Federal Ministry of Health

Ethiopian Health Management Information System: Data Recording and Reporting Procedures Manual

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Policy and Planning Directorate

July, 2017

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Purpose of this module

This manual is primarily intended for use by health workers at all levels of the health system who are involved in managing health related data. This document describes the procedures to be used for routine data collection and reporting at all levels of the health system in Ethiopia. Given the very dynamic nature of the health system, this document will be updated when information systems procedures are changed. It provides detail instructions for completing HMIS recording and reporting tools. In addition, reportable data elements and indicators from each recording tools are also described.

Organization of this manual

This manual is organized into three sections:

1. **Section 1:** Individual Medical Recording tools and its procedures: Provides information about the individual recording tools and how to complete the forms
2. **Section 2:** Registers and tally sheets and its completing procedures: Provides detail description of all HMIS registers and tally sheets and its recording procedures
3. **Section 3:** Reporting tools and Procedures: Provides description of the reporting formats, reporting channel, period and reporting hierarchy.
4. **Section 4:** Annexes: This includes all the forms that have been described in the previous sections

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Module 2: HMIS Recording, reporting tools and Procedures

Session duration: 8 days

Session Learning Objectives

At the end of this session, participants will be able to:

- Define and describe each individual recording tools
- Describe the types, purposes and contents of each individual medical record and register
- Describe the recording procedures of individual medical records, registers and tally sheets
- Describe the types, purposes and contents of reporting formats and reporting procedures for each level of the health system

Topics Covered

- Individual medical records and its recording procedures
- HMIS registers and recording procedures
- HMIS tally sheets and recording procedures
- HMIS Reporting (types of reporting formats, frequency of reporting and report/data flow)

Teaching Methods

- Facilitator presentations
- Exercises and group work
- Presentations by participants
- Plenary discussion

Materials Needed

- PowerPoint presentation

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- LCD and computer loaded with PowerPoint slides
- Flip charts and colored markers
- Facilitator's & participant's manuals
- Folders, pen, pencil and note book paper
- blank piece of paper per participant and trainer
- Handout

2.1 Module Introduction

In order to respond to the additional M&E requirements by the Health Sector Transformation Plan and the introduction of new health initiatives, HMIS revision has recently been done by the Federal Ministry of Health. The revision resulted in addition of new indicators and modification and/or removal of the existing indicators. Following the revised list of indicators, the existing recording and reporting formats have been modified and new recording formats are also developed.

The recording instruments are developed based on the level & capacity of the health institutions and the scope of health services they deliver. Health posts use a family folder to record health services that they provide while health centers and hospitals (including private for profit and private for not profit facilities) use individual medical records and registers to capture medical and health services from each individual. Registers will be used to capture selected data elements from individual medical records that are important for reporting. In order to simplify report compilation, tally sheets are developed for each level, including for health posts. Routine reports follow the health system's hierarchy to reach to the Federal Ministry of Health of Ethiopia so that evidence based decisions and policy making can be done.

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In this section, the revised recording and reporting tools and procedures will be discussed in detail. This training manual is prepared for use by all health workers at health facilities and administrative health units (WoHOs, ZHDs, RHBs, FMOH). It will be useful to make health workers familiarized with the recording and reporting tools and procedures.

Purpose of this module

This manual is primarily intended for use by health workers at all levels of the health system who are involved in managing health related data. This document describes the procedures to be used for routine data collection and reporting at all levels of the health system in Ethiopia. Given the very dynamic nature of the health system, this document will be updated when information systems procedures are changed. It provides detail instructions for completing HMIS recording and reporting tools. In addition, reportable data elements and indicators from each recording tools are also described.

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2.2 Individual medical recording tools and procedure

Session Learning Objectives

At the end of this session, participants will be able to:

- Define and describe each individual recording tools
- Describe the types, purposes and contents of each individual medical records
- Describe the recording procedures of individual medical records

Topics Covered

- Individual medical records 9Individual folder, patient form, service ID card, appointment card, Master Patient index, Tracer card)
- Individual medical record issuing and archiving procedure

Time needed: 4 hours

Introduction

Individual Medical Recording tools are those which are used to record the medical and clinical information of individual clients and/or patients. At health center and hospital levels, each client/patient is expected to have an individual record where all the services provided are recorded kept. In this section, each medical recording tools and its contents will be discussed in detail.

Individual folder

It is a folder that is used as a pouch to contain all the medical records of each patient/client. The data elements at the front part of the folder includes personal identification data elements (socio demographic characteristics of the individual) and should be filled by Medical Record Unit workers at the time of registration. The inside part of the folder contains a summary sheet to

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summarize the medical record of patient/clients at each visit and should be filled by service providers immediately after the service is provided.

Purpose of integrated folder

- To integrate all medical & health service records of an individual patient or client so that the holistic medical data of individuals can be accessed in one folder, whenever required.

Summary sheet:

- It is available in the inside section of the folder
- It is used to summarize all services provided and helps to fast-track an individual's service history. In order to plan investigation and treat appropriately, the clinician/service provider can see the details of the history inside the folder.

Notes:

⇒ Each individual, who obtains service in the health facility, must have a folder kept in the medical record department with a unique individual MRN (Medical Record Number).

⇒ MRN should be written on the front part of the folder and also on the summary sheet section of the folder (inside part of the folder).

⇒ Medical Record Number (MRN):

- It is a unique number to an individual in a health facility.
- Identifies an individual client/patient to the specific facility.
- Helps to trace an individual folder during repeated visits to the facility (using the service ID card, where MRN is written on it).
- Only one MRN is assigned to one client in one health facility. MRN should be a 5-digit number for a health center and a 6-digit number for a hospital, e.g. at a health center, MRN starts with 00001, and at a hospital with 000001.

⇒ An individual should obtain an individual folder to get any single service at the facility.

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⇒ All individual medical records, i.e. cards that have clinical notes, request forms etc…must be kept in the folder.

⇒ The folder is replaced by tracer card when it is distributed out for service, and rearranged with the tracer card inserted in when it is back shelved. Meanwhile receipt of distributed folders should be signed by respective service unit that received them. When the folder returns to the reception area, the tracer card must be inserted in the folder and the folder will take its position to where it was before the distribution.

⇒ The following is a sample of the information to be completed on the individual integrated folder:

- Health facility name, MRN, date of registration, client name, age (preferably date of birth); address etc.
- Front page of the folder is completed by MRU workers
- Summary sheet is filled by the service provider at time of service provision.

⇒ If summary sheet becomes full, another form can be prepared and be kept in the folder.

⇒ Folder is preferably shelved in its spine by sequential order of medical record numbers in the MRU.

⇒ Folder is distributed to individual service rooms/departments based on shown up request of an individual client/patient for required service

⇒ No folder can be kept out of MRU after completion of service. However, folders of admitted patients can be kept in the respective department until the patient is discharged.

⇒ The folder is replaced by tracer card when it is distributed out for service, and rearranged with the card inserted in when it is back shelved. When the folder returns to the MRU, the tracer card must be inserted in the folder and the folder take its position.

Patient form/Patient card

Patient card is a free form and has three sections:

1. Section to write <u>chief complaint and detailed clinical notes</u>

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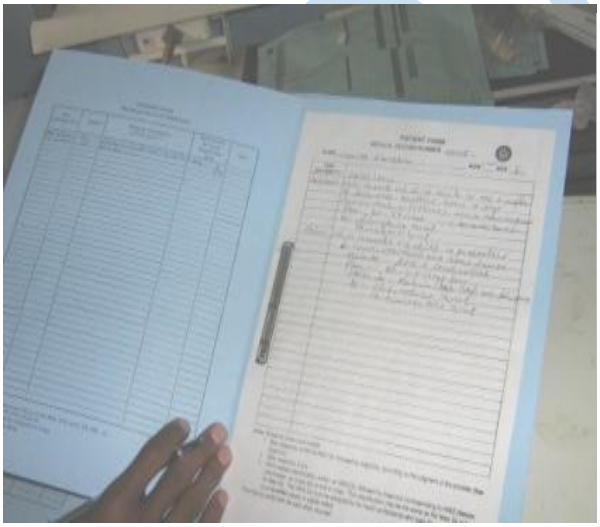
2. Section to write the main diagnosis and other diagnosis (if any).
3. Section to write NCoD (National Classification of Disease)

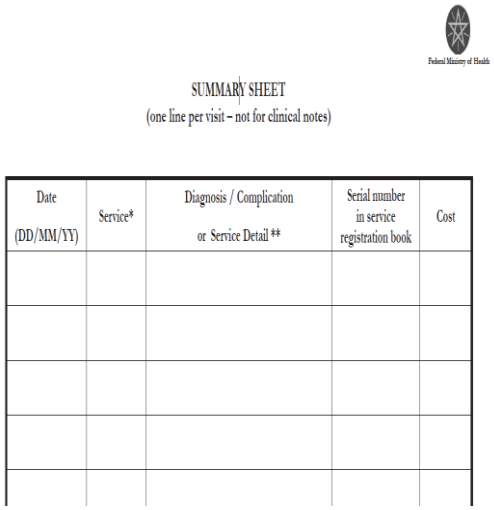
Main diagnosis may or may not exactly fit NCoD; however, it should be made to match in to the NCoD for national reporting. Main diagnosis is always one disease entity; however, a patient can have one or more other diagnosis for clinical management and to be recorded in the card but not to be reported.

Demonstration

Show the individual medical folder and patient form to the participants. Show them how the data elements can be completed on the folder. Individual medical folder and summary sheet are displayed in the figure below.

Fig 1: Individual medical folder and Summary sheet





SUMMARY SHEET
(one line per visit – not for clinical notes)

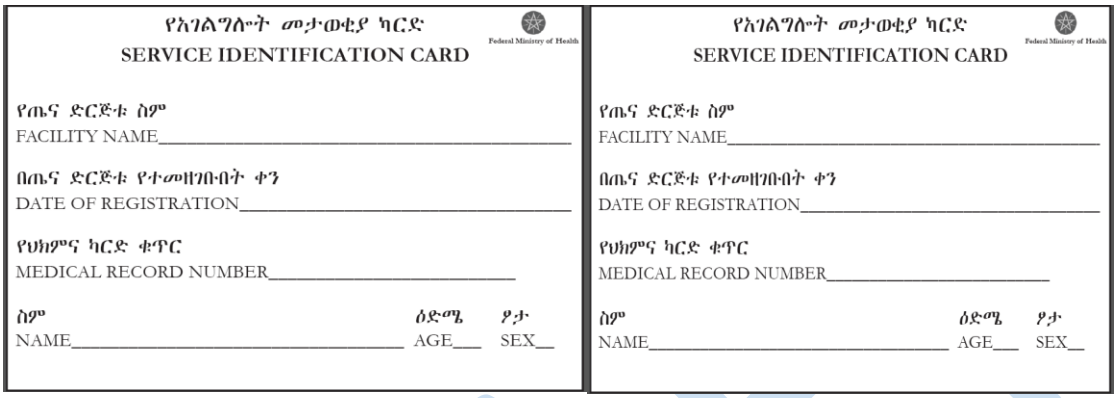
Date (DD/MM/YY)	Service*	Diagnosis / Complication or Service Detail **	Serial number in service registration book	Cost

Service ID card

Service Identification (ID) Card is a small card which is used as an identification for patients/clients. It is issued at the time of registration at the Medical Record Unit (MRU). Whenever the patient/client visits the facility at subsequent visits, he/she will show the service ID card so that the MRU worker can find the folder by using the MRN on the service ID card.

- It has the following data elements and should be completed by MRU workers: Name, age, sex, MRN, date of registration, address etc..
- The card should be made available in the MRU

Fig. 2: Service Identification Card



Appointment card

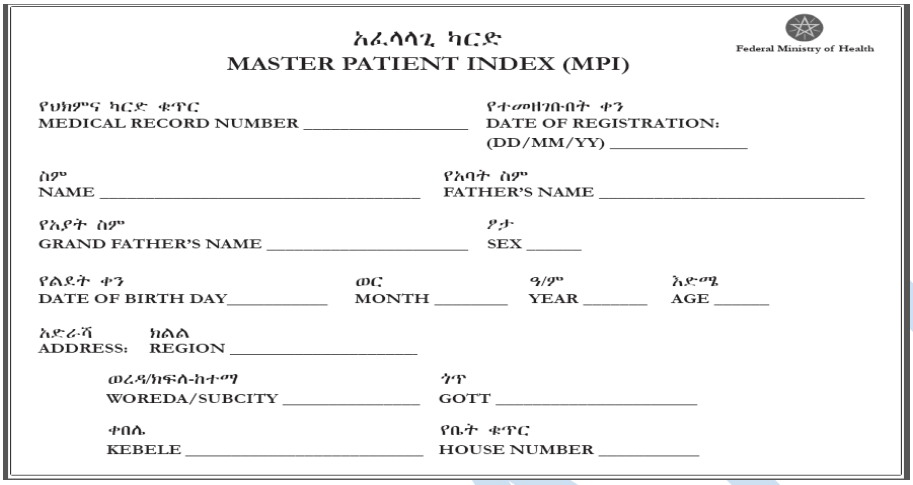
- This is a small card which is used to remind for services which require appointments (Example: For FP, ANC, ART, TB patients…)
- It should be made available in service departments which provide appointments.
- It will be completed / filled by service providers and be provided to patients/clients who are given an appointment for another service.

Master Patient Card

- It is a small card which is used to retrieve patient folder when MRN is unknown (if the service ID is lost).
- A file box (MPI box) should be prepared in a way which can accommodate all the English alphabets so that a name which starts with each letter can be put together.
- It is placed in MRD (in file box) and it is archived based on English alphabetical order
- The EMR-MRU electronic system can simplify the arduous MPI archiving system. In facilities where electronic system is implemented, manual MPI archiving will not be necessary. EMR-

MRU (Electronic Medical Record-Medical Record Unit Module) is an electronic system which is used in MRUs to register and retrieve patient's folder using computers.

Fig. 3: Master Patient Card



አፈላላጊ ካርድ
MASTER PATIENT INDEX (MPI)

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የህክምና ካርድ ቁጥር
MEDICAL RECORD NUMBER _____

የተመዘገበበት ቀን
DATE OF REGISTRATION:
(DD/MM/YY) _____

ስም
NAME _____

የአባት ስም
FATHER'S NAME _____

የአያት ስም
GRAND FATHER'S NAME _____

ፆታ
SEX _____

የልደት ቀን
DATE OF BIRTH DAY_____

ወር
MONTH _____

ዓ/ም
YEAR _____

እድሜ
AGE _____

አድራሻ
ADDRESS:

ክልል
REGION _____

ወረዳ/ክፍለ-ከተማ
WOREDA/SUBCITY _____

ጎጥ
GOTT _____

ቀበሌ
KEBELE _____

የቤት ቁጥር
HOUSE NUMBER _____

Tracer Card

- This is an A4 size card which helps us to track the folder when it is not in the MRU.
- It is assigned during first registration at the MRU, immediately after a folder is issued.
- The folder must always be replaced by its tracer card when it is distributed out to service units.
- It should be signed by the folder receiving unit.
- When the folder is returned back to the MRU, the tracer card should be replaced by the folder, and the tracer card will be out in the folder.

Individual medical record issuing and archiving tips

- Issue folder with only patient form inside; when a patient is presented only for an outpatient (OPD) and is not admission case but if the patient is admitted to one of the inpatient departments, we have to issue a folder with patient form and admission/ discharge card inside.

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- If a client is presented only for ANC service, delivery or PNC services, we have to issue a folder with only one integrated RH card inside.
- Issue a folder with only woman's card inside; when none pregnant client is presented for one or all of the following services at a time: For FP, TT vaccination, and abortion (safe or post abortion) services.
- Issue a folder with all cards (patient form, RH card, woman's card and admission/ discharge card inside); when a patient requires all the associated services.
- No folder/patient record is kept overnight outside the MRU (card room) except of those admitted.
- New HMIS proposes old inactive cards to be destroyed after 10 years of the last entry.

Exercise 1: Exercise on individual medical records

Case scenario 1:

Kassahun Mulugeta, 30 years old man, came to Addis ketema Health Center on Meskerem 20, 2009 EC. It was his first visit to the health center. At the time he arrived at the health center, the last MRN number was 24,560. Three weeks after his initial visit, he came back to the health center for a 7 days gentamycin injection prescribed by a private clinic for his acute pyelonephritis. Complete the following exercise;

a) a. In which of the visits should Kassahun draw an integrated medical folder before he gets the services?
b) What would his MRN be?
c) Kassahun came back to the health center on Tahisas 06, 2009 and diagnosed and treated for pneumonia. Demonstrate how heis summary sheet would appear.
d) List types of individual medical records that Kassahun could have.
e) Describe the importance of summary sheet in the folder

Exercise on service ID, appointment card and MPI

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A. Discuss two purposes that service ID serves for the provider and the client.
B. If a patient loses his/her appointment & service ID cards, how could the patient access to appointing service unit/department in the health facility & what is the procedure to resupply?
C. List health services/programs, which commonly have appointment?
D. Map the difference and similarities between service ID and appointment cards, and point out the reasons to issue and keep them separately instead of two in one.
E. If a client has to attend 2 services that have appointment in a facility, how many appointment cards does she/he need?
F. Given a patient/client have both appointment and service ID cards, writing Medical Record Number (MRN) in either of the cards is sufficient, yes/ no? Justify your answer.
G. Describe the importance of tracer card and MPI card

Other individual medical Records

There are different types of individual medical recording tools other than the above mentioned ones that are used for different services such as integrated reproductive health card, women card, prescription forms, lab request formats etc.. In the following sections, the remaining individual medical records will be discussed with the registers corresponding to it. Example: Integrated RH card will be discussed while discussing RH registers and tally sheets.

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2.3 Registers and tally sheets

1. Maternal and CHILD Health Cards, Registers & Tallies

Contents:

- Integrated RH card and women's card.
- Types and contents of MCH registers: Fourteen registers that are used for maternal and child health services including EPI and nutrition services
- Tally sheets used for MCH services
- Reportable data elements and indicators from MCH registers
- Exercises on these registers

Objectives of the session

At the end of this session, participants will be able to:

- Describe the purposes and filling procedure of integrated RH cared and women's card.
- Understand the recording procedures of MCH related registers. MCH registers include the following:- Family Planning register, LAFP (Long acting FP) Removal Register, ANC register, Delivery register, PNC register, PMTCT, Comprehensive Abortion Care Register, CINuS (Comprehensive and Integrated nutrition services) register, PLW (Pregnant and Lactating Women), TFP (Therapeutic Feeding Program) register, EPI, HPV (Human Papilloma Vaccination) register, TT (Tetanus Toxoid) register, NICU (Neonatal Intensive care Unit) register and Integrated RH register (For Private clinics).
- Understand MCH related tally sheets that includes FP tally, FP dispensing tally, ANC tally, abortion tally, pregnancy test tally sheet, EPI tally and CINuS tally.
- Recognize reportable data elements from MCH registers.

In this section, all recording and report compilation procedures from the 14 MCH registers will be dealt in detail. The MCH register list includes registers that are used to record maternal health,

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child health, EPI and nutrition related services. Moreover, tally sheets that are required for MCH programs will be discussed.

1.1 Family Planning Register

Topics Covered

- Introduction to the Family Planning register
- Procedures of completing Family Planning register
- Reportable data element from the Family Planning register
- Indicators calculated from the Family Planning register
- Tally sheets used for Family Planning services
- Summary of the Family Planning register

Objectives of this session

- To describe the purposes of Family Planning (FP) register
- To properly record the required family planning service data elements to the FP register
- To accurately identify and able to extract reportable data elements from FP register.
- To compute and describe HMIS indicators using the family planning reportable data elements

Time needed: 4 hours

Introduction

Family Planning Register is a longitudinal register that is used to capture HMIS data related to family planning services. Once the FP client is registered, one row is adequate to record services for one fiscal year. After the fiscal year is completed, the client ishould be registered again in the same registration book but with different serial number and reported again in the new fiscal year as a repeat client. The information required to complete the FP register is obtained from woman's card. The register should be kept in the Family Planning service room.

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- Family Planning register captures clients receiving family planning services at the health facility.
- Information for the register is abstracted from women card.
- The women card & register are both completed by the service provider at the time of service.
- The women card should be kept in the individual folder.
- The register includes summary information for reporting FP data elements that are used for the calculation of indicators related to family planning.
- The register is kept in the Family Planning room.

Family Planning register is abstracted from women card. The service provider will record all the required information of individual clients using women card. After the service is provided, the service provider should take the abstracted data elements from women card to the Family Planning register so that monthly report compilation can be easy from the register.

The training participants should have a sample of women card and family planning register and FP tally sheet so that they can follow the facilitator's demonstration of completing these recording tools.

How to complete Family Planning Register

The cover page

- The cover page contains the Federal ministry of health logo to denote that the register is being used in all public and private health facilities.
- In the Middle, it shows the level of health facilities intended to use this register; the name of the register and the third component of the cover page is the part in which the care provider ought to record the address of the health facility:- Region, Sub-city/Woreda, Health facility name, and beginning and start date of the register.
- All the above data are crucial for the use of the register appropriately in the facility and needs to be recorded **before starting to use the register** by the care provider for the first time and

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it should be written with eligible hand writing. If more than one department is available in the facility providing the service we can denote this by writing identifying note at any open space on the cover of the register with marker or bold hand writing by writings such as "Family Planning unit #1", "Family planning unit #2".

Family Planning tally sheet should be used to capture FP reports that are disaggregated by age, type of acceptors and by Family planning method. Moreover, PICT tally sheet will be used for those who were provided with PITC (Provider Initiated Testing & Counseling) service.

The instruction

- The instruction part of FP register is found in the inside part next to the cover page. It contains information about all the basic procedures of how to use the Family Planning register appropriately. Before using any register, all care providers are required to read the procedures thoroughly.

The main part of the register and its recording and reporting procedures

1. **Personal Identification Section (columns 1-5):** This section is used to record the personal identification data elements for the family planning client.
    - **Serial Number (Column one)**: This column is to show the temporal sequence of the clients visiting the facility for the specific family planning service. It should be filled with starting from positive whole number (1, 2, 3….up to the end of the register). Restarting numbering in every new month or at the end of each reporting period is not required. We have to continue numbering till the register pages get exhausted & new register is started.
    - **MRN** (Medical Record Number) (Column 2): is a unique individual identifier taken from the individual integrated folder in health centers and hospitals. This is confidential & uniquely identifying number for a client from other clients as long as he/she visits one specific facility.
    - **Name** (Column 3): Full name of the client should be recorded in eligible hand writing (Name, Father's name and Grandfather's name).
    - **Age** (Column 4): To be completed in years

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- **Sex** (Column 5): Sex of the client as M=Male; F=Female

2. **Registration date Section (Column 6):** Date client registered in this registration book, written as (EC) Day / Month / Year (DD/MM/YY)
3. **Type of acceptor section (column 7-8):** This section is used to identify whether the client is new or repeat family planning acceptor.
   - **New acceptor** at registration Column (7): Tick if client is new acceptor at the time of registration by tick mark (√).

     "New acceptors" refers to the number of acceptors who receive family planning services from a recognized program for the first time irrespective of the method used. This is not the number of consultations and emergency contraceptive. Each acceptor is enumerated once in the year, at the first consultation for contraception in the fiscal year. The number of new acceptors measures the ability of the program to attract new clients to its services.
   - **Repeat acceptor** at registration (Column 8): Tick if client is repeat acceptor at the time of registration by tick mark (√).

     "Repeat acceptors" refers to the number of acceptors who receive family planning services from a family planning program previously irrespective of the method used. Long acting FP method users will also be counted as repeat every year including routine checkup for ongoing use of a long term method such as Implants, IUCD, TL and Vasectomy.

     Note: - Definition of terms "New acceptor and Repeat acceptor"

     Look at the family planning register column 7 and 8; one family planning client is considered as new or repeat client only once in one fiscal year (From Senie 21 of the previous year up to Senie 20 of the current year). So, if the client gets registered as new client in Meskerem 3, 2009 then the client won't be considered as new or repeat client till Senie 20 of 2009. At the end of one fiscal year the old family planning is better be replaced by new one whether the register pages filled or not. All clients in the previous

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fiscal year must be recorded once again in new pages of the old register and considered as repeat clients in the new fiscal year.

4. **HIV Counselling and testing Section (Columns 9-14):** These columns of the register are reserved to record HIV counseling and testing related services and its result.
   - **HIV test offered (Column 9):** Tick if HIV test offered under provider initiated HIV counseling and testing guidelines.
   - **HIV test accepted (Column 10):** Tick if client tested for HIV/AIDS and received test result.
   - **HIV Test result (Column 11):** Enter R in red pen if test is reactive; NR in normal color of pen if test is not reactive; or I in normal color of pen if test is indeterminate.
   - **HIV specific counseling/method offered (Column 12):-** Tick if HIV specific contraceptive counseling / methods is offered. if the following counseling is provided or the client received dual method for this specific purpose.

     Note: - HIV specific counseling indicates provision of comprehensive family planning counseling to HIV infected clients to prevent acquisition of different strain of HIV virus and protection of unwanted pregnancy. So, during the counseling of HIV infected family planning clients the following points should be reminded
     - ☞ Dual protection is critical in reducing transmission of STIs and HIV. For PLWH dual use helps to prevent transmission of the virus to uninfected partner. In addition, dual use helps the PLWH to prevent acquisition of other strains of HIV that could be drug resistant. The other use is to prevent these clients from unwanted pregnancy due to decreased efficacy of hormonal contraceptive methods when taken with some anti-retroviral drugs
     - ☞ PLHIV have equal rights to have a family, bear and rear children.
     - ☞ HIV positive women shall be informed about the implications of pregnancy and prevention of pregnancy shall be encouraged.
     - ☞ Use of hormonal contraceptives is possible in all HIV positive women
     - ☞ Use of FP methods is recommended because the benefit to be obtained from use of the contraceptives outweighs the potential risk of unwanted pregnancy. However, it

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should be known that some antiretroviral drugs affect bioavailability and efficacy of hormonal contraceptives.

- **Positive and linked to ART (Column13):** Tick if HIV Positive and linked to ART clinic in the health facility and or in other health facilities**.**
- **Target Population category (Column 14):** This is a column where we identify the target category of the client for whom we provided a PITC service. Choose the code for the target category as specified at the end of each page. The target population categories are: Female Commercial Sex workers, Long distance drivers, mobile workers/daily laborers, Prisoners, OVC/Children of PLHIV, Other MARPS and General Population.

5. **TT status checked (Column 15): Tick this section if the TT status of the woman is checked.**
6. **Contraindication for IUCD (Column 16): Tick if there is any identified contraindication for IUCD.**

Note: - Contraindications for IUD includes the following

- Client (or partner) has other sex partners
- Sexually transmitted genital tract infections (GTI) within the last 3 months or other chronic STI (e.g. HBV, HIV/AIDS).
- Pelvic infection (PID) or ectopic pregnancy (within the last 3 months)
- Heavy menstrual bleeding (twice as much or twice as long as normal)
- Severe menstrual cramping (dysmenorrhea) requiring analgesics and/or bed rest.
- Bleeding/spotting between periods or after intercourse
- Symptomatic valvular heart disease
- other

7. **Clinical exam and contraceptive method provided Section (Column 17-19):** These columns are used to record the type of contraceptive provided and the date to the client.
   - **Visit No (1-5) (Column 17):-** This is used to record the visit numbers in the current fiscal year. Even though all the five rows are not finished in the fiscal year, we have to leave the remaining rows blank and re-register the client in a new row in the new fiscal year.

Note on completing the five rows: - If for example one client came to a health center for the first time on Tir 1, 2009 and attended two consecutive appointment with Oral contraceptive

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on Megabit 1 and Ginbot 1, then the three consecutive fields (Row 1 on Tir 1; Row 2 on Megabit 1 and Row 3 on Ginbot 1) get filled at the time of service provision. Let's assume the client is appointed for Hamle 1, 2009 for her fourth visit, then we should not record this client on the fourth row of this register. Rather we will record this client on new row of the same register with new serial number or we must record on new register for the new fiscal year as repeat client because the 2009 fiscal year is completed and a new fiscal year is started starting from the month of Hamle.

- **Visit Date (Column 18):-** Date of visit, written as (Ethiopian Calendar) Day / Month / Year (DD/MM/YY) format.
- **Contraceptive provided (Column 19)**:- Contraceptive method provided (record modern methods only by using the following abbreviations)

The following abbreviations are used in the register to record contraceptive provided

- MaC = Male Condom
- FeC = Female Condom
- OC = Oral Contraceptive
- Inj = Injectable
- EC=Emergency contraceptive
- Diaph = Diaphragme
- IUCD = Intra-utérine Contraceptive devise
- Imp= Implant
- TL= Permanent Contraception Method for Tubal Legation
- V= Permanent Contraception Method for Vasectomy

8. **Appointment and remark Section (Column 20-21):** This section is to record the appointment date and any type of remark for each client.
   - **Appointment date (Column 20):** Follow up appointment every year for each methods
   - **Remark/Name &signature (Column 21)**:- Any additional suggestions, comments…follow up appointment.

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Reportable data elements and indicators from family planning register

Please look at the bottom of the register. You will find blank boxes which are planned for summation of reportable data elements which are not supposed to be collected by using tally sheet (Especially for VIA screening and its result). After counting the numbers of clients per each page, fill the boxes at the bottom of the register with counted number. For FP acceptors reporting, we need to use a FP tally sheet that can allow us identify FP clients by type of acceptor (New and repeat), by age categories and by type of family planning methods. The reportable data elements from this register are the following:

- **Number of new acceptors (Column 7):-** Disaggregated by five age categories as displayed at the FP tally sheet. The total count of new FP acceptors in the count box at the end of each page should be equal to what we tallied on the FP tally sheet.
- **Number of Repeat acceptors (Column 8)**:- Disaggregated by five age categories as displayed at the FP tally sheet. The total count of repeat FP acceptors in the count box at the end of each page should be equal to what we tallied on the FP tally sheet.
- **Number of clients tested for HIV (Column 10)**:- Separate PITC tally sheet used for reporting
- **Number of clients tested positive for HIV (Column 11)**:- Separate PITC tally sheet used for reporting
- **Contraceptives provided by method (Column 19)**: For logistic calculation, use a separate family planning dispensed count tally sheet. Please look at the Displayed Family planning dispensed count and Family planning service tally sheets.

Indicators to be calculated from this register are:

- Contraceptive acceptance rate (CAR)
- Percentage of people living with HIV who know their status

In order to compute these indicators, please refer to the "Indicator reference sheet manual" and read the definition, interpretation and other components of the above indicator.

Summary

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Family planning register is kept at the family planning department but in some cases if the facility is providing integrated FP service with other services like ART, VCT, TB clinic etc…, a separate FP register may be placed in these departments, filled by the respective care provider in the departments. The data for the report is gathered on monthly basis by the HMIS focal person by directly copying the sum of the data element at the end of each page and counting the figures from the family planning tally sheet. The health care providers at the department have the responsibility to ensure that the standardized recording and reporting procedures have been followed.

The analysis of family planning service indicators should be performed on a regular basis and should be displayed by using appropriate charts so that appropriate program monitoring and actions can be taken according to the findings. The responsibility of analyzing the ANC indicators, preparing and updating of the display charts and presenting the information for the performance monitoring team for informed decision making falls primarily on the HMIS focal person or the health information technician. For further information on assuring data quality and information use, please refer the data quality and Information Use training modules.

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1.2 LAFP (Long acting Family Planning) Removal Register

Topics Covered

- Introduction to the LAFP removal register
- Procedures of completing LAFP removal register
- Reportable data element from the LAFP removal register
- Indicators calculated from the LAFP removal register
- Tally sheets for LAFP removal

Objectives of this session

- To describe the purpose of LAFP removal register
- To properly record the required family planning service data elements to the LAFP removal register
- To accurately identify and able to extract reportable data elements from the LAFP removal register.
- To compute and describe HMIS indicators using the LAFP removal reportable data elements

Time needed: 1 hour

Introduction

This register is used to record data for clients who have had long acting family planning methods and returned back for removal. The family planning methods that are included for removal are implants (different types) and IUCD. Data is abstracted from women card and entered to the LAFP removal register.

Training participants should have a sample copy of the LAFP removal register and follow the procedures of filling the data elements.

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How to complete the register

In order to complete this register, please follow the instruction that is detailed on the first page of the register.

- ☞ Identification Section (Columns 1-4): This section is the identification section of the client including S.No, MRN, Name and Age of the client.
- ☞ Registration related data elements (columns 5-6): This section includes the date the client came and registered for removal and the date the insertion was done.
- ☞ Information about the insertion and removal of the LAFP (columns 7-11): It includes the type of LAFP used, place of insertion, and duration of use, date of removal and reasons for removal. For the type of LAFP method, use the codes which are available as footnote. For column 8 (Place of LAFP insertion), please use the codes that are available at the bottom of the register (Put as a footnote at the end of each page). For the duration of use, fill as per the code at the end of each page. On column 11, write the reason for removal by selecting one of the codes that are available at the end of each page of the register.
- ☞ PITC HIV testing and counselling information (Columns 12-17): These columns are used to record PITC testing and counselling service and the result of the testing, provision of HIV specific counselling and linkage to HIV services if the client is found to be HIV positive. Target Population category (Column 15) is a column where we identify the target category of the client for whom we provided a PITC service. Choose the code for the target category as specified at the end of each page. The target population categories are: Female Commercial Sex workers, Long distance drivers, mobile workers/daily laborers, Prisoners, OVC/Children of PLHIV, Other MARPS and General Population.
- ☞ Column 18: It is a column where you tick if you provided a post removal counselling service and leave empty if counselling was not done.
- ☞ Column 19: It is a remarks column where the provider writes anything relevant to the client.

Reportable data elements from the register

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- ☞ Total number of Premature LAFP removals performed during the reporting period (within 6 months of insertion) disaggregated by FP method type - This is found from the count box at the bottom of each sheet
- ☞ Total LAFP removals performed during the reporting period, disaggregated by FP method type – This is found from the count box at the bottom of each sheet
- ☞ **Total number of clients tested for HIV**:- Separate PITC tally sheet used for reporting
- ☞ **Total number of clients tested positive for HIV**:- Separate PITC tally sheet used for reporting

Indicators from this register

There is no HMIS indicator from this register. However, program people can monitor the implementation and use of LAFP methods from the monthly report. We can compute the proportion of premature removal of LAFP methods since we have the report on a monthly basis.

1.3 Antenatal Care (ANC) Register

Topics Covered

- Introduction to the ANC register
- Procedures of completing the ANC register
- Reportable data element from the ANC register
- Indicators calculated from the ANC register
- Summary of the ANC register

Objectives

- To describe the purpose of ANC register
- To properly record the required ANC data elements from ANC service
- To accurately identify and able to extract the reportable data elements from the ANC register.
- To compute and describe HMIS indicators using the ANC reportable data elements

Time needed: 4hours

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Introduction

Antenatal care register is designed to record data elements regarding antenatal care service provided to a client during pregnancy. The Antenatal care register is a longitudinal register, where one row is used to document follow up data for one pregnancy. Data elements for ANC register are abstracted from the integrated RH card (Integrated ANC, labour, delivery, neonatal and postnatal care card).

- Antenatal care (ANC) register lists all clients who received Antenatal care services at the facility.
- The ANC register captures clients receiving Antenatal care services at the health facility.
- Information for the register is abstracted from the RH card.
- The RH card and register are both completed by the service provider at the time of service.
- The RH card should be kept in the individual folder.
- The register includes summary information for calculation of indicators related to Antenatal care.
- The register is kept in the Antenatal care room.

Before we proceed on the details of ANC register, we will first discuss about the integrated RH card where detail information about ANC, delivery and PNC care services is documented. After that, the details of the three registers (ANC, Delivery and PNC registers) will be discussed.

Integrated RH (Integrated ANC, labor, delivery, neonatal & Post-natal care) card

- Integrated RH card is an individual medical record card used to document data for women who need the following services: Antenatal Care service, delivery, PNC and neonatal services. It helps us to document detailed history, physical examination results, laboratory investigations and other clinical data for women and neonates who received one of the above mentioned services.

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- The facilitator should show the integrated RH card to the participants and explain the details of the data elements in it. The card andits data elements are displayed in the annex section. Have a look at each data elements and discuss on it.
- Data for ANC, delivery and PNC registers is an abstract information from the integrated RH card

HOW TO COMPLETE THE ANTENATAL CARE REGISTER

The cover page

- The cover page contains the Federal ministry of health logo to denote that the register is being used in all public and private facilities found under FMOH.
- In the Middle the level of health facilities intended to use this register and the name of the register itself.
- The third component of the cover page is the part in which the care provider ought to record the facility's Region, Sub-city/Woreda, Health facility name, and beginning and start date of the register.
- All the above data are crucial for the use of the register appropriately in the facility and needs to be recorded **before starting to use the register** by the care provided with eligible hand writing. If more than one department is available in the facility providing the service we can denote this by writing identifying note at any open space on the cover of the register with parker or bold hand writing. Like Antenatal care unit #1, Antenatal care unit #2.

The instruction

The instruction part is found in the inside part next to the cover. It contains all the basic procedures how to use the Antenatal care register appropriately. Before using any register, all care providers are required to read the procedures thoroughly.

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The main part of the register and its recording and reporting procedures:

1. **Personal Identification Section (Columns 1-6):** This section is used to record the demographic characteristics of the woman that received ANC service. The data elements include Serial number (column 1), Name (Column 2), MRN (column 3), Age (column 4), LMP (column 5) and EDD (Column 6).
    - **Serial Number (Column 1)** - Write sequential serial number in the registration book. This column is just to show the sequence of the clients visiting the facility for one pregnancy care. It should be filled with starting from positive whole number (1, 2, and 3….Up to the end of the register). We are not required to restart numbering in every new month or at the end of each reporting period, just continuous number till the register pages get exhausted & new register is started.
    - **Name/Kebele (column 2)**: write the name of the woman on the upper section of the row and write the kebele where the woman came in the lower row. Note that, if the woman came from another woreda, the name of the woreda should also be documented.
    - **MRN (Medical record number) (Column 3):** Write unique individual identifier from her 'INDIVIDUAL FOLDER'. This is uniquely identifying number for the client from other clients as long as she visits the specified facility.
    - **Age (Column 4)**: Write the age of the women in years from her 'INDIVIDUAL FOLDER'.
    - **Last menstrual period (Column 5)**: Write last normal menstrual period of the women in day/month and year (dd/mm/yy) from her RH integrated card. This is the date at which the client's menses just stopped, at the beginning of the pregnancy; should be recorded in Ethiopian calendar, in two digits like DD/MM/YY. For example if the clients LMP is on Meskerem 20, 2009, then you should record as 20 (the daty in two digits)/01(Meskerem in two digits) /09 (to denote the year in two digit standardized format. 20/01/10 not 20/01/2010.

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- **EDD (Expected date of delivery) (Column 6)**: Write the expected date of delivery in day/month /year (dd/mm/yy) after calculation based on the LMP recorded in the format as the LMP.

2. **Focus ANC section (column 7-18):** this section is used to record data elements that are related to focused ANC services. It is abstracted from the integrated RC card.
   - **Visit Number (column 7)**: This is to document the number of ANC visit as 1, 2, 3 or 4. An ANC client should have at least 4 focused ANC visits during her pregnancy period. So, the number of visits is by default printed on the register and the client gets registered on the first row (Visit 1) if she comes for the first time despite her gestational age. This is simply designed to capture the number of clients who have attended the ANC care for the first time up to four times for calculation of ANC 1^{st} and ANC 4^{th} care coverage indicators. If the woman received more than four ANC visits, it will not be recorded on the register but should be documented on the integrated RH card.Clients coming from other health facilities after attending the first ANC visit can be recorded at the second row(visit 2) by skipping the first visit to prevent double reporting but it should be noted on the remark column where the client have attended the first ANC visit.
   - **Date of visit (Column 8)**: Write the exact date of the visit recorded in the same way as Last menstrual period.
   - **Gestational age in weeks (GA) (column 9)**: Put the gestational age of the women in weeks. Gestational age of the pregnancy is calculated based on the Last menstrual period and should be recorded with DD/MM/YY format as already been mentioned.
   - **Fundal Height in cm (Column 10):** Write the fundal height of the pregnant mother using centimeters
   - **Syphilis test result (R/NR/ND) (Column 11):** Write "R" for women tested reactive for syphilis, write "N" for women tested non reactive for syphilis and if the test is not done, write ND to denote not done. Women who received syphilis screening test service should be documented on the integrated HR card. Syphilis affects the health of pregnant

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mothers and their fetus. It may cause abortion, still birth, premature birth and congenital anomalies. Performing syphilis screening test on all pregnant mothers who attend antenatal care helps to detect the disease early so that appropriate treatment can be provided to protect the mother and the fetus from complications.

- **Syphilis Treatment Given (Column 12):** Tick (√) if syphilis treatment is given.
- **Hepatitis test result (R/NR/ND) Column 13):** Write R if the test result is reactive and write NR in ordinary pen if the test result is non reactive. If the test is not done, please write ND to denote not done.
- **Hepatitis treatment given (Column 14):** This is to document if the woman is provided with hepatitis treatment by ticking in the column.
- **TT provided (dose number) (Column 15):** Write actual dose of Tetanus toxoid (TT) the women received. TT immunization is one of the preventive therapies provided to all pregnant mothers at any visit of the ANC service. During the ANC visit, provide TT vaccination for pregnant mothers and record the cumulative no. of doses the client received in this column as 1, 2, 3 ….
- **Ferrous sulphate/Folic acid provided (Column 16):** Write the amount of tablets provided during ANC visit. **Ferrous sulphate/Folic acid** is one of the preventive therapies provided to all pregnant mothers at any visit of the ANC service. We will indicate this service provision by putting tick mark in the column **(√).** If not provided leave the column blank.
- **Deworming provided (Column 17):** Deworming is provided for pregnant women in the 2nd or 3rd trimester of pregnancy. Tick (√) for women received deworming at 2nd or 3rd trimester pregnancy.
- MUAC (cm) **(Column 18):** Put the Mid Upper Arm Circumference (MUAC) result of pregnant women in cm.

3. **HIV Assessment and Follow up Section (Columns 19-24):** In this section, assessment of the pregnant woman for HIV and its follow up will be documented. It includes HIV test offering and linking with HIV services if the woman is tested positive. From this section, the HIV testing and counselling should be reported to the PMTCT testing and PITC sections of HMIS report.

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- **HIV test accepted (Column 19):** Tick (√) for women accepted HIV test .we will mark the acceptance of this service (Only if the client tested) by putting tick mark in this column.
- **HIV test result (P/N) Column 20):** Write" P" for women tested positive for HIV and write "'N' for women tested HIV negative.
- **Target population Category (column 21)**: This is a column where the woman's target group category is identified. There are codes at the end of the page (as footnote) for each population category. Choose the code and enter in the column. If the woman is not one of the MARPS groups, choose code G (general population).
- **HIV Test results received with posttest counseling (√ column 22)**: This is to indicate if the woman received her test result after testing.
- **HIV positives linked to ART (column 23)**: Tick (√) if the woman is positive and linked to ART.

4. **Partner Testing section (Columns 25-27):** This section is to document HIV testing and its result for partners of ANC clients.
   - **HIV test accepted (Column 25):** Tick if the partner has accepted HIV testing
   - **Partner HIV Test result (P/N/ND) (Column 26):** Write P with red pen if the partner HIV result is positive and write N if the partner result is negative.
   - **Partner's target population Category (column 27):** This is a column where the woman's partner target group category is identified. There are codes at the end of the page (as footnote) for each population category.
   - **HIV Positive partner Linked to ART (Column 28):** Tick (√) if the partner is tested positive and linked to ART.
5. **Counselling Section (columns 29-32):** This section is used to document about the different counselling services (Other than HIV counselling) during pregnancy.
   - **Counseled on infant feeding (Column 29):** If the woman counseled for infant feeding record tick mark (√) if she is advised and counselled on infant feeding
   - **Identified and advised on danger signs (Column 30):** Tick (√) for women on whome danger signs are identified and advised during pregnancy. Mark by putting tick mark in this column only if any danger signs have been identified and counselled accordingly.

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Note: - Some of the danger signs for the mother during pregnancy are the following:- Severe fatigue; Severe abdominal pain; Bleeding from the vagina; Fever; Unusual swelling of face/fingers/legs; Severe and continued headache; Rapid or difficult breathing; Foul smelling vaginal discharge; Convulsions/fits; Loss of consciousness; Blurred vision

- **Counselling on family planning (Column 31)**: Tick if she is advised on family planning options after delivery
- **Nutritional Counseling provided (Column 32):** Tick(√) if pregnant woman provided nutritional Counseling (Eat one extra meal every day, Eat variety and diversified food, Deworming at 2nd or 3rd trimester ,Iron folic acid tablets every day minimum at least 90 days plus And Sleep under insecticide treated bed net).

6. **Remark/Appointment/Action (Column 33):** Write date of appointment and you may write any case which is not included in this registration book and any actions taken. We can record any information we render being necessary to record any information or next appointment date of the client. For example we may record the name of the facility received ANC 1st follow up at nearby facility and came to our health facility for the second visit. (Reason for leaving the first column blank)

Reportable data elements and indicators from ANC register

Please look at the bottom of the ANC register to identify some of the reportable data elements from this register. At the end of column 7, 11, 12, 13, 14, there are boxes to sum up the data elements for reporting from the same page for the respective service being provide. But if the page is the final page for the specified month it may hold the sum of data for the whole month. For HIV testing related reports (Both the woman and her partner), a PITC tally sheet should be used to compile HIV testing and test result report disaggregated by age and population category.

This first ANC attendant data (Column 7) is used as an input for the calculation of first ANC care coverage in the catchment population of the respective facility. The fourth ANC care follow up is aggregated by using ANC service tally sheet for convenience (Please look at the ANC service tally sheet); this data is used for calculation of the ANC fourth care coverage.

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The data from column119 i.e. ANC clients tested positive Plus negative for Syphilis is used as an input for the calculation of Percentage of pregnant women attending antenatal care clinics tested for syphilis.

Data from column 19 of this register is used as input for calculation of the indicator Percentage of pregnant women who were tested for HIV and who know their results during pregnancy, labor and delivery and post-partum period.

As a summary, the following are reportable data elements from the ANC register:

1. Number of pregnant women that received ANC first visit by maternal age (Disaggregated by age as 10-14, 15-19 and 20+)
2. Total number of pregnant women that received four antenatal care visits (Disaggregated by age as 10-14, 15-19 and 20+)
3. Total Number of pregnant women tested for syphilis
4. Total Number of pregnant women tested for syphilis with Reactive Test result
5. Total Number of pregnant women tested for syphilis with Non-Reactive Test result
6. Total number of Reactive pregnant mother treated for syphilis
7. No. of pregnant women attending antenatal care tested for hepatitis
8. No. of pregnant women attending antenatal care tested Reactive for hepatitis test
9. No. of pregnant women attending antenatal care tested Non-Reactive for hepatitis test
10. Number of pregnant women tested and know their result during pregnancy
11. Number of new Positive women during ANC,L&D and Postpartum
12. Total Number of partners of pregnant ,laboring and lactating women tested and know their results

Indicators to be calculated from ANC register are

1. Antenatal care coverage – First visit (The proportion of women that received antenatal care at least once during the current pregnancy)
2. Antenatal care coverage – four visits (The proportion of women that received antenatal care four or more times during the current pregnancy.

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3. Percentage of pregnant women attending antenatal care clinics tested for syphilis.
4. Percentage of pregnant women who were tested for HIV and who know their results during pregnancy, labor and delivery and post-partum period

Summary on ANC register

ANC register is longitudinal register that should be kept at ANC service delivery unit, filled by the respective care provider and the data for the report is gathered on monthly basis by the **HMIS focal person** by directly copying the sum of the data element at a the end of each page and /or from the *data on the ANC service tally.* The health care provider at the department is has the responsibility to ensure that the standardized recording procedures have been followed and the data should be counterchecked between the *register and the ANC service tally* being used at the department for each month.

The analysis of the ANC service indicators should be made on regular basis and should be displayed by using appropriate charts to establish good Monitoring and Evaluation system of the program. The responsibility of analyzing the ANC indicators, preparing and updating of the display charts and presenting the information for the performance monitoring team, for informed decision making falls on the HMIS focal person or the health information technician hired for this purpose in the facility. Please look at the Information use and data quality for further reading.

1.4 Delivery Register

Content

- Introduction to the delivery register
- Procedures how to complete the delivery register.
- Reportable data element from the Delivery register.
- Indicators calculated from the delivery register.
- Summary of the delivery register.

Objectives

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- To describe the purpose of the delivery register
- To properly record the required delivery service data elements from delivery register
- To accurately identify & be able to extract the reportable data elements from the delivery register
- To be able to compute and describe HMIS indicators using the delivery reportable data elements

Time needed: 4 hours

Introduction

Delivery register is a serial register used to capture comprehensive maternal and new born services provided at the delivery unit. The register should be kept in the delivery or MCH unit to capture the data elements required from delivery and related services and needs to be documented with optimal quality to enhance the accurate collection of the data. Each care provider have the ethical and moral obligation to record the data on the register accordingly and use the information collected for regular informed decision making; to improve the quality of service provided at local level and support the policy direction to be designed at the higher level.

- Delivery register lists all clients who gave birth at the facility.
- Information for the register is abstracted from the integrated RH card.
- Integrated RH card is completed at the time of service and then abstracted data elements will be transferred to the delivery register afterwards, in the same day of service delivery.
- The integrated RH card should be kept in the individual folder of each delivery client
- The register includes summary information for calculation of indicators related to delivery.
- The register is kept in the delivery room.

HOW TO COMPLETE THE DELIVERY REGISTER

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The cover page

- The cover page contains the Federal ministry of health logo to denote that the register is being used in all public and private facilities found under FMOH.
- In the Middle the level of health facilities intended to use this register and the name of the register itself.
- The third component of the cover page is the part in which the care provider ought to record the facility's Region, Sub-city/Woreda, Health facility name, and beginning and start date of the register.
- All the above data are crucial for the use of the register appropriately in the facility and needs to be recorded **before starting to use the register** by the care provided with eligible hand writing. If more than one department is available in the facility providing the service we can denote this by writing identifying note at any open space on the cover of the register with parker or bold hand writing. Like delivery unit #1, delivery unit #2.
- The instruction part is found in the inside part next to the hard cover. It contains all the basic procedures how to use the delivery register appropriately. Before using any register, all care providers are required to read the procedures thoroughly.

The main part of the register and its recording and reporting procedures

The Delivery care register is serial register printed on A3 size sheet in Landscape alignment with two pages; right and left page.

1. **Identification section (Columns 1-5):** This section is a personal identification section that includes demographic characteristics of women.
    - **Serial Number (Column 1):** Sequential serial number in registration book; to be entered in client's registration cared for later identification in the register.
    - **MRN (Medical record number) (Column 2):** Write/copy the Medical Record Number (MRN) from the client individual folder in HC and hospital .It could be a five or six digit number given to the client in the medical record unit/card room at the initial encounter of the client at the facility based on the health facilities standard expecting the number

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of population in the catchment. This is uniquely identifying number for the client from other clients as long as he/she visits the one specific facility.

- **Name of the mother (Column 3):** Write the name of the mother who delivers in the health facility and it should be recorded in eligible hand writing.
- **Age (Column 4):** Write age of the mother in years.
- **Kebele (column 5):** This is a place where we write the address of the mother (Kebele information)

2. **Labor and maternal outcome section:** In this section, you find information about the outcome of mothers and the labor. It includes the following data elements (Columns 6-14):
   - **Delivery date and time (Column 6):** Write date and time the client delivered written as (E.C.). DD/MM/YY- 00:00 The date of the delivery (after expulsion of the placenta) in Ethiopian calendar & in DD/MM/YY format as usual and the time should be recorded just below the date in HH:MM format in the same column.
   - **SVD (spontaneous vaginal delivery) (Column 7):** Tick if the delivery is spontaneous vaginal delivery.
   - **Caesarean section (Column 8):** Tick if the delivery is caesarean section.
   - **Forceps / Vacuum Extraction (Column 9):** Tick if the delivery is Vacuum extraction.
   - **Episiotomy (Column 10):** Tick if the delivery supported by episiotomy.
   - **Other procedures (Column 11):** Tick if the delivery is by other procedures than mentioned. If the delivery assisted with either of Ergometrine, Oxytocine, Misoprostol and or if a mix of them and or use a mix of Forceps / Vacuum Extraction and or Episiotomy delivery procedures.
3. **Maternal status Section (Column 12-14):-** reserved for maternal condition and indicate by tick mark in each respective column.
4. **Obstetric complication section (Column 15-20)**:- indicate by a tick mark in each respective column with the specified type of complication. The complications include: pre-ecclamsia, Ecclampsia, APH, PPH and Other complications.
5. **Newborn outcome section (Column 21-27)**:- This section is used to record outcomes related to the newborn.

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- **Alive (Column 21)**: Tick if the newborn is alive at birth.
- **Apgar score 1'/5' (Column 22)**: Enter Apgar score at the 1st and 5th minutes, written as 1'/5' (The Apgar score should be recorded at first and fifth minute out of 10).
- **Sex of the new born (Column 23)**: Enter M for male, F for female.
- **Weight of newborn in grams (Column 24)**: Enter weight of newborn only in grams for the purpose of standardization.
- **Still birth (Column 25)**: This section is filled if the delivery is a still birth (dead born). Write 1 if the still birth is fresh and write 2 if the still birth is macerated.
- **Live birth, died before arrival at facility (Column 26)**: Tick if live birth, died before arrival at facility.
- **Live birth, died after arrival or delivery in facility (Column 27)**: Tick if live birth, died after arrival or delivery in facility. Total newborns should be reported as the sum column 26 and 27.

6. **Newbornm Conditions section (Columns 28-33):** This section is used to identify the newborn's MRN and to record (by ticking) whether we provide Vit K, TTC eye ointment, Chlorhexidine, OPV 0 and BCG in the respective columns.
7. **Maternal HIV+ care and follow up Section (Columns 34-42):** In this section, we record HIV testing and counselling service and linkage with HIV services if the mother is tested positive for HIV.

- **HIV testing accepted (Column 34)**:-indicate by tick mark if client is tested for HIV.
- **HIV re-testing accepted (Column 35):** Tick (√) if the mother have already tested and know her status and accepts re testing for HIV
- **HIV test result (P/N) (Column 36)**: Write P in red pen if the test result is positive, write N in normal color if the result is negative.
- **Known HIV positives (transferred from ART)(Column 37)**: Tick this column if the mother is a known HIV positive
- **Target population Category (Column 38):** Choose one of the population category that is available as footnote.

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- **HIV positive delivery linked to PMTCT (Column 39):** Write 1 if the mother linked to PMTCT in same facility and write 2, if mother linked to other facility PMTCT.
- **Counseled on feeding options (Column 40):** Tick if mother counseled on feeding options for HIV positives. This part should be ticked even though the mother does not reach on decision but only for providing the counseling.
- **Mother's ART Regimen (Column 41):** Write mother's regimen based on the code.
- **Newborn NVP for 6 weeks or 12 weeks (Column 42):** Write 6 or12 weeks if newborn is given NVP.

8. **Partner testing section (columns 43-46)**
    - **Partner, HIV testing accepted (Column 43):** Tick if the partner/husband accepts testing for HIV.
    - **Partner HIV test result (P, or N) (Column 44):** Write **P** if the test result is positive, write **N** if the result is negative.
    - **HIV Positive partner Linked to ART (Column 45):** Tick if the partner is positive and linked to ART.
    - **Target population category(Column 46)**: select one of the listed categories at the footnote that fits for the partner
9. **Immediate Post-partum family planning (IPPFP) section (column 47-49):** If the mother was provided with a family planning method within 48 hours after deliver, write the type of contraceptive provided in the column and tick on new or repeat acceptor column (Refer on FP register section for the definition of new and repeat).
10. **Problem identified on the newborn (columns 50-55):** Indicate the presence of the specified health problems with tick mark (√).
11. **Breast feeding initiation time (Column 56)**
    - Indicate the identification of breast feeding within these time periods (<1, 2-3, >3hours) by selecting the codes that are available at the footnote.
12. **Treatment and outcome (columns 57-59):** Tick column 57 if the newborn was provided with oxygen/resuscitated. If the newborn survived after resuscitation, tick column 58, or if the newborn died, tick column 59.

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13. **Age at death (Column 60): If the newborn died, write the age of death on column 60.**
14. If the newborn died, the cause of death should be recorded in column 61: The cause of death should be selected from the list in the register.
15. **If alive, Birth notification given for the mother (Column 62):** Tick if the mother given information about birth notification.
16. **Managed by (Column 63):**- Name of the care provider (clinician) who provided the service should be documented in this column.
17. **Remark (Column 64)**:- We can record any information we render necessary to record.

Reportable data elements and indicators from delivery care register

Please look at the bottom of the register. You will find boxes which are used to enter sum of reportable data elements used as input for indicator calculation from delivery register. After counting the numbers of clients per each page, fill the boxes at the bottom of the register with counted number. The reportable data elements from this register are the following:

- Number of attended deliveries
- Number of deliveries by cesarean section
- Number of institutional maternal deaths
- Number of live births
- Number of still births
- Total number of newborns weighed
- Number of newborns whose weight is less than 2500gms
- Number of early neonatal deaths
- Number of women who received HIV test

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- Number of women who tested HIV positive
- Total IPPFP acceptors, disaggregated by age and contraceptive methods
- Number of neonates treated for birth asphyxia & survived

Indicators to be calculated by using data from this register are

- Proportion of births attended by skilled personnel
- Caesarean section rate
- Proportion of maternal (institutional) death
- Still birth rate (institutional)
- Early neonatal death rate (institutional)
- Proportion of asphyxiated neonates who were resuscitated (with bag & mask) and survived
- Percentage of pregnant women who were tested for HIV and who know their results during pregnancy, labor and delivery and post-partum period
- Percentage of Low birth weight newborns

For further information on the indicators and evidence based decision making please look at the indicator definition Manual and information use and data quality modules.

Summary

Delivery register is kept at delivery department, filled by the respective care provider and the data for the report is gathered on monthly basis by the **HMIS focal person** by directly copying the sum of the data element at a the end of each page. The health care provider at the department is has the responsibility to ensure that the standardized recording procedures have been followed.

The analysis of the delivery service indicators should be made on regular basis and should be displayed by using appropriate charts; to establish good Monitoring and Evaluation system of the

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program. The responsibility of analyzing the delivery indicators, preparing and updating of the display charts and presenting the information for the performance monitoring team, for **informed decision making** falls on the HMIS focal person or the health information technician hired for this purpose in the facility. Please look at the Information use and data quality module for further reading.

Exercise on Delivery Register

1. Your ANC client W/roAlemitu Adera-29 (see ex.10) with MRN 02332 came in labor which started 10 hrs back on 22/10/ 1998 to Bishoftu HC. Her claimed LMP was on 25th of Meskerem, 1998. She was examined and investigated: wt 54 kg; height 168 cm, BP 110/60, Blood type O +ve, and also tested for HIV but negative. She gave SVD to high active male baby(apgar score of 8& 10 in 1st and 5th minute) weighing 2.4 kg after 6 hours of admission and registered as 3rd mother in your delivery register to whose new born assigned MRN 23456/2000 and time specific antigens were given by the attending nurse, her condition was stable after delivery.
2. W/ro Bekelech, 34 years of age, who is resident of Genbo health center's catchment, came after 2 hours labor started on 29th Sene 1/2000. Her existing individual record MRN was 04563 then examined for all vital signs, She is HIV positive mother, her cervical dilatation was 6 cm, fetal heart rate was absent on which she was followed for 4 hrs and physician in charge decided and carried out forceps delivery registered as 4th mother in your delivery register. Unfortunately the birth is ended as still birth. Her condition was unstable and referred to next health facility.
3. W/ro Jemanesh 25, resident in Guay health center catchment with medical record number of 02000 came after 3 hours labor started on 23/10/2000. She had 1 spontaneous and 1 C/S deliveries previously, the physician decided and carried out C/S registered as 2nd mother in the delivery register and she was died after 2 days of the procedure.

Answer the following and discuss the answers

1. Fill the delivery register accordingly.

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2. Assume Jemanesh had post-partum hemorrhage (PPH) for which she was advised and kept on close follow up, how would her record be filled in the register?
3. Enlist reportable data elements and their corresponding columns (in the register) by referring to the above cases.
4. Some of your health facility staff, who conducted a delivery with complication, did not record obstetric complication and you discovered it, which of the indicator will be affected as you understand? If there are such cases under your mentor ship how can it be corrected?
5. Refer to the case 2 registration above; indicate possible indicator (s) and corresponding column(s) that this client and the delivery outcome be considered.

1.5 Postnatal (PNC) Register

Content

- Introduction to the PNC register.
- Procedures of completing the PNC register.
- Reportable data element from the Delivery register.
- Indicators calculated from the PNC register.
- Summary of PNC register.

Objectives

- To describe the purpose of PNC register
- To properly record the required PNC service data elements in the PNC register.
- To accurately identify and able to extract the reportable data elements from the PNC register.
- To enable how to calculate indicators using the PNC reportable data elements.

Time needed: 3 hours

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Introduction

The postnatal register and its recording and reporting procedures used for public and private health facilities (Health center, Clinic and Hospital) will be detailed in the following sections.

Postnatal care is a care given to women within 42 days after they gave birth, irrespective of the time elapsed at their first visit. The first 7 days after delivery, however, is the most critical period when the majority of maternal and newborns die. As a result, it is recommended to give special attention to the first seven days after delivery. The first seven days of PNC is further disaggregated as: PNC in the first 24 hours; PNC within 1-2days (25-48 hours) after delivery, PNC from 2 to 3 days (49hrs to 72 hrs) and PNC from 73 hours to 7th day after delivery.

- The postnatal register lists all clients who gave birth at the facility.
- The postnatal register captures clients receiving postnatal services at the health facility.
- One main row has four sub rows; each sub row is used for one visit.
- Information for the register is abstracted from the integrated RH card (the postnatal section).
- Integrated RH card and register are both completed by the service provider at the time of service.
- The integrated RH card should be kept in the individual folder.
- The register includes summary information for calculation of indicators related to the postnatal.
- The register is kept in the postnatal room.

How to complete the postnatal care register

The cover page

- The cover page contains the Federal ministry of health logo to denote that the register is being used in all public and private facilities found under FMOH.

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- In the Middle the level of health facilities intended to use this register and the name of the register itself.
- The third component of the cover page is the part in which the care provider ought to record the facility's Region, Sub-city/Woreda, Health facility name, and beginning and start date of the register.
- All the above data are crucial for the use of the register appropriately in the facility and needs to be recorded before starting to use the register by the care provided with eligible hand writing. If more than one department is available in the facility providing the service we can denote this by writing identifying note at any open space on the cover of the register with parker or bold hand writing. Like Postnatal care unit #1, Postnatal care unit #2.
- The instruction part is found in the inside part next to the hard cover. It contains all the basic procedures how to use the delivery register appropriately. Before using any register, all care providers are required to read the procedures thoroughly.

Procedure of completing the postnatal care register

The PNC care register is longitudinal as previously mentioned and printed on A4 size sheet in vertical (portrait) alignment. Next we are going to discuss each component in detail in such a way that it can be used by any health care provider working in the PNC department and for further knowledge of the Health information technicians (HMIS focal person working in the facility) beyond mere collection of the ANC data on monthly or quarterly basis.

1. **Identification Section (columns 1-9): This is a section that is used to identify both the mother and the newborn**
   - **Serial Number (Column 1)** - this column is just to show the temporal sequence of the clients visiting the facility for the specific care. It should be filled with starting from positive whole number (1, 2, and 3….Up to the end of the register). We are not required to restart numbering in every new month or at the end of each reporting period, just continuous number till the register pages get exhausted & new register is started.
   - **Name of mother (column 2)**: This is to record the name of the mother

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- **Mother's MRN (Medical registration number) (Column 3):** is a five or six digit number given to the client in the medical record department at the initial encounter of the client at the facility. This is uniquely identifying number for the client from other clients as long as he/she visits the one specific facility.
- **Mothers age (Column 4)**:- supposed to be filled in **years. For all other HMIS registers** for clients between one month and one year of age the age should be recorded in months followed by **M**, in days for clients less than one month of age followed by **D**.
- **Woreda/Kebele (column 5)**: this is to record the address of the mother (Name of Woreda and/or kebele)
- **Infant's data of birth (Column 6):**- Should be recorded in Ethiopian calendar in two digit format (**DD/MM/YY)**.
- **Place of delivery (column 7):** Choose the code that is available at the end of each page
- **Infants MRN (Column 8)**:- Filled with the same way as above
- **Sex of the baby (Column 9):**- Recorded with abbreviation either as F or M.

2. **PNC Visits Section**: This section includes visit Period (column 10) and visit date. Based on the corresponding time period the woman came after delivery, write the date in front of the five time periods described in the register. If she came within 24 hours after delivery (Or if the mother stayed in the facility for 24 hours after delivery), then write the date corresponding to the row that says "in 24 hours". In the same token, if she came between 49 hours and 72 hours, then write the date in front of this time category. Fill the other rows accordingly.
3. **Maternal Health Status:** Write code after assessing the status of the mother as : Normal, Complicated and managed, Died, Complicated and referred
4. **HIV assessment Section (Column 13-18):** This section is for HIV testing and counselling and its result and is completed as follows
    - **HIV testing performed (Column 13)**:-indicate by tick mark if client is tested for HIV.
    - **HIV test result (P/N) (Column 14)**: Write P in red pen if the test result is positive, write N in normal color if the result is negative.
    - **Target population Category (Column 15):** Choose one of the population category that is available as footnote.

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- **HIV Posttest counselling (Column 16):** Tick if mother was provided with a posttest counselling service.
- **HIV Positive linked to ART (Column 17):** Tick this if the mother is tested HIV positive during the PNC service and linked to ART service in the facility or to another facility providing ART service.
- **Known HIV positives (transferred from ART) (Column 18):** Tick if the mother is known HIV positive and is linked to ART service during the PPNC period.

18. **Partner testing section (columns 19-22):** this section is completed if the PNC client's partner came and tested for HIV. The columns are completed in the same way as in the other registers described previously.
19. **Counselling section (Columns 23-26):** These columns are completed by a tick mark if the woman was counselled on FP, EPI, danger signs, nutrition & cord care in the respective columns.
20. **Newborn assessment (Columns 27-33):**
    - Fill the weight of the newborn in grams in column 27
    - Tick column 28 if he/she is breast feeding at the time of the PNC visit.
    - Column 29: If any problem is identified on the newborn, choose one of the complications coded in the register. If the identified problem is not available in the list, please specify.
    - Column 30: Write the type of treatment given for the identified problem (using codes that are listed in the column). Specify the treatment if it is other than the coded treatment types.
    - Column 31-33: This is the column where we record the treatment outcome for newborns for whom treatment have been provided. Choose the treatment outcomes coded in the column. If died, write the age of death on column 32. An dthe cause of death has to be specified in column 34.
21. **Immediate Post-partum family planning (IPPFP) section (column 34-36):** If the mother was provided with a family planning method within 48 hours after deliver, tick the type of acceptor the mother was (New or repeat) and write the type of contraceptive provided in the column (use codes that are available at the bottom of each page).

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22. **Managed by (Column 37)**:- Name of the care provider (clinician) who provided the service should be documented in this column.
23. **Remark (Column 38)**:- We can record any information we render being necessary to record or next appointment of the client

Reportable data elements and indicators from PNC register

Please look at the register immediately at the bottom of the register. **At the end of some columns,** there are boxes to sum up the reportable data elements from the PNC register, for that specific page. The total monthly report should be the sum of all the total pages for that specific reporting month. The following are the reportable data elements from the PNC register:

- ✓ Number of postnatal visits within 7 days of delivery (Disaggregated by period)
- ✓ *Number of institutional maternal death,*
- ✓ *Number of pregnant women who were tested for HIV and who know their results during pregnancy, labor and delivery and post-partum period*
- ✓ *Number of women tested positive for HIV*
- ✓ Number of neonatal deaths in the first 24 hrs of life/institutional/
- ✓ Number of neonatal deaths between 1-7 days of life/institutional/
- ✓ Number of sick young infants 0-2 months treated for sepsis
- ✓ Total IPPFP acceptors, disaggregated by age and contraceptive methods
- ✓ Number of Newborn weighing <2000gm and premature newborns for which KMC initiated
- ✓ Number of neonates treated for birth asphyxia & survived

Indicators to be calculated from this register are

1. Early postnatal care coverage
2. Institutional maternal death.

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3. Percentage of pregnant women who were tested for HIV and who know their results during pregnancy, labor and delivery and post-partum period
4. Early institutional neonatal death rate
5. Proportion of Sick Young infants treated for sepsis/VSD (Very Severe Disease)
6. Proportion of low birth weight or premature newborns for whom KMC was initiated after delivery
7. Proportion of asphyxiated neonates who were resuscitated (with bag & mask) and survived

The facilitator should show how each column of the register can be filled.

Please refer to the Indicator reference sheet for further information about the indicators from the PNC register.

Summary (PNC Register)

PNC register is kept at the PNC service unit, filled by the respective care provider and the data for the report is gathered on a monthly basis by the HMIS focal person by directly copying the sum of the data element at a the end of each register page. The health care provider at the department has the responsibility to ensure that the standardized recording procedures have been followed.

The analysis of the PNC service indicators should be made on regular basis and should be displayed by using appropriate charts to establish good Monitoring and Evaluation system of the program. The responsibility of analyzing the ANC indicators, preparing and updating of the display charts and presenting the information for the performance monitoring team, for informed decision making falls on the HMIS focal person or the health information technician hired for this purpose in the facility. Please look at the Information use and data quality module for further reading.

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1.6 PMTCT Register

Topics Covered

- Introduction to the PMTCT register
- Procedures how to complete the PMTCT register
- Reportable data element from the PMTCT register
- Indicators calculated from the PMTCT register
- Summary of the PMTCT register

Objectives

- To describe the purpose of the PMTCT register
- To properly record the required PMTCT data elements on PMTCT register
- To accurately identify and able to extract the reportable data elements from the PMTCT register
- To enable the computation of PMTCT indicators from PMTCT register

Time needed: 4 hours

Introduction

PMTCT register is a longitudinal register. It is used to follow HIV positive pregnant and lactating women and their HIV exposed infants. Based on Option B+ strategy, all HIV positive pregnant and lactating women should start ART, irrespective of their clinical stage and CD4 count.

- PMTCT register lists all clients who received PMTCT services at the facility.
- The PMTCT register captures clients receiving PMTCT services at the health facility.
- Information for the register is abstracted from the RH card.
- The integrated RH card and PMTCT register are both completed by the service provider at the time of service.
- Integrated RH card should be kept in the individual folder.

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- The register includes summary information for calculation of indicators related to PMTCT.
- The register is kept in the PMTCT room.

How to complete PMTCT Register

The cover page

- The cover page contains the Federal ministry of health logo to denote that the register is being used in all public and private facilities found under FMOH.
- In the Middle the level of health facilities intended to use this register and the name of the register itself.
- The third component of the cover page is the part in which the care provider ought to record the facility's Region, Sub-city/Woreda, Health facility name, and beginning and start date of the register.
- All the above data are crucial for the use of the register appropriately in the facility and needs to be recorded **before starting to use the register** by the care provided with eligible hand writing. If more than one department is available in the facility providing the service we can denote this by writing identifying note at any open space on the cover of the register with parker or bold hand writing. Like PMTCT unit #1, PMTCT unit #2.

The instruction

- The instruction part is found in the inside part next to the hard cover. It contains all the basic procedures how to use the PMTCT register appropriately. Before using any register, all care providers are required to read the procedures thoroughly.

The main part of the register and its recording and reporting procedures

1. **Registration at Registration section (Columns 1-6):** This section is used to record data elements that are used to identify individual PMTCT clients. Basic demographic characteristics, Unique ART number and date of registration are recorded here.
2. Columns 7 and 8 are used to identify whether the PMTCT client started ART for the first time or whether she has known her HIV status (Whether she started ART or not) before she came

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for ANC service. Use column 7 to identify those who are newly diagnosed and started ART (At ANC, delivery or PNC service points) and use column 8 to identify those who already knew their status before they are pregnant (before they came for ANC service).

3. **ANC related data section (Columns 9-14):** These columns are where ANC related data elements are filled. It includes recording LNMP, EDD, gestational age in weeks, Ferrous Sulfate/Folic Acid Provided, syphilis screening result and selection of infant feeding options. The filling procedure is already discussed on the ANC register section.
4. **Delivery related data section (Columns 15-20):** Register delivery related data elements under these columns. It includes recording delivery date, Sex of Infant, place of delivery, delivery outcome, ART received by the mother during L&D. The completing procedure is already discussed on the delivery register section above.
5. **Family planning Section (Column 22-**24): This section is used to record for women who received contraceptives during PMTCT follow up. Columns 22 and 23 are used to identify whether the woman is new or repeat contraceptive acceptor (Tick on the appropriate column). In column 24, write the type of contraceptive the mother was provided, filled based on the abbreviation at the bottom of each page.
6. **Partner HIV testing section (column 25-**28): This section is used to document whether partners are tested and its test result. On column 25, tick if the partner accepted HIV testing, on column 26, write the test result as P or N (Positive or negative), or ND if partner testing was not done. On column 27, select the target population category by selecting one of the listed population categories. If the partner is HIV positive and linked to to ART service, tick column 28.
7. **Maternal HIV care section (column 29-37):** These columns are filled whenever applicable only. It includes: TB symptom screening (P/N/ND), INH prophylaxis (if provided), Date TB treatment is started (if TB treatment is started), initial CD4 count (Value/ND), CD4 count, WHO clinical stage, Write yes/no to indicate whether Maternal CPT is started or not, Date ART is started, code for the initial ART regimen and Viral load test result at entry to PMTCT (<1000 /ml (undetectable) or >1000/ml).

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8. **HIV exposed infant follow up section (column 38-45):** These columns are used to follow the HIV exposed infant. Follow the instructions on the register on how to fill these columns.
9. **Remark column (column 46):** This section is used to write any relevant information regarding the mother and/or the exposed infant.
10. **Mother and infant COHORT follow up section (column 47-87):** Write the regimen the mother is taking at each month; and for data elements related with "Infant status", Write NVP for 1st month of life and CPT after 1st month of life; Write "TO" if the infant is Transferred Out to other facility; Write LTF if the infant is lost to follow up; write D for Known Dead. Write DN for Discharged negative infants. At months 6, 12, 18, 24 and 30, additional assessment results should also be documented (Regimen MUA and CD4 count).

Data elements for reporting from PMTCT register

- Number of HIV positive Pregnant women who received ART to reduce the risk of mother to child transmission during ANC for the first time
- Number of HIV positive Pregnant women who received ART to reduce the risk of mother to child transmission during L&D for the first time
- Number of HIV positive Pregnant women who received ART to reduce the risk of mother to child transmission during PNC for the first time
- Number of known HIV-positive women who get pregnant and linked to ANC/PMTCT
- Number of known HIV-positive women who get pregnant while on ART and linked to ANC/PMTCT
- Number of HIV exposed infants who received an HIV test 0- 2 months of birth (Disaggregation: Negative, Positive)
- Number of HIV exposed infants who received an HIV test 2-12 months of birth (Disaggregation: Negative, Positive)
- Number of infants born to HIV positive women started on co-trimoxazole prophylaxis within two months of birth

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- Number of HIV exposed infants who received ARV prophylaxis (Disaggregation: For 6 weeks, For 12 weeks)
- Number of HIV exposed infants receiving HIV confirmatory (antibody test) by 18 months (Disaggregation: HIV positive, HIV negative)
- Total Number of partners of pregnant, laboring and lactating women tested and know their results.
- Number of adults who are currently on ART by regimen type (Disaggregation: pregnant and non-pregnant)
- Number of PLHIV who are documented as Lost/lost to follow up during the reporting period.
- Number of adults and children with HIV infection newly started on ART.
- Number of adults and children who are still on treatment at 12 months after initiating ART
- Number of persons on ART in the original cohort including those transferred in, minus those transferred out (net current cohort).
- Total number of adult and pediatric ART patients with an undetectable viral load <1000copies/ml at 6 month
- Number of adults and children who initiated ART in the 6 months prior to the beginning of the reporting period with a viral load count at 6 month visit
- Total number of adult and pediatric ART patients with an undetectable viral load <1000copies/ml in the reporting period
- Number of adult and pediatric ART patients with a viral load test in the reporting period.
- Number of PLHIV who were assessed/screened for malnutrition
- Number of PLHIV that were nutritionally assessed and found to be clinically undernourished (disaggregated by Age, Sex, Pregnancy and nutritional status)
- Number of clients enrolled in HIV care who were screened for TB during the reporting period

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Indicators from PMTCT Register

- Percentage of pregnant, Laboring and lactating women who were tested for HIV and who know their results
- Percentage of HIV-positive pregnant women who received ART to reduce the risk of mother-to child-transmission (MTCT) during pregnancy, L&D and PNC
- Proportion of HIV exposed Infants with Virological test
- Percentage of infants born to HIV-infected women who were started on co-trimoxazole prophylaxis within two months of birth
- Percentage of infants born to HIV-infected women receiving antiretroviral (ARV) prophylaxis for prevention of mother-to-child transmission (PMTCT)
- Percentage of partners of pregnant, laboring and lactating women tested for HIV during the reporting month
- Percentage of HIV exposed infants receiving HIV confirmatory (antibody test) test by 18 months

Other Indicators which can be computed from the PMTCT Register

- Percentage of people living with HIV who know their status
- Percentage of people living with HIV receiving ART
- Percentage of patients on ART with a suppressed viral load (<1000 copies/ml) in the past 12 months Early viral load suppression rate
- ART retention rate
- Number of adults and children with HIV infection newly started on ART
- HIV screening for TB patients
- TB Screening for HIV positive Clients
- Latent TB infection (LTBI) treatment for HIV positive clients newly enrolled to care
- Anti-Retroviral Therapy (ART) for HIV positive TB patients

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1.7 Comprehensive abortion cares register

Topics Covered

- Introduction to the Comprehensive abortion care register.
- Procedures how to complete the Comprehensive abortion care register.
- Reportable data elements from the Comprehensive abortion care register.
- Indicators calculated from the Comprehensive abortion care register.
- Summary of the Comprehensive abortion care register.

Objectives

- To describe the purpose of the Comprehensive abortion care register
- To properly record the required data elements from comprehensive abortion care service
- To accurately identify and able to extract reportable data elements from the Comprehensive Abortion Care register.
- To identify and calculate HMIS indicators using the Comprehensive abortion care reportable data elements.

Time needed: 1 hour

Introduction

This register is used to document safe abortion and post abortion care services. It is a case/serial register where one row is used once for a single patient/client.

- Comprehensive abortion care register lists all clients who received comprehensive abortion care services at the facility.
- The comprehensive abortion care register captures clients receiving comprehensive abortion care services at the health facility.
- Information for the register is abstracted from the women card.

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- The women card and the comprehensive abortion care register are both completed by the service provider at the time of service.
- The women card should be kept in the individual folder.
- The register includes summary information for calculation of indicators related to Comprehensive abortion care.
- The register is kept in the Comprehensive abortion care room.

How to complete the Comprehensive abortion care register

The cover page

- The cover page contains the Federal ministry of health logo to denote that the register is being used in all public and private facilities found under FMOH.
- In the Middle the level of health facilities intended to use this register and the name of the register itself.
- The third component of the cover page is the part in which the care provider ought to record the facility's Region, Sub-city/Woreda, Health facility name, and beginning and start date of the register.
- All the above data are crucial for the use of the register appropriately in the facility and needs to be recorded **before starting to use the register** by the care provided with eligible hand writing. If more than one department is available in the facility providing the service we can denote this by writing identifying note at any open space on the cover of the register with parker or bold hand writing. Like Comprehensive abortion care unit #1, Comprehensive abortion care unit #2.

The instruction

The instruction part is found in the inside part next to the hard cover. It contains all the basic procedures how to use the Comprehensive abortion care register appropriately. Before using any register, all care providers are required to read the procedures thoroughly.

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The main part of the register and its recording and reporting procedures

- **Identification at registration section (Columns 1-4):** This is to document basic demographic characteristics of the woman who received safe or post abortion services. Record the serial number, date, age and MRN of the client.
- **Reproductive History Section** (Columns 5-8):
    - Gestational age should be documented in weeks
    - Write the gravidity and parity of the woman in the corresponding columns.
    - Document the number of previous abortions
- **Type of abortion service (Columns 9-10)**: Identify the type of abortion service provided at the health facility: If it is a safe abortion service, tick at column 9 or if it is a post abortion service, tick at column 10.
- **Diagnosis/reason to conduct a safe/abortion** (Column 11):
    - Write the code at the bottom of the register to indicate the reason for termination of pregnancy.
    - For safe abortion cases, select one of the coded reasons for the services: Rape or incest, maternal condition, Fetal deformity
    - For post abortion cases, select one of the coded diagnoses : incomplete abortion, inevitable abortion, missed abortion & others
- **Procedure used for uterine evacuation and its management** (Column 12-20): write the appropriate option of procedure used, the department in which the procedure is performed and any type of drugs used in the respective columns. If she is referred, tick column 20 to indicate that the abortion patient is referred for better care.
- **Post abortion Contraception (Columns 21-25):** Post abortion contraceptive counselling and provision is one of the most important services for women who have had abortion since fertility returns as early as 2 weeks after abortion. In these columns, record the data elements related to FP counselling and the type of FP method provided as per the instruction. Tick column 20 if she is counselled. Tick 21 if she expressed desire for FP, tick either column 22 or column 23 based on the type of acceptor the mother is. On column 24, write the type of contraceptive provided.

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- **HIV assessment section (Column 26-**30): This is a section where we record HIV testing and counselling service and the result. The data elements are similar to the HIV assessment sections that are discussed in the other registers previously.
- **Outcome section (Columns 31-32**): Document the outcome of the abortion care service in these columns. If the woman died, it should be recorded under column 30.
- **Columns 31-**34 are used to document if there are other tretments and/or services are provided and to write any relevant information in the remarks section and to write the name and signature of the service provider.

Data elements for reporting from the comprehensive abortion care register

- Number of safe abortions performed (disaggregated by age as: 10-14, 15-19, 20-24, 25-29, 30+).
- Number of post abortions performed (disaggregated by age as: 10-14, 15-19, 20-24, 25-29, 30+)
- Number of women receiving comprehensive abortion care in the first trimester
- Number of women receiving comprehensive abortion care in the second trimester
- PITC report: number of HIV tests performed, Number of Positive HIV tests
- Number of maternal deaths (institutional)
- Number of new and repeat family planning acceptors

Indicators from abortion register

- Number of women receiving comprehensive abortion care service
- Institutional maternal deaths

Other Indicators from abortion register

- Percentage of people living with HIV who know their status
- Contraceptive acceptance rate

DRAFT

1.8 Integrated RH Register for primary Private Clinics

Integrated RH register is used for primary private clinics only and it contains four services, namely, family planning, ANC, delivery and postnatal services in one register. It is designed to be used by **primary private clinics only**. The register is divided into four sections: FP, ANC, delivery and PNC section.

Note: To be used by **primary private clinics only.**

Family planning section of the RH register (for primary clinics only)

- Service provider has to complete the RH register, after service provision.
- It is used to document the contraceptive methods provided at the primary clinic and is kept in the service delivery room.
- The information required to complete the family planning register is obtained from woman's card.

How to record data in the register?

- Locate the Family Planning part of the RH Register during the exercise session. The facilitator should show each row of the register and demonstrate how each can be filled.
- Make sure each participant has filled the FP section of the register accordingly.
- See the previous sections on how FP register is completed.

Antenatal care section of the RH registers (for primary clinics only)

- The ANC section of the RH register is a longitudinal section, where a single row is for follow up of one pregnancy.
- It lists all clients enrolled in antenatal care at your facility and will enable you to follow the expecting mother throughout her pregnancy.
- The RH register is completed by the service provider at time of service.
- Information for the register is abstracted from the integrated RH card.

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- How to Record Data in the Register? Locate the Antenatal Care section of the RH Register and show how each section is completed. The facilitator will go over the register in detail.

Delivery care section of the RH register (for primary clinics only)

- The purpose of this section is to determine: skilled delivery attendance & other related indicators listed on the indicator definition manual.
- Information for the register is abstracted from the integrated RH card.
- The facilitator should go through each data element and show to the participants on how each row can be filled.

Postnatal care sections of the RH register (for primary clinics only)

- The purpose of this section is to determine postnatal care coverage.
- The postnatal section lists all clients receiving postnatal services at the health facility. One main row has three sub rows; each sub row is for one visit.
- Information for the register is abstracted from the individual RH card.
- The facilitator should go through each data element and show to the participants on how each row can be filled.

1.9 PREGNANT AND LACTATING WOMEN (PLW) SCREENING REGISTER

Topics Covered

- Introduction to the PLW screening Register
- Procedure of completing PLW screening register.
- Reportable data elements from the PLW screening register.
- Indicators calculated from the PLW screening register.
- Summary of the PLW screening register.

Objectives

DRAFT

- To comprehend the purpose of the PLW screening register
- To properly record the required data elements from PLW screening service
- To accurately identify and able to extract the reportable data elements from PLW screening register
- To identify and calculate HMIS indicators using the PLW screening reportable data elements.

Time needed: 1 hour

Introduction

This register is used to record information regarding screening of pregnant and lactating women for acute malnutrition. Nutritional screening for Pregnant and lactating women should be done on a monthly basis to monitor the nutritional status of women and provide nutritional counselling and other services accordingly.

How to complete the PLW screening register

1. Identification Section (Columns 1-8): In these columns, the personal identification related data elements are recorded. The data elements include Serial number, Name, MRN, age, address and status (Pregnant or lactating) at the time of registration.
2. PSNP Section: This is to be ticked if the woman is a productive safety Net Program (PSNP) beneficiary.
3. Nutritional screening section (columns 10-22): In this section, the monthly nutritional screening that includes weight and MUAC measurements and the corresponding nutritional assessment will be documented. On column 10, the data elements that are required to be measured and documented during each month's nutritional screening period are available. For each month when the screening is done, write the screening result in the corresponding row. We have to use codes that are available at the bottom of each page during recording of data elements such as nutritional counselling and Actions taken.

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Reportable data elements from this register

- Total number of PLW screened for acute malnutrition
- Total number of PLWA with MUAC < 23 cm
- Total number of PLWA with MUAC >= 23cm
- Number of pregnant women De-wormed

Indicators from PLW Screening register

- Proportion of pregnant and lactating women (PLW) screened for acute malnutrition

2. Registers for Immunization and other Child Health Services

Contents

- Infant Immunization (EPI) and growth monitoring Register, CINuS(Comprehensive and Integrated Nutrition Services) Register, TT immunization register, HPV Immunization register, TFP (Therapeutic Feeding Program) register, NICU (Neonatal Intensive Care Unit) register and the corresponding tallies
- Reportable data elements and indicators from these registers
- Exercises and group presentation on registers of immunization and other child health services

Objectives of the session:

✓ At the end of this session, participants will be able to:

- Describe how data is abstracted from individual medical records to Infant Immunization (EPI) and growth monitoring Register, CINuS(Comprehensive and Integrated Nutrition Services) Register, TT immunization register, HPV Immunization register, TFP (Therapeutic Feeding Program) register, NICU (Neonatal Intensive Care Unit) register
- Describe the recording procedures of the above listed registers
- Identify all types of tally sheets used for immunization and other child health services and describe how tallies are completed from the registers
- Recognize reportable data elements from the above listed registers

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1.10 INFANT IMMUNIZATION AND GROWTH MONITORING REGISTER

Topics Covered

- Introduction to the Infant Immunization and Growth Monitoring Register
- Procedure of completing Infant Immunization and Growth Monitoring register.
- Reportable data elements from Infant Immunization and Growth Monitoring register.
- Indicators calculated from Infant Immunization and Growth Monitoring register.
- Summary of the Infant Immunization and Growth Monitoring register.

Objectives

- To describe the purpose of Infant Immunization and Growth Monitoring register
- To properly record the required data elements from Infant Immunization and Growth Monitoring service
- To accurately identify and able to extract reportable data elements from Infant Immunization and Growth Monitoring register
- To identify and calculate HMIS indicators using the Infant Immunization and Growth monitoring reportable data elements.

Time needed: 2 hour

Introduction

Infant immunization register is a longitudinal register, where one row is used to document all the required immunization services data of one child. The register should be completed by the service provider at time of service. This register is kept in the immunization room.

Tally sheets: Immunization tally is filled at the end of each day to simplify reporting (see the tally below).

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How to record information on the register?

Find infant immunization register from the annex section and see each data element in each column of the register.

- Personal information section of the register (Columns 1-10): Complete the MRN, name of the infant, date of birth in Day/Month/Year (DD/MM/YY) format, sex of the infant, name and MRN of the mother, address and registration date. Write the date of registration on column 10, in Day/Month/Year (DD/MM/YY) format
- In the spaces provided document the date immunization was provided to the child in the corresponding column for each vaccine type.
- Antigens provided (Columns 12-18): Each column contain the types of antigens provided for the infant (BCG, OPV 0-3, IPV, Pentavalent vaccine 1-3, PCV 1-3, Rota vaccine 1-2 and measles vaccine). Write the date when the infant has received each antigen.
- Fully immunized by first birthday (column 19): Tick if the infant has received all types of vaccines before his first birthday. If the child is fully immunized by the first birthday indicate with a (√) mark.
- Neonatal tetanus protection section of the register (Column 20-22): Ask the mother whether she had received two doses of TT immunization during her last pregnancy (write the number of TT doses in column 20) or ask her whether she had three or more doses of TT at any time before her pregnancy (write the number of TT doses that she had in column 21). If the number of doses in column 20 is 2 or if the number of doses in column 21 is three or more, then the child is considered as being protected at birth (tick column 22).
- Growth monitoring section of the register (Column 23-25): This is used to register the date the infant's weight was measured (column 23), document the weight of the child on column 24 and write the WFA in z-score on column 25.
- If Vitamin A is received write the date in Day/Month/Year (DD/MM/YY) format in the space provided on column 26.
- Column 27 is used to write remarks (any type required to write about the infant).

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What is Protection at birth (PAB)???

Protection at Birth against neonatal tetanus: infants who were protected from neonatal tetanus at birth by the immunization of their mothers with protective dose of TT during pregnancy or before the pregnancy. Protective dose of TT means if the mother had two doses of TT during her pregnancy or if she had three or more doses at any time any time before the pregnancy.

a) Ask the mother of the infant if she has a TT record card.
   - If she has, go to (b) below.
   - If she has not, ask if she can remember receiving number of doses of TT during pregnancy.

b) You can consider that the infant was protected from NT at its birth (PAB) if the above holds true, and the mother has received two doses of TT during the recent pregnancy or at least three doses of TT in the past.

c) Ideally, PAB questions should take into account all doses received as well as intervals between these doses.

Q What do we mean by fully immunized? Discuss

<u>Using the Immunization tally</u>

Immunization tally is used to simplify the reporting of data elements related to immunization from the infant immunization and growth monitoring register. Once you complete filling the infant immunization register, please follow the following procedure to complete the immunization tally and count.

Immunization tally uses data from two registers:

1. Infant immunization register
2. TT immunization register (discussed in the next session)

a) **When/Where to complete the immunization tally?**

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Immunization tally is completed immediately after the child/ woman is vaccinated, the daily immunization service provided should be completed at the end of each day:

b) **Data elements used for Immunization Tally**

- The facilitator should prepare a sample of immunization tally sheet and show to the participants on how it can be completed.
- Infant Immunizations data elements are tallied as follows: The tally has two separate columns for under one, and one year and older age infants, further separated by tally and count for each vaccine type.
    - **BCG** - is tallied on line 1
    - **DPT-HepB-Hib1** - is tallied on line 2.1
    - **DPT-HepB-Hib1** - is tallied on line 2.2
    - **DPT-HepB-Hib3** - is tallied on line 2.3
    - **OPV 1-3 and IPV**- are tallied on line 3.1 to line 3.4
    - **PCV is tallied on line 4**.1 to 4.3
    - **Rota vaccine is tallied on line 5**.1 to 5.2
    - **Measles (MCV 1 and MCV 2)** - is tallied on line 6.1 and 6.2
    - **Fully immunized children under 1 year** - are tallied on line 7
    - **A Child protected at birth from N. Tetanus** - are tallied on line 8
    - **TT tally is done separately for TT1-TT5.**

Data Element for reporting from infant immunization register: Immunization data elements are reported from the EPI register. In addition, growth monitoring related data is also reported from this register (see CINuS tally sheet in CINuS session to understand growth monitoring related data elements).

1. BCG
2. OPV 1 AND OPV 3
3. IPV
4. Pentavalent vaccine 1 and 3
5. PCV vaccine 1 and 3
6. Rota vaccine 1 and 3

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7. Measles 1 and Measles 2
8. Fully immunized
9. Protected at birth
10. Total weights weighed
11. Z score above -2
12. Z score between -2 and -3
13. Z score below -3

Indicators from Infant immunization and growth monitoring register

The following indicators are computer from immunization register

- DPT1-HepB1-Hib1 (pentavalent First dose) immunization coverage (< 1 year)
- DPT3-HepB3-Hib3 (Pentavalent third dose) immunization coverage (< 1 year)
- OPV 3 (Oral Polio Vaccine third dose) Immunization Coverage (< 1 year)
- Pneumococcal conjugated vaccine (PCV3) immunization coverage (< 1 year)
- Rotavirus vaccine 2nd dose (Rota2) immunization coverage (< 1 year)
- IPV (Inactivated Polio Vaccine) Immunization Coverage (< 1 year)
- Measles (MCV1) immunization coverage (< 1year)
- Measles second dose (MCV2) immunization coverage (1-2 year)
- Fully immunization coverage (< 1 year)
- Proportion of infants protected at birth against neonatal tetanus
- Vaccine wastage rate

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1.11 TT (Tetanus Toxoid) Immunization Register

Topics Covered

- Introduction to TT register
- Procedures of completing TT register.
- Reportable data elements from TT register.
- Indicators calculated from TT register.
- Summary of TT register.

Objectives

- To describe the purpose of TT register
- To properly record the required data elements from TT service
- To accurately identify and able to extract the reportable data elements from TT register
- To identify and calculate HMIS indicators using TT immunization data elements.

Time needed: 1 hour

Introduction

TT immunization register is used to record information when tetanus toxoid immunization is provided to women (pregnant and non-pregnant). The only reportable data element from this register is the total number of TT doses provided, in order to calculate TT vaccine wastage rate. It is a Longitudinal Register; one row is used for one client till she completes all the 5 doses. The Register is completed by service providers at the time of service provision.

How to record data on the register?

TT immunization register is available at the annex section of this manual. The recording procedure is as follows:

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- Identification section (columns 1-7): These columns are used to record identification related data elements (Name, MRN, age and address of the woman).
- Registration (Column 8): This is the date when the woman first received TT vaccine and is recorded as DD/MM/YY.
- Immunization service for pregnant women (Column 9-13): these columns are used to record the date when a pregnant woman receives TT immunization.
- Immunization service for non-pregnant women (Column 14-18): these columns are used to record the date when non-pregnant woman receives TT immunization.
- Column 19: If Vitamin A is provided to the woman, document the date (DD/MM/YY).
- Column 20 is a remarks column where any relevant information such as appointment date are recorded as required.
- Data for reporting is abstracted by using the immunization tally sheet (See the previous section on immunization tally).

Reportable data elements:

- Number of women who have received TT1 vaccination
- Number of women who have received TT2 vaccination
- Number of women who have received TT3 vaccination
- Number of women who have received TT4 vaccination
- Number of women who have received TT5 vaccination
- TT doses given / doses opened/dose damaged/dose expired

Indicators from TT register

- TT vaccine wastage rate

DRAFT

1.11 HPV Immunization Register

Topics Covered

- Introduction to HPV register.
- Procedures of completing HPV Register
- Reportable data elements from HPV Register
- Indicators calculated from HPV Register
- Summary of HPV Register

Objectives

- To describe the purpose of HPV Register
- To properly record the required data elements from HPV services
- To accurately identify and able to extract the reportable data elements from HPV Register
- To identify and calculate HMIS indicators using the HPV Register

Time needed: 1 hour

Introduction

HPV register is used to document human papilloma virus immunization that is provided for children aged 9 years of age. Human papilloma virus (HPV) vaccine for girls in early adolescence (before their first sexual contact) addresses the common Human papilloma viruses which are associated with the development of cervical cancer in later ages. The register captures doses of HPV provided to girls.

Procedure of completing HPV immunization register

1. **Identification Section (Column 1-7):** this section is used to record the demographic characteristics of girls receiving HPV vaccine. The data elements such as Serial number, MRN, name and date of birth are recorded in the same way as described in the previous registers. For columns 6 and 7, fill based on the education status of the girl. If the girl is in school, write her grade. If she is out of school, tick column 7.

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2. **Address Section (Column 8-11):** This is used to record the specific address of the girl including the woreda, kebele, got and house number.
3. **Registration section (column 12):** Record the date of registration in Ethiopian calendar with a format DD/MM/YY.
4. **Vaccination Section (Column 13-14):** Write the date HPV1 is provided on column 13 and write the date HPV2 is provided on column 14.
5. **Remarks/Appointment section (column 15):** This is used to record any remark regarding the girl such as appointment date for the second HPV.

Reportable data elements from HPV immunization register

- Number of girls 9 year of age who have received first dose of human papilloma virus vaccine
- Number of girls 9 year of age who have received second dose of human papilloma virus vaccine
- HPV doses given /doses opened/dose damaged/dose expired

Indicators from HPV immunization register

- HPV 1 (Human Papilloma Virus vaccine (1st dose) Immunization coverage (9 years old girls)
- HPV 2 (Human Papilloma Virus vaccine (1st dose) Immunization coverage (9 years old girls)
- HPV Vaccine wastage rate

1.12 Neonatal Intensive Care Unit (NICU) Register

Topics Covered

- Introduction to NICU register
- Procedures of completing NICU Register
- Reportable data elements from NICU Register
- Indicators calculated from NICU Register

DRAFT

Objectives

- To describe the purpose of NICU Register
- To properly record the required data elements from NICU services
- To accurately identify and able to extract the reportable data elements from NICU Register
- To identify and calculate HMIS indicators using the NICU Register

Time needed: 1 hour

INTRODUCTION

Neonatal Intensive Care Unit (NICU) register is a register that is used to record information about neonates who have been treated in the neonatal intensive care unit. Neonatal intensive care unit (NICU) is a unit where we provide treatment and care for babies who have problems such as Prematurity and other severe problems. The service is only provided in Hospitals with NICU standard, which have a trained manpower and allocated enough space as per the standard, with basic equipment as per the NICU level. The register captures data that is related to the type of treatment provided and the treatment outcome of the treatment in the NICU.

- The register is a serial register where one row is used to register a single neonate
- It has two wings: the left and right wings (pages).
- It should be completed by service providers after the service is provided. Reportable data elements will be compiled at the end of each month and be sent to the HMIS unit.

Procedure of completing NICU Register

The register has a total of 49 rows and users are expected to follow the instruction at the first page of the register. The procedure of completing the register is as follows:

1. **Identification Section (Columns 1-7):** This section is used to identify individual neonates with their demographic characteristics. It includes completing the following data elements:
    - Serial number: Write the serial number as 1, 2, 3 etc to indicate the sequential number where the neonate is registered.
    - MRN: Medical record number of the neonate from the individual medical folder.

- Name of the neonate: Write the name of the neonate in full
- Sex: Write M for male and F for female
- Name of mother: The name of the mother should be written in this column
- Adress: The Zone, Woreda, Kebele and Gott from where the neonate came should be documented. The zone and Kebele should be recorded in column 6 (The zone in the upper row and the woreda in the lower row); the Kebele and Gott should be recorded in column 7 (The kebele in the upper row and Gott in the lower row).

2. **Admission Information (Columns 8-12):** This section is used to register information about the admission of the neonate. It includes the following information:
    - Admission date and Time (DD/MM/YY - 00:00): On column 8, write the date and time of admission in Ethiopian Calendar and in the format that is written in the register.
    - Temprature (Column 9): Record the temperature of the neonate at admission in degree celcius.
    - Respiratory rate (column 10): Record the respiratory rate of the neonate per minute.
    - Apical Heart rate per minute (Columnn11): record the number of heart beats per one minute in the column.
3. **Delivery Information Section (columns 13-18):** In this section, there are data elements that are to be completed.
    - Gestational Age (weeks) (Column 13): Record the getational age at the time of the neonate's delivery. It should be recorded the number of weeks (Not months).
    - Delivery date and Time (DD/MM/YY - 00:00) (Column 14): record the date and time of delivery in Ethiopian calendar.
    - Mode of delivery (Column 15): Write the mode of delivery by choosing one of the codes available at the bottom end of each page. Write 1 for spontaneous, write 2 if the mode pf delivery was by CS and write 3 if the mode of delivery was instrumental.
    - Place of delivery (Column 16): This is to know the place of delivery by recording 1 if the delivery was at home, write 2 if the delivery was in the same facility as the newborn is being treated and write 3 if the delivery was in another facility and referred to this facility for NICU service.

- Apgar score (column 17): Write the Apgar score at the first and fifth minutes.
- Birth Weight (column 18): Write the weight of the neonate at admission in grams.

4. **Maternal Condition Section (Columns 19-23):** In this section, record the status of the mother (whether alive or dead and test results for HIV, Hepatitis B &C, VDRL)
    - PITC (P/N): Write P if the mother is tested for HIV and tested positive; Write N if tested negative for HIV, if HIV test is not done, leave the space empty.
    - Hepatitis B (P/N): Write P if the mother was tested for Hepatitis B and tested positive. If she was tested negative for Hepatitis B, write N. If the test was not done, leave the space empty.
    - Hepatitis C (P/N): Write P if the mother was tested for Hepatitis C and tested positive. If she was tested negative for Hepatitis C, write N. If the test was not done, leave the space empty.
    - VDRL (P/N): Write P if the mother was tested for syphilis and tested positive. If she was tested negative for Syphilis, write N. If the test was not done, leave the space empty.
    - On column 23, write A if the mother is alive or D if she is dead.
5. **Admission Problems Section (column 24-30):** This section is used to document the type of problems diagnosed for the neonate that is admitted to the NICU.
    - Prematurity: Tick column 24 if the neonate is admitted for prematurity. If not, leave the space empty.
    - Low Birth Weight: Tick column 25 if the neonate has low birth weight. If not, leave the space empty.
    - Sepsis: Tick column 26 if the neonate has sepsis at admission. If not, leave the space empty.
    - RDS: Tick column 27 if the neonate had Respiratory Distress Syndrome. If not, leave the space empty.
    - Perinatal Asphyxia (PAS): tick column 28 if the neonate had Perinatal Asphyxia. If not, leave the space empty.

- Congenital malformation: tick column 29 if the neonate has perinatal asphyxia. If not, leave the space empty.
- Other (Specify): Specify the type of complication that the newborn had other than the listed complications.

6. **Management Section (Column 31-41):** In this section, write the type of medical treatment/management that we provided to the neonate that is admitted to the NICU.
    - CPAP (column 31): Tick (✓) the box if the newborn is treated with Continuous Positive Air way Pressure (CPAP).
    - Resuscitation (column 32): Tick (✓) if the newborn is resuscitated with Bag and Mask.
    - KMC (column 33): Tick (✓) if KMC (kangaroo mother care) was initiated for the newborn.
    - Antibiotics (column 34): Tick (✓) if the newborn is treated with any form of antibiotic
    - Anticonvulsants (column 35): Tick (✓)if the newborn is treated with anticonvulsant
    - Phototherapy (column 36): Tick (✓) if the newborn has received phototherapy treatment
    - Glucose (column 37): Tick (✓) if the newborn is treated with Glucose after admission
    - O2 (oxygen) (column 38): Tick (✓) if the newborn is treated with oxygen (With nasal prong or face-mask)
    - Blood transfusion (column 39): Tick (✓)if the newborn has received blood transfusion
    - Incubator/Thermal care (column 40): Tick (✓)if the newborn was placed in an incubator for treatment
    - Other specify (column 41): Specify the type of management provided other than the listed medical treatment/management.

7. **Discharge Information (column 42-48):** This section is completed when the neonate is discharged from the NICU.
    - Discharge Date and Time: write the date and time of discharge in Ethiopian Calendar
    - Discharge Weight (gms): Write the weight of the neonate at discharge in grams.

- Discharge status: Write the status of the neonate at discharge, by selecting the code that is available at the bottom end of each page. The discharge status may be one of the following: Recovered, died, transferred or Other (to be specified).
- Survived after resuscitation (column 45): Tick this column if the Newborn has received resuscitation at the NICU and his/her condition has improved
- If died, (age in days): In column 46, write the age of death in days if the neonate died during the course of treatment.
- Cause of death (Column 47): if the neonate died, write the cause of death in column 47 by choosing one of the codes available at the end of each page as footnote. The causes of death may be: Prematurity; sepsis, prenatal asphyxia, congenital malformation or other causes that needs to be specified.
- Length of stay: On column 48, write the total number of days the neonate stayed during the admission period.

8. **Remarks Section:** This column is used to write any type of remark that needs to be written for each neonate who has been treated in the NICU. It may include remarks such as from where the neonate was referred from or to where the neonate is referred to.

Reportable data elements from NICU Register

The following data elements are reported from NICU register on a monthly basis.

- Number of Newborn weighing <2000gm and premature newborns for which KMC initiated
- Number of Newborn weighing <2000gm and or premature
- Number of neonates resuscitated and survived
- Total number of neonates resuscitated
- Total neonates admitted to NICU
- Newborns who are diagnosed to have Sepsis
- Total neonates discharged during the reporting period
- Number of newborns who recovered

- Number of newborns who died
- Number of newborns who transferred out
- Number of newborns who have other treatment outcome
- Number of newborns who have survived after resuscitation

Indicators calculated from NICU register

- low birth weight or premature newborns for whom KMC was initiated after delivery
- Asphyxiated neonates who were resuscitated (with bag & mask) and survived
- Treatment outcome of neonates admitted to NICU for management of severe newborn cases
- Number of sick young infants 0-2 months treated for sepsis
- Early institutional neonatal death

1.13 Comprehensive & Integrated Nutrition Services (CINuS) Register

Topics Covered

- Introduction to CINuS Register register.
- Procedures of completing the CINuS Register
- Reportable data elements from CINuS Register
- Indicators calculated from CINuS Register

Objectives

- To describe the purpose of CINuS Register
- To properly record the required data elements from CINuS services
- To accurately identify and able to extract the reportable data elements from CINuS Register
- To identify and calculate HMIS indicators using the CINuS Register

DRAFT

Time needed: 2 hours

Introduction

- Comprehensive and Integrated Nutrition Services register (CINus) register is a longitudinal register, where one row can be used for one child for one year in repeated visits.
- The information is completed by the service provider after delivering the service/ end of duty hours. It should be placed in well-baby clinics.
- Comprehensive and Integrated Nutrition Services register (CINus) is used to record for the following services:
    1. Growth monitoring for children under 2 years of age: There is a growth monitoring and promotion program that should be conducted on a monthly basis. Growth monitoring and promotion (GMP) is a prevention activity that uses growth monitoring (GM), i.e. measuring and interpreting growth, to facilitate communication and interaction with caregiver and to generate adequate action to promote child growth through: Increased caregiver's awareness about child growth, improved caring practices and increased demand for other services, as needed. It includes measurement of weight and classification of the nutritional status of the child based on WFA metric.
    2. Nutritional screening for children under 5 years of age: This is the process of identifying children who may be at nutritional risk or potentially at risk, and who may benefit from appropriate nutritional intervention. Screening may need to be repeated regularly (monthly based). Screening program helps to prevent or detect problems early by screening than discover serious problems later. It includes measurement of weight, height/length, MUAC and checking for the presence of absence of bilateral edema and then classifying the child based on the screening findings.
    3. Deworming and Vitamin A supplementation: The CINuS register is also used to record vitamin A supplementation and deworming services that we provide to children.

DRAFT

How to complete the register?

- Identification section (column 1 to 8): These columns are used to record identification related data elements (Name, MRN, age and address of the child, name and MRN of his/her mother).
- PSNP beneficiary (column 9): This is to document whether the family is a productive safety Net Program beneficiary or not.
- GMP Section (Column 10-22): This section is used for children who are less than 2 years of age and are participating in growth monitoring and promotion program. Each column is divided into four rows which are used to record the date of visit, the age (in months), weight (kg) and the nutritional classification based on WFA result as Normal, moderate underweight or severe underweight. The GMP data is completed on a monthly basis longitudinally when the baby came for the service.
- Nutrition Screening Section (Column 23-35): This section is used for children who are less than 5 years of age for whom nutritional screening is done. Nutritional screening may be done on a monthly basis and every time the child is screened, it should be recorded and reported. For a single child, there are seven rows which are used to record date of screening, age, measurement of weight, height and MUAC, checking for the presence of bilateral edema and categorization of the nutritional status of the child based on the criteria as Normal, MAM (Moderate Acute Malnutrition) or SAM (Severe Acute Malnutrition) on a monthly basis.
- Vitamin A and Deworming Section (columns 36-48): this section is used to record the date of visit and whether Vitamin A or deworming was provided in month X.
- Time and Age Appropriate Counseling Section (columns 49-61): These columns are to record appropriate counselling service provision on breast feeding, initiation of complementary feeding, complementary feeding (DD= dietary diversity, FF= Food

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frequency, FC= Food consistency) and feeding of sick child. It has to be completed for months when the service is provided.

- Action column (column 62): This is used to write any action that is taken for the child that is registered in that row.

Discussion points

- **What is WFA (Percentage of Weight for Age)**
- **How do you calculate %WFA?**

Comprehensive and Integrated Nutrition Service tally sheet

- It is used to simplify reporting of CINuS related reportable data elements
- The tally is used to tally GMP, nutritional screening and Vit.A & deworming services, disaggregated by age and nutritional status category.
- The facilitator has to show the CINuS tally to the participants and tell them on how it is completed.
- **How the tally is completed:**
  - For GMP section: Number of weights recorded with WFA >-2 Z score, Z score between -2 and -3 and Z score < -3 will be tallied (Age 0-5 months and 6-23 months separately). The total weighed will be the sum of the three classifications mentioned. The tally and the corresponding count should be recorded correctly.
  - For Nutritional Screening Section: Number of children with nutritional classification of N, MAM and SAM will be tallied. The sum will give us the total number of children screened for malnutrition. This isn disaggregated into two age categories as: Age 0-5 months and Age 6-59 months.
  - Vitamin A/Deworming section: This is to tally the number of children for whom Vit A was provided (disaggregated by age as 6-11 months and 12-59 months) and for children who have been dewormed. The corresponding count need to be recorded next to the tally.

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Data elements for reporting from CINuS register

- Total number of children less than 2 years weighted during GMP session (disaggregated as 0-5 months and 6-23 months)
- Number of weights recorded with moderate malnutrition, by age (Z-score between -2 and -3) : moderate Underweight (disaggregated as 0-5 months and 6-23 months)
- Number of weights recorded with severe malnutrition, by age (Z-score below (-3) : Severely underweight (disaggregated as 0-5 months and 6-23 months)
- Total Number of children < 5 years screened for acute malnutrition (disaggregated as 0-5 months and 6-59 months)
- Number of weights recorded with moderate acute malnutrition (disaggregated as 0-5 months and 6-59 months)
- Number of weights recorded with severe acute malnutrition (disaggregated as 0-5 months and 6-59 months)
- Number of children who were provided with vitamin A supplementation
- Number of children dewormed

Indicators computed from CINuS register

- Proportion of children under 2 years of age who participated in Growth Monitoring and Promotion
- Proportion of children under five years screened for acute malnutrition
- Proportion of children 24-59 month dewormed
- Proportion of children aged 6-59 months who received vitamin A supplementation

1.14 Therapeutic feeding Program (TFP) register

Topics Covered

- Introduction to TFP register.
- Procedures of completing TFP Register

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- Reportable data elements from TFP Register
- Indicators calculated from TFP Register

Objectives

- To describe the purpose of TFP Register
- To properly record the required data elements from TFP services
- To accurately identify and able to extract the reportable data elements from TFP Register
- To identify and calculate HMIS indicators using the TFP Register

Time needed: 2 hour

Introduction

TFP register is used to record the therapeutic feeding that is provided for Children < 5 with Severe Acute Malnutrition (SAM). Data related to the admission and treatment outcome of children who have been admitted to TFP centers will be recorded in this register.

Recording procedure for TFP Register

1. Personal Identification and address section (Columns 1-10): Personal demographic characteristics and address of the child who is admitted to TFP are registered in these columns. Completing such types of demographic and address related data elements is already discussed in the other sections.
2. Admission Section (Column 11-19): In this section, we record information regarding the child at admission
    - Type of admission: if the child is admitted as new patient, then we write N on column 11, if he/she is not new we write N to denote no.
    - Date of admission: Write the date the child is admitted on column 12.
    - Weight: Write the weight of the child in Kg in column 13.

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- Height: The height of the child should be recorded in centimeters under column 14.
- WFH%: This is to record the Weight-for-Height percentage that is plotted based on the measurements on column 13 and 14 against WHO WFH reference curve. It should be recorded as: <70%, 70%-80% or >80%
- Oedema (0, +, ++, +, +++): This column is used to record the presence or absence of Oedema and its severity. If there is no bilateral pitting oedema, write 0. If there is oedema, use the following to denote the degree of edema:
    - += grade + (Mild :Both feet/ankles bilateral pitting Oedema)
    - ++= Grade ++ (Moderate :Both feet ,plus legs, hands or lower arms)
    - +++= Grade +++ (Severe : generalized bilateral pitting oedema, including both feet, legs, arms and face)
- MUAC (cm): In column 18, write the mid upper arm circumference in centimeters
- Diagnosis (Marasmus,Kashork or,Both): In column 19, Write the nutritional diagnosis of the child by writing codes as MA for Marasmus or KA for Kwashiorkor or BO= both (if Diagnosis is marasmus and Kwashiorkor).

3. Discharge Section (columns 20-25): These columns are used to document measurements of the child at discharge. It includes recording the date of discharge in column 20, the weight at discharge in column 21, the height at discharge in column 22, the WFH% in column 23, presence or absence of oedema and its severity in column 24 and the MUAC at discharge in column 25.
4. **Minimum weight for non oedematous children Recovered Section: Write the m**inimum weight in kg during stay at OTP or SC and record the date the minimum weight is gained.
5. Length of stay: Write total number of days between admission and discharge for cured non edematous children
6. Treatment outcome section (column 29): In this column, write the codes for the outcome of the treatment for each individual child. The treatment outcomes are defined as follows:

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- Recovered (Cured): If the child is free from medical complications and have achieved and maintained sufficient weight gains. Malnourished Children admitted to feeding programmers are discharged with the following criteria: MUAC ≥11.0 cm AND ≥15% weight gain from admission weight with no edema for 2 consecutive visits (at hospital level WFH ≥85 %.).
- Died = Child that has died while he was in the program. For out-patient program, the death has to be confirmed by a home visit
- Unknown: Patient that has left the program but his outcome (actual defaulting or death) is not confirmed/ verified by a home visit
- Defaulter: Patient that is absent for 2 consecutive weighing (2 days in in-patient and 2 weeks in out-patient), confirmed by a home visit
- Non-responder: Patient that has not reached the discharge criteria after 40 days in the in-patient program or 2 months in the out-patient program
- Medical transfer: Patient that is referred to a health facility/ hospital for medical reasons and this health facility will not continue the nutritional treatment
- Transfer Out :Patient that has started the nutritional therapeutic treatment in your program and is referred to another site to continue the treatment

7. Remarks column: This column is used to write anything that deemed necessary for each individual child.

Reportable data elements from TFP register

- Total number of children with SAM admitted to TFP (OTP &SC) during the reporting period
- Total number of children who exit from severe acute malnutrition treatment
- Number of children who recovered from severe malnutrition
- Number of children who recovered from severe malnutrition
- Number of children who died from severe malnutrition
- Number of children who have been transferred out to another TFP center
- Number of children who defaulted from severe malnutrition treatment
- Number of children who became non-respondent for severe malnutrition treatment

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- Number of children who were medically transferred out during severe malnutrition treatment
- Number of children whose treatment outcome is unknown after treatment in TFP
- recovered from severe malnutrition

Indicators from TFP register

- Treatment outcome for management of SAM in children under 5 year: Proportion of children who have been treated for severe malnutrition and:
  - ✓ Recovered
  - ✓ Died
  - ✓ Defaulted
  - ✓ Non-respondent
  - ✓ Medically transferred
  - ✓ Transferred out
  - ✓ Unknown treatment outcome

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3. Disease Prevention and Control Registers

In this section, we will discuss:

- HIV recording and reporting tools: VCT Register, Pre ART and ART register
- Tuberculosis and Leprosy recording tools: Tuberculosis, DR TB and Leprosy Register
- All diseases recording and reporting tools: OPD and IPD registers

2.1 VCT, Pre-ART, ART and PEP Register and tally sheet:

Contents

- HIV intake and follow-up form
- Recording procedure of VCT, PreART, ART and PEP registers
- Reportable data and indicators from VCT, PreART, ART and PEP registers
- Exercises and group presentation on VCT, PreART, ART and PEP registers

Objectives of the section:

At the end of this section, participants will be able to:

- Describe the recording procedures to VCT, Pre-ART, ART and PEP
- Recognize reportable data elements from VCT, Pre-ART, ART and PEP registers

2.1.1 VCT register

Contents

- VCT registers: Data elements and recording procedure
- Reportable data elements and indicators from VCT registers

Objectives of this section

At the end of this session, participants will be able to:

- Understand the recording procedures of VCT registers.
- Recognize reportable data elements from VCT register.

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Time needed: 1 hour

Introduction

VCT register is used to record and document data for HIV. It is used to capture HMIS data related to HIV testing services. Data is extracting from the VCT register report compilation. VCT register captures clients receiving VCT services at the health facility.

HOW TO COMPLETE THE VCT REGISTER

The cover page

- The cover page contains the Federal ministry of health logo to denote that the register is being used in all public and private health facilities.
- In the Middle the level of health facilities intended to use this register and the name of the register itself and the third component of the cover page is the part in which the care provider ought to record the facility's Region, Sub-city/Woreda, Health facility name, and beginning and start date of the register.
- All the above data are crucial for the use of the register appropriately in the facility and needs to be recorded before starting to use the register by the care provider for the first time and it should be written with eligible hand writing.

The instruction

- The instruction part of VCT register is found in the inside part next to the cover page. It contains information about all the basic procedures of how to use the VCT register appropriately. Before using any register, all care providers are required to read the procedures thoroughly.

How to complete VCT register?

- **Identification:** Record the demographic information
  - **Date:** enter date client counseled.
  - **Client code:** enter code given to the client at the VCT center

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- **Couple code:** assign couple code for those who come as couple.
- **Age & sex**

➢ **Counseling Services:**

- Pre-Test Counseling Offered: (✓) if client offered pretest counseling.
- HIV Test Accepted: (✓) if client accepted test.
- Post-test Counseled: (✓) if client received post-test counseling
- Received HIV Test Result: (✓) if client received HIV test result
- Final HIV Test result: enter R in red pen if test is reactive; NR in normal color of pen if test is not reactive; or I in normal color of pen if test is indeterminate.
- Screened for STD: (✓) if client screened for STD
- Result of STD screen: enter P if the client's STD screen is positive; enter N if the client's STD screen is negative
- If positive referred for STD: (✓) if client is positive and referred for STD.
- Screened for TB: (✓) if client screened for TB
- Result of TB screen: enter
- P if the client's TB screen is positive; enter N if the client's TB screen is negative.
- If positive referred for TB: (✓) if client positive and referred for TB

VCT tally sheet

- This tally is used to simplify reporting of data elements from the VCT register. VCT data is reported disaggregated by age and sex. See VCT tally from the annex section and see each data element.

Reportable data elements from VCT register

- Number of individuals who have been tested for HIV and who received their results (disaggregated by age and sex).
- Number of people who tested positive for HIV (disaggregated by age and sex).

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2.2.2 Pre-ART register

Contents:

- Recording procedures of Pre-ART register
- Reportable data elements and indicators from Pre-ART registers

Objectives of the section:

At the end of this session, participants will be able to:

- Understand the recording procedures of Pre-ART registers.
- Recognize reportable data elements from Pre-ART register.

Time needed: 1 hour

Introduction

Pre-ART register is used to record and document data for patients who are before ART started. It is also used as a patient monitoring tool during the intensive and continuous phases of TB treatment. It is used to capture HMIS data related to HIV services. Once the HIV client is registered, one row is used to record still the final outcome evaluated. The information required to complete the Pre-ART,ART register is obtained from HIV intake form. Data is extracting from the Pre-ART register report compilation.

- Pre-ART register captures clients receiving services at the health facility.
- The HIV intake and/or follow up forms Pre-ART register are both completed by the service provider at the time of service delivery.

HOW TO COMPLETE THE Pre-ART REGISTER

The cover page

- The cover page contains the Federal ministry of health logo to denote that the register is being used in all public and private health facilities.
- In the Middle the level of health facilities intended to use this register and the name of the register itself and the third component of the cover page is the part in which the care

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provider ought to record the facility's Region, Sub-city/Woreda, Health facility name, and beginning and start date of the register.

- All the above data are crucial for the use of the register appropriately in the facility and needs to be recorded before starting to use the register by the care provider for the first time and it should be written with eligible hand writing.

The instruction

The instruction part of Pre-ART register is found in the inside part next to the cover page. It contains information about all the basic procedures of how to use the PreART register appropriately. Before using any register, all care providers are required to read the procedures thoroughly.

How to complete pre-ART register

- Registration section (Column 1-7): These columns are where demographic characteristics of the patient are recorded at the time of registration. It includes date of registration, MRN, name, address and the date at which the patient is confirmed HIV positive.
- Follow up section (Column 8-16): These columns are used to record data elements at each visit during follow up. It has five rows, where the follow up data are recorded during all the five visit periods. The follow up data elements are: weight, height, MUAC measurements, BMI (which is calculate as weight/(height)^2 , nutritional screening result, therapeutic/food support, whether clinical staging was performed, CD4 count, and whether TB screening was performed at each visit.
- TB/HIV co-infection section (Columns 17-24): These columns are used to document TB treatment start and stop date (column 17) if the patient was diagnosed to have TB; document INH prophylaxis dates (columns 18-24) if the patient was screened for TB and active TB was ruled out.
- CTX start and stop date (Column 25): fill the date when co trimoxazole prophylaxis was started and stopped, if it was provided.

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- ANC registration number (Column 26): Fill the ANC registration of the woman if she was pregnant and is linked to ANC service room.
- Contraceptive provision (Column 27): Tick if the woman is not pregnant and is using any modern contraceptive methods.
- Follow up outcome (Columns 29-32): These columns are used to record the final outcome of follow up of patients on pre-ART. It includes: removed from pre-ART care (on column 29), death (column 30), lost (column 31) or transferred to other facilities (column 32).
- Entry to ART sections (Column 33-37): These columns are used to record when the patient is eligible to ART. Fill the columns by reading the instructions on the register.

Tallies used for pre-ART register

Pre-ART enrollment and service tally sheet: This tally sheet is used to simplify reporting of data elements from the pre-ART register. The data elements are disaggregated by age and sex. It includes tallying the following data elements:

- Number of PLWHIV who had TB screening at enrollment
- Number of PLWHIV who had TB screening at their last visit
- Number of PLWHIV who are currently receiving CTX
- Number of PLWHIV who were screened for nutritional status and found to be under nourished
- Number of undernourished PLWHIV who received therapeutic or food support
- Number of women living with HIV/AIDS who are using a modern contraceptive method

Reportable data elements from pre-ART register

- Number of PLWHIV who had TB screening at enrollment
- Number of PLWHIV who had TB screening at their last visit
- Number of PLWHIV who are currently receiving CTX
- Number of PLWHIV who were screened for nutritional status and found to be under nourished
- Number of undernourished PLWHIV who received therapeutic or food support
- Number of women living with HIV/AIDS who are using a modern contraceptive method

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2.2.3 ART register

Contents

- Recording procedure of ART register
- Reportable data elements from ART registers
- Indicators from ART register

Objectives of the section

At the end of this session, participants will be able to:

- Understand the recording procedures of ART registers
- Recognize reportable data elements and indicators from ART register

Time needed: 3 hours

Introduction

ART register is used to record and document data for patients who are on HIV treatment. It is also used as a patient monitoring tool. It is used to capture HMIS data related to HIV services. The information required to complete the VCT, Pre-ART, ART and PEP register is obtained from HIV intake and/or follow up form. Data is extracting from the ART register report compilation.

- ART register captures clients receiving services at the health facility.
- The HIV intake and/or follow up forms ART register are both completed by the service provider at the time of service delivery.

How to complete the art register

The cover page

- The cover page contains the Federal ministry of health logo to denote that the register is being used in all public and private health facilities.

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- In the Middle the level of health facilities intended to use this register and the name of the register itself and the third component of the cover page is the part in which the care provider ought to record the facility's Region, Sub-city/Woreda, Health facility name, and beginning and start date of the register.
- All the above data are crucial for the use of the register appropriately in the facility and needs to be recorded **before starting to use the register** by the care provider for the first time and it should be written with eligible hand writing. If more than one department is available in the facility providing the service we can denote this by writing identifying note at any open space on the cover of the register with marker or bold hand writing by writings such as "ART unit #1", "ART unit #2"..

The instruction

- The instruction part of ART register is found in the inside part next to the cover page. It contains information about all the basic procedures of how to use the ART register appropriately. Before using any register, all care providers are required to read the procedures thoroughly.

How to complete ART register:

- Registration section (Column 1-7): These columns are where demographic characteristics of the patient are recorded at the time of registration. It includes date of registration, MRN, name, sex, age, and address.
- Status at starting ART section (column 8-15): These columns are used to record data elements at initiation of ART. The assessment and data elements include functional status of the patient, weight, height, MUAC, BMI, and nutritional screening result and food support provision, WHO clinical stage and CD4 count. The facilitator has to show how each data element can be completed.
- TB/HIV co-infection section (Columns 16-24): These columns are used to document TB screening and its result (column 16 and 17), TB treatment start and stop date (column 18) if

the patient was diagnosed to have TB; document INH prophylaxis dates (columns 19-24) if the patient was screened for TB and active TB was ruled out. Enrolled to Appointment Spacing Mode DD/MM/YY) (Columns 25): Enter date patient enrolled into Appointment Spacing Model, written as (EC) Day/ Month/ Year (DD/ MM/YY)

- Enrolled to appointment spacing model (Column 25): Enter date patient enrolled into Appointment Spacing Model, written as (EC) Day/ Month/ Year (DD/ MM/YY)
- CTX start and stop date (Column 26): fill the date when co trimoxazole prophylaxis was started on the upper row and the date the treatment is stopped in the upper row of column 26.
- Contraceptive provision (Column 27): Tick if the woman is not pregnant and is using any modern contraceptive methods.
- Date Referred to PMTCT (DD/MM/YY) /Date Returned (DD/MM/YY) (Column 28): If the patient is pregnant, enter the Date Referred to PMTCT Clinic for Option B+ on the upper row and date returned from PMTCT on the lower row 1st line regimen (Column 29-30):
  - ⇒ **Original Regimen:** write the code for the 1st line regimen that that patient has started. (See code at the bottom of the ART register)
  - ⇒ **Substitutions:**
    - If there is a 1st substitution within the 1st line regimen, write the code for the 1st substitute regimen, the reason code, and the date substitution was done.
    - If there is a 2nd substitution, transfer this information to the bottom line and write in the code for the 2nd substitute regimen, the reason code, and the date substitution was done.
- 2nd line regimen (Column 31-32):
  - ⇒ **Regimen**: if the patient has been switched to a 2nd line regimen, write the code for this regimen.
  - ⇒ **Switches:**
    - If there is a switch within the 2nd line regimen, write in the code for the substitute regimen, the reason code, and the date.

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- If there is a 2nd switch, write in the code for the substitute regimen, the reason code, and the date.

- 3nd line regimen (Column 33-34): Enter the codes for third line regimens, if provided
  - ⇒ **Regimen**: if the patient has been switched to a 3nd line regimen, write the code for this regimen.
  - ⇒ **Switches:**
    - If there is a switch within the 3nd line regimen, write in the code for the substitute regimen, the reason code, and the date.
    - If there is a 3nd switch, write in the code for the substitute regimen, the reason code, and the date.

Follow up section35-86 (column 335-86): Write the drug regimen code at each column, for each month. In the 6th, I2th, 24th, and 36th months enter the regimen, functional status, weight/height, CD4 as described above. For viral load at 6th, I2th , 24th , and 36th --- months, write the date VL sample collected as (EC) Day/ Month/ Year (DD/MM/YY) on the upper row if viral load is performed at 6th, I2th , 24th , and 36th months; on the lower row. Write undetectable if the viral load is < 1,000 copies per ml, detectable if viral load is > 1,000 copies per ml.

Important points about the ART register

- The second page of the register is used to document ARV regimens or ART treatment out come during the first 36 months after starting ART.
- Under "Month 0" enter the name of the month and the year (EC) in which the patients in this cohort started ART. This applies for all the patients on this page of the register since they are all in the same cohort, started in this month.
- Under "Month 1" write the name of the next month and year (EC) and continue in this manner for all 36 columns.
- When you reach the end of a calendar year, be sure to change the year.

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- In the 6th, 12th, 24th, and 36th months enter the regimen, functional status, wt / ht, and CD4.
- Transferred patients are to be grouped into a similar cohort by keeping some space for possible transfer in patients.

Tallies used for ART register

Three types of tallies are used to facilitate reporting from the ART register. These include ART enrollment tally, currently on ART and receiving clinical services tally and currently on ART tally by regimen.

Three types of tallies are used to facilitate reporting from the ART register. These include ART enrollment taly, currently on ART and receiving clinical services tally and currently on ART tally by regimen.

1. **ART enrollment tally:** This tally sheet is used to simplify reporting of ART data elements at enrollment. The data elements are disaggregated by age and sex. It includes tallying the following data elements:
   - Persons enrolled into ART in each month
   - Persons enrolled in this month and received the following services:- Number of PLWHIV who had TB screening at enrollment, Number of PLWHIV who are currently receiving CTX, Number of PLWHIV who were screened for nutritional status and found to be under nourished, Number of undernourished PLWHIV who received therapeutic or food support, Number of PLWHIV who are on ART and received INH prophylaxis, Number of women living with HIV/AIDS who are using a modern contraceptive method).
2. **Currently on ART and receiving clinical services tally:** This tally sheet is used to simplify reporting of ART data elements for patients who are currently receiving ART. The data elements are disaggregated by age and sex. It includes tallying the following data elements: Number of PLWHIV who had TB screening, Number of PLWHIV who are currently receiving CTX, Number of PLWHIV who were screened for nutritional status and found to be under nourished, Number of undernourished PLWHIV who received therapeutic or food support, Number of PLWHIV who are on ART and received INH prophylaxis, Number of women living

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with HIV/AIDS who are using a modern contraceptive method). Moreover, it is also used to report number of patients for whom viral load test is performed at 12 months after initiating ART and patients with an undetectable viral load at 12 months.

3. **Currently on ART by regimen tally sheet:** This tally sheet is used to simplify reporting of ART data elements for patients who are currently receiving ART by type of regimen. The data elements are disaggregated by regimen, age and sex.

Reportable data elements from ART register

- Number of PLWHIV who had TB screening at enrollment
- Number of PLWHIV who had TB screening at their last visit
- Number of PLWHIV who are currently receiving CTX
- Number of PLWHIV who were screened for nutritional status and found to be under nourished
- Number of undernourished PLWHIV who received therapeutic or food support
- Number of women living with HIV/AIDS who are using a modern contraceptive method
- ART cohort who were alive and on ART 12 months after initiating ART
- Number of PLWHA on ART for whom viral load test is performed at 12 months
- Number of PLWHA on ART who had undetectable viral load at 12 months

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2.2.4 Post Exposure prophylaxis (PEP) register

Contents

- Recording procedure of PEP register
- Reportable data elements from PEP registers
- Indicators from PEP register

Objectives of the section

At the end of this session, participants will be able to:

- Understand the recording procedures of PEP registers
- Recognize reportable data elements and indicators from PEP register

Time needed: 1 hour

Introduction

This register is used to record for people who are taking post exposure prophylaxis, either for occupational or non-occupational risks. The reportable data elements from this register are number of people who received PEP for occupational and non0-occupational risks.

Recording procedure

The register is completed in the following way.

- **Serial Number (SN):** A sequential number assigned to patients up on registration (e.g. 1, 2, 3, etc) for later identification
- **MRN/Card Number:** Unique individual identifier used on medical information folder, for HC and hospital.

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- **Reporting Date:** Use Ethiopian Calendar and a format of DD/MM/YYYY to register when patient is enrolled in PEP service
- **Age:** Enter client's age in year
- **Sex:** Enter 'M' for male and 'F' for Female
- **Occupation:** Enter the code given for the current Occupation of the exposed person
- **Case Team:** Enter the code given here for the Department or case team in which the client works
- **Exposure Duration:** Write the time from time of exposure to the time the exposed person appeared for PEP service in hours
- **Exposure Type:** Enter the code given for the different types of exposures 1. Occupational 2. non-occupational
- **Exposure Code:** Put the exposure code types among the lists provided under the foot note of the PEP register. E.g. If a client is exposed to few drops of blood for short duration of time, write "EC1" under the 'Exposure code/type' column.
- **Baseline HIV status**
    - **Source person:** Write 'P' for reactive) or 'N' for non reactive depending or 'UK' for unknown status (not tested)
    - **Exposed person:** Write 'P' for reactive) or 'N' for non reactive depending or 'UK' for unknown status (not tested)
    - **Source of Exposure:** 1. Needle stick injury 2. Skin injury with sharps 3. Blood and products splash 4. Potentially infectious body fluids 5. Rape 6. Other (Specify)
- **PEP PROVISION**
    - **Eligible**: If the client is eligible for PEP Write 'Y' to say yes , if patient not eligible write "N"I indicating No
    - **ARV Regimen:** Put the PEP drug regimen code 1. AZT +3TC 2. TDF +3TC 3. TDF+3TC+EFV 4. AZT+3TC+EFV 5. AZT+3TC+LPV/r 6. TDF+3TC+LPV/r
    - **Time b/n exposure and PEP (in hours):** Write the spent from time of exposure to the initiation of the ARV regimen in hours

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Reportable data elements from PEP register

- Number of persons provided with post-exposure prophylaxis (PEP) disaggregated as occupational and non-occupational

Indicators from PEP register

- Number of persons provided with Post-Exposure prophylaxis

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2.2 Tuberculosis, DR TB and Leprosy registers

Contents

- Tuberculosis treatment cards
- Recording procedure of TB, MDR TB and leprosy registers
- Reportable data and indicators from TB, MDR TB and leprosy registers
- Exercises and group presentation on Tuberculosis, MDR TB and leprosy registers

Objectives of the section

At the end of this section, participants will be able to:

✓ Describe the purposes and filling procedure of TB and MDR TB treatment cards.

✓ Describe the recording procedures to TB, MDR TB and Leprosy registers

✓ Recognize reportable data elements from TB, MDR TB and Leprosy registers

In this section, all recording and report compilation procedures from the TB register will be dealt in detail.

2.2.1 Tuberculosis Register

Contents

- TB treatment card
- Recording procedures of Unit TB register
- Reportable data elements and indicators from Unit TB register

Objectives of the section

At the end of this session, participants will be able to:

- Describe the purposes and filling procedure of TB treatment card
- Understand the recording procedures of TB registers

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- Recognize reportable data elements from TB register

Time needed: 5 hours

Introduction

Unit Tuberculosis register is used to record and document data for patients who are on TB treatment. It is also used as a patient monitoring tool during the intensive and continuous phases of TB treatment. It is used to capture HMIS data related to TB services. Once the TB client is registered, one row is used to record still the final outcome evaluated. The information required to complete the TB register is obtained from TB treatment card. TB data is extracting from the TB register for quarterly TB report compilation.

- It is a longitudinal register where patients are followed for the whole period of treatment (up to 8 months) once they are registered.
- Data is abstracted from the patient's folder/patient form, especially at the beginning of the registration period. Then, follow up can be performed on the register (by ticking on the follow up columns of the register).
- TB register captures clients receiving TB services at the health facility.
- The TB treatment card & register are both completed by the service provider at the time of service delivery.
- The TB treatment card should be kept in the individual folder.
- The register includes information for clinical monitoring in the health facility only and for reporting TB data for the analysis of TB indicators by different users.
- The register is kept in the TB room.

How to complete the TB **register**

The cover page

- The cover page contains the Federal ministry of health logo to denote that the register is being used in all public and private health facilities.

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- In the Middle the level of health facilities intended to use this register and the name of the register itself and the third component of the cover page is the part in which the care provider ought to record the facility's Region, Sub-city/Woreda, Health facility name, and beginning and start date of the register.
- All the above data are crucial for the use of the register appropriately in the facility and needs to be recorded before starting to use the register by the care provider for the first time and it should be written with eligible hand writing. If more than one department is available in the facility providing the service we can denote this by writing identifying note at any open space on the cover of the register with marker or bold hand writing by writings such as "TB unit #1", "TB unit #2"..

The instruction

The instruction part of TB register is found in the inside part next to the cover page. It contains information about all the basic procedures of how to use the TB register appropriately. Before using any register, all care providers are required to read the procedures thoroughly.

The main part of the register and its recording and reporting procedures

- **MRN** (Medical Record Number) (Column 1): is a unique individual identifier taken from the individual integrated folder in health centers and hospitals. This is confidential & uniquely identifying number for aclient from other clients as long as he/she visits one specific facility.
- **Unit TB No. (Column 2)**: This column is just to show the temporal sequence of the clients visiting the facility for the TB service. It should be filled with starting from positive whole number (1, 2, and 3….Up to the end of the register). Restarting numbering in every new month or at the end of each reporting period is not required.
- **Name and Address of the TB patient** (Column 3): On the upper space: Write the patient's name (individual, father, grandfather) i.e Full name of the client should be recorded in eligible hand writing (Name, Father's name and Grandfather's name). On the Lower space: Write the address of patient (woreda, kebele, House .No, Phone No). Patient address information is very important to trace back if incase patient is lost from follow

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up. The full name of patient's goes on the upper line, and the lower line is for the physical address/place of residence for each TB patient. The best description of where the patient lives should be written in the lower space including Woreda, Kebele, House number and Phone number.

- **Sex, Age and Height (cm)** (Column 4): Upper space: Write the patient's sex: M=Male; F=Female Middle space: Write the patient's age in years, and Lower space: Write the patient's height in centimeters (NB: To be used to calculate BMI column #11).Sex: Write "M" for Male patient and " F" for Female Patient. The space next row in the same column is age in years. If the patient is a child under one year old, write the number of months followed by /12. E.G., 6 months would be 6/12.
- **Workplace of the TB patient** (Column 5): Work place: Write work place of TB patient. Write" HF" for a patient who is working in public or private health facility (Clinic, Health center or Hospitals) at the time of TB diagnosis including health care workers and supporting staffs. Write "NHF" for TB patient working in other sectors including those workinAg in RHB, Zonal and Woreda health offices.

  NB: Information from this column helps to know the number of health care providers including support staff who are currently working in the facilities have TB.
- **Address of the contact person of the TB patient** (Column 6): On the upper space: Write the contact person's name (individual, father, grandfather) and and full address of the contact in the lower space of the column including Woreda, kebele, House No and Phone number.
- **Linkage to the TB service** :(Column 7): Source of initial referral: This section helps to assess the contribution of community health workers/health extension (HEWs) in identifying presumptive TB cases. Write 'HEWs' if the patient was initially referred by HEWs i.e write 'HEWs' if the patient was initially identified and referred by Health extension worker from the community. Write 'Public HF' if the patient was initially visited health facility by him/her self i.e write 'Public HF' if the registered TB patient was diagnosed and linked to receive treatment to TB unit within the same public Health facility or from another public health facility. Write 'PPM HF' if the patient was initially referred

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for TB diagnosis from other health facilities i.e if the patient was referred to the health facility or TB clinic by PPM sites for TB diagnosis or to initiate anti TB treatment. Note that PPM HFs includes public health facilities not directly under the scope of the national TB program including Prison, Uniformed Health facilities; NGO clinic, Faith Based Organization clinics and private health facilities. Note that if your clinic is a recognized PPM sites, enter 'PPM HF' for all registered TB patients on UNIT TB register and make sure that appropriate information on the type of PPM site is marked in the upper part of reporting formats before sending report to next higher level.

- **Baseline Xpert MTB/RIF test result** (Column 8): On the upper Space: Write Xpert MTB/RIF test result resistance type as:-

  T = MTB detected, rifampicin resistance not detected

  RR = MTB detected, rifampicin resistance detected

  TI = MTB detected, rifampicin resistance indeterminate

  N = MTB not detected

  I = invalid / no result / error

- Xpert MTB/RIF test result: it is a rapid diagnostic test; helps to improve TB and DR TB case detection in specific groups of patients such as children and HIV infected presumptive TB cases and Presumptive DR TB patients. Lower space: Write Lab. Serial number of the Xpert MTB/RIF test
- **Diagnostic Smear result** (Column 9): On the upper space: Enter the smear result as "P" for positive result using red pen; "N" for negative results and "U" for not done/results not available and on the lower space: Write Lab. Serial number of the smear test. This Smear examination result record the results of the patient's pre-treatment sputum smear result. In all cases (except young children), three sputum examinations should be done (spot, morning, spot) How to fill this section: The correct responses for the Results column are "P" using red color for positive and "N" for negative; "U" for not done/results not available. Upper: Category N, R, F, L,T, O and Lower: P/Pos, P/Neg or EP(Column 10):

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N=new case: A patient who has never had treatment for TB or has been on anti-TB treatment for less than one month.

R=Relapse: A TB patient who have previously been treated for TB, were declared cured or treatment completed at the end of their most recent course of treatment, and are now diagnosed with a recurrent episode of TB (either a true relapse or a new episode of TB caused by reinfection).

F=Treatment after Failure: Treatment after failure patients are those who have previously been treated for TB and whose treatment failed at the end of their most recent course of treatment.(it is similar with previous definition, a patient who, while on treatment remained smear or culture positive at the end of the five 'months' or later, after commencing treatment)

L= Treatment after loss to follow-up: patients who have previously been treated for TB and were declared lost to follow-up at the end of their most recent course of treatment.

T=Transfer in: A patient who started treatment in one health facility (reporting unit) and transferred to another health facility (reporting unit) to continue treatment.

O=other previously treated patients are those who have previously been treated for TB but whose outcome after their most recent course of treatment is unknown or undocumented

NB: Category of patient should be recorded in this section. The proper category of patient is necessary to determine the appropriate treatment regimen.

In the lower space: Write the type of TB:

P/Pos= Bacteriologically confirmed TB cases using available confirmatory diagnostic methods

P/Neg= clinically diagnosed pulmonary TB cases

EPTB= Extra-pulmonary TB cases (Bacteriologically & clinically diagnosed)

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- **Nutritional Assessment and status Baseline weight** (Column 11): On the upper space: Enter the weight of the patient in Kg.and then on the lower space: Calculate BMI and Enter the value. BMI is computed as weight in kg divided by height in meter square. For patient age 5-18 years, use BMI-for-age and refer standard charts. Measure and enter MUAC in cm for pregnant, bedridden or under-five patient

  Nutritional status: classification (Column 12): nterpret the anthropometry and enter the result as either "Normal"; "MAM" or "SAM":

  - **SAM criteria in Adults:** BMI <16 OR MUAC <18cm; for pregnant women and lactating mothers MUAC <19 cm OR edema of both feet without clear cut other cause.
  - **MAM criteria in Adults:** BMI 16 - <17.5 OR MUAC 18 - <21 cm For pregnant women and lactating mothers: MUAC 19- <23 cm OR For HIV positive client: Confirmed (>5% weight loss since last visit) or reported weight loss (e.g. loose clothing) AND No edema of both feet.
  - **No Acute Malnutrition/Normal:** BMI >17.5 OR MUAC >21 cm or pregnant women and lactating mothers >23 cm) AND No edema of both feet

- **Intensive phase: Drug** (Column 13): Enter the treatment regimen (Fixed Dose Combination) used in the intensive phase.
- **Intensive phase Dose** (Column 14): Enter the treatment dosage of (Fixed Dose Combination) used in the intensive phase.
- **Treatment Started** (DD/MM/YY) (Column 15): Enter the date TB treatment started in EC using DD/MM/YY format.
- **Write the month** (Column 16): Write the name of month for each month of intensive treatment as follows: If treatment begins in Tikmt, write "Tik" on the first line of column 16. When the month is completed, and if the patient continues treatment, write the name of the next Month Hidar as "Hid" on the second line of column 16, etc, for as long as intensive phase treatment continues.

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- **Days of month** (Column 17-46): Tick (✓) each day the patient receives DOTS treatment and Mark(X) for days not receiving DOTS treatment. These columns are used to follow/monitor when the patient takes his/her daily treatment. Tick under each column whenever the patient takes the drugs.
- **HIV test offered (Column 47):** Tick (✓) if HIV test offered under provider initiated HIV counseling and testing guidelines.
- **HIV test performed (Column 48):** Tick (✓) if client tested for HIV/AIDS.
- **HIV Test results (Column 49):** Enter "R" in red pen if test is reactive or the patient has documented evidence of enrolment in HIV care such as enrolment to pre-ART register or in the ART register Enter "NR" in normal color of pen if test is not reactive at the time of TB diagnosis;

  Write "Unknown" if HIV testing is not done or no other documented evidence of enrolment in HIV care

- **CPT Started (DD/MM/YY) (Column 50**): Enter the date CPT started, written as (EC) Day / Month / Year (DD/MM/YY) for co infected patients.
- **Enrolled in HIV care (DD/MM/YY) (Column 51):** Enter the date patient enrolled in HIV care (PreART), written as (EC) Day / Month / Year (DD/MM/YY)
- **ART started (DD/MM/YY): (Column 52):**
- Upper space: Enter the date patient started ART, written as (EC) Day / Month / Year (DD/MM/YY). Lower space: Enter the unique ART number for a patient who started ART Treatment in the same facility. If the patient referred to other facility, write as "referred to other facility".

NB: It is the responsibility of the TB focal person of the facility to ensure the effectiveness of referral linkage and its outcome of the patients to the patient preferred and nearest ART Clinic.

Upper space: Presumptive DR-TB and Lower space: DST Result. (53):

Enter **Y=Yes** if the patient is presumptive DR-TB as per the national guideline

Enter **N=No** if the patient is NOT presumptive DR-TB as per the national guideline

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Lower space:

Enter No RR - if the DST result of the patient shows no resistance at least to Rifampicin

Enter **'RR-TB'** if patient DST result is resistance to Rifampicin only

Enter **MDR-TB'**= if patient DST result of the patient is resistance to both Rifampicin and INH (MDR-TB)

Enter **Pre-XDR** = if the DST result of the patient shows resistance to Isoniazid and rifampicin and either a fluoroquinolone or second-line injectable drugs but not both.

Enter **XDR**= if the DST result of the patient show resistance to any fluoroquinolone and to at least one of three second-line injectable drugs (capreomycin, kanamycin and amikacin), in addition to multidrug resistance.

- If DR TB confirmed (**Column** 54):

Upper space: If the patient confirmed with DR TB, Write the name of the health facility that the patient referred for treatment

Middle space :Enter treatment started date using Ethiopian Calendar(DD/MM/YY)

Record the date when the clinical team decided that the patient deserve DR-TB treatment; in most case the date of registration and date of start will be the same if the patient started the treatment upon arrival and if no other investigation/s are important before the start of the DR-TB treatment.

Lower Space: Write a new unique patient identification number assigned by DR TB treatment initiating center. The DR-TB unique number is assigned as follows:

Region/Type of facility/facility code/five digit serial number with DR prefix.

For instance, If a patient is started on SLD treatment at St peter hospital and is the 22nd patient to be put on SLD at the center.

His/her unique MDR number will be: 14/08/020/DR00022

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Please write only the five digit number with DR prefix on the space provided as the facility type and code are already written at the top of each page.

Contact screening: Household /Close contacts (Column 55): Upper space: Write total number of Household and/ or close contacts including fewer than 5 children (Number

Middle space: Enter total contacts screened for TB at HF at least once (Number)

Lower space: Enter number of TB cases diagnosed among contact of index TB cases (Number).

Contact Screening: This section records the number of people that the TB patient thinks s/he has come in contact with, along with the number of contacts screened for TB and also Number of TB diagnosed cases among contacts. Record the number of people that the TB patient thinks they have come in contact with in the upper space of the column. Of these people, record the number of contacts screened for TB in the middle space and record the number of TB diagnosed among contact in the lower space.

Contact screening and treatment for LTBI: Under Five Year (Column 56):

Upper space:) Enter total number under-five contacts with index TB case (Number)

Middle space: Enter the number of under 5 children Household and/ or close contacts screened for TB at HF at least once (Number)

Middle Space: Enter the number of under 5 contact screened for TB and free from sign and symptom of TB

Lower space: Enter number of under 5 children free from TB and put on IPT.

Sputum results: Follow Up(Column 57-59):

Upper Space: Write Lab. Serial number of the sputum smear test

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Lower Space: Enter the smear result as "P" for positive result using red pen; "N" for negative results and "U" for not done/results not available

Nutritional Assessment: End of second month of treatment (Column 60):

Upper space: Enter the weight of the patient in Kg.

Lower space: Calculate BMI and enter the value. BMI is computed as weight in kg divided by height in meter square. For patient's age 5-18 years, use BMI-for-age and refer a standard chart. Measure and enter MUAC in cm for pregnant & lactating women, bedridden or under-five patient

Nutritional status: classification (Column 61): See description on column #12 above and enter the classification in the space provided.

Continuation phase: Drugs Column 62): Enter the TB drugs therapy used in the continuation phase.

Continuation phase: Dose Column 63): Enter the TB drugs therapy dosage used in the continuation phase.

Continuation phase: weekly adherence monitoring chart (Column 64-77): Write the date in the appropriate week row of the month, when the TB client collects the weekly doses of TB treatment.

Final treatment outcome and Date treatment outcome assigned (Column 78):

Upper space: Enter final outcome of TB treatment:

Cured: A pulmonary TB patient with bacteriologically confirmed TB at the beginning of treatment who was smear- or culture-negative in the last month of treatment and on at least one previous occasion.

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Treatment completed : A TB patient who completed treatment without evidence of failure BUT with no record to show that sputum smear or culture results in the last month of treatment and on at least one previous occasion were negative, either because tests were not done or because results are unavailable.

Treatment failure: A TB patient whose sputum smear or culture is positive at month 5 or later during treatment.

Died: A TB patient who dies for any reason before starting or during the course of TB Treatment.

Lost to follow up: A TB patient who did not start treatment or whose treatment was interrupted for 2 consecutive months or more.

Not evaluated: A TB patient for whom no treatment outcome is assigned. This includes cases "transferred out" to another treatment unit as well as cases for whom the treatment outcome is unknown to the reporting unit.

Moved to DR-TB Register : A patient who has been diagnosed as having DR-TB as per the national guideline prior to being declared as' Failure' and is placed on DR-TB TB treatment

NB: If patient is transferred out to another facility, write the receiving HF name and contact address on the remark place with pencil and confirm the final result and report to the next level during the appropriate reporting period.

Lower space: *Enter the date on which final outcome is assigned in EC using DD/MM/YY format*

Nutritional interventions (Column 79):

Upper space: Enter the type of nutritional treatment as "RUTF" or "RUSF"

Lower space: Enter the data on which nutritional treatment is started in EC using DD/MM/YY

Nutritional treatment: Outcome (Column 80):

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Upper space: Record the final outcome of the therapeutic or supplementary food treatment as: recovered/cured; No change; other outcome (specify)

The following arithmetic measure should be consider to label patients as recovered/cured from nutrition related problem, if Adult (non-pregnant/lactating) with BMI ≥18.5 ; Pregnant and lactating-with MUAC ≥ 23 cm,; Children: Under 5 years -WHZ-score above the -2 or WHM greater than 80% ; and Children :5-18 years -BMI for-Age Z- score above the -2

Lower space: Enter the data on which nutritional treatment outcome assigned date in EC using DD/MM/YY.

TB Treatment Adherence support (Column 81-82):

Mark(✓) under Health Post if individual patient received support for TB treatment adherence(all efforts and services provided including treatment observation, adherence counseling, pill counting and other activities to monitor both the quantity and timing of the medication taken by a patient) at health post by HEWs at least during continuation phase of the treatment.

Mark (✓) under Health facility If the treatment adherence support provided by the health care worker at health facility throughout the course of the treatment.

Remarks(Column83): Write any additional information about the patient that may assist the treatment provision service.

Data elements for reporting from TB register:

- Number of bacteriologically confirmed New Pulmonary TB cases detected in the quarter (Disaggregated by age and sex)
- **Number of clinically diagnosed New pulmonary TB cases detected in the quarter** (Disaggregated by age and sex)
- **Number of clinically diagnosed and bacteriologically confirmed new EPTB cases detected in the quarter** (Disaggregated by age and sex)

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- **Number of RELAPSE (bacteriological confirmed andclinically diagnosed) TB cases detected in the quarter** (Disaggregated by age and sex)
- **Number of bacteriologically confirmed relapse TB cases (Disaggregated by sex)**
- **Number of c**linically diagnosed relapse TB cases **(Disaggregated by sex)**
- **Number of** Treatment after failure **(Disaggregated by sex)**
- **Number of** Treatment after lost to follow-up **(Disaggregated by sex)**
- **Number of** Other previously treated (unknown & undocumented treatment outcome **(Disaggregated by sex)**
- **Total number of new bacteriologically confirmed TB cases enrolled in cohort (PTB+)**
- Number of cured TB cases
- Number of Treatment completed TB cases
- Number of Died TB cases
- Number of Lost to follow up
- Number of Not evaluated
- Number of Moved to MDR TB treatment
- **Total number of new clinically confirmed pulmonary TB cases enrolled in the cohort (P/Neg)**
- **Treatment outcomes of P/Neg patients (Treatment completed, died, Lost to follow up, failure, not evaluated, moved to MDR Tb treatment)**
- **Total number of clinically diagnosed and bacteriologically confirmed new EPTB cases enrolled in the cohort (EPTB)**
- **Treatment outcomes of EPTB patients (Treatment completed, died, Lost to follow up, failure, not evaluated, moved to MDR Tb treatment)**
- **Number of TB case detected and registered on TB unit register who are initially referred by the community**
- **Number of cohort new TB cases(all forms) successfully treated and provided with treatment adherence support by the community in the same quarter of the previous EFY**

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- **Total number of new patients with TB (all forms) given treatment adherence support at community level for at least full course of the continuation phase treatment in the same quarter of the previous EFY**
- Total number of children under 5 contacts with index of drug suscptible pulmonary TB cases during the reporting period
- The number of under-five years contacts with index of pulmonary TB cases screened for TB in the reporting period
- The number of under-five years contacts with index of pulmonary with TB cases screen negative result in the reporting period
- Total number of under-five years contact free from TB and put on treatment of LTBI treatment (IPT) in the reporting period

Indicators from TB Register

- Tuberculosis case detection rate (all forms)
- Tuberculosis Re-treatment Rate
- Cure Rate for bacteriologically confirmed new PTB cases
- Treatment Success Rate (TSR) among bacteriologically confirmed NEW PTB cases
- Treatment success rate among clinically diagnosed new TB cases
- Death Rate among new all forms of TB cases
- Lost to follow up rate among new all forms of TB cases
- TB case detection contributed by community
- Treatment success of TB patients who received community-based treatment support
- Latent TB Infection (LTBI) treatment coverage for under five years children who are contacts of pulmonary TB cases
- Drug Susceptibility Test (DST) coverage for TB patients
- Number of Drug Resistant (DR) TB cases detected
- DR-TB cases enrolled on DR TB Treatment (Second Line Drugs)
- Percentage of Drug resistant TB (DR TB) cases with six month interim result

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Exercise on TB register

TizitaSeifeMerga is a resident of Bishoftu town, Kebele 02, house number 234 with age 34 years. Her MRN is 00002 in Beishoftu Health Center. She was working as commercial sex worker for the last 10 years. She had cough for more than two months. She was advised to visit near by health center and to get tested for TB by her colleagues. She visited Bishoftu health center on Ginbot 12, 2000. She was ordered to provide spot - morning - spot sputum test and the test result was smear positive for pulmonary TB for first time. Her lab number was 123 and her weight was 49 kg. She was put on DOTS with fixed dose combination chemotherapy (R, INH, Z& E) on the following day. Her contact person was Martha Desalew who is resident of Bishoftu, Kebele 02, and house number 123. Tizta was also offered HIV test and the result was positive. Cotrimoxazole chemoprophylaxis was started on the same day when anti-TB treatment is initiated. She was also linked to HIV care on the same day

1. Complete the registers appropriately
2. Describe the cases that all four rows in unit TB register can be used during DOT's intensive phase
3. When do you do sputum check for category 2 patients and in which column would you register the result
4. When would you say a patient is multiple drug resistance?

2.2.2 Drug Resistant Tuberculosis (MDR TB) Register

- This register is used by facilities which started the treatment of multi drug resistant tuberculosis. It is used to record data for patients who are on MDR TB treatment. It is also used as a monitoring tool during the intensive and continuous phases of MDR TB treatment.
- It is a longitudinal register where patients are followed for the whole period of treatment once they are registered.

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- Data is abstracted from the patient's folder, especially at the beginning of the registration period. Then, follow up can be performed on the register (by ticking on the follow up columns of the register).
- The register has to be completed by the health service provider at the time of service provision.
- It should be kept in MDRTB treatment room.

How to complete the register?

The register has sections for registration, laboratory test results, follow up sections for the intensive and continuous sections, and treatment outcome section. The register is completed in a similar way at tuberculosis register is completed. Follow the instruction on the register and complete it accordingly.

Reportable data elements from DR register

- Number of Drug Resistant (DR) TB cases detected
- DR-TB cases enrolled on DR TB Treatment (Second Line Drugs)
- Percentage of Drug resistant TB (DR TB) cases with six month interim result
- Final Outcome of DR-TB cases

Indicators from DR Register

- Number of Drug Resistant (DR) TB cases detected
- DR-TB cases enrolled on DR TB Treatment (Second Line Drugs)
- Percentage of Drug resistant TB (DR TB) cases with six month interim result
- Final Outcome of DR-TB cases

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2.2.3 Leprosy Register

- Leprosy register is a longitudinal register where a patient registered is followed until the end of the treatment period.
- The register is kept in leprosy treatment room and is completed by the leprosy care provider

How to complete the register?

- **Identification section of the register (column 1-5):** These columns are used to document the demographic characteristics of the patient, including the name and address of the contact person of the patient.
- **Lab result and patient category (columns 6-7):** these columns are used to record the laboratory result of the patient (the smear result), lab number and category of the patient (PB or MB).
- **Disability Grade (Col. 8-10):** These columns are used to record the disability grade of the eyes, hands and feet and total disability status.
- **Date starting treatment (Col 11):** Write the date treatment is started
- **Total number of HH contacts (Col. 12):** Write the number of HH contacts on the upper row and the total number of HH contacts diagnosed with leprosy on the lower row.
- **Attendance table (Column 13-25):** column for each month with name at the top.
    - For MDT, enter the date MDT given in the column for the appropriate month.
    - For steroids, enter the dosage in Mgs in red color.

- **Column 26 -29:** enter the treatment outcome in the appropriate column.Enter the date that treatment was stopped.
    - ***Treatment completed*** (col. 26): A patient who has completed a full course of MDT within the prescribed period.
    - ***Died*** (col. 27): A patient who dies of any cause during the course of MDT.

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- ***Default*** (col. 28): A patient who has failed to collect more than three four-weekly (monthly) doses (consecutive or cumulative) of MDT.
- ***Transfer out*** (col. 29): A patient who has started treatment in one Woreda (reporting unit) and has been transferred to another Woreda (reporting unit) and for whom the treatment outcome is not known at the time of evaluation of treatment results.

- Complete the other columns as per the instruction in the register

Reportable data elements from leprosy register

- New leprosy cases identified (by age)
- Category of leprosy treatment (PB/MB)
- Disability grades
- Treatment outcome of leprosy treatment

Indicators from leprosy register

- Leprosy case notification
- Grade II disability rate among new cases of leprosy
- Leprosy treatment completion rate

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2.3 OPD abstract register and tallies

Topics Covered

- Introduction to the OPD abstract register
- Procedures of completing the OPD abstract register
- Reportable data element from the OPD abstract register
- Indicators calculated from the OPD abstract register
- Summary of the OPD abstract register

Objectives

- To describe the purposes of OPD abstract register
- To define & properly record the required data elements from outpatient department services.
- To accurately identify & able to extract the reportable data elements from the OPD abstract register
- To define and calculate indicators using the OPD abstract reportable data elements

Time needed: 8 hours

Introduction

OPD abstract register is a serial register. The register lists all patients who received outpatient services at the health facility. It is used for outpatient patients 5 years and older in health facility. Under five years old children will be recorded in the IMNCI register and the service is provided in IMNCI unit. The register is kept in the OPD unit to capture the diagnosis disease data based on the nationally customized diseases classification (NCoD – National classification of Diseases) & needs to be documented with optimal quality to enhance the accurate collection of the data; for the morbidity report and indicator calculation. Each care provider has the ethical and moral obligation to record the data on the register accordingly and use the information collected for regular informed decision making; to improve the quality of service provided at local level and support the policy direction to be designed at the higher level.

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- OPD abstract register lists all outpatient patients 5 years and older in the health facility who received outpatient service at the facility.
- The OPD abstract register captures clients receiving outpatient services at the health facility.
- Information for the register is abstracted from the patient form.
- The patient form and register are both completed by the service provider at the time of OPD service.
- The patient form should be kept in the individual folder.
- The register is kept in the OPD room.

HOW TO COMPLETE THE OPD abstract REGISTER:

The cover page

- The cover page contains the Federal ministry of health logo to denote that the register is being used in all public and private facilities found under FMOH.
- In the Middle the level of health facilities intended to use this register and the name of the register itself.
- The third component of the cover page is the part in which the care provider ought to record the facility's Region, Sub-city/Woreda, Health facility name, and beginning and start date of the register.
- All the above data are crucial for the use of the register appropriately in the facility and needs to be recorded **before starting to use the register** by the care provided with eligible hand writing. If more than one department is available in the facility providing the service we can denote this by writing identifying note at any open space on the cover of the register with parker or bold hand writing. Like OPD unit #1, OPD unit #2.

The instruction

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- The instruction part is found in the inside part next to the hard cover. It contains all the basic procedures how to use the OPD abstract register appropriately. Before using any register, all care providers are required to read the procedures thoroughly.

The main part of the register and its recording and reporting procedures

How to complete OPD register

- **Registration Date:** Write the date the patient received the service.
- **Visit Type:** The patient visit type should be classified as new and repeat and a tick (✓) mark is used in the respective columns.

  How would you define a new visit? Repeat visit?

  - ***New Visit*** is patient visit for a new episode of illness.
  - ***Repeat Visit***is a patient who visits the health facility for the same episode of illness and or for follow up etc

Note: The ultimate decision, whether a client/patient is defined as new or repeat diagnose is left to the knowledge of attending clinician

- **Assessment, diagnosis, and treatment:**
  - Enter the Diagnose from the patient card as HMIS disease classification in the diagnosis columns.
  - If the patient is referred; indicate with (✓) and site referral documented at the remark.
- **Other data elements/columns:** Complete in the same way. The participants can refer to the instruction section of the OPD register, which is available at the first pages of the register.
- **Data elements for reporting**
  - HMIS disease classification (disaggregated by age, sex and visit type)
  - New visit
  - Repeat visit
  - PITC: HIV test offered, test provided and test results

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Tally sheets used in OPD

The following tallies from OPD abstract register are completed by the service provider, preferably at the end of each service day.

- **OPD Service Tally Sheet:** This tally sheet should be completed at the end of service delivery OPD against sex, age; by new and repeat attendance. It should be done at the end of each working day. This tally sheet is used to analyze OPD attenedance per capita indicator and should be kept at Medical Record Unit and departments where patients do not visit Medical Record Unit to get service at follow up such as TB clinic, dressing and others
- **PITC tally:** This tally sheet is used to document HIV test and its result. The tally sheet is completed with a disaggregation by age and sex.

Summary points for discussion

Make sure about the following points on OPD register and tally sheets:

- Definitions of new and repeat OPD visits
- Correctly defining each data element on OPD register
- OPD diagnosis and attendance tally and the procedure of tallying from the OPD register
- Review reportable data elements and indicators from OPD register

Exercise 2: Exercise on OPD register and tallies

W/ro Aregash Hailu, 25 years old woman who is brought in supported by her family on Ginbot 10, 2009. Her old card is found (MRN 12340). She complains of high grade fever, chills and rigors. On arrival, the nurse measured the vital signs and documented a temperature of 39.8 0C, pulse was 120/minute & BP was 110/70 mmHg. Pallor is found on physical examination. Laboratory results confirmed the diagnosis of Falciparum malaria and Anemia. She was given a prescription for Co-Artem and sent home.

W/ro Aregash returns after 7 days on Ginbot 17. Her fever has resolved. She now complains that she has persistent watery diarrhea for the last 2 days. The vital signs are normal and physical examination is normal & Stool examination is negative. She was given ORS and advised to return

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if she has no improvement. She is offered counseling & testing for HIV at this visit but declines to be tested without talking to her husband.

W/roAregash returns after two days on Ginbot 19. She still has diarrhea and you gave her additional ORS & reassured her that she will get better. She has discussed about getting tested for HIV with her husband and wants to be tested today. HIV test is performed & was negative. Let us assume that W/roAregash is admitted to medical ward on her subsequent visit.

1. Fill the OPD abstract register accordingly.
2. What NCoD do you write on this register?
3. List appropriate tally/ies W/roAregash can be considered.

2.4 Admission/Discharge register and tallies

Recording and reporting procedures of Admission/Discharge register at public or private health facilities (Health center, Clinic and Hospitals).

Topics Covered

- Introduction to the Admission/Discharge register.
- Procedures how to complete the Admission/Discharge register.
- Reportable data element from the Admission/Discharge register.
- Indicators calculated from the Admission/Discharge register.
- Summary of the Admission/Discharge register.

Objectives

- To comprehend the purpose of the Admission/Discharge register at the facility level.
- To properly record the required Admission/Discharge service provided by the health facilities in the Admission/Discharge register.
- To accurately identify and able to extract the reportable data elements from the Admission/Discharge register.

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- To enable how to calculate indicators using the Admission/Discharge reportable data elements.

Time needed: 2 hours

Introduction

Admission/Discharge register is a serial register, in the register lists all patients who received inpatient services at the health facility. It is used for outpatient patients 5 years and older in health facility. Under five year children will be recorded in the IMNCI register in the being provided at the IMNCI unit. The register is kept in the Admission/Discharge unit to capture the diagnosis and treat disease data based on the national agreed ICD10 diseases classification and needs to be documented with optimal quality to enhance the accurate collection of the data; for the morbidity, mortality and indicator calculation. Each care provider have the ethical and moral obligation to record the data on the register accordingly and use the information collected for regular informed decision making; to improve the quality of service provided at local level and support the policy direction to be designed at the higher level.

- Admission/Discharge register lists all outpatient patients 5 years and older in the health facility who received admission services at the facility.
- The Admission/Discharge register captures clients receiving admission services at the health facility.
- Information for the register is abstracted from the patient form.
- The patient form and register are both completed by the service provider at the time of service.
- It is completed by the service provider on admission and upon discharge.
- The patient form should be kept in the individual folder.
- The register is kept in the admission room.

How to complete the admission/discharge register

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The cover page

- The cover page contains the Federal ministry of health logo to denote that the register is being used in all public and private facilities found under FMOH.
- In the Middle the level of health facilities intended to use this register and the name of the register itself.
- The third component of the cover page is the part in which the care provider ought to record the facility's Region, Sub-city/Woreda, Health facility name, and beginning and start date of the register.
- All the above data are crucial for the use of the register appropriately in the facility and needs to be recorded before starting to use the register by the care provided with eligible hand writing. If more than one department is available in the facility providing the service we can denote this by writing identifying note at any open space on the cover of the register with parker or bold hand writing. Like Admission/Discharge unit #1, Admission/Discharge unit #2.
    - OPD diagnosis & attendance tallies are completed from the register immediately after service delivery against age & sex; new & repeat attendance. Moreover, PICT tally sheet will be used for those who were provided with PITC (Provider Initiated Testing & Counseling).

The instruction

- The instruction part is found in the inside part next to the hard cover. It contains all the basic procedures how to use the Admission/Discharge register appropriately. Before using any register, all care providers are required to read the procedures thoroughly.

The main part of the register and its recording and reporting procedures:

- **Identification:** Complete as per the instruction written in the register.

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- **Date of admission:** Write the date the patient is admitted in the ward. It should be in Ethiopian Calendar and follow the format DD/MM/YYYY.
- **HMIS admission disease classification (Column 7):** Write the HMIS disease classification of the patient at admission.
- **PITC (Columns 8-**10): Tick the columns if HIV test is offered, and if HIV test are provided. And write the HIV test result on column 10.
- **Discharge Information (Columns 11-**14): These columns are used to write while the patient is discharged. If the discharge diagnosis is similar to the admission diagnosis, then column 7 and 14 will be same. Otherwise, the two diagnoses can be different. It is the discharge diagnosis which is used for reporting.
- **Other data elements/columns:** Complete in the same way. The participants can refer to the instruction section of the admission/discharge register.
- **Data elements for reporting**
  - Number of admission (Column 7)
  - PITC test offered (Column 8)
  - PITC performed (accepted) (Column 9)
  - PITC test result (positive result) (Column 10)
  - Number of discharge (Column 11)
  - Length of stay (Column 12)
  - NCoD on discharge (Column 14)

Tally sheets used in IPD

The following tallies from IPD register are completed by the service provider.

- **IPD Service Tally Sheet:** This tally sheet should be completed at the end of service delivery to tally the total discharges, length of sgtay and deaths. ICU related data elements are also tallied on this register.
- **PITC tally:** This tally sheet is used to document HIV test and its result. The tally sheet is completed with a disaggregation by age and sex.

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Exercise: Exercise on admission/discharge register

A 25 years old Sara Alemayehu from Dejenworeda came to DebreMarkos hospital, 5th visiting patient to get ward physician on the same day and 25th patient after HMIS implementation in that hospital. She is admitted for lower abdominal pain with rebound tenderness and hypotension on the 10th of Tikimit, 1999. The surgeon evaluated her on admission and documented acute abdomen with a possibility of a ruptured appendix, ectopic pregnancy or pelvic inflammatory disease. She also accepted the offer and HIV test was negative. She was taken to the OR and a ruptured appendix was removed. She developed acute peritonitis and was kept on antibiotics for 14 days. She also developed pneumonia and UTI while she was in the hospital. She was discharged on Hidar 18 improved for which she paid 400 birr all in one with receipt number of 002321.

1. Complete Admission/discharge register accordingly and complete the appropriate tally (ies) for the above patient.
2. What are admission and discharge diagnosis of the above patient?
3. Assuming that Sara is one among the 5 companions on discharge, 2 of whom were co-admitted and others were on Tikimit 20. What is average length of stay? Given there will be ten times similar admissions to 20 available beds nd the condition continues for a couple of years. What will be your action as East Gojam Zone health manager?
4. Assume that Sara left the hospital on her own, what will be filled & in which column?
5. Enumerate reportable data elements.
6. Enumerate indicators that will be calculated from this register.

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4. Other Registers

Contents

Contents

- Recording procedure of operation, referral registers, Emergency, ICU, Ambulance registers
- Reportable data and indicators from these registers

Objectives of the session:

- ✓ At the end of this session, participants will be able to:
  - Understand how data is abstracted from individual medical records to the above mentioned registers
  - Understand the recording procedures of these registers
    - Recognize reportable data elements

In the next sessions, we will see the details of these registers one by one.

4.1 Emergency Register

Topics Covered

- Introduction to Emergency register
- Procedures of completing Emergency register
- Reportable data element from Emergency register
- Indicators calculated from Emergency register
- Summary of the Emergency register

Objectives

- To describe the purpose of Emergency register
- To properly record the required Emergency data elements from Emergency service
- To accurately identify and able to extract the reportable data elements from the Emergency register.

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- To compute and describe HMIS indicators using the Emergency reportable data elements

Time needed: 2 hours

Introduction

Emergency register is a register that is prepared for use in the emergency department. It should be placed in the emergency department and filled by service providers after service is provided.

Recording procedure

1. **Identification Section (column 1-7):** This section is used to record the personal identification of patients. It includes recording serial number, date, MRN from the patient's folder, age in years, sex and address of the patient.
2. **Arrival information (Column 8-11):** In these columns, arrival related information should be documented. On column 8, write the time of arrival as HH:MM:SS and in column 9, write the time the patient is seen by a triage officer as HH:MM:SS. In column 10, the mode of arrival should be documented as By ambulance or police car or if by other mode, it should be specified. The referral source should be documented in colun 11 as: self referred, referred from HC or Hospital or other (specified).
3. **Triage and diagnosis section (column 12 and 13):** In column 12, the triage category of the patient should be documented by choosing one of the coded categories. The traiage categories include Red (1), Orange (2), Yellow (3), Green (4) or blue (5). In column 13, write the diagnosis of the patient at arrival. It should be the NCoD diagnosis.
4. **Patient category (column 14 and 15):** In these columns, the patient should be classified as new or repeat and ticked under one of the columns. For the definition of new and repeat patient, refer to the OPD register where the definitions of new and repeat are defined and described.
5. **Disposition after triage (column 16):** In this column, write the code from the description on the foot note: 1 = Resuscitation, 2 = procedure/OR , 3 = Examination room, 4 = Waiting area

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6. **HIV assessment section (column 17-20):** In these columns, HIV testing and its results will be documented. Tick column 17 if an HIV test is offered for the patient; tick column 18 if HIV test is performed for the patient and write the test result of the patient in column 20 (as Reactive, non-reactive or Indeterminate). For column 19, write the target population category of the patient by choosing one of the listed categories at the end of each page of the register. The target population categories include: A=Female Commercial Sex Worker, B= Long truck driver, C=Mobile workers/daily labourers, D= Prisoners, E=OVC/children of PLWHA, F=Other MARPS, G=General Population
7. **Diagnosis at discharge (column 21):** Write the NCoD diagnosis of the patient at discharge.
8. **Date of discharge (column 22):** Write the date of discharge as DD/MM/YY
9. **Length of stay (column 23):** Write the total number of days the patient stayed
10. **Patient outcome section (column 24-27):** Tick the outcome of the treatment on the appropriate outcome. The outcomes include: Transferred out, stabilized and discharged, admitted or died.
11. **Remarks column (column 28):** Write any relevant data in this column.

Reportable data elements from emergency register

- Number of patient attendance in emergency room
- Total length of stay
- Total number of deaths
- Number of cases by NCoDs

Indicators from emergency register

- Top 10 causes of morbidity
- Average length of stay
- OPD attendance per capita
- Emergency room mortality

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4.2 ICU Register

Topics Covered

- Procedures of completing ICU register
- Reportable data element from ICU register
- Indicators calculated from ICU register

Objectives

- To describe the purpose of ICU register
- To properly record the required data elements from ICU service
- To accurately identify and extract the reportable data elements from the ICU register.
- To compute and describe HMIS indicators using the ICU reportable data elements

Time needed: 1 hour

Recording Procedure

ICU register is used to record information about patients who are treated in the Intensive Care Unit (ICU).

1. Identification Section (column 1-5): This section is used to record the personal identification data elements such as MRN, Name, age, sex. The recording procedure for these data elements is similar to our discussion in previous sections. It is also available at the instruction section of the register.
2. Admission Section (column 6-7): in this section, write the date of admission to the ICU unit in column 6 and the diagnosis at admission (NoCD) in column 7.
3. HIV assessment section (8-11): In this section, document the HIV assessment and its result, if PICT is provided for the patient. Tick columns 8 and 9 if HIV test is offered and performed respectively. In column 10, choose one of the target population category that is available in the bottom section of each page. In column 11, write the result of the HIV test as R for positive tests, NR for negative tests and I for indeterminate test results.

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4. Invasive mechanical ventilation section (column 12 and 13): In this section, write yes if invasive mechanical ventilation is provided, otherwise, write no. In column 13, write the number of days the patient was on invasive mechanical ventilation.
5. Patient information at discharge (column 14-17): In this section, document the date, length of stay, diagnosis and status of the patient at discharge from the ICU. Write the date of discharge in column 14, the diagnosis at discharge (NoCD) in column 15, the length of stay in column16 and the patient outcome at discharge in column 17. The patient outcome at discharge may be discharged, transferred out, died or other outcomes. Use the codes that are available at the end of each page.
6. Remark column (19): This column is used to record any relevant information about the patient.

Reportable data elements from ICU register

- *Total number of patients admitted to ICU*
- *Number of deaths in ICU*
- *Number of clients tested for HIV*
- *Number of clients tested positive for HIV*

Indicators from ICU register

- Admission rate
- Mortality rate in multi-disciplinary ICU
- Number of individuals Tested and counseled for HIV and who received their test results

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4.3 Ambulance register

Topics Covered

- Procedures of completing Ambulance register
- Reportable data element from ambulance register
- Indicators calculated from ambulance register

Objectives

- To describe the purpose of ambulance register
- To properly record the required Emergency data elements from ambulance service
- To accurately identify and extract the reportable data elements from the ambulance register
- To compute and describe HMIS indicators using the operation reportable data elements

Time needed: 30 minutes

Introduction

Ambulance register is used to record information about calls for emergency ambulance service request and the type of ambulance service provided. It is to be placed in Woreda ambulance dispatch centers. Ambulance related reportable data elements will be compiled on a monthly basis and reported on a monthly reporting format of Woreda Health Offices. The woreda health office should collect data about the number of calls and the type of ambulance service disaggregated by the type of cases served and the type of professional who accompanied during the ambulance service on a monthly basis.

Recording procedures

1. **Identification section (column 1-8):** This section is used to record data elements that are required to identify individuals who called the dispatch center and those who are patients that need the ambulance service.

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- Serial Number (column 1): Enter the serial number sequentially starting from 1 until the end of the budget year and start again from 1 at the first day of new budget year.
- Date: Enter the date of the call to the ambulance dispatch center, written as DD/MM/YY in Ethiopian calendar.
- Time of call: In column 3, write the time of call, written as HH:MM:SS (Hour: Minute: Second) in Ethiopian system
- Name of call person: In column 4, write the name of the person who called to the ambulance dispatch center. This is not the place where you write the name of the patient.
- Place of call (column 5): Ask the caller from where he/she is calling and write the answer in this column. If the call is from a health facility, write HF; if it is from home, write 'home', if it is from kebele, write 'kebel', if from other places, specify the place and enter into the column.
- Tel. number (column 6): Write the telephone number of the caller in this column
- Demographics of the patient (column 7-10): In these columns, ask the demographic characteristics of the patient and enter the date in the respective columns including name of patient, sex, age and his/her address.

2. **Reason for calling section (column 11-13)**: The call receiver should ask the reason for calling to initially identify the problems of the patient. Tick column 11 if the reason is for labor and delivery service; tick column 12 if the reason is for traffic accident, write the other reasons in column 13.
3. **Ambulance service received section (Column 14-16):** This section is to document if the service is provided for the specified reason. This should be completed only if the service provided.
4. **Ambulance dispatch and the time it takes section (column 17-21)**: This section is used to document when and for how long the ambulance service has taken.
    - Time of ambulance dispatch: Write the time of ambulance dispatch as HH:MM:SS
    - Person who accompanied the patient in ambulance: Write the type of professional who accompanied the patient by choosing one of the codes. If the patient is

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accompanied by EMTs (Emergency Medical Technicians), write 1; if the patient was accompanied by other health professionals such as nurses, write 2.

- Time of arrival to the patient or accident place should be documented in column 19 as HH:MM: SS.
- Time of Ambulance arrival at HF: Document the time the ambulance has arrived at a health facility after the patient is taken.
- Average time of travel: In column 21, write the time that takes from dispatch to arrival to a health facility (The time length between time in column 17 & time in column 20).

4. **Name of health facility**: In column 22, write the name of the health facility to where the patient is taken to.
5. **Distance from patient address:** Write the distance from the patent's address to the health facility.
6. **Reason for not providing ambulance service:** This column is completed if there was an ambulance call but the ambulance service was not provided. The reasons should be filled by using the available codes at the bottom of each page: 1 = ambulance is dispatched to another place / on service at the time of call; 2 = ambulance on maintenance/not functional at the time of the call, 3 = No driver at the time of the call, 4 = No fuel, 5.= other reason
7. **Remarks column:** This column is used to write any relevant information about the patient.

Reportable data elements from ambulance register

- Total number of Ambulance dispatched in the reporting period
- Total number of Ambulance dispatched with Emergency Medical Technicians (EMT)
- Total number of Ambulance dispatched without Emergency Medical Technicians
- Total number of Ambulance dispatched for labour and delivery cases
- Total number of Ambulance dispatched for road traffic accident
- Total number of Ambulance dispatched for other health problems
- Total number of community calls made during the reporting period

Indicators from ambulance register

- Pre-hospital ambulance service response rate

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4.4 Operation register

Topics Covered

- Procedures of completing operation register
- Reportable data element from operation register
- Indicators calculated from operation register

Objectives

- To describe the purpose of operation register
- To properly record the required Emergency data elements from operation service
- To accurately identify and extract the reportable data elements from the operation register
- To compute and describe HMIS indicators using the operation reportable data elements

Time needed: 30 minutes

Introduction

Operation register is used to record data from patients who have had an operation (major or minor surgery) in the facility. The register should be placed in Operation Theaters (both in minor and major OR rooms. It should be completed by service providers in the department.

Recording Procedures

1. **Personal Information Section (column 1-5):** In these columns, please write the personal identification data elements that includes Serial number, MRN (Form the individual medical folder), Date (Write as DD/MM/YY), the time of operation (In Ethiopian timing system as 00:00) and the ward where the operation is performed.
2. **Preoperative diagnosis (Column 6):** in this section, write the diagnosis of the patient before the operation was performed.

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3. **Operation procedure Section (Column 7-8):** This section is used to record the type of procedure performed and the post-operative diagnosis. The preoperative and post operative diagnosis may or may not be the same. If the post-operative diagnosis is the same as the post-operative diagnosis, then write the word “Same” in column 8.
4. **Anesthesia section (Column 9-10):** this section is used to record the type of anesthesia used during the operation procedure, identified as general anesthesia or regional anesthesia. If the patient was provided with general anesthesia, then tick column 9 but if the patient was provided with regional anesthesia, then tick column 10.
5. **Name of professionals involved (column 11-14):** The names of the surgeon (in column 11), anesthetist (column 12), Scrub nurse (column 13) and assistants (column 14) should be documented.
6. **Operation outcome section (column 15-17):** The outcome of the operation procedure is documented in this section. If the patient is stable after the operation, then tick column 15; if the patient is critically sick after the procedure, then tick column 16 and if the patient died after the operation, then tick column 18.
7. **Remarks Section (column 18):** This section is used to write any relevant information regarding the patient who undergo the surgical operation.

Reportable data elements from OR register

- Number of Cataract surgeries performed

Indicators from OR register

- Cataract surgical rate

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4.5 Referral register

Topics Covered

- Introduction to the referral register
- Procedures of completing referral register
- Reportable data element from referral register
- Indicators calculated from referral register
- Summary of the referral register

Objectives

- To describe the purpose of referral register
- To properly record the required data elements from referral service
- To accurately identify and able to extract the reportable data elements from the referral register.
- To compute and describe HMIS indicators using the referral reportable data elements

Time needed: 1 hour

Introduction

Referral register is used to document patients who are referred to other facilities for better medical care or follow up care. The referral out can be to higher health facilities (for better care) or to lower health facilities for continuity of care. It is also used to document referred in patients from other health facilities or from the community. Refer the instruction on how the register can be completed.

The facilitator should show the register to the participants and complete the register together.

Recording Procedure

1. Identification Section (Column 1-6): These columns are used to record the identification related data elements. It is completed in the same way as other registers discussed before.

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2. Emergency Referral Section (column 7-12): This is used to document those who are emergency. The transfer-in cases are recorded in columns 7-9. If the patient is referred from other health facility with communication before arrival, column 7 should be ticked, otherwise if the referral is done without communication, column 8 will be ticked. If the patient is self-referred, then he will be ticked under column 9. For Transferred out patients, tick column 10 if the patient is referred with communication to the other facility, tick column 11 if the patient is transferred out without communicating the other facility and if the referral is with an ambulance, tick column 12.
3. Non-Emergency Referral Section (Column 13-14): For non-emergency (cold cases), if the patient is referred out, tick column 11. Otherwise if the cold case is referred in, tick column 12.
4. Reason for referral (columns 15-18): This section is used to document the reasons for the referral in or referral out. Tick on the corresponding column based on the reason of the referral that includes: Gynecology/Obstetrics (column 15), Medical reasons (column 16), Surgical reason (column 17), Trauma (column 18)
5. Feedback section (Column 19): This is to document if feedback is received or provided (to be ticked).

Reportable data elements:

- Number of referred patients (emergency + non- emergency) Recording

Indicators from the referral register:

- Referral Rate

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4.6 Trachomatous Trichiasis (TT) Surgery register

Topics Covered

- Procedure of completing TT surgery register
- Reportable data element from TT surgery register
- Indicators calculated from TT surgery register

Objectives

- To describe the purpose of TT surgery register
- To properly record the required data elements from referral service
- To accurately identify and extract the reportable data elements from the TT surgery register.
- To compute and describe HMIS indicators using TT surgery reportable data elements

Time needed: 30 minutes

Introduction

TT surgery register is used to record data for patients for whom trachomatous trichiasis surgery. It should be placed in a room where TT surgery is performed. If the TT surgery is performed at an outreach place, the register should be taken to the outreach site and the recording should be done there.

Recording Procedure

1. **Identification Section (Column 1-7):** This section is used to record the personal identification data elements that includes name, age, sex, address and date of registration. For name, use the upper row to record the name of the individual and use the lower row to record his/her father's and grand father's name.

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2. **Modality (column 8):** This is used to record the modality (site) where the TT surgery was performed. The modality may be static (write static), mobile (write mobile) or outreach (write outreach).
3. **Diagnosis section (column 9-12):** Tick the appropriate diagnosis for the upper lid and lower lid. If the diagnosis is on the Right Upper Lid, tick under RUL, If it is on left upper lid, write LUL. For the lower lid, if it is on the right side, tick under RLL (Right lower lid). If the diagnosis is on the left lower lid, tick under LLL.
4. **Post Operation Follow up section (column 13-16):** The result of the post OP follow up between 7-14 days and between 3 to 6 onths should be documented in this section. For 7-14 post OP follow up, use the codes to document the presence or absence of the listed outcomes after the operation. Write 1 if there is a good result and only suture is removed; write 2 if there is eyelid closure defect; write 3 if there is cellulitis; write 4 if there is local infection. For the 3 to 6 months post follow up, write 1 if there is good correction; write 2 if there is trichiasis; write 3 if there infection; write 4 if there is lagophthalmos.
5. **Treatment Offered Section (column 17):** Write 1 if Zithromax is provided, or write 2 if TEO (Tetracycline eye Ointment).
6. **Name of IEC (Surgeon):** on column 18, write the name of the surgeon who performed the operation.
7. **Remarks column:** Column 19 is used to record any information that is relevant to the patient.

Reportable data elements from TT surgery register

- Numbers of individuals who are treated by Zithromax or TEO for Trachoma

Indicators computed from TT surgery register

- Therapeutic Coverage for preventive chemotherapy diseases (PCT)

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4.7 Central Register

Topics Covered

- Introduction to central register
- Procedures of completing central register
- Reportable data element from central register
- Indicators calculated from central register

Objectives

- To describe the purpose of central register
- To properly record the required data elements for central register
- To accurately identify and extract the reportable data elements from the central register
- To compute and describe HMIS indicators using the central reportable data elements

Time needed: 30 Minutes

Introduction

Central Register is used to record basic demographic and financing related information about individual patients or clients receiving services at health facilities. It is placed at the Medical Record Unit & should be completed by MRU workers. This register captures all individuals coming to the facility so that total number of visits in the facility can easily be known.

Recording procedure

1. Column 1: This is used to record the serial number of patients/clients.
2. Column 2: In this column, write the date the patient/client is registered
3. Column 3: Write the Medical Record Number (MRN) of the individual patient/client
4. Column 4: Name of the patient/client should be registered in this column
5. Column 5: Age in years
6. Column 6: Sex of the patient/client
7. Column 7: Disability status of the patient/client should be documented in this column. Disability types that are visible to the MRU worker need to be documented in this section. The MRU worker should ask the patient/client if she/he has any type of disability and put the finding into this column by choosing the coded disability types. Write 1 if there is a

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vision loss; write 2 if there is hearing loss; write 3 if there is a mobility impairment, If there is any other disability, it should be specified.

8. Column 8: Enter the patient/client's payment type as 1 if he/she has a Community Based Health Insurance (CBHI); Write 2 if he/she is to be served by a credit; Write 3 if he/she is a cash paying person; Write 4 if he/she has an exempted service and Write 5 if he/she has a fee waiver.

Reportable data elements from Central register

- Total number of Outpatient Visits
- OPD visits <5: Male
- OPD visits < 5: – Female
- OPD visits 5-10: – Male
- OPD visits 5-10: – Female
- OPD visits 11-19: – Male
- OPD visits 11-19: – Female
- OPD visits 20-29: – Male
- OPD visits 20-29: – Female
- OPD visits 30-45: – Male
- OPD visits 30-45: – Female
- OPD visits 46-65: – Male
- OPD visits 46-65: – Female
- OPD visits >=66: – male
- OPD visits >=66:– Female
- Total number of CBHI Members visit made to HF within a month

Indicators computed from Central register

- Outpatient attendance per capita
- Total number of CBHI Members visit made to HF within a month

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2.4 HMIS Reporting formats and procedures

Contents:

- Reporting by type and period, and reporting channel
- Report Timeliness and completeness

Objectives of the session:

- ✓ At the end of this session, participants will be able to:
  - Define types of HMIS reports by type and period
  - Describe HMIS reporting channel and schedule
  - Define reporting timeliness and completeness

Time required: 8 hours

Introduction

The Ethiopian HMIS is designed in a way that can capture data from all health institutions (health facilities and administrative health units) in the country, including MOH, NGO, private for profit, and other governmental organizations. The HMIS report includes data elements regarding the services they provide, the disease cases they treat, mortality data and on administrative data such as human resources, finance, and logistics. Data from facilities will be aggregate and reviewed on a monthly and/quarterly basis and are transmitted through an integrated channel to assure standardization, consistency, and quality control.

Reporting channel and period: HMIS reports of health institutions will be through an integrated and one channel only. An HMIS unit of health institutions will be responsible for the overall management of HMIS data. Routinely collected data will be collected from service units/departments and will be compiled by Health Information System professionals working in

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HMIS unit. Reporting to the next level follows the health system's hierarchy. Health posts will submit their report to their cluster health center, which then compiles data from the health center and satellite health posts to send to Woreda Health Office. Woreda Health Offices compiles routine reports from the health centers and from the WoHOs and send it to the ZHDs. Zonal Health Departments then send their report to the RHB and then to the FMOH. For regions that have no functional WoHOs, health facilities will send their report to ZHDs (Example: Addis Ababa city Administration). For regions that have no functional ZHDs, the WoHOs will send their report to the RHB. wegions without ZHDsA monthly report is from the 21st of the previous month up to the 20th of the reporting period. Example: For Tikimt 2009 EC monthly report, the data should be collected from Meskerem 21 upto Tikimt 20, 2009. The reporting channel and period of public, private health facilities and administrative health units will follow the following schedule, as depicted in the table.

Table 1: Reporting level and reporting period of public health facilities

S.No.	Type of Health care facility	Reporting level	Latest date report should be submitted
1	Health posts	Cluster health center	26th of the month
2	Health Centers	Sub-city/woreda/town health offices	26th of the month
3	Primary Hospital	Zone/sub-city/woreda	26th of the month
4	General Hospital	Region/subcity/Zone	26th of the month
5	Specialized Hospital	FMoH	26th of the month

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Table 2: Reporting level and time of private health facilities

S.No.	Type of Health care facility	Reporting level	Latest date report should be submitted
1	Primary clinic	Sub-city/woreda/town health offices	26th of the month
2	Medium clinic	Sub-city/woreda/town health offices	26th of the month
3	Speciality Clinic	Sub-city/ woreda/ town health offices	26th of the month
4	Speciality Center	Woreda/Region	26th of the month
5	Primary Hospital	Region/Sub-city	26th of the month
6	General Hospital	Region /Zone/Subcity	26th of the month
8	Specialized Hospital	RHB	26th of the month

Table 3: Reporting level and time of all health institutions

S.No.	Type of Health care facility	Reporting level	Latest date report should be submitted
1	Health facilities	Sub-city/woreda/town health offices	26th of the month
2	Woreda Health Offices	Zonal Health Departments (Sub-cities)	2nd of the next month
3	ZHDs/Sub-cities	Regional Health Bureaus	7th of the next month
4	Regional Health Bureaus	FMOH	15th of the next month

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HMIS Report Types

The HMIS is designed to generate different types of reports that can capture important data elements to monitor and evaluate health programs in Ethiopia.

Types of reports by period:

- Monthly reports
- Quarterly reports
- Annual reports
- Weekly reports

Quarters for HMIS reporting

⇒ Quarter 1: Sene 21 – Meskerem 20
⇒ Quarter 2: Meskerem 21 – Tahsas 20
⇒ Quarter 3: Tahsas 21 – Megabit 20
⇒ Quarter 4: Megabit 21 – Sene 20

Types of reports by content

- OPD morbidity report
- IPD morbidity and mortality report
- Service reports
- PHEM reports

Each health facility is expected to send service and disease reports on a monthly basis. In addition, diseases which are under surveillance should be reported on a weekly basis or immediately when an immediately reportable disease is seen in the facility.

Each type of the above mentioned reporting formats are available in the annex section. Check it and use the following section to understand how it is completed.

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Procedure of completing reporting formats

Health centers, clinics and hospitals

- The report includes on the services they provide, the disease cases they see, and on administrative data such as human resources, finances, and logistics.
- Data will be collected by health workers in each service unit or support departments.
- Aggregate and review their data monthly or quarterly.
- Data are transmitted through an integrated channel to assure standardization, consistency, and quality control.
- Report to their respective administrative office monthly, quarterly and annualy (Woreda, Zone or Regional Health Bureau).
- They may also report to local government or other partners.

Administrative health offices:

The administrative health offices (Woreda Health offices, Zonal health departments and Regional Health Bureaus) aggregates the data they received from health facilities, adds their own data, monitors their own performance based on these reported data elements and reports to the next level.

Summary of HMIS data flow

Data flow should supply users with data in an effective and efficient manner.

☞ **Who:** Most HMIS data are generated at health facilities. The HMIS gathers data from all participating facilities, including MOH, NGO, private for profit, and other governmental organizations. Health facilities check and review HMIS data and then forward it to their designated administrative office. The administrative office aggregates the data it receives, adds its own administrative data, monitors its own performance based on these reported

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and self-generated data, and forwards the HMIS report to the next level.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 disaggregate 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 etc... HMOs report administrative data and data from facilities in their jurisdiction. They disaggregate data by facility type and ownership.
- **When:** Facilities aggregate, review and report their data monthly, quarterly and annually. Administrative levels also submit their data on a monthly, quarterly and annual basis. The specific dates are described in the table above.
- **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.

- To respond to immediate events, particularly for the purpose of outbreak detection and control, the data channel has a fast track system. Immediately notifiable diseases data is communicated through appropriate channel, directly to the designated disease prevention and control unit (public health emergency management unit) at each level of the health system.

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Annexes

1. Individual Medical Recording tools
2. Registers
3. Tally sheets
4. HMIS Reporting formats

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