interruption of treatment
		Date transferred to ARV clinic	Put the date when the transfer was done
Observation			Write up any precision

Table 13: Mother Infant Pair Register

MOTHER-INFANT PAIR REGISTRATION AND INFORMATION											
Date of child	Serial number	Registration numberof the child exposed to HIV	Child Name in Full Upper space: Surname Lower space: Given name	Child Date of Birth	Date scheduled for screening (DBS/PCR)	Mother's ANC number	Discordant Mother HIV negative? (O/N)	Mother's	Child Sex (M/F)	Child weight at birth (gms)	Method of feeding (AA/AM)

CHILD FOLLOW UP INFORMATION											
6 Weeks					9 Months				18 Months		
ARV-NVP	CTX	DBS/PCR			Serology				Serology		
Received NVP up to 6 weeks? (O/N)	Date started	Date screened (DBS)	Results of	Date of receipt of result)	Date	Date of screening	Screening results (P/N/NC)	Date of receipt of result	Date scheduled for screening	Date of screening	Screening Results (P/N/NC)

CHILD FOLLOW UP INFORMATION						
Date of result submission	*Date of weaning*	**Date of final screening**	**Final HIV status (P/N/ NC)**	**Date and reasons for exiting the program** *Upper space:* **Date** *Lower space:* **Raisons (DEAD, P, N, N/BF, NC, LOST, TO)**	**Date child registered in Pre-ART** *Upper space:* **Date** *Lower space:* **TRACNet ID#**	**Date of ART initiation**

MOTHER'S FOLLOW UP INFORMATION									
ARVs taken during breast-feeding 1. Tritherapie Prophylaxie 2. Tritherapie TTT	**1st screening**		**2nd screening**		**3rd screening**		**4th screening**		**5th screening**
	Discordant HIV Test **Upper row:** HIV results **Lower row:** Date	**CD4** **Upper row:** CD4 count **Lower row:** Date	**Discordant** HIV Test **Upper row:** HIV results **Lower row:** Date	**CD4** **Upper row:** CD4 count **Lower row:** Date	**Discordant** HIV Test **Upper row:** HIV results **Lower row:** Date	**CD4** **Upper row:** CD4 count **Lower row:** Date	**Discordant** HIV Test **Upper row:** HIV results **Lower row:** Date	**CD4** **Upper row:** CD4 count **Lower row:** Date	**Discordant** *HIV Test* Upper row: HIV results Lower row: Date

MOTHER'S FOLLOW UP INFORMATION					Observation
6th screening		Mother ARV			
Discordant HIV Test **Upper row:** HIV results **Lower row:** Date	**CD4** **Upper row:** CD4 count **Lower row:** Date	**End date for Mother ARV prophylaxis**	**Completed PMTCT ARV prophylaxis?**	**Date transferred to ART clinic**	

11. Nutrition Register

11.1. Purpose of the format

The purpose of the register is a continuous monitoring to determine: the extent of risk of nutrition-related health problems in the catchment area of health center; which population groups or areas of the country face greatest risk; and the likely causes of risk and changes in the above risk factors over time;

11.2. Presentation of the format

The register is a set of columns for collecting following information:

- General information: required information to identify the client
- Nutritional status monitoring: calculation of main indicators to assess the nutritional status;
- Those Indicators are calculated six times for monitoring.

11.3. Data sources

This register is facility based. It is filled in by health care providers at health center by collection and analysis of patient data.

11.4. Preparation and submission

The register is kept at health facility and is used to aggregate data for the monthly HMIS report. It could be consulted by other persons for other purposes such as research, survey, or supervision.

11.5. Definitions of terms and indicators

Z-score: For population-based assessment, there are two ways of expressing child growth survey results using Z-scores. One is the commonly used cut-off-based prevalence; the other includes the summary statistics of the Z-scores: mean standard deviation, standard error, and frequency distribution.

Prevalence-based reporting: For consistency with clinical screening, prevalence-based data are commonly reported using a cut-off value, often <-2 and >+2 Z-scores. The rationale for this is the statistical definition of the central 95% of a distribution as the "normal" range, which is not necessarily based on the optimal point for predicting functional outcomes.

The WHO Global Database on Child Growth and Malnutrition uses a Z-score cut-off point of <-2 SD to classify low weight-for-age, low height-for-age and low weight-for-height as moderate and severe under nutrition, and <-3 SD to define severe under nutrition. The cut-off point of >+2 SD classifies high weight-for-height as overweight in children.

The use of -2 Z-scores as a cut-off implies that 2.3% of the reference population will be classified as malnourished even if they are truly "healthy" individuals with no growth impairment. Hence, 2.3% can be regarded as the baseline or expected prevalence. To be

precise the reported values in the surveys would need to subtract this baseline value in order to calculate the prevalence above normal. It is important to note, however, that the 2.3% figure is customarily not subtracted from the observed value. In reporting underweight and stunting rates this is not a serious problem because prevalences in deprived populations are usually much higher than 2.3%. However, for wasting, with much lower prevalence levels, not subtracting this baseline level undoubtedly affects the interpretation of findings.

Summary statistics of the Z-scores: A major advantage of the Z-score system is that a group of Z-scores can be subjected to summary statistics such as the mean and standard deviation. The mean Z-score, though less commonly used, has the advantage of describing the nutritional status of the entire population directly without resorting to a subset of individuals below a set cut-off. A mean Z-score significantly lower than zero—the expected value for the reference distribution—usually means that the entire distribution has shifted downward, suggesting that most, if not all, individuals have been affected. Using the mean Z-score as an index of severity for health and nutrition problems results in increased awareness that, if a condition is severe, an intervention is required for the entire community, not just those who are classified as "malnourished" by the cut-off criteria.

BMI : Body Mass Index (BMI) is a measure of body fat based on height and weight that applies to adult men and women.

Calculation BMI=Weight/height² (Weight in kgs and height in cms)

BMI Categories:

- Underweight = <18.5
- Normal weight = 18.5–24.9
- Overweight = 25–29.9
- Obesity = BMI of 30 or greater

Oedema: Your body uses a number of processes to maintain normal fluid balance. This balance requires that you get the proper intake of certain nutrients and electrolytes to keep your body running at its best. Without these nutrients, you may experience a condition known as edema, which occurs when fluids begin to build up improperly in your tissues, causing abnormal swelling of your extremities or other body parts. Because malnutrition is a serious condition, failing to correct malnutrition and edema can have life-threatening consequences.

MUAC: Mid Upper Arm Circonference or MUAC is a set of indicators to assess malnutrition:

- MUAC less than 110mm (11.0cm), RED COLOUR, indicates Severe Acute Malnutrition (SAM). The child should be immediately referred for treatment.

- MUAC of between 110mm (11.0cm) and 125mm (12.5cm), RED COLOUR (3-colour Tape) or ORANGE COLOUR (4-colour Tape), indicates Moderate Acute Malnutrition (MAM). The child should be immediately referred for supplementation.

- MUAC of between 125mm (12.5cm) and 135mm (13.5cm), YELLOW COLOUR, indicates that the child is at risk for acute malnutrition and should be counselled and followed-up for Growth Promotion and Monitoring (GPM).
- MUAC over 135mm (13.5cm), GREEN COLOUR, indicates that the child is well nourished.

11.6. Detailed instructions for completing format

ID:	Number given to each new patient when registered
Form No /medical file:	Number on medical file
Client full name:	Record the name and surname in full
Sex:	Record M or F
Date of Birth :	Record the date in format dd/mm/yy
Father name:	Record both name and surname
Mother name:	Record both name and surname
District :	Choose among 30 district's names one appropriate
Sector	Be sure to write the right sector
Cell	The cell should be entered also
Village	Once the village is registered, you are sure to be able to localize patient in community. Be sure to check in with CHW the right address.
Date	Record the date of registration
weight	Record the weight in Kgs
Height	Record the height in cms
W/H (Z-score	Calculate the ration
H/A (Z-score)	Calculate the ration
W/A (Z-score)	Calculate the ration
BMI	Use information obtained above for weight and height
Oedema	Record Y or N by consulting the patient using known signs of oedema
MUAC	Put the size in cms
HIV test (Yes or No,)	Put Y if result is positive or N if negative
Screening TB (Yes or No)	Put Y if screening is done or N if not done
Type of malnutrition: moderate with/without complication, severe with/without complication	Use the table below to choose type of malnutrition
type of nutritional treatment (intensive/supplementation)	What is prescribed to patient? Put 1 if it is "intensive treatment" or 2 If it is supplementation with 6 stage monitoring
Reason of exit:	Tell why the patient is not under monitoring

Type of traitment:
1= intensive treatment**, 2**= supplementation with monitoring from 1-6 stage

Malnutrition threshold:

Indice	Malnutrition Degree	% of themedian	Z-scores
weight per age	moderate	90%	2 ET
	Severe	85%	3 ET
Weight per height	moderate	80%	2 ET
	Severe	75%	3 ET
Weight per age	moderate	70%	2 ET
	Severe	60%	3 ET

Table 14: NUTRITION SERVICE REGISTER

NUTRITION SERVICE REGISTER

Year :

PROVINCE:
DISTRICT :
HOSPITAL :
HEALTH CENTRE:

ID	Form No /medical file	Admission date	NAME & PRENAME OF CLIENT	Sex (M/F)	Date of Birth	Father's name	Mother's name	District	Sector	Cell	Village

Nutritional status monitoring												
Date	weight	height	W/H (Z-score)	H/A (Z-score)	W/A (Z-score)	BMI	oedema	MUAC	Test VIH (Yes or No,)	Screening TB (Yes or No)	Type of malnutrition:moderate with/without complication, severe with/ without complication	type of nutritional treatment (intensive/ supplementation)

Monitoring 1									Monitoring 2								
Date	Weight	Height	W/H(Z-score)	H/A (Z-score)	W/A (Z-score)	BMI	oedeme	MUAC	Date	Weight	Height	W/H(Z-score)	H/A (Z-score)	W/A (Z-score)	BMI	oedeme	MUAC

Monitoring 3									Monitoring 4								
Date	Weight	Height	W/H(Z-score)	H/A (Z-score)	W/A (Z-score)	BMI	oedeme	MUAC	Date	Weight	Height	W/H(Z-score)	H/A (Z-score)	W/A (Z-score)	BMI	oedeme	MUAC

Monitoring 5									Monitoring 6									reason of exit:
Date	Weight	Height	W/H(Z-score)	H/A (Z-score)	W/A (Z-score)	BMI	oedeme	MUAC	Date	Weight	Height	W/H(Z-score)	H/A (Z-score)	W/A (Z-score)	BMI	oedeme	MUAC	

Reason of exit:

A= Abandon
R= Referé
D= Décédé
C= Contre référence
G= Guérri

12. PEP prophylaxis Register

12.1. Purpose of the format:

This register covers information needs for the management of health workers who may be exposed to Human Immuno-Virus or Hepatitis B Virus during the course of their work, other workers, such as the police, people who may be sexually assaulted and exposed to HIV or any other person who may be exposed to HIV. This Register covers not only health workers but all other persons who come to the facility to post-exposure interventions at the facility.

12.2. Presentation of the format

The register is divided into 5 sections:

1. The patient registration information
2. The risk assessment
3. Exposure background
4. Care and date
5. HIV tests for follow up

12.3. Data sources

The register is filled in by staff in charge of PEP at health facility.

12.4. Preparation and submission

Depending on how the facility is organized, the first seven (7) columns can be completed upon the client getting into contact with the facility and the remaining columns can be updated as the service is offered or the intervention is provided. Each facility can decide who completes the register, bearing in mind aspects such as the training of the staff member and confidentiality.

12.5. Definition of Terms & Indicators

(all terms have been defined previously)

12.6. Detailed Instructions for completing formats

No	This is a counter of all the clients in the facility. The number is reset at the beginning of each year. For example, the first client in 2012 will take up number 0001, the next one 0002. If the register fills, the next available number is transferred to the newly opened register. However, at the end of the year, the numbering is closed and restarted in the new year
Date enrolled (dd/mm/yy)	This is the date that the client reports the incident to your facility. Use the format dd/mm/yy.
File number	Record the number given to the file of the client .
Name in full	Enter the full name of the client
Date of birth	Ask to patient the date of birth and write it in format dd/mm/yy and try to check inwith the ID if client hesitates
Age in years	For adults enter the age in completed years at last birthday while for infants use the notation x/52.
Sex	Enter M for Male and F for Female
Adress: District/Sector **Neighborhood/Phone Number**	Ask and write the names of District, sector and village if possible. Write the mobile phone number for the client
Type of exposure (Code)	Record the type of exposure as assessed using code from 1 to 3 as proposed in the bottom of the register
Severity of exposure (Code)	Based on the assessment, classify the exposure as: 1=Important 2=Intermediate 3 =Minima
Nature of exposure (Code)	Record the nature of the exposure based using the following codes from 1 to 16 as proposed in the bottom
Date and time of exposure	Record the reported time and date when the exposure took place. This is very important information as it provides part of basis for evaluating whether the prophylaxis should be given or not. Note: Enter date in the format dd/mm/yy and time with an appropriate suffix (am or pm)
Date and time of arrival	Record the date and hour in the 24 hour format when the client arrived at the facility
HIV status of the source patient	Using code specif the HIV status of the source patient
HIV status of the client	Record the HIV status of the patient before at pre prophylaxis assessment. Enter the following codes: 1=HIV negative 2=HIV positive 3=Deferred
Pregnancy test	Write result of test as « negative » or « positive »
Previous exposure	For each exposure, write the type,the date of exposure and ARV regimen prescribed using codes. If the client has received PEP before, record the duration of PEP (in the upper row) and use the codes below to state which drug(s) the client was put on for prophylaxis
ARV Regimen (code)	If a patient has been commenced on prophylaxis, enter the drug combinations using code as shown in the bottom of the register.
Intervention time (Number of hours)	If PEP has been initiated, record the time intervention took. The time format should be in number of hours.
Reference	Write if the client is referred to another facility
HIV screening	Write HIV status for each of the 4 tests done for follow up

Table 15: PEP Register

Year _____ Month _____ Health Facility Name:_____

PATIENT REGISTRATION AND INFORMATION								RISK ASSESSMENT							
No.	Date d'enrôlement enrolled Date (dd/mm/yy)	File number	Name in Full	Date of Birth	Age (years)	Sex (M/F)	Adress: District/Sector Quartier/Phone Number	Type of exposure (Code)	Severity of exposure (Code)	Nature of exposure (Code)	Date and time of exposure	Date and time of arrival	HIV status of the source patient	HIV status of the client	Pregnancy test
01															
02															
03															
04															
05															
06															
07															

Type of exposure (Code)

Accident d'Exposition au Sang/Liquides
1. Biologiques
2. Viol
3. Contact Sexuel Accidentel

Severity of exposure (Code)

1.Important
2.Intermediate
3.Minima

Nature of exposure (Code)

1.Sang
2.LCR
3.Liquide Amniotique
4.Secretions genitales/ Sperme
5.Piqûre profonde
6.Piqûre Aiguille creuse
7.Piqure avec prelevement laboratoire
8.Dispositif intravasculaire
9. Coupure avec bistouri à travers gants
10. Piqûre avec aiguille IM ou SC
11.Exposition cutanéo muqueuse
12.Piqûre avec aiguille pleine
13.Piqûres avec seringues abandonnées
14.Crachats
15.Morsures
16.Griffures

PREVIOUS EXPOSURE				PRISE EN CHARGE ET DATE			MONITORING		
For each exposure, mention the date, exposure type and the ARV regimen prescribed. (Codes)									
Expo 1	Expo 2	Expo 3	Expo 4	ARV (Code)	Intervention time (Number of hours)	Reference	HIV SCREENING		
							M1	M2	M6

Regime ARV

1.TDF/3TC/KALETRA
2.TDF/3TC/EFV
3.AZT/3TC/KALETRA
4.AZT/3TC/EFV
5.OTHERS (Specify)

13. Pre-ART Register

13.1. Purpose of the format

The pre-ART register lists all patients enrolled in HIV care at a health facility. Pre-ART means "before ART". However, this register should include all patients even if they have already started ART on their own or in another programme outside the facility. The only exception is when patients have already begun ART in another facility and they transfer in with records. The pre-ART register is a tool for monitoring those patients who are enrolled in HIV care and to track their progress as they become eligible for ART. All patients who first enroll for HIV care, whether they are on ART or not, are initially listed in the pre-ART register and counted as enrolled in HIV care. This includes patients who transfer in with or without records who were previously in care at another facility but are not yet on ART. The only patients who will not be entered into the pre-ART register are patients already on ART who transfer in with records. Patients who were taking ART but do not have the records to demonstrate this will have to be entered into the system as a new patient. You then continue to record data on the patient in the pre-ART register until they start ART. Once the patient begins ART, he or she is transferred to the ART register and is no longer tracked through the pre-ART register.

13.2. Presentation of the format

This register consists of a number of vertical columns and horizontal rows. The register is a chronic care register as opposed to an acute (once-off care) register.
The rows contain the names of patients, one patient per row. The columns contain information about that patient, one piece of information per column. As you will see, all the information that ends up on this register originally comes from individual patient's record form.

13.3. Data sources

The information required to complete the pre-ART register can be found on the individual patient's record form at health facility.

13.4. Preparation and submission

The Register is prepared at health facility and is filled in by HIV care and treatment team. It is used to transfer clients in ART register and to generate periodic reports for HMIS at District and Central level.

13.5. Definition of terms and indicators

CD4 Count: While CD4 counts are not a direct HIV test--e.g. they do not check the presence of viral DNA, or specific antibodies against HIV--they are used to assess the immune system of a patient. Patients often undergo treatments when the CD4 counts reach a level of 350 cells per microliter; less than 200 cells per microliter in an HIV-positive individual is diagnosed as AIDS. Medical professionals also refer to CD4 tests to determine efficacy of treatment.

WHO clinical stage: HIV disease staging and classification systems are critical tools for tracking and monitoring the HIV epidemic and for providing clinicians and patients with important information about HIV disease stage and clinical management. There is WHO clinical staging of HIV/AIDS for adults and adolescent and WHO clinical staging of HIV/AIDS for infant and children.

13.6. Detailed instructions for completing format

Facility Name:	Copy this information in the respective fields at the top of page of the register.
No:	Health facility file number of the patient. Note: *It is not all facilities that have Health facility file number it depends on the filing system of the health facility*.
Date enrolled:	Date enrolled in this facility. If a patient transfers in (with records) from another facility but is not yet on ART, note the date enrolled in your facility.
TRACNET number:	If the client is still registered in TRACNET, write the number
Name and surname:	Name, on the top line, Surname on the bottom line
Status at enrolment:	record the appropriate status for the patient's status at enrolment in care and treatment.
WHO stage:	record the last clinical stage known. If the patient is a transfer in patient, you may have past clinical staging data from the records and can fill in accordingly.
CTX (Cotrimoxazole):	if the patient is taking cotrimoxazole, enter the start date in the top line and stop date in bottom line.
TB Treatment:	indicate start date on the top line and stop date on the bottom line.
PMTCT:	If the patient is pregnant, write the estimated due date in the top line of the column and write ANC number at the bottom line.
Date medically eligible for ART:	record the date when the patient became medically eligible for ART. ARV/Date ART started: record in the date and transfer this patient to the ART register.
NB: Instructions for completing quarterly follow-up status are given on top of the format.	

Table 16: Registre pre-ARV/Pre-ART Register

Cohort: Year _____ Month: _____ Health Facility Name:_____

	Patient Registration and Information								Fill in when applicable		PTME/ *PMTCT*				ARV	
No.	Enrollment Date (dd/mm/yy)	TRACnet number	Name in Full Upper space Surname Lower space given name	Date of Birth	Age	Sex (M/F)	Admission mode (PMTCT, VCT, TB TT, TI transfer-in, HIV-exp for HIV exposed infant)	WHO Stage	CTX Upper space: start date lower space: end date	TB Traitment Upper space: start date lower space: end date	For each pregnancy, record Expected delivery date, ANC No.					
											Pregnancy 1	Pregnancy 2	Pregnancy 3	Pregnancy 4	Date medically eligible for ART	Date ART started (transfer to ART register)

Top Row:
CD4 count and date
----->*did not have scheduled visit for this quarter*
LOST - *not seen this quarter, but scheduled for a visit*
TO - *Transferred elsewhere (record to where)*
DEAD / Record date

Middle Row: TB Status Codes
TB TT =Currently on TB treatment
(+) = Positive TB screening (record date)
(-) = Negative TB screening(record date)
U =Not screened for TB

Bottom Row: WHO Clinical Stage
Record the WHO clinical stage

Quarterly Follow-up status (CD4, TB screening and WHO stage)																			
Year:				**Year:**				**Year:**				**Year:**				**Year:**			
Q1 Jan-Mar	Q2 Apr-Jun	Q3 Jul-Sep	Q4 Oct-Dec	Q1 Jan-Mar	Q2 Apr-Jun	Q3 Jul-Sep	Q4 Oct-Dec	Q1 Jan-Mar	Q2 Apr-Jun	Q3 Jul-Sep	Q4 Oct-Dec	Q1 Jan-Mar	Q2 Apr-Jun	Q3 Jul-Sep	Q4 Oct-Dec	Q1 Jan-Mar	Q2 Apr-Jun	Q3 Jul-Sep	Q4 Oct-Dec

14. ART Register

14.1. Purpose of the format

The purpose of the register is to collect in a single location (the register) the same information (a column) about an entire group of patients (transferred from their individual patient's record form). Whereas the information on patient's record form allows you to monitor what is happening with each individual patient, the information collected on the register allows you to monitor what is happening with your whole group of patients. So, like the pre-ART register, the ART register is a tool used for patient monitoring and programme monitoring. If drugs are ordered on a monthly basis, for example, the ART register can be used to keep track of the distribution of ARV regimens. The ART register is also used to support cohort analyses of important variables at 6 months, 12 months, and then yearly.

14.2. Presentation of the format

Like the pre-ART register, the ART register consists of a number of vertical columns and horizontal rows. The register is a chronic-care register as opposed to an acute register. This means that the rows contain the names of patients, one patient per row. The columns contain information about that patient, one piece of information per column. As you will see, all the information that ends up on this register originally comes from individual patient's record form.

14.3. Data sources

The information required to complete the ART register can be found on the patient's record form and from the lab.

14.4. Preparation and submission

This register is kept at health facility and it is used by care and treatment team to generate periodic reports such as Health center HMIS monthly report.

14.5. Definition of terms and indicators

Clinical treatment failure: Treatment failure happens when the anti-HIV medications you take can't control your infection. There are three types of treatment failure: virologic failure, immunologic failure, and clinical progression.

Virologic failure happens when anti-HIV medications can't reduce the amount of virus in the blood. (While taking medications, viral load doesn't drop or it repeatedly rises again after having dropped.)

Immunologic failure happens when the immune system doesn't respond to anti-HIV medications. (While taking medications, CD4 count doesn't rise or it drops.)

Clinical progression happens when a person has symptoms of HIV disease despite taking anti-HIV medications. The three types of treatment failure may happen alone or together. In general,

virologic failure happens first, followed by immunologic failure, and then clinical progression. They may happen months to years apart.

14.6. Detailed instructions for completing format

Cohort:	A patient is put in a cohort based on the year and month he or she started ART regardless of where the ART was started. Each page of the ART register should only be used for recording/updating information on patients in the same cohort, one row per patient.
No. :	Patient clinic number in Care and treatment at the facility;
Date ART start:	Write the date transferred from pre-ART register;
TRACnet number:	Write the same number as in Pre-ART register;
Name and surname:	Name, on the top line, Surname on the bottom line;
CD4:	Give CD4 count at start of ART on the top line and the date when information was availed if different from start date;
CTX:	if the patient is taking cotrimoxazole, enter the start date in the top line and stop date in bottom line;
TB Treatment:	indicate start date on the top line and stop date on the bottom line;
PMTCT:	If the patient is pregnant, write the estimated due date in the top line of column and write ANC number at the bottom line.
Original Regimen:	Write in the **code** for the 1st-line regimen which is found at the bottom of the ART Register;
1st line regimen:	Write in the **reason and date** for the 1st substitute regimen in the top line. If there a substitutions second reason and date within the 1st- line regimen, this will be recorded in the bottom line;
2nd line switches:	Write in the code for this 2nd-line regimen plus reason and date. If the patient later substitutions substitutes within the 2nd-line regimen, transfer this information plus reason and date into the bottom line of the column;
The next pages of the ART register are used to document **ARV regimens or ART treatment interruptions during the next 36 months.** Write in the calendar months in the column headings in this part of the register. Under “Month 0” enter the name of the month and the year in which the patients in this cohort started ART. This applies to all the patients on this page of the register since they are all in the same cohort who started in this month. Under “Month 1” write the name of the next month and year and continue in this manner for all 36 columns. For the months” 6;12;18;24;30;36” provide CD4 count and date, WHO stage and TB status accordingly.	

Table 17: ART Register

Cohort: Year _____ **Month** _____ **Health Facility Name:**_____

Registration and Patient Information						Status at start of ART treatment				Fill in when applicable		PMTCT				Original ART Regimen	1st line Regimen	2nd line Regimen
No.	ART Start Date	TRACnet number	Name in Full Upper space: Surname Lower space: Given name	Sex (M/F)	Date of Birth	Age	Weight	WHO Stage	(CD4% for infants) Date	CTX Upper space : start date Lower space: end date	TB Traitment Upper: start date Lower : end date	For each pregnancy, record Expected delivery date, ANC No.					Substitutions 1st: Reason, Date 2nd: Reason, Date	Switches, Substitutions 1st: Reason, Date 2nd: Reason, Date
												Pregnancy 1	Pregnancy 2	Pregnancy 3	Pregnancy 4			

Registration and Patient Information						Status at start of ART treatment				Fill in when applicable		PMTCT				Original ART Regimen	1st line Regimen	2nd line Regimen
No.	ART Start Date	TRACnet number	Name in Full Upper space: Surname Lower space: Given name	Sex (M/F)	Date of Birth	Age	Weight	WHO Stage	(CD4% for infants) Date	CTX Upper space : start date Lower space: end date	TB Traitment Upper: start date Lower : end date	For each pregnancy, record Expected delivery date, ANC No.					Substitutions 1st: Reason, Date 2nd: Reason, Date	Switches, Substitutions 1st: Reason, Date 2nd: Reason, Date
												Pregnancy 1	Pregnancy 2	Pregnancy 3	Pregnancy 4			

1st line Regimens

Adultes/ Adults
1a = TDF + 3TC/FTC + NVP
1b = TDF + 3TC/FTC + EFV
1c = ABC + 3TC + NVP
1d = ABC + 3TC + EFV

Enfants /Children
4a = TDF + 3TC/FTC + NVP
4b = TDF + 3TC/FTC + EFV
4c = ABC + 3TC + NVP
4d = ABC + 3TC + EFV

Alternative 1st line Regimens

Adulte / Adults
3a = AZT+3TC/FTC+NVP
3b = AZT+3TC/FTC+EFV

Children
6a = AZT+3TC+NVP
6b = AZT+3TC+EFV

2nd line Regimens

Adults
2a = AZT + 3TC + Lop/rit
2b = AZT + 3TC + Lop/rit
2c = TDF + 3TC + Lop/rit

Enfants/Children
5a = AZT + 3TC + Lop/rit
5b = ABC + 3TC + Lop/rit
5c = AZT + ABC + 3TC + Lop/rit

Alternative 2nd line Regimens

Children
7a = ABC + 3TC + Lop/rit
7b = AZT + ABC + 3TC + Lop/rit

Write in month																															
Month 0	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6				Month 7	Month 8	Month 9	Month 10	Month 11	Month 12				Month 13	Month 14	Month 15	Month 16	Month 17	Month 18							
							CD4 / Date	WHO stage	TB Status							**CD4 / Date**	WHO stage	TB Status								**CD4 / Date**	WHO stage	TB Status			

Reasons for Regimen change « Codes »
1. Toxicité et effets secondaires/ Toxicity and side effects
2. Grossesse/Pregnancy
3. Risk of pregnancy
4. Nouvelle infection de TB/ Due to new TB
5. Drug out of stock
6. Other Reason (specify)

Reasons for switch to 2nd line
7. *Clinical treatment failure*
8. *Immunologic failure*
9. *Virologic failure*

Write in month																													
Month 19	Month 20	Month 21	Month 22	Month 23	Month 24				Month 25	Month 26	Month 27	Month 28	Month 29	Month 30				Month 31	Month 32	Month 33	Month 34	Month 35	Month 36			
						CD4 / Date	**WHO stage**	**TB Status**							**CD4 / Date**	**WHO stage**	**TB Status**							**CD4 / Date**	**WHO stage**	**TB Status**

Si arrêt des medicaments, ajouter les raisons (et les semaines d'interruptions si recommencé tardivement) / *if follow-up status is "STOP", then add reasons (and weeks of interruption if later restarted)*

1. *Toxicity/side effects*
2. *Pregnancy*
3. *Treatment failure*
4 *Poor adherence*
5. *Illiness, hospitalization*
6. *Drugs out of stock*
7. *Patient needs financial support*
8. *Other patient's decision*
9. *Treatment interruption Plan*
10. *Other*

TB status codes
TB TT =Currently on Anti- TB treatment
(+) =Positive TB screening (record date)
(-) =Negative TB screening
U =Not screened for TB

15. TB Register

15.1. Purpose of the format

The TB case register contains information related to the TB cases put under treatment in a given CDT and its CTs.

15.2. Presentation of the format

- This is an printed register, with many pages whose each contain lines and columns
- Lines report data of one patient on the left and right page
- Colums indicate information that should be collected for a patient:
  - left page: data on identification, treatment and case type
  - right page : bacilloscopie, autres examens, VIH, contacts etc.

15.3. Data Sources

- TB Laboratory Exam Form;
- TB Laboratory register ;
- ARV/PMTCT service liaison card,
- TB transfer form,
- TB Treatment form for the cases transferred,
- Radiography form;
- Patient treatment record (information on contacts) ;
- Individual Identification Card ;
- Other information provided by the patient in the anamnesis ;

15.4. Preparation and submission

- Information are collected by the TB service responsible of CDT
- The TB service responsible of CDT has to update the register according to TB treatment start date and the availability of bascilloscopic results and other information
- The TB service responsible of CDT keeps the register in 'the TB/HIV one stop service'
- The register is kept within TB service of CDT and is not transmitted
- The register's information are analysed for getting different periodical repports

15.5. Definition of terms & Indicators

CDT Center of Diagnostic and Treatment
TC Treatment Center
F Failure
N New
TPM+ Pulmonary TB with positive smears
R Relapse
Rp Return after abandonment
TEP Extra-Pulmonary TB
TPM- Pulmonary TB Negative smears
TPM0 PulmonaryTB with Microscopy not done

15.6. Detailed Instructions for completing format

- **Registration date:** correspond to the date on which the patient present himself/herself to the CDT to start treatment (new) or continue treatment (transfers), this should be written under the format jj/mm/aaa ;
- **Sequence number:** this is the annual and successive sequence number given to the patient who is starting TB treatment;
- **Serial number:** the annual sequence number given in the labo register by the CTD laboratory assistant, corresponding to the serial number transcribed in the laboratory register ;
- **Name and given name (see lab register)** : writte the full name in all letters without shortening;
- **Sex: M** for male and **F** for female;
- **Age :** record the exact age expressed in years of lives and not birth date at the beginning;
- **Adress :** record the patient's residence adress (district, sector, cell and village) ;
- **Case Type:** tick with **X**, in the box corresponding to the patient's case type;
- **Treatment :**
    - **treatment start date:** put the date on which the treatment has been initiated, under the format jj/mm/aaaa ;
    - **Treatment Category:** mark by **I** for Cat I (firstly-treatment), by **II** for Cat II (retreatment), and **III** for Cat III (pediatric treatment)
    - **Treatment Unit:**
        - ✓ Use FOSA initials. Example: **G**= CS Gihara;
        - ✓ For the CDT having many CT of whose names start by the same letter, we add the vowel to the first consonant (example: CT Gihara = **Gi** and CT Gahanga = **Ga**). For more than CS with the same initilals, by convetion we add the 3rd letter eg : **Gah** for Gahanga and **Gat** for Gatagara;
        - ✓ For the district hospitals CDT having CT Health Facility with the same name, put the hospital name followed by the initials HD (example : **Byumba HD)** .for its CT Health Facility put the Health Facility name followed by its initials CS (example : Byumba CS) ;
        - ✓ For the CDT whose name are already made by initials, rewritte the same initials (example : **CHUK**) ;
        - ✓ For the ASC : write the AS complete name and given name who is monitoring the patient, without shortening, as well as the AS start monitoring date, under the format jj/mm/aaaa ;
- **Bacilloscopic Results:**
    - **Diagnostic (Diagnosis) :**
        - ✓ Record neg if the bacilloscopic result is negative;
        - ✓ If the result is positif, write in red according to the result (that is to say 1-**9BAAR, +, ++,+++)**
        - ✓ If among the 3 samples, several were positive, write the one which has more + ;
    - **Monitoring Results (Cn)**: record in the corresponding box to the monitored month the results below :
        - ✓ Record neg if the bacilloscopic result is negative
        - ✓ If the result is positif, write in red according to the result (that is to say 1-**9BAAR, +, ++,+++)**
        - ✓ If among the 3 samples, several were positive, write the one which has more +;

- **Other exams:**
    - La RX radiography: Mark with N for a normal radiography, CU for unilateral Cave, CB for bilateral Cave, IU unilateral infiltrate, IB for bilateral infiltrate,
    - GXP (date, result) : Write the result found during the exam b**y** genexpert that is to say MTB+ RIF+ either Invalid ; as well as the date of the result, under the format jj/mm/aaaa
    - **Culture:** report the date of the availability of the result of the culture in CDT, under the format jj/mm/aaaa and the result submitted by LRN: + if positive, Neg if negative, C if contaminated**.**
    - Sensitivity Test: indicate:
        - ✓ S: molecules initials to which microbes are sensitive eg: S: E, S to say sensitive to ethambutol and streptomycin;
        - ✓ And R: molecules initials to which microbes are resistant eg: R : R, P to say resistant to rifampicin and pyrazinamide.
- **Date and Treatment outcome:**
    - record the date under the format jj/mm/aaaa in the corresponding box with the suitable result ;
    - For the patients transferred in the course of treatment, wait the end of the treatment period before noting anything in this column. While waiting, note in the observation column that the patient has been transferred, the health facility to which he has been transferred and the transfer date and continue to monitor that patient with the FOSA transfer. As soon as the treatment result is available (as demonstrated by his/her treatmnet form), complete that column in the suitable sub-column.
- **HIV screening:** record the HIV screening date under the format jj/mm/aaaa in the corresponding column. For the HIV screening result, it necessary to specify, **pos** for Positive in red or **neg** for negative.
- **Management of HIV:** Tick by X in the column corresponding to the given information:
    - **Unité de PEC:** préciser le nom de FOSA qui prend en charge l'infection VIH du malade;
    - **File number:** write the HIV patient file number
    - **Under CTX** (yes/not and start date if yes): record yes if the patient is on CTX prophilaxis and **NOT** if the patient is not on CTX prophilaxis. If **YES** write under the format jj/mm/aaaa the start date of taking CTX ;
    - **CD4** (Nbr/mm3) : record in the corresponding box the CD4 number during TB diagnosis and at the end of TB diagnosis;
    - **ART:** record **YES** if the patient is on ART treatment and **NO** if the patient is not on ART treatment. If **YES**, record under the format jj/mm/aaaa ARTs start date. Record the ART regimen in the corresponding box ;
- **Contacts data:**
    - **Screened number:** record the number of screened contacts in the patient's entourage;
    - **Number of TB cases:** record the number of TB cases diagnosed among screened contacts in the patient's entourage;
    - Record also in the corresponding box the number of children<5years among the contacts put under INH
- **Observations:** record any necessary obeservation for the sake of the patient's monitoring.

Table 18: TUBERCULOSIS CASES REGISTER FOR CDT

TUBERCULOSIS CASES REGISTER FOR CDT (Left page)

REGISTRATION							CASES TYPE									TREATMENT			
Regis-tration number	No of TB register	Labora-tory serial number	Name and given name	Sex	Age	Address: District, Sector, Cell, Village	TPM+				TPM+	TPMO	TEP	Other	T coming from	Treatment start-ing date	Category treatment (I, II, ou II)	Treat-ment Unit (FOSA, AS)	As name and starting date of A3 follow up
							N	R	E	Rp									

TUBERCULOSIS CASES REGISTER FOR CDT (Right page)

BACILLOSCOPIC RESULTS									OTHER EXAMS				DATE AND TREATMENT RESULT						HIV test	HIV MANAGEMENT					Contacts			Observations
Diagn.	C2	C3	C4	C5	C6	C7	C8	C9	RX (date, re-sult)	GXP (date, re-sult)	Culture (date, result)	Sensibil-ity test (date, result)	Healed	TT	E	De-ceased	PDV	Transferred	Date	HIV PEC Unit	Under CTX (yes/ not and start-ing date if yes)	CD4 (Nbr mm3)		Under ARV		Number of contacts screened in	Number of TB cases among the contacts	Number of children<5 years among the contacts put under INH	Observation
																			Re-sult	File number		At Dg TB	A is in TT	Yes/ not (starting date if yes)	regi-men				

16. Under five Growth Monitoring Register

16.1. Purpose of the format

– To identify children with growth deviation *i.e.*, undernutrition and over nutrition and to identify diseases and conditions that manifest through abnormal growth. It can be used also to:

- To discuss health promotion related to feeding, hygiene, immunization and other aspects of the child's health and behavior; education of parents to allay their anxiety about their child's growth.
- To sensitize pediatricians to use growth charts.

16.2. Data sources

Data are collected by CHWs in villages

16.3. Presentation of the format

The format is a series of columns in which the information on the growth of each child in the village is recorded. It is made of three parts: the first concerns general information about the child, the second part is made of successive measurements for growth monitoring and the last part is the verification of the actions taken

16.4. Preparation and submission

The register is filled by the community health team (the community health worker or pairs) and then it is brought to the health center for the purpose of supervision and coaching. After discussions the community health worker returns with the register to the village. The CHW is supervised by community health officer from health center using a supervision format.

16.5. Definition of terms and indicators

RUTF: Ready-to-use Therapeutic Food (RUTF) has revolutionized the treatment of severe malnutrition – providing foods that are safe to use at home and ensure rapid weight gain in severely malnourished children. The advantage of RUTF is that it is a ready-to-use paste which does not need to be mixed with water, thereby avoiding the risk of bacterial proliferation in case of accidental contamination. The product, which is based on peanut butter mixed with dried skimmed milk and vitamins and minerals, can be consumed directly by the child and provides sufficient nutrient intake for complete recovery. It can be stored for three to four months without refrigeration, even at tropical temperatures. Local production of RUTF paste is already under way in several countries including Congo, Ethiopia, Malawi and Niger.

SOSOMA: a composite flour « SOSOMA » is a very nutritious flour produced from the mixture of maize grains, soy beans and sorghum. It is high nutritious flour with high content of protein and energy. It is recommended in prevention and treatment of micronutrient deficiency diseases.

16.6. Detailed instructions for completing format

Name & surname of child	Record the full name of the children
N° growth monitoring card	Record the code as visible on U5 growth monitoring card
Sex	Record F if female or M if male
Date of birth	Record the date on format dd/mm/yy
Mother's name	Record the full name of mother
Father's Name	Record the full name of father
Age in months after birth	Count from date of birth and write number of months after birth
Vaccinated at time	Record Y if appointment was respected or N if not respected
Wheight in kgs	Record weight in kgs with decimals if applicable
Weight/Age	Calculate this indicator to express underweight. Indicator is given in %.Indicate G if indicator is in green zone (the child is well nourished),Y if in yellow zone (the child to be follow up for growth promotion and monitoring) or R if indicator is in red zone (severe acute malnutrition, to be referred)
Oedema	Record Y or N
Takes RUTF or SOSOMA	Record Y or N
Home visit	Record Y or N
Referred	Record Y or N

Table 19: Under Five growth Monitoring Register

District:..... Sector:..... Health Center:..... Cell:..... Village:.....

To fill all chidren under five years in the village							Month..... Year.....											Month..... Year.....											Month..... Year.....										
#	Child name	growth Monitoring Form number	Sex Male/ Female	Date birth __/__/__	Mother name	Father name	Age in month	Vaccinated in appropriate period? (y/n)	weight (kg)	Weight/ age (√)			MUAC (√)			Oedeme (y/n)	got RUTF or SOSOMA? (y/n)	Home visit? (y/n)	Sent to hospital? (y/n)	Age in month	Vaccinated in appropriate period? (y/n)	weight (kg)	Weight/ age (√)			MUAC (√)			Oedeme (y/n)	got RUTF or SOSOMA? (y/n)	Home visit? (y/n)	Sent to hospital? (y/n)	Age in month	Vaccinated in appropriate period? (y/n)	Ibiro (kg)	Weight/ age (√)			MUAC (√)			Oedeme (y/n)	got RUTF or SOSOMA? (y/n)	Home visit? (y/n)	Sent to hospital? (y/n)
										C	H	T	C	H	T								C	H	T	C	H	T							C	H	T	C	H	T				
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To fill all chidren under five years in the village							Month.............................. Year..............................													Month.............................. Year..............................													Month.............................. Year..............................												
#	Child name	growth Monitoring Form number	Sex Male/ Female	Date birth __/__/__	Mother name	Father name	Age in month	Vaccinated in appropriate period? (y/n)	weight (kg)	Weight/ age (√)			MUAC (√)			Oedeme (y/n)	got RUTF or SOSOMA? (y/n)	Home visit? (y/n)	Sent to hospital? (y/n)	Age in month	Vaccinated in appropriate period? (y/n)	weight (kg)	Weight/ age (√)			MUAC (√)			Oedeme (y/n)	got RUTF or SOSOMA? (y/n)	Home visit? (y/n)	Sent to hospital? (y/n)	Age in month	Vaccinated in appropriate period? (y/n)	Ibiro (kg)	Weight/ age (√)			MUAC (√)			Oedeme (y/n)	got RUTF or SOSOMA? (y/n)	Home visit? (y/n)	Sent to hospital? (y/n)
										C	H	T	C	H	T								C	H	T	C	H	T								C	H	T	C	H	T				
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SUBTOTALS – sum columns at end of each month and transfer to SISCom report							Month 9-12 mos incom vacc													Month 9-12 mos incom vacc													Month 9-12 mos incom vacc												

Month………… Year…………												Month………… Year…………												Month………… Year…………												Monitoring				
Age in month	Vaccinated in appropriate period? (y/n)	weight (kg)	Weight/ age (√)			MUAC (√)			Oedeme (y/n)	got RUTF or SOSOMA? (y/n)	Home visit? (y/n)	Sent to hospital? (y/n)	Age in month	Vaccinated in appropriate period? (y/n)	weight (kg)	Weight/ age (√)			MUAC (√)			Oedeme (y/n)	got RUTF or SOSOMA? (y/n)	Home visit? (y/n)	Sent to hospital? (y/n)	Age in month	Vaccinated in appropriate period? (y/n)	weight (kg)	Weight/ age (√)			MUAC (√)			Oedeme (y/n)	got RUTF or SOSOMA? (y/n)	Home visit? (y/n)	Sent to hospital? (y/n)	Provided Vit A	Got sell tablet	Back to village program	Back to village program	Explanations
			C	H	T	C	H	T								C	H	T	C	H	T								C	H	T	C	H	T					Month/ year	Month/ year	Month/year	Month/ year	

Month.............................. Year..............................														Month.............................. Year..............................														Month.............................. Year..............................														Monitoring				
Age in month	Vaccinated in appropriate period? (y/n)	weight (kg)	Weight/ age (√)			MUAC (√)			Oedeme (y/n)	got RUTF or SOSOMA? (y/n)	Home visit? (y/n)	Sent to hospital? (y/n)	Age in month	Vaccinated in appropriate period? (y/n)	weight (kg)	Weight/ age (√)			MUAC (√)			Oedeme (y/n)	got RUTF or SOSOMA? (y/n)	Home visit? (y/n)	Sent to hospital? (y/n)	Age in month	Vaccinated in appropriate period? (y/n)	weight (kg)	Weight/ age (√)			MUAC (√)			Oedeme (y/n)	got RUTF or SOSOMA? (y/n)	Home visit? (y/n)	Sent to hospital? (y/n)	Provided Vit A Month/ year	Got sell tablet Month/ year	Back to village program Month/year	Back to village program Month/ year	Explanations
			C	H	T	C	H	T								C	H	T	C	H	T								C	H	T	C	H	T									
Month 9-12 mos incom vacc													Month 9-12 mos incom vacc													Month 9-12 mos incom vacc																	

17. VCT Book Register

17.1. Purpose of the format

In order to create and sustain demand for counselling and testing services and to ensure the impact of VCT in the comprehensive response to HIV/AIDS, VCT register plays a key role for appropriate monitoring and evaluation of VCT interventions. Data collected will be utilized to monitor progress in counselling and testing program implementation, quality control and other important issues.The program indicators will be monitored and evaluated at program level.

17.2. Presentation of the format

The format is a serie of 19 columns that allow first to identify the client and his previous test result. No examination or consultation is conducted.

17.3. Data sources

Data are recorded from VCT clients.

17.4. Preparation and submission

The form is kept in the VCT room and the person completing the form is the VCT counselor.

17.5. Definition of terms and indicators

Coabiting matrimonial statute: When two persons live togather like man and woman without bieng legally married.

Mixed disability: When a person cumulates more than one disability, for example with one leg and deaf

17.6. Detailed Instructions for completing format

Date	Record the date on which the client presented to the VCT service
Serial number	Before the registration, give to the client the serial number following the previous client
Client code	If any code system is used or if the client has already a code, record the client'code
Name and given name	Write the name and given name in full
Age	Record the client's age in completed years
Sex	Record M if it is a boy or man, F it is a girl or woman
Matrimonial status	Choose the most appropriated form: • écrire Record : 'married' if the person is married in front of a civil authority, 'single' when the person live alone and has not been married, • 'separated' when the person is no longer living with his/her spouse when the separation has not been imposed by court • 'divorced' when the divorce has been pronounced by a tribunal • 'Cohabiting' when the person living with another without being 'married' • 'Widow (er)' when his/her spouse is deceased
Tel no and head of family name	This is the person who live and support the family in which lives the client. Record his tel number.

District	Record the district name
Sector	Record the sector nam
Cell	Record the sector name
Village	Record the village name
Person living with disability, which one ?	Reply by yes or not. If it is yes provide the kind of disability and specify
Education level	Choose the level : • Primary means that he/she has done one year from 1 to 6 years; • Secondary from 1 to 6; • University when the person did more than secondray level ;
Tests done previously	If the patient has been screened : give the number of test in the first box last test result : record 'positive' or 'negative' in the 2nd box , record the month and year of the last test in mm/yy format
Observation	Give any other necessary information

Table 20: VCT Register

Date	Serial number	Client code	Name and surname	Age	Sex	Matrimonial statute	Name of Familly Head and his telephone number	District	Sector	Cell	Village
						Married					
						Single					
						Separated					
						Divorced					
						Coabiting					
						Widower					

Person living with disability. (yes/ not). If yes which one?	**Profession**	**Education level**	**Tests previously done**			**Observation**
Blind	Employee	None	Number of tests done previously	Last test result	Last test result	
Deaf-dumb	Housekeeping	Primary				
Physical disability	Farmer	Secondary				
Mental disability	Trader	University level			Month and year	
Mixed or other disability	Domestique					
	Student					
	Others					

18. VCT-Counselling Register

18.1. Purpose of the format

The counselling register follows the VCT registration register. It serves at registering the VCT results and allows ensuring the program continuity. Allows to evaluate the the two types of counseling before and after the test. Its comparison with HIV registers such as pre ART and ART register allows to know the clients'retention in the program and then know its efficiency.

18.2. Presentation of the format

The format is also set of 14 columns retaking some information contained in the entry register to VCT as well as information on measures taken according to tests results and councelling sessions before and after tests.

18.3. Data sources

The register is completed by counselors before the clients leave the service. They can divide the information contained in the VCT register.

18.4. Preparation and submission

Le registre est gardé au site VCT et il doit être rempli pour chaque client qui finit son test. Il est utilisé pour confectionner les rapports périodiques. The register is kept in VCT site and has to be filled for every client who finish his/her test. It is used to prepare periodical reports.

18.5. Definitions of terms and indicators

Counselling: Counselling is a private conversation with a specially trained person aimed at helping you to help yourself. Counseling encourages you to explore possible solutions to your problems, and to consider the impact that certain decision may have on your life. HIV and AIDS counseling provided at Voluntary Counseling and Testing (VCT) sites is free and confidential. This means that the counselor cannot tell anyone about your result without your permission. You must receive face-to-face counseling before you have the test. This is known as pre-test counseling, and is aimed at ensuring that you make a well-informed decision about whether to have the HIV test or not, and encourages you to explore the possible impact that having the test may have on your life.

Pre-Test Counselling: This is the kind of counseling you get before you decide whether you want to have the HIV antibody test.

Post-Test Counselling: This is the kind of counseling you get after you have had the test.

18.6. Detailed instructions for completing format

Date	Record the date on which the client had the counseling
Numéro d'ordre	Record the number in the register according to the registration of successive customers
Client Code	During the test, the client got a code for confidentiality reason, record that code.
Age	Record the client's age or at default his/her birth date in dd/mm/yyyy format
Sexe	Record M for Male and F for Female
Person living with disability (yes/ not) if yes which one?	Record O or N. if it is O, specify the type of disability following the discribed categories.
Type de counseling	Choose the appropriate counselling type and record it
Reason for screening	Explain the reason why the client did the screening choosing one of the suggested options
Counselling pre test	Record O if it has been done, N in the contrary
Screening result	Record P if the result is positive, N if it is negative
Counselling post test	Record O if it done, N in the contrary case
Reference	Record O if the client is referred in another service, N in a contrary case. If it is O specify the referral service choosing among the suggested services
number of taken condoms	If the client took condoms before leave, record the number
Observation	Record any necessary fact

Table 21: Counselling Register

Date	Serial number	Client code	Age	Sex	Person living with disability (yes/ not) if yes which one?	Type of counselling	Reason for screening	Pre-Test Counselling is done yes/ not	Screening result	Post-Test Counselling is done yes/ not	Referred to service	Number of condoms taken	Observation
					Blind	Individual	Volontary				TB		
					Deaf-dumb	Couple	Weeding				PF		
					Physical disability	accompanied by a parent or guardian	Confirmation				PMTC		
					Mixed disability or others						STIs		
											ARV		
											Others (specify)		

19. Child death audit

19.1. Purpose of the format

The purpose of this guide is to standardize the approach and to assist the audit team to properly fill the audit format from the whole of the existing media and thus allow the correct entry in the database of information collected on the format.

19.2. Presentation of the format

The format of child deaths audit is composed of seven sections which are the following:

A. General Information
B. Mode of admission
D. Physical examination on admission (pathological signs found)
E. Complementary examinations requests
F. Hospital treatment and monitoring
G. Conclusions on the death

All information or questions contained in the sheet are useful and should be collected and/or analyzed. No question should be skipped without being discussed, that it is applicable or not.

19.3. Data sources

To complete the format, members of the audit team should use the following:

- Hospital records of infant deaths (or child) if it was admitted to the neonatal unit or was hospitalized.
- File delivery (including the partograph) of the mother if the baby died in the delivery room or in the case of stillbirth.
- Data transfer from the mother (or the deceased child) if the birth took place in the facility where the death occurred or transfer form newborn if the infant deaths referred by another health facility.
- Other documents deemed useful that can provide additional information that can help gather information to complete the audit record.

19.4. Preparation and submission

19.5. Definition of terms and indicators

Anamnesis: Medical history, information gained by a physician by asking specific questions of a patient;

Lethargy: is a subjective feeling of tiredness which is distinct from weakness, and has a gradual onset. Unlike weakness, fatigue can be alleviated by periods of rest. Fatigue can have physical or mental causes.

Conjunctival or palmar pallor: The conjunctivae (the mucous membranes that line the inner surface of the eyelid and the exposed surface of the eyeball) are normally a healthy red colour. In anaemia (haemaglobin < 90g/L), these tissues become unnaturally pale. Pallor of the conjunctivae is therefore a sign of anaemia used in clinical examination. Pallor is a pale color of skin which can be caused by illness, emotional shock or stress, stimulant use, or anemia. Pallor is more evident on the face and palms. It can develop suddenly or gradually, depending on the cause. It is not usually clinically significant unless it is accompanied by a general pallor (pale lips, tongue, palms, mouth and other regions with mucous membranes).

Jaundice bulbar conjunctiva: The bulbar conjunctiva is colorless and we look at the underlying scleral icterus through it (ideally in the presence of natural light).

Severe Respiratory Distress:

Acute Respiratory Distress Syndrome (**ARDS**), also known as **Respiratory Distress Syndrome** (**RDS**) is a life-threatening reaction to injuries or acute infection to the lung. Rails to pulmonary auscultation: Crackles, crepitations, or rales are the clicking, rattling, or crackling noises that may be made by one or both lungs of a human with a respiratory disease during inhalation. They are often heard only with a stethoscope ("on auscultation").

Gastroenteritis: Gastroenteritis or infectious diarrhea is a medical condition characterized by inflammation of the gastrointestinal tract that involves both the stomach and the small intestine, resulting in some combination of diarrhea, vomiting, and abdominal pain and cramping.

Septicemia: Sepsis, the state of putrefaction and decay, is a potentially deadly medical condition characterized by a whole-body inflammatory state caused by severe infection. Septicemia is a related medical term referring to the presence of pathogenic organisms in the bloodstream, leading to sepsis.

Pathognomonic sign: A pathognomonic sign is a particular sign whose presence means that a particular disease is present beyond any doubt. Labelling a sign or symptom "pathognomonic" represents a marked intensification of a "diagnostic" sign or symptom.

19.6. Detailed instructions for completing format

This form must be completed for all children deceased who were aged 29 days to 59 months.

A. GENERAL INFORMATION ON THE DEATH CHILD

This part contains information related to the localisation of the Health Facility in which the child died and other identifications of the dead child such as:

1. Province Example : North Province
2. District: Example: Gakenke District
3. Hospital catchement area: Eg: catchement area of Nemba Hospital
4. Health Facility : to complete if the death occured at the Health Facility level
5. Hospitalisation number: To copy as found on the hospital records if the child had been hospitalized
6. Sex: Tick M if the sex is masculin and F if sex is feminin
7. Age of child in months: Try to count the child's age in months if you know the date of birth
8. Admission Date: Enter the date when the deceased child had been hospitalized, check the hospitalization record
9. Date of death: Record the date of death found on the hospital record: In the database you will select the date on the calendar
10. The number of audit should follow the monthly order: Example if the case to be audited is the fourth death recorded during the month of December 2012, then the number of the audit will be: infant 04/decembre / 2012
11. Record the level of health facility where the death occurred

B. MODE D'ADMISSION ADMISSION DATE

1. Identify whether the deceased child was admitted referred by another health unit or not, Use the transfer form if it is available
2. If for the previous question, you answered yes, then record the origin health facility.if the answer was no, then tick NA meaning that the child was admitted not reffered,
3. If for question 12 you answered yes and you find the transfer form then record yes. If the child was not referred, to this question you tick NA
4. Same thing if for question 12 and 14 the answer was yes, you must choose between the answers yes or no depending on the quality of information found on the transfer form
5. If you have information about when the transfer had been made with respect to the admission, choose the answer to give. Always NA means that the child was not admitted referred
6. In function of the transfer time with respect to the admission, choose a corresponding responsee

C. HISTORY AND VITAL SIGNS THE ADMISSION

1. For this question many answers are possible. Tick all moans presented by the deceased child. If there is another moan not listed among the 5, tick also in front of another symptom or major moan and for the question 19 specify the moan or symptom in all letters. In the Database before symptoms ticked on the audit form, it must be ticked yes, for those which are not ticked they will not be recordered
2. Specify if you found that there was not another major sign not listed in question18

D. PHYSICAL EXAMINATION AT THE ADMISSION (DISEASE SIGNS FOUND)

1. Same as question 18, several answers are possible, you must tick the present signs and for the question 21 specify if there was another sign not listed, if not write anything and leave out. In the database, we will not write anything before another symptom.
2. Specify in all lowercase letters and without accent if you had ticked in front of another major sign for question 20
3. Choose the intervale of breathing frequency if it had been calculated during the examination for admission
4. Select the range of temperature at admission if it was done at admission

E. ADDITIONAL EXAMINATION REQUESTED

1. If in your critical analysis according to the signs and present symptoms at admission or in hospital you find that there is an examen that was not requested whereas it was mentioned, answer yes and for the question 25
2. Mention in one of these tests that you consider important that was omitted.Mention it in all letters (lower case and without accent)
3. If you find that all requested exams are done and mentioned in the folder, answer by yes but if this is not the case for the next question
4. Select the reasons which may cause that the results are not available in the file. More than one answer is possible. If there is another cause not listed among the set, tick in front of other causes and clarify that cause in all letters for the following question 28
5. Specify another cause of question 27
6. Record the HIV status of the child (or mother) according to the results or information known, if the test has not been asked, answer that the status is unknown

F. TREATMENT AND HOSPITAL MONITORING

1. Note: For this question, before to answer, you must make a deep analysis of the social support and give your opinion about general support. Do not answer it without deep analysis,
2. If for question 30 you found that social support was not correct, then say in what this one was not correct. Here more than one answer are possible. In database, you will answer yes to the statement that was ticked on the form for this question, for others you will respond if no. But if for question 30 the answer was no, then on the form for that question, nothing will be ticked and in the database data you will leave out the terms related to them.
3. If you find that all prescribed drugs have been administered in time answer yes
4. If for question 32 the answer was no, then choose the reason, more than one answer is possible, then in the database, the handling will be the same as for question 31 according to the answers found

G. CONCLUSION ON DEATH

1. Taking into account the time and date of admission, specify after how much time the death occurred
2. Give your opinion about the circumstances of death depending on whether monitoring was regular in hospitalization. The circumstances of death are not well described if during monitoring we had not shown that the state of the child has gradually worsened
3. According to the medical notes found in the hospital record, specify when dated the last medical visit
4. Choose one diagnosis that you think could be main that can be considered as a cause of death: If diagnostis is other than the 12 listed then select another and in this case for the question 38, record this diagnosis in all lower case letters without accents

5. Specify whether for question 37 you found that the diagnosis was another

6. By analyzing the chosen diagnostic which is considered as the cause of death, you must check if this diagnosis is justified according to clinical or even paraclinical signs that the deceased child presented and answer yes or no

7. If for question 39 these signs are findable according to the available information in the file, record one of them. Example: tick smear highly positive for severe malaria, low Hemoglobin in cases of anemia, typical radiograph for LRTI,..

8. If in the analysis, you find that there are preventable factors that can be linked to the death of the child, answer yes and for the question 42 choose these factors

9. If for question 41, you answered yes, for this question select the factors that you have identified. Several answers are possible. In the databases you answer yes to the factors that had been identified on the form, while for others you will answer by no. But if for question 41, you answered no, in this case on the file for question 42 nothing will be ticked and in the database, all terms related to that will be left out.

10. So after reviewing all the questions and answer, we must make one or two recommendations that you consider most important with respect to the identified factors for question 42. Recommendations should be formulated in action verbs.

Table 20: AUDIT FORM OF INFANT DEATHS IN HEALTH FACILITIES (July 2012)

REPUBLIC OF RWANDA
MINISTRY OF HEALTH
MATERNAL AND CHILD HEALTH UNIT

AUDIT FORM OF INFANT DEATHS IN HEALTH FACILITIES (July 2012)

A. GENERAL INFORMATION

1. Province: …..... 2. District of :……..

3. Catchement area of the hospital of :…… (HF of :……..)

4. Decaesed child name ……..……

5. Hospital number I__I__I__I__I__I__I__I__I__I 6. Sex (M ou F) I__ I

7. Child age in month I__I__I

8. Admission date at the hospital I_ I__II__I__II__I__I I_ I_ I 9. Date du décès I__I__II__I__II__I__I

10. Date of death I__I__I__I_2I0I1I__I (Infant - -/Month/Year)

11. Type of FOSA where the child is deceased

(a) Health Facility	☐
(b) Hospital District	☐
(c) Reference Hospital	☐

B. Admission mode

1. Is the child admitted referred by another health unit ? (If no go to question 18)	Yes ☐ No ☐
2. If yes from which health unit is he referred ?	
(a) ASC (PCIME –C) (b) Health Unit (c) Health Center (d) Private Clinic (e) District Hospital	☐ ☐ ☐ ☐ ☐
3. Is the transfer form found in the medical record?	Yes ☐ No ☐
4. If the transfer form is found explain if the reason of the child transfer was well documented (Containing all elements allowing subsequent management)	Yes ☐ No ☐

5. If the child is referred by another FOSA the reference has been immediat (the child has not been initially hospitalized)	Yes ☐ No ☐
6. If not, the reference has ben done after how much time talen by the referring FOSA ? (a) Lower than 6 hours (b) between 6 and 24 hours (c) between 24 hours and 72 hours (d) more than 72 hours (e) not marked/ unknow	☐ ☐ ☐ ☐ ☐

C. Symptoms/amnesis and vital signs on admission	
1. Which of the following symptoms were present on admission? (a) Fever or antecedents : (b) Diarrhea: (c) Vomiting : (d) Convulsions or antecedents: (e) Cough or breathing difficulties:	☐ ☐ ☐ ☐ ☐
2. If other symptoms (complaint) which? (Specify) ……	
D. Physical examination on admission (pathological signs found)	
1. Which of the following signs that the child presented on admission? (a) State of unconsciousness or lethargy (b) Conjunctival pallor or palmar (c) Icterus of bulbar conjunctiva (d) Severe respiratory distress (e) Rails with pulmonary auscultation (f) Signs of dehydration (g) Obvious signs of malnutrition	☐ ☐ ☐ ☐ ☐ ☐ ☐
2. Another important pathological physical signs found (specify) :……	
3. What is the interval of the respiratory frequency on admission? (a) Less than 40 movements / min (b) 40- 50 movements / min (c) 50- 60 movements / min (d) Over 60 minute movements / min (e) not marked	☐ ☐ ☐ ☐ ☐

4. Temperature on admission : (a) < 36.5 degrees Celsius (b) 36.5-37.5 degrees Celsius (c) >37.5 degrees Celsius (e) not	☐ ☐ ☐ ☐
E. Additional tests requested	
1. Are there had additional tests deemed necessary that have not been asked on admission or in hospitalization	Yes ☐ No ☐
2. If yes, specify the test the most important omitted?.....	
3. All results of exams requested are they made and recodered in the patient's file?	Yes ☐ No ☐
4. If not why? (a) Child deceased before we have the results (b) Out of material / reagent (c) State of the Child (severe state) (d) Other causes	☐ ☐ ☐ ☐
5. If other cause specify which one ……	
6. HIV status (if> 18 months if <serology mother) (a) negative (b) positive (c) unknown	☐ ☐ ☐
F. Treatment and hospital monitoring	
1. Is there any gaps in the management of the disease, and monitoring? (including admission to hospital)	Yes ☐ No ☐

2. If yes what is the gap (a) Deficiencies related to the treatment protocol (choice of drugs, dosage, ...) (b) Deficiencies related to the request of additional exams (c) Gaps related to hospital monitoring	☐ ☐ ☐

3. All drugs prescribed have been found and administered in time?	Yes ☐ No ☐
4. Otherwise what made that drugs prescribed are not given (a) Lack of maney to procure (lack of health insurance or lack copayment) (b) Drug is not often used in FOSA (c) Out of stock of this drug (d) Deceased before medications are administered (e) Other cause	☐ ☐ ☐ ☐ ☐
G. Conclusion on the death	
34. After how long time of hospitalization the death occur? (a) 6 hours (b) 6-24 hours (c) 24-48 hours (d) After 48 hours (e) More than 7 days	☐ ☐ ☐ ☐ ☐
35. The circumstances of death are they marked and well described in the medical record?	Yes ☐ No ☐
36. When did the last medical examination before the death of the child dated? (a) Less than 6 hours (b) 6-12 hours (c) More than 12 hours (d) Deceased without being seen by the doctor (e) Deceased in admission	☐ ☐ ☐ ☐ ☐
37. What is the main final diagnosis retained marked in the file (one diagnosis)? (a) Malaria (b) Malnutrition (c) Febrile gastroenteritis (d) Diarrhea complicated by severe dehydration (e) Meningitis (f) Fever of unidentified origin (g) Infection of the lower respiratory parts (h) Anemia from unidentified origine (i) Septicemia (j) Urinary infection (k) Heart desease (l) Acute abdomen (m) No specific diagnostic marked (n) Other	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

38. Other diagnostic specify:.....	
39. Is there a pathognomonic sign upon which the final diagnosis is based?	Yes ☐ No ☐
40. If so, mark a (Physics or paraclinical)……	
41. Is there factors that can be blamed for this death?	Yes ☐ No ☐
42. If so what factors from the following can be challenged? (a) Delay of consultation by the family of the sick child (b) Transfer delay by the first who made the FOSA support (c) Inadequate care (examination and treatment.) from the inpatient admission (d) Poor monitoring / evaluation during hospitalization (Late detection of severity signs) (e) Investigations on the disease which are not depth (f) Other factor	☐ ☐ ☐ ☐ ☐ ☐
43. If other specify:……	
Give one or two recommendations that you consider important for this case of death 1…… 2……	

20. Neonatal Death Audit

20.1. Purpose of the format

The main purposes of the audit is to enable a high quality systematic approach to the provision of care around the time of a neonatal death including investigation and audit to enhance the accuracy of information about the causes of death and important contributing factors for stillbirth which will:

- Assist parents in gaining a better understanding of the cause of the death of their infant;
- Assist parents and clinicians in the planning and management of future pregnancies;
- Enhance the ability to undertake effective monitoring of strategies aimed at reducing perinatal deaths;
- Contribute to the body of knowledge to further reduce perinatal death; and

20.2. Presentation of the format

The format of Neonatal deaths audit is composed of five sections which are the following:

A. General Information
B. Admission of newborn (or mother) and vital signs at the admission
D. Delivery and the state of the new born
F. Hospital treatment and monitoring
G. Conclusions on the death of the new born

All information or questions contained in the sheet are useful and should be collected and/or analyzed. No question should be skipped without being discussed, that it is applicable or not.

20.3. Data Sources

Most of the information is completed by the staff in charge of post natal care but some information may come from maternity register or from antenatal care register, especially those related to the mother.

20.4. Preparation and submission

Neonatal death audit format is filled in monthly in health center and hospital. It is transmitted to the district hospital by health centers and districts hospitals report to the referral hospitals and the latter report to the central level.

20.5. Definition of terms and indicators

Vaginal Eutocic delivery: It is the natural method of birth

Obstructed labor vaginal: Labour is considered obstructed when the presenting part of the fetus cannot progress into the birth canal, despite strong uterine contractions.

Obstructed labor by Caesarean: The obstruction can only be alleviated by means of an operative delivery, either caesarean section or other instrumental delivery.

Fetal pelvic disproportion: Abnormally large size of the fetus in relation to the maternal pelvis, leading to difficulties in delivery.

Hypokinesia with failure of oxytocin: A heart disease which occurs when a woman is taking oxytocin, a drug used to speed delivery.

Hyperkinesia: Also called hyperkinesis is an abnormal increase in muscular activity, or hyperactivity, especially in children.

Iterative Caesarean: A woman who has already given birth by caesarean section, especially if she has had several, is seen in general, when a new pregnancy, propose an iterative cesarean section, that is to say a scheduled caesarean section without any medical indication that the fact that she already had one or more caesarean sections.

Mechanical dystocia: Mechanical dystocia occurs when the baby is too big for the pelvis, has malpresentation or is mal positioned .It may also be related to an obstruction such as an overfull bladder or a large fibroid in the lower segment of the uterus.

Hypoglycemia: is a medical emergency that involves an abnormally diminished content of glucose in the blood. The term literally means “low sugar blood”.

Hypothermia: Hypothermia is a condition in which core temperature drops below the required temperature for normal metabolism and body functions which is defined as 35.0 °C (95.0 °F). Body temperature is usually maintained near a constant level of 36.5–37.5 °C (98–100 °F) through biologic homeostasis or thermoregulation.

Hyaline membrane disease / apnea of prematurity or CSD newborn (Maladie des membranes hyalines/apnée de la prematurité ou SDR du nouveau né). Respiratory distress syndrome of the newborn, also called hyaline membrane disease, is the most common cause of respiratory distress in premature infants, correlating with structural and functional lung immaturity.

20.6. Detailed instructions for completing format

A. GENERAL INFORMATION ABOUT THE STILLBIRTH

This section contains information related to the location of the health facility in which the newborn is deceased as:

1. Province: Example: Estearn Province
2. District: Example: Kayonza District
3. Hospital Catchment Area, example: Catchment Area of Gahini Hospital

   For districts with more than one district hospital, we can have more than one catchement area. Here, we must record the name of the hospital corresponding to the catchement area. If the death occurred at the District hospital you will record nothing in front of the health center: you must complete the name of the health center if the death in question took place at the health center.
4. Month in which the death occurred : Example: November
5. Year in which the new born is deceased: Example: 2012
6. As often the new borns have no name, you must record the name of their mother (Example: Baby Nyiramana)
7. You must tick the corresponding box to the sex of the stillbirth.
8. For the hospitalization file number, you must recod the number found on the file of the newborn in hospital. If the deceased newborn has not been hospitalized (Example: Stillbirth), you must record the number which is on the mother's delivery file. If it is not, you must record the one of the partograph: 'neo 12/novembre /2012' The numbering of the audit is monthly: If for example the audited case is the third for the month of November during 2012 year, you should record 'neo 03/november/2012'. If during the month of November, we had a total of 12 cases of neonatal death, the last audit number will be 'neo 12/november / 2012'
9. Place of birth may differ from place of death: Tick the box corresponding to the birth place of the deceased newborn for which the audit is being carried out
10. Tick in the box corresponding to the interval of weight at birth. Example: if the birth weight of the newborn is 1350 gr, you will tick in front of the interval 1000Gr - 1499Gr
11. Tick in the box corresponding to death place. Here, it should be noted that the place of death may differ birth place. Place of death will almost always be the level of health facility where the audit is currently being done.

B. ADMISSION OF NEWBORN (OR HIS MOTHER) AND VITAL SIGNS AT THE ADMISSION

1. For this question, we must tick the box that corresponds to the age that had the deceased newborn. Here it should be noted that the stillbirth is a death that occurs shortly after birth when resuscitation gives no success. Often these deaths occur in the delivery room because born with low APGAR and do not survive more than 30 minutes but it may happen that these cases die in neonatal if the newborns with birth pain are immediately routed to neonatology appropriate care.
2. For this question you must tick 'yes' if the newborn is not admitted referred: In such a situation, it is either the mother who is admitted referred or she came herself.

3. If the previous question was answered 'yes' for this question 15 by referring to the information found on the partograph or obstetrical file, we must check in what phase the mother is admitted and answer yes or no depending on the phase in which she is admitted. Tick NA (Not Applicable) if for question 14 you had answered 'No'

4. For that question, if the mother of the newborn was admitted in active phase (question 15 is answered 'yes'), referring to the information found on the obstetrical admission file, you should check if the mother of the newborn had no problems at the admision such as fetal distress, hemmorragie ... and answer 'yes' if there were any problems at admission. You will answer NA (Not Applicable) if question 15 was not answered 'yes'

5. For this question you need to answer 'yes' for all newborn for whom the hospital file was done. Normally, these are all newborns who did not die at birt.

6. For that matter for any newborn having been hospitalized whatever place of birth, we must check if the transfer form is findable and is give appropriate answer. This is applicable even for newborns who were born in the maternity hospital in which the death occurred because the internal transfer form is required. You will answer NA (Not Applicable) if the newborn had not been hospitalized (question 17 is "no")

7. For this question we must answer 'yes' or 'no' if question 18 was answered 'yes'. In other cases we must answer by NA (Not Applicable)

8. To this question, you will select the missing information on the transfer form if for the previous question (19) you had answered 'No'. In this case several answers are possible. Then tick before each box corresponding to the information missing on the transfer form. Then, in the database each piece of missing information resort with alternative answer 'yes' or 'no'. Then you will answer 'yes' to the missing information that were ticked on the audit form and answer "no" to the information that was not ticked on the audit form. If, on the other hand for question 19, we had not answered 'no', which means that on the audit form no information will not be ticked, then in this case in the database you will record anything before missing information on the transfer form (this means 'Neither yes nor no') you will simply leave out the 4 questions from: **information related to delivery up to earlier management before transfer**

9. If the question 17 was answered 'yes' you must tick the time that the newborn spent in hospital before dying. Tick NA if the newborn had not been hospitalized.

10. For this question, referring to the hospital file (if the newborn was hospitalized) tick in the box that corresponds to the temperature interval of newborn at admission. If the temperature was not taken tick not indicated, if he has not been hospitalized tick NA.

C. DELIVERY AND STATE OF THE NEWBORN AT BIRTH

1. Indicate if the newborn was premature or not. Indicate no if born at term

2. If the newborn was premature, referring to obstetric file, choose the interval corresponding to the term of pregnancy. If the information is not on file tick 'not indicated.' If it was not premature then tick NA.

3. Tick 'yes' if you have evidence that corticosteroids were administered to the mother during labor before delivery in case of premature birth. If you do not have the evidences answer no. Answer no information if you are not sure (especially for cases for which delivery has not started in the health facility where the death occurred) and answer NA if the delivery was not premature or the corticoids were not indicated.

4. Tick the box that corresponds to the mode of delivery by which the birth happened
5. If delivery is by cesarean section specify the main caesarean section indication (**only one**). You will tick it in the database
6. According to the available information on the delivery file, indicate if the newborn had shouted immediately at birth. In this case often APGAR score is >6. If you do not have reliable information tick no info**.**
7. This question is applicable to a new-born who had not shouted at birth. Then, if the latter has been able to shout at the 5 th minute. If you do not have information do not respond to it. If the new-born had shouted, answer NA.
8. If you find in the files that the vitamin K had been administered at birth or within 3 hours which have followed the birth mark yes otherwise mark no. If you don't know (case admitted transferred) indicate no info.

D. HOSPITAL MONITORING AND TREATMENT

1. As the previous question record yes if you find the prescription and administration of the aminiphylline, if you cannot find it whereas indicated mark not. If was not indicated mark NA.
2. To answer this question, we must do an analysis of what was stated that has been done and well done before concluding. Do not hurry to the conclusion because for answer you must check if the protocols have been respected as recommended: If you really find that there is no inconsistency answer 'yes' if no management was indicated or could not be applied (dead at birth by example) mark NA.
3. If the previous question you responded that the management has not been correct, tick the box that corresponds to the shortcomings detected during management (several gaps are possible). In the database to each deficiency, you will need to reply by yes or no, but if to the previous question (32) had been answered by yes or NA, you will leave out the 3 gaps in management which means that this is 'neither yes nor no'.

E. CONCLUSION ON THE NEWBORN DEATH

1. Among the 7 proposed causes of death, choose one and tick it. Tick other cause not quoted above if the cause of death is not found among the 6 set out. The cause of death will be regarded as neonatal infection if the latter is diagnosed or if when you analyze the way deliver occurred, you find the infectious risk which was very high, the cause of death will be regarded as complication of prematurity if you have eliminated the other causes (especially asphyxiation and neonatal infection) and that the newborn is a big premature.
2. For questions 35, 36.37 you must concretely write which neonatal infection, which congenital malformation or any other cause according to the answer that was given to the question 34. If the cause of death is not part of these statements, you will not mark these questions. N.B.: all writtings should be made in lowercase letters and without accents.
3. If prematurity is considered as main factor of death then select among the statements which complication had been diagnosed in the deceased newborn. Here, the answer may be more than one. In the Database, mark yes in front of the statement which had been ticked, for the one which had not been ticked mark no. But if the cause of death is not complication of the great prematurity, nothing will be ticked for the question 38 and in the database all the 3 statements corresponding to this question will be left out.

4. For this question, before responding to it, you must review the whole process and circuit of the admission of the mother in labor, the birth and the follow up of the new-born after the birth. A death surely avoidable is a death for which we clearly identifies a shortcoming which could make possible that the newborn survive if the breach had not take place. A death is inevitable for example a death due to congenital malformation incompatible with life, the very large prematurity in our working conditions or the situation when we made a deep analysis and found that everything had been done well but that unfortunately the newborn is deceased (these cases are not many because in the analysis we must consider all the delays community- Health Center- District or Reference Hospital). In case of doubt when we are not sure, we must mark that the death 'may be avoidable'.

5. For this question 40 if question 39 was responded that the death was preventable, then for this question it is necessary to choose the level where an action or if something should have been done (but has not been done) the death could not take place. This level should not go beyond the health facility where the death took place. Example: If the death took place at the level of the district hospital, the hospital of reference cannot be considered as level of preventability. For this question more than one answer is possible. Then tick the levels where you feel that something has not been well done .In the database, select yes whereas for other levels which were not ticked on the audit form tick not. If for question 39 you had concluded that the death is inevitable, then on the audit form nothing will be ticked for question 40 and in the database you will leave out all levels from community level up to the level of hospital reference

6. If you find that there are the factors that can be put in question for the death audited, then answer yes. Normally if you have found that the death could be avoided and the level of preventability, the answer must be yes.

7. After you have answered that there are factors that can be put in question, then you must select these factors by ticking before each factor identified (several answers are possible). You must respond to this question after having made a reflection on the entire path traveled by the mother or the newborn until the death of the latter. In the database, you will respond by yes in front of each factor which had been ticked on the audit form. For those who had not been ticked on the audit form you must respond by not.

8. Then after you have reviewed all the questions and answer, you must make one or two recommendations that you feel are most important in functions of the factors identified for the question.

9. Recommendations must be formulated in action verbs.

Table 23: Neonatal death audit format

REPUBLIC OF RWANDA **MINISTRY OF HEALTH** **MATERNAL AND CHILD HEALTH UNIT** **NEONATAL DEATH AUDIT FORMAT IN HEALTH FACILITIES (JULY 2012)**	
A. General information on the stillborn	
1. Province:	
2. District :	
3. Catchement area of the hospital:	(health facility:----------)
4. Month in which the death occurred:	5. Year: 20 - -
6. Name of the newborn deceased (Baby ……): ……	
7. Sex of the newborn	a. Male ☐ b. Feminin ☐
8. Hospitalisation file number of the newborn (of the mother (if deceased at birth):	
9. Audit number (- --- / --- /20-- --) (Neo - - /Month/year)	
10. Place of birth a. On the way b. At home c. Health Unit d. Health Center e. District Hospital f. Private Hospital g. Reference Hopital	☐ ☐ ☐ ☐ ☐ ☐ ☐
11. Interval of weigh at birth a. > 2500 Gr b. 1500 Gr - 2500 Gr c. 1000Gr- 1499Gr d. 500Gr-999 Gr e. unknown (not marked)	☐ ☐ ☐ ☐ ☐
12. Place of death a. Health Unit b. Health Center c. District Hospital d. Private Hospital e. Reference Hopital	☐ ☐ ☐ ☐ ☐
13. Period of death in relation to birth? a. At birth b. from 30 min - 48 Hours c. from 48 hours - 7 days d. from 8 days - 28 days	☐ ☐ ☐ ☐

B. Admission of the newborn (or his mother) and vital signs	
14. Is the newborn born in the same Fosa where he is deceased?	1. Yes ☐ 2. No ☐
15. If yes, the mother of the newborn has she been admitted in active phase of delivery?	1. Yes ☐ 2. No ☐
16. If Q14 is yes, the mother of the newborn was admitte during labor with signs threatening the fœtus life? (SFA For ex.)?	1. Yes ☐ 2. No ☐
17. The newborn has been in hospitalization before dying? (if not go to question 23)	1. Yes ☐ 2. No ☐
18. If the newborn has been hosptalized, transfert form (even the internal transfer form) has it been found in the newborn file?	1. Yes ☐ 2. No ☐
19. If yes are all necessary information found on the transfer form ?	1. Yes ☐ 2. No ☐
20. If not what are the missing necessary information? a. Information related to delivery b. Newborn state at birth (cry, APGAR,..) c. Gestures done by the newborn at birth d. Anterior management before the transfert	☐ ☐ ☐ ☐
21. If the newborn has been hospitalized, for how long? a. less than 48 hours b. 48 hours - 7 days c. from 7 – 14 days d. More than 14 days	☐ ☐ ☐ ☐
22. Which was the Temperature at admission in hospital? a. < 35 °C b. 35 °C - 36.5 °C c. 36.5 °C - 37.5 °C d. > 37.5 °C e. not indicated	☐ ☐ ☐ ☐ ☐
C. Delivery and newborn state at birth	
23. Is the newborn pematurate?	1. Yes ☐ 2. No ☐
24. If yes, what was the age interval of the pregnancy in weeks? a. 22 - 27 weeks b. 28 - 33 weeks c. 34 - 36 weeks d. not indicated	☐ ☐ ☐ ☐
25. If the newborn is premature, Corticoid were administered to the mother during labor before delivery?	1. Yes ☐ 2. No ☐ 3. No info ☐
26. Which mode of delivery? a. Vaginal eutocic delivery b. Obtructed labor vaginal c. Obstructed labor caesarean	☐ ☐ ☐

27. If delivery by Caesarean, which was the indication? a. Fetal distress b. Foeto pelvic disproportion c. Hypokinesia with failure of oxytocin d. Hyperkinesia e. Obstructed Presentation (breech, face, forehead) f. Iterative Caesarean g. Another type of mechanical dystocia h. Bleeding during labor i. Another indication not quoted above	☐
28. The newborn did he cried vigorously at birth (APGAR at birth> 6)	1. Yes ☐ 2. No ☐ 3. No info ☐
29. If no did the newborn cry at the 5th minute?	1. Yes ☐ 2. No ☐ 3. No info ☐
30. Vitamin K has he been given at birth or within 3hours after birth?	1. Yes ☐ 2. No ☐ 3. No info ☐
D.Treatment and hospital monitoring **N.B: this part concern the cases which has been hospitalized**	
31. Cafeine ou aminophylline in case of treatment of premature delivery < 33 weeks (ou <1500Gr) (NA If the newborn is not < 33SA ou <1500gr)	1. Yes ☐ 2. No ☐ 3. NA ☐
32. In general do you judge management correct from admission to death? (NA means that the newborn has not been hospitalized)	1. Yes ☐ 2. No ☐ 3. NA ☐
33. If no what are the shortcomings observed in management? a. Shortcomings related to the respect of treatment protocal of the newborn or mother (protocol, measuring ,…….) b. Incomplete invistigation c. Shortcomings related to hospital monitoring	☐

E. Conclusion on the newborn death	
34. Death cause retained according to audit committee (choose one that you consider main)	
a. Asphyxy and/or its complications b. Various neonatal infection c. Complication of high prematurity d. Congenital malformation incompatible with life e. Concrete death cause not clarified f. Other cause not quated below	☐
35. If neonatal infection specify which one	……
36. If congenital malformation which one?	……
37. If other cause of death which one? (specify)	……...

38. If prematurity complication which one among the following? a. Hypoglycemia b. Hypothermia c. Hyaline membrane disease / apnea of prematurity or SDR of the newborn d. Another complication of prematurity	☐ ☐ ☐ ☐
39. In conclusion the death is considered as (analyze all progression of the mother or the newborn before concluding) a. Surely avoidable b. Perhaps avoidable c. Unavoidable	☐ ☐ ☐
40. If avoidable at which level one or actions should be carried out and avoid that the death happen? a. Community level b. Health Center level c. District Hospital level d. Reference Hospital level	☐ ☐ ☐ ☐
41. Are there factors that can be put in question fot the death of that newborn?	1. Yes ☐ 2. No ☐
42. If yes what are the factors that can be put into question for the death of the new born? a. Delay in consultation by the mother for delivery or for newborn care b. Late transfer of the mother or newborn by the first FOSA for delivery or for neonal care c. Bad monitoring in delivery or late decision d. Insufficient logistic material for the good management e. Inadequate management of the new born (protocol of management not respected, inadequate monitoring of th enewborn in hospitalization,……..)	☐ ☐ ☐ ☐ ☐
43. Write one or two recommendations related to the factors quoted above that you consider important to evoide such death in the future: a. …… b. …… c. ……	

21. TB Quarterly Report

21.1. Purpose of the format

Quarterly TB Report is the core document that is produced by supervisors and health team at quarterly review meetings aimed at:

- Measure the level of activities achievement of TB control during the expired quarter in the coverage area of each of the hospitals, compared to the national indicators;
- Identify the strengths and weaknesses, and the corrective measures, the responsibilities as well as the delays in execution, for the next quarter;
- Provide basic data used to produce the quarterly report that guide plannings of the TB & DSB Division;

21.2. Presentation of the format

- The report format consists of 7 sections:
  - Identification of the health facility;
  - HIV testing among TB cases;
- Laboratory:
  - The suspects identified and by detection system
  - La positivité de crachats par charge bacillaire; The positivity of sputum bacillary load
  - HIV testing among suspects
- Screening for TB among groups most at risk ;
- Community DOT;
- bacteriological control at the end of intensive phase
- Results: treatment outcome by type of TB case or according to certain specific groups of the population, the children on ARV treatment, prophylaxis on INH:
- The suspicion TB MR: culture for the cases likely of TB MR
- Management of TB MR cases
- Pharmacy: quantity in stock at the end of the quarter, compressed, expired drugs during the past quarter, stock out, drugs expiring next quarter;

21.3. Data sources

- Register of TB cases in CDT and register for monitoring of TB case in CT;
- Laboratory Register to the CDT and suspects Registry at the TC
- Traitment form of the TB patient ;
- Register of TB screening at the entrance of the prisoner in the prison
- Register of preventive treatment to the INH;
- Evaluation form of TB deaths;
- Execution Register of IEC;
- Sorting Register of coughing,
- TB-MR patient's file;
- Registry of treatment MR-TB;
- Form of pharmacy stock;
- Any other useful tool capable of facilitating the assessment meeting

21.4. Preparation and submission

- Holding a meeting of the CDT and itsTC for elaboration, verification, approval depending on the format of the transmission form of the report described here below;

TRANSMISSION FORM OF QUARTERLY TB REPORT TRIMESTRIEL TB

DISTRICT …….. CDT ……..……..
Quarter:……Year…….

Type of report	Prepared by	Checked by	Approved by	stamp	Received by	Corrections done by
Report CDT	TB Management	Data manager CDT	CDT-CS: Titulaire		Data manager HD	
Date, Name, Function, Signature						
Compilation HD	Data manager	M&E HD	HD Director		M&E TB &ORD Division	
Date, Name, Function, Signature						

- Date, sign and stamp the report before the assessment meeting;
- Each FOSA should make the analysis of its report;
- The CDT Transmission report (and its TCs) to the district hospital two days before the assessment meeting, using the TB report transmission form described above;

Before the meeting

- **For Health Centers:**
  - They prepare their quarterly reports, each according to its format (CDT, TC);
  - Each FOSA describes the analysis of results and the recovery strategies of the pending indicators
  - Each CDT compiles its data with those of its TC and transmit them to the hospital;
  - The Data Managers analyze the reports of their health Centers;
  - The holders responsible of CDTs shall transmit the reports to the HD;

- **To the Hospital**
  - The Data Managers of the HD compile the reports of their CDTs in the district report format;
  - The M&E, supervisors PF TB, the laboratory assistant and the PF supervisor Community of the HD shall verify the CDTs reports the date of the meeting, introduce (discuss) the synthesis of strong points and weak points (the pending indicators) of each FOSA and District as well as the reorganization plan of pending indicators;
  - The Director of the Hospital convened the meeting of all FOSA of the coverage area of its HD;

During the meeting

- The Director of the HD led the meeting
- The M&E verifies the consistency of the data between the reports and the registers and other data sources;
- Each FOSA shows the analysis result and strategies for recovery of the pending indicators;
- The M&E presents the synthesis of the weak and strong points (the pending indicators) of each FOSA and District as well as the reorganization plan of pending indicators;
- The hospital prepares the meeting report, signed by the Doctor Director of the HD The signed report is transmitted to the central level, at the district and in each FOSA concerned

- **Note:** In case of need, the TB & ORD Division gives the message in report with new guidelines and transmits them the calendar of supervisions of the next quarter;
- The compiled copies of quarterly reports (hard and soft) of the HD coverage area, dates, signed and stamped are forwarded to the TB & ORD Division, not later than the 7th day of the 1st month following the end of the quarter assessed;
- The District Hospital keeps and archives copies of reports of all FOSA of its coverage area;

21.5. Definition of terms and Indicators

ARV	Anti Retro Viral (Treatment)
ASC	Animator of Health Community
CDT	Centre of Treatment and Diagnosis
CT	Traitment Center
DOTS	Directly Observed Treatment Short course chemotherapy
E	Failure
E	Isoniazid
H	Isoniazid
INH	Isoniazid
M&E	Monitoring and Evaluation
Neg	Negative
N	New Case
Pos	Positive
PVV	Persons living with HIV
R	Relapse
R	Rifampicin
RP	Return after abandonnment
S	Streptomycin
TB	Tuberculosis

TBMR	Multi-Drug Resistant Tuberculosis
TEP	Extra pulmonary TB
TP ou trad	Traditional healers
TPM+	Pulmonary TB with smear positive
TPM-	Pulmonary TB Negative smears
TPM0	Pulmonary TB with microscopy not done
VIH	Human Immunodeficiency Virus
Z	Pyrazinamide

21.6. Detailed instructions for completing the format

- We have an Excel file
- Start by delimiting the quarter to assess in the data source registry, and clearly identify the column to fill in the format of the quarterly report
- Write the report by section
- Use the ticking of sheet (report-draft or draft) for evoiding deletion.

1. Recording section

- To report the cases registered, use the register of TB cases and:
  - Consider its column 'TPM', under column 'N' for the NTPM+, under column 'R' for the relapses, Under column "E" for the failures, and Under column "RP" for relapses. Consider its column "TPM+", under column "N" for the NTPM+, Under column "R" for the relapses, Under column "E" for the failures, and Under column "RP" for relapses;
  - Pour les cas TPM-, TPM0, EP, considérez les colonnes 'TPM-, TPM-, TPM0, EP'
  - To report the cases called "other", count the cases in the other column of the cases register, and note the number obtained in the box corresponding to the report
- Don't count the incoming transfers
- Each time calculate the total cases
- To save the cases by age and sex
  - For all cases, match each time the name of the patient, sex, age
  - Categorize the cases by age and sex (M for male and F for the female of " 0-14 years", "15 -24 years ", "25-34 years", "35-44 years", "45-54 years", " 55-64" and ≥ 65 years and note the number obtained in the appropriate box;
  - Check if the total obtained (by adding up the numbers in the boxes) is equal to the number of cases in the recording case section;

2. Recording Section of TB cases by HIV status

- Distribute, separately, the case according to the categories NTPM+ , other types [TPM+ (R, E, RP), extrapulmonary disease and others); by age groups of "0-14 years" and "≥15 years ", and by sex;

- **For NTPM+ cases:**

  - Note the NTPM+ cases obtained in the column "NTPM+ " on line "Registered", taking into account the age groups of " 0-14 years" and of " ≥15 years ", and sex;

  - Count the TPM+ new cases tested for HIV and note in the column "NTPM+ " on line "tested" by taking into account the age groups of "0-14 years" and "≥15 years ", and sex;

  - Count the TPM+ new cases tested for HIV and note them in the column "new TPM+ " on the line "HIV+" the number of HIV cases obtained, taking into account the age groups " 0-14 years" and " ≥15 years ", and the sex;

  - Count among the number of HIV+ cases obtained those who are on CTX and record the number obtained in the column "new TPM+" under line CTX, taking into account the age groups of "0-14 years" and "≥15 years ", and sex;

  - Count among the number of HIV+ cases obtained those who are on ARV treatment and record the number obtained in the column "new TPM+" under line ARVS, taking into account the age groups of " 0-14" and " ≥15 years ", and sex;

- **For 'All other cases' :**

  - **On the line 'Registered',** note their number by subtracting the number of NTPM+ from total cases, taking into account the age groups of " 0-14 years" and " ≥15 years ", and the sex;

  - **On the line 'tested',** note the number of those who are tested for HIV, taking into account the age groups of "0-14 years" and "≥15 years ", and the sex

  - **On the line 'HIV Test',** by matching the type of case and the HIV test result, count and note the number of those who are positive, excluding the incoming transfers, and taking into account the age groups of " 0-14 years" and " ≥15 years ", and the sex;

  - **On the line CTX**, those who are positive, count and note the number of those who are under cotrimoxazole during the quarter assessed, taking into account the age groups of " 0-14 yeras" and " ≥15 years ", and sex;

  - **On the ARVs line**, those who are positive, count and note the number of those who are under ARVs treatment during the quarter assessed, taking into account the age groups of " 0-14 years" and " ≥15 years ", and sex;

3. Laboratory Sections, Contacts, community Dots

- For any section, use the Laboratory Register (LR);

- **Heading "the number of suspects and the smears ",**

  - Sub-heading "The number of suspects detected by ",

- ✓ **On CDT line**: consider the column suspected by, in the sub-column CDT of the LR. Count all ticked cases in this sub-column;
- ✓ **On I CT ine**: consider the column suspected by, in the sub-column CT of the LR. Count all ticked cases in this sub-column;
- ✓ **On the ASC line**: consider the column suspected by, in the sub-column ASC of LR. Count all ticked cases in this sub-column;
- ✓ **On line Traditional Healers**: consider the column suspected by, in the sub-column trad of the LR. Count all ticked cases in this sub-column;
- ✓ **On Line Total:** Add and record all the suspects of the CDT, CT, ASC, and traditional healers.

- **Heading " the number of positive suspects ":**
  - Sub-heading 'Number of suspects detected by':
    - ✓ **On CDT line:** consider the LR results column, count and note the number of positive suspects in the CDT;
    - ✓ **On TC line:** consider the RL column results, count and note the number of positive suspects in the TC;
    - ✓ **On ASC line:** consider the LR column results, count and note the number of positive suspects by the ASCs;
    - ✓ **On Traditional Healers line**: consider the RL column results, count and note the number of positive suspects by the TP;
    - ✓ **On Total Line:** Add up and record all positive suspects of CDT, CT, ASC, traditional healers;

- **Heading 'No.Smear of diagnosis (exclude the smears of control)'**
  - **On the line '1 ,2 ,3':** consider the column results, in the sub columns 1,2,3 of the LR, count and note all the smears (in term of smears and not of suspects) having had as results 1 ,2 ,3 ;
  - **On the line 1-9 B**: Consider the column results, in the sub columns 1, 2, 3 of the RL, count and note all the smears (in term of smears and not of suspects) having had as results 1-9 B;
  - **On the line Neg:** Consider the column results, in the sub columns 1, 2, 3 of the RL, count and note all the smears (in term of smears and not of suspects) having had as results Neg.

- **Heading 'No. Smear of monitoring' (exclude the results of diagnosis):**
  - **On the line '1 ,2 ,3' :** consider the control column of the RL, count and note all the smears (in term of smears and not of suspects) having had as results 1 ,2 ,3;
  - **On the line 1-9 B**: Consider control column RL, count and note all the smears (in term of smears and not of suspects) having had as results 1-9 B;
  - **On the line Neg:** Consider control of RL column, count and note all the smears (in term of smears and not of suspects) having had as results Neg.
  - **Total of smears:** add the numbers of smear of diagnostics and of monitoring.

- **Heading: 'HIV screening among the suspects whose HIV status is unknown' :**
  - **On the line 'Nbr suspects PVV**': Consider the column HIV date/result of the RL, count and note the number of suspect PVV (suspect whose HIV status was known during the suspicion of the TB) on the corresponding line of the report;
  - **On the line 'Nbr suspects tested':** Consider the column HIV date/result of the RL, count and note on the corresponding line of the report the number of TB suspects tested for HIV during the suspicion of the TB;
  - **On the line 'Nbr HIV+ suspects among the tested':** Consider the column HIV date/result of the RL, count and note on the corresponding line of the report the number of TB suspects tested for HIV during the suspicion of the TB and whose result has been positive;
  - **On the line 'Nbr HIV+': suspects :** Add the number of PVV and that of HIV+ suspects among the suspects tested during the suspicion
- **Heading 'Community DOTS':**
  - **Nbr of cases newly entrusted to the ASC:** In the case registry, match the names and the treatment unit column and count the number of patients monitored by the ASC that appear in this column during the period of reporting
- **Heading "examination of contacts of cases TPM+ registered ":**
  - For the line 'Number of contacts examined': in the case register, to the right page, contact column, under column contacts examined, count the number of contacts examined during the period of reporting;
  - For the line 'Nb case TB/contacts': In the case register, at the right page, contact column, under column NbTB case, count the number of TB cases among the contacts examined during the period of reporting;
  - For the line 'Nb contacts <5 years / INH': In the register of contacts on INH, count the number of children registered during the period of reporting,
- Heading 'PRISONS: TB screening at the entry':
  - For the line 'Nb incoming detainees': In the registry of screening of inmates at the entrance, consider the column 'names' and count the number of inmates who entered in prison during the quarter assessed;
  - For the line 'Nb with consideration at the entry' : In the registry of screening of inmates to the entrance, consider the column 'TB suspect' and count the number of detainees that have undergone the TB screening (column TB suspect, total of under columns yes and no);
  - For the line 'Nb TB suspects to the entry': In the registry of screening of detainees at the entry, consider the column 'TB suspect' and count the number of detainees that have undergone the TB screening and whose answer is 'YES';

- For the line 'Nb case TPM+ diagn. to the entry': In the registry of screening of the detainees to the entry, consider the column 'Expected Result' and count the number of inmates and whose answer is 'Pos';

4. Treatment Result Section

- Delimit the quarter to assess in the cases register and clearly identify the column to fill for the CDT report: the quarter to consider for the evaluation of the treatment outcome is the same quarter of reporting but a year earlier;
- Complete the report by heading corresponding to the case categories;
- Use a score sheet (draft sheet);
- The treatment result sheet is divided into several headings;
- **Heading "New case TPM+ ":**
  - **Registered:** Check the cases register, record all patients names registered during the quarter assessed, consider the column TPM+ under column 'N', count and note their number on the recorded line of the report;
  - **Healed**: Check the cases register**,** record all patients names registered during the quarter evaluated, consider the TPM+ column under column 'N', count and note the number whose result is saved as 'Healed' in considering the sub-column 'Healed' in the column 'Date and treatment outcome';
  - **T. completed:** Check the cases register, record all patients names registered during the quarter assessed, consider the column TPM+ under column 'N', count and note the number whose result is recorded as 'TT' by considering the sub-column 'TT' in the column 'Date and treatment outcome';
  - **Failure:** Check the cases register, record all patients names registered during the quarter assessed, consider the column TPM+ under column 'N', count and note the number whose result is recorded as 'E' by considering the sub-column 'E'of the column 'Date and treatment outcome';
  - **Deceased:** Check the cases register, record all patients names registered during the quarter assessed, consider the column TPM+ under column 'N', count and note the number whose result is recorded as 'deceased' by considering the sub-column 'deceased' in the column 'Date and treatment outcome';
  - **PDV:** Check the cases register, record all the patients names registered during the quarter evaluated, consider the column TPM+ under column 'N', count and note the number whose result is recorded as 'PDV' by considering the sub-column 'PDV' in the column 'Date and treatment outcome';
  - **Transferred**: Check the cases register, record all patients names registered during the quarter assessed, consider the column TPM+ under column 'N', count and note the number whose result is recorded as 'Transferred to ... ' by considering the sub-column 'Transferred to ... ' in the column 'Date and treatment outcome';
  - **Not-assessed**: Check the cases register, record all patients names registered during the quarter evaluated, consider the column TPM+ under column 'N', count and note the number of patients

whose none of the sub-columns of the column 'date and treatment outcome' is ticked, and whose treatment record is not available to record the result.

- **Heading "New case TPM-, TPM0, and PET ":**
  - **Registered**: Check the cases register, record all patients names registered during the quarter assessed, consider the column TPM-, TPM0 and PET together, count and note their number on the recorded line of the report;
  - **T. completed**: Check the cases register , record all patients names registered during the quarter assessed, consider the column TPM-, TPM0 and PET together, count and note the number whose result is recorded as 'TT' by considering the sub-column 'TT' in the column 'Date and treatment outcome'
  - **Deceased:** Check the cases register, record all patients names registered during the quarter assessed, consider the column TPM-, TPM0 and TEP together, count and note the number whose result is recorded as 'Deceased' by considering the sub-column 'Deceased' of the column 'Date and treatment outcome';
  - **PDV**: Check the cases register, record all patients names registered during the quarter evaluated, consider the column TPM-, TPM0 andTEP together, count and note the number whose result is recorded as 'PDV' by considering the sub-column "PDV'of the column 'Date and treatment outcome';
  - **Transferred**: Check the cases register, record all patients names registered during the quarter assessed, consider the column TPM-, TPM0 and TEP together, count and note the number whose result is recorded as 'transferred' by considering the sub-column 'transferred to…' in the column 'Date and treatment outcome';
  - **Not-assessed**: Check the cases register, record all patients names registered during the quarter evaluated, consider the column TPM-, TPM0 andTEP together, count and note the number count and note the number of patients whose none of the sub-columns of the column 'Date and treatment outcome' is ticked, and whose treatment form is not available to record the result.
- **Heading "Relapse":**
  - **Registered**: Check the cases register, record all patients names registered during the quarter assessed, consider the column TPM+, sub-column R, count and note their number on the recorded line of the report;
  - **Healed**: Check the cases register, record all patients names registered during the quarter assessed , consider the column TPM+ , sub-column R, count and note the number whose result is recorded as 'Healed' by considering the sub-column 'Healed' in the column 'Date and treatment outcome';
  - **T. completed**: Check the cases register,record all patients names registered during the quarter assessed , consider the column TPM+, sub-column R, count and note the number whose result is recorded as 'TT' in considering the sub-column 'TT' in the column 'Date and treatment outcome';
  - **Failure**: Check the cases register, record all patients names registered during the quarter assessed, consider the column TPM+ , sub-column R, count and note the number whose result is recorded as 'E' by considering the sub-column 'E' in the column 'Date and treatment outcome';

- **Deceased**: Check the cases register, record all patients names registered during the quarter assessed , consider the column TPM+ , sub-column R, count and note the number whose result is recorded as 'Deceased' by considering the sub-column 'Deceased' in the column 'Date and treatment outcome';
- **PDV**: Check the cases register, record all patients names registered during the quarter assessed, consider the column TPM+, sub-column R, count and note the number whose result is recorded as 'PDV' by considering the sub-column 'PDV' in the column 'Date and treatment outcome';
- **Transferred**: Check the cases register, record all patients names registered during the quarter assessed, consider the column TPM+, sub-column R, count and note the number whose the result is recorded as 'Transferred' by considering the sub-column 'transferred to ... ' of the column 'Date and treatment outcome';
- **Not Assessed**: Check the cases register, record all patients names registered during the quarter assessed, consider the column TPM+, sub-column R, count and note the number of patients whose none of the sub-columns of the column "Date and treatment outcome " is ticked, and whose treatment form is not available to record the result.

- **Heading 'Resumption of treatment after abandonment':**
  - **Registered**: Check the cases register, record all patients names registered during the quarter assessed, consider the column TPM+, sub-Rp column, count and note their number on the recorded line of the report;
  - **Healed**: Check the cases register, record all patients names registered during the quarter assessed, consider the column TPM+, sub-Rp column, count and note the number whose result is recorded as "Healed" by considering the sub-column "Healed" in the column "Date and treatment outcome";
  - **T. completed**: Check the cases register, record all patients names registered during the quarter assessed, consider the column TPM + , sub-Rp column, count and note the number whose result is recorded as "TT" by considering the sub-column "TT" in the column "Date and treatment outcome";
  - **Failure**: Check the cases register, record all patients names registered during the quarter assessed, consider the column TPM+, sub- column Rp, count and note the number whose result is recorded as 'E' by considering the sub-column 'E' in the column 'Date and treatment outcome';
  - **Deceased**: Check the cases register, record all patients names registered during the quarter assessed, consider the column TPM+, sub- column Rp, count and note the number whose result is recorded as 'Deceased' by considering the sub-column 'Deceased' in the column 'Date and treatment outcome';
  - **PDV**: Check the cases register, record all patients names registered during the quarter assessed , consider the column TPM+, sub- column Rp, count and note the number whose result is saved as 'PDV' by considering the sub-column 'PDV' in the column 'Date and treatment outcome';
  - **Transferred**: Check the cases register, record all patients names registered during the quarter assessed, consider the column TPM+ , sub-column Rp, count and note the number whose result is recorded as 'transferred' by considering the sub-column 'transferred to ... 'of the column 'Date and treatment outcome';

- **Not-assessed**: Check the cases register, record all patients names registered during the quarter evaluated, consider the column TPM+, sub- column Rp, count and note the number of sick people whose any of the sub-columns of the column 'Date and treatment outcome' is ticked, and whose treatment record is not available to record the result.

- **Heading 'Failed':**
  - **Registered**: Check the cases register, record all patients names registered during the quarter assessed, consider the column TPM+ , sub-column E, count and note their number on the recorded line of the report;
  - **Healed**: Check the cases register, record all patients names registered during the quarter assessed , consider the column TPM+ , sub-column E, count and note the number whose result is registered as 'healed' by considering the sub-column 'healed' in the column 'Date and treatment outcome';
  - **T. completed**: Check the cases register, record all patients names registered during the quarter assessed , consider the column TPM+ , sub-column E, count and note the number whose result is recorded as 'TT' by considering the sub-column 'TT' in the column 'Date and treatment outcome';
  - **Failure:** Check the cases register, record all patient names registered during the quarter evaluated, consider the TPM+ column, sub-column E, count and record the number whose result is recorded as 'E' by considering the sub-column 'E' of the column 'Date and treatment outcome';
  - **Deceased**: Check the cases register, record all patients names registered during the quarter assessed, consider the column TPM+ , sub-column E, count and note the number whose result is registered as 'Deceased' by considering the sub-column 'Deceased' in the column 'Date and treatment outcome';
  - **PDV**: Check the cases register, record all patients names registered during the quarter assessed , consider the column TPM+ , sub-column E, count and note the number whose result is registered as 'PDV' by considering the sub-column 'PDV' in the column 'Date and treatment outcome';
  - **Transferred**: Check the cases register, record all patients names registered during the quarter assessed , consider the column TPM_+ , sub-column E, count and note the number whose result is recorded as "transferred" by considering the sub-column "transferred to ... " in the column "Date and treatment outcome";
  - **Not-assessed**: Check the cases register, record all patients names registered during the quarter evaluated, consider the column TPM+ , sub-column E, count and note the number of patients whose none of the sub-columns of the column "Date and treatment outcome" is ticked, and whose treatment record is not available to record the result.

- **Heading 'Other Cases':**
  - **T. completed:** Check the cases register, record all patients names registered during the quarter assessed , consider the column 'other', count and note the number whose result is recorded as 'TT' by considering the sub-column 'TT' in the column "Date and treatment outcome";
  - **Failure:** Check the cases register, record all patients names registered during the quarter assessed , consider the column 'other', count and note the number whose result is recorded as 'E' by considering the sub-column 'E' in the column "Date and treatment outcome";

- **Deceased:** Check the cases register, record all patients names registered during the quarter assessed , consider the column 'other', count and note the number whose result is recorded as 'deceased' by considering the sub-column 'deceased' in the column 'Date and treatment outcome';
- **PDV:** Check the cases register, record all patients names registered during the quarter assessed, consider the column 'other', count and note the number whose result is recorded as 'PDV' in considering the sub-column 'PDV' in the column 'Date and treatment outcome';
- **Transferred:** Check the cases register, record all patients names registered during the quarter assessed , consider the column 'other', count and note the number whose result is recorded as 'transferred' by considering the sub-column 'transferred to ... ' in the column 'Date and treatment outcome';
- **Not-assessed:** Check the cases register, record all patients names registered during the quarter evaluated, consider the column 'other', count and note the number of patients whose none of the sub-columns of the column 'Date and treatment outcome' is ticked, and whose treatment record is not available to register the result;
- **Registered:** Check the cases register, record all patients names registered during the quarter assessed, consider the column 'HIV test', count and note the number if those with a positive result,
- **Healed and T. completed:** Check the cases register, record all patients names registered during the quarter assessed, consider ALL THE TYPES OF CASES TOGETHER. In considering the column "HIV test", and the number of those with a positive result, count and note the number of those whose result is recorded as 'Healed' and 'TT' by considering the sub-column 'Healed' and 'TT' in the column 'Date and treatment outcome';
- **Failure:** Check the cases register, record all the patients names registered during the quarter assessed, consider ALL THE TYPES OF CASES TOGETHER. In considering the column 'HIV test', and the number of those who have a positive result, count and note the number of those whose result is recorded as 'E' in considering the sub-column 'E' in the column 'Date and treatment outcome';
- **Deceased:** Check the cases register, record all patients' names registered during the quarter assessed, consider ALL THE TYPES OF CASES TOGETHER. In considering the column 'HIV test', and the number of those who have a positive result, count and note the number of those whose result is recorded as 'deceased' in considering the sub-column 'Deceased' in the column 'Date and treatment outcome';
- **PDV:** Check the cases register, record all patients names registered during the quarter assessed, consider ALL THE TYPES OF CASES TOGETHER. In considering the column 'HIV test', and the number of those with a positive result, count and note the number of those whose result is registered as 'PDV' by considering the sub-column 'PDV' in the column 'Date and treatment outcome';
- **Transferred:** check the cases register, record all patients names registered during the quarter assessed, consider ALL THE TYPES OF CASES TOGETHER. In considering the column 'HIV test', and the number of those who have a positive result, count and note the number of those whose result is recorded as 'transferred' in considering the sub-column 'transferred to etc....' in the column 'Date and treatment outcome';

- **Not - assessed:** check the cases register, record all patients names registered during the quarter assessed, consider ALL THE TYPES OF CASES TOGETHER. In considering the column 'HIV test', and the number of those with a positive result, count and note the number of those whose none of the sub-columns of the column 'Date and treatment outcome' is ticked, and whose treatment record is not available to record the result;
- **Number of patients on ARV at the end of the T. TB:** Check the cases register, record all patients' names of registered during the quarter assessed; consider ALL THE TYPES OF CASES TOGETHER. In considering the column 'HIV test', and the number of those who have a positive result, count and note the number of those whose result is YES by considering the sub-column 'ARV' in the column 'HIV management'.

- **Heading 'Cases followed by ASC':**
  - **Registered:** Check the cases register, record all patients names of registered during the quarter assessed, consider ALL THE TYPES OF CASES together and the column 'treatment', sub-column 'treatment unit', count and note the number of those marked AS;
  - **Healed and T. completed:** Check the cases register, record all patients names registered during the quarter assessed, consider ALL THE TYPES OF CASES together and the column 'treatment', sub-column 'treatment unit', and those marked 'AS'. Count and note the number of those whose result is recorded as 'Healed' and 'TT' in considering the sub-column 'Healed' and 'TT' in the column 'Date and treatment outcome';
  - **Failure:** check the cases register, record all patients names registered during the quarter assessed, consider ALL THE TYPES OF CASES together, and the column 'treatment', sub-column 'treatment unit', and those marked 'AS'. Count and note the number of those whose result is recodered as 'E' considering the sub-column 'E' in the column 'Date and treatment outcome';
  - **Deceased:** check the cases register, record all patients names registered during the quarter assessed, consider ALL THE TYPES OF CASES together, and the column 'treatment', sub-column 'treatment unit', and those marked 'AS'. Count and note the number of those whose result is recodered as 'Deceased' considering the sub-column 'Deceased' in the column 'Date and treatment outcome';
  - **PDV:** check the cases register, record all patients names registered during the quarter assessed, consider ALL THE TYPES OF CASES together and the column 'treatment', sub-column 'treatment unit', and those marked 'AS'. Count and note the number of those whose result is recodered as 'PDV' considering the sub-column 'PDV' in the column 'Date and treatment outcome';
  - **Transferred:** check the cases register, record all patients names registered during the quarter assessed, consider ALL THE TYPES OF CASES together and the column 'treatment', sub-column 'treatment unit', and those marked 'AS'. Count and note the number of those whose result is recorded as 'transferred' considering the sub-column 'transferred to' in the column 'Date and treatment outcome';
  - **Not-assessed:** check the cases register, record all patients names registered during the quarter assessed, consider ALL THE TYPES OF CASES together, and the column 'treatment', sub-column

'treatment unit', and those marked 'AS'. Count and note the number of those whose none of the sub-columns of the column 'Date and treatment outcome' is ticked, and whose treatment record is not available to record the result.

- **Heading 'Children of 0-14 years':**
    - **Registered:** check the cases register, record all patients names registered during the quarter assessed, consider the column 'AGE', count and note the number of those whose age is 0-14 years included;
    - **Healed and T. completed:** check the cases register, record all patients names registered during the quarter assessed, consider the column 'Age', count and note the number of those whose age is 0-14 years included. Count and note the number of those whose result is recorded as 'healed' and 'TT' considering the sub-column 'Healed' and 'TT' in the column 'Date and treatment outcome';
    - **Failure:** check the cases register, record all patients names registered during the quarter assessed, consider the column 'Age', count and note the number of those whose age is 0-14 years included. Count and note the number of those whose result is recodered as 'E' in considering the sub-column 'E' in the column 'Date and treatment outcome';
    - **Deceased:** check the cases register, record all patients names registered during the quarter assessed, consider the column 'Age', count and note the number of those whose age is 0-14 years included. Count and note the number of those whose result is recodered as 'Deceased' considering the sub-column 'Deceased' in the column 'Date and treatment outcome';
    - **PDV:** check the cases register, record all patients names registered during the quarter assessed, consider the column 'Age', count and note the number of those whose age is 0-14 years included. Count and note the number of those whose result is recodered as 'PDV' considering the sub-column 'PDV' in the column 'Date and treatment outcome'
    - **Transferred:** check the cases register, record all patients names registered during the quarter assessed, consider the column 'Age', count and note the number of those whose age is 0-14 years included. Count and note the number of those whose result is recorded as 'transferred' by considering the sub-column 'Transferred to' in the column 'Date and treatment outcome';
    - **Not- assessed:** check the cases register, record all patients names registered during the quarter assessed, consider the column 'Age', count and note the number of those whose age is 0-14 years included. Count and record the number of those whose none of the sub-column of th ecolumn 'Date and treatment' is not ticked and whose treatment record is not available to register the result.

- **Heading 'Men':**
    - **Registered:** Check the cases register , record all patients names registered during the quarter assessed, consider the column "sex", count and note the number of those whose gender is male;
    - **Healed and T. completed:** check the cases register, record all patients names, count and note the number of those whose gender is male. Count and note the number of those whose result is recordered as 'healed' and 'TT' in considering the sub-column 'healed' and 'TT' in the column 'Date and treatment outcome';

- **Failure:** check the cases register, record all patients names registered during the quarter assessed, consider the column 'sex', count and note the number of those whose gender is male. Count and note the number of those whose result is recodered as 'E' considering the sub-column 'E' in the column 'Date and treatment outcome';
- **Deceased:** check the cases register, record all patients names registered during the quarter assessed, consider the column 'Sex', count and note the number of those whose gender is male. Count and note the number of those whose result is recodered as 'Deceased' in considering the sub-column 'Deceased' in the column 'Date and treatment outcome';
- **PDV:** check the cases register, record all patients names registered during the quarter assessed, consider the column 'Sex', count and note the number of those whose gender is male. Count and note the number of those whose result is registered as 'PVD' considering the sub-column 'PVD' in the column 'Date and treatment outcome';
- **Transferred:** check the cases register, record all patients names registered during the quarter assessed, consider the column 'Sex', count and note the number of those whose gender is male. Count and note the number of those whose result is recorded as 'transferred' by considering the sub-column 'transferred to' in the column 'Date and treatment outcome';
- **Not-Evaluated:** check the cases register, record all patients names registered during the quarter assessed, consider the column 'Sex', count and note the number of those whose gender is male. Count and note the number of those whose none of the sub-columns of the column 'Date and treatment outcome' is ticked, and whose treatment record is not available to record the result.

- **Heading 'Women'**
  - **Registered:** Check the cases register , record all patients names registered during the quarter assessed, consider the column "sex", count and note the number of those whose gender is female;
  - **Healed and T. completed:** Check the cases register, record all patients names registered during the quarter assessed, consider the column "sex", count and note the number of those whose gender is female. Count and note the number of those whose result is recorded as 'Healed' and "TT" by considering the sub-column 'Healed' and 'TT' in the column "date and treatment outcome ";
  - **Failure:** Check the cases register, record all patients names registered during the quarter assessed, consider the column "sex", count and note the number of those whose gender is female. Count and note the number of those whose result is registered as "E"by considering the sub-column "E" in the column "date and treatment outcome";
  - **Deceased:** Check the cases register, record all patients names registered during the quarter assessed, consider the column 'sex', count and note the number of those whose gender is female. Count and note the number of those whose result is registered as 'Deceased' by considering the sub-column 'Deceased' in the column 'Date and treatment outcome';
  - **PDV:** Check the cases register, record all patients names registered during the quarter assessed, consider the column 'sex', count and note the number of those whose gender is female. Count and note the number of those whose result is recorded as 'PDV' by considering the sub-column 'PDV' in the column 'Date and treatment outcome';

- **Transferred:** Check the cases register, record all patients names registered during the quarter assessed, consider the column 'sex', count and note the number of those whose gender is female. Count and note the number of those whose result is recorded as 'transferred' by considering the sub-column 'transferred' in the column 'Date and treatment outcome';
- **Not Evaluated:** Check the cases register, record all patients names registered during the quarter assessed, consider the column 'sex', count and note the number of those whose gender is female. Count and note the number of those whose none of the sub-columns of the column 'Date and treatment outcome' is ticked, and whose treatment record is not available to record the result.

- **Heading 'Contacts on INH'**
  - **Registered:** Check the contacts register Go to the register of on INH, count and note the number of all children < 5 years who have begun the preventive treatment, by excluding the incoming transferred;
  - **Healed and T Completed :** Check the contacts register on INH, count and note the number of all children < 5 years who have begun the preventive treatment, by excluding the incoming transferred. Count and note the number of those whose result is registered as 'TT' by considering the sub-column'TT' of the column 'END (date/result)', sub-column 'TT'.

Use the TB cases register, and consider the quarter preceding the quarter currently evaluated;

5. Bacteriological control section at the end of intensive phase

- **Sub-heading 'NTPM+ control at 2 month'**
  - **Registered:** consider the column 'Type of case', sub-column 'TMP+', sub-sub-column 'N' from the cases register, count and note the number of boxes ticked;
  - **Positive to C2:** consider the column 'smear result', under-column 'C2', of the case registrer, count and note the number of boxes with positive result ;
  - **Negative :** Consider the column 'smear result', under-column 'C2', of the case registrer, count and note the number of cases with negative result ;
  - **Deceased:** Consider the column 'Date and treatment results', sub-column 'Deceased' of the cases register, count and note the number of boxes bearing the death date;
  - **Transferred**: consider the column 'Date and treatment results', sub-column 'transferred to ….. ' of the cases register, count and note the number of boxes bearing the date and the place of transfers;
  - **Controlling not-done:** consider the column 'Smear Results', sub-column 'C2', or the column 'Date and treatment results', sub-column 'Deceased' or the 'Date and treatment results', sub-column 'transferred to …' of the cases register, count and note the number of boxes without smear results NOR death date or date and place of transfers.

- **Sub-heading ' relapse control at 3 month'**
  - **Registered:** consider the column 'Type of case', sub-column 'TMP+', sub-sub-column 'R' of the cases register, count and note the number of boxes ticked

- **Positive to C3:** consider the column 'Smear results', sub-column 'C3' of the cases register, count and note the number of boxes with positive results;
- **Negative:** consider the column ' smear results', sub-column 'C3', of the cases register, count and note the number of boxes with negative results;
- **Deceased:** consider the column 'Date and treatment results', sub-column 'deceased', of the cases register, count and note the number of boxes bearing the death date;
- **Transferred:** consider the column 'Date and treatment results', sub-column 'transferred to … . ' of the cases register, count and note the number of boxes bearing the date and the place of transfers;
- **Controlling not done:** consider the column "Smear results", sub-column 'C2', or the column 'Date and treatment results', sub-column 'deceased' or the 'Date and treatment results', sub-column 'transferred to … .', of the cases register, count and note the number of boxes without smear results NOR death date or date and place of transfers.

- **Sub-heading 'Resuming after abandonment control at 3 months':**
  - **Registered:** consider the column 'Type of case', sub-column 'TMP+', sub-sub- column 'RP' of the cases register, count and note the number of boxes ticked;
  - **Positive to C3:** consider the column 'Smear results', sub-column 'C3', of the cases register, count and note the number of boxes with positive results;
  - **Negative:** consider the column 'Smear results', sub-column 'C3', of the cases register, count and note the number of boxes with negative results;
  - **Deceased:** consider the column 'Date and treatment results', sub-column 'Deceased', of the cases register, count and note the number of boxes bearing the death date;
  - **Transferred:** consider the column 'Date and treatment results', sub-column 'transferred to … . ', of the cases register, count and note the number of boxes bearing the date and the place of transfers;
  - **Controlling not done :** consider the column 'Smear result', sub column 'C2' OR the column 'Date and Treatment result', sub column 'Deceased' OR the column 'Date and Treatment result', sub column 'transferred to…..' of the case register, count and note the number of cases without smear result neither death date nor date and place of transfers.

6. Section Suspicion of the TBMR

- **Number of NTPM+ positive to C2 having had a culture:** consider the column 'Type of case', sub-column 'TPM+', sub-sub-column 'N' of the cases register; consider also the column "smear results ", sub-column 'C2', of the cases the register; consider also the column 'Other exams', sub-column 'culture (date and result)', of the cases register. Count and record the number of boxes with positive results to C2 and which have the date in the sub-column culture;

- **Number of cases having had a culture at the beginning of treatment:**
  - **Failure:** consider the column 'Types of cases', sub-column 'E', of the cases register; consider also

the column 'Other exams', sub-column 'culture (date and result)', of the cases register. Count and record the number of boxes that have the date in the sub-column culture;

- **Relapse:** consider the column 'Types of cases', sub-column 'R', of the cases register; consider also the column 'Other exams', sub-column 'culture (date and result)', of the cases register. Count and record the number of boxes that have the date in the sub-column culture;
- **RP**: Consider the column 'Types of cases', sub column 'RP' of the cases registrer, consider also the column 'Other exams', sub column 'Culture (date and result) of the cases register. Count and note the number of cases that have the date in the sub column culture; RP: consider also the column 'Other exams', sub column 'Culture (date and result)' column "Types of case' , sub column 'RP' of the cases register. Count and note the number of boxes that have the date in the sub column culture;

- **Nbr prisonniers NTPM+: Nbr prisoner NTPM+**
  - **For the prison CDT:** Consider the column 'Types of cases', sub-column 'N', of the cases register of CDT Prison; consider also the column 'Other exams', sub-column 'culture (date and result)', of the cases register. Count and record the number of boxes that have the date in the sub-column culture;
  - **For the prison CT :** consider the column 'registered case at CDT as (tyes of case)' in the monitoring register TBCT of the Prison; consider also the column 'Other exams' sub column ' culture (date and result)' of the cases register. Count and record the number of boxes that have the date in the sub column culture;
- **Number of health agents NTPM+:** Consider the notification forms of tuberculosis among health staff. Identify those who are classified NTPM+. Check the cases register, identify their names; count and record the number of c NTPM+ ases that have the date in the sub-column culture;
- **Number of PVV NTPM+:** consider the column 'Type of case', sub-column 'TMP', sub-sub-column 'N' of the cases register; Consider also the column 'HIV Test (date and result)' and count and recod the number of boxes with positive result; consider finally the column 'Other exams', sub-column 'culture (date and result)', of the cases register. Count and record the number of boxes with the date in the sub-column culture;
- **Number of contacts TB-MR examined:** See "the TB MR medical record" of all TB-MR patients registered during the quarter assessed, on page Examination of contacts. Count and record all contacts investigated.
- **Number of NTPM+ contacts MDR having had a culture:** see 'TBMR medical record' of all TB-MR patients registered during the quarter assessed, on page Exam of contacts, column 'sputum (date/ result)', sub column 'culture'. Count and record the number of boxes with the date in the sub column 'culture'.

7. Management of TBMR cases Section

- Use the medical record TBMR, and consider the quarter preceding the quarter currently evaluated;
- Line ' Number of case TB MR in treatment at the beginning of the quarter' : count and note the number of medical record MDR-TB of TBMR patients during treatment on the 1st day of the quarter assessed;

- Line 'Number of TB MR cases confirmed during the quarter' : count and note the number of TB-MR medical record of TB-MR patients confirmed during the quarter assessed;
- 'Number of TBMR cases hospitalised in specialised centers at the end of the quarter' : count and record the number of TB-MR medical record of TBMR patients hospitalised in specialised centers the last day of the quarter assessed ;
- Number of TBMR cases ambulatory (CDT and CT) count and record the number of TB-MR medical records of TB MR patients followed by CDT-CT, during the quarter evaluated ;

8. Pharmacy section

- Quantities at the end of the quarter (tablets): For each product, take the corresponding stock sheet and record quantity in units (Nbr of tablets, Nbr of needles, Nbr of ml, etc), to the last day of the quarter assessed;
- Expired drugs during the quarter assessed: for each product, check the expiration date on the container of the product, and record the name as well as the quantity of the expiring product (quantity in units as Nbr of tablets, Nbr of needles, Nbr of ml, etc), during the quarter assessed;
- Out of stock (indicate name of the medicine and Nb of days): For each product, check stock record, check the balance column drugs with quantity of zero, which has caused the discontinuation of treatment of the patient;
- Medicines expiring the next quarter: for each medicine check the expiration date on the container and report on the report form the name of the medicine and its quantity (the quantity in units as Nbr tablets, Nbr of needles, Nbr of ml, etc), expiring during the quarter following the quarter evaluated.

Table 24: TB quarterly report format

RWANDA BIOMEDICAL CENTER
A Healthy People. A Healthy Nation

RWANDA BIOMEDICAL CENTRE
INSTITUTE OF HIV/AIDS, DISEASE PREVENTION & CONTROL (IHDPC)
Tuberculosis & Other Respiratory Communicable Diseases Division

TUBERCULOSIS QUARTERLY REPORT

I. Identification			
1. Name of Health facility		5. Year	
2. Total population of catchement area		6. Quarter	
3. Province		7. Sector	
4. District		8. Cell	
9. Type of tuberculosis service	□ Centre of treatment (CT) □ Centre of Diagnosis and Treatment (CDT)		

II. Number of TB cases registered (CDT only)

Type of cases	0-14 years		15-24 years		25-34 years		35-44 years		45-54 years		55-64 years		≥ 65 years		Total		Total
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
1. NTPM+ New Pulmonary TB with smear positive																	
2. Relapses																	
3. Failures																	
4.Treatment after abandonment																	
5. NTPM- Pulmonary TB Negative smears																	
6. NTPM0 Pulmonary TB with Microscopy Not Done																	
7. Extra Pulmonary TB																	
8. Others																	

III. HIV testing among TB cases (excluding incoming transfers)

	NTPM+ (NSS+)				Other forms (NTPM-/0, EPTB, Retreatment and others)			
	0-14 years		≥15 years		0-14		≥15 years	
	M	F	M	F	M	F	M	F
1. Registered								
2. Tested for HIV (PLHIV and newly tested)								
3. HIV positive								
4. CTX								
5. ARVs								

IV. LABORATORY				
	CDT	CT	CHWs	TP/Traditional Healers
1. Number of patients suspected by				
2. Number of positive suspects detected				

V. Number of Smears examined FOR CDT ONLY (CDT Will complete including CTs)			
	1+, 2+, 3+	**1-9 B/100 ch.**	**Nég**
1. Number of smear of diagnosis			
2. Number of follow up smears			

VI. TB/HIV and TB among people at high risk of TB	
1. Number of TB suspects living with HIV/AIDS	
2. HIV screening among TB Suspects With unknown HIV status	
3. Number of TB suspects With unknown HIV status tested for HIV	
4. Number of TB suspects With unknown HIV status whose Status become HIVpositive (after test)	
5. Total number of HIV positive suspects	
6. Number of HIV+ TB suspects who beneficiated from Genexpert test	
7. Total number TB retreatment cases	, ,

VII. Number of persons at high risk groups of TB screened for TB disease				
Risk group :	Total Number	Screened for TB	TB Suspects	Detected TB Cases
1. Prisonners at entry				
2. Elderly aged ≥ 55 years				
3. Children aged <15 years				
4. Contacts of SS++ (NTPM+ et retreatement)				
4.1. Contacts of SS++ (NTPM+ and retreatment) < 5 years initiated on INH				
5. HIV+ persons				

VIII. Community DOTS	
	Number
1. Number of TB cases newly entrusted to CHWs during the quarter evaluated	

IX. Bacteriological conversion at the end of intensive (Data for the previous quarter on quarter evaluate) (CDT Only)							
Result / Type of case	Registered	Positive C_2	Positive C_3	Negative	Deaths	Transfered	Control not done
1. NSS+ control at C2							
2. Relapse at C3							
3. Return after abandonment control at 3rd month (C3)							
4. Failures at C3							

Treatment Outcome (previous year evaluated: do not include incoming transfers) (CDT Only)								
	Registered	Cured	Completed treatments	Failures	Deaths	Lost follow up	Transfered	evaluated
1. NTPM+ New Pulmonary TB with smear positive								
2. Rechutes / Relapses								
3. Échecs / Failures								
4. Return after abandonment								
5.NTPM- Pulmonary TB Negative smears								
6.NTPM0 Pulmonary TB with Microscopy Not Done								
7. ExtraPulmonary TB								
8. Others								
9. Children 0-14 years								
10. Men (all forms)								
11. Women (all forms)								
12. Number of TB/HIV+ patients								
13. Number of TB /HIV patients initiated ART before the end of TB treatment (exclude the incoming transfers)								
14. Number of children ≤5 years put on INH								
Number of TB patients followed by CHW successfully treated								

Suspicion of MDR/TB: Number of eligible persons who had culture of their sputum done		
Culture/Type of TB	Number registered	Number with culture done
1. Number of positive SS+ at C2		
2. Number of Failures		
3. Number of Relapses		
4. Number of Return after default		
5. Number of NSS+ in prison		
6. Number of NSS+ among health providers		
7. Number of NSS+ among PLWHIV		
8. Number of NSS+ diagnosed in High-risk area		
9. Number of MDR/TB contacts examined		
10. Number of TB cases diagnosed among MDR TB contacts		
11. Number of SS+ in contact with MDR TB patient who had culture		

Management of MDR TB cases	
	Number
1. Number of MDR/TB cases on treatment at the beginning of quarter	
2. Number of MDR/TB cases confirmed during the quarter	
3. Number of MDR/TB on treatment at the end of quarter	
4. Number of MDR/TB patients on treatment at the end of quarter in the specialized unit	
5. Number of MDR/TB patients on treatment at the end of quarter in ambulatory	

X. TB DRUGS MANAGEMENT

	Tracer drug	Quantity at the beginning the quarter	Quantity received during the quarter	Quantity Dispensed during the quarter	Stock at End of Quarter	Quantity Expired / Damaged/ Lost	Days out of Stock	Quantity to be Expired during next quarter	
								Quantity	Expiration Date
First line	RHZE								
	RH (150/75)								
	RHE								
	Streptomycine								
	Ethambutol 400 mg								
Pediatrics	Seringues								
	Diluant								
	RHZ								
	RH (60/30)								
	RH (60/60)								
	Ethambutol 100 mg								
	INH 100 mg								
LABO	Fuschine								
	Bleu de Méthylène								
	Ac. Sulfurique								
	Auramine								
	Permanganate								
	Ac. Chlorhydrique								
	Crachoirs								
	Lames								
2nd –line TB MR	Ofloxacine 200 mg								
	Levofloxacine 250 mg								
	Kanamycine vial 1gr								
	Amikacine vial 0,5 gr								
	Capreomycine vial 1gr								
	Prothionamide 250 mg								
	Cyclosérine 250 mg								
	Pyrazinamide 400 mg								
	PASER granulés								
	Clofazimine 100 mg								
	PYRIDOXINE								

22. PBF TB Quarterly Report

22.1. Purpose of the format

The format is designed to collect data used to calculate indicators used for TB quarterly Performance Based Financing Payments (PBF). There are 5 slightly different forms used for the different types of facilities (CDT – HD, CDT-HC, CT-HC, CDT-Prison, CT-Prison) because their package of indicators is different. Only the first is included as a sample after this section

22.2. Presentation of the format

The template is a table of 5 columns: 1st column is for the sequence number of indicators, the 2nd column is the list of indicators that are collected. The 3rd column is for quantities, 4th column is for tariff, 5th column is for total value in Rwandan francs as product of 4thX5th columns

22.3. Data sources

Data sources are TB registers and patient files maintained by the CT, CDTs at different levels: Hospitals, Health Centers and prisons

22.4. Preparation and submission

The evaluation and data entry is conducted by the supervisory staff from the PBF Support unit. The Unit evaluates District Hospitals and DH's evaluate HC and Prisons. A paper copy of the report is stored at the District hospital and the data are entered by the supervisors into the PBF-TB database by the 15th day after the end of each quarter.

22.5. Definition of terms & Indicators

CQ: Control of Quality
Bascilloscopy: analysis of secretions or organs for research of the bacilli
TPM+: Pulmonary Smear Positive TB
INH: Izoniazid, drug to treat pulmonary TB
TBMR: Multi-Drug Resistant TB
CDT: Centre for the detection and treatment of TB
CT: CT scans are used to identify non-pulmonary TB

22.6. Detailed instructions for completing format

For eachof the items on the form the supervisor should enter either 1 or 0 (for Yes and No) or a number representing the total number of cases encountered or IEC sessions conducted during the reporting period. Note that some of the denominator data requires entering data from the period 1 year before the current reporting period.

Table 25: PBF TB District Hospital Assessment Sheet

PBF TB District Hospital Assessment Sheet

District:	**Assessment Date:**		
	Assessed Term:		
	Assessed Year:		
DH Name:	**FOSAID:**		

No	Indicator	Quantity	Unit Cost	Total Amount
1.	Enter 1=yes or 0=no depending upon whether or not there was a quality control during the period that showed no major error		5,000	-
2.	Enter 1=yes or 0=no depending upon whether or not the HD collected slides and conducted QC and send discordant slides to the national lab		25,000	-
3.	Enter the number of children who began treatment during the quarter		10,000	-
4.	Enter the number of TBHIV+ patients who received cotrimoxazole during the quarter		2,500	-
5.	**Total number of TB HIV+ patients registered**			
6.	Number of TB suspectes examines according to norms during the period		2,500	-
7.	Number of TB suspects tested for HIV+		2,320	-
8.	**Number of TB suspects who don't know thier HIV status**			-
9.	Number of contacts examined of NTPM+, retreatment and TBMR patients		2,000	-
10.	**Number of cases of NTPM+, retreatment and TBMR**			
11.	Number of TPM+ cured (of new and retreated patients who began treatment one year ago)		10,000	-
12.	**Number of TPM+ (new and retreated) who began treatment one year ago**			-
13.	Number of TBHIV+ who received ARVs during their anti-TB treatment (of cases registered one year ago		10,000	-
14.	**Number of TB HIV+ cases registered one year ago.**		-	-
15.	Number of contacts <5 years who completed preventive treatment with INH (of thos who began preventive treatment a year ago)		5,000	-
16.	**Number of contract <5 who began preventive treatment with INH one year ago)**			-
17.	Number of NTPM+ who had a sputum control in C2 and for whom each positive sample was sent to the LNR		5,000	
18.	Number of new cases TPM+ registered the previous period			-
19.	Number of retreated cases registered las quarter that had a culture at the beginning of their treatment		5,000	-
20.	**Number of retreated cases registered during the period**			-
21.	Number of TBMR under outpatient treatment who had control cultures during the period		20,000	-
22.	**Number of TBMR under outpatient treatment during the period**			-
23.	The CDT did not have a stockout during the quarter (1=no stockout, 0=stockout)		5,000	-
24.	The CDT has implemented the minimum package of infection control (1=yes, 0=no)		25,000	-
25.	The facility submitted the TB quarterly report on time and correct (1=yes, 0=no)		20,000	-
26.	Number of patients transferred out during the quarter who continue their treatment		2,500	-
27.	**Total number of patients transferred out**			-
28.	Number of IEC sessions planned and implemented correctly		1,000	-
29.	Number of results of treatment available for all transferred cases during the quarter		2,500	-
30.	The last quarterly report was analyzed with graphs and weaknesses identified and solutions proposed		30,000	-
31.	The basic tools (forms, registers) of the TB program are available in all FOSA.		10,000	-
32.	The CDT and CT were supervised monthly by the HD		4,000	-
33.	**Number of CDT and CT in the Hospital's catchment area**			
		Total		-

Strong points, points à improve and recommendation on the back

Name and Signature of the evaluators **Name and Signature of the Assessed**

Grille d'évaluation Hopital de District PBF TB

District:

Nom HD:

Date d'évaluation:

Trimestre évalué:

Année evaluée:

FOSAID:

N°	Indicator	Quantite	Cout Unitaire	Montant Total
1	Le CDT y compris l'HD a eu un CQ de la bacilloscopie au cours du trim écoulé et pas d'erreur majeure. (oui=1 ; non=0)		5,000	-
2	L'HD a collecté les lames pour CQ de ses CDT au cours du trimestre évalué; les résultats sont disponibles et la copie a été envoyée au LNR avec toutes les lames discordantes (oui=1 ; non=0)		25,000	-
3	Nb d'enfants de 9-14 ans mis sous traitement TB au cours du trimestre évalué		10,000	-
4	Nb de cas TB/VIH+ enregistrés au cours du trimestre évalué et qui reçoivent le cotrimoxazole		2,500	-
5	Nb des cas TB VIH+ enregistrés			-
6	Nb de suspects de la tuberculose examinés selon les normes au cours du trimestre évalué		2,500	-
7	Nb de suspects de TB testés pour le VIH (suspects dont le statut VIH n'est pas connu)		2,320	-
8	Nb de suspects TB dont le statut VIH est inconnu			-
9	Nb de contacts examinés (contacts des cas NTPM+, retraitement et TBMR)		2,000	-
10	Nb de cas NTPM+, retraitement et TBMR			-
11	Nb de cas TPM+ GUERIS (nouveaux et retraitement enregistrés au cours du trimestre évalué il y a un an)		10,000	-
12	Nb de TPM+ (nouveaux et retraites) il y a un an			-
13	Nb de cas TB/VIH+ qui ont reçu les ARVs pendant le traitement antiTB (cas enregistrés au cours du trimestre évalué il y a 1 an)		10,000	-
14	Nb de cas TB VIH+ enregistre il y a un an			-
15	Nb contacts < 5 ans ayant complété le traitement préventif à l' INH (contacts mis sous INH au cours du trimestre évalué il y a 1 an)		5,000	-
16	Nb de contacts <5 ans mis sur INH il y a 1 an			-
17	Nb de NTPM+ ayant eu le frottis de contrôle en C2 ; pour tout contrôle positif, l'échantillon a été envoyé pour culture au LNR (cas enregistrés au cours du trimestre précédent le trimestre évalué)		5,000	-
18	Nb de nouveaux cas TPM+ enregistre dans la periode precedente			-
19	Nb de cas de retraitement ayant eu une culture en début de traitement (cas enregistrés au cours du trimestre évalué)		5,000	-
20	Nb de cas de retraitement enregistre durant le trimestre evalue			-
21	Nb de cas TBMR en traitement ambulatoire ayant eu les cultures de contrôle au cours du trimestre évalué selon les normes		20,000	-
22	Nb de cas TBMR en traitement au cours du trimestre evalue			-
23	Le CDT n'a pas eu de rupture de stock au cours du trimestre évalué (pas de rupture = 1; rupture = 0)		5,000	-
24	Le CDT applique le paquet minimum de contrôle de l'infection établi par le programme (oui = 1; non = 0) évaluation chaque trimestre, 25000)		25,000	-
25	La FOSA a présenté son rapport trimestriel à temps ; complet et correct. (oui = 1; non = 0) (l'infirmier s'est présenté à la réunion d'évaluation à l'heure avec le rapport déjà fait, correct et complet.)		20,000	-
26	Nb de patients transferes out durant le trimestre evalue qui poursuivent le traitement		2,500	-
27	Nb de patients transferes out			-
28	Nb de sessions IEC qui sont planifiees et executees correctement		1,000	-
29	Nb de resultats de traitement disponibles pour les cas transferes pour le trimestre evalue		2,500	-
30	Le dernier rapport trimestriel du CDT a ete analyse avec les points faibles et solutions degagees et des graphiques mis		30,000	-
31	Les outils du programme sont disponibles dans toutes les FOSA		10,000	-
32	Les CDT et CT ont ete supervises mensuellement par l'HD		4,000	-
33	Nombre de CDT et CT dans la zone de rayonnement de l'HD * 3			
			Total	-

Points forts, Points à améliorer et Recommandations au verso

Nom et signature des évaluateurs

Nom et signature de l'évalué

23. IMCI Register

23.1. Purpose of the Format

The IMCI (Integrated Management of Childhood Illness) register records selected information about children seen using IMCI protocol in health facilities. The register is designed to help service providers monitor continuity of care and to facilitate the preparation of monthly reports. Each age group (0-7 days, 7-2 months and 2 months to 5 years) has a separate section of the register.

23.2. Presentation of the Format

Each page of the register includes 4 rows for new cases (patients who come for the first visit for a particular disease episode) or four children per page.

The registry is designed with columns representing the steps of integrated management of childhood illness. For example for a child from 2 months to 5 years, these are: identification (number, names of children, parents' names, addresses, anthropometric measurements), the health complaint that brought the child to the health facility, the general signs of danger, questions to the mother of the four main symptoms (cough or difficulty breathing, diarrhea, fever and ear problem), the signs of malnutrition, HIV / AIDS, immunization status, Vitamin A and Mebendazol, classifications of other problems not included in the protocol, treatment, counseling for the mother, and follow-up of the status of the sick child.

Underneath each symptom are the associated signs and history that is requested, under the dotted line are the classifications or possible conclusions guiding the course of action.

Note:

- To facilitate the classification of each symptom, below the dotted line are possible classifications
- In front of each classification, there is a check box, the provider must check the box if the classification applies to the child.

23.3. Data Sources

Information necessary to complete the register is obtained either from the interview with the patient or accompanying guardian, or from physical examination by the health worker (observational and palpation) and synthesis of the latter by the provider via the IMCI algorithm.

23.4. Preparation and Submission

The register is maintained by the IMCI care provider at the health facility level. Summary data from the register are tallied using a tally sheet (see below) and reported in the IMCI section of the HMIS Monthly Report.

23.5. Definition of Terms & Indicators

New IMCI case: If this is the first visit of the child for this particular episode of illness or symptom it considered a new case and should begin a new row in the register.
Old IMCI case: If the child was examined a few days ago for the same disease, it is therefore a follow-up visit or an old case.
Newborn: Children ages 0 days until the age of 1 week.
Infants: in the course, any child age 1 week up to age 2 months.
Children: Children ages 2 months until the age of 5 years.

23.6. Detailed Instructions for completing the register

1. Choose the appropriate section of the register depending upon the age of the child:

When a mother brings a child to the clinic because he is sick and the child is sent to you, you must know the age of the child in order to choose the appropriate register and begin the evaluation process.

Decide which group of children age 0 to 7 days, 1 week to 2 months or 2 months to 5 years

- If the child is 0-7 days, use the registry Newborn: 0 TO 6 DAYS.
- If the child is older than 6 days and has not yet two months, it is considered an infant. Use the section of the Registry for INFANTS.
- If the child's age is between 2 months and 5 years, choose the register SICK CHILD AGE 2 MONTHS UP TO 5 YEARS. A child who is already 5-years old should not be assessed using the IMCI protocol. He or she should be cared for using the regular outpatient protocol and register.

Record data in each of the columns as follows:

1. **Date of visit:** this is the date of initial consultation for this episode/signs of disease or health at this facility.
2. **Serial No:** Each newly registered IMCI Client receives a new number for each episode of disease assigned by the health facility. Registration numbers may be issued as a single serial number 0.1, 2, 3 ... etc. .., or 2012/1, 2012/2 2012/3, etc ... New numbers are issued to children whether they have been treated at the facility before or not – as long as it is a new episode of disease.
3. **Child's Name:** record the surname and first name. You could also record a familiar nickname
4. **Parents Names:** record the names of Mother and father by first name and surname. In some areas, individuals are known by nicknames, Such as "Maman Alex". You could also record the more familiar nickname.
5. **Address:** record the Sector, cell and village. The address facilitates follow up.
6. **Age**: a newborn, an infant and a child's age is expressed respectively in days, weeks and months
7. **Gender**: record M for male or F for females

8. **The complaint of the child**: Typically this is the child's health problem as described by the mother in her own words. Do not paraphrase in medical jargon.

9. **Signs of danger/Symptoms:** These columns vary depending upon the age of the child. Evaluate the child first for general danger signs and symptoms. If these exist the child should most likely be referred. Use the check boxes to indicate the presence or existence of each observation/ symptom. Don't limit yourself to the signs and symptoms related to the primary complaint of the child, continue to evaluate each of the columns. For malnutrition the health worker should also note the weight for height, height for weight, weight for age and MUAC in mm. Underneath the dotted line, indicate the primary classification(s) of illness identified these will later be tallied for the monthly report.

10. **Other problems:** Since IMCI does not address all the problems of sick children, assess for other problems mentioned by the mother. For example, it can be noted that the child has a skin infection, itching or swelling of glands in the neck. Or any other problem observed by the health worker during evaluation.

11. **Treatment:** Record the treatment for the health problems identified. Name (s) (of medicine(s), quantity per day, number of times per day and number of days.

12. **Counseling**: Counsel the mother or the caregiver. The health worker should check the box corresponding to the advice provided. If the patient has to be refered, the health officer should provide any pre-referral treatment and in the column "referred to" cite the name of the referral clinic.

13. **Follow up:** Record the date of the follow-up visit. When the patient returns for follow up, also note the date and result of the visit by checking the appropriate box.

14. **Observation:** Note other information such as the refusal of a transfer, home visits if the follow-up visit was not respected, etc..

Table 26: Sample of IMCI register

REGISTRE DES ENFANT de 0 A 7 JOURS

Date N° de fiche	Nom Adresse	Age en jours Sexe	Poids T°	Plainte actuel	EVALUATION (cochez le signe présent, écrivez ou cochez si nécessaire) et CLASSIFICATION									Autres problèmes	Traitement			Suivi		Observation
					Recherche d'une infection grave	Recherche d'une infection bactérienne locale	Recherche d'hypothermie	Recherche d'un petit poids	Recherche d'une infection oculaire	VIH/SIDA	Problème d'alimentation	Examen d'allaitement	Etat vaccinal à jour		Médicaments reçus	Conseiller la mère	Référé à	Rendez-vous de suivi (Date)	Fait le Date Résultats	
					☐ Convulsions actuelles ☐ Incapable de téter ☐Respiration rapide (> 60 / minute) ☐ Tirage sous-costal grave ☐ Geignement ☐Mouvement inférieur à la normal ☐Mouvement que si on le stimule ☐ Température ≥ 37,5°C ☐ Température < 35,5°C ☐ Ictère grave: Age <24hr or > 14 days ☐ rougeur ombilical s'étendant à la peau ☐ Pustules cutanées nombreuses et sévères ☐ Pustules cutanées	☐Oui ☐Non suppurant ☐ Pustules sur la peau	☐Oui ☐Non ☐ Temp <35,5°C	☐Oui ☐Non Poids de naissance ☐ <1500g ☐ entre 1500g et 2500g	☐Oui ☐Non ☐ Yeux enflés ☐Yeux purulent	☐ Sérologie du nouveau-né positive ☐ mère séropositive VIH connue présente ☐ sérologie de la mère VIH inconnue	☐Oui ☐Non ☐ Difficultés de s'alimenter ☐ Allaitement au sein ☐ Allaitement (Nbre de fois en 24h___) ☐ Reçoit autres aliments et liquides ☐ Reçoit du lait artificiel Observer dans la bouche pour : ☐ muguet ☐ bec de lièvre ☐ fente palatine	☐ Menton touche le sein ☐Bouche grandement ouverte ☐ Lèvre inférieure éversé vers l'extérieur ☐ Aréole plus visible au dessus qu'au dessous Prise du sein: ☐Bonne ☐Mauvaise ☐Pas du tout Succion: ☐Efficace ☐Non-effic. ☐Pas du tout	☐Oui ☐Non ☐BCG ☐Polio 0			☐ Allaitement ☐ Chauffer l'enfant ☐Espacement de naissance ☐Conseil sur l'alimentation/ position sein et traitement à domicile ☐Quand revenir			☐Amélioré ☐Détérioré ☐Stationnaire ☐non documenté ☐Décédé	
					☐ Infection Bactérienne Grave Ou ☐ Maladie Grave	☐ Infection Bactérienne Locale	☐ Hypothermie	☐ Très Petit Poids ☐ Petit Poids	☐ Gonococcie Oculaire Probable ☐ Conjonctivite Purulente du Nouveau-né	☐ Infection VIH Confirmée ☐ Transmission VIH Possible ☐ Infection VIH Probable	☐ Maladie grave ☐ Difficultés d'alimentation ☐ Alimentation inadéquate	☐ Allaitement maternel insuffisante ☐ Alimentation inadéquate	☐ Vaccination pas à jour							
					☐ Convulsions actuelles ☐ Incapable de téter ☐Respiration rapide (> 60 / minute) ☐ Tirage sous-costal grave ☐ Geignement ☐Mouvement inférieur à la normal ☐Mouvement que si on le stimule ☐ Température ≥ 37,5°C ☐ Température < 35,5°C ☐ Ictère grave: Age <24hr or > 14 days ☐ rougeur ombilical s'étendant à la peau ☐ Pustules cutanées nombreuses et sévères ☐ Pustules cutanées	☐Oui ☐Non suppurant ☐ Pustules sur la peau	☐Oui ☐Non ☐ Temp <35,5°C	☐Oui ☐Non Poids de naissance ☐ <1500g ☐ entre 1500g et 2500g	☐Oui ☐Non ☐ Yeux enflés ☐Yeux purulent	☐ Sérologie du nouveau-né positive ☐ mère séropositive VIH connue présente ☐ sérologie de la mère VIH inconnue	☐Oui ☐Non ☐ Difficultés de s'alimenter ☐ Allaitement au sein ☐ Allaitement (Nbre de fois en 24h___) ☐ Reçoit autres aliments et liquides ☐ Reçoit du lait artificiel Observer dans la bouche pour : ☐ muguet ☐ bec de lièvre ☐ fente palatine	☐ Menton touche le sein ☐Bouche grandement ouverte ☐ Lèvre inférieure éversé vers l'extérieur ☐ Aréole plus visible au dessus qu'au dessous Prise du sein: ☐Bonne ☐Mauvaise ☐Pas du tout Succion: ☐Efficace ☐Non-effic. ☐Pas du tout	☐Oui ☐Non ☐BCG ☐Polio 0			☐ Allaitement ☐ Chauffer l'enfant ☐Espacement de naissance ☐Conseil sur l'alimentation/ position sein et traitement à domicile ☐Quand revenir			☐Amélioré ☐Détérioré ☐Stationnaire ☐non documenté ☐Décédé	
					☐ Infection Bactérienne Grave Ou ☐ Maladie Grave	☐ Infection Bactérienne Locale	☐ Hypothermie	☐ Très Petit Poids ☐ Petit Poids	☐ Gonococcie Oculaire Probable ☐ Conjonctivite Purulente du Nouveau-né	☐ Infection VIH Confirmée ☐ Transmission VIH Possible ☐ Infection VIH Probable	☐ Maladie grave ☐ Difficultés d'alimentation ☐ Alimentation inadéquate	☐ Allaitement maternel insuffisante ☐ Alimentation inadéquate	☐ Vaccination pas à jour							
					☐ Convulsions actuelles ☐ Incapable de téter ☐Respiration rapide (> 60 / minute) ☐ Tirage sous-costal grave ☐ Geignement ☐Mouvement inférieur à la normal ☐Mouvement que si on le stimule ☐ Température ≥ 37,5°C ☐ Température < 35,5°C ☐ Ictère grave: Age <24hr or > 14 days ☐ rougeur ombilical s'étendant à la peau ☐ Pustules cutanées nombreuses et sévères ☐ Pustules cutanées	☐Oui ☐Non suppurant ☐ Pustules sur la peau	☐Oui ☐Non ☐ Temp <35,5°C	☐Oui ☐Non Poids de naissance ☐ <1500g ☐ entre 1500g et 2500g	☐Oui ☐Non ☐ Yeux enflés ☐Yeux purulent	☐ Sérologie du nouveau-né positive ☐ mère séropositive VIH connue présente ☐ sérologie de la mère VIH inconnue	☐Oui ☐Non ☐ Difficultés de s'alimenter ☐ Allaitement au sein ☐ Allaitement (Nbre de fois en 24h___) ☐ Reçoit autres aliments et liquides ☐ Reçoit du lait artificiel Observer dans la bouche pour : ☐ muguet ☐ bec de lièvre ☐ fente palatine	☐ Menton touche le sein ☐Bouche grandement ouverte ☐ Lèvre inférieure éversé vers l'extérieur ☐ Aréole plus visible au dessus qu'au dessous Prise du sein: ☐Bonne ☐Mauvaise ☐Pas du tout Succion: ☐Efficace ☐Non-effic. ☐Pas du tout	☐Oui ☐Non ☐BCG ☐Polio 0			☐ Allaitement ☐ Chauffer l'enfant ☐Espacement de naissance ☐Conseil sur l'alimentation/ position sein et traitement à domicile ☐Quand revenir			☐Amélioré ☐Détérioré ☐Stationnaire ☐non documenté ☐Décédé	
					☐ Infection Bactérienne Grave Ou ☐ Maladie Grave	☐ Infection Bactérienne Locale	☐ Hypothermie	☐ Très Petit Poids ☐ Petit Poids	☐ Gonococcie Oculaire Probable ☐ Conjonctivite Purulente du Nouveau-né	☐ Infection VIH Confirmée ☐ Transmission VIH Possible ☐ Infection VIH Probable	☐ Maladie grave ☐ Difficultés d'alimentation ☐ Alimentation inadéquate	☐ Allaitement maternel insuffisante ☐ Alimentation inadéquate	☐ Vaccination pas à jour							
					☐ Convulsions actuelles ☐ Incapable de téter ☐Respiration rapide (> 60 / minute) ☐ Tirage sous-costal grave ☐ Geignement ☐Mouvement inférieur à la normal ☐Mouvement que si on le stimule ☐ Température ≥ 37,5°C ☐ Température < 35,5°C ☐ Ictère grave: Age <24hr or > 14 days ☐ rougeur ombilical s'étendant à la peau ☐ Pustules cutanées nombreuses et sévères ☐ Pustules cutanées	☐Oui ☐Non suppurant ☐ Pustules sur la peau	☐Oui ☐Non ☐ Temp <35,5°C	☐Oui ☐Non Poids de naissance ☐ <1500g ☐ entre 1500g et 2500g	☐Oui ☐Non ☐ Yeux enflés ☐Yeux purulent	☐ Sérologie du nouveau-né positive ☐ mère séropositive VIH connue présente ☐ sérologie de la mère VIH inconnue	☐Oui ☐Non ☐ Difficultés de s'alimenter ☐ Allaitement au sein ☐ Allaitement (Nbre de fois en 24h___) ☐ Reçoit autres aliments et liquides ☐ Reçoit du lait artificiel Observer dans la bouche pour : ☐ muguet ☐ bec de lièvre ☐ fente palatine	☐ Menton touche le sein ☐Bouche grandement ouverte ☐ Lèvre inférieure éversé vers l'extérieur ☐ Aréole plus visible au dessus qu'au dessous Prise du sein: ☐Bonne ☐Mauvaise ☐Pas du tout Succion: ☐Efficace ☐Non-effic. ☐Pas du tout	☐Oui ☐Non ☐BCG ☐Polio 0			☐ Allaitement ☐ Chauffer l'enfant ☐Espacement de naissance ☐Conseil sur l'alimentation/ position sein et traitement à domicile ☐Quand revenir			☐Amélioré ☐Détérioré ☐Stationnaire ☐non documenté ☐Décédé	
					☐ Infection Bactérienne Grave Ou ☐ Maladie Grave	☐ Infection Bactérienne Locale	☐ Hypothermie	☐ Très Petit Poids ☐ Petit Poids	☐ Gonococcie Oculaire Probable ☐ Conjonctivite Purulente du Nouveau-né	☐ Infection VIH Confirmée ☐ Transmission VIH Possible ☐ Infection VIH Probable	☐ Maladie grave ☐ Difficultés d'alimentation ☐ Alimentation inadéquate	☐ Allaitement maternel insuffisante ☐ Alimentation inadéquate	☐ Vaccination pas à jour							

24. IMCI Tally Sheet

24.1. Purpose of the Format

The IMCI tally sheet is used at the end of each month to compile data from the IMCI register in order to report on the HMIS monthly report form.

24.2. Presentation of the Format

Each row represents a different classification of diseases and the columns represent the age groups of children seen. In the first row is the total number of children seen during the reporting month. Below that are rows that represent each of the IMCI classifications as well as some other priority diseases. Because of the integrated nature of IMCI protocols, one child may be diagnosed with more than one disease classification.

24.3. Data Sources

The data used to fill the tally come from the IMCI register. Each age group column corresponds to the different sections of the IMCI register, so the provider must remember to go through each section to tally the cases seen during the reporting month for the different columns.

24.4. Preparation and Submission

This IMCI tally sheet is used only to tally data for reporting. There is no need to keep the sheet after the report has been prepared. One of the service providers in the health center or the data manager gathers up all IMCI registers (in case a facility has more than one active IMCI register in use at a time) and prints out a copy of the tally sheet for use. This format is not transmitted, but is used to tally data for monthly reports.

24.5. Definitions of Terms & Indicators

New IMCI case: If this is the first visit of the child for this particular episode of illness or symptom it considered a new case and should begin a new row in the register.

24.6. Detailed Instructions for completing the Tally Sheet

Beginning with the first section of the IMCI register (children 0-6 days) the data manager or health worker identifies the rows of children seen during the previous month. S/he then goes through the disease classifications at the bottom of each row and places a mark (ㅓ) in the appropriate column and row for each classification that is checked, or for any of the other classifications noted in the column to the right of the IMCI register. Once 4 marks have been placed, the fifth case is represented by a line across the other four as follows: (𝍸) Once all of the rows have been counted, the marks are added up for each cell and the total number is written in the cell. This number is then transferred to the HMIS monthly report in the IMCI section.

Table 27: Sample of IMCI Tally Sheet

Tally Sheet for Integrated Management of Childhood Illnesses for children under 5:				
		0 - 6 days	7 days - 8 weeks	2 - 59 months
A) Children treated according to IMCI protocol				
B) Diagnoses:				
1.	Bacterial infection, severe or very severe			
2.	Bacterial infection local			
3.	Hypothermia moderate			
4.	Prematurity			
5.	Very low weight			
6.	Low weight for age			
7.	Feeding problems			
8.	Conjunctivitis, purulent of newbon			
9.	Eye infections, other			
10.	Diarrhea with dehydration			
11.	Diarrhea no dehydration			
12.	Diarrhea bloody (dysentery)			
13.	Diarrhea persistent (HIV negative)			
14.	HIV infection confirmed			
15.	HIV infection probable or suspected			
16.	HIV infection possible			
17.	Pneumonia severe or very severe respiratory disease			
18.	Pneumonia			
19.	Cough or cold other ARI without pneumonia			
20.	Malaria severe (confirmed)			
21.	Febrile disease very severe (plasmodium negative)			
22.	Malaria simple with minor digestive symptoms (confirmed)			
23.	Malaria simple (confirmed)			
24.	Malaria (presumed)			
25.	Measles severe complicated			
26.	Measles with eye and/or mouth complications			
27.	Measles uncomplicated			
28.	Mastoiditis			
29.	Ear infection acute			
30.	Ear infection chronic			
31.	Anemia severe			
32.	Anemia simple			
33.	Skin Infection Scabies			
34.	Skin Infection Fungal mycoses superficial			
35.	Skin Infection Other			
36.	Intestinal parasites			
37.	Teeth and gum infections			
38.	Urinary tract infections			
39.	Food poisoning			
40.	Fractures			
41.	Physical traumas, other than fractures			

25. Out-patient Register

25.1. Purpose of the Format

The Outpatient register serves the purpose of tracing patient's visits history in order to guide clinical officers during each consultation. The case-based information collected in the register can play an important role in tracing individuals in case of an outbreak. The centralized summary of case-information within each register facilitates acts as a useful monitoring and evaluation tool.

25.2. Presentation of the Format

Each row is a single consultation visit. Unlike for chronic care registers, the Outpatient register is an acute (or one-off) care registers. That means that a patient can be entered more than once in the same register. Every patient who visits the hospital has to get registered prior to getting any consultation, treatment or investigations done.

25.3. Data Sources

For every visit to the health facility, the first point of information correction is at the reception where the patient is required to provide demographic information such as name, age, sex and address, previous visits to the facility and health insurance details, department or unit and consultant to be visited. During consultation with the clinical staff, information on history, diagnosis and prescribed medication and investigation might be collected on individual patient file (depending on the type of facility) and should be transferred to the outpatient register for cases that are not admitted to the health facility.

25.4. Preparation and Submission

This register is currently maintained by each health worker who provides outpatient care. Typically a busy health center will have several registers active at the same time. Records should be entered at the time of the consultation. This format is not transmitted, but is used to tally data for monthly reports.

25.5. Definitions of Terms & Indicators

New Cases: A new case of a disease is a patient presenting with a particular diagnosis for the first time during a specific disease episode. Disease episodes differ depending upon the nature of the disease, below are some guidelines:

Old Cases: An old case of a disease is a patient presenting for follow-up care for a diagnosis that was previously recorded as a new case.

Diagnosis	Type	How to classify an episode
Malaria	Acute	Typical episode is brief (1 week or less), classify as new case unless clearly a follow-up visit.
Diarrhea	Acute	Typical episode is brief (1 week or less), classify as new case unless clearly a follow-up visit.
ARI	Acute	Typical episode is brief (1 week or less), classify as new case unless clearly a follow-up visit.
TB	Chronic	Initial contact is NC, all subsequent visits are OC until cured. Relapsed old case is counted as OC.
HIV	Chronic	Initial contact is NC, all subsequent visits are OC
HIV Opportunistic Infections	Chronic	
Fracture	Acute	Initial contact is NC, all subsequent visits are OC
Hypertension	Chronic	
Diabetes	Chronic	

25.6. Detailed Instructions for Completing Format

Please note that the columns in the register are referred to as column 1, column 2, etc. even though they are not actually numbered on the register.

Outpatient register— left-hand side (page 1)

1. **Month serial number:** Record the patient's month serial number for the month. At the beginning of the month, restart numbering at 1. Then assign each patient visiting that month the next serial number. This is a quick way of tracking how many patients consulted each month.
2. **Day serial number:** Record the patient's day serial number for the day. At the beginning of the day, re-start numbering at 1. Then assign each patient visiting that day the next serial number. This is a quick way of tracking how many patients consulted each day.
3. **Date of visit:** Record the date of the visit in format dd/mm/yyyy
4. **Name in Full:** Record full name of the patient with the family name written in the upper space and given name in lower space (e.g KAGUBARE / Marie).
5. **Age**: Record the patient completed age in months for infants less than 1 year) and in years if patient is 1 year or older in the appropriate age category column corresponding the exact age of the patient.
6. **Sex:** record the gender of the patient as "M" for male or "F" for female.
7. **New case / Old case**: Classify as "NC" for new case or "AC" for old case. A new case means a new episode of illness diagnosed in a patient during a consultation. To facilitate the new case we define a maximum period between two episodes of illness, making any new episodes occurring after this period a new case. An average period of one month is used in Rwanda for all diseases (except for chronic diseases whose therapeutic management is long and which have their own definitions). An old case is a patient registered as new case for an episode of disease already diagnosed and treated and returned to the consultation within a period of 1 month because she or he is not cured. This definition does not include chronic diseases such as leprosy, tuberculosis, AIDS, diabetes .., requiring long therapeutic care.
8. **Weight:** record the current weight of the patient in kilograms

9. **Type of health insurance**: record the type of health insurance held by the patient.
10. **Gestation age if pregnant**: record the gestational age in weeks. Gestational age is the time measured in weeks from the day of the mother's (in this case pregnant woman's) last menstruation to the current date. Obtain the woman's last menstruation date and subtract it from the current date of consultation visit to calculate the gestation age of the current pregnancy.
11. **Addresse: family head:** record the name of the family head. The family head is an individual in the household who provides support and maintenance to household members either related to him or her by blood, marriage or through adoption.
12. **Addresse**: **sector:** record the sector in which the patient currently resides
13. **Addresse**: **cell:** record the cell in which the patient currently resides
14. **Addresse**: **village:** record the village in which the patient currently resides
15. **Catchment area**: Record "Z" if patient currently resides within the health facility catchment area, "HZ" if the patient currently resides outside the health facility catchment but within the district where the facility is located and "HD" if patient currently resides outside the district where the facility is located.
16. **Presentation/clinical signs and symptoms:** record annotated list of most significant symptoms (from history) and signs (from examination).
17. **Fever:** Record any fever the patient had within the last 24 hours in the column "<24h" and over the last 24 hours in the column ">24h"
18. **Past history of anti-malarial use in community:** record details of any anti-malarial treatment (drug name, dose and duration) the patient might have had from the community before coming to the facility for consultation in this column. Note ф instructions in the footnote.

Outpatient register— right-hand side (page 2)

1. **Investigations / laboratory examinations:** record any investigations or laboratory examinations conducted during consultation in this column.
2. **Main Diagnosis**: record the main diagnosis. Case definition criteria should be used for reporting purposes only, and not to guide clinical management or treatment. If more than one diagnosis is made, use a separate row to record each
3. **Secondary Diagnosis**: record any secondary diagnosis. See instructions above
4. **Treatment / Action taken**: record annotated treatment given. Only include treatment or action relevant to the diagnosis. For prescribed drugs, record name, dose and duration.
5. **STI Screening***:* For adult patients, indicate the STI screening outcome as P=positif; N=negative; PF=pas fait; or PA=pas applicable
6. **Outcome:** Record outcome as "A" for improved, "H" for hospitalized, "R" for referred, "D" for died and "C" for counter-referral.
7. **Reason for non-payment:** record reason for non-payment of facility bills for patients even when the patient has health insurance

Table 28: Sample of Outpatient Register

Month serial number	Day serial number	Date of visit	Patient file number	Name in Full Upper space: *Surname* Lower space: *given name*	Address			*Catchment area* (Z, HZ,HD)	New Cases (NC) / Old Cas (AC)	Registration status 1. referred 2. regular patient 3. counter referral	AGE							Sex (M/F)	Weight
					Head of Family	Upper row: District Lower row: Sector	Upper row: Cell Lower row: village				0-11 month	1-4 years	5-14 years	15-19 years	20-34 years	35-49 years	50+ years		
								9.86	10.71		9.14	9.14	9.14	9.14	9.14	9.14	9.14	9.43	12.3
Presentation/clinical signs and symptoms																			

Investigations / laboratory examinations	Examination results	*Pregnancy status* 1. Pregnant 2. Not Preg 3. Not applicable	*Diagnosis*			*Treatment / Action taken*	*STI Screening* **P=**positif (préciser IST) **N=**negatif **PF=**not done **PA=**not applicable	*Outcome* **[A,H,R,C,D]** **	*Type of health insurance (Specify)*
			Main	*Disease Code*	*Secondary*				
		17.14							

** **Outcome:**
A=Outpatient,
H=Hospitalized,
R= Referred,
D= Deceased,
C= Counter referral

26. Hospitalization Register

26.1. Purpose of the Format

The In-patient (hospitalization) register serves the purpose of tracing patient's consultation visits history, investigations, procedures and medication in order to guide clinical officers during each consultation. The case-based information collected in the register can play an important role in tracing individuals in case of an outbreak. The centralized summary of case-information within each register facilitates acts as a useful monitoring and evaluation tool

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26.2. Presentation of the Format

Each row is a single admission. Like the outpatient register, a patient can be entered more than once in the same register depending on the different admissions. Patient registration begins when the patient is allotted a bed in the ward.

26.3. Data Sources

For every admission to the health facility, the first point of information correction is at the ward where the patient is required to provide demographic information such as name, age, sex and address, health insurance details, and patient's clinical data. During the length of stay in the hospital, information on investigations, procedures and medication is collected and should be transferred to the inpatient register. Please note that the columns in the register are referred to as column 1, column 2, etc. even though they are not actually numbered on the register.

26.4. Preparation and Submission

This register is currently maintained by within each hospital ward. Records should be updated when the patient is admitted and as treatment is administered during the hospital stay. When the patient is discharged, the reason for discharge must also be added and in the case of multiple diagnoses, the diagnosis at discharge should be highlighted for the patient. This format is not transmitted, but is used to record summary data for the preparation of monthly reports.

26.5. Definitions of Terms & Indicators

Admission: A patient admitted for inpatient hospital care during the month, typically the diagnosis is recorded at discharge. For example: a patient is admitted to the hospital with severe headache and fever, following positive lab test for malaria patient is treated successfully for severe malaria and released. The admission would be recorded as "malaria severe".

Death: This is a recorded as the diagnosed primary cause of death at discharge regardless of the cause of admission. Deaths are recorded the month that they take place, regardless of the month of admission.

26.6. Detailed Instructions for Completing Format

The following are the columns that are to be filled in for the In-patient register:

1. **Hospital serial number:** Record the patient's hospital serial number for the month. At the beginning of the month, restart numbering at 1. Then assign each patient admitted that month the next serial number. This is a quick way of tracking how many patients are admitted each month.
2. **Patient file number**: Record the patient's file number from the patient's dossier.
3. **Name in Full**: Record full name of the patient with the family name written in the upper space and given name in lower space (e.g KAGUBARE / Marie).
4. **Age**: Record the patient completed age in months for infants less than 1 year) and in years if patient is 1 year or older in the appropriate age category column corresponding the exact age of the patient.
5. **Sex:** record the gender of the patient as "M" for male or "F" for female.
6. **Weight:** record the current weight of the patient in kilograms
7. **Type of health insurance**: record the type of health insurance held by the patient.
8. **Address: family head**: record the name of the family head. The family head is an individual in the household who provides support and maintenance to household members either related to him or her by blood, marriage or through adoption.
9. **Address**: **sector:** record the sector in which the patient currently resides
10. **Address: cell:** record the cell in which the patient currently resides
11. **Address**: **village:** record the village in which the patient currently resides
12. **Catchment area**: Record "Z" if patient currently resides within the health facility catchment area, "HZ" if the patient currently resides outside the health facility catchment but within the district where the facility is located and "HD" if patient currently resides outside the district where the facility is located.
13. **Clinical signs and symptoms**: record annotated list of most significant symptoms (from history) and signs (from examination).
14. **Main Diagnosis**: record the main diagnosis. Case definition criteria should be used for reporting purposes only, and not to guide clinical management or treatment. If more than one diagnosis is made, use a separate row to record each
15. **Secondary Diagnosis:** record any secondary diagnosis. See instructions above
16. **Investigations / laboratory examinations**: record any investigations or laboratory examinations conducted during consultation in this column.
17. **Examination results:** Record annotated list of the results of investigations or laboratory examinations.
18. **Treatment / Action taken:** record annotated treatment given. Only include treatment or action relevant to the diagnosis. For prescribed drugs, enter name, dose and duration.
19. **STI Screening:** For adult patients, indicate the STI screening outcome as P=positif; N=negative; PF= not done; or PA= not applicable
20. **Internal referrals:** Indicate if there are any transfer or referral to another care unit with the hospital and indicate the unit and service (e.g. PIT)
21. **Date of admission:** Record the date when the patient was admitted in the hospital. This is the date when the patient was allotted a bed.
22. **Date of exit:** record the date of exit for the patient from the hospital
23. **Length of stay (days):** Record the number of days between admission and exit in this column
24. **Reason for exit:** Record the reason for exit using the options provided in legend at the bottom of register page. Record as 1= authorized discharge, 2= unauthorized discharge, 3= death <24 hours, 4= death >24 hours and 5= referral.

Table 29: Sample of Hospitalization Register

Republic of Rwanda

Ministry of Health

Sample of Hospitalization Register

Hospital serial number	Patient file number	Name in Full Upper space Surname Lower space given name	Address			origin (Z, HZ,HD)	New Cases (NC) / Old Cases (AC)	Registration status 1. Referred 2. Reglar patient 3. Counter referral	AGE							Sex (M/F)	*Weight*	Clinical signs and symptoms
			Family head	Upper row: District Lower row: Sector	Upper row: Cell Lower row: village				0-11 months	1-4 years	5-14 years	15-19 years	20-34 years	35-49 years	50+ years			

Diagnosis			Investigations / laboratory examinations	Examination results		*HIV Screening* **P=**positif **N=**negatif **PF=**not done	*STI Screening* **P=**positif **N=**negatif **PF=**not done **PA=**not applicable	*Internal referrals**	*Date of admission*	*Date of exit*	*Length of stay (days)*	***Rea-son for exit (C,R,D,E)***	*Type of health insurance*
Main	Disease Code	Secondary			Treatment / Action taken								

*:**Références Internes** :
Indicate if it is atransfer to another health unity and mention it or to another health service (PIT) and mention it

‡**reason for exit:**
1. Authorized discharge
2. Unauthorized discharge
3. Death <24 hours
4. Death >24 hours
5. Referral

27. District CBHI Office Monthly Activity Report (MR-4)

27.1. Purpose of the Format

The purpose of this format is report on the routine activities at the District CBHI office. The format integrates data on supervision, membership, health events and financial data.

27.2. Presentation of the Format

The form is a single page form printed on A4 paper. The most recent version is available for download on the Rwanda CBHI web site in case there are changes.

27.3. Data Sources

The data for the format comes from:

- Copayment receipt book;
- Reports from CBHI sections in the district;
- District CBHI office assounts;
- Hospitalization and OPD records from district CBHI office.

27.4. Preparation and Submission

The manager of the CBHI District office at the Administrative District is responsible for consolidating the data from each of the relevant departments and completing the paper form. It is helpful to use a tally sheet to compile the data from the registers.

Once the form is complete and checked for errors, a paper copy is submitted to the national level. The district CBHI office staff are responsible for entering the data into the CBHI indicator database software. Reports must be submitted or entered by the 5th day of the month for the period covering the previous month.

27.5. Definition of Terms & Indicators

Some key general terms and indicators are defined in this section more detailed definitions are covered in the instructions for each section of the report.

Copayment: this is a fixed payment made by CBHI members each time that they use health services. It is designed to moderate use and discourage abuse of health services.

District Pooling risk fund: This is a fund set up for CBHI sections to contribute a part of their income to cover the cost of referral care in district hospitals.

CBHI common fund: This is a common fund into which all CBHI sections contribute that is used to help finance CBHI sections with less income.

27.6. Detailed Instructions for Completing Format

Report the numbers or amounts for each of the following indicators during the reporting period:

Identification:

1. **District CBHI office name:** enter the name of the reporting District CBHI Office. Typically the name should be the name of the district. Each CBHI section/office has a unique FOSAID in the national health facility registry. If a new CBHI section is opened, it will need to acquire a FOSAID from the HMIS department at the national level before any data can be entered in the system.
2. **Month:** enter the month for which the data are being reported. For example if you complete the report on March 2nd the data are usually reported for the previous month (February)
3. **Year:** enter the year for which the data are being reported.

Indicators:

1. **Number of adherent this month:** record the total number of members who paid or had their memberships renewed during the month
2. **Number of sections supervised this month:** record the number of CBHI sections that were supervised by this district CBHI office during the month
3. **Number of sections audited by the district auditor:** record enter the number of CBHI sections audited by the district CBHI auditor during the month
4. **Number of monthly coordination meetings this month:** record the number of monthly coordination meetings held this month (usually 1 per month)
5. **Number of quarterly meetings of the CA:** record the number of quarterly meetings of the District CBHI board held during the month.
6. **Amount received from the government this month:** record the total amount received from the central government to support CBHI activities during the month.
7. **Amount received from sections this month:** record the total amount received from CBHI sections for the district pooling risk this month.
8. **Amount received from other partners this month:** record the amount contributed to the district CBHI fund from partners during the month
9. **Amount reimbursed by sections for patients roaming this month:** record the amount reimbursed by the CBHI sections for patient roaming during the month.
10. **Amount received to the common account from copayments this month:** record the amount received in the common account for copayments during the month
11. **Amount transferred to the national pooling risk this month:** record the amount transferred from the district to the national pooling risk this month.
12. **Total payment amount of staff gross salaries this month:** record the total amount spent on personnel salaries in the District CBHI section this month
13. **Total amount spent for running cost this month:** record the total amount spent on running costs other than personnel this month.
14. **Amount spent for inter-section patient roaming in this district this month:** record the amount spent to pay CBHI sections to cover inter-section patient roaming
15. **Amount paid for care of mutuelle members this month for (area, outside the area):** record the total amount paid for care of mutuelle members at the district level during this month.
16. **Balance in the pooling risk account this month:** record the balance in the polling risk account this month

17. **Balance in the common account this month:** record the balance in the common account this month.
18. **Balance in the petty cash this month:** record the balance in the petty cash account this month
19. **Care cost of areas this month: relared to consultations, medicines, consumbales, hospitalization, laboratory, radiology and others:** record the total amount spent for care in the zone this month.
20. **Number of mutuelle members from the area treated this month:** Number of CBHI members from the area treated as outpatients this month
21. **Number of mutuelle members from the area hospitalized this month:** Number of CBHI members from the area hospitalized this month.
22. **Number of mutuelle members from outside the zone treated as outpatients this month:** Number of CBHI members from the outside the zone treated as outpatients this month
23. **Number of mutuelle members from outside the zone hospitalized this month:** Number of CBHI members from the outside the zone hospitalized this month.
24. **Number of mutuelle members from outside the district treated as outpatients:** Number of CBHI members from outside the district treated as outpatients this month.
25. **Number of mutuelle members from outside the district hospitalized this month:** Number of CBHI members from outside the district hospitalized this month.
26. **Care cost for mutuelle members from outside the district this month: related to consultations, medicines, consumables, hospitalization, laboratory, radiology and others:** record the total cost of care for CBHI members from outside the district during the month.
27. **Amount paid for the ambulance this month:** record the total amount paid for ambulance services during the month.

Table 30: Sample District CBHI Office Monthly Activity Report – Page 1

Ministry of Health

Support Technical Team to Mutuelles de Sante (STTMS)

MONTHLY DISTRICT ACTIVITIES REPORT SHEET OF MUTUELLES DE SANTE

District Name: ..... Month: ..... Year:.....

No	Indicators	Value	Unit
1.	Number of adherent this month		Number of persons
2.	Number of Sections supervised this month		Number of sections
3.	Number of sections audited by the district auditor		Number of sections
4.	Number of monthly coordination meetings this month		Meetings
5.	Number of quarterly meetings of the CA		Meetings
6.	Amount received from the government this month		Rwf
7.	Amount received from sections this month		Rwf
8.	Amount received from other partners this month		Rwf
9.	Amount reimbursed by sections for patients roaming this month		Rwf
10.	Amount received to the common account from copayments this month		Rwf
11.	Amount transferred to the national pooling risk this month		Rwf
12.	Total amount of staff gross salaries this month		Rwf
13.	Total amount spent for running cost this month		Rwf
14.	Amount spent for inter-section patient roaming in this district this month		Rwf
15.	Amount paid for care of mutuelle members this month for (area, outside the area)		Rwf
16.	Balance in the pooling risk account this month		Rwf
17.	Balance in the common account this month		Rwf
18.	Balance in the petty cash this month		Rwf
19.	Care cost of areas this month: related to consultations, medicines, consumbales, hospitalization, laboratory, radiology and others:		Rwf
20.	Number of mutuelle members from the area treated this month		Number of persons
21.	Number of mutuelle members from the area hospitalized this month		Number of persons
22.	Number of mutuelle members from outside the zone treated as outpatients this month		Number of persons
23.	Number of mutuelle members from outside the zone hospitalized this month		Number of persons
24.	Number of mutuelle members from outside the district treated as outpatients		Number of persons
25.	Number of mutuelle members from outside the district hospitalized this month		Number of persons
26.	Care cost for mutuelle members from outside the district this month: related to consultations, medicines, consumables, hospitalization, laboratory, radiology and others		Rwf
27	Amount paid for the ambulance this month		Rwf

Date of preparation……...../…….…../……... **Name and signature:**

Date of approval……...…../……..…../……... **Name and signature:**

Date of receipt……..…../……..…../……..….. **Name and signature:**

28. CBHI Section Monthly Activity Report (MR-3)

28.1. Purpose of the Format

The purpose of this format is report on the routine activities at the CBHI section. The format integrates data on membership, health events and financial data.

28.2. Presentation of the Format

The form is a single page form printed on A4 paper. The most recent version is available for download on the Rwanda CBHI web site in case there are changes.

28.3. Data Sources

The data for the format comes from:

- Membership contribution register
- Copayment receipt book
- CBHI member's health care register

28.4. Preparation and Submission

The manager of the CBHI Section at the Health Facility is responsible for consolidating the data from each of the relevant departments and completing the paper form. It is helpful to use a tally sheet to compile the data from the registers especially to count the number of members (active and passive) by Ubudehe category.

Once the form is complete and checked for errors, a paper copy it is submitted to District CBHI section. The CBHI section staff are responsible for entering the data into the CBHI indicator database software (if the facility has a computer and internet connection). If the facility does not have computer resources, the copy of the paper form that is transmitted to the Administrative District where the District CBHI Manager will do the data entry. Reports must be submitted or entered by the 5th day of **the month for the period covering the previous month.**

28.5. Definition of Terms & Indicators

Some key general terms and indicators are defined in this section, more detailed definitions are covered in the instructions for each section of the report.

Active CBHI members: These are members who have paid their own CBHI membership contributions on behalf of themselves and family members (typically they are only from Ubudehe categories 2 and 3, as all housholds in category 1 are entitled to have their contributions paid for them by the government.

Passive CBHI members: These are members whose CBHI membership contributions are paid by a third party. This can be the government (or Global Fund) for indigents, or a private company or NGO who is paying the Mutuelle on behalf of their staff.

Categories 1, 2 & 3: these are the Ubudehe income categories. Category 1 represents the poor who are entitled to have their Mutuelle payments paid for them as indigents. Categories 2 and 3 pay a different rates according to CBHI policy.

Copayment: this is a fixed payment made by CBHI members each time that they use health services. It is designed to moderate use and discourage abuse of health services.

District Pooling risk fund: This is a fund set up for CBHI sections to contribute a part of their income to cover the cost of referral care in district hospitals.

CBHI section common fund: This is a common fund into which all CBHI sections contribute that is used to help finance CBHI sections with less income.

28.6. Detailed Instructions for Completing Format

Indicators: report the numbers or amounts for each of the following indicators during the reporting period:

1. **CBHI section name:** enter the name of the reporting section or Mutuelle Office. Typically the name should include the name of the village or sector in which the facility is located, but it can also be a proper name like "Croix du Sud". If there is more than one facility with the same name, it is helpful to add the district or sector name and the type of health facility. Each CBHI section has a unique FOSAID in the national health facility registry. If a new CBHI section is opened, it will need to acquire a FOSAID from the HMIS department at the national level before any data can be entered in the system.
2. **Number of active beneficiaries from the 2nd category of the mutuelle:** record the number of active members in Ubudehe category 2 who paid their contributions during the reporting period.
3. **Number of active beneficiaries from the 3rd category of the mutuelle:** record the number of active members in Ubudehe category 3 who paid their contributions during the reporting period.
4. **Number of passive beneficiaries from the 1st category of the mutuelle**: record the number of passive members in Ubudehe category 1 whose contributions were paid by another party during the reporting period.
5. **Number of passive beneficiaries from the 2nd category of the mutuelle:** record the number of passive members in Ubudehe category 2 whose contributions were paid by another party during the reporting period.
6. **Number of passive beneficiaries from the 3rd category of the mutuelle:** record the number of passive members in Ubudehe category 3 whose contributions were paid by another party during the reporting period.
7. **Contribution collected this month from active members of the 2nd category of mutuelle:** record the amount in Rwandan Francs that was collected during the month from active members in Ubudehe category 2
8. **Contribution collected this month from active members of the 3rd category of mutuelle:** record the amount in Rwandan Francs that was collected during the month from active members in Ubudehe category 3
9. **Contribution collected this month from passive members of the 1st category of mutuelle** record the amount in Rwandan Francs that was collected from payments on behalf of passive members in Ubudehe category 1 during the month.
10. **Contribution collected this month from passive members of the 2nd category of mutuelle:** record the amount in Rwandan Francs that was collected from payments on behalf of passive members in Ubudehe category 2 during the month.
11. **Contribution collected this month from passive members of the 3rd category of mutuelle:** record the amount in Rwandan Francs that was collected from payments on behalf of passive members in Ubudehe category 3 during the month.
12. **Copayment (amount received):** record the amount in Rwandan Francs collected through the sale of copayments or "ticket moderateurs".

13. **Other income,materials selling, donation, interests, etc:** record the amount in Rwandan Francs of other receipts such as interests from banks, donations, etc…. during the period
14. **Number of new mutuelle members cases treated in ambulatory:** report the number of new cases of CBHI members from this section who received care during the month.
15. **Care cost for mutuelle members in ambulatory in the area**: record the amount in Rwandan Francs that was paid to the health facilities in the zone for outpatient care during the reporting period.
16. **Total number of mutuelle members from the zone hospitalized:** report the number of new cases of CBHI members from this section who were hospitalized during the reporting period.
17. **Hospitalization cost of mutuelle members from the zone:** record the amount in Rwandan Francs that was paid to the health facilities in the zone for hospitalization during the reporting period.
18. **Total number of hospitalization days of mutuelle members from the zone:** record the total number of hospital days of CBHI members from this section during the reporting period.
19. **Membership account balance at the end of the month (cash contribution + bank contribution):** record the balance in Rwanda Francs of the balance in the membership account at the end of the month.
20. **Copayment account balance, material selling and other income at the end of the month (cash + bank):** record the balance in Rwanda Francs of the balance in the copayment and other receipts account at the end of the month.
21. **Petty Cash balance:** record the balance in Rwanda Francs of the balance in the petty cash account at the end of the month.
22. **Outstanding credit (due to the CBHI):** record the value of credits due to the CBHI section at the end of the month.
23. **Outstanding debt (owed by the CBHI):** record the value of outstanding debts owed by the CBHI section to other parties at the end of the month.
24. **Credit recovered:** record the value of credits recovered during the reporting period.
25. **Debt paid:** record the value of debts paid off during the reporting period.
26. **Total of running cost**: record the amount paid out for CBHI section running costs.
27. **Amount paid to other sections for the care of mutuelle members from the zone:** record the amount paid out to other CBHI sections/providers for care provided to members from this CBHI section.
28. **Amount paid for care to Health Facility:** record the amount paid to the Health Facility served by this CBHI section for care provided to its members.
29. **Amount transferred to the district pooling risk:** record the amount transferred to the district pooling risk during the period
30. **Amount transferred to the sections common fund**: record the amount transferred to the CBHI common fund during the period.
31. **Number of beneficiairies from other health insurance:** record the number of patients seen in the health facility who were covered by other health insurance plans (RAMA, SORAS, etc.).

Contributions from Partners: report the number and amounts paid by each partner for each of the categories of passive members during the reporting period:

1. **Partner name:** Record the name of the organization paying for passive members. This could be a private company, NGO or government subsidy such as Global Fund payments for indigents.
2. **Paid category (1, 2, 3):** Record the category of passive members for whom payments were made. If payments were made for multiple categories by the same partner, report each category on a separate line.

3. **Number of persons covered:** Record the number of individuals covered by each partner for each category.
4. **Total amount (FRW):** Record the total amount paid for the individuals reported on this row.

Patient Roaming: report the number and amounts paid to other health facilities for care provided to them while roaming. Use one line per CBHI section that requested payment for roaming patients during the reporting period:

1. **District:** Record the name of the district where the CBHI members were treated.
2. **Mutuelle section:** Record the name of the CBHI section that recorded the roaming patients during the reporting period.
3. **Number of patients:** Record the number of patients treated
4. **Amount to pay:** Record the amount that the other CBHI section has requested as reimbursement for care provided to the roaming patients.

Table 31: Sample CBHI Section Monthly Activity Report – Page 1

Ministry of Health

Technical Team Support to Mutuelles de Sante (TTSMS)

ACTIVITIES MONTHLY REPORT SHEET OF SECTIONS OF MUTUELLES DE SANTE OF DISTRICT

Section name: ..... **Month:**..... **Year:**.....

No	Indicators	Value	Unity
1.	Number of active beneficiaries from the 2nd category of the mutuelle		Number of persons
2.	Number of active beneficiaries from the 3rd category of the mutuelle		Number of persons
3.	Number of passive beneficiaries from the 1st category of the mutuelle		Number of persons
4.	Number of passive beneficiaries from the 2nd category of the mutuelle		Number of persons
5.	Number of passive beneficiaries from the 3rd category of the mutuelle		Number of persons
6.	Contribution collected this month from active members of the 2nd category of mutuelle		Rwf
7.	Contribution collected this month from active members of the 3rd category of mutuelle		Rwf
8.	Contribution collected this month from passive members of the 1st category of mutuelle		Rwf
9.	Contribution collected this month from passive members of the 2nd category of mutuelle		Rwf
10.	Contribution collected this month from passive members of the 3rd category of mutuelle		Rwf
11.	Copayment (amount received):		Rwf
12.	Other income, materials selling, donation, interests, etc		Rwf
13.	Number of new mutuelle members cases treated in ambulatory		Number of cases
14.	Care cost for mutuelle members in ambulatory in the area		Rwf
15.	Total number of mutuelle members from the zone hospitalized		Number of persons
16.	Hospitalization cost of mutuelle members from the zone		Rwf
17.	Total number of hospitalization days of mutuelle members from the zone		Rwf
18.	Membership account balance at the end of the month (cash contribution + bank contribution)		Rwf
19.	Copayment account balance, material selling and other income at the end of the month (cash + bank)		Rwf
20.	Petty Cash balance		Rwf
21.	Outstanding credit (due to the CBHI)		Rwf
22.	Outstanding debt (owed by the CBHI)		Rwf
23.	Credit recovered		Rwf
24.	Debt paid		Rwf
25.	Total of running cost		Rwf
26.	Amount paid to other sections for the care of mutuelle members from the zone		Rwf
27.	Amount paid for care to Health Facility		Rwf
28.	Amount transferred to the district pooling risk		Rwf
29.	Amount transferred to the sections common fund		Rwf
30.	Number of beneficiaries from other health insurance		Number of persons

Table 32: Sample CBHI Section Monthly Activity Report – Page 2

Partner's contributions				
No	**Partner name**	**Paid category (1, 2, 3)**	**Number of persons covered**	**Total amount (Rwf)**
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Patient Roaming				
No	**District**	**Mutuelle Section**	**Patient number**	**Amount to pay**

Prepared date…..... /…..../…..... **Name and signature:**

Date approved…..... /…..../…..... **Name and signature:**

Date of receipt…..... /…..../…..... **Name and signature:**

29. District CBHI Office Monthly Activity Report (MR-4)

29.1. Purpose of the Format

The purpose of this format is report on the routine activities at the District CBHI office. The format integrates data on supervision, membership, health events and financial data.

29.2. Presentation of the Format

The form is a single page form printed on A4 paper. The most recent version is available for download on the Rwanda CBHI web site in case there are changes.

29.3. Data Sources

The data for the format comes from:

1. Co-payment receipt book
2. Reports from CBHI sections in the district
3. District CBHI office accounts
4. Hospitalization and OPD records from district CBHI office

29.4. Preparation and Submission

The manager of the CBHI District office at the Administrative District is responsible for consolidating the data from each of the relevant departments and completing the paper form. It is helpful to use a tally sheet to compile the data from the registers.

Once the form is complete and checked for errors, a paper copy it is submitted to the national level. The district CBHI office staff are responsible for entering the data into the CBHI indicator database software. Reports must be submitted or entered by the 5th day of the month for the period covering the previous month.

29.5. Definition of Terms & Indicators

Some key general terms and indicators are defined in this section, more detailed definitions are covered in the instructions for each section of the report.

Copayment: this is a fixed payment made by CBHI members each time that they use health services. It is designed to moderate use and discourage abuse of health services.

District Pooling risk fund: This is a fund set up for CBHI sections to contribute a part of their income to cover the cost of referral care in district hospitals.

CBHI common fund: This is a common fund into which all CBHI sections contribute that is used to help finance CBHI sections with less income.

29.6. Detailed Instructions for Completing Format

Indicators: report the numbers or amounts for each of the following indicators during the reporting period:

Identification:

1. **District CBHI office name:** Record enter the name of the reporting District CBHI Office. Typically the name should be the name of the district. Each CBHI section/office has a unique FOSAID in the national health facility registry. If a new CBHI section is opened, it will need to acquire a FOSAID from the HMIS department at the national level before any data can be entered in the system.
2. **Month:** Record the month for which the data are being reported. For example if you complete the report on March 2nd the data are usually reported for the previous month (February)
3. **Year:** Record the year for which the data are being reported.

Indicators:

1. **Number of adherent this month:** record the total number of members who paid or had their memberships renewed during the month
2. **Number of sections supervised this month:** record the number of CBHI sections that were supervised by this district CBHI office during the month
3. **Number of sections audited by the auditor District:** record the number of CBHI sections audited by the district CBHI auditor during the month
4. **Number of monthly coordination meetings this month:** record the number of monthly coordination meetings held this month (usually 1 per month)
5. **Number of quarterly meetings of the CA:** record the number of quarterly meetings of the District CBHI board (Conseil d'Administration) held during the month.
5. **Amount received from government this month:** record the total amount received from the central government to support CBHI activities during the month.
6. **Amount received from sections this month:** record the total amount received from CBHI sections for the district pooling risk this month.
7. **Amount received from other partners this month:** record the amount contributed to the district CBHI fund from partners during the month
8. **Amount reimbursed by sections for mobility care this month:** record the amount reimbursed by the CBHI sections for patient roaming during the month.
9. **Amount received to the common account from copayment this month:** record the amount received in the common account for copayments during the month
10. **Amount transferred to the pooling risk this month:** record the amount transferred from the district to the national pooling risk this month.
11. **Total payment amount of gross salary for staff this month:** record the total amount spent on personnel salaries in the District CBHI section this month
12. **Total amount expensed for running/ functioning cost this month:** record the total amount spent on running costs other than personnel this month.
13. **Amount spent on mobility intersections in the District this month:** record the amount spent to pay CBHI sections to cover inter-section patient roaming
14. **Amount payed for care of mutuelle members this month for (zone, out of zone):** record the total amount paid for care of mutuelle members at the district level during this month.

15. **Pooling risk balance this month:** record the balance in the polling risk account this month
16. **Common account balance this month:** record the balance in the common account this month.
17. **Petty cash balance this month:** record the balance in the petty cash account this month
18. **Care cost in zones this month: related to consultations, medicines, consummables, hospitaliation, laboratory radiology and other care:** record the total amount spent for care in the zone this month.
19. **Number of mutuelle members from the zone treated in ambulatory this month:** Number of CBHI members from the zone treated as outpatients this month
20. **Number of mutuelle members from the zone hospitalized this month:** Number of CBHI members from the zone hospitalized this month.
21. **Number of mutuelle members outtside the zone treated in ambulatory this month:** Number of CBHI members from the outside the zone treated as outpatients this month
22. **Number of mutuelle members outside the zone hospitalized this year:** Number of CBHI members from the outside the zone hospitalized this month.
23. **Number of mutuelle members outside the district treated in ambulatory thi smonth:** Number of CBHI members from outside the district treated as outpatients this month.
24. **Number of mutuelle members outside the district hospitalized this month:** Number of CBHI members from outside the district hospitalized this month.
25. **Care cost of mutuelle members outside the district this month: related to consultations, medicines, consumables, hospitalization, laboratory, radiology and others:** record the total cost of care for CBHI members from outside the district during the month.
26. **Amount paid for the ambulance this month:** record the total amount paid for ambulance services during the month.

Table 33: Sample District CBHI Office Monthly Activity Report

REPUBLIC OF RWANDA

MINISTRY OF HEALTH
TECHNICAL TEAM SUPPORT TO MUTUELLES DE SANTE (TTSMS)

ACTIVITIES MONTHLY REPORT SHEET OF SECTIONS OF MUTUELLES DE SANTE OF DISTRICT

District name:..... **Month:**.....**Year:**.....

No	Indicators	Value	Unity
1.	Number of adherent this month		Number of persons
2.	Number of sections supervised this month		Number of persons
3.	Number of sections audited by the auditor District		Number of persons
4.	Number of monthly coordination meetings this month:		Meetings
5.	Number of quarterly meetings of the CA		Meetings
6.	Amount received from government this month		Rwf
7.	Amount received from sections this month		Rwf
8.	Amount received from other partners this month		Rwf
9.	Amount reimbursed by sections for mobility care this month		Rwf
10.	Amount received to the common account from copayment this month		Rwf
11.	Amount transferred to the pooling risk this month		Rwf
12.	Total payment amount of gross salary for staff this month		Rwf
13.	Total amount expensed for running/ functioning cost this month		Rwf
14.	Amount spent on mobility intersections in the District this month		Rwf
15.	Amount payed for care of mutuelle members this month for (zone, out of zone)		Rwf
16.	Pooling risk balance this month		Rwf
17.	Common account balance this month		Rwf
18.	Petty cash balance this month		Rwf
19.	Care cost in zones this month: related to consultations, medicines, consummables, hospitaliation, laboratory radiology and other care		Number of persons
20.	Number of mutuelle members from the zone treated in ambulatory this month		Number of persons
21.	Number of mutuelle members from the zone hospitalized this month		Number of persons
22.	Number of mutuelle members outside the zone treated in ambulatory this month		Number of persons
23.	Number of mutuelle members outside the zone hospitalized this year		Number of persons
24.	Number of mutuelle members outside the district treated in ambulatory this month		Number of persons
25.	Number of mutuelle members outside the district hospitalized this month		Number of persons
26.	Care cost of mutuelle members outside the district this month: related to consultations, medicines, consumables, hospitalization, laboratory, radiology and others		Rwf
27.	Amount paid for the ambulance this month		Rwf

Prepared date …..... /…...../…..... **Name and signature:**

Date approved…..... /…...../…..... **Name and signature:**

Date of receipt…..... /…...../…..... **Name and signature:**

30. Health Center, District Hospital, Referral Hospital, Private Clinic and Dispensary Monthly HMIS Report (MR-1, 2, 3, 4, 5,)

30.1. Purpose of the Format

The purpose of this format is to report on the routine activities health facilities. The format integrates data on the full package of health services as well as financial and logistics data. The forms are very similar for each level – although certain sections are not competed at levels where a particular service is not offered. The first part of these instructions cover most of the tables that are common across all reports at the end are additional tables included for higher levels,

30.2. Presentation of the Format

The form is a single page form printed on A4 paper. The most recent version is available for download on the Rwanda HMIS web site in case there are changes.

30.3. Data Sources

The data for the format comes from:

1. OPD register
2. IMCI Register
3. Hospitalization register
4. GBV register
5. ANC Register
6. Maternity Register
7. Postnatal care register
8. Vaccination Register
9. Nutrition screening register
10. Nutrition Rehabilitation files and registers
11. Laboratory registers
12. Stock cards
13. Financial register or accounting ledger
14. Reference/Counter-Reference forms
15. Records of LLINs distributed during mass campaigns

Additional registers for Hospital level:

1. Surgery register
2. Anesthesia register
3. Physiotherapy register
4. Blood bank stock cards
5. Medical imagery register

30.4. Preparation and Submission

The data manager at the Health Facility is responsible for consolidating the data from each of the relevant departments and completing the paper form. Once the form is complete and checked for errors, it is submitted to the Titulaire for approval. Following approval, the Data manager is responsible for entering the data into the HMIS software (if the facility has a computer and internet connection). If the facility does not have computer resources, the copy of the paper form that is transmitted to the District Hospital that will be used by the District Data Manager to do the data entry. Reports must be submitted or entered by the 5th day of the month for the period covering the previous month.

30.5. Definition of Terms & Indicators

Some key general terms and indicators are defined in this section, more detailed definitions are covered in the instructions for each section of the report.

Outpatient consultations: these are services provided in the outpatient clinics of the health facility for ambulatory care patients who are not admitted.

New cases: A new case of a disease is a patient presenting with a particular diagnosis for the first time during a specific disease episode. Disease episodes differ depending upon the nature of the disease.

Repeat/Old cases: An old case of a disease is a patient presenting for follow-up care for a diagnosis that was previously recorded as a new case.

Referrals: outpatients who have been referred to a high level health facility.

Counter referrals received: outpatients who have been previously referred to higher level and have been subsequently referred back to the health facility for care and follow-up.

Maternal Deaths: A maternal death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. (WHO)

Infant deaths: are divided into several categories**:**

- Still birth macerated
- Still birth fresh
- Death in delivery room
- Infant death 0-6 days after delivery
- Infant death 7 to 28 days after delivery

IMCI (Integrated Management of Childhood Illnesses): this is an integrated of service protocol for managing care for sick children under 5 years of age.

Hospitalizations: These are cases that are admitted for inpatient care and/or observation in the health facility for at least one night.

Irreversible disabilities due to GBV: these are physical or psychological disabilities caused by GBV that have a permanent effect on the victim

30.6. Detailed Instructions for Completing Format

I. Identification and Important Communications

A) Report identification:

1. **Facility name:** record the name of the reporting health facility. Typically the name should include the name of the village or sector in which the facility is located, but it can also be a proper name like "Croix du Sud". If there is more than one facility with the same name, it is helpful to add the district or sector name and the type of health facility.
2. **Catchment area population:** record the number that reflects the actual catchment population of the health facility. In most cases this should be the population of all of the villages or cells which the health facility serves. Typically the District helps to determine the catchment area populations of each health facility on an annual basis.
3. **Province:** record the name of the province in which the health facility is located
4. **District:** the name of the administrative district where the health facility is located.
5. **Year:** record the 4-digit number of the year for which the data are being reported.
6. **Month:** the month for which the data are being reported, this can be either written as text (January) or as a number: 1.
7. **Sector:** the name of the administrative sector where the health facility is located.
8. **Cell:** the name of the cell where the health facility is located.

B) Important comments related to the health facility during the past month:

Use this section to write brief notes to the district hospital about special issues that the health facility was facing during the reporting period. Please report positive events as well as issues. These comments are categorized according to the following headings.

1. **Epidemiology**
2. **Medicines/supplies**
3. **Vaccines – cold chain**
4. **Equipment**
5. **Infrastructure**
6. **Transport**
7. **Personnel**
8. **Other**

C) Report Approvals/Processing:

This section of the form is used to record form approvals and processing.

1. **Name of In-charge:** print the name of the health facility in-charge or titulaire
2. **Qualification:** print the qualification or job title of in-charge (usually Titulaire)
3. **Signature:** this is a space for the signature of the person who approved the report at the health facility.
4. **Date sent:** the person sending the report to the higher level should enter the data the report was sent.
5. **Date of reception:** at the district office, the receiving staff member – usually the data manager or M&E officer should enter the date the report is received.

6, Name: the name of the person who received the report – usually at the district level

7, Signature: the person who received the report should sign here.

8. **Date entered in DHIS:** once data have been entered into the computer the data should be recorded here by the data manager.

II. Outpatient Consultations

A) **Outpatient Morbidity summary table*:*** this table summarizes all outpatient visits by age and gender. Data managers should use a tally sheet to compile these figures from the OPD register as well as from the IMCI register and the tables on Gyneco-Obstetrical care and Neonatal care.Typically these data should be compiled using a tally sheet with the different age, gender categories in the columns and the different types of morbidity in the rows. Health workers should begin counting in the registers at the beginning of the reporting month and place a mark for each type of case.

1. **New cases:** A new case of a disease is a patient presenting with a particular diagnosis for the first time during a specific disease episode. Disease episodes differ depending upon the nature of the disease.

2. **Repeat/Old cases:** An old case of a disease is a patient presenting for follow-up care for a diagnosis that was previously recorded as a new case. Old cases and new cases should be distinguished in the OPD register in the column (OC/NC), make sure not to count new cases.

B. Referrals:

1. **Referred to hospital:** outpatients who have been referred to a high level health facility for diagnostic services or care.

2. **Counter referrals received:** outpatients who have been previously referred to higher level and have been subsequently referred back to the health facility for care and follow-up.

C. Health insurance status of new cases:

1. **Insured:** this is the total number of all new outpatient cases who were covered by some sort of insurance (Mutuelle, RAMA or other).

2. **Non-Paying New cases:** this is the number of new cases that did not pay for their care.

3. **Number of Indigents of non-paying new cases**: this is the number of non-paying cases who are indigents.

D. Special causes of OPD visits:

The Ministry of Health is interested in tracking certain types of health risks. As a result they are requesting health facilities to report on numbers of outpatients presenting due to these two categories of health risks, regardless of their diagnosis:

1. Road traffic accidents:

2. Natural or man-made disasters (floods, earthquakes, etc)

E) **New cases of priority health problems in OPD:** this section of the report should also be completed with the aid of a tally sheet containing the names and ICD-10 codes of each of the diagnoses in the rows and cells large enough to tally the number of males and females in each of the age groups. Only a selected number of priority diseases are reported by disease. Report the new cases next to the primary diagnosis for each patient. If the diagnosis is not listed count the new case in the last row of the table next to “All other new cases not reported above”. NOTE: All children <5 years coming for outpatient care should be recorded under the IMCI section and not recorded in the OPD register to avoaid the risk of double counting. Diagnoses that are not a part of the IMCI protocol are entered in the other classifications column of the IMCI register.

III. Integrated Management of Childhood Illnesses for children under 5

This new section of the monthly report reflects the fact that all children under 5 who present at health facilities are to be assessed using the IMCI protocol. In the past these children were recorded only in the OPD register.

A) Children treated according to IMCI protocol: record the total number of children treated according to the IMCI protocol during the month

B) Diagnoses: note the number of children diagnosed with each of the listed diagnoses or syndromes by age group. Do not record any values in the grey cells as these children are not to be treated at the health center level. If a child had more than one diagnosis, record every diagnosis.

IV. Chronic Diseases and Mental Health

1. Diagnosis: Most of these patients should be recorded in the OPD or special program registers. For each diagnosis record the number of Males and Females:

- **New Cases**
- **Old Cases**
- **Referrals –** patients referred out (usually to a higher level facility) during the reporting period.
- **Deaths –** patients who died due to these diagnoses during the reporting period (NOTE: should this include deaths at health facility and those in the community who were under chronic care at the facility)

V. Hospitalizations

A. Present at the beginning of the month: this is the number of inpatients occupying hospital beds on the first day of the month.

B. Admissions during the month: this is the total of all admissions for hospitalization during the month;

C. Discharges during the month

1. Cured: this is the number of patients discharged from the hospital during the month because they are cured.

2. Deceased: this is the number of discharges during the month due to death

3. Abandoned: this is the number of inpatients who fled or otherwise abandoned their hospital treatment against the advice of medical staff.

4. Referred to the district hospital: this is the number of inpatients who were discharged for referral to a different health facility.

D) Present at the end of the month: this is the total number of patients present in the hospital beds at the end of the month.

E) Number of beds: this is the total number of inpatient beds available at the health facility at the end of the month.

F) Admissions who are insured: this is the total number of new admissions during the month that were insured (Mutuelle, RAMA or other)

G) Potential Number of hospitalization days: this is the number of beds multiplied by the number of days in the month, for example: if a health center has 20 beds and the month has 30 days, then there are 600 potential hospitalization days.

H) Total hospitalization days (Hospitalization Effective): This is the monthly sum of actual number of beds occupied per day. These data should be obtained from the daily census and added up for each day of the month.

I) Number of hospital days of discharged patients: This should come from the hospitalization register, calculate the total days of hospitalization for each discharged patient and then enter the sum of all hospital days across all wards.

J) **Specials causes of admissions and deaths** the Ministry of Health is interested in tracking certain types of health risks. As a result they are requesting health facilities to report on numbers of hospital admissions and deaths among inpatients presenting due to these two categories of health risks, regardless of their diagnosis:

1. Road traffic accidents:

2. Natural or man-made disasters (floods, earthquakes, etc)

VI. Gender Based Violence

The fields in this section of the report should be filled in based on data collected in the GBV register. All data are disaggregated in 3 age groups (Under 5 years, 5-19 years, 20 years and over) and by gender:

1. **GBV survivors with symptoms of sexual violence:** record the number of individuals who presented symptoms of sexual violence.
2. **GBV survivors with symptoms of physical violence:** record the number of individuals who presented symptoms of physical violence.
3. **GBV survivors referred to higher level:** record the number of GBV survivors who were referred for additional care or assessment to the district hospital or other referral facility.
4. **GBV survivors referred by police:** record the number of GBV survivors referred to the health facility by police.
5. **GBV survivors referred by community health workers:** record the number of GBV survivors referred to the health facility by CHWs.
6. **GBV survivors HIV+ 3 months after exposure**: record the number of GBV survivors who are HIV+ 3 months after exposure (Note: in order to find these individuals you need to go back in the register 3 months earlier and count the number of survivors whose HIV test results became positive).
7. **GBV survivors pregnant 4 weeks after exposure:** record the number of female GBV survivors who became pregnant 4 weeks after exposure (Note: in order to find these individuals you need to go back in the register for the previous month and count the number of survivors whose pregnancy test was positive).
8. **GBV survivor received emergency contraception within 72 hours:** record the number of female GBV survivors who were administered emergency contraception within 72 hours.
9. **GBV survivor received post exposure HIV prophylaxis within 48 hours:** record the number of GBV survisors who were administered post-exposure HIV prophylaxis within 48 hours.
10. **GBV survivors with irreversible disabilities due to GBV:** record the number of GBV survivors with irreversible disabilities due to GBV.
11. **GBV Deaths:** record the number of GBV survivors who died due to their injuries.

VII. Antenatal Care

The data in this section of the report should come from the ANC register

1. **ANC New Registrations:** record the number of pregnant women who registered for ANC care during the reporting period.
2. **ANC First standard visit 1st trimester:** record the number of pregnant women who completed their first ANC standard visit during the 1st trimester of their pregnancy during the reporting period.
3. **ANC standard visit during 9th month:** record the number of pregnant women who came for a standard visit during their 9th month during the reporting period
4. **ANC 4th standard visit:** record the number of pregnant women who completed their 4th ANC standard visit during the reporting period.

5. **ANC high risk pregnancy detected:** record the number of high risk pregnancies detected
6. **ANC pregnancy under 15 years:** record the number of pregnant women under 15 years of age who registered for ANC during the reporting period
7. **ANC high risk pregnancies referred:** record the number of high risk pregnancies that were referred for care or assessment at higher levels (District Hospital or other referral facility)
8. **ANC TT 1st given:** record the number of pregnant women who received their 1st Tetanos Toxoid vaccination
9. **ANC TT 2nd or more given:** record the number of pregnant women who received their Tetanos Toxoid vaccination boosters (2 or more doses)
10. **ANC Iron and Folic Acid supplements administered (90 tablets / full course):** record the number of pregnant women who received a full course of Iron and Folic Acid supplements during the reporting period.
11. **ANC Insecticide Treated Bed nets distributed:** record the number of pregnant women who received LINNs.
12. **ANC deworming performed:** record the number of pregnant women who were dewormed.
13. **ANC Vitamin A administered:** record the number of pregnant women who received their vitamin A supplementation.
14. **ANC malnutrition screening performed (MUAC):** record the number of pregnant women who were screened for malnutrition using MUAC (Middle Upper arm circumference)
15. **ANC malnourished (MUAC < 21 cm):** record the number of pregnant women whose MUAC was less than 21 cm.
16. **ANC anaemia tested:** record the number of pregnant women who were tested for anemia
17. **ANC anaemia Severe <7gm /dl:** record the number of pregnant women with severe anemia (<7gm/dl)
18. **ANC HIV tested:** record the number of pregnant women tested for HIV during the period
19. **ANC HIV tested positive:** record enter the number of pregnant women tested positive for HIV during the period
20. **ANC HIV tested who know their results:** record the number of pregnant women tested for HIV during the period who were informed of their results
21. **ANC syphilis tested:** record the number of pregnant women tested for syphilis during the period
22. **ANC syphilis tested positive:** record the number of pregnant women tested for syphilis during the period

VIII. Gyneco-Obstetrical Complications

The entries in this section typically come from the maternity or hospitalization register, though some data may also be recorded in the OPD register. Data are to be disaggregated by 2 age groups (under 20 years and 20 years and above) and by type of case (OPD NC, Admissions and Deaths)

A. Cases and Deaths: for each of the following obstetrical problems, note the number of OPD cases, inpatient admissions and deaths recorded during the reporting period.

1 Abortions (symptoms suggesting induced abortion)

2 Miscarriages (spontaneous abortions)

3 Ectopic pregnancy

4. Threat of premature delivery
5. Antepartum Haemorrhage (APH)
6. Post-partum hemorrhage (PPH) *
7. Sepsis / Postpartum infection
8. Prolonged or Obstructed labor
9. Eclampsia /Severe Pre Eclampsia
10. Uterine rupture/tear
12. Foetal Distress
13. Perineal tear (3rd Degree)
14. Fistula (vesico vaginal or rectal)
15. Anemia Severe (<7gm/dl)
16. Malaria (confirmed) Treated
17. HIV/Opportunistic Infections
18. Complication Other (Specify)

B. Emergency Obstetric Care Interventions (Basic): for each of the following interventions enter the total number carried out during the reporting period.

1. Intravenus Antibiotics
2. Intravenus Anti-hypertensives
3. Manual removal of placenta
4. Manual vacuum aspiration (Post-Abortion Care)
5. Vacuum extraction

C. Women placed under observation for 72 hours or more: note the number of women place under observation for 72 hours or more as inpatients due to obstetrical complications or risk factors.

IX. Deliveries

This section of the monthly report should come from the Maternity Register:

1. **Deliveries, normal:** record the total number of normal deliveries performed at the maternity during the reporting period
2. **Deliveries, abnormal (dystocic):** record the total number of abnormal or dystocic deliveries performed at the maternity during the reporting period
3. **Deliveries 15 years and under:** record the total number of deliveries performed for women 15 years and under.
4. **Multiple Pregnancies (twins, triplets):** record the total number of multiple pregnancies delivered in the maternity during the reporting period. Count each multiple birth as one, regardless of the number of infants born (twins, triplets, etc…)
5. **Deliveries referred to Hospital:** record the total number of deliveries referred to the District Hospital or other referral facility during the reporting period. (Note: Should this include women who delivered at HC but were immediately referred due to PPH or other factors, or only those who were transferred before delivery and delivered at the hospital)

6. **Maternal deaths Total:** This should be the sum of all deaths recorded in table VIII.A above
7. **Births, live:** record enter the number of live births at the maternity during the reporting period.
8. **Birth weight <2.5 kg (alive not premature):** record the number of live births at the maternity that were of normal gestation but weighed <2.5 kg
9. **Birth weight <2.5 kg (among prematures 22-37 weeks):** record the number of live births at the maternity that were premature but weighed <2.5 kg
10. **Still births macerated (>22 weeks or >500 grams):** record the number of still births that were macerated
11. **Still births fresh (>22 weeks or >500 grams):** record the number of still births that were fresh
12. **Deaths of live born babies**: for this table, separate the number of deaths of live born babies into the following 3 time frames:
    - Death in delivery room
    - Death 0-6 days (excl. death at birth)
    - Death 7 to 28 days
13. **Newborns breastfed within 1 hour of delivery:** record the number of newborns who were breastfed within 1 hour of delivery.
14. **Newborns who didn't cry at birth:** record the number of newborns who didn't cry at birth.
15. **Newborns resuscitated:** record the number of newborns who were resuscitated
16. **Newborns referred to higher level:** record enter the number of newborns who were referred to the district hospital or other higher level referral facility.

X. Postnatal care

This section of the monthly report should come from the Postnatal Care Register:

1. **PNC visits within 3 days of birth:** record the number of postnatal care visits that took place within 3 days of birth during the reporting period. Count only the number of infants seen, don't count twice if there were multiple visits of the same child within 3 days of birth.
2. **PNC visits between 4-10 days of birth:** record the number of postnatal care visits that took place between 4-10 days of birth during the reporting period. Don't count children who visited less than 3 days and who returned for another visit between 4 and 10 days.
3. **PNC vitamin A:** Number of women (both breastfeeding and non-breastfeeding) who receive two high-dose supplements (200,000 IU per dose) of vitamin A within six weeks of giving birth
4. **PNC MUAC screened for malnutrition:** record the number of mothers who were screened for malnutrition using middle upper arm circumference during a PNC visit.
5. **PNC malnourished (MUAC < 21 cm):** record Enter the number of mothers who were screened for malnutrition using middle upper arm circumference during a PNC visit whose MUAC was < 21 cm.
6. **PNC complication referred:** record the number of infants or mothers who were referred to a district hospital or other higher level referral facility due to complications identified during a PNC visit.

XI. Neonatal causes of outpatient care, hospitalization and deaths

This section may require data from the Maternity register, OPD register and Hospitalization register. For each diagnosis, enter the number of cases by age (0-6 days and 7- 28 days) and by type of case (OPD NC, Admissions and Deaths)

1. Asphyxia
2. Hypothermia
3. Prematurity (22 to 37 weeks)
4. Congenital malformation
5. Respiratory infection s
6. Meningitis
7. Skin infections
8. Urinary tract infections
9. Tetanus Neonatal
10. Neonatal infections, other
11. All other causes of neonatal distress: record only if the diagnosis is not counted in one of the categories above.

XI. Male circumcisions

The MOH is promoting male circumcision as an intervention to reduce HIV/AIDS transmission. These data should be recorded in the OPD register or circumcision register still under development.

1. **Male circumcisions performed in the facility:** record the number of males circumcised in the health facility by the following age groups:
    - < 30 days ,
    - 30 days - 14 years,
    - >=15 years

XII. Vaccinations

The data for this table should come from the Vaccination register: Each vaccine Antigen/Item distributed should be broken out by age group (0-11 months, >=1 year).

1. BCG
2. Polio-Zero (P0)
3. Polio 1-DTP-HepB/Hib1
4. Polio 2-DTP-HepB/Hib2
5. Polio 3-DTP-HepB/Hib3
6. Pneumococus 1
7. Pneumococus 2
8. Pneumococus 3
9. Rotavirus 1

10. Rotavirus 2
11. Rotavirus 3
12. Measles
13. Insecticide impregnated bed nets distributed

XIII. Nutrition screening in OPD

As part of new national protocol, all children seen in the OPD are to be screened for nutrition status. Most of the items should be broken out by age groups (0-5 months, 6 – 59 months, 5-14 years, 15 + years) unless the cell is grey in which case the age group does not apply.

1. Screened for malnutrition
2. Malnourished children (total):
    - Marasmus (Wasting)
    - Marasmic Kwashiorkor
    - Kwashiorkor
    - Underweight (Weight/Age)
    - Stunted (Height/Age)
3. Goitre
4. Vitamin A deficiency “keratomalacia
5. Vitamin A distributed during routine supplementation (6 month doses)
6. Mebendazole distributed during routine de-worming (6 month doses)
7. Referred to malnutrition program

XV. Outpatient Rehabilitation of Malnourished

These data should be compiled from the nutrition rehabilitation register and patient files. Data should be disaggregated by the following categories of malnourished individuals: Acutely Malnourished (Moderate), Acutely Malnourished (Severe), Chronically Malnourished, Pregnant/Lactating women. The first three categories should be broken out by age groups (<5year and 5 years and above). For each type of malnutrition, record the following:

1. **Present at beginning of month**: the number of patients under treatment at the beginning of the month
2. **Admissions**
    - New Cases
    - Relapsed Cases
3. **Discharges**
    - Cured
    - Referred
    - Abandoned
    - Deceased
4. **Present at the end of the month**

XVI. Family Planning

The data on family planning services are divided into 2 main categories: user information and contraceptive stock information. For each item in the list report the number of new users, defaulters and active users at the end of the month. These figures for new users should come from the the FP register, while the figures for defaulters and active users at the end of the month should come from counting client records in the tickler file box (échéancier).

New User: These users are easiest to count from the FP register by going to the first entry for the reporting month and counting the number of new registrations at the facility. A new user is an individual who:

- adopts a family planning method for the first time in their life, or
- used FP earlier but stopped using it for whatever reason (pregnancy, abstinence, etc..) and wants to re-start contraception, or
- Used FP at a different site and begins to use contraceptives at a new location for the first time, or
- Used one FP method previously and has decided to change to a new method in the same facility.

Defaulters or drop-outs: are those users who have missed their next scheduled appointment by more than one month. For example, if Jeannine received 3 cycles of pills at the beginning of February and she doesn't return for her scheduled follow-up appointment at the beginning of May, she will be counted as a defaulter in May. Also if a women comes to the health facility to say that she no longer wants to use a contraceptive method – for whatever reason (desires pregnancy, no longer in union, etc...) she is also considered a defaulter or dropout.

Active user at end of month: This figure is easiest to calculate from the tickler file box as well. After removing the client records for people who have defaulted, tally the remaining client records by method using a tally sheet.

For those methods that are renewable, also note the quantity distributed, the stock at the end of the month and days of stock out during the reporting period. These figures are most easily determined from the stock card or stock register where each transaction is recorded. Note: when reporting quantity distributed, do not include stocks transferred to other health facilities or lost/damaged. This should only represent those stocks distributed to clients as it is used to calculate couple years of protection.

Below are the contraceptive methods that should be offered at the health center level:

1. Oral Contraceptives: Note: if the facility stocks different brands of oral contraceptives, combine the numbers when reporting here.
2. Injectables (Depo-Provera)
3. Implants
4. IUD
5. Male condoms
6. Female condoms
7. Other barrier methods (gel, diaphram)
8. Cycle beads
9. Auto-observation

XVII. Family Planning

The data on laboratory tests should come from the lab registers. Typically health centers will maintain separate registers for different types of lab test, be sure to include data from all registers when compiling the monthly report.

XVIII. Laboratory

You will note that many of the boxes are greyed out in the form. That is because some types of test are not specific to one diagnosis, for example blood smears and stool samples. In this case report the total number of tests done and the number of negative tests. Then report the positive tests in the row next to the micro-organism detected. If one sample is positive for more than one micro-organism, then record the result as positive in both places.

The following is the list of lab tests and results that are typically offered at the health center level. If your facility does not provide a specific lab test, write N/A in the corresponding box.

1. **Blood Smears**
   - Plasmodium
   - Micro-filaria
   - Borellia
   - Trypanosoma
2. **Rapid Diagnostic Tests for Malaria**
3. **Stools (number of samples analyzed)** of which:
   - Entamoeba histolytica
   - Entamoeba coli
   - Giardia
   - Ascariasis
   - Ankylostomiasis (hookworms)
   - Schistosoma
   - Trichuris
   - Taenia
   - Other parasites

4. **Urine** of which:
   - Sugar
   - Albumin
   - Pregnancy test

5. **Sputum** of which:
   - Diagnosis of TB by microscopy
   - Control of TB positive patients

6. **Blood** of which:
   - Hemoglobin
   - RPR
   - HIV final result
   - ESR/VS
   - Full Blood Count (FBC/NFS)

- ALAT (GPT)
- Creatinine
- Blood glucose (glycemie)
- Amylase
- CD4

7. Lab tests, other

XIX. Stock of Tracer Drugs

In order to monitor the stock of certain essential drugs and commodities, a limited number of products have been identified to be reported on each month. This does not replace the logistics system that should manage all commodities required at the health facility. For each item, enter the: Quantity Dispensed, Quantity Expired / Damaged/ Lost, Stock at End of Month and Days out of Stock. These figures should all be obtained from the stock card or stock register.

The following is the list of items that should be reported on each month by the health center level, if you have other formulations of the same product, do not report them here: only the dosages and forms that have been listed below.

1. Albendzole tab 400mg
2. Mebendazole syrup 100mg/5ml
3. Mebendazole tab 500mg
4. Praziquantel tab 200mg
5. Oral Rehydration Salts packet
6. Vitamin A
7. Zinc tab 10mg
8. Amoxycillin tab 250 mg
9. Amoxycillin syrup 125mg/5ml
10. Coartem _Artéméther+ Lumefanthrine tab 20 mg + 120mg (6x1)
11. Coartem _Artéméther+ Lumefanthrine tab 20 mg + 120mg (6x2)
12. Coartem _Artéméther+ Lumefanthrine tab 20 mg + 120mg (6x3)
13. Coartem _Artéméther+ Lumefanthrine tab 20 mg + 120mg (6x4)
14. Iron sulfate+Folic Acid tab 200mg/0.25mg
15. Artemeter vial 20 mg/ml
16. Artesunate vial 60mg/ml
17. Rapid Diagnostic Tests for malaria (RDT)
18. Quinine vial 300 mg/ml
19. Quinine tab 300 mg
20. Ciprofloxacine tab 250mg
21. Metronidazole vial 500mg/ml
22. Cotrimoxazole tab 400 mg + 80 mg

XX. Finances

This section of the report should be prepared using data from the general ledger, accounting register or accounting software (QuickBooks, Sage, etc...). Be sure to align you general ledger with the categories of receipts and expenditures listed below, so that it is easier to produce your monthly reports. The following are the categories of receipts and expenditures that should be reported:

A) Receipts	B) Expenditures
1. Preventive care	1. Purchase of medicines, medical materials
2. Curative care (including hospitalization)	2. Salaries, social security, professional taxes, personnel payments
3. Deliveries	3. Employee bonuses
4. Laboratory	4. Travel expenses
5. Sale of medicines/ supplies	5. Office supplies / printed materials / medical records
6. Minor surgery	6. Maintenance and repair of medical equipment
7. Issue of Medical-Legal Documents	7. Maintenance and repair of non-medical equipment
8. Sale of patient records/forms	8. Maintenance and repair of transport
9. Transport of patients	9. Maintenance and repair of infrastructure
10. Performance Based Financing	10. Maintenance/cleaning supplies
11. Other State Subsidies	11. Fuel and motor oil
12. Contributions from other donors	12. Water and Electricity
13. Bank interest	13. Communication (Telephone, Internet…)
14. Mutuelle receipts	14. Training
14.1 Co-payments	15. Costs associated with indigents
14.2 Payment for care	16. Purchase medical equipment
14.3 Payment for medication	17. Purchase non-medical equipment
15. Other health insurance (RAMA / MMI / FARG/ Private insurers)	18. Purchase transport
15.1 Co-payments	19. Other expenses
15.2 Payment for care	
16.3 Payment for medication	
16. Other receipts	
Total Receipts (A)	**Total Expenses (B)**

After recording all of these transactions, complete the credit and debit statement to complete your financial report

Total credits: all parties who owe the FOSA money, goods (e.g. medicines) or services (ex. consultations) provided.

Total debts: all parties who whom the FOSA owes money, goods (e.g. medicines) or services (ex. consultations) provided.

Other non-paying clients: patients other than indigents for whom was not paid for by the patient nor any other organization.

Credits for goods and services during the month: All credits in goods (e.g. medicines) or services (ex. consultations) – financial credits are not counted.

E) Financial Statement			
C) Credits		**D) Debts**	
Description	*Amount*	*Description*	*Amount*
1. Credits at the beginning of the month (e)		1. Debts at the beginning of the month (i)	
2. (+) Additional credits during the month (f)		2. (+) Total debts this month (j)	
3. (-) Reimbursements during the month (g)		3. (-) Reimbursements this month (k)	
4. Total credits at the end of the month (H) = (e+f)-(g)		4. Debt at the end of the month (L) = (i+ j) -(k)	

F) Receipts in hand	***G) Pending Receipts***				***H) Total pending receipts***
1. From the population (C)	2. Indigents (u)	3. Other non-paying clients* (v)	4. Credits for goods and services during the month** (w)	5. Total receipts not received (X) = u+v+w	(Y)= (C) + (X)
I***) Ratio of pending receipts/receipts in hand*** (Z) =(X) X100/ (Y)					

Additional Tables for District and Referral Hospital levels include:

I. Hospitalization: In this table the variables are broken out by the key services reported in each column:

A) Summary statistics

1. Number of beds (a)
2. Present at the beginning of the month
3. Admissions during the month of which:
   - Referred from the Health Centre
   - Non-referred patients
4. Discharges during the month (b) of which
   - Authorized/Cured
   - Abandoned
   - Deaths
   - Referred
   - Counter-referred
5. Present at the end of the month
6. Total hospitalization days for discharged patients (c)
7. Actual hospitalization days (d)

At the District Hospital level the services are:

- Internal Medicine
- Pediatrics
- Surgery
- Gyn. Obst.

- Nut. Rehab.
- Intensive care Neonatology

At the Referral Hospital level the services are:

- ENT
- Emergency
- Internal Medicine
- Pediatrics Surgery
- Gyn. Obst.
- Stoma-tology
- Intensive care
- Other service

II. Surgery

In the surgery table, key types of surgical interventions are listed in the rows and in each column the number of cases are reported according to the following headings:

- Type of surgical intervention
- Urgent interventions
- Planned interventions
- Post-surgical Infection Total: Note that it is not necessary to break out post surgical infections by each procedure, only by category of surgery.

III. Anesthesia

In the anesthesia table record the number of cases that were treated with the following types of anesthesia:

- General Anesthesia
- Regional Anesthesia
- Local Anesthesia
- Other types of anesthesia

IV. Physiotherapy

Record the number of physiotherapy sessions provided (not the number of new cases)

- Physical therapy
- Audiology
- Speech therapy

V. Inpatient Nutrition Rehabilitation: From the nutrition rehabilitation register report the following:

1. Present beginning of month
2. Hospitalized
    - o New Cases
    - o Relapsed Cases

3. Discharges
    - o Cured
    - o Referred
    - o Abandoned
    - o Deceased
4. Present at end of month

VI. Blood Bank Security

For health facilities that have blood banks should report the following variables broken out by (service: Internal Medicine, Pediatrics, Surgery,, Gyn. Obst, Intensive care, Neonatology)

A. Transfusions

1. Number of patients transfused
2. Number of packs of blood

B. Blood pack stock management: Stock situation [Number received (donated and from other blood banks), Number Used, Number Destroyed or damaged, Remaining in Stock] should be reported for the following blood types:

1. Type A
2. Type B
3. Type AB
4. Type O

VII. Medical imagery

Record the number of cases evaluated with the following types of medical imagery:

1. X-Ray Lung
2. X-Ray Bones
3. X-Ray Abdomen without preparation
4. X-Ray Abdomen with dye
5. X-ray other
6. Gastroscopy
7. Ultrasound (Echography)
8. ECG
9 Other medical imagery