**HMIS Procedures Manual (Ethiopia)**

The complete RHIS curriculum is available here:

[https://www.measureevaluation.org/our-work/](https://www.measureevaluation.org/our-work/routine-health-information-systems/rhis-curriculum)

[routine-health-information-systems/rhis-curriculum](https://www.measureevaluation.org/our-work/routine-health-information-systems/rhis-curriculum)

**2.2.4c**





**Federal Ministry of Health**

Health Management Information System (HMIS) /

Monitoring and Evaluation (M&E)

HMIS Procedures Manual: Data Recording

and Reporting Procedures

***HMIS / M&E Technical Standards: Area 3***

HMIS Reform Team

second edition

January 2010

# Executive Summary

Reform of the Health Management Information System and Monitoring and Evaluation (HMIS/M&E) began with a Business Process Re‑engineering (BPR) Assessment. This technical and process assessment identified lack of standardization and duplicative information recording and reporting processes as two major barriers to providing quality information efficiently. This document contains the revisions in recording instruments and reporting procedures proposed to standardize and streamline the HMIS/M&E.

The HMIS captures much of its service and disease surveillance data from client/patient records that health professionals maintain for care and follow up. HMIS simply exploits this routinely established procedure and builds on its potential without itself imposing a totally separate requirement. Obviously there is a need for close integration between client/patient recording and HMIS reporting.

The recording instruments and processes to be reformed fall into four major areas:

1. **Client / patient encounter formats** record interactions between clients or patients and care providers and other technical or administrative health staff. The information recorded may include medical history, clinical observations, diagnosis, treatment, laboratory, pharmacy, and financial data. The formats proposed here are based on current Federal Ministry of Health (FMOH) guidelines and regional practices.
2. **Intrafacility data flow** describes the way patient/client encounter formats follow an individual through the facility and how the medical information recorded by one practitioner can be consolidated so that it becomes available for other practitioners.
3. **HMIS reporting formats** contain the data required for the indicators used in M&E for performance improvement.
4. **HMIS data flow** moves data from facilities and administrative offices through the reporting chain from facility to regional and nation offices. While HMIS/M&E reform includes a plan for electronic transmission of data from woreda onwards, in accord with instructions from the Ministry and international best practices, the first stage in reform is to develop a clean manual system. The formats and processes in this document implement this manual system.

This document covers the formats and procedures for recording and reporting, which is *Technical Area 3* as described in the *Introduction*.

# Introduction to HMIS/M&E Technical Documentation

Monitoring and Evaluation (M&E) is an action-oriented management tool that uses indicators to improve performance and remove bottlenecks.[[1]](#footnote-1) These core indicators for action-oriented M&E come from routine service and administrative records through the Health Management Information System (HMIS).[[2]](#footnote-2) HMIS and M&E are complementary processes; reforming one means reforming the other.

Four technical areas have been identified for documentation of standards for the reformed HMIS/M&E. Extensive consultation with managers and program officers in the last half of 2006 produced consensus on indicator definitions and disease classification required for M&E of the health sector and programs. Reliable and timely supply of these indicators requires consistent information collection instruments and procedures. Use of the information to improve performance requires the effective application of M&E principles and guidelines. Standards, guidelines, and implementation procedures have been laid out for each of these areas in a series of documents on *HMIS / M&E Technical Standards*.

1. Indicator definitions: *HMIS / M&E Redesign Technical Standards: Area 1*Includes indicator definition, interpretation, method of calculation, and data source.
2. Disease classification and case definitions: *HMIS / M&E Redesign Technical Standards: Area 2*Includes classification of diseases to be reported through HMIS and case definitions appropriate for higher and lower capacity facilities.
3. HMIS Data Recording and Reporting Procedures: *HMIS / M&E Redesign Technical Standards: Area 3*Includes procedures and formats for recording medical information during client/patient encounters and for reporting and transmitting HMIS data. These tools are based on the indicator definitions and disease classification established in the first two technical documents.
4. HMIS / M&E information use guidelines and display tools: *HMIS / M&E Redesign Technical Standards: Area 4*Includes guidelines for self-assessment by individuals and health institutions, as well as externally assisted performance monitoring such as supervision, participatory review, and dissemination. Guidelines for visual presentation of information are also included.

Three overarching principles have guided the redesign of these technical standards.

**Standardization.** Common definitions of indicators, data collection instruments, and data processing and analysis procedures form the foundation for effective HMIS/M&E. Without consistent principles and definitions performance cannot be systematically measured and improved across locations or over time.

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

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

A combined application of these principles supports the implementation of an effective and efficient HMIS/M&E in accord with the objectives of Business Process Reengineering (BPR).

**Contents**

[Executive Summary i](#_Toc250828312)

[Introduction to HMIS/M&E Technical Documentation ii](#_Toc250828313)

[Acronyms vii](#_Toc250828314)

[Section 1: Client / patient encounter formats 1](#_Toc250828315)

[1 Annex 1: Recording instruments used by all services 9](#_Toc250828316)

[1.1 Integrated medical records 9](#_Toc250828317)

[1.1.1 Individual folder 9](#_Toc250828318)

[1.1.2 Individual summary sheet 10](#_Toc250828319)

[1.1.3 Patient card 11](#_Toc250828320)

[1.2 Service and appointment cards 13](#_Toc250828321)

[1.2.1 Service identification card 13](#_Toc250828322)

[1.2.2 Appointment card 13](#_Toc250828323)

[1.3 Medical records management 13](#_Toc250828324)

[1.3.1 Master patient index (MPI) 13](#_Toc250828325)

[1.3.2 Tracer card 14](#_Toc250828326)

[Promotive and Preventive Services 14](#_Toc250828327)

[2 Annex 2: Reproductive Health 15](#_Toc250828328)

[2.1 Woman’s card 15](#_Toc250828329)

[2.2 Family Planning 15](#_Toc250828330)

[2.2.1 Family Planning (FP) register 15](#_Toc250828331)

[2.2.2 Contraceptives issued 16](#_Toc250828332)

[2.3 Integrated Antenatal, Labor, Delivery, Newborn and Postnatal Care Card 17](#_Toc250828333)

[2.4 Antenatal care (ANC) register 18](#_Toc250828334)

[2.5 Delivery register 19](#_Toc250828335)

[2.6 Postnatal care (PNC) register 20](#_Toc250828336)

[2.7 Obstetric and gynecological registers 21](#_Toc250828337)

[2.7.1 Safe / post abortion registration 21](#_Toc250828338)

[3 Annex 3: Expanded program on immunization (EPI) and Growth Monitoring 22](#_Toc250828339)

[3.1 Immunization registers and tallies 22](#_Toc250828340)

[3.1.1 Infant immunization and growth monitoring register 22](#_Toc250828341)

[3.1.2 Tetanus Toxoid (TT) immunization register 23](#_Toc250828342)

[3.1.3 EPI tally sheet for all immunizations 24](#_Toc250828343)

[3.2.1 Growth monitoring register 25](#_Toc250828344)

[3.2.2 Growth monitoring tally sheet 26](#_Toc250828345)

[Curative Services 27](#_Toc250828346)

[4 Annex 4: OPD, IPD, and multiple services 28](#_Toc250828347)

[4.1 Outpatient department (OPD) 28](#_Toc250828348)

[4.1.1 Integrated Management of Newborn and Child Illness (IMNCI) Register (for under 5s) 28](#_Toc250828349)

[4.1.2 OPD abstract register 29](#_Toc250828350)

[4.1.3 OPD Diagnosis and attendance tally 30](#_Toc250828351)

[4.1.4 OPD Repeat attendance tally (for injection / dressing room) 31](#_Toc250828352)

[4.2 IPD 32](#_Toc250828353)

[4.2.1 Admission and discharge card 32](#_Toc250828354)

[4.2.2 IPD admission and discharge register 33](#_Toc250828355)

[4.2.3 IPD morbidity and mortality tally 34](#_Toc250828356)

[4.3 Registers used by multiple services at OPD and IPD 35](#_Toc250828357)

[4.3.1 Operation register 35](#_Toc250828358)

[4.3.2 Referral register 36](#_Toc250828359)

[4.4 Support Services 36](#_Toc250828360)

[4.4.1 Tracer drug availability 36](#_Toc250828361)

[4.4.2 Tracer drug days out of stock tally 37](#_Toc250828362)

[5 Annex 5: HIV / AIDS and TB & Leprosy 38](#_Toc250828363)

[5.1 Provider Initiated HIV Counseling and Testing (PIHCT) 38](#_Toc250828364)

[5.1.1 Provider Initiated HIV Counseling and Testing (PIHCT) Tally 38](#_Toc250828365)

[5.2 Voluntary counseling and testing (VCT) 39](#_Toc250828366)

[5.2.1 Voluntary counseling and testing (VCT) register 39](#_Toc250828367)

[5.2.2 VCT Tally 39](#_Toc250828368)

[5.3 Pre-Antiretroviral therapy (PreART) 40](#_Toc250828369)

[5.3.1 Pre-Antiretroviral therapy (PreART) register 40](#_Toc250828370)

[5.3.2 Pre-ART Tally 41](#_Toc250828371)

[5.4 Antiretroviral therapy (ART) 41](#_Toc250828372)

[5.4.1 ART register 41](#_Toc250828373)

[5.4.2 ART Enrollment Tally 42](#_Toc250828374)

[5.4.3 ART Regimen Tally 43](#_Toc250828375)

[5.5 HIV Exposed Infant (HEI) 44](#_Toc250828376)

[5.5.1 HIV exposed infant (HEI) register 44](#_Toc250828377)

[5.6 Tuberculosis – Directly Observed Short Course (TB / DOTS) 44](#_Toc250828378)

[5.6.1 TB (DOTS) register 44](#_Toc250828379)

[5.7 Leprosy 45](#_Toc250828380)

[5.7.1 Leprosy register 45](#_Toc250828381)

[6 Annex 6: Private sector recording and reporting 45](#_Toc250828382)

[Section 2: Intrafacility information flow 46](#_Toc250828383)

[2.1 Integrated patient/client records 46](#_Toc250828384)

[2.2 Implications for client / patient flow 47](#_Toc250828385)

[2.3 Implementation of integrated medical records 48](#_Toc250828386)

[Section 3: HMIS reporting forms 48](#_Toc250828387)

[Section 4: HMIS Data flow 50](#_Toc250828388)

[Section 5: Data Quality 57](#_Toc250828389)

[5.1 Checking Data Accuracy in Monthly Report 57](#_Toc250828390)

[5.2 Completeness and Timeliness of Reporting 60](#_Toc250828391)

[Glossary: Description of types of recording formats 61](#_Toc250828392)

[Section 6. Sources 63](#_Toc250828393)

Annex 1: FORMS USED BY ALL SERVICES

Annex 2: REPRODUCTIVE HEALTH REGISTERS, FORMS, AND INSTRUCTIONS

Annex 3: EPI & GROWTH MONITORING REGISTERS, INSTRUCTIONS, AND TALLIES

Annex 4: CURATIVE SERVICES: OPD and IPD CARDS, REGISTERS, TALLIES, AND INSTRUCTIONS

Annex 5: HIV/AIDS AND TUBERCULOSIS/LEPROSY REGISTERS, TALLIES, AND INSTRUCTIONS

Annex 6: PRIVATE SECTOR PROCEDURES, TALLIES, AND REPORTING FORMS

Annex 7: SERVICE DELIVERY REPORTING FORMATS AND INSTRUCTIONS

Annex 8: DISEASE REPORTING FORMATS

# Acronyms

AIDS Acquired Immune Deficiency Syndrome

ANC Antenatal Care

ART Antiretroviral Therapy

ARV Antiretroviral

BEOC Basic Emergency Obstetric Care

BoFED Bureau of Finance and Economic Development (Regional)

BPR Business Process Reengineering

CAR Contraceptive Acceptance Rate

CEOC Comprehensive Emergency Obstetric Care

CPR Contraceptive Prevalence Rate

CSA Central Statistical Authority

CSRP Civil Service Reform Program

CYP Couple Years of Protection

DOTS Directly Observed Therapy (Short Course)

EDHS Ethiopia Demographic and Health Survey

EPC Epidemic Prevention and Control

EPI Expanded Programme on Immunization

FMOH Federal Ministry of Health

FP Family Planning

HAPCO HIV/AIDS Prevention and Control Office

HC Health Center

HEW Health Extension Worker

HIV Human Immunodeficiency Virus

HMIS Health Management Information System

HP Health Post

HSDP Health Sector Development Program

HSEP Health Sector Extension Program

IMNCI Integrated Management of Newborn and Childhood Illness

IPD Inpatient Department

LMIS Logistics Management Information System

M&E Monitoring and Evaluation

MB Multibacillary leprosy

MDG Millennium Development Goals

MoFED Ministry of Finance and Economic Development

MPI Master Patient Index

MR Medical Record

MRN Medical Record Number

NBTS National Blood Transfusion Service

NNT Neonatal Tetanus

OPD Outpatient Department

PAB Protection at birth (from neonatal tetanus)

PASDEP Plan for Accelerated and Sustained Development to End Poverty

PB Paucibacillary leprosy

PIHCT Provider Initiated HIV Counseling and Testing

PLWHA People Living with HIV/AIDS

PMTCT Prevention of Mother to Child Transmission (of HIV/AIDS)

PNC Postnatal care

PPD Planning and Programming Department

PTB Pulmonary tuberculosis

RH Reproductive Health

TB Tuberculosis

TBA Traditional Birth Attendant

tTBA trained Traditional Birth Attendant

TT Tetanus toxoid

UNGASS United Nations General Assembly Special Session

VCT Voluntary Counseling and Testing

WoFEDO Woreda Finance and Economic Development Office

WFA Weight-for-age

WHO World Health Organization

WMS Welfare Monitoring Survey

WorHO Woreda Health Office

# Section 1: Client / patient encounter formats

The service and administrative records create the information base needed to operate the health system. These records supply information for medical services, supervision, research, accounting, insurance, and legal requirements, as well as for overall management of services through the Health Management Information System and Monitoring and Evaluation (HMIS/M&E).

Information recorded during the encounter between a health care provider and a client or patient forms the heart of the information base; these records are supplemented by records of medical support services such as laboratory and dispensary, and by administrative financial and personnel records.

Service data are generated as health workers provide service to individual clients and patients. Health workers use multiple formats to record health-related information. In a facility, the process of recording starts when the client / patient arrives at the facility, continues while staying and moving from unit to unit within the facility, and concludes when the client / patient checks out of the compound. When outreach services are provided, similar forms are used to record information. The recording formats that are used for these purposes in Ethiopia are documented in Annexes 1-6.

Lack of standardization creates a major constraint in HMIS/M&E. Consistent recording formats reinforce standards of clinical assessment and treatment and standards for data and indicators so that performance in different locations can be compared.

The standardized client/patient encounter recording formats in this document have been developed in accord with international standards and best practices, and through consultation with technical programs and care providers.

After determining the contents of the standard formats, the most appropriate instrument to record the information was selected and designed. Client / patient information is typically recorded in registers and/or on patient cards retained at the facility.[[3]](#footnote-3) Two basic, and sometimes conflicting, principles were followed in designing the recording instruments: first, make information available to other care providers (usually this principle supports use of cards filed in an individual medical record); second, minimize the time and cost required in recording (often this principle supports use of preformatted registers).

Generally, there is a need for open-ended information recorded on a card when the condition or illness is complex so that the information to be recorded may not be predicted. This is the situation in curative care and when assessment during routine preventive services reveals complications. The level of service provided by the facility itself also determines the need for open ended-information. The Business Process Reengineering (BPR) assessment of workflow in both facilities and administrative institutions also shows the importance of reducing unnecessary duplications in recording information on cards and registers, as well as eliminating unnecessary repetitions of information review.

Based on these principles, and on discussions with HMIS/M&E stakeholders and implementers, a set of client/patient encounter recording instruments, aggregation and tallying tools, and reporting formats have been developed. The information recording instruments and procedures aim at simplicity and efficiency, with a shift to more complex instruments and procedures when necessary.

Examples of these instruments, along with detailed instructions for use, are included in the Annexes to this manual. (Some of the instruments are printed on a larger size of paper than the size used in this manual. These instruments have been reduced for reproduction here.)

* Annex 1: Forms used by all services
* Annex 2: Reproductive and maternal health
* Annex 3: Expanded Programme on Immunization (EPI) and growth monitoring
* Annex 4: Curative services: Outpatient Department (OPD) and Inpatient Department (IPD)
* Annex 5: HIV/AIDS and Tuberculosis (TB)/Leprosy
* Annex 6: Private Sector
* Annex 7: Service Delivery
* Annex 8: Disease Reporting

The following diagram illustrates the relationship between the medical records forms and the HMIS indicators. A summary list of the HMIS medical records forms is included after this diagram.

The next section in this manual lists each form in detail, with detailed information on their purpose in the providing care and HMIS information, who maintains them, where they are kept, and data compilation procedures. Replicas of each form and instructions for completing them are in the Annexes.

**Medical Records Forms and HMIS Indicators**

B1.1-5 General Morbidity

& Mortality

B2a, B2e Communicable

Diseases

D1-D8 Utilization

4.1.3 OPD diagnosis &

attendance

4.1.4 OPD repeat

attendance

4.2.3 IPD morbidity &

mortality

4.1.1 IMNCI

4.1.2 OPD Abstract

4.2.2 IPD Admission/

Discharge

**CARDS**

**TALLIES**

**HMIS INDICATORS**

**REGISTERS**

2.1 Woman’s Card

2.3 Reproductive Health Card

1.1.3 Patient Card

4.2.1 Admission /

Discharge Card

2.2.1 Family Planning

2.4 Antenatal

2.5 Delivery

2.6 Postnatal

2.7.1 Abortion

2.2.2 Contracept. Iss.

3.1.1 Infant Immun.

/Grow. Mon.

3.1.2 TT Immun.

3.2.1 Grow. Mon.

3.1.3 Immun.

3.2.2 Grow. Mon.

**Reproductive Health**

A1.1-2 Family Planning

A1.3 Antenatal

A1.5-9 Delivery-related

A1.10 Postnatal

A1.4 Abortion

**Child Health & Immunization**

A2.1-2 Nutrition

A3.1-5 Immun. Cov.

A3.6 Vaccine Wastage

**Outpatient Department (OPD) & Inpatient Department (IPD)**

**HIV/AIDS, TB, & LEPROSY**

HIV/AIDS

5.1.1 PIHCT

5.2.2 VCT

5.3.2 Pre-ART

5.4.2 ART Enrollment

5.4.3 ART Regimen

HIV/AIDS

5.2.1 VCT

5.3.1 Pre-ART

5.4.1 ART

HIV/AIDS, TB, and leprosy programs have special cards for monitoring treatment

HIV/AIDS

B2d.2 VCT

B2d.3 PIHCT

B2d.5 PMTCT

B2d.7 ART

5.6.1 TB

5.6.1 Leprosy

**SUPPORT SERVICES**

4.4.1 Drug availability tally

4.4.2 Drug stock out days

Logistics forms

C4.1 Drug availability

C4.2 Stock out duration

B2b.1 TB Case detection

B2b.2 DOTS treatment

results

B2c TB/HIV coinfection

B2b.3 New cases

B2b.4 Grade II disability

B2b.5 Child leprosy

B2b.6 Treatment completion

B2b.3 New leprosy cases

B2b.4 Grade II disability

B2b.5 Child leprosy cases

B2b.6 Treatment completion

B2b.1 TB Case detection

B2b.2 DOTS treatment results

B2c TB / HIV Coinfection

**Recording Formats used by Multiple Services**

|  |  |  |
| --- | --- | --- |
| **1.1 Integrated medical records** | | |
| 1.1.1 | Individual folder | Contains all medical records from a facility for a single individual. |
| 1.1.2 | Individual summary sheet | One line summary of services received by individual from facility. |
| 1.1.3 | Patient Card | Contains care provider’s clinical observations, notes, laboratory results, diagnosis, treatment, and HMIS disease classification for every acute outpatient encounter and for each admission.  This card provides data for sixteen indicators:   * Main causes of morbidity and mortality (5 indicators) * Morbidity and mortality for specific diseases (5 indicators) * Provider Initiated HIV Counseling and Testing (PIHCT) (1 indicator) * Outpatient department (OPD) and inpatient department (IPD) utilization (5 indicators)   and data required for disease reporting:   * Cases and deaths according to HMIS disease classification |
| **1.2 Service and appointment cards** | | |
| 1.2.1 | Service Identification Card | Identifies individual registered at clinic; contains Medical Record Number (MRN), the identification for all of the individual’s medical records. |
| 1.2.2 | Appointment Card | Remind individual of next appointment at facility. The same card is used by all services at the facility. |
| **1.3 Medical records management** | | |
| 1.3.1 | Master patient index (MPI) | Card index of all individuals registered at the facility, ordered by patient name; links an individual’s name with their Medical Record Number (MRN). |
| 1.3.2 | Tracer Card | Track location of individual folder when it is removed from file shelf. |

**Preventive and Promotive Service Recording Formats**

|  |  |  |
| --- | --- | --- |
| **2 Reproductive health** | | |
| 2.1 | Woman’s card | Contains retrospective and prospective history of a woman’s reproductive health status and services. |
| ***2.2 Family planning*** | | |
| 2.2.1 | Family planning register | Longitudinal record of family planning services and screening provided to a client in a single year.  This register collects data required for two indicators.   * Contraceptive Acceptor Rate (CAR) * Provider Initiated HIV Counseling and Testing (PIHCT) |
| 2.2.2 | Contraceptives issued | Monthly record of contraceptives distributed.  This form collects data required for one indicator.   * Contraceptive Prevalence Rate (CPR) |
| ***Antenatal, delivery, and postnatal care*** | | |
| 2.3 | Reproductive health card | Records antenatal, delivery, newborn, and postnatal care for a single pregnancy.  This form collects data required for nine indicators.   * Antenatal, Delivery, Postnatal, and Neonatal Care and outcomes (8 indicators) * Prevention of Mother to Child Transmission (PMTCT) (1 indicator) |
| 2.4 | Antenatal care register | Longitudinal record of antenatal care provided to a client during a single pregnancy.  This register collects data required for two indicators.   * Antenatal Care Coverage (ANC) * Prevention of Mother to Child Transmission (PMTCT) |
| 2.5 | Delivery register | Record of intrapartum care provided to a mother and newborn during a single delivery.  This register collects data required for seven indicators.   * Maternal and neonatal care and outcomes (6 indicators) * Prevention of Mother to Child Transmission (PMTCT) |
| 2.6 | Postnatal care register | Record of postnatal care provided to a client after all delivery services are completed.  This register collects data required for two indicators.   * Postnatal Care Coverage (PNC) * Neonatal Death Rate (Institutional) |
| ***2.7 Obstetric and gynecological registers*** | | |
| 2.7.1 | Safe / post abortion care register | Record of care provided in relation to a single abortion.  This register collects data required for two indicators.   * Abortion Care * Maternal Death Rate (Institutional) |
| **3 Child health and Expanded programme on immunization (EPI)** | | |
| ***3.1 Immunization registers and tallies*** | | |
| 3.1.1 | Infant immunization and growth monitoring register | Longitudinal record of immunizations and growth monitoring provided to infants (children under 1 year of age and those completing the under 1 immunizations)  This register collects data required for seven indicators:   * Immunization coverage (5 indicators) * Vaccine wastage rate * Proportion of moderate / severe malnutrition |
| 3.1.2 | Tetanus Toxoid (TT) immunization register | Longitudinal record of tetanus toxoid (TT) immunizations provided to women of reproductive, or pre-reproductive, age.  This form collects data required for one indicator.   * Vaccine wastage rate. |
| 3.1.3 | EPI tally sheet for all immunizations | Daily tally of immunizations given to under 1s to calculate coverage, and of doses of infant antigens and tetanus toxoid given to all age groups to calculate vaccine wastage.  This tally collects data required for six indicators:   * Immunization coverage (5 indicators) * Vaccine wastage rate |
| ***3.2 Immunization registers and tallies*** | | |
| 3.2.1 | Growth monitoring register | Longitudinal record of growth monitoring provided to children who have completed their infant immunizations, but who are below 3 years of age.  This register collects data required for one indicator.   * Proportion of moderate / severe malnutrition |
| 3.2.2 | Growth monitoring tally sheet | Daily tally of number of children under 3 years weighed in each Weight for Age (WFA) category.  This tally collects data required for calculating one indicator:   * Proportion of moderate / severe malnutrition |

**Curative Care Recording Formats**

|  |  |  |
| --- | --- | --- |
| **4. OPD, IPD, and multiple services** | | |
| **4.1 Outpatient Department (OPD)** | | |
| 4.1.1 | Integrated Management of Newborn and Child Illness (IMNCI) Register (for under 5s) | Records clinical signs and symptoms, assessment, and treatment or referral of illness amongst children under 5 years of age. Format of register guides assessment according to IMNCI principles.  This register provides data for seven indicators:   * Top 10 causes of morbidity amongst children under 5 years * Morbidity for specific diseases (4 indicators) * Outpatient department (OPD) utilization (2 indicators)   and data required for disease reporting:   * Cases according to HMIS disease classification |
| 4.1.2 | OPD abstract register | Records demographic information, type of attendance, diagnosis, referral, PIHCT counseling, and costs and charges for the first OPD attendance for a condition that requires curative care. (Currently, the financial information is not recorded.)  This register collects data required for nine indicators   * Main causes of morbidity and mortality (2 indicators) * Morbidity for specific diseases (4 indicators) * Provider Initiated HIV Counseling and Testing (PIHCT) * Outpatient department (OPD) utilization (2 indicators)   and data required for disease reporting:   * Cases according to HMIS disease classification |
| 4.1.3 | OPD Diagnosis and attendance tally | Daily tally of OPD attendance and new cases.  This tally collects data required for eight indicators   * Main causes of morbidity and mortality (2 indicators) * Morbidity for specific diseases (4 indicators) * Outpatient department (OPD) utilization (2 indicators)   and data required for disease reporting:   * Cases according to HMIS disease classification |
| 4.1.4 | OPD Repeat attendance tally (for injection / dressing room) | Daily tally of OPD attendance that is followup for an earlier OPD first attendance for curative care and in which all services are provided in the injection / dressing room.  This tally collects data required for two indicators   * Outpatient (OPD) attendance per capita * Outpatient (OPD) visits per practitioner per day |
| **4.2 Inpatient Department (IPD)** | | |
| 4.2.1 | Admission and discharge card | One card is completed for every admission / discharge.  This card is the data source for thirteen indicators:   * Main causes of morbidity and mortality (5 indicators) * Morbidity and mortality for specific diseases (5 indicators) * Inpatient department (IPD) utilization (3 indicators)   and data required for disease reporting:   * Cases and deaths according to HMIS disease classification |
| 4.2.2 | IPD admission and discharge register | Records demographic information, admission and discharge dates, HMIS disease classification, status at discharge, referral, PIHCT counseling, and costs and charges for a single admission.  This register collects data required for fourteen indicators   * Main causes of morbidity and mortality (5 indicators) * Morbidity and mortality for specific diseases (5 indicators) * Provider Initiated HIV Counseling and Testing (PIHCT) (1 indicator) * Inpatient department (IPD) utilization (3 indicators)   and data required for disease reporting:   * Cases and deaths according to HMIS disease classification |
| 4.2.3 | IPD morbidity and mortality tally | Daily tally of IPD cases and deaths.  This tally collects data required for ten indicators   * Main causes of morbidity and mortality (5 indicators) * Morbidity and mortality for specific diseases (5 indicators)   This tally collects data required for disease reporting:   * Cases and deaths according to HMIS disease classification |
| **4.3 Registers used by multiple services at OPD and IPD** | | |
| 4.3.1 | Operation register | Records patient’s demographic information; reason for, type and outcome of operation; and care providers. |
| 4.3.2 | Referral register | Records patient’s demographic information; reason for and destination of referral; and care providers. |
| **4.4 Support services** | | |
| 4.4.1 | Tracer drug availability | Monthly record of tracer drug availability. This form tracks whether each tracer drug was available whenever it was needed during the month.  This tally collects data required for one indicator:   * Essential drugs availability |
| 4.4.2 | Tracer drug days out of stock tally | Monthly record of days tracer drug out of stock. This form tracks the number of days the drug was out of stock.  This tally collects data required for one indicator:   * Average stockout duration |
| **5. HIV / AIDS and TB & Leprosy** | | |
| **5.1 Provider Initiated HIV Counseling and Testing (PIHCT)** | | |
| 5.1.1 | Provider Initiated HIV Counseling and Testing (PIHCT) Tally | Daily count of Provider Initiated HIV Counseling and Testing (PIHCT) services.  This tally collects data required for one indicator.   * Provider Initiated HIV Counseling and Testing (PIHCT) Services |
| **5.2 Voluntary Counseling and Testing (VCT)** | | |
| 5.2.1 | Voluntary counseling and testing (VCT) register | Records client’s demographic information, HIV testing, STD and TB screening, and referral.  This register collects data required for one indicator   * Voluntary Counseling and Testing (VCT) Services |
| 5.2.2 | Voluntary Counseling and Testing (VCT) Tally | Daily count of Voluntary Counseling and Testing (VCT) services.  This tally collects data required for one indicator.   * Voluntary Counseling and Testing (VCT) Services |
| **5.3 Pre-Antiretroviral therapy (PreART)** | | |
| 5.3.1 | Pre-Antiretroviral therapy (PreART) register | Records client’s demographic information, HIV testing, TB treatment, referral, and enrollment in PreART treatment.  This register collects data required for one indicator   * Cumulative HIV care enrollment |
| 5.3.2 | Pre-ART Tally | Daily tally and count of newly enrolled pre-ART patients by age group, gender, and pregnancy status.  This tally collects data required for one indicator.   * Cumulative HIV care enrollment |
| **5.4 Antiretroviral therapy (ART)** | | |
| 5.4.1 | Antiretroviral therapy (ART) register | Records client’s demographic information, HIV testing, TB treatment, and ART treatment.  This register collects data required for three indicators   * Cumulative ART care enrollment * ART by regimen * ART survival rates |
| 5.4.2 | ART Enrollment Tally | Daily tally and count of newly enrolled ART patients by age group, gender, and pregnancy status.  This tally collects data required for one indicator.   * Cumulative ART care enrollment |
| 5.4.3 | ART Regimen Tally | Monthly tally and count of ART patients on each regimen at the end of the month.  This tally collects data required for one indicator.   * ART by regimen |
| **5.5 HIV Exposed Infant (HEI)** | | |
| 5.5.1 | HIV Exposed Infant (HEI) register | Longitudinal record of HIV exposed infant’s demographic information, testing, and outcome at 18 months. |
| **5.6 Tuberculosis – Directly Observed Short Course (TB / DOTS)** | | |
| 5.6.1 | TB (DOTS) register | Records TB patient’s demographic information, diagnosis, HIV/AIDS screening, intensive and continuation phase treatment, and treatment outcome.  This register collects data required for four indicators   * Tuberculosis (TB) case detection rate. * Treatment results of smear-positive pulmonary TB cases (DOTS cohort) * Proportion of registered TB patients who are tested for HIV * Proportion of registered TB patients who are HIV positive |
| **5.7 Leprosy** | | |
| 5.7.1 | Leprosy register | Longitudinal record of leprosy patient’s demographic information, diagnosis, treatment, and disability grade at end of treatment.  This register collects data required for four indicators   * New cases of leprosy * Grade II disability rate among new cases of leprosy * Leprosy cases amongst children less than 15 years of age * Leprosy treatment completion rate |

## 1 Annex 1: Recording instruments used by all services

At Health Centers, Clinics, and Hospitals service and medical records are maintained on separate cards and forms, as well as on registers. All cards and forms that record the services and health status for a single individual are kept in the integrated medical record folder. The medical practitioner can refer to the observations, findings, and treatment provided by all services. Access to the facility’s complete medical records for an individual enables the practitioner to provide holistic quality care.

This section of the *Procedures Manual* describes recording instruments that are shared by multiple services. These include records that remain in the facility, as well as identification and appointment cards that are retained by the client / patient.

All medical services at Health Centers, Clinics, and Hospitals share three types of recording instruments: Integrated medical records, Service and appointment cards, and Medical records management.

### 1.1 Integrated medical records

| 1.1.1 Individual folder | |
| --- | --- |
| **Purpose** | Contains all medical records from a facility for a single individual. File folder has preprinted spaces for  a. Individual’s demographic information  b. Summary sheet for all services provided in facility, which provides practitioner with a snapshot of all services received.  c. All preventive, chronic, OPD, and IPD services. |
| **Who maintains** | a. *Care provider* uses the instruments already in the folder or adds new forms while providing service. At the end of service, the care provider adds any new forms to the top and makes a notation in the summary sheet (1.1.2, below) regarding the care provided.  b. *Card room clerk* issues the folder upon registration of a new individual, retrieves the folder from the filing shelves for a registered patient returning for service, tracks its location until it returns to the card room, then files it in its normal location. |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | Kept in Card Room and filed by individual’s MRN. When the patent receives care in the facility, the folder is taken to the appropriate service room. The tracer card (1.3.2, below) tracks the folder’s location. |
| **Format of instrument** | Paper file folder for A4 paper, with expandable spine and fastener on the left side. Registration information is printed on front, with the summary sheet on the inside front cover. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, records may be retained in active storage for 5 years after last visit and retained in inactive storage for 10 years after last visit or death. |
| **Data compilation procedures** | No data compiled from Individual Folder. |

| 1.1.2 Individual summary sheet | |
| --- | --- |
| **Purpose** | Contains summary of services received by individual from facility  a. Provides practitioner with a snapshot of all services received.  b. Links individual and MRN to service registers. |
| **Who maintains** | a. *Care provider* makes a notation in the summary sheet regarding the care provided at the end of the service.  b. *Card room clerk* adds additional sheets of preprinted A4 paper when more space is required. |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | Kept in individual folder. |
| **Format of instrument** | Printed on the inside front cover of individual folder, with additional sheets on preprinted A4 paper added when more space is required. |
| **Archival procedures** | Same procedure as for individual folder. (See Section 1.1.1, above) |
| **Data compilation procedures** | No data compiled from Individual Summary Sheet. |

| 1.1.3 Patient card | |
| --- | --- |
| **Purpose** | Contains care provider’s clinical observations, notes, laboratory results, diagnosis, treatment, and HMIS disease classification for every acute outpatient encounter and for each admission.  This card provides data for sixteen indicators:   * Main causes of morbidity and mortality (5 indicators) * Morbidity and mortality for specific diseases (5 indicators) * Provider Initiated HIV Counseling and Testing (PIHCT) (1 indicator) * Outpatient department (OPD) and inpatient department (IPD) utilization (5 indicators)   and data required for disease reporting:   * Cases and deaths according to HMIS disease classification |
| **Who maintains** | *Care provider* makes observations, notes and diagnosis when care is provided. |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | Kept in individual folder. |
| **Format of instrument** | Preprinted, front and back, on heavy stock A4. |
| **Archival procedures** | Same procedure as for individual folder. (See Section 1.1.1, above) |
| **Data compilation procedures** | This card provides data for sixteen indicators:   * Top 10 causes of morbidity amongst children under 5 years, Indicator B1.1. * Top 10 causes of mortality amongst children under 5 years, Indicator B1.2. * Top 10 causes of morbidity amongst persons 5 years and above, Indicator B1.3. * Top 10 causes of mortality amongst persons 5 years and above, Indicator B1.4. * Inpatient mortality rate, Indicator B1.5. * Malaria morbidity and case fatality rate, Indicator B2a * Case fatality rate for meningitis [inpatients], Indicator B2e.1 * Measles, Indicator B2e.4 * Neonatal tetanus, Indicator B2e.5 * Dracunculiasis (Guinea worm), Indicator B2e.6 * Provider Initiated HIV Counseling and Testing (PIHCT), Indicator B2d.3. * Outpatient (OPD) attendance per capita, Indicator D1.2 * Outpatient (OPD) visits per practitioner per day, Indicator D1.3 * Admission rate, Indicator D1.4 * Bed occupancy rate (BOR) , Indicator D1.5 * Average Length of Stay (ALoS) , Indicator D1.6   and data required for disease reporting:   * Cases and deaths according to HMIS disease classification   + Disaggregated by age   + Disaggregated by gender   The *Patient Card* data for these indicators are summarized in registers and tallied from the registers.  OPD demographic, attendance, disease classification, and PIHCT services recorded on this *Patient Card* are summarized in *OPD abstract register* (see Section 4.1.2, below) and further tallied for reporting.  IPD demographic, disease classification, length of stay, status at discharge, and PIHCT services are summarized in *Admission / Discharge Card* (See Section 4.2.1, below) and *IPD Admission Discharge Register* (See Section 4.2.2, below) and further tallied for reporting. |

### 1.2 Service and appointment cards

| 1.2.1 Service identification card | |
| --- | --- |
| **Purpose** | Identify individual registered at clinic.  a. Contains the Medical Record Number (MRN) and basic demographic information on the individual.  b. Primary tool for finding an individual’s medical record using the MRN. |
| **Who maintains** | *Card room clerk* issues the service identification card when the individual first registers at a clinic. |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | Client / patient keeps card. |
| **Format of instrument** | Preprinted, front and back, on heavy stock, approximately 1/8 A4 size. |
| **Archival procedures** | None needed. |
| **Data compilation procedures** | No data compiled from Service Identification Card. |

| 1.2.2 Appointment card | |
| --- | --- |
| **Purpose** | Remind individual of next appointment at facility. The same card is used by all services at the facility. |
| **Who maintains** | *Service provider* completes the date and service for the appointment and issues a new appointment card as required. |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | Client / patient keeps card. |
| **Format of instrument** | Preprinted, front and back, on heavy stock, approximately 1/8 A4 size. The front side identifies the patient; the reverse includes space for 9 appointments. |
| **Archival procedures** | None needed. |
| **Data compilation procedures** | No data compiled from Appointment Card. |

### 1.3 Medical records management

| 1.3.1 Master patient index (MPI) | |
| --- | --- |
| **Purpose** | Card index of all individuals registered at the facility, ordered by patient name.  a. Links an individual’s name with their Medical Record Number (MRN).  b. Supports retrieval of an individual’s file when their MRN is unknown. |
| **Who maintains** | *Card room clerk* fills the MPI card when the individual registers for the first time. Card room clerk is responsible for maintaining the index. |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | Kept in file box in card room. |
| **Format of instrument** | Preprinted, front and back, on heavy stock, approximately ¼ of A4 size. |
| **Archival procedures** | An individual’s card should not be removed from the MPI. If an individual’s folder is moved to inactive storage, the card should be moved to an inactive MPI. |
| **Data compilation procedures** | No data compiled from Master Patient Index. |

| 1.3.2 Tracer card | |
| --- | --- |
| **Purpose** | Track location of individual folder when it is removed from file shelf. |
| **Who maintains** | *Card room clerk* maintains the tracer card by recording the location of the folder when it is taken to a service area. |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility** | Kept in individual folder when folder is filed on card room shelf; replaces folder on card room shelf when individual folder is moved. |
| **Format of instrument** | Preprinted, front and back, on heavy A4 stock. |
| **Archival procedures** | The tracer card replaces the individual folder on the card room shelf when the folder is moved to inactive storage. |
| **Data compilation procedures** | No data compiled from Tracer Card. |

## Promotive and Preventive Services

At Health Centers, Clinics, and Hospitals, preventive and promotive services are recorded on registers. Simple services, like immunizations, are recorded primarily on registers, supplemented by some client-based and facility-based cards. More complex services, like reproductive health, record detailed information on cards at HC, Clinic, and Hospital, with summary registers for supervision and HMIS data compilation. At HC, Clinic, and Hospital, data are compiled from registers, either directly or with the assistance of tally sheets.

At Health Centers, Clinics, and Hospitals promotive and preventive services comprise two categories of medical services: Reproductive Health and Child Health / EPI.

Formats and instructions for reproductive health are in Annex 2: Reproductive Health Registers, Forms, and Instructions.

Formats and instructions for child health and EPI are in Annex 3: Child health and Expanded programme on immunization (EPI) Registers, Instructions, and Tallies.

## 2 Annex 2: Reproductive Health

| 2.1 Woman’s card | |
| --- | --- |
| **Purpose** | Contains retrospective and prospective history of a woman’s reproductive health status and services:   * General Medical Information, * Vaccinations, * Obstetric History, * Counseling and Testing (including Sexually Transmitted Infections), * Family Planning, and * Abortion Care. |
| **Who maintains** | *Care provider* obtains history, makes observations, and records care provided. Card should be added to medical records folder when woman first comes for family planning, tetanus toxoid immunization, or abortion services. |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | Kept in individual folder. |
| **Format of instrument** | Preprinted, front and back, on green heavy stock A4. |
| **Archival procedures** | Same procedure as for individual folder. (See Section 1.1.1, above) |
| **Data compilation procedures** | No data compiled from Woman’s Card. |

### 2.2 Family Planning

| 2.2.1 Family Planning (FP) register | |
| --- | --- |
| **Purpose** | Longitudinal record of family planning services and screening provided to a client in a single year.  a. A client’s utilization of FP services for a single year is recorded on a single line in the register. After the year is completed, the client is registered again, on another line in the FP registration book. This enables yearly monitoring of new and repeat clients.  b. The record of services for a complete year on a single line supports continuity and quality of care.  c. Client’s HIV screening, testing, and counseling are recorded  This register collects data required for two indicators.   * Contraceptive Acceptor Rate (CAR) * Provider Initiated HIV Counseling and Testing (PIHCT) |
| **Who maintains** | *Care provider* records observations and care provided. Care provider also makes appropriate entries on Woman’s Card. |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | FP service room. |
| **Format of instrument** | Preprinted on standard A3 paper; vertical format. The entry for a single client spans one page. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, registers may be retained in active storage for 2 years after the last entry in the register and retained in inactive storage for 7 years after the last entry in the register. |
| **Data compilation procedures** | This register collects data required for two indicators.   * Contraceptive Acceptor Rate (CAR), Indicator A1.2.   + Sum new and repeat acceptors in register at end of month. * Provider Initiated HIV Counseling and Testing (PIHCT), Indicator B2d.3.   + Register records number of HIV tests offered, number provided, and number testing positive. Tally is kept with register, and these data should be tallied by provider immediately after service is completed. If this instruction is not observed, there is a high risk that tests will be miscounted because the date the test is given is not recorded in the FP register. Tally is kept with register until end of month data compilation, then moved to archive maintained by HMIS in-charge. (See description of *PIHCT tally*, in Section 5.1.1, below.) |

| 2.2.2 Contraceptives issued | |
| --- | --- |
| **Purpose** | Monthly record of contraceptives distributed that provides annual total that can be used to estimate contraceptive prevalence rate (CPR).  This form collects data required for one indicator.   * Contraceptive Prevalence Rate (CPR) |
| **Who maintains** | *Service provider* or *Store keeper* completes the information at the end of the month, based on Contraceptive Logistics and Request Form – LMIS-LR (2005) |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | FP logistics room / store room. |
| **Format of instrument** | Preprinted on single sheet of standard A4 paper, horizontal format. |
| **Archival procedures** | At end of year, this tally form is given to the HMIS in-charge for archiving. National and regional regulations for retention should be observed. If these regulations are unknown, tally sheets may be retained for 5 years and then discarded. |
| **Data compilation procedures** | This form collects data required for one indicator.   * Contraceptive Prevalence Rate (CPR), Indicator A1.1.   + Monthly counts of products dispensed are maintained at the facility, then aggregated and reported annually to estimate the Contraceptive Prevalence Rate (CPR). |

| 2.3 Integrated Antenatal, Labor, Delivery, Newborn and Postnatal Care Card | |
| --- | --- |
| **Purpose** | Record antenatal, delivery, newborn, and postnatal care for a single pregnancy.  a. This card follows the protocol of four focused antenatal care visits.  b. The use of a single card to record clinical observations and care for mother and newborn during all stages of maternity promotes continuity and quality of care.  This form collects data required for nine indicators.   * Antenatal, Delivery, Postnatal, and Neonatal Care and outcomes (8 indicators) * Prevention of Mother to Child Transmission (PMTCT) (1 indicator) |
| **Who maintains** | *Care provider* completes the information required. After service completed, care provider makes appropriate entries in Woman’s Card and related registers (ANC, delivery, PNC) and tally sheets. |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | Card kept in individual’s medical records folder. (See Section 1.1.1, above) |
| **Format of instrument** | Preprinted on both sides of heavy stock A3 paper. The A3 sheet is folded to create a four-sided folder. |
| **Archival procedures** | Same procedure as for individual folder. (See Section 1.1.1, above) |
| **Data compilation procedures** | All integrated card data for ANC, delivery, PNC, and HIV/AIDS services are summarized on the registers for these services. (See Sections 2.4-2.6, below.) |

| 2.4 Antenatal care (ANC) register | |
| --- | --- |
| **Purpose** | Longitudinal record of antenatal care provided to a client during a single pregnancy.  a. This record follows the protocol of four focused antenatal care visits.  b. The record of services for a single pregnancy on a single line supports continuity and quality of care.  c. Client’s obstetric screening and HIV screening, testing, and counseling are recorded.  This register collects data required for two indicators.   * Antenatal Care Coverage (ANC) * Prevention of Mother to Child Transmission (PMTCT) |
| **Who maintains** | *Care provider* completes the register from entries made on *Integrated Antenatal, Labor, Delivery, Newborn and Postnatal Care Card* (see Section 2.3, above). |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | ANC service room. |
| **Format of instrument** | Preprinted on standard A3 paper; horizontal format. The entry for a single client spans one page. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, registers may be retained in active storage for 2 years after the last entry in the register and retained in inactive storage for 7 years after the last entry in the register. |
| **Data compilation procedures** | This register collects data required for two indicators. Both are summed directly from the register at the end of the month.   * Antenatal Care Coverage (ANC), Indicator A1.3.   + Sum new (first) attendances in register at end of month. * Prevention of Mother to Child Transmission (PMTCT), Indicator B2d.5.   + Sum HIV tests provided and positive tests in register at end of month. |

| 2.5 Delivery register | |
| --- | --- |
| **Purpose** | Record of intrapartum care provided to a mother and newborn during a single delivery.  a. The record of services for a single delivery on a single line supports continuity and quality of care.  b. Client’s HIV services, including screening, testing, counseling, and provision of ARVs are recorded.  c. Newborn services, including immunization, are recorded.  d. This register accords with the medico-legal requirements for recording birth.  This register collects data required for seven indicators.   * Maternal and neonatal care and outcomes (6 indicators) * Prevention of Mother to Child Transmission (PMTCT) |
| **Who maintains** | *Care provider* completes the register from entries made on Integrated Antenatal, Labor, Delivery, Newborn and Postnatal Care Card (see Section 2.3, above). |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | Delivery room. |
| **Format of instrument** | Preprinted on standard A3 paper; horizontal format. The entry for a single client spans one page. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, registers may be retained in active storage for 2 years after the last entry in the register and retained in inactive storage for 7 years after the last entry in the register. |
| **Data compilation procedures** | This register collects data required for seven indicators. All are summed directly from the register at the end of the month.   * Deliveries with skilled attendant, Indicator A1.5.1.   + Sum number of deliveries in register at end of month. * Caesarean Section Rate, Indicator A1.6.   + Sum number of Caesarean sections in register at end of month. * Maternal Deaths (Institutional), Indicator A1.7.   + Sum number of maternal deaths in register at end of month. * Stillbirth Rate, Indicator A1.8.   + Sum number of live and still births in register at end of month. * Neonatal Death Rate (Institutional), Indicator A1.9.   + Sum number of neonatal deaths in register at end of month. * Low Birth Weight Rate (Institutional), Indicator A2.1.   + Sum number of newborns with low birth weights and number weighed in register at end of month. * Prevention of Mother to Child Transmission (PMTCT), Indicator B2d.5.   + Sum number of HIV+ deliveries and number with ARV provided to mother and newborn in register at end of month. |

| 2.6 Postnatal care (PNC) register | |
| --- | --- |
| **Purpose** | Record of postnatal care provided to a client after all delivery services are completed. (Care provided as part of delivery service is recorded in the delivery register, not in the postnatal register. Similarly, counts of postnatal care include only women who seek care after delivery services are complete.)  a. The record of services for a single mother on a single line supports continuity and quality of care.  b. Client’s HIV services, including screening, testing, counseling, and provision of ARVs are recorded.  c. Newborn services, including immunization, are recorded.  This register collects data required for two indicators.   * Postnatal Care Coverage (PNC) * Neonatal Death Rate (Institutional) |
| **Who maintains** | *Care provider* completes the register from entries made on Integrated Antenatal, Labor, Delivery, Newborn and Postnatal Care Card (see Section 2.3, above). |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | Postnatal care room. |
| **Format of instrument** | Preprinted on standard A3 paper; horizontal format. The entry for a single client spans one page. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, registers may be retained in active storage for 2 years after the last entry in the register and retained in inactive storage for 7 years after the last entry in the register. |
| **Data compilation procedures** | This register collects data required for two indicators. Both are summed directly from the register at the end of the month.   * Postnatal Care Coverage, Indicator A1.10.   + Sum new (first) attendances in register at end of month. * Neonatal Death Rate (Institutional), Indicator A1.9.   + Sum number of neonatal deaths in register at end of month. |

### 2.7 Obstetric and gynecological registers

| 2.7.1 Safe / post abortion registration | |
| --- | --- |
| **Purpose** | Record of care provided in relation to a single abortion.  a. Registration format follows standard set by MoH in *Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia*, June 2006, Addis Ababa, Appendix IV.  b. Single event of post abortion care.  This register collects data required for two indicators.   * Abortion Care * Maternal Death Rate (Institutional) |
| **Who maintains** | *Care provider* completes the register from entries made on *Woman’s Card* (see Section 2.1, above). |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | Abortion care room. |
| **Format of instrument** | Preprinted on standard A3 paper; horizontal format. The entry for a single client spans one page. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, registers may be retained in active storage for 2 years after the last entry in the register and retained in inactive storage for 7 years after the last entry in the register. |
| **Data compilation procedures** | This register collects data required for two indicators. Both are summed directly from the register at the end of the month.   * Abortion Care, Indicator A1.4.   + Sum number of safe abortions performed in register at end of month. * Maternal Death Rate (Institutional), Indicator A1.7.   + Sum number of maternal deaths in register at end of month. |

## 3 Annex 3: Expanded program on immunization (EPI) and Growth Monitoring

### 3.1 Immunization registers and tallies

| 3.1.1 Infant immunization and growth monitoring register | |
| --- | --- |
| **Purpose** | Longitudinal record of immunizations and growth monitoring provided to infants (children under 1 year of age and those completing the under 1 immunizations)  a. The record of immunization and growth monitoring for a single child on a single line supports continuity and quality of care.  b. The Road to Health card, which records a single child’s immunizations and monitors growth, is retained by the child’s care giver.  This register collects data required for seven indicators:   * Immunization coverage (5 indicators) * Vaccine wastage rate * Proportion of moderate / severe malnutrition |
| **Who maintains** | *Service provider* completes the information required by the register and Road to Health card as service is provided |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | Immunization room. |
| **Format of instrument** | Preprinted on standard A3 paper; horizontal format. The entry for a single client spans one page. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, registers may be retained in active storage for 2 years after the last entry in the register and retained in inactive storage for 7 years after the last entry in the register. |
| **Data compilation procedures** | Data for all indicators collected through this register are recorded on two tallies – one for immunization services and one for growth monitoring. Both tallies – *EPI tally sheet for all immunizations* (see Section 3.1.3, below) and *Growth monitoring tally sheet* (see Section 3.2.2, below) – are kept with the register. All vaccinations and growth monitoring observations are tallied when the service is given. If this instruction is not observed, there is a high risk that vaccinations and growth monitoring results will be miscounted because the process of tallying from a longitudinal register that contains services given at several different times is error-prone. The tallies are kept with register until end of month data compilation, then moved to the archive maintained by HMIS in-charge.  Vaccinations are tallied on the *EPI tally sheet for all immunizations* (see Section 3.1.3, below). Antigens for which coverage is reported are tallied individually for under ones. All other doses are used to calculate vaccine wastage and are tallied by vaccine and age.  The number of under 3s in each Weight for Age (WFA) category is tallied on the *Growth monitoring tally sheet* (see Section 3.2.2, below): normal nutrition (>=80% WFA); with moderate malnutrition (<80% and >=60% WFA); and with severe malnutrition (<60% WFA). |

| 3.1.2 Tetanus Toxoid (TT) immunization register | |
| --- | --- |
| **Purpose** | Longitudinal record of tetanus toxoid (TT) immunizations provided to women of reproductive, or pre-reproductive, age.  a. The record of immunizations for a single woman on a single line supports continuity and quality of care.  This register collects data required for calculating one indicator   * Vaccine wastage rate |
| **Who maintains** | *Service provider* completes the information required by the register from the Woman’s Card. |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | Immunization room. |
| **Format of instrument** | Preprinted on standard A3 paper; horizontal format. The entry for a single client spans one page. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, registers may be retained in active storage for 2 years after the last entry in the register and retained in inactive storage for 7 years after the last entry in the register. |
| **Data compilation procedures** | TT vaccinations given are tallied on *EPI tally sheet for all immunizations* (see Section 3.1.3, below), which is kept with the register. All vaccinations are tallied when the service is given. If this instruction is not observed, there is a high risk that vaccinations will be miscounted because the process of tallying from a longitudinal register that contains services given at several different times is error-prone. The tally is kept with register until end of month data compilation, then moved to the archive maintained by HMIS in-charge. |

| 3.1.3 EPI tally sheet for all immunizations | |
| --- | --- |
| **Purpose** | Daily tally of immunizations given to under 1s to calculate coverage, and of doses of infant antigens and tetanus toxoid given to all age groups to calculate vaccine wastage.  This tally collects data required for six indicators:   * Immunization coverage (5 indicators) * Vaccine wastage rate |
| **Who maintains** | *Service provider* tallies the required data from *Infant immunization and growth monitoring register* (see Section 3.1.1, above) and *Tetanus Toxoid (TT) immunization register* (see Section 3.1.2, above). |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | Kept with the immunization register with which it is used – either *Infant immunization and growth monitoring register* (see Section 3.1.1, above) or *Tetanus Toxoid (TT) immunization register* (see Section 3.1.2, above). After end of month data compilation, tally sheet is moved to the archive maintained by HMIS in-charge. |
| **Format of instrument** | Preprinted on single sheet of standard A4 paper; vertical format. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, tallies may be retained in active storage for 2 years after the last date on the tally and retained in inactive storage for 7 years after the last date on the tally. |
| **Data compilation procedures** | This tally collects data required for five immunization coverage indicators:   * Pentavalent first dose (under 1s), Indicator A3.1. * Pentavalent third dose (under 1s), Indicator A3.2. * Measles (under 1s), Indicator A3.3. * Full immunization (under 1s), Indicator A3.4. * Protection at Birth (PAB) against neonatal tetanus, Indicator A3.5.   and for calculating the vaccine wastage rate   * Vaccine wastage rate, Indicator A3.6.   All vaccinations are tallied when the service is given. If this instruction is not observed, there is a high risk that vaccinations will be miscounted because the process of tallying from a longitudinal register that contains services given at several different times is error-prone.  Antigens for which coverage is reported are tallied individually for under ones. All other doses are used to calculate vaccine wastage and are tallied by vaccine and age. |

| 3.2.1 Growth monitoring register | |
| --- | --- |
| **Purpose** | Longitudinal record of growth monitoring provided to children who have completed their infant immunizations, but who are below 3 years of age.  a. The record of growth monitoring for a single child on a single line supports continuity and quality of care.  b. The Road to Health card, which records a single child’s immunizations and monitors growth, is retained by the child’s care giver.  This register collects data required for one indicator.   * Proportion of moderate / severe malnutrition |
| **Who maintains** | *Service provider* completes the information required by the register and Road to Health card as service is provided |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | Growth monitoring room. |
| **Format of instrument** | Preprinted on standard A4 paper; horizontal format. The entry for a single client spans one page. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, registers may be retained in active storage for 2 years after the last entry in the register and retained in inactive storage for 7 years after the last entry in the register. |
| **Data compilation procedures** | This register collects data required for calculating one indicator   * Proportion of moderate / severe malnutrition amongst under 3s weighed, Indicator A2.2.   The number of under 3s in each Weight for Age (WFA) category is tallied on the *Growth monitoring tally sheet* (see Section 3.2.2, below): normal nutrition (>=80% WFA); with moderate malnutrition (<80% and >=60% WFA); and with severe malnutrition (<60% WFA).  All growth monitoring observations are tallied when the service is given. If this instruction is not observed, there is a high risk that growth monitoring results will be miscounted because the process of tallying from a longitudinal register that contains services given at several different times is error-prone. The tally is kept with register until end of month data compilation, then moved to the archive maintained by HMIS in-charge. |

| 3.2.2 Growth monitoring tally sheet | |
| --- | --- |
| **Purpose** | Daily tally of number of children under 3 years weighed in each Weight for Age (WFA) category (≥ 80% WFA, <80% and ≥ 60% WFA, and <60% WFA) of each child weighed.  This tally collects data required for calculating one indicator   * Proportion of moderate / severe malnutrition |
| **Who maintains** | *Service provider* tallies the required data from *Infant immunization and growth monitoring register* (see Section 3.1.1, above) and *Growth monitoring register* (see Section 3.2.1, above). |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | Kept with the Growth Monitoring register with which it is used – either *Infant immunization and growth monitoring register* (see Section 3.1.1, above) or *Growth monitoring register* (see Section 3.2.1, above). After end of month data compilation, tally sheet is moved to the archive maintained by HMIS in-charge. |
| **Format of instrument** | Preprinted on single sheet of standard A4 paper; vertical format. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, tallies may be retained in active storage for 2 years after the last date on the tally and retained in inactive storage for 7 years after the last date on the tally. |
| **Data compilation procedures** | This tally collects data required for calculating one indicator   * Proportion of moderate / severe malnutrition amongst under 3s weighed, Indicator A2.2.   All growth monitoring observations are tallied when the service is given. If this instruction is not observed, there is a high risk that numbers of children in each weight category will be miscounted because the process of tallying from a longitudinal register that contains services given at several different times is error-prone.  The number of under 3s in each Weight for Age (WFA) category is tallied: normal nutrition (>=80% WFA); with moderate malnutrition (<80% and >=60% WFA); and with severe malnutrition (<60% WFA). |

## Curative Services

At Health Centers, Clinics, and Hospitals a Patient Card, described above in Section 1.1.3, is used to record clinical details in both OPD and IPD. Specialty and chronic services, such as TB/Leprosy and HIV/AIDS, also have special cards and registers. Additionally, support services such as laboratory, radiology, and pharmacy also have special forms to guide and record their services. All facilities – HCs, Clinics, and Hospitals – summarize OPD and IPD services provided on registers, and data are compiled from registers, either directly or with the assistance of tally sheets.

Curative and chronic care services use five categories of recording formats: Outpatient Department (OPD), Inpatient Department (IPD), Support Services, HIV/AIDS, and TB/Leprosy.

Formats and instructions for OPD, IPD, and multiple services are in *Annex 4: OPD and IPD Cards, Registers, Tallies, and Instructions*. Formats and instructions for HIV/AIDS and TB and Leprosy are in *Annex 5*.

## 4 Annex 4: OPD, IPD, and multiple services

### 4.1 Outpatient department (OPD)

| 4.1.1 Integrated Management of Newborn and Child Illness (IMNCI) Register (for under 5s) | |
| --- | --- |
| **Purpose** | Records clinical signs and symptoms, assessment, and treatment or referral of illness amongst children under 5 years of age.  a. Format of register guides assessment according to IMNCI principles.  b. Each column on the line shows the results of one step in IMNCI assessment and provides a record that demonstrates the quality of care.  This register collects data required for seven indicators   * Top 10 causes of morbidity amongst children under 5 years * Morbidity for specific diseases (4 indicators) * Outpatient department (OPD) utilization (2 indicators)   and data required for disease reporting:   * + Cases according to HMIS disease classification |
| **Who maintains** | *Care provider* records the information required by the register as service is provided.  Summary of diagnosis and treatment should also be entered on Patient Card. Diagnosis should be entered on Summary Sheet. |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | OPD room for under 5s. |
| **Format of instrument** | Preprinted on standard A3 paper; horizontal format. The entry for a single child spans two pages. Two registers are used:  a. one for children under 2 months of age and  b. one for children between 2 and 60 months.  This register is designed and distributed by the IMNCI technical support group. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, registers may be retained in active storage for 2 years after the last entry in the register and retained in inactive storage for 7 years after the last entry in the register. |
| **Data compilation procedures** | IMNCI register data required to calculate the morbidity and utilization indicators are tallied directly from this register. Immediately after service is provided (preferred procedure), or at the end of the day (alternative procedure for a busy facility), the attendance type and disease classification by age and gender are entered into the facility’s tally sheets by the provider.  See description of *OPD Diagnosis and attendance tally (HC, Clinic, and Hospital)* (see Section 4.1.3, below).  The tally is kept with register until end of month data compilation, then moved to archive maintained by HMIS in-charge. |

| 4.1.2 OPD abstract register | |
| --- | --- |
| **Purpose** | Records demographic information, type of attendance, diagnosis, referral, PIHCT counseling, and costs and charges for the first OPD attendance (new case) for a condition that requires curative care. (Currently, the financial information is not recorded.)  a. All first attendances for individuals 5 years of age and older should be recorded in this register.  b. This register should also be used for under 5s if the provider uses the Patient Card to record services for under 5s instead of the IMNCI register.  c. Followup attendance for the same condition is recorded on the *OPD Repeat attendance tally (for injection / dressing room)* (see Section 4.1.4, below).  This register collects data required for nine indicators:   * Main causes of morbidity and mortality (2 indicators) * Morbidity for specific diseases (4 indicators) * Provider Initiated HIV Counseling and Testing (PIHCT) * Outpatient department (OPD) utilization (2 indicators)   and data required for disease reporting:   * Cases according to HMIS disease classification |
| **Who maintains** | *Care provider* records the information required by the register from the Patient Card immediately after service is provided (preferred procedure) or at the end of the day (alternative procedure for a busy facility). |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | OPD room for 5 years and older. |
| **Format of instrument** | Preprinted on standard A3 paper; horizontal format. The entry for a single person spans one page. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, registers may be retained in active storage for 2 years after the last entry in the register and retained in inactive storage for 7 years after the last entry in the register. |
| **Data compilation procedures** | Data required to calculate morbidity, PIHCT, and utilization indicators are tallied from this register. The tally may be made by the provider at the same time the case is registered in the abstract register, or the HMIS officer may tally from the register prepared by the provider at the end of the day. See description of *OPD Diagnosis and attendance tally* (see Section 4.1.3, below), and *PIHCT Tally* (see Section 5.1.1, below).  The tally is kept with register until end of month data compilation, then moved to archive maintained by HMIS in-charge. |

| 4.1.3 OPD Diagnosis and attendance tally | |
| --- | --- |
| **Purpose** | Daily tally of OPD attendance and new cases by age category and gender.  This tally collects data required for eight indicators   * Main causes of morbidity and mortality (2 indicators) * Morbidity for specific diseases (4 indicators) * Outpatient department (OPD) utilization (2 indicators)   and data required for disease reporting:   * Cases according to HMIS disease classification |
| **Who maintains** | *Care provider* tallies the required data from *Integrated Management of Newborn and Child Illness (IMNCI) Register (for under 5s)* (see Section 4.1.1, above). *Care provider* or HMIS officer tallies the required data from *OPD abstract register* (see Section 4.1.2, above). |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | Kept with the register with which it is used – *Integrated Management of Newborn and Child Illness (IMNCI) Register (for under 5s)* (see Section 4.1.1, above) or *OPD abstract register* (see Section 4.1.2, above). After end of month data compilation, tally sheet is moved to the archive maintained by HMIS in-charge. |
| **Format of instrument** | Preprinted on two sheets of standard A3 paper; horizontal format. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, tallies may be retained in active storage for 2 years after the last date on the tally and retained in inactive storage for 7 years after the last date on the tally. |
| **Data compilation procedures** | This tally collects data required for eight indicators   * Top 10 causes of morbidity amongst children under 5 years, Indicator B1.1. * Top 10 causes of morbidity amongst persons 5 years and above, Indicator B1.3. * Malaria morbidity and case fatality rate, Indicator B2a * Measles, Indicator B2e.4 * Neonatal tetanus, Indicator B2e.5 * Dracunculiasis (Guinea worm), Indicator B2e.6 * Outpatient (OPD) attendance per capita, Indicator D1.2 * Outpatient (OPD) visits per practitioner per day, Indicator D1.3   and data required for disease reporting:   * Cases according to HMIS disease classification   + Disaggregated by age (<5 years; >=5 and <15 years; >= 15 years)   + Disaggregated by gender   Ideally all cases are tallied at the time service is provided and immediately after details are entered in *IMNCI register* (see Section 4.1.1, above) or *OPD abstract register* (see Section 4.1.2, above). In a busy facility this may be not be practical. In this situation, the *OPD abstract register* may be tallied at the end of the day by the care provider or HMIS officer. The *IMNCI register* may also be tallied at the end of the day; the care provider should do this IMNCI tally, because it requires technical understanding of the IMNCI protocols and register. |

| 4.1.4 OPD Repeat attendance tally (for injection / dressing room) | |
| --- | --- |
| **Purpose** | Daily tally of OPD attendance that is followup for an earlier OPD first attendance for curative care and in which all services are provided in the injection / dressing room.  This tally collects data required for two indicators   * Outpatient department (OPD) utilization (2 indicators) |
| **Who maintains** | *Service provider* tallies attendance as service is provided in the injection / dressing room. |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | A copy of the *OPD Repeat attendance tally* should be kept in each injection and dressing room so that followup visits that require only those services can be tallied by the *service provider*.  After end of month data compilation, the tally sheet is moved to the archive maintained by HMIS in-charge.  Repeat attendances seen in the OPD room are recorded in the *IMNCI register* (see Section 4.1.1, above) or *OPD abstract register* (see Section 4.1.2, above) and are tallied as repeat attendances on the *OPD Diagnosis and attendance tally* (see Section 4.1.3, above). These attendances should not be tallied on the *OPD repeat attendance tally (for injection / dressing room)* that is described in this section. |
| **Format of instrument** | Preprinted on one sheet of standard A3 paper; horizontal format. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, tallies may be retained in active storage for 2 years after the last date on the tally and retained in inactive storage for 7 years after the last date on the tally. |
| **Data compilation procedures** | This tally collects data required for two indicators   * Outpatient (OPD) attendance per capita, Indicator D1.2 * Outpatient (OPD) visits per practitioner per day, Indicator D1.3   All repeat attendances seen only at the injection / dressing room must be tallied as the service is provided; otherwise the information will be lost. |

### 4.2 IPD

| 4.2.1 Admission and discharge card | |
| --- | --- |
| **Purpose** | One card is completed for every admission / discharge.  a. on admission: Records medical, demographic, contact, and administrative information  b. records medical, demographic, cost, and administrative information  This card is the data source for thirteen indicators:   * Main causes of morbidity and mortality (5 indicators) * Morbidity and mortality for specific diseases (5 indicators) * Inpatient department (IPD) utilization (3 indicators)   and data required for disease reporting:   * Cases and deaths according to HMIS disease classification |
| **Who maintains** | *Admitting and discharging medical and administrative officers* complete the required information. The *Patient Card* (see Section 1.1.3, above) is a primary source of medical data. |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | Kept in individual folder, except during administrative and HMIS processing for admission and discharge. |
| **Format of instrument** | Preprinted, front and back, on heavy stock half-size A4. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, records may be retained in active storage for 5 years after last visit or death and retained in inactive storage for 10 years after last visit or death. |
| **Data compilation procedures** | Data required to calculate disease and utilization indicators are summarized on the *Admission / Discharge Card*. IPD demographic, diagnostic, condition at discharge, and length of stay from *Admission and Discharge Card* are summarized in *OPD admission and discharge register* (see Section 4.2.2, below) and further compiled for reporting. |

| 4.2.2 IPD admission and discharge register | |
| --- | --- |
| **Purpose** | Records demographic information, admission and discharge dates, HMIS disease classification, status at discharge, referral, PIHCT counseling, and costs and charges for a single admission. (Currently, the financial information is not recorded.)  a. Recording admission and discharge data for each admission on a single line facilitates review of care and calculation of length of stay.  This register collects data required for fourteen indicators   * Main causes of morbidity and mortality (5 indicators) * Morbidity and mortality for specific diseases (5 indicators) * Provider Initiated HIV Counseling and Testing (PIHCT) (1 indicator) * Inpatient department (IPD) utilization (3 indicators)   and data required for disease reporting:   * Cases and deaths according to HMIS disease classification |
| **Who maintains** | *HMIS officer* or *Care provider* records the information required by the register from the Patient Card and Admission Discharge Card immediately after admission and discharge (preferred procedure) or at the end of the day (alternative procedure for a busy facility). |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | IPD records room (preferred) or ward (alternative). |
| **Format of instrument** | Preprinted on standard A3 paper; horizontal format. The entry for a single person spans one page. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, registers may be retained in active storage for 2 years after the last entry in the register and retained in inactive storage for 7 years after the last entry in the register. |
| **Data compilation procedures** | The data for three utilization indicators collected through this register are summed directly from the register at the end of the month.   * Admission rate, Indicator D1.4.   + Sum admissions in register at end of month. * Bed Occupancy Rate (BOR), Indicator D1.5.   + Sum discharges in register at end of month. * Average Length of Stay, Indicator D1.6.   + Sum length of stay in days at end of month.   Data required to calculate morbidity and mortality and PIHCT indicators are tallied from this register. Immediately after the discharge register entry is completed, the HMIS officer enters the diagnosis by age, gender, and outcome into the facility’s *IPD morbidity and mortality tally* (see Section 4.2.3, below) and the PIHCT data into the *PIHCT tally* (see Section 5.1.1, below). The tallies are kept with register until end of month data compilation, then moved to archive maintained by HMIS in-charge. |

| 4.2.3 IPD morbidity and mortality tally | |
| --- | --- |
| **Purpose** | Daily tally of IPD cases and deaths by age category and gender.  This tally collects data required for ten indicators   * Main causes of morbidity and mortality (5 indicators) * Morbidity and mortality for specific diseases (5 indicators)   and data required for disease reporting:   * Cases and deaths according to HMIS disease classification |
| **Who maintains** | *HMIS officer* (preferred) or *Care provider* (alternative) tallies the required data from *IPD admission and discharge register* (see Section 4.2.2, above). |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | Kept with the register with which it is used – *IPD admission and discharge register* (see Section 4.2.2, above). After end of month data compilation, tally sheet is moved to the archive maintained by HMIS in-charge. |
| **Format of instrument** | Preprinted on two sheets of standard A3 paper; horizontal format. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, tallies may be retained in active storage for 2 years after the last date on the tally and retained in inactive storage for 7 years after the last date on the tally. |
| **Data compilation procedures** | This tally collects data required for ten indicators   * Top 10 causes of morbidity amongst children under 5 years, Indicator B1.1. * Top 10 causes of mortality amongst children under 5 years, Indicator B1.2. * Top 10 causes of morbidity amongst persons 5 years and above, Indicator B1.3. * Top 10 causes of mortality amongst persons 5 years and above, Indicator B1.4. * Inpatient mortality rate, Indicator B1.5. * Malaria morbidity and case fatality rate, Indicator B2a * Case fatality rate for meningitis [inpatients], Indicator B2e.1 * Measles, Indicator B2e.4 * Neonatal tetanus, Indicator B2e.5 * Dracunculiasis (Guinea worm), Indicator B2e.6   and data required for disease reporting:   * Cases and deaths according to HMIS disease classification   + Disaggregated by age (<5 years; >=5 and <15 years; >= 15 years)   + Disaggregated by gender |

### 4.3 Registers used by multiple services at OPD and IPD

| 4.3.1 Operation register | |
| --- | --- |
| **Purpose** | Records patient’s demographic information; reason for, type and outcome of operation; and care providers. |
| **Who maintains** | *Care provider* records the information required by the register. |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | Not specified. |
| **Format of instrument** | Preprinted on standard A3 paper; horizontal format. The entry for a single person spans one page. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, registers may be retained in active storage for 2 years after the last entry in the register and retained in inactive storage for 7 years after the last entry in the register. |
| **Data compilation procedures** | No data compiled from Operation Register. |

| 4.3.2 Referral register | |
| --- | --- |
| **Purpose** | Records patient’s demographic information; reason for and destination of referral; and care providers. |
| **Who maintains** | *Care provider* records the information required by the register. |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | Not specified. |
| **Format of instrument** | Preprinted on standard A3 paper; horizontal format. The entry for a single person spans one page. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, registers may be retained in active storage for 2 years after the last entry in the register and retained in inactive storage for 7 years after the last entry in the register. |
| **Data compilation procedures** | No data compiled from Referral Register. |

### 4.4 Support Services

| 4.4.1 Tracer drug availability | |
| --- | --- |
| **Purpose** | Monthly record of tracer drug availability.  a. This form tracks whether each tracer drug was available whenever it was needed during the month. If the drug is unavailable once when needed, the drug is reported as unavailable during the month.  b. This method of tracking stock outs provides a simple way to estimate drug availability until a logistics system is in place that can track the number of days a tracer drug is out of stock.  This tally collects data required for one indicator:   * Essential drugs availability |
| **Who maintains** | *Service provider / dispenser / pharmacist* ticks a month if a drug was requested but unavailable. |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | Logistics / store room or pharmacy. After end of month data compilation, tally sheet is moved to the archive maintained by HMIS in-charge. |
| **Format of instrument** | Preprinted on standard A4 paper; horizontal format. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, tally sheets may be retained for 5 years and then discarded. |
| **Data compilation procedures** | This tally collects data required for one indicator:   * Essential drugs availability, Indicator C4.1   If there is no tick in the month, the drug is reported as available all month. If there is a tick in the month, the drug is reported as not available all month. |

| 4.4.2 Tracer drug days out of stock tally | |
| --- | --- |
| **Purpose** | Monthly record of days tracer drug out of stock.  a. This form tracks the number of days the drug was out of stock.  b. This method of tracking drug availability requires a logistics system that can track the number of days a tracer drug is out of stock.  This tally collects data required for one indicator:   * Average stockout duration |
| **Who maintains** | *Service provider / dispenser / pharmacist* enters the number of days in a month that the drug was out of stock. |
| **Where used** | Health Center / Clinic / Hospital that have a logistics management information system (LMIS) that tracks days of stock outs. |
| **Location in facility:** | Logistics / store room or pharmacy. After end of month data compilation, tally sheet is moved to the archive maintained by HMIS in-charge. |
| **Format of instrument** | Preprinted on standard A4 paper; horizontal format. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, tally sheets may be retained for 5 years and then discarded. |
| **Data compilation procedures** | This tally collects data required for one indicator:   * Average stockout duration, Indicator C4.2   The total number of days in the month that each drug was out of stock is calculated. |

## 5 Annex 5: HIV / AIDS and TB & Leprosy

### 5.1 Provider Initiated HIV Counseling and Testing (PIHCT)

| 5.1.1 Provider Initiated HIV Counseling and Testing (PIHCT) Tally | |
| --- | --- |
| **Purpose** | Daily count of Provider Initiated HIV Counseling and Testing (PIHCT) services.  a. Tests offered, tests performed, and test results  b. by age group (under 15 years, 15-24 years, and 25 and above) and gender.  c. ANC and TB PIHCT are tallied on the cards and registers for those services. All other services use this PIHCT tally.  This tally collects data required for one indicator.   * Provider Initiated HIV Counseling and Testing (PIHCT) Services |
| **Who maintains** | *Care provider* or *HMIS officer* completes the tally   * at the end of the day, from appropriate register, for OPD and IPD – *OPD abstract register* (see Section 4.1.2, above) and *IPD admission and discharge register* (see Section 4.2.2, above); * immediately after client receives service, for FP – *Family Planning (FP) register* (see Section 2.2.1, above). |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | Kept with the register with which it is used – *OPD abstract register*, *IPD admission / discharge register*, and *FP register*. After end of month data compilation, tally sheet is moved to the archive maintained by HMIS in-charge. |
| **Format of instrument** | Preprinted on standard A3 paper; horizontal format. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, tallies may be retained in active storage for 2 years after the last date on the tally and retained in inactive storage for 7 years after the last date on the tally. |
| **Data compilation procedures** | This tally collects data required for one indicator: PIHCT Services, Indicator B2d.3: Tests offered, performed, and positive   * + Disaggregated by age (<15 years; >=15 and <25 years; >= 25 years)   + Disaggregated by gender   These data are summed directly from the PIHCT tally. |

### 5.2 Voluntary counseling and testing (VCT)

| 5.2.1 Voluntary counseling and testing (VCT) register | |
| --- | --- |
| **Purpose** | Records client’s demographic information, HIV testing, STD and TB screening, and referral.  This register collects data required for one indicator   * Voluntary Counseling and Testing (VCT) Services |
| **Who maintains** | *Service provider* records the information required by the register as the service is provided. |
| **Where used** | Health Center / Clinic / Hospital where VCT service is provided. |
| **Location in facility:** | VCT room. |
| **Format of instrument** | Preprinted on standard A3 paper; horizontal format. The entry for a single person spans one page. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, registers may be retained in active storage for 2 years after the last entry in the register and retained in inactive storage for 7 years after the last entry in the register. |
| **Data compilation procedures** | At the end of the day the provider tallies steps taken in counseling and testing   * whether counseled, whether accepted testing, and whether test positive * by age group (15-24 and 25 and older) * by gender   in the *VCT Tally* (see Section 5.2.2, below). The tallies are kept with register until end of month data compilation, then moved to archive maintained by HMIS in-charge. |

| 5.2.2 VCT Tally | |
| --- | --- |
| **Purpose** | Daily count of Voluntary Counseling and Testing (VCT) services.  a. Tests offered, tests performed, and test results  b. by age group (15-24 years and 25 and above) and gender.  This tally collects data required for one indicator.   * Voluntary Counseling and Testing (VCT) Services |
| **Who maintains** | *Service provider* completes the tally at the end of the day, from *VCT register* (see Section 5.2.1, above). |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | Kept with the register with which it is used – *VCT register*. After end of month data compilation, tally sheet is moved to the archive maintained by HMIS in-charge. |
| **Format of instrument** | Preprinted on standard A3 paper; horizontal format. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, tallies may be retained in active storage for 2 years after the last date on the tally and retained in inactive storage for 7 years after the last date on the tally. |
| **Data compilation procedures** | This tally collects data required for one indicator: VCT Services, Indicator B2d.2: Tests offered, performed, and positive   * + Disaggregated by age (15-24 years; and 25 years and above)   + Disaggregated by gender   These data are summed directly from the VCT tally. |

### 5.3 Pre-Antiretroviral therapy (PreART)

| 5.3.1 Pre-Antiretroviral therapy (PreART) register | |
| --- | --- |
| **Purpose** | Records client’s demographic information, HIV testing, TB treatment, referral, and enrollment in PreART treatment.  This register collects data required for one indicator   * Cumulative HIV care enrollment, Indicator B2d.7a |
| **Who maintains** | Completed by the *ART data clerk*, based on the intake and followup forms. |
| **Where used** | Health Center / Clinic / Hospital where PreART service is provided. |
| **Location in facility:** | PreART room. |
| **Format of instrument** | Preprinted on standard A3 paper; horizontal format. The entry for a single person spans one page. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, registers may be retained in active storage for 2 years after the last entry in the register and retained in inactive storage for 7 years after the last entry in the register. |
| **Data compilation procedures** | At the end of the day the *ART data clerk* tallies persons enrolled in PreART   * by age group (infants < 18 months, children 19-59 months, children 5-14 years) * by gender and pregnancy status (non-pregnant females > 14 years, pregnant females, and males > 14 years)   in the *Pre-ART Tally* (see Section 5.3.2, below).  The tallies are kept with register until end of month data compilation, then moved to archive maintained by HMIS in-charge. |

| 5.3.2 Pre-ART Tally | |
| --- | --- |
| **Purpose** | Daily tally and count of newly enrolled pre-ART patients by age group, gender, and pregnancy status.  This tally collects data required for one indicator.   * Cumulative HIV care enrollment |
| **Who maintains** | *ART data clerk* completes the tally at the end of the day, from *Pre-ART register* (see Section 5.3.1, above). |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | Kept with the register with which it is used – *Pre-ART register*. After end of month data compilation, tally sheet is moved to the archive maintained by HMIS in-charge. |
| **Format of instrument** | Preprinted on standard A4 paper; vertical format. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, tallies may be retained in active storage for 2 years after the last date on the tally and retained in inactive storage for 7 years after the last date on the tally. |
| **Data compilation procedures** | This tally collects data required for one indicator: Cumulative HIV care enrollment, Indicator B2d.7a   * by age group (infants < 18 months, children 19-59 months, children 5-14 years) * by gender and pregnancy status (non-pregnant females > 14 years, pregnant females, and males > 14 years)   These data are summed directly from the *Pre-ART tally*. |

### 5.4 Antiretroviral therapy (ART)

| 5.4.1 ART register | |
| --- | --- |
| **Purpose** | Records client’s demographic information, HIV testing, TB treatment, and ART treatment.  This register collects data required for three indicators   * Cumulative ART care enrollment * ART by regimen * ART survival rates |
| **Who maintains** | Completed by the *ART data clerk*, based on the intake and followup forms. |
| **Where used** | Health Center / Clinic / Hospital where ART service is provided. |
| **Location in facility:** | ART room. |
| **Format of instrument** | Preprinted on standard A3 paper; horizontal format. The entry for a single person spans two pages. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, registers may be retained in active storage for 2 years after the last entry in the register and retained in inactive storage for 7 years after the last entry in the register. |
| **Data compilation procedures** | At the end of the day the *ART data clerk* tallies persons enrolled in ART   * by age group (infants < 18 months, children 19-59 months, children 5-14 years) * by gender and pregnancy status (non-pregnant females > 14 years, pregnant females, and males > 14 years)   in the *ART Enrollment Tally* (see Section 5.4.2, below). These data are used to calculate Cumulative ART care enrollment, Indicator B2d.7b.  At the end of the month the *ART data clerk* tallies persons receiving ART   * by regimen   in the *ART Regimen Tally* (see Section 5.4.3, below). These data are used to calculate ART by regimen, Indicator B2d.7c.  At the end of the month the *ART data clerk* uses the *ART Register* to complete the HF ART Cohort Report Form (forms and procedures supplied by HAPCO), which provides the data required to calculate ART survival rates, Indicator B2d.7d.  The tallies are kept with register until end of month data compilation, then moved to archive maintained by HMIS in-charge. |

| 5.4.2 ART Enrollment Tally | |
| --- | --- |
| **Purpose** | Daily tally and count of newly enrolled ART patients by age group, gender, and pregnancy status.  This tally collects data required for one indicator.   * Cumulative ART care enrollment |
| **Who maintains** | *ART data clerk* completes the tally at the end of the day, from *ART register* (see Section 5.4.1, above). |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | Kept with the register with which it is used – *ART register*. After end of month data compilation, tally sheet is moved to the archive maintained by HMIS in-charge. |
| **Format of instrument** | Preprinted on standard A4 paper; vertical format. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, tallies may be retained in active storage for 2 years after the last date on the tally and retained in inactive storage for 7 years after the last date on the tally. |
| **Data compilation procedures** | This tally collects data required for one indicator: Cumulative ART care enrollment, Indicator B2d.7b   * by age group (infants < 18 months, children 19-59 months, children 5-14 years) * by gender and pregnancy status (non-pregnant females > 14 years, pregnant females, and males > 14 years)   These data are summed directly from the *ART tally*. |

| 5.4.3 ART Regimen Tally | |
| --- | --- |
| **Purpose** | Monthly tally and count of ART patients on each regimen at the end of the month.  This tally collects data required for one indicator.   * ART by regimen  |  |  | | --- | --- | | **ADULT REGIMENS** | **CHILD REGIMENS** | | ***Adult first line regimen*** | ***Child first line regimen*** | | 1a(30)=d4t(30)-3TC-NVP | 4a=d4T-3TC-NVP | | 1a(40)=d4t(40)-3TC-NVP | 4b=d4T-3TC-EFV | | 1b(30)=d4t(30)-3TC-EFV | 4c=AZT-3TC-NVP | | 1b(40)=d4t(40)-3TC-EFV | 4d=AZT-3TC-EFV | | 1c=AZT-3TC-NVP |  | | 1d=AZT-3TC-EFV |  | | ***Adult second line regimen*** | ***Child second line regimen*** | | 2a=ABC-ddl-LPV/R | 5a=ABC-ddl-LPV/R | | 2b=ABC+ddl-NFV | 5b=ABC+ddl-NFV | | 2c=TDF-ddl-LPV/R | 5c=TDF-ddl-LPV/R | | 2d=TDF-ddl-NFV | 5d=TDF-ddl-NFV | |
| **Who maintains** | *ART data clerk* completes the tally at the end of the month, from *ART register* (see Section 5.4.1, above). |
| **Where used** | Health Center / Clinic / Hospital |
| **Location in facility:** | Kept with the register with which it is used – *ART register*. After end of month data compilation, tally sheet is moved to the archive maintained by HMIS in-charge. |
| **Format of instrument** | Preprinted on standard A4 paper; vertical format. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, tallies may be retained in active storage for 2 years after the last date on the tally and retained in inactive storage for 7 years after the last date on the tally. |
| **Data compilation procedures** | This tally collects data required for one indicator: ART by regimen, Indicator B2d.7c  These data are summed directly from the *ART tally*. |

### 5.5 HIV Exposed Infant (HEI)

| 5.5.1 HIV exposed infant (HEI) register | |
| --- | --- |
| **Purpose** | Longitudinal record of HIV exposed infant’s demographic information, testing, and outcome at 18 months. |
| **Who maintains** | Register is completed by the *HEI data clerk*, based on the HEI followup card which is maintained and distributed by Paediatric AIDS program. |
| **Where used** | Health Center / Clinic / Hospital where HEI service is provided. |
| **Location in facility:** | HEI room. |
| **Format of instrument** | Preprinted on standard A3 paper; horizontal format. The entry for a single person spans one page. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, registers may be retained in active storage for 2 years after the last entry in the register and retained in inactive storage for 7 years after the last entry in the register. |
| **Data compilation procedures** | No HMIS data compiled from HEI register. |

### 5.6 Tuberculosis – Directly Observed Short Course (TB / DOTS)

| 5.6.1 TB (DOTS) register | |
| --- | --- |
| **Purpose** | Records TB patient’s demographic information, diagnosis, HIV/AIDS screening, intensive and continuation phase treatment, and treatment outcome.  This register collects data required for four indicators   * Tuberculosis (TB) case detection rate, Indicator B2b.1. * Treatment results of smear-positive pulmonary TB cases (DOTS cohort), Indicator B2b.2. * Proportion of registered TB patients who are tested for HIV, Indicator B2c.1. * Proportion of registered TB patients who are HIV positive, Indicator B2c.2. |
| **Who maintains** | *Service provider* completes the information required by the register according to DOTS protocol. |
| **Where used** | Health Center / Clinic / Hospital where TB/DOTS service is provided. |
| **Location in facility:** | TB/DOTS treatment room. |
| **Format of instrument** | Preprinted on standard A3 paper; horizontal format. The entry for a single person spans two pages. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, registers may be retained in active storage for 2 years after the last entry in the register and retained in inactive storage for 7 years after the last entry in the register. |
| **Data compilation procedures** | Data are compiled quarterly by *TB control officer* for analysis of cohort completing treatment in current quarter. |

### 5.7 Leprosy

| 5.7.1 Leprosy register | |
| --- | --- |
| **Purpose** | Longitudinal record of leprosy patient’s demographic information, diagnosis, treatment, and disability grade at end of treatment.  This register collects data required for four indicators   * New cases of leprosy, Indicator B2b.3. * Grade II disability rate among new cases of leprosy, Indicator B2b.4. * Leprosy cases amongst children less than 15 years of age, Indicator B2b.5. * Leprosy treatment completion rate, Indicator B2b.6. |
| **Who maintains** | *Service provider* completes the information required by the register according to leprosy program protocol. |
| **Where used** | Health Center / Clinic / Hospital where leprosy service is provided. |
| **Location in facility:** | Leprosy treatment room. |
| **Format of instrument** | Preprinted on standard A3 paper; horizontal format. The entry for a single person spans two pages. |
| **Archival procedures** | National and regional regulations for retention should be observed. If these regulations are unknown, registers may be retained in active storage for 2 years after the last entry in the register and retained in inactive storage for 7 years after the last entry in the register. |
| **Data compilation procedures** | Data are compiled quarterly by *leprosy control officer* for analysis of cohort completing treatment in current quarter. |

## 6 Annex 6: Private sector recording and reporting

Assessments of private sector hospitals and clinics show that most of them use a set of patient cards and registers to collect data for planning and management of the health institution as well as for reporting. Some of the formats used are substantially different from the public sector formats.

In order to help private providers to fill in the proposed reports, two options are given (or a combination of the two options):

A. Use the FMoH formats for registers and tally sheets.

B. This option may need revision in accord with changes in HMIS forms. Use a set of tally sheets specifically developed for the private sector. The following tally sheets are proposed (actual formats are in Annex 6):

1. Monthly Family Planning Acceptor Tally
2. Annual Family Planning Method Dispensed Count
3. Monthly Antenatal and Postnatal Care Tally
4. Monthly Safe Abortion Tally
5. Monthly Delivery Tally
6. Monthly Maternal and neonatal Institutions Deaths
7. Monthly EPI Immunization Tally
8. Monthly Provider Initiated HIV Counseling and Testing (PIHCT) Tally
9. Monthly OPD New And Repeat Attendance Tally
10. Monthly IPD Admission, Death, and Discharge Tally

For more complex reporting requirements the standard FMOH registers and recording tools should be used (HIV/AIDS and TB). If tally sheets are used, FMOH has the authority to review the private facility’s recording instruments and procedures to ensure that the data reported meets quality standards.

# Section 2: Intrafacility information flow

## 2.1 Integrated patient/client records

The first step in integrating information and using it to improve service begins with patient / client care. All medical records for an individual which are kept within the facility should be available to a care provider when services are provided. Without as complete knowledge as possible of a person’s medical history, a patient may be misdiagnosed or inappropriately treated. The HMIS/M&E include three facility record keeping procedures that significantly improve the integration of medical records, their availability to service providers, and their suitability for use with the emerging health insurance initiative.

1. **Unique Medical Records Number (MRN) for each client / patient.**  This number remains constant over time and across all services in a single facility. Ideally this number would be unique nationwide; this is a requirement for nationwide insurance schemes that cover multiple providers. Within a single facility, it links all the information related to a specific individual.
2. **Individual folder with unique MRN that contains medical information from different departments, from both IPD and OPD, and from preventive and curative services**. Each individual has a folder, kept at the health facility, which contains all of the medical records accumulated during service provision at the facility. This includes all client/patient cards, laboratory forms, etc. All of the individual recording instruments: cards, registers, summary sheets, etc contain fields that link to the MRN.

The folders are kept in the card room and filed by MRN, so the individual folders for a given household are filed together. The care provider can then easily locate the records for other family members if this information is needed. This method of filing combines the need for confidentiality, even within families, with the advantages of a comprehensive perspective offered by a family folder.

1. **Summary sheet** in each individual’s folder which records the visit date, service, outcome, cost, etc on a single line for each visit to the facility. The summary sheet serves as brief history of the individual’s clinical and preventive service interactions with the facility.

## 2.2 Implications for client / patient flow

An individual is required to have a MRN to receive service at the facility. In order to make comprehensive medical records available to all care providers, records for all services should be kept in the integrated folder, which is filed by MRN in the Card Room. If the individual is not registered at the facility, registration, which includes receipt of a MRN and integrated folder, is required before service can be provided. There are no exceptions to this rule.[[4]](#footnote-4) A patient previously registered at the facility goes directly to the Card Room to initiate service. In this case, the integrated folder and summary sheet are retrieved using the individual’s MRN. The integrated folder for both newly and previously registered individuals is sent to the service room via messenger.

In order to maintain the reduced waiting time for essential public health services, a “fast track” for access to these services should be maintained in the Card Room. “Fast track” services are immunization, ANC, PNC, under 5 OPD, TB/Leprosy, and HIV/AIDS specialty services. Ideally the “fast track” is implemented with a separate window where individuals attending these services notify their presence to have their records taken to the service room. If a separate window is infeasible, a separate “fast track” queue should be set up.

## 2.3 Implementation of integrated medical records

The following steps should be taken to implement the integrated medical records system in each facility:

1. **Announcement to staff by facility head.**  The first step in integrating the medical records is for the facility head to explain the procedural changes and their rationale to the staff.
2. **Orientation and training of Card Room clerks.**  Card Room clerks should be oriented in the new procedures and the reasons for introducing them so they can explain the new procedures to clients and patients. The clerks should be trained in assigning a unique MRN, in completing the demographic information on the outside of the integrated card, in filing the cards, and in serving the “fast track” to minimize waiting time.
3. **Establish “fast track” in Card Room.**  A “fast track” window or queue should be established to minimize waiting time for immunization, ANC, PNC, under 5 OPD, TB/Leprosy, and HIV/AIDS specialty services.
4. **Signage.**  The “fast track” line and new procedures should be explained on signs clearly posted at the entrance to the facility and in the Card Room.
5. **Assignment of MRN and integrated folder.**  Each client and patient should be assigned a MRN and integrated folder. A previously registered individual should be assigned a MRN and folder at their first attendance after the new procedures are established. Their existing medical records, from all services, including the existing OPD card and IPD folder, should be inserted into the new integrated folder.
6. **Filing the integrated folder during the pilot test.**  During the pilot test the integrated folders should be filed separately, in numeric order, on a special shelf. This will aid in evaluating the implementation of the integrated folder system.

# Section 3: HMIS reporting forms

The HMIS reporting formats collect and transfer the data required to calculate the indicators used in performance monitoring. The data are gathered from the client / patient encounter formats, using tally sheets, and entered onto the reporting formats.

The quarterly and annual reporting formats for each level, along with the definition for each data item reported and the register item and tally source for each data item, are included in Annexes 7 (Service Delivery) and 8 (Diseases).

# Section 4: HMIS Data flow

**HMIS data flow**

|  |
| --- |
| **Summary.** Data flow should supply consumers with data in an effective and efficient manner.  **Who:** Most HMIS data are generated at facilities. Facilities check and review data, then forward it to their designated administrative office (usually WorHO). The administrative office aggregates the data it receives, adds its own administrative data, monitors its own performance based on these reported and self-generated data, and forwards the HMIS report to the next level.  The HMIS gathers data from all participating facilities, including MOH, NGO, private for profit, and other governmental organizations. The facilities are grouped according to level of service.   * Health Posts provide community-based service, primarily preventive and promotive, along with simple curative care. Usually they are owned by the MOH/Communities. * Health Centers / Clinics usually provide primary care services. Some may provide more complex or specialized services; they may also have beds for observation or maternity cases. They may be owned by MOH, NGOs, private for profit, or other governmental organizations. * Hospitals provide a wide range of curative services, including inpatient service. Like Health Centers / Clinics, they may be owned by MOH, NGOs, private for profit, or other governmental organizations.   The administrative level that receives data from facilities aggregates the data by facility type and ownership. This aggregation methodology is maintained throughout the reporting chain so that even at the federal level it is possible to disaagregate data by facility type and ownership.  Other data that have an influence on health care provision may be available from other sectors, from surveys, etc. While these data may be important for health sector decision-making, they are not collected through the HMIS and are not a part of the HMIS data flow.  **What:** Facilities report on the services they provide, the disease cases they see, and on administrative data such as human resources, finances, and logistics. HMOs report administrative data and data from facilities in their jurisdiction. They disaggregate data by facility type and ownership.  **When:** Facilities aggregate and review their data monthly. They report to their administrative office quarterly. Administrative levels forward results quarterly. Annual reports include additional data that are not collected quarterly. These reports follow the same line and principles of disaggregation as the quarterly reports.  **How:** Data are transmitted through an integrated channel to assure standardization, consistency, and quality control. Facilities and HMOs form nodes on this channel. Each HI node may distribute to, and assemble data from, separate internal program or support departments. The HI may also report laterally to local government or other partners.  Routine data are assembled monthly and reported quarterly as described above. To respond to immediate events, particularly for the purpose of outbreak detection and control, the data channel has a fast track. Immediately notifiable disease data are transmitted via a yellow envelope (or electronic channel when available) directly to the designated disease prevention and control expert at each level. This expert notifies the next disease prevention and control expert in the reporting chain and the HMIS officer / in-charge at the same level. |

The following paragraphs provide a rationale for the data flow.

* **Consumers.**
* ***Monitoring frequency.*** Each consumer has its own frequency for monitoring programs and diseases. In general, facilities are expected to monitor their performance monthly, while administrative offices monitor performance quarterly or less frequently.
* ***Reporting frequency.*** Quarterly from facility to woreda / subcity; quarterly from woreda / subcity onwards. Facilities analyze their performance monthly and report to woredas / subcities quarterly. Woredas report onwards quarterly, depending on regional guidelines; regions report to FMOH quarterly.
* ***Reporting line.*** The reporting line follows the supervisory line, with health institutions reporting to their supervising institutions. In general, this means that Health Posts and Health Centers / Clinics report to the woreda / subcity; hospitals to the zone / region; woredas to the zone / region; zones to region; regions to FMOH.

There is an additional need for exchange of information between institutions that have a collaborative relationship. For example, Health Posts collaborate with the local Health Center for service delivery; similarly Health Posts collaborate with the kebele administration. The woreda in which a hospital is located has a particular interest in hospital performance because many of its services may be delivered to woreda residents. Administrative offices have a collaborative relationship with local governing bodies that fund their operations. These “partnership” reporting channels may vary from location to location and are be used as the need arises. The “supervisory” reporting channel is fixed; its guidelines must be strictly observed to ensure completeness of reporting and to avoid double counting.

* ***Level of detail.*** The level of detail needed at each level is determined by the indicators used for performance review. Clearly each woreda needs to know the performance of each of its facilities so that it can identify areas in need of support. Some indicators at the federal level are based on woreda performance. For example, the number and proportion of woredas with a VCT center, or with immunization coverage above 80%. In order to supply the information to calculate these indicators, details per woreda and facility type and ownership are needed at the national level. Therefore, from woredas onwards data per month, per facility type and ownership, per woreda, are required. (This HMIS implementation plan also includes an automated system in which this level of detail does not impose an excessive reporting burden.)

The inclusion of private sector facilities in the HMIS reporting flow provides an opportunity to monitor public private partnership in the implementation of programs such as HIV/AIDS, TB, disease notification, and Safe Motherhood. Disaggregation of indicators for these programs along public / private ownership lines will show the extent of this partnership. For the purposes of comparison, it is proposed that the three types of private sector clinics (small, medium, and large) be aggregated under the category of Health Center.

* ***Information and Communications Technology (ICT).*** At woreda level and upwards. Data analysis and transmission will be automated through data entry of facility data at the woreda level. At woreda level and upwards production of reports (tables, charts, and maps) will be automated. Data will be transmitted electronically, by CD, internet, or direct input into a data warehouse, depending on the infrastructure available.
* ***Special needs.*** The Epidemic Prevention and Control Unit has responsibility for detection of disease outbreaks and activation of control measures. The frequency of reporting for immediately notifiable diseases and for diseases under epidemic alert (those for which the number of cases has exceeded the alert threshold) varies from the routine monthly reporting. While the reporting line follows the supervisory channel, the reports need to be transmitted as quickly as possible to the responsible person through a “fast track” channel.

The manual “fast track HMIS channel” uses the yellow envelope practice currently employed to send information directly to the disease expert responsible for epidemic control at each level. With implementation of the electronic HMIS, the “fast track channel” will use electronic transmission.

* **Effectiveness.**
* ***Data quality.*** Data must be of sufficient quality to support decision-making. Poor quality data lead to poor decisions. Data reported through multiple channels is a known source of inconsistent data of undetermined quality.

When data flow through an integrated channel, it is possible to institute data quality checks and correction measures, and to train personnel in these quality assurance procedures. Data flowing through an integrated channel are also internally consistent and unambiguous. They reflect the same period of time and the same location; their definitions and collection protocols are known.

* **Efficiency.**
* ***Efficient flow.*** The flow is designed to minimize the time and costs in transmitting data between locations. The amount of data to be transmitted has already been decreased by the adoption of a revised indicator and disease list. The process of data transmission will be further streamlined in two ways. First, the BPR HMIS assessment identified duplication as a major source of inefficiency. Currently data are transmitted through multiple channels. Each channel adds overhead costs; integrating data transmission into an integrated channel will eliminate this duplication and its associated costs. Second, the introduction of Information and Communications Technology (ICT) to support data transmission will reduce the labor-associated recurrent data processing costs from woredas onwards.

**HMIS/M&E Reporting Flow Diagram**

**Health Post**

**Zonal Health Department**

**Regional Health Bureau**

**FMOH**

**International Bodies**

**WHO, UN, etc**

**Zonal Hospital**

**(MOH, NGO, private, etc)**

**Health Center /**

**Clinic**

**Woreda Council**

**Kabele Council**

**Regional Council**

**Council of Ministers**

**Other Ministries**

**Development Partners**

Routine supervisory (fixed) channel – monthly / quarterly / annual

Priority epidemic alert (fixed) channel – immediate / weekly

Partnership (variable) channel – monthly / quarterly / annual

(illustrative destinations – report destinations may be added or reduced)

**Woreda Health Office**

**Woreda Hospital**

**(MOH, NGO, private, etc)**

**Federal and Regional Hospitals report to the appropriate levels**

**HMIS/M&E Information Flow within HI**

Reports flow into HI through HMIS in-charge, who disseminates compiled information to responsible officer. These officers review and may provide feedback or additional processing.

**FH**

**officer**

**HMIS**

**in-charge**

**logistics**

**officer**

**Env-San**

**officer**

**DPC**

**officer**

**from reporting HI**

**to next HI in reporting line**

At the facility, HMIS reports cover a single month, according to the Ethiopian calendar. Monthly results, along with quarterly totals, are forwarded onwards each quarter. Annual reports cover the Ethiopian Fiscal Year (EFY), which begins in Hamle (July of Gregorian calendar) and ends in Sene (June of Gregorian calendar) of the next year.

**HMIS Reporting Schedule**

| **From** | **To** | **Report**  **arrival date at reporting destination** | **Frequency of** | | **Comment** |
| --- | --- | --- | --- | --- | --- |
| **reporting** | **aggregation / assessment** |
| Health post | WorHO with copy to HC | 8th of month | Quarterly and annual | Monthly | HC won’t include HP info in its report to WorHO |
| Health center | WorHO | 8th of month | Quarterly and annual | Monthly |  |
| District hospital | WorHO / ZHD | 8th of month | Quarterly and annual | Monthly |  |
| Regional / referral hospital | RHB / FMOH | 8th of month | Quarterly and annual | Quarterly |  |
| WorHO | ZHD / RHB | 15th of month | Quarterly and annual | Quarterly |  |
| ZHD | RHB | 21st of month | Quarterly and annual | Quarterly |  |
| RHB | FMOH | 28th of month | Quarterly and annual | Quarterly | Selected few activities may require quarterly reporting |

Note: Arrival date in all cases refers to the following month after each quarter or fiscal year. This schedule is intended to provide enough time for review of results to improve data quality, particularly at the facility.

This schedule presumes a manual system. Introduction of electronic transmission from the woreda onwards should reduce the transmission type for reports.

# Section 5: Data Quality

## 5.1 Checking Data Accuracy in Monthly Report

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

The following steps show how the quality of HMIS data can be estimated using a sample of 12 data elements and comparing the results with a standard LQAS table. Selected data elements from the monthly report submitted to the woreda are compared with the tallies and register sums that are the sources of these data elements. If a high proportion of the numbers are the same, then the quality of the data can be assumed to be high; if a low proportion is the same, then the quality of the data is low.

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

**Data Accuracy Check Sheet**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Month for which data accuracy is checked\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Randomly Selected Data Elements from the monthly reporting form | Figures from the Monthly report form (2) | Figures counted from registers & tallies (3) | Do figures from columns 2 & 3 Match? | |
|  |  |  | YES | NO |
| 1. Disease cases for a single disease / age / gender group |  |  |  |  |
| 2. OPD attendance for a single age / gender group |  |  |  |  |
| 3. Family planning monthly report section |  |  |  |  |
| 4. Maternal health monthly report section |  |  |  |  |
| 5. Child health |  |  |  |  |
| 6. EPI monthly report section |  |  |  |  |
| 7. Logistics |  |  |  |  |
| 8. TB (if service provided) |  |  |  |  |
| 9. HIV/AIDS (if service provided) |  |  |  |  |
| 10. |  |  |  |  |
| 11. |  |  |  |  |
| 12. |  |  |  |  |
| Total | | |  |  |

1. The total in number in the “Yes” column corresponds to the percentage of data accuracy in the following LQAS table. For example, if total “yes” number is 2, the accuracy level is between 30-35%; if total number in the “yes” column is 7, the accuracy level is between 65-70%.

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

1. Circle the data accuracy percentage and write it in section D3.2 of the monthly report and submit to the woreda office.
   * You could set a target for achievement in a specified period and use it for monitoring progress. The target can be broken down on monthly basis. For example, if data accuracy is improving by 5% on monthly basis, the correct match number should increase accordingly as shown in the LQAS table. As the correct match number increases compared to previous months, it reflects improvement in level of data accuracy.
   * Achievement of data accuracy level at 95% means a high level of accuracy and needs to be maintained at that level.

Note: Please note that with sample size of 12 data elements, the data accuracy ranges +15%. That means that if the data accuracy is 30%, the range is between 15% and 45%.

## 5.2 Completeness and Timeliness of Reporting

Reporting completeness (the proportion of reports expected that were received) and timeliness (the proportion of reports expected that were received on time) and important indicators of data quality. Completeness and timeliness are also HMIS indicators. If reports are incomplete, the data may give an inaccurate picture of performance, leading to poor decisions; if reports are late, then the information may not be available when needed to make a decision. The following table should be used by institutions that receive reports to summarize the completeness and timeliness of reporting.

**Reports Received**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name of** | **Hamle** | | **Nehase** | | **Meskerem…etc** | |
| **Reporting HI** | **Date received** | **Late?** | **Date received** | **Late?** | **Date received** | **Late?** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

# Glossary: Description of types of recording formats

**1. Central card room**: is a place where patients show up as they arrive at the facility and register for services. Each patient/client gets a unique registration number, called a **Medical Record Number (MRN)**, based on the serial number reached at the time of registration. Corresponding to the registration number, date, a few personal and residential data are entered on the **individual medical record folder** that will hold all of the client’s medical records from all services. The customer gets an individual **patient card** which will be inserted in the individual medical record folder and forwarded to the examination room. The examining practitioner records pertinent findings and treatments on card. At the end of the service, the individual medical record folder will be returned to the card room for proper filing. If the client happens to return another time for medical reasons, the card room clerk will pull the folder from its shelf and the recording process flows again.

In almost all cases, patients are charged with examination fees before they get registered and are examined at this point.

**2. Service identification card:** is a small piece of hard paper (card) that patients/clients get from facilities as they register for service. This card typically bears the name, address, date of registration, and MRN. The identification / registration information noted on the card is used to find customer's individual facility based medical records folder from the archive whenever he/she shows up another time for service. Customers have to securely keep this card at home and bring it with them whenever they revisit facility. Different type of cards kept by the client may also be issued by curative and preventive/promotive services units of the same facility.

**3. Individual patient card:** This is a card on which health professionals document detailed information pertaining to medical examinations/investigations and actions on a single customer. This card is issued during registration at first visit as described in #1 above. Facilities may also have different forms for curative and preventive/promotive services they provide.

**4. Registration book:** commonly used by preventive services and disease programs. They too are used for curative care in smaller health facilities where individual patient charts may not be available and in sick child clinics. In a classic situation, MRN, serial number, date, personal identification, medical assessments and services given are recorded. Customers are registered in this book in the order they come for the services. In many instances (EPI, ANC, FP, TB/LP) clients will have to make several repeat visits until they complete or terminate from the service. Such cases are registered once (first visit) and subsequent visits are simply checked along the same line by going back to the page (registration date/number) of first visit. This type of recording is called longitudinal.

Other services that require a single contact per episode of event (curative, delivery) customers are registered serially so longitudinal recording becomes unimportant. Each subsequent visit is registered as new.

**5. Departmental (administrative) register:** Unlike registration book (point 4, above) where service departments maintain detailed medical/health facts on patients and clients, here departments record a few identification information like card number, date, name and sex, type of service, etc. This record is useful mainly for administrative purposes like: estimating daily work load per practitioner, number of service users for reporting, retrieving client cards during revisit, follow up on legal cases, supervisors check, etc.

**6. Tally:** A sheet of paper with services listed on and blank space in front is used to mark the number of clients that used services. The tally in most places in Ethiopia is made by a forward slash ('**/'**) representing one service provided. When 4 slash marks have been made, the next mark (the fifth) crosses the previous four. This makes it easier to count the tally strokes. The tally is supposed to be done immediately or as soon as possible. The aim is to easily count the number of service users in a given period of time, basically for reporting, without having to go to individual client record or registration books.

# Section 6. Sources

[Medical Records Manual: A Guide for Developing Countries.](http://www.wpro.who.int/NR/rdonlyres/7FB74A3F-34F6-4C46-A9F0-1F0D52D04254/0/MedicalRecordsManual.pdf) WHO (WPR). 2006. <http://www.wpro.who.int/NR/rdonlyres/7FB74A3F-34F6-4C46-A9F0-1F0D52D04254/0/MedicalRecordsManual.pdf>

1. *HSDP-III Strategic Plan*, Section 3.12.5, p. 114. [↑](#footnote-ref-1)
2. The service and administrative records are readily available, and information can be derived from them at relatively small cost. Therefore, they are uniquely suited to provide indicators for timely and reliable decision making. *Health Metrics Network: A Framework and Standards for Country Health Information System Development, Second Edition*, WHO, 2007, describes the various sources of health information and their comparative advantages on pp. 28 *et. seq*. [↑](#footnote-ref-2)
3. Some client cards are retained by the client, such as the *Road to Health Card* for children. These are different from facility-based cards, and the rationale for using them or not differs from service to service. They are discussed below along with the registration formats recommended for each service. [↑](#footnote-ref-3)
4. Emergency services may be provided immediately, but the patient must be registered as soon as practical. This is the procedure currently followed. [↑](#footnote-ref-4)