AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D. C. 20523

BIBLIOGRAPHIC INPUT SHEET

FOR AID USE ONLY
Batch 98

ARDA

1. SUBJECT CLASSIFICATION	A. PRIMARY: Health	NA00-0000-G324
	B. SECONDARY: General--Haiti	

2. TITLE AND SUBTITLE

Health care in Haiti; a manual of statistical norms, procedures and forms for DSPP (Departement de la Sante Publique et de la Population)

3. AUTHOR(S)

(101) Westinghouse Health Systems, Columbia, Md.

4. DOCUMENT DATE	5. NUMBER OF PAGES	6. ARC NUMBER
1978	215p.	ARC

7. REFERENCE ORGANIZATION NAME AND ADDRESS

Westinghouse

8. SUPPLEMENTARY NOTES *(Sponsoring Organization, Publishers, Availability)*

9. ABSTRACT

10. CONTROL NUMBER PN-AAG-366	11. PRICE OF DOCUMENT
12. DESCRIPTORS Health services Manuals Statistics Health data collection system Haiti	13. PROJECT NUMBER 521051000 14. CONTRACT NUMBER AID/la-C-1179 15. TYPE OF DOCUMENT

AID 590-1 (4-74)

Health Systems

Project: 521-11-510-070

Contract: AID/la-C-1179

Submitted by:
Westinghouse Health Systems
Box 866
Columbia, Maryland 21044

Submitted to:
Department of State
Agency for International Development
Regional Operations Division
Latin America
Washington, D.C. 20523

A MANUAL OF STATISTICAL NORMS, PROCEDURES AND FORMS FOR DSPP

PREFACE

Activities to improve Haiti's health information system in support of regional and central health planning activities have been accorded high priority under this project. This report details the operating plan for reorganization of the health data collection and analysis system, (constituting deliverable C.1.c. (2) as per ammendment 2 to this contract.) The system reorganization as outlined herein is currently being implemented. Its outputs are expected to form the analytic basis for updating of Haiti's National Health Plan. A Course Manual (in French), used in The Regional Statistical Course to train Ministry of Health personnel and new statistical technicians, is supplemental to this manual. It was delivered to the Government of Haiti, but is not included here.

The Manual of Norms and Procedures in this volume, here translated from the original French, as well as the Course Manual referenced above, were prepared by the Westinghouse Health Systems field team, and were directed and written by Jacques St. Surin.

MATRIX OF CONTRACT ARTICLES AND PROJECT REPORTS

CONTRACT REF.	CONTRACT DESCRIPTION	1.a. A PLAN FOR THE REORGANIZATION OF THE BUREAU OF HEALTH PLNG.	1.b. TRAINING REQUIREMENTS FOR PERSONNEL OF BHP	1.c(1) AN EVALUATION OF THE EXISTING DATA SYSTEM	1.c(2) A DETAILING OF THE REORGANIZATION OF THE HEALTH DATA COLLECTION AND ANALYSIS SYSTEM	1.d. A NATIONAL HEALTH PLAN FOR HAITI	1.e. A SPECIFIC PLAN FOR THE IMPROVEMENT OF THE ADMINISTRATIVE SYSTEM OF THE MINISTRY	1.f. A GRADUAL INTEGRATION PLAN OF THE NATIONAL SERVICE OF MALARIA ERADICATION INTO MCH	1.g.i. COMPONENT RPT. FOR THE DEV. OF THE ADMIN. IMPROVEMENT PLAN: FINANCING	1.g.ii COMPONENT RPT. FOR THE DEV. OF THE ADMIN. IMPROVEMENT PLAN: MANPOWER AND TASK ANALYSIS	1.g.iii COMPONENT RPT. FOR THE DEV. OF THE ADMIN. IMPROVEMENT PLAN: DRUG INVENTORY & SUPPLY SYSTEMS.	1.g.iv COMPONENT RPT. FOR THE DEV. OF THE ADMIN. IMPROVEMENT PLAN: ANAL. OF PHYSICAL FACILITIES	1.g.v. COMPONENT RPT. FOR THE DEV. OF THE ADMIN. IMPROVEMENT PLAN: TRANSPORTATION SYSTEMS	2.a. A RPT. OF ACTIVITY BY EACH CONSULTANT/SPECIALIST
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1.	ORGANIZATION & DEV. PLAN, BHPE	●	●											
	DEVELOPMENT OF AN ADMIN. SYSTEMS IMPROVEMENT PLAN:													
2.	HEALTH MANPOWER COMPONENT									●				
3.	HEALTH FACILITIES COMPONENT												●	
4.	MEDICAL LOGISTICS & SUPPLY COMPONENT											●		
5.	ANALYSIS OF THE BUDGET STRUCTURE & ITS RELATIONSHIP TO PLANNING								●					
6.	HEALTH TRANSPORTATION SYSTEM													●
7.	ASSESSMENT OF THE HEALTH STATISTICS AND INFORMATION SYSTEM			●										
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10.	HEALTH CARE FINANCIAL SYSTEM FINANCE SYSTEM COMPONENT FOR THE DEV. OF AN ADMIN. SYSTEMS IMPROVEMENT PLAN.								●					
11.	RPT. ON INTEGRATED TRANSPORTATION SYSTEM, TRANSPORTATION COMPONENT FOR THE DEV. OF AN ADMIN. SYSTEMS IMPROVEMENT PLAN							●*						●
12.	DRUGS, LOGISTICS, AND SUPPLIES COMPONENT FOR THE DEV. OF AN ADMIN. SYSTEMS IMPROVEMENT PLAN										●			
13.	INSTITUTIONAL ANALYSIS, FINANCIAL SYSTEM COMPONENT FOR THE DEV. OF AN ADMIN. SYSTEMS IMPROVEMENT PLAN								●					
14.	PROGRAM BUDGETING COURSE DOCUMENTS, FINANCIAL SYSTEM COMPONENT FOR THE DEV. OF AN ADMIN. SYSTEMS IMPROVEMENT PLAN								●					
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16.	OUTLINE OF A REVISED NATIONAL HEALTH PLAN					●**								
17.	FINAL CONSULTANT ACTIVITIES RPT													●

* A CONTRACT MODIFICATION IS IN PROCESS AT THIS TIME TO CHANGE I.C.1.f. TO READ:

AN INTEGRATION PLAN FOR THE TRANSPORTATION SYSTEM OF THE NATIONAL SERVICE OF MALARIA ERADICATION INTO THE MOH.

** A CONTRACT MODIFICATION IS IN PROCESS AT THIS TIME TO CHANGE I.C.1.d. TO READ:

PREPARATION OF AN OUTLINE AND PROCEDURES FOR A NATIONAL HEALTH PLAN FOR HAITI.

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INTRODUCTION

Today nobody questions the prime importance of health in a nation's social and economic development process. The definition of health, given by the World Health Organization, as:

> "A condition of physical, mental, and social well-being, not only an absence of illness or infirmity"

places it among the highest priorities in any national policy aiming at general well-being.

In this connection, a number of laws have been passed in Haiti during the last twenty (20) years contributing to the gradual establishment of a system of medical and health care to adequately serve all of the population in the country.

In connection with this, one of the most important legislative acts has been the promulgation of the organic law followed by a decree pertaining to the restructuring of the Department of Public Health and Population (ref. Le Moniteur No. 68 dated Thursday, 26th August 1971, and Le Moniteur No. 90 dated Thursday, 20th November 1975) the widened purpose of which has been clearly spelled out in Article 1 of the above-mentioned decree which states: "The Department of Public Health and Population is a state entity which controls all the country's Health and Population activities. In the public sector, it has both executive and normative functions and in the private sector, only normative functions."

The inventive characteristic of this Department's new structure is the regionalization of medical and health services. This implies a strengthening of regional health activities aiming at the promotion, protection, and safeguarding of health at both individual and community levels. This is indispensable to the well being of the Haitian family.

At this point, within the framework of the implementation of the above-mentioned law and decree, one must emphasize the importance of establishing a body responsible for the collection of those bio-statistical data that are indispensable to proper evaluation of medical and national health activities and to develop valid planning of Public Health Programs.

In a document written by Dr. Cedomir Vukmanovic, Director of Belgrade Federal Institute for Public Health (Yugoslavia) and presented to the Second International Conference of National Commissions for Population and Health Statistics held in Copenhagen from October 1st through 5th, 1973, it has been stated that: "All innovations that were brought about in the organization of health services, care delivery, health techniques, management, and economy, demand the collection of a new type of data and the adoption of new methods in order to establish an information system that will enable all those involved in the improvement of the people's health to study the outputs and efficiency of health programs and the results obtained so far. . .

Statistical information is more and more necessary to the evaluation of people's health conditions, the distribution of personnel and resources the use of medical services by the population, demands and needs, as well as the cost of provided services.

Therefore, it is necessary to develop a statistical system covering the whole country, providing a minimum of normalization and various clarifications: Definitions, classifications, and indications concerning data delivery, confidentiality of information, etc. . ."

All of the above-mentioned considerations legally and theoretically justify the creation of a Central Statistics section and services within the Department of Public Health and Population, at the level of health regions as well as at the level of health districts, endowed with a relative operational autonomy, in compliance with the requirements of the National Health Plan.

Setting up and operating this statistics services network will yield perceptible results only following the establishment of statistics activities norms which are to be applied at all levels, and which may facilitate the interpretation and analysis of collected data.

As pointed out by Mr. Forest E. Linder, Director of International Program of Population Statistics Laboratories, North Carolina University's School of Public Health, United States, in an article entitled: "Health Statistics Recent Evaluation"(see WHO Chronicle. Volume dated February 30, 1976).

"It is not surprising to establish the fact that the more health activity expands, the more an ever increasing amount of information is needed in order to cope with it, manage it, and develop it. A simple and limited health program required only simple, limited, and approximate statistics. An intricate and complete health program can be carried out only on the basis of complete, complex, and more and more precise data.

However, it does not mean that nowadays, gathering more and more information is still the only thing that matters. They have to be related to one another so that they gradually form a sub-system of health accounting that can be linked with wider systems of national accounting.

Mr. Forest E. Linder carried on later: "For a long period of time, health systems had only small and scattered statistics units, responsible for gathering information on one particular aspect of health activity. The traditional 'public health' type of organization has been outdated by a new and much wider concept of 'social medicine' type." Consequently, in the future, these isolated units will give way to more complete and efficient systems, more appropriate to gather, analyze, and interrelate data pertaining to all health conditions and programs."

The Department of Public Health and Population, with this evolution in mind, had decided to lay the foundations to a more national system of health statistics that is likely needed to actually facilitate its planning, management, and evaluation.

Therefore, this MANUAL OF STATISTICS NORMS will include various chapters dealing with the purpose of the Statistics Central Section, its legal foundation, its organization and resources. It will also deal with the organization and resources of statistics services at the region and district levels, in university, regional, district hospitals, in health centers with or without beds, and in dispensaries. It will also develop a pattern describing the different stages of medical care process as well as the definition of terms and expressions commonly used in medical and health activities.

Health indexes and methods to interpret will also be developed, as well as the methodology to record vital facts and additional information required by a satisfactory classification of diseases according to the international classification proposed by the World Health Organization (WHO).

It is hoped that these norms will be received by both officials of health organizations and private health institutions who will certainly appreciate the effort made by the Department of Public Health and Population to generalize and harmonize the collection of health statistics data which are prerequisite to a proper understanding of health problems in Haiti. These activities are essential to planning efforts leading toward higher quality, comprehensive availability, and more efficient health care delivery.

I. LEGAL FOUNDATION OF THE STATISTICS CENTRAL SECTION

The existence and operation of any institution must be based on well-defined legislative or statutory texts. As far as the Statistics Central Section is concerned, reference must be made to two documents:

1. The Organic Law of the Department of Public Health and Population (see Le Moniteur No. 68 dated August 28, 1971) which stipulates that:

   a. Technical services within the Secretary of State for Public Health and Population include: The Statistics Central Section. . . (Article 12).

   b. The Statistics Central Section has the following duties:

      - Centralize all data pertaining to health and health administration;

      - Provide all statistical information to other services within the Department of Public Health and Population (Article 13).

2. The decree concerning the organic restructuring of the Department of Public Health and Population (see Le Moniteur No. 90 dated November 20, 1975) which, despite the reference it made of a prospective population service, at the present time concerns only statistical activities as stated in Articles 35, 40, and 41 of the said decree,

   Article 35. The following specialized services are organized within the Department of Public Health and Population: The Population Service. . .

   Article 40. The Population Service is headed by a professional with a degree in statistics.

   Article 41. Where population statistics are involved, the Population Service works in close collaboration with the Haitian Statistics Institute.

In order to avoid any misinterpretation of these legislative texts, it is essential to point out that at one time, the Department of Public Health and Population was divided into two large services: Public Health Service and Population Service.

While the Population Service still exists in theory, there was a need to discontinue its operation, for lack of financial means to buy or rent modern machinery necessary to the performance of population endeavors.

Since then, it has been decided that it is currently more useful to rely on one Statistics Section with more modern activities and objectives. It is understood that the Population Service will resume its operation when financial means and materials are available.

In any case, the Statistics Section can be considered as a virtual sub-division of the Population Service for which provisions have been made in the Decree concerning the restructuration of the Department of Public Health and Population (Le Moniteur No. 90 dated November 20, 1975).

Besides the above-mentioned specific articles from the organic law and the decree, other articles of the same legislative texts pertaining to the general structure of the Department of Public Health and Population are also considered as legal foundations to the Statistics Central Section as the latter is an entity within the said Department. In this connection, the following articles can be quoted:

Article 1. The Department of Public Health and Population is a state entity which controls all activities in matters of health and population in Haiti.

Article 6. The administrative and technical activities of the Department of Public Health and Population are carried out, at the level of Central Administration, by a main organization called Direction - general for Public Health (Direction generale de la Sante Publique) as well as by specialized services under the direct supervision of the Secretary of State for Public Health and Population and which are organized according to the general rules of the Department of Public Health and Population.

Article 12. The general rules of the Department of Public Health and Population, such as they will be adopted or modified later on, can freely modify the boundaries of Health Regions, as well as Health Districts in order to improve the efficiency of the administrative system set up by this organic law.

Article 13. To take part in the planning of health programs for the region;

To organize, control, and evaluate the operations of the Health Region's health institutions;

To coordinate the Region's medical and health activities, mostly ordinary ones, in the private as well as public sectors;

To train and prepare health personnel assigned to the Region.

Article 21. The Health District includes, besides a District Hospital where the District's Administration is housed, Health Centers, with or without beds, and Rural Dispensaries located within one specific geographical area.

Article 22. To supervise and control Health Institutions located within the District.

Article 24. The Health Institutions in one Health District are, in declining order of importance, the Region Hospital, District Hospitals, Health Centers-Hospitals, Health Centers with or without beds, and Rural Dispensaries.

Article 28. The Districts' hospitals also serve as hospitals of reference for cases encountered in less sophisticated health institutions in Districts.

Article 41. As far as population statistics are concerned, the Population Service works in close collaboration with the Haitian Statistics Institute.

Article 58. Clauses of laws will establish norms that are applicable to health institutions in the private sector and will determine the responsibilities of the Department of Public Health and Population as to the application of these norms.

II. GENERAL FUNCTIONS OF THE STATISTICS CENTRAL SECTION

In compliance with international criteria and taking into consideration the various limitations of the Department of Public Health and Population, the Statistics Central Section has been assigned the following functions:

1. Gather, develop, analyze, and publish health statistical informatio in the whole country, emphasizing the outstanding points of each health region.
2. Organize and conduct surveys related to health and population whenever the needs arise.
3. Do research in the field of health and population statistics.
4. Publish, annually, a summary supported by figures, of all medical and health activities carried out by the Department of Public Health and Population.
5. Collaborate in developing work programs on common activities to be carried out in the different regions.
6. Cooperate with all other official organizations in preparing programs related to health activities in the country.
7. Promote and organize personnel training in the field of statistics.
8. Periodically present reports as well as recommendations on health situations based on specific surveys.
9. Convene or be involved in the organization of seminars and conferences dealing with the issues of health and population statistics
10. Set up or help throughout the country's societies supporting statistics in general and health and population statistics in particular.

It must be noted that besides these general functions, the Statistics Central Section must perform certain specific tasks resulting from the very nature of these activities, i.e.:

1. Disseminate and provide statistical information to any public or private, national or international institution requesting them, and, if possible, to the public in general.

2. Request necessary information on subjects related to the health sector from other organizations of the Haitian Civil Service, and possibly from international organizations.

3. Cooperate with the National Commission for Statistics Coordination (Commission Nationale de Coordination Statistique) and the Haitian Statistics Institute.

4. Exchange publications with overseas health offices and with other international organizations.

III. ORGANIZATION OF STATISTICS SERVICES IN THE DEPARTMENT OF PUBLIC HEALTH AND POPULATION

The control of health and population activities in the country can be achieved only through an efficient system of statistics services that must be developed at all levels stated by Article 24 of the November 20, 1975, decree, i.e.: Regional, district (district hospital), health center-hospital, health center with or without beds, and rural dispensary.

It is obvious that this service's multiplicity will work adequately on only one condition: that there exists a Statistics Central Section, the main task of which will consist of setting norms, organizing, coordinating, and supervising statistics activities at these different levels.

In carrying out its above-mentioned functions, the Statistics Central Section will be aiming at well-defined targets that can be summarized as follows:

- Decentralize statistics information at the Central Office and make it available to all levels.
- Establish health statistics services at the district and region levels.
- Improve the organization of statistics services in health institutions.
- Supervise statistics services at all levels, and coordinate their activities.

ORGANIZATION OF THE STATISTICS CENTRAL SECTION

The Statistics Central Section includes the following components:

Technical Directorate which has the following functions:

Development and recurring review of norms

Control, review, and criticism of submitted reports.

Codification of answers

Cards perforation

Verification of punched cards

Data classification and tabulati

Diagram and printing

Analysis and interpretation

Publication

Administration includes the following administrative services:

Reception and filing of letters, documents, reports, etc...

Correspondence

Equipment Resources

The Statistics Central Section has the following types of equipment resources at its disposal to perform its task:

Tabulator

Verifier

Perforator

Card Sorter

IBM Typewriter

Calculators

Filing cabinets

Vehicles

Kardex

Typewriters

Off-set printing machine

Reduction and photocopy machine

Mimeograph machine

Human Resources

It has the following personnel at its disposal, in order to carry out its functions most efficiently:

One Statistician, Chief of Service

One Statistician, Assistant-Chief of Service

One 1st Class Professional Statistician

One 2nd Class Professional Statistician

Two 3rd Class Professional Statisticians

One 1st Class Statistical Technician

Two 2nd Class Statistical Technicians

Six 3rd Class Statistical Technicians

Two Printing Workers

One Mechanic

One Secretary in charge of filing

Three Personal Typists

Note: More information concerning these different appellations of the statistics personnel will be provided later on.

ORGANIZATION OF STATISTICS REGIONAL SECTIONS

Statistics Regional Sections are entities under respective regional directorates, and are responsible for organizing, in conjunction with other regional administrative branches, all activities in the field of statistics in Health Districts. They have the following attributes:

1. Direct health statistics activities at regional levels.
2. Organize the collection of all statistics information in public, mixed, and private health institutions in the regions.
3. Plan and perform, in the field of statistics, special studies in the regions.
4. Centralize, collect, analyze, and publish health statistics in the regions.

5. After preliminary processing, send progress reports from the regions' health situations to respective regional directors.

6. Every two months, present summaries of reports on the regions' health institutions with adequate statistics materials.

7. Control and supply the regions' health institutions with adequate statistics materials.

8. Coordinate all health statistics activities in the regions and supervise the implementation of the national statistics system.

9. Establish necessary links with the regions' competent authorities in order to obtain statistics about vital facts that take place outside health institutions.

10. Prepare and train personnel in charge of statistics activities at the level of the regions.

11. Disseminate statistics information of the regions.

12. Establish relations with similar organizations in the country.

13. Coordinate, all non-routine activities in the field of health statistics with the central authority.

14. If necessary, provide collaboration to all statistics activities being carried out in the regions.

15. At the beginning of every week, inform appropriate authorities about cases of communicable diseases that have been diagnosed.

16. Make sure that monthly reports are dispatched by all institutions (official, mixed, or private) to the Statistics Central section.

Resources of the Statistics Regional Section

Each of the Regional Statistics Sections will be provided with the following equipment resources:

Calculators

Mimeograph machine

Typewriter

Vehicle

Kardex

Medican records

Index-cards

Desks

Chairs

Filing cabinets

Tables

Telephone

Office supplies, etc...

Once in full operation, regional statistics sections will include the following human resources:

One 3rd Class Professional Statistician

One 1st Class Statistical Technician

One 2nd Class Statistical Technician

Two 3rd Class Statistical Technicians

GENERAL VIEWS ON STATISTICS SERVICES IN HEALTH INSTITUTIONS

In order to obtain a better idea about the operations and roles played by Statistics Services of Health Institutions, it is necessary to express certain general views concerning physical resources; in particular, the premises and attributes assigned to all persons in charge of one statistics section in a health institution.

The Premises

Whatever the category of the health institution, it must include one sector intended for statistics activities. Preferably, this sector should

be located in the out-patient area and should be facing the main entrance of the institution, and near the emergency ward. It should be spacious enough, not only to accommodate people who come for medical care but have not filled out the required forms, but also to house medical and other files. The amount of space must be in direct relation with the importance of the institution.

Lesser important health institutions such as Dispensaries and Health Centers without beds may include only one room intended for admission and files and where medical records will also be kept.

But as far as the other institutions (hospital, health center-hospital) are concerned, they will include at least two rooms, one of which will be intended for the gathering of people requesting medical care, whereas the other will serve as headquarters for medical records and any other statistics activity.

Functions and Attributes of Persons in Charge of Different Statistics Sections

Persons in charge in different statistics sections have the following functions:

Direct health statistics activities at the institution level.

Organize medical records as well as other records such as:

- Out-patient examination
- Hospitalization
- Service statistics

Inform the administration every month about all activities carried out by the unit as shown by statistics collected during the month.

Draft reports (on communicable diseases, births, deaths, hospital activities, etc...) that are to be sent to the Regional Office.

Receive daily progress reports from dispensaries under their jurisdiction, control and forward these reports to the Regional Office.

Organize and supervise statistics activities at the dispensary level.

ORGANIZATION OF STATISTICS SERVICES IN UNIVERSITY, REGION, DISTRICT HOSPITALS AND HEALTH CENTER WITH BEDS

In these different institutions, statistics services will include:

1. A Directorate
2. An Admission Section
3. A Medical Records Section
4. A Data Collection and Processing Section

Directorate

The Directorate includes the Chief of the Statistics Service, his typists, secretary, and clerks.

The functions of the Service Chief consist of:

1. Direct the operation of the unit for which he is responsible.
2. Carry out and enforce the norms.
3. Evaluate work system and methods in order to assess the service output and make necessary changes.
4. Distribute tasks and assign responsibilities.
5. Select personnel.
6. Train and prepare personnel.
7. Supervise personnel efficiency both in quantity and in quality.
8. Collaborate with research endeavors in the field of statistics.
9. Coordinate activities with the Department's other sections or services.

Admission

The main task that falls on employees assigned to the Admission Section is to start medical files for the institutions's new patients and to keep the old patients' files.

Depending on whether it is a case of an out-patient examination, a

discharge release, or an emergency, the methodology to use is the following:

Out-Patient Examination

1. It is necessary to identify the patient (new or old to the institution).
2. Start the new patient's file or request the old patient's file from the records office.
3. Provide files to different consultation services.
4. Keep track of files sent to different services and sent back to the records office.
5. Daily control of recorded files.
6. Keep index-cards up-to-date.
7. Check regularly and strictly on assigned identification numbers.
8. Have the files of patients who have set appointments ready and send the file required by an examination well ahead of time.

Hospitalization

1. Complete the patient's file after having checked upon the hospitalization sheet issued by the consulting physician and signed daily by him.
2. Keep the in-patients' records up-to-date.
3. Record daily the number of in-patients in all wards, and update with the number of in-patients who have been admitted during non-office hours.
4. Receive, review, and correct the file of the discharged patient (alive or dead).
5. Perform a quantitative analysis of the file by using the discharge sheet duly signed by the consulting physician.
6. File the records.
7. Deliver birth certificates for all new-born babies.

Medical Records

The medical records are housed in a place provided with furniture intended

for keeping medical files, in ascending numerical order, according to the system, and the size of which will depend on the level of the institution.

The medical records employee or personnel will have the following tasks:

1. Organize and notation of medical files.
2. Control of medical files in and out flow, etc.
3. Filing.

Data Processing

Data processing is the responsibility of the service's statistics section. The functions of the personnel assigned to this branch will include:

1. Reception of forms and verification of collected information
2. Codification of diseases by using international classification (Morbidity and Mortality)
3. Registration and notification of communicable diseases
4. Registration of deaths (certificate or statement)
5. Maintaining a diagnosis index
6. Registration of births and deliveries
7. Data generation and analysis and publication of a monthly bulletin
8. Dispatch of data and reports to the district or regional office and to the DSPP Central Service.

ORGANIZATION OF STATISTICS SERVICES IN HEALTH CENTERS WITHOUT BEDS

In health centers without beds, the organization of the statistics service will include:

- Admission
- Medical records
- Service statistics

Admission

Admission will be done according to the different types of examinations: general, prenatal, pediatric (well child care and examination of sick children), family planning. In each case, the patient must be identified (new or old to the institution) in order to know whether to look for an established clinical file or to start a new file with a new registration number.

In the case of health centers without beds, the clinical file includes: a patient-index, an appointment card, and a form in accordance with the requested service.

Medical Records

As far as medical records are concerned, the employee's functions are more or less the same as for hospitals and health centers with beds, i.e.:

- Organization and notation of files
- Registration of files in and out flow
- Filing in ascending numerical order

Service Statistics

In health centers without beds, the employee or personnel of service statistics will have the following functions:

- Reception of forms and registration of collected information
- Notification of cases of communicable diseases
- Data generation
- Dispatch of data to regional or district office
- Registration and supervision of all activities pertaining to statistics within the areas they cover.

ORGANIZATION OF STATISTICS SERVICES IN DISPENSARIES

As far as dispensaries are concerned, the organization is as follows:

- Admission
- Medical records
- Service statistics

Admission

Admission will be done for all types of out-patient examinations which fall in these general categories: general examination, prenatal examination, pediatric examination, family planning, and referral of complicated cases.

Medical Records

In a dispensary, medical records consist of dispensary cards which will be filed in alphabetical order.

Service Statistics

As far as service statistics are concerned, they will consist of dispensary reports to be drafted and dispatched to the district or regional office.

SPECIAL STATUS OF PRIVATE OR VOLUNTARY HEALTH INSTITUTIONS

As our basic chart follows the principle of free enterprise, it is quite out of the question for the DSPP to dictate norms as to the physical aspect of private institutions.

However, as all medical and health activity is placed under the control of this department, as a general rule, all health institutions must, according to their respective categories, respect the minimum guidelines applicable to government institutions.

However as far as statistics information per se are concerned, all health institutions operating within the territory of the Haitian Republic must provide data that may be requested by government institutions of the same category.

In this connection, the health institutions must dispatch to the regional offices, under the jurisdiction of which they operate, monthly reports about not only their hospital activities but also about vital statistics in which they may have some kind of involvement.

The private facilities must also be staffed with a minimum number of trained personnel to fill out forms which must be returned to the regional offices at the same regular interval as official institutions.

Upon request from the institution, the personnel to be used for this purpose may be trained by the DSPP, and may eventually come from an officially recognized institution. Even though these personnel do not quantitatively meet the norms recommended by this manual, their quality should not, in any case, be below the level required by official institutions of the same category.

IV. PROCESS OF MEDICAL ATTENDANCE TO A PATIENT

Before discussing human and physical resources needed by each category of institution, it is necessary to consider, as a whole, the different stages of the process of medical attendance provided to a patient.

OUT-PATIENT EXAMINATION

Upon his arrival at the institution, the patient is given a ticket bearing a number which corresponds to the order of arrival. This ticket allows the patient to proceed on to the waiting room where he will wait to be summoned by the individual in charge of admission - the second person the patient has to deal with.

First Visit to the Institution

The patient states to the person in charge of admission that he is seeking medical care from the institution for the first time. The person in charge of admission checks upon the patient's statement by looking into the card-index cabinet. The situation wherein a patient has two or more medical files in the institution must be avoided by all means.

The patient's statement is true, i.e., it is actually the first time that he has sought medical care from the institution. In this case, the person in charge of admission starts a new medical file for the patient by filling out:

1. An index card
2. An appointment card
3. Any form required by the service from which the patient is seeking care, i.e., a prenatal examination sheet in the case of a pregnant woman; a general examination sheet in the case of an adult seeking a general examination; an odontology sheet if the examination is related to teeth, etc.

Note: When a new medical file is started, a registration number is assigned to the patient permanently, that is to say that this number remains the same for the patient whenever he is seeking any future medical attention, even from another institution. The patient should be made aware of this.

The patient's statement is not true, that is to say that the search made in the card index cabinet shows that the patient has already benefited from the institution's medical attention and therefore has a patient identification. The person in charge of admission must remain courteous, friendly, and supportiv in dealing with the patient. He must take this opportunity to educate this patient to the use and continuity of his record number. This confusion frequently occurs as a result of patients being unaware of previous attendance at the facility and that once they have been seen, their number generates a permanent file regardless of changes in their own lives or elapsed time between visits Adequate instruction when patients have their initial visits can reduce this problem.

Subsequent Visits to the Institution

For a patient who has already received medical care from the institution, the person in charge of admission will proceed as follows:

1. Using the registration number on the index card, obtain the medical records from the files.
2. Once the record is located, verify that the characteristics recorded in this record actually correspond to the patient's such as: the patient's name, his mother's name, his date of birth, etc.
3. Fill out a new appointment card for the patient, advising him politely to protect it and to bring it every time he needs to seek medical attention from the institution.

Important Notes

1. If the service requested is different from the ones the patient has already received, fill out any new form required by the service and add it to the existing file.
2. If the patient has his appointment card with the name of the institution and the number of the medical file at hand, it is not necessary to try to locate his file in the index card cabinet. In such a case, the person in charge of admission must proceed as follows:

a. Try to locate the medical file by directly using the number on the appointment card.

b. Compare the characteristics recorded in the file with the person presenting the card.

c. Fill out a new appointment card.

d. Fill out any appropriate forms in the case where the service requested is different from previous services to the patient.

3. After having accomplished all of these tasks, the person in charge of admission directs the patient to the place where he must go to wait until he is called for by his last and first names for the examination. Meanwhile, an auxiliary on duty will forward his file to the examination ward. However, this auxiliary will wait until several files are ready before proceeding to their distribution in respective examination wards.

   Once the examination is over, the person in charge will appoint an auxiliary to collect all the files and hand them back to the records section for necessary actions.

4. For each dispersed file, the record keeper will use a substitution card with the number of the corresponding file. Once the file is handed back, he must check the content, put the forms in order, if there is a need for it, and in the case where some documents are missing, get in touch immediately with the physician involved to arrange for their return. When everything is in a correct order, he will proceed to put all the files back in the appropriate spaces and will remove substitution cards as he proceeds with this operation.

HOSPITALIZATION

In a hospital or a health center with beds, when the physician has decided, after an out-patient examination, that the patient has to be hospitalized, the process to apply is as follows:

1. The consulting physician fills out the corresponding form (request for hospitalization) which he sends to the hospitalization service.

2. Upon receipt of a hospitalization request sheet duly filled out and signed by the consulting physician, the hospitalization service checks upon the availability of beds in the indicated ward.

3. If there is no vacant bed available, the hospitalization service will inform the consulting physician at once. The latter will try to find an adequate solution jointly with the person in charge of the ward in question or the Chief of Service.

4. If there is a vacant bed available, the hospitalization service will comply with the request and report the fact to the appropriate employee in the statistics service so that the whole hospitalization file is updated. Besides the already mentioned forms, the hospitalization file includes:

   a. A temperature sheet
   b. A prescription and medical instruction sheet
   c. A nurse sheet
   d. A progress sheet
   e. An anamnesis sheet

   If needed, the following forms will be added:

   f. Request for laboratory tests
   g. Results of laboratory tests
   h. Request for x-ray and x-ray form
   i. An anesthesia sheet
   j. An operation form

   Other additional forms will be available to ward nurses who will add them to different files as needed.

In order to make this work easier, the person in charge of the administrative section will make available a supply of files, prepared in advance, with forms numbered from 1 to 5. When the need arises, all he has to do is add the registration number and fill out the corresponding spaces with the patient's identification.

EMERGENCY SERVICE

When a patient shows up at an institution for diagnosis or treatment, or in a case in which an immediate action from a physician, a dentist or member of the auxiliary personnel (intern, nurse, etc.) is needed, the following situations are planned:

During Office Hours

Regardless of the number of patients in the waiting line, the person in charge of admission must write down the emergency patient's last and first names on the already prepared medical file, which he keeps for this purpose, stamp the emergency seal on it, and escort the patient immediately to the ward where he is to receive the needed attention.

If the emergency case requires a hospitalization, the ward nurse must fill out the forms and, on the same day, inform the records service for proper actions.

If the patient is discharged immediately, his file must be kept and sent to the records service of the institution.

During Non-Office Hours

The employee in charge (nurse, auxiliary, or other) has at his disposal files prepared ahead of time for this purpose. He will follow carefully the same procedures mentioned above.

In a case where hospitalization is involved, and even in the case where the patient is discharged immediately, the nurse of the ward where the patient has been treated, must forward the files to records service for appropriate actions on the following day.

DISPENSARY

Upon his arrival, a patient seeking medical care from an institution will be given a serial number and will proceed to the waiting room where he will be called forth to give personal information that will be recorded on the dispensary card while waiting for the requested service.

In the case of a first visit, the employee will give the patient an appointment card bearing the dates set for the second and subsequent visits.

In all other cases, the patient will have to show his appointment card. NOTE: In the case where the patient has lost or misplaced his appointment card, the employee will try to locate the dispensary card in the corresponding filing cabinet. If the dispensary card is found, he will issue a new appointment card while making recommendations to the patient.

V. STATISTICAL EQUIPMENT AND PERSONNEL RESOURCES OF HEALTH INSTITUTIONS

EQUIPMENT RESOURCES

Regional Hospital

The regional hospital will have the following materials and equipment:

- Medical records
- Index card box
- Table
- Metallic filing cabinet
- Typewriter
- Calculator
- Desk
- Chair
- Mimeograph machine
- Kardex
- Telephone
- Cabinet
- Vehicle

District Hospital

Same equipment as regional hospital.

Health Center with Beds

Same as for district or regional hospital.

Health Center Without Beds

Health center without beds will have the following materials and equipment:

- Shelves
- Index card box
- Desk
- Calculator
- Typewriter
- Filing cabinet
- Chair
- Telephone
- Kardex

HUMAN RESOURCES

Regional Hospital

Once in full operation, the regional hospital will have the following human resources:

- One first class statistical technician
- One second class statistical technician
- One third class statistical technician
- One first class auxiliary statistician
- Two second class auxiliary statisticians

District Hospital

The district hospital will have the following human resources:

- One second class statistical technician
- One third class statistical technician
- One first class auxiliary statistician
- Two second class statistical auxiliary statisticians

Health Center (With or Without Beds)

The health center will have the following human resources:

- One first class auxiliary statistician
- One second class auxiliary statistician

Dispensary

The dispensary will need only one second class auxiliary statistician who will also be an auxiliary in charge, with an adequate training in the field of statistics.

Statistical personnel requirements for specialized health institutions such as: maternity hospital, sanitarium, psychiatric and mental health hospital follow:

Maternity Hospital

One third class statistical technician
One first class auxiliary statistician
One second class auxiliary statistician

Sanitarium

One first class auxiliary statistician
One second class auxiliary statistician

Psychiatric Hospital

One third class statistical technician
One first class auxiliary statistician
One second class auxiliary statistician

Mental Hospital

A mental health hospital will need only one second class auxiliary statistician.

GENERAL VIEWS ON HUMAN RESOURCES

As it has already been established, human resources assigned to different levels are divided into different categories which must be well defined. Thus, for each category of resources, one must determine the characteristics of the function to be carried out and set the requirements and qualifications needed in the field of education, work experience and ability.

Second Class Auxiliary Statistician

Characteristics of the Function

Under direct supervision, the second class auxiliary performs less difficult statistical work, such as:

- Collect data from the source as well as indirectly.
- Code data
- Work out simple tables from completed forms, carry out the same type of activities according to the needs of each service (work out simple calculations, classify magazines, or sort out articles which may interest the service, prepare in order to make comparisons easier, and be able to put them together, etc...)

Minimum Requirements in Education and Work Experience Alternatives

- Must have had four years of secondary education or equivalent, or
- Must hold primary school certificate, plus at least three years service in a health institution as an employee, or
- Must have taken part in medical auxiliary training courses and, in the case of the person who does not hold a primary school certificate, must have worked at least five years in a position involving the same responsibility or
- Must have worked as a statistical auxiliary in any ministerial department.

Required Qualifications

- Ability to follow oral or written instructions
- Ability to collect data directly from interviewing persons
- Ability to operate calculators

First Class Auxiliary

Characteristics of the Function

Under immediate supervision, a first class auxiliary statistician carries out fairly complicated work such as:

- Maintain statistical records
- Draft a table related to activities specific to one particular service of one branch of health
- Work out fairly difficult digital calculations in view of preparing calculation tables
- Be able to calculate the whole series of related measures
- Supervise a small group of auxiliaries of a lesser category
- Collect data that may be of interest to the service from national as well as international publications

Minimum Requirements in Education and Work Experience Alternatives

- Must have had at least five years of secondary education or
- Must have worked at least for three years as a second class auxiliary statistician

Required Qualifications

- Adequate ability to draft information tables with or without figures
- Ability to keep a statistical register
- Ability to work out fairly complicated calculations
- Ability to supervise a limited group of auxiliaries and office clerks

Third Class Statistical Technician

Characteristics of the Function

Under general supervision, a third class statistical technician carries out statistical works of a certain complexity, from working out relative value calculations to determining central tendency and dispersion measures and form characteristics. He must be able to:

- Reproduce statistics data in diagrams after having determined the appropriate diagram
- Supervise a limited group of auxiliary statisticians and employees of the same level as the latter
- Review technical works done by auxiliaries
- Draft statistics reports in general

Minimum Requirements in Education and Work Experience Alternatives

- Must hold a secondary school certificate, majoring in science
- Must have had at least five years of secondary education plus any kind of training in statistical sciences or
- Must have worked at least five years as a first class auxiliary statistician

Required Qualifications

- General knowledge of compilation methods
- Knowledge of calculation methods of central and dispersion measures and form characteristics
- Ability to program tables and diagrams

Second Class Statistical Technician

Characteristics of the Function

Under general supervision, a second class statistical technician is expected to do fairly difficult statistical works. He must be able to:

- Draft fairly complex statistics tables and select diagrams to be used according to cases
- Work out calculations on descriptive statistics in general, i.e., measures of central tendency, measures of dispersion, form characteristics, retrogression and correlation.
- Work out forms required by surveys
- Develop tables on comparative efficiency of various services in health institutions
- Finally supervise a group of technicians of lesser important categories

Minimum Requirements in Education and Work Experience Alternatives

- Must hold a secondary school certificate, majoring in sciences, plus two years of university education or
- Must hold a secondary school certificate plus full attendance in statistics training course of the Haitian Statistics Institute or any institution of the same kind that is officially recognized or
- Must have worked at least two years as a third class statistical technician

Required Qualifications

- Sound knowledge of mathematics and statistics techniques to be used
- Ability to work out fairly complex calculations in mathematics as well as in statistics
- Ability to plan appropriate graphs and diagrams
- Ability to draft reports supported by documents
- Ability to lead technical and non-technical personnel

First Class Statistical Technician

Characteristics of the Function

Under general supervision, a first class statistical technician is expected to do fairly difficult statistical work. He must be able to:

- Supervise a group of lesser important civil servants by organizing, distributing and checking on their work.
- Collect statistics and test them in order to determine their validity.
- Develop code for data processing as well as for records
- Draw up and develop tables and graphs that are to be published
- Draft correspondence or the unit he is responsible for.
- Write evaluation reports on personnel under his authority.

Minimum Requirement in Education and Work Experience Alternatives

- Must hold a secondary education certificate, majoring in sciences plus three years of university education or
- Must be graduated from the Haitian Statistics Institute plus at least two years work experience as first class statistical technician
- Must have at least three years experience as a second class technician

Required Qualifications

- General knowledge in mathematics and statistics techniques to be utilized and ability to make use of these techniques at proper time.
- Ability to analyze and interpret statistical data
- Ability to program, organize, distribute and supervise the work of the personnel under his authority.
- Ability to draft reports supported by documents

Third-Class Statistician

Characteristics of the Function

According to service needs, he will have to do fairly difficult work which may consist of:

- Working out a model of form to be used in a health survey
- Drafting a tabulation plan
- Performing statistical analysis of survey results
- Participating in a conference or seminar on health in general
- Leading a limited group of non-professsional personnel

Minimum Requirements in Education and Work Experience Alternatives

- Must have a diploma in statistics or
- Must have completed successfully statistics courses organized by the Haitian Statistics Institute and have participated in an in-service course on health statistics or any related subject in an internationally renowned institution or
- Must hold a diploma and have taken a specialization course in health statistics or any related field

Required Qualifications

- Be responsible
- Ability to program, organize, distribute and supervise the work done by non-professional personnel
- Co-operative mind for team work

Second Class Statistician

Characteristics of the Function

According to service needs, this category of professionals must be able to carry out highly intricate statistical work such as:

- Develop a model of form to be used for collecting health data
- Develop a tabulation plan
- Analyze a survey and draw conclusions
- Develop a personnel training program
- Be the section's representative to a national or international conference
- Give a lecture or conduct a training seminar for either personnel from different statistics services or professional personnel specialized in other fields.
- Supervise the services daily operational activities and direct the personnel as necessary
- Lead an important group of professionals or non-professionals
- Draft reports to be submitted to department authorities or to be presented to a national or international conference.

Minimum Requirements in Education and Work Experience Alternatives

- Must hold a statistician diploma and have served at least three years as a second class statistician in the field of health or any related field or
- Must have a statistician diploma plus a specialization course in health statistics or any related field plus two years experience or
- Must be graduated from the statistics courses of the Haitian Statistics Institute or any similar instituions, have participated in an in-service training course in health statistics or any related subject and also have worked at least five years in this specialization.

Required Qualifications

- Ability to lead professional or non-professional personnel
- Ability to make decisions on short notice
- Ability to deal with other fellow civil servants of any category
- Ability to program, organize, distribute, and supervise the work done by personnel under his authority
- Ability to draft reports

First Class Statistician

Characteristics of the Function

According to the service needs, this category of professional must be able to:

- Develop and coordinate short, mid, and long term programs
- Set up domestic systems and procedures for organizing, coordinating, evaluating and controlling statistical activities
- Draft forms to be used in health data collection
- Develop a tabulation plan

Minimum Requirements in Education and Work Experience Alternatives

- Must have a diploma in statistics and have worked at least seven years as a first class statistician in the field of health or any related fields or
- Must have a diploma plus a specialization in statistics plus five years of progressive experience in the field of health or any related field or
- Must have graduated from a statistics course organized by the Haitian Statistics Institute or any similar institution, have participated in an in-service training course and have worked at least ten years in this specialization, in the field of health or any related subject.

Required Qualifications

- Initiative to develop and coordinate short, middle and long term programs
- Initiative to develop domestic systems and procedures or organization, coordination, evaluation, and control
- Ability to lead professional and non-professional personnel.
- Ability to deal with other fellow civil servants of any category
- Ability to draft reports

Chief Statistician

He is the civil servant responsible for all the works to be done in the field of statistics at the Department of Public Health and Population; by common consent with the Department's authorities, he must set the Section's objectives and determine implementation methods in order to insure the system efficiency.

Characteristics of the Function

These are similar to the first class statistician.

Minimum Requirements in Education and Work Experience Alternatives

- Must hold a statistician diploma and have worked at least ten years as a chief statistician in the field of health or any related field
- Must hold a diploma, plus a specialization course in statistics, plus seven years of progressive experience in the field of health or any related field.
- Must have graduated from a statistics course organized by the Haitian Statistics Institute or a similar institution, have taken part in an in-service course and have worked at least twelve years in this specialization, also in the field of health or any related activity.

VI. DEFINITIONS

In order to insure a totally uniform understanding and interpretation of the norms that appear in this manual, a series of definitions, units, and terms follows. By so doing, we will arrive at a homogeneity of criteria in the uses of these norms both at the central and the regional levels. As it is difficult to include exhaustively all the definitions that may be used in the national health statistics system, we may refer ourselves, whenever there is a need for it, to the glossary compiled by the World Health Organization and which is used by all member countries. Therefore, the following list is purely enunciative and is by no means, limitative.

In any case, we must avoid working out characteristic definitions and, in case of doubt, it will be advisable to refer to respective regional offices in cases where solutions are not available at the level of health institutions.

HOSPITAL

Institution offering hospitalization facilities and including certain facilities for the diagnosis, treatment and rehabilitation of ailing people or of people suspected to be ill or of women in childbirth.

It is an institution that may or may not provide out-patient services. It must be noted that an institution dealing exclusively with the disabled, the elderly, etc. who are neither ill nor recovering from serious illnesses, nor women in childbirth, cannot be considered as a hospital.

It can be a general or specialized hospital according to whether it has the capability to treat all types of diseases or patients of all ages. In the first case, the institution has to provide services in basic specializations only, such as medicine, surgery, pediatrics and obstetrics. In any other case, it will be a specialized hospital.

HEALTH CENTER HOSPITAL

It is a small hospital run by a licensed physician or a physician and a resident, registered nurses and resident nurses, including some small range intermediate services and in a position to provide only limited medical services.

HEALTH CENTER

A unit staffed by a physician or a resident, offering care to out-patients, and which, provides certain activities in health primary prevention.

DISPENSARY

It is an institution responsible at the local level for carrying out medical prevention and attendance operations, with priority on active means of prophylaxis and education, in the fields of health and sanitation.

SERVICE

Middle level executive unit grouping one or several related sections that may deal with either administration or medicine.

OUT PATIENT EXAMINATION

Care provided to out-patients for all kinds of specializations.

HOSPITAL BED

Installed for the regular use of in-patients. Does not specifically refer to its physical aspect; includes a unit covering equipment, personnel and space required to live in and to maintain in operation. Can be standard-sized for adults or smaller for children. Among the latter, mention should be made of those intended for sick new-born babies and incubators for premature babies. The term bed is a significant term which

accounts for the capacity (physical plant and staff) of a hospital to care for one in-patient.

However, do not include in the category of hospital beds, those intended for normal new-born babies such as cribs and delivery tables.

AVAILABLE BEDS

Beds actually installed and ready for use.

NON-AVAILABLE BEDS

Beds which despite the fact that they are installed, cannot for some reason be used.

BED-DAY

Concept referring to the availability of a bed that may be occupied during a 24-hour period.

PATIENT-DAY

Service provided to an in-patient during 24 hours which corresponds to a day for a daily census. A bed occupied during ten days has a potential capacity of 30 bed-days, but has actually provided a 10 patient-day service.

MEDICAL EXAMINATION

Care provided to a patient by a professional in an out-patient service. If a patient has been examined by several physicians, it will be considered that he has had only one consultation. On the contrary, if the patient is seen the same day or at the same place, at different hours, by several physicians, the service provided will be considered as many examinations as the number of physicians to have seen the patient.

An examination is not only the service provided to sick people in need of an examination or a treatment, one must take into consideration follow up examinations as well as check ups on healthy persons, whenever there is at least one physician involved.

The same definition can also be applied to home-calls.

ADMISSION

Concept implying the entrance to a service and the subsequent occupation of a bed. Cannot be applied to the births of alive or still-born babies that take place in the hospital, nor to the deaths of persons during their transport to the health institution or deaths that take place in the emergency ward.

EXIT

Refers to the action of leaving a health institution where one has received in-patient care. This occurs when either the physician has so decided or the patient has decided to leave the institution on his own.

DURATION OF STAY

Number of days spent in a hospital by a patient admitted to any service. For the purpose of reckoning, the day of admission is included but the day of the exit (discharge) is not.

DIAGNOSIS

Process consisting of finding out the presence and the characteristics of a disease from signs and symptoms or to arrive at a conclusion from external examination. May also be defined as word or sentence used by a physician to identify the disease of the patient; the reason why the patient requires, seeks or is being provided with medical attendance.

SURGICAL OPERATION

Consists of surgical process done on a patient at a given time on a same surgical accessway and to a common purpose.

SURGICAL PROCESS

Any systematic operation performed on or in a patient's body, which can be complete in itself, by a physician, a dentist or any other licensed professional with or without any instrument, in order to put disjointed or defective parts back in good condition, to remove foreign boides from ailing, or traumatized tissues, to assist a delivery or to help in a diagnosis.

On this ground, the definition will include incisions, excisions, amputations, introductions, endoscopies, repairs, destructions, stitchings and operations.

ALIVE BIRTH

Complete expulsion or extraction from the mother's body, notwithstanding the duration of pregnancy, of a baby which, after the separation, has breathed or shown some sign of life such as a heartbeat, the pulsation of the umbilical cord or the perceptive contraction of a voluntary muscle, whether or not the umbilical cord has been cut off, or the placenta has remained attached or not. The product of such a birth is considered an alive birth.

DEATH

Permanent disappearance of any sign of life at any time following birth, without any possibility of revival.

FETAL DEATH

Death of a product of conception that takes place before its complete expulsion or extraction from the mother's body,notwithstanding the duration of pregnancy; death is indicated by the fact that, after this separation, the fetus does not breath, show any sign of life such as heartbeat, pulsation of the umbilical cord or perceptive contraction of a voluntary muscle.

MATERNAL MORTALITY

Death caused by complications from pregnancy, delivery or puerperium.

AUTOPSY

Examination of a corpse by a physician pathologist or professional assigned for this purpose in order to determine direct, indirect, or contributing causes of death; it is done by anatomical, pathological, or toxicological examinations of the corpse's organs.

VII. INDEXES AND METHOD OF CALCULATION

The number of available beds each day serves as an index to resources.

Available beds can be determined as follows:

1. Average number of available beds =

$$\frac{\text{Number of available bed-days during one period}}{\text{Number of days in the period}}$$

The average number of in-patients makes possible the evaluation of the use of available bed resources and can be reckoned as follows:

2. Average number of in-patients according to daily census =

$$\frac{\text{Number of patient-days of one period}}{\text{Number of days in the period}}$$

The average number of beds occupied daily during a period is an index to the degree of resource utilization and is conveyed in percentage as follows:

3. Rate of bed occupancy =

$$\frac{\text{Number of patient-days of the period}}{\text{Number of bed-days in the period}}$$

The average number of exited (discharged) patients' hospitalization days during a given period provides an index measuring the average of the stay's duration and can be calculated as follows:

4. Average duration of stay =

$$\frac{\text{Number of hospitalization days of all exited patients during a period of time}}{\text{Number of exited patients during that period}}$$

Sometimes, an index is calculated by using the same denomination as for measuring the duration of the patient's stay. Despite the fact that the meaning differs slightly from the one given previously, its calculation is much easier as daily census is used and as this information is always available.

5. Average number of patient-days =

$$\frac{\text{Number of patient-days during a period of time}}{\text{Number of exited patients during the same period}}$$

Bed occupancy, an index of the average number of exited patients during a period of time, is reckoned as follows:

6. Bed Occupancy =

$$\frac{\text{Number of exited patients during one period}}{\text{Average number of available beds during this period}}$$

The time interval of occupancy indicates the number of days during which a bed remains vacant between an exit and a new admission:

7. Occupancy Interval =

$$\frac{\text{Number of bed-days during a period of time} - \text{No. of patient-days during the peri}}{\text{Number of exits during the same period}}$$

The average number of exits indicating the daily average number of admitted and exited patients during a period of time, can be calculated as follows:

8. Average number of exits =

$$\frac{\text{Number of exits during a period of time}}{\text{Number of days in this period}}$$

The average duration of the patient's stay while waiting to be operated on, that is to say (uninterrupted stay prior to a surgery) the average number of days between admission and surgery, can be obtained by:

9. Average duration prior to surgery =

$$\frac{\text{Number of hospitalization days of admitted and operated on patients during a period of time}}{\text{Number of admitted and operated on patients during the same period}}$$

The rate of hospital mortality, the importance of which is limited just like any crude rate, is obtained by:

10. Rate of hospital mortality =

$$\frac{\text{Number of exits caused by death during one period of time}}{\text{Number of exits during the period}}$$

The hospital lethality rate, an index which measures more efficiently mortality in a health institution, is reckoned as follows:

11. Rate of hospital lethality =

$$\frac{\text{Number of deaths caused by a specific disease during a period of time}}{\text{Number of new casualties from the same disease admitted during the same period of time}}$$

The rate of autopsies is obtained by:

12. $$\frac{\text{Number of autopsies performed on deceased in-patients during a period of time}}{\text{Number of in-patient deaths during the same period}}$$

It can also be calculated as follows:

Rate of autopsies =

$$\frac{\text{Total amount of autopsies performed during one period of time X 100}}{\text{Total of deceased patients during the same period on whom autopsy could have been performed}}$$

The average number of daily examinations, an index for examinations performed in out-patient services during a period of time, is reckoned as follows:

13. Average number of daily examinations =

$$\frac{\text{Number of out-patient examinations during one period}}{\text{Number of days included in the period}}$$

Percentage of first examinations, indicating the number of first examinations in relation to the total amount, is thus reckoned:

14. Percentage of first examinations =

$$\frac{\text{Number of first examinations during one period X 100}}{\text{Number of examinations during the period}}$$

The index of examination concentration, measuring the average number of examinations for each first examination, is the exact reverse of the previous quotient. It is thus reckoned:

15. Examinations concentration index =

$$\frac{\text{Number of examinations during a given period}}{\text{Number of first examiantions during the same period}}$$

VIII. RECORDING OF VITAL STATISTICS

The recording of vital facts concerns births and deaths, and is done differently depending upon whether it is done in cities or in rural areas.

BIRTH CERTIFICATES

A card issued to any woman having given birth to a child, be it within or outside a health institution. She must produce it when notifying an official acting as a registrar of the child's birth. The name of the child's mother, the delivery date, the mother's place of residence, and the sex of the child will be listed on this card.

Birth certificates come in books of 25 or 50 each. For each delivery, a certificate is torn off and given to the newborn child's mother, whereas the filled out stub remains in the book. At the beginning of each month, the regional office is responsible for collecting the stubs corresponding to the number of certificates that have been issued during the preceding month.

In Cities

Any health institution, including a public, mixed, or private maternity hospital, will be provided with a sufficient amount of books so that birth certificates will be issued, without exception, to all women having given birth in this maternity hospital. In this case, birth certificates will be on white paper.

Outside of maternity hospitals, a different colored card will be used. Any person (physician, nurse, auxiliary, trained or untrained matron) performing deliveries outside of maternity hospitals must have at his/her disposal a sufficient amount of certificates to be issued to women having given birth to children. The stubs of issued certificates will also be collected by the regional office at the beginning of each month.

If a woman presents herself to the registrar without the certificate issued to her by the person who performed her delivery, the registrar will write the birth certificate according to the mother's notification, but

will not give it to her until she comes back to see him with a certificate, which may have been forgotten at home, or may be a new one issued by the person in charge of the delivery or the health institution.

In this case, the new certificate, as well as its stub, will bear a conventional sign.

But in case the woman presents herself to the registrar without the certificate because the person who performed her delivery did not give her one, the registrar will write a certificate but will not give it to her yet. In order to get the certificate, the mother must contact the person who performed her delivery, or the health institution, in order to be issued a certificate. In such a case, neither the certificate, nor the stub will bear the conventional sign.

In Rural Areas

Where there is a maternity hospital, for all deliveries, the procedure will be the same as stated in the foregoing, i.e., certificate will be issued to the woman who gave birth to a child with an explicit recommendation to keep it and to bring it to the registrar at the time of birth notification.

If a woman living in a rural area gives birth in a city maternity hospital, she will be issued a certificate from that hospital.

The health agent, or a rural police officer, if there is no health agent, will issue a birth certificate to any woman residing in the section and whose delivery has been performed at home by a trained or untrained matron. The health agent or the rural police officer will not have to interfere in cases where the delivery took place in a maternity hospital in cities or in his section, even if the woman lives in the section he is assigned to.

The stubs of certificates issued by the health agent or the rural police officer will be collected at the beginning of each month by the regional office.

If the mother presents herself without the certificate to the registrar, he will always write the birth certificate upon the mother's notification, but she must get from the institution where she gave birth a new certificate

bearing a conventional sign. It would be without the conventional sign in th case where the person in charge of delivery did not issue a certificate to the mother.

The color to be used by the registrar will depend on the location (pink for within, white for outside) where the delivery took place.

All certificates brought in by mothers or filled out by the registrar, with or without the conventional sign, will be collected at the beginning of each month by the regional office.

INFORMATION ON DEATH

Prior to the burial, the deceased person's family must present to the cemetery office or keeper a permission to bury issued by:

- The University-Hospital in Port-au-Prince
- Hospitals or health centers in provincial towns
- The rural police officer in rural areas

In Port-au-Prince

Death Occurring in a Health Institution

In this case, a death certificate will be filled out by the physician who is the chief of the service where the death occurs, stating in the certificate, in an established order, causes that brought about death.

This certificate, signed either by the physician Chief of Service or any regular physician appointed by him, is given to the family of the deceased who will use it to request a permission to bury form from the section responsible for exit statistics at the University hospital. The employee in charge then issues a permission to bury to the family of the deceased and keeps the certificate.

It is useful to state again that no permission to bury will be issued unless the applicant produces a death certificate duly signed by the consulting physician. Moreover, the consulting physician is reminded that he must always state the cause of death on the certificate.

At the beginning of each month, the person in charge of exit statistics at the University Hospital will dispatch to the headquarters of the metropolitan area all death certificates collected during the previous month.

Death Occurring Outside a Health Institution

The Deceased Was Assisted by a Physician

The physician will fill out and sign the death certificate to be given to the family of the deceased. This certificate will enable the family to request a permission to bury form from the University Hospital. The section in charge of exit statistics will keep the certificate and will issue a permission to bury form to the family of the deceased or any authorized person.

The Deceased Was Not Assisted by a Physician

The family of the deceased presents itself to the section responsible for exit statistics of the University Hospital. Upon notification from the family, the section will fill out, in this case, the space corresponding to "proof of death" while trying to find out the possible causes for death. After this formality, a permission to bury is issued to the family of the deceased or any authorized person.

At the beginning of each month, the person in charge of exit statistics will dispatch all death certificates or proof of death collected during the previous month to the head office of the metropolitan area.

In Provincial Towns

The situation is more or less the same as in Port-au-Prince.

Death Occurring In a Health Institution

The consulting physician fills out and signs a death certificate to be given to the family of the deceased. The latter presents this certificate to the employee in charge of issuing permission to bury in the health institution. The employee keeps the certificate and issues the permission to bury.

At the beginning of each month, all certificates collected during the previous month are dispatched to the headquarters of the regional office for further actions.

Death Occurring Outside a Health Institution

The Deceased Was Assisted by a Physician

The physician will fill out a death certificate to be given to the family of the deceased. The latter will present itself to the health institution responsible for issuing permission to bury forms in order to obtain one. The certificate will be kept by the concerned section which, at the beginning of each month, will dispatch all certificates collected during the previous month to the headquarters of the regional office, through established hierarchial channels.

The Deceased Was Not Assisted by a Physician

The family of the deceased will contact either the hospital administrator or the center physician who will, in this case, write a proof of death. This proof enables the family of the deceased to request a permission to bury form from the section in charge at the health institution. The above-mentioned section issues the permission and keeps the proof of death. At the beginning of every month, all proofs of death, as well as all death certificates, will be dispatched to the regional office headquarters, through established hierarchial channels.

In Rural Areas

Death Occurring in a Health Institution

The procedure to follow will be the same as recommended for cities.

Death Occurring Outside a Health Institution

The Deceased Was Assisted by a Physician

In this case, the procedure to follow will be the same as the one recommended for provincial towns. However, if there is no health institution in the area, the family of the deceased, once it is given a certificate, will contact the rural police officer who will issue a permission to bury and keep the certificate.

The Deceased Was Not Assisted by a Physician

In any other case, the police officer will write the proof of death when issuing the permission to bury. He will always try to get information from the family as to the possible causes of death.

At the beginning of each month, the rural police officer will dispatch all death certificates and proof of death collected and issued during the past month to the headquarters of the military district to which he belongs. The regional office will be responsible for collecting, within its zone of operation, all certificates and proofs brought to various headquarters of military districts.

IX. PRECAUTIONS REQUIRED IN STATING CAUSES FOR DEATHS

In order to obtain information as close as possible to international classifications, physicians should avoid using the incomplete terms included in the following list. This list has been adopted by the World Health Organization and indicates the information required to expand the terms to complete units of information. Persons employed in statistics sections, in general any of them, who may have singled out a comment similar to one classified as incomplete on the list, should report it to the person in charge of the section, who will find a way to contact the physician who signed the certificate and ask him to make appropriate expansion and corrections.

Regional offices, in particular, will be responsible for reviewing causes of death in order to provide necessary precision before proceeding to forward the certificates to the central office for final processing.

EXAMPLES OF INCOMPLETE MENTION OF DEATH CAUSES*

Incomplete Term	Required Additional Information In Order To Establish a Satisfactory Classification According to International Classification
Abcess	Location and cause (T.B. for instance)
Pelvic abcess	Cause: Was it a result of a puerperal or post-abortive infection?
Delivery	Complication: Was it apparent or foreseeable before the delivery?
Mental alienation	Kind of mental problem; direct cause of death; disease causing it (congenital disease, brain disease, arteriosclerosis syphilis)
Anemia	Form, in case of a primary anemia; cause in case of a secondary anemia

*Not all terms fully translated to English due to idiosyncrasies of terminology.

EXAMPLES OF INCOMPLETE MENTION OF DEATH CAUSES

Incomplete Term	Required Additional Information In Order To Establish a Satisfactory Classification According to International Classification
Aneurysm	Aortic (abdominal or thoracic), arterial, arterial-veinous, cardiac; atheromatous or syphilitic
Angina	Agranulocytory, diphteritic, false croup, streptococic, Vincent's chest
Carbuncle	Location
Apoplexy	Location of the lesion; recent or late after-effects
Appendicitis	Sharp, grumbling, perforated
Arteriosclerosis	Was it accompanied by hypertension(benign or malignant)? When applicable, nature of heart, brain, and kidney manifestations
Arteritis	By arteriosclerosis, syphilitic; of the brain, of the coronary
Arthritis	Sharp, gonococcal, gouty, infectious, osteoarthritic, rheumatic, tuberculous, due to sharp joint rheumatism
Ascites	Cause
Asphyxiation	Cause
Atheroma	Aorta, artery, heart valve
Liver yellow atrophy	Cause, if known, for instance: sharp infectious hepatitis, pregnancy or puerperal toxemia, transfusion, innoculation
Paget's disease	Bones, breast or skin
Valvular disease	Reach valvule, acute or chronic, rheumatism, by arteriosclerosis, by hypertension, or other. If rheumatism, was it articulary, acute, at the time of death.
Malformation	Congenital, or traumatic or other cause, type or organ reached

EXAMPLES OF INCOMPLETE MENTION OF DEATH CAUSES

Incomplete Term	Required Additional Information In Order To Establish a Satisfactory Classification According to International Classification
Malnutrition	Congenital, or due to an insufficient diet; due to a disease or a lack of care (baby) low weight at birth degree M1, M2, M3, Kwashiokor, Marasm
Meningitis cerebro-spinal	Meingococic, tuberculosis or other cause
Metritis	See endometry
Myocarditis	Rheumatismal acute, on rheumatismal, rheumatismal chronic, other myocarditis chronic (but avoid the term to describe the degeneration of myocard)
Neoplasm	Benign or malignant; type and location, if malignant (see cancer)
Nephritis	Acute, subrate with ocdemes, chronic infections cause or toxic if it is known hypertension, arteriosclerosis, cardiopathy, pregnancy
Neuritis	Localization, cause (for example alcoholism, lead, rheumatism)
Obstruction	Cause (for example, cancer, stensosis congenital hernia)
Pulmonary edema	Acute, hypostatique, secondary to the cardiapathie or insufficient cardiac with hypertension
Rachis deformation	Type, cause; congenital or acquired
Insanity	Responsible disease of morbid state
Dermatite or Dermite	Type
Diabetes	Complication or disease which provoked the death. Take particular care to make distinction between the diabetes as initial cause and the diabetes as being contributing cause.
Diarrhea	Cause

EXAMPLES OF INCOMPLETE MENTION OF DEATH CAUSES

Incomplete Term	Required Additional Information In Order To Establish a Satisfactory Classification According to International Classification
Cardiac Dialation	Responsible disease of morbid state
Dysentery	Baciliary amcebic or due to other protozoa
Eclampsia	Cause; was it known before giving birth
Prostration	Nature of traumatism (fracture internal traumatism; external cause)
Embolism	Localization and cause, give birth or abortion associated; If following an operation, precise disease which necessitated surgery
Enuphalita	Acute infections sequel of encephalite infectious, post vaccinale, post examthematius, idiopathic, meningococcic suppurated, tuberculosis
Endocarditis	Acute or chronic; rheumatismal, par arteriascherosis, by hypertension or other; see rheumatismal. Was there rheumatism particularly acute at the time of death?
Stenosis	Congenital, cause in case of acquired stenosis; for example, burn cancer
Stomatitis	Aphtous, diphtheric,mycotic, herpetic septic, of Vincent due to a avitaminose
Suffocation	Cause for example by bedding, by inhalation of food or smoke, mechanic immersopn, to birth
Syndrom Parkinson	See Parkinsonism
Syphilis	Congenital, new of late, organ reached
Tetany	Parathyroidal associated to rachitism convulsion
Tetanus	Mode of infection if it is know, for example: light trauma, grave trauma, puerperal
Thrombosis	Arterial for example, cerebral, coronary mesenteric, pulmonary, retrictinie, of sinus intracrania pyogen, non pyogen, sequel post abortive, puerperal, veinous (localization) portale, following surgery

EXAMPLES OF INCOMPLETE MENTION OF DEATH CAUSES

Incomplete Term	Required Additional Information In Order To Establish a Satisfactory Classification According to International Classification
Toxemia	Cause, if happens while pregnant distinguish albuminuria, eclampsia hyperamia, hepatitis, hypertension. If happens after giving birth, precise date of onset.
Traumatism	Nature of traumatism, part of the body reached. Was there an accident, suicide, homicide, war wound? Location and circumstances of accident.
Abortion	Spontaneous or procured and reason if there was infection or toxemia
Bronchitis	Acute, chronic, allergic, capillary emphysematous
Burn	Localization; by fire,an explosion, a liquid or burning object, a corrosive substance, radiation
Calculus	Localization
Cancer,carcinoma	Location of the primary cancer, if known. Location of secondary cancer starting point in case of cancer of the lips, the tongue, the mouth of the throat of the large intestine, uterus. Histologic type if it is known.
Carditis	Ando, myo, or pericarditis, acute, rheumatismal
Cholera	Rheumatismal of Huntington, gravidic
Cirrhosis of the Liver	Cause; for example, alcoholism
Cerebral Congestion	Cause
Convulsion	Cause
Attacks	Apoplexic, appendicitis, epilectic eclampsy hysterical
Dibility	Responsible disease of morbid state
Congenital Dibility	Cause if it is known; period of gestation, weight at birth, anomaly or disease eventually associated
Cardiac Failure	Responsible disease of the morbid state

EXAMPLES OF INCOMPLETE MENTION OF DEATH CAUSES

Incomplete Term	Required Additional Information In Order To Establish a Satisfactory Classification According to International Classification
Rachitism	Fetal evolution, nephric, scorbutic sequel (for example, genu valgum)
Cebral Infarction	Cause (for example embolism) avoid the term when it is dementia reticulasareome, reticulo-endotheliose, reticulase follicular lymphoid. See stenosis
Reticulo-endotheliose	Reticulasarcome, reticulo-endotheliose, reticulase follicular lymphoid
Narrowing Stricture	See stenosis
Rheumatism	Acute articular (see also this rubric) sub acute articular, muscular, gonococcic. Avoid using this term for other disease; for example, articular rheumatism chronic should be designated specifically as rheumatoid arthritis, osteo-arthritis, spondylitis, etc.
Acute Articular	Distinguish cardiac infection with articular
Rheumatism	Rheumatism evolutive at time of death. Cardiac lesion which are sequel of acute articular rheumatism.
Salpingitis	Acute, chronic, gonococcic, tuberculosis post abortive, puerperal
Sclerosis	Arterial, cerebral, coronary, in medullar patch
Senility	Disease which caused death
Septicemio	Cause of eventual localization (see also puerperal fever)
Silicosis	Professional cause, associated tuberculosis
Spondylitis	Ankylosing, deforming, sacro-iliac gonococcic tuberculosis
Oste is	Cause, localization
Malaria	Tiersian fever benign, tiersian malign bilious hemoglobic, with plasmadium vivax, falciparum, ovale etc., relapse of induced malaria

EXAMPLES OF INCOMPLETE MENTION OF DEATH CAUSES

Incomplete Term	Required Additional Information In Order To Establish a Satisfactory Classification According to International Classification
Paralysis, paresis	Cause and localization of the lesion and precise form (for example acute ascending agitating, amyotrophic, obstetric origin due to a cerebro vascular ecsion, general glottis, infantile, saturnine, of Landry specified nerve, hysteric
Paralysis general	Progressive, or responsible disease of the morbid condition (alcoholism)
Paraplegia	Spasmodic due to an obstetric lesion, due to medullar lesion
Parkinsonism	Is it an agitating paralysis or sequels
Parkinson syndrome	Of and acute infectious encephalitis
Perimetritis peritonitis	Cause of infection. What was it due to?
Phlebitis	Puerperal infection of the post abortive
Phlegmon	Cause, localization
Pneumoconiosis	Asbestosis, byssinosis, silicosis. Was it of professional origin? Was there an associated tuberculosis?
Pnemonia	Broncho, lobar, atypic, interstitial chronic, hypostatic, grippal of the newborn, tuberculosis, consecutive to the measles
Pneumothorax	Cause
Prematurity	Congenital debility, etc.

X. STATISTICAL INFORMATION CONFIDENTIALITY

Data collected at the level of various services in a health institution are confidential; therefore, they can be used only for the purpose of statistics. Other than physicians, nurses, and auxiliaries, only the employees of the statistics service will have access to records or forms that have been filled out at the time of admission to health institutions. They should not, in any case, communicate any information, even partially, to anyone else, even in the same department or health institution, except when the person has a special authorization from the institution's director. Any breach of these provisions will be considered as a violation of the patient's or client's file and can be penalized according to the rules of the department.

At no point will published statistics enable the identification of the client or the patient. For this purpose, all employees of statistics sections in health institutions will be notified of the following situations which constitute breaches to statistic information confidentiality and may consequently entail a penalty to the offender:

- Disclosure of confidential information
- Request and acquisition of information without the proper authorization
- Handling of information without prior authorization
- Deliberate carelessness allowing non-authorized persons to have access to classified information
- Objection to a patient or client providing the required information
- Finally, any other situation that may lead to the knowledge of information concerning one or several patients by unauthorized persons

APPENDIX A

LIST OF FORMS USED TO COMPILE HEALTH STATISTICS AT THE INSTITUTIONAL LEVEL AND WITHIN THE MEDICAL RECORD

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PATIENT-INDEX CARD

D.S.P.P. FORM 01

Made out of white cardboard and filed in alphabetical order, the patient-index card serves the purpose of locating rapidly the records of patients or clients who turn up at a health institution without their appointment cards. This card is used in hospitals, dispensary-hospitals, and health centers.

How To Fill Out An Index-Card

Entering Last and First Names

The receptionist will ask the person's last and first names. Last name means the patient's or client's family name, and first name means christian name, notwitstanding the person's marital status. The family name has to be always written in capital letters and preceded by Mm in the case of a married woman.

Example: Bernard Josette
Mm Paul Virginia

Registration Number

It is a number assigned to a patient or a client on his admission to a health institution. Registration numbers will form a continuous sequence that will grow longer in proportion with the number of people seeking medical treatment who turn up at the health institution for the first time. The worker in charge of assigning numbers will write down the number assigned duly and permanently to the patient on all the forms that will make up the patient's medical file.

He will see to it that the number is neither lacking nor duplicated. Even in the case whereby a patient moves from one service to another within the same health institution he cannot be assigned two or more registration numbers. On the other hand, the same registration number should not be, in any case, assigned to two or more patients.

Entering the Mother's Last and First Names

The worker in charge will ask the last and first names of the patient's mother and will record them according to the instructions given in the foregoing.

Entering the Spouse's Name

Same instructions as in 2 and 3. Leave blank space in case the patient is not married.

Entering the Address

The worker in charge will ask the patient's full address and write down for:

Urban Areas

The house number, the name of the street, if possible the name of the neighborhood, the name of the town.

Example: Address: 29, rue Tiremasse, Port-au-Prince
18, rue 21A, Carenage, Cap-Haitian

Rural Areas

The dwelling-place, the Commune, the rural section. If possible, give some landmark that will help locate the patient when there is a need for it.

The address on the index slip must be updated. For this purpose, use lines (b,c,d, etc.). At each visit, the receptionist will make sure that a patient has not moved from the address he gave at his last visit to the institution.

Admission Procedure

The patient's admission date and requested service are entered on the first line of the table. The date must consist of the day, month, and year. The same data are repeatedly recorded on the following lines every time the patient requests a different service.

1. Nom et Prénom _____

2. IMMATRICULATION [ ]

3. Nom de la Mère _____

4. Nom du Conjoint _____

5. Adresse : a) _____

b) _____

c) _____

d) _____

6. ADMISSION :

DATE	SERVICE	DATE	SERVICE

INDEX PATIENT

D.S.P.P. Form. 01

1. Nom et Prénom _____

2. IMMATRICULATION [ ]

3. Nom de la Mère _____

4. Nom du Conjoint _____

5. Adresse : a) _____

b) _____

c) _____

d) _____

6. ADMISSION :

DATE	SERVICE	DATE	SERVICE

INDEX PATIENT

D.S.P.P. Form. 01

2. APPOINTMENT CARD

D.S.P.P. FORM 02

The appointment card, made out of cardboard, bears the patient's proposed appointment dates on its front side. It is given to the patient who must show it to the people in charge of admission every time he goes in for a visit. The back side of the appointment card serves as a national immunization card on which the different types and doses of the vaccine given to the patient are recorded. An efficient use of this card will permit verification of the patient's immunization against certain diseases anytime.

It is therefore recommended that the admission section, or any person in charge of admission who issues this card, provides the patient with all necessary explanations so that the card will be well-kept and brought along every time the patient comes in for a visit.

Appointment Card Specifications

The receptionist must enter on the appointment card the following:

Name of the Institution

Write out in full and clearly the name of the institution. For example, Hospital Justinien.

Last and First Names

Write down last and first names in the appropriate space. (See similar instructions for Patient Index-Card, DSPP 01).

Rendez-vous

Service	Date

1. Etablissement

2. Nom de Famille | Prénom

3. Immatriculation

4. Date de Naissance

Jour	Mois	Année

N.B. Toute personne qui aurait retrouvé cette carte est priée de la rapporter à l'établissement sus-mentionné.

CARTE DE RENDEZ-VOUS

D.S.P.P. Form. 02

Rendez-vous

Service	Date

1. Etablissement

2. Nom de Famille | Prénom

3. Immatriculation

4. Date de Naissance

Jour	Mois	Année

N.B. Toute personne qui aurait retrouvé cette carte est priée de la rapporter à l'établissement sus-mentionné.

CARTE DE RENDEZ-VOUS

D.S.P.P. Form. 02

Rendez-vous

Service	Date

1. Etablissement

2. Nom de Famille | Prénom

3. Immatriculation

4. Date de Naissance

Jour	Mois	Année

N.B. Toute personne qui aurait retrouvé cette carte est priée de la rapporter à l'établissement sus-mentionné.

CARTE DE RENDEZ-VOUS

D.S.P.P. Form. 02

Rendez-vous

Service	Date

1. Etablissement

2. Nom de Famille | Prénom

3. Immatriculation

4. Date de Naissance

Jour	Mois	Année

N.B. Toute personne qui aurait retrouvé cette carte est priée de la rapporter à l'établissement sus-mentionné.

CARTE DE RENDEZ-VOUS

3. NATIONAL IMMUNIZATION CARD

D.S.P.P. FORM 03

The national immunization card is constituted by the back side of the appointment card. All data pertaining to immunizations are recorded on this card. It will be filled out every time a person (be it a child or an adult) is given a vaccine.

The health agent, the auxiliary, the nurse, or the physician who gives the shot, etc. will write down, in the proper box, the date on which the vaccine has been given.

In the case of a small-pox vaccine or a tine test where a reading is needed, the date and the result of the reading must be recorded clearly in the appropriate space.

DEPARTEMENT DE LA SANTE PUBLIQUE
ET DE LA POPULATION
CARTE NATIONALE DE VACCINATION

Vaccine	1ère Dose	2ème Dose	3ème Dose	Rappel
Di Te Per				
Polio				
Di Te Tab				
Tétanos				
Typhoide				
Autre				

	Dose Unique
Variole	
B.C.G.	

Date de Lecture_____ Résultat_____

Date TB Test _____ Résultat_____

D.S.P.P. Form. 03

DEPARTEMENT DE LA SANTE PUBLIQUE
ET DE LA POPULATION
CARTE NATIONALE DE VACCINATION

Vaccins	1ère Dose	2ème Dose	3ème Dose	Rappel
Di Te Per				
Polio				
Di Te Tab				
Tétanos				
Typhoide				
Autre				

	Dose Unique
Variole	
B.C.G.	

Date de Lecture_____ Résultat_____

Date TB Test _____ Résultat_____

D.S.P.P. Form. 03

4. GENERAL EXAMINATION SHEET

D.S.P.P. FORM 04

The general examination sheet is a form on which first clinical impressions of the consulting physician regarding any adult (15 years of age or over) seeking medical attention during an out-patient examination are recorded.

Instructions On How To Fill Out The General Examination Form

Entering the Admission Date

In the appropriate box, indicate the day, month, and year of admission.

Entering File or Registration Number

In the corresponding box, write down the number assigned to the patient when he was admitted.

Entering Last and First Names

Write down clearly and neatly the patient's last and first names in compliance with the instructions given for the index-cards (D.S.P.P. 01).

Sex Specification

In the corresponding space, specify the patient's sex: male or female.

Entering the Date of Birth

In the corresponding box, write down the day, month, and year of birth. In the case where the patient is unable to give his exact date of birth, use certain historical dates, certain important events, such as natural disasters to find out the approximate year of birth (see paragraph 1 of the appointment-card).

Entering the Address

Write down clearly the patient's full address (see paragraph 5 of the index-card) by giving the following specifications for:

Urban Areas

The number of the house, the name of the street; if possible, the neighborhood and the town.

Rural Areas

The dwelling-place, the rural section, and the commune. Indicate, if possible, some landmark that will permit location of the patient whenever there is a need for it.

Entering the Mother's Last and First Names

Comply with the instructions given earlier (see paragraph 3 of the index-card section).

Entering a Reference, Last and First Names

Write down clearly the last and first names, and, if possible, the address of a reference who can provide information and so on upon request. If the reference has a telephone, write down the number. Indicate the relationship between the patient and the reference.

Examination Report (excluding hospitalization care)

Front and back sides.

1. Date - Indicate the date on which the examination takes place.
2. Problems, Symptoms, and Diagnosis - Opposite the date, the consulting physician will record problems and symptoms he has noticed and will write down his provisional diagnosis.
3. Treatment and Recommendations - The consulting physican will record the prescribed medication and recommendations made to the patient.
4. Signature of the Consulting Physician - The consulting physician must sign his name in the appropriate space after every examination.

1. DATE D'ADMISSION

2. No. D'ENTRE[illegible]

3. NOM DE FAMILLE | PRENOM | 4. SEXE | 5. DATE DE NAISSANCE

6. ADRESSE COMPLETE (Préciser pour les zones rurales : Habitation, Section Rurale et Commune)

7. NOM ET PRENOM DE LA MERE

8. PERSONNE RESPONSABLE

a) Nom et Prénom _____ b) Adresse _____

c) Téléphone _____ d) Lien de Parenté _____

9. CONSULTATION (Soins d'Hospitalisation exclus)

9.1. DATE	9.2. PROBLEMES, SYMPTOMES ET DIAGNOSTIC	9.3. TRAITEMENT ET RECOMMANDATIONS	9.4. CONSULTANT Md. Inf. ou Aux.	9.5. SIGNATURE

S.P.P. Form. 04

FEUILLE DE CONSULTATION GENERALE

9.1. DATE	9.2. PROBLEMES, SYMPTOMES ET DIAGNOSTIC	9.3. TRAITEMENT ET RECOMMANDATIONS	9.4. CONSULTANTS: Md. Inf. ou Aux.	9.5. SIGNAT

5. PEDIATRIC EXAMINATION SHEET

D.S.P.P. FORM 05

This form is required for all children below 15 years of age who seek medical attention from a health institution. It includes data pertaining to the child's personal characteristics, his immunizations record. On the backside of the sheet is the child's weight/age diagram which will make possible the control of the child's nutritional condition through his fifth year of age.

Specifications

Admission Date

Indicate the day, month, and year.

File or Registration Number

It is the number assigned to the child as soon as he is admitted into a health institution. See similar instructions for index-card.

Last and First Names

See similar instructions for index-cards.

Date of Birth

Indicate the day, month, and year of the child's birth. In case of doubt, see similar instructions for appointment-cards.

Sex

Indicate the child's sex by writing male or female in the appropriate space.

Full Address

Indicate as precisely as possible:

Urban Areas

The number of the house, the name of the street, and, if possible, the neighborhood, and the name of the town.

Rural Areas

The dwelling-place, the rural section, and the commune.

Mother's Last and First Names

Write down clearly the last and first names of the child's mother.

Reference

Indicate clearly the last and first names, and, if possible, the full address of the person to whom one can refer for information and so on.

Pregnancy Complications

To be filled out by the auxiliary, the nurse, or the consulting physician. Indicate pregnancy complications leading to that child's birth.

Delivery Mode

Indicate the mode by which that child has been delivered. Record clearly: normal, forceps, caesarean, others.

Personal and Family Medical Backgrounds

Write down clearly personal and family medical backgrounds.

Type of the Child's Feeding

According to the current way in which the child is fed: breast-fed, bottle fed, or a combination of both. Put down a mark (x) in the appropriate box.

Duration of the Breast-Feeding Period

In the appropriate space, indicate the period during which the child has been breast-fed.

Is the Mother Using a Contraceptive Method?

Write down "yes" or "no" as the case may be.

Immunization

Opposite the type of vaccine or in one of the "dose" columns, as the case may be, write down the date on which the child has been immunized. In the appropriate box, write down small-pox and tine test, as well as the date(s) on which the test(s) has (have) been made.

Clinical Examinations

Date

Write down the day, month, and year of the examination.

Weight (in kilograms)

Opposite the date, write down the child's weight, in kilograms, in the appropriate box.

Diet

Indicate the child's diet. Use the symbol reproduced at the bottom of the form:

Breast-feeding only, mark down	(.)
Breast-feeding plus supplement, mark down	(.)+
If the child has been weaned, mark down	(/.)++

Problems, Symptoms, and Diagnosis

Write down neatly and clearly the child's problems and symptoms and also indicate clearly the provisional and proposed diagnosis.

Treatment and Recommendations

In the proper space, write down the prescribed medication and recommendations made.

Food and Vitamin

Fill out the appropriate space by using the symbols that are reproduced at the bottom of the form.

If the child is given a vitamin A capsule - mark down "A"
If the child is given food - mark down "N" (for Nourriture)
If the child is given both food and vitamin - mark down "A", "N"

Back side of the sheet

1. DATE D'ADMISSION

2. No. D'IMMATRICULATION

3. NOM DE FAMILLE | PRENOM

4. DATE DE NAISSANCE

5. SEXE

6. ADRESSE COMPLETE (Préciser pour les zones rurales : Habitation, Section Rurale et Commune)

7. NOM ET PRENOM DE LA MERE

8. PERSONNE RESPONSABLE

a) Nom et Prénom _____ b) Adresse _____

c) Téléphone _____ d) Lien de Parenté _____

9. Complications de la Grossesse (à remplir par l'Auxiliaire, l'Infirmière ou le Médecin consultant) _____

10. Mode d'Accouchement _____ 11. Antécédents Familiaux et Personnels _____

12. TYPE D'ALLAITEMENT

Naturel	Mixte	Artificiel

13. Durée de l'allaitement maternel _____

14. La mère suit-elle une méthode de Contraception _____

15. VACCINATION

VACCINS	1ère Dose	2ème Dose	3ème Dose	Rappel	Rappel
DPT					
DPT					
Polio					
Tétanos					
Typhoide					
Variole	Dose Unique	Date Lecture	Résultat		
B.C.G.	Dose Unique	Date Lecture	Résultat		
Autres					

16. EXAMENS CLINIQUES

Date	2. Poids Kg.	3. Régime alimentaire	Problèmes, Symptomes et Diagnostic	5. Traitement et Recommandations	6. Nourriture et type de vitamine	Vu par Md. Inf ou Aux

(S) = sein seulement

(S)+ = sein + supplément

(S)++ = sevré

(A) : l'enfant reçoit une capsule de vitamine

(N) : l'enfant reçoit de la nourriture à la Clinique

P. Form. 05

FEUILLE DE CONSULTATION PEDIATRIQUE

DEPARTMENT OF PUBLIC HEALTH AND POPULATION, HAITI

HOW TO USE WEIGHT/AGE CURVE DIAGRAMS FOR CHILDREN AGED 0 THROUGH 5

1. Always find out the child's month and year of birth, enter these data in the first box enclosed in a heavy line.

2. For each age group, there are 12 boxes in which to record the month of birth, and the 11 subsequent months of the year.

3. Let's take an example:

   Pierre was born on September 1974. So "September 1974" is entered in the first box enclosed by a heavy line; "September 75" in the second box enclosed by a heavy line; "September 76" in the third box enclosed by a heavy line; "September 77" in the fourth box enclosed by a heavy line; "September 78" in the fifth box enclosed by a heavy line.

   The remaining boxes in each group are used for the other months of the year. In the case of Pierre, the other boxes will be filled out as follows: October, November, December, January, February, March, April, May, June, July, and August.

4. When the child gets to the clinic, his weight is recorded in the box which indicates the date on which the weight has been taken.

   For example, If the date of the day is July 1976, the weight of Pierre (who was born in September 1974) will be recorded in the column "22 months". Beforehand all the boxes must have been filled out with different months of the year.

   It must be noted that if the weighing session was held in July, the auxiliary will record the children's weights opposite the column which indicates July. The month of July will be recorded in different places in each of the children's cards, assuming that all those children were not born during the same month.

A child who is less than one year old, will have his age recorded in the first group (0 through 1), whereas a child from 1 through 2 will have his age recorded in the second group.

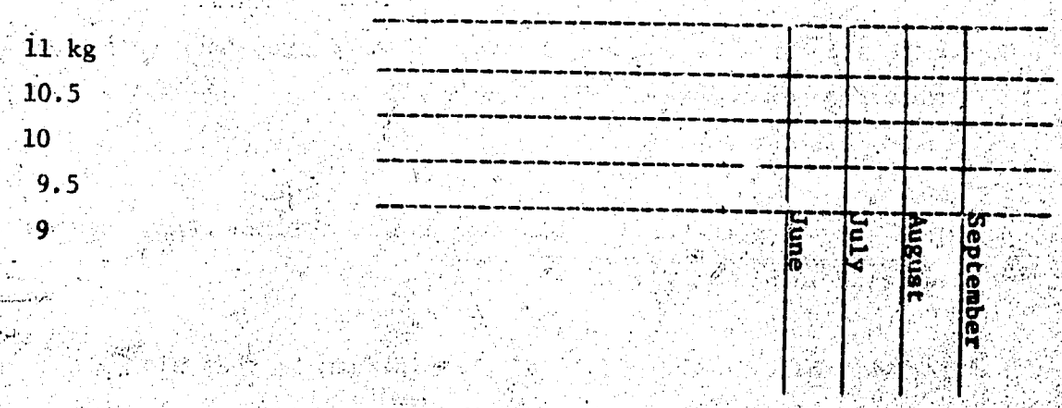
Entering months on cards this way will help avoid making mistakes in counting the child's age in months.

5. After having properly filled out the boxes with different months of the year, proceed to weigh the child and record his weight by making a big dot in the middle of the column corresponding to the current month.

If the child's weight amounts to an exact number in kilograms, the dot will be placed right in the middle of the column, on the vertical line (graduated to the left) corresponding to the exact amount of the weight in kilograms.

If the child's weight is barely over the kilogram but does not reach half a kilo, the dot will be placed a little over the kilogram line and below the half-kilo line (always in the middle of the column indicating the month);

EXAMPLE:



	Month	Weight
Child 1	July	9 kg 500
Child 2	August	10 kg 300
Child 3	September	11 kg

To read the diagram one must use the norm to diagnose protein calorie malnutrition (relation weight/age).

7. The child's growth cannot be measured by taking his weight only once. The only way to find out whether a child has a normal growth or not is to weigh him regularly. The line made by joining together all the dots will indicate whether the child has a normal or an abnormal growth.

8. The mother must keep the weight diagram and bring it along with the child for each appointed visit.

9. Each child's file must include an updated weight/age diagram.

10. Weighing a child regularly and entering his weight in the weight/age diagram are indispensable in order to know the child's growth and nutritional conditions.

HOW TO WEIGH

1. Have a good pair of scales, preferably graduated in kilograms, and tenth of a kilogram.

2. Calibrate the scales before weighing, that is to say, make sure that the scales are accurately set to zero (0).

3. Weigh the child or the adult bare-footed (without any shoes) with a minimum of clothing. A child under two years of age must be weighed naked (without any clothes on).

4. Make sure that the child has empty hands, that he is not concealing anything in his hands.

5. Put the child in the middle of the platform so that his weight will be accurate.

6. Once the person (be it a child or an adult) is placed on the scales, the cursor must be moved back and forth until the knife-edge stays in balance (the knife-edge must stay right in the middle).

7. Read the weight carefully from a position opposite to the scales dial so that the reading will be accurate, without any deviation.

8. Write down the child's weight before taking him away from the scales, and use this datum to fill in the weight/age diagram for children aged 0 through 5.

9. After each child has been weighed, make sure that the scale is set at zero so that it will give an accurate weighing.

10. In case there is no baby-scale available, and the children cannot stand by themselves on the scales; the best way to proceed is to weigh the child's mother by herself first. Write down her weight, then weigh her again, this time holding the child; then write down the weight. In order to get the child's weight, take away the weight of the mother alone from the weight of the mother and child. The difference resulting from this taking away is the child's weight that is to be recorded in the file.

11. The weight will always be in kilograms and tenths of kilograms. (for example: 3kg 100; 10 kg 900). When the scales are graduated in pounds, the weight will be recorded in pounds and quarters of a pound, for instance 8 pounds 3/4 (three quarters), 23 pounds, 16 pounds and a quarter. A conversion table from pounds to kilograms will be used (annex) to enable to record the weight in kilograms and tenths of a kilogram.

HOW TO MEASURE THE HEIGHT

Required Materials

1. For children aged 0 through 23 months, a measuring board is needed (100 cm long and 50 cm wide) at the end of which a 20 cm high plank is erected, forming a right angle, on which children's heads will rest. The board is graduated in centimeters, the best way would be to nail a measuring tape on the board. This board is called infantometer.

2. In the case of children who can stand on their feet (24 months old), a vertical wall with right angles and perfectly horizontal floor are essential. Fix the measuring tape onto the wall from the floor.

3. A piece of wood with right angles is also needed for a cursor.

4. A vertical measuring board can also be used. At the bottom of this board a small plank is fixed, on which to lean feet. A measuring tape is also nailed on the board. The cursor is used to rest heads on.

5. Height is measured in centimeters and half centimeters.

Methodology

1. Measure the child bare-footed (without any shoes).

2. In the case of children aged 0 through 23 months: length is measured by laying the child down in a horizontal position on the measuring board (length measured from the top of the head to the heels).

3. Make the child lie down on the board and keep his head firmly against the head-rest plank, and have him look upward.

4. With the help of an assistant, stretch out his knees and legs until the heels rest on the board.

5. Move the cursor two to three times in order to get the most accurate reading possible.

6. Read the height by standing in front of the measuring tape and before letting the child go from the board.

7. Children over 24 months of age have to be measured in the standing position. One has to make sure that they are standing against the graduated measuring tape, keeping their feet parallel to one another, with their heels, behinds, shoulders, and heads against the vertical wall. Heads are usually in an upward position.

8. In the case where a vertical measuring board is used, the child must be against the board, with his two feet parallel to one another on the small horizontal plank, with his heels, behind, shoulders, and head touching the vertical board.

9. Verify the child's height with a cursor.

10. Slowly bring down the cursor until the hair is flattened and the top of the head can be felt.

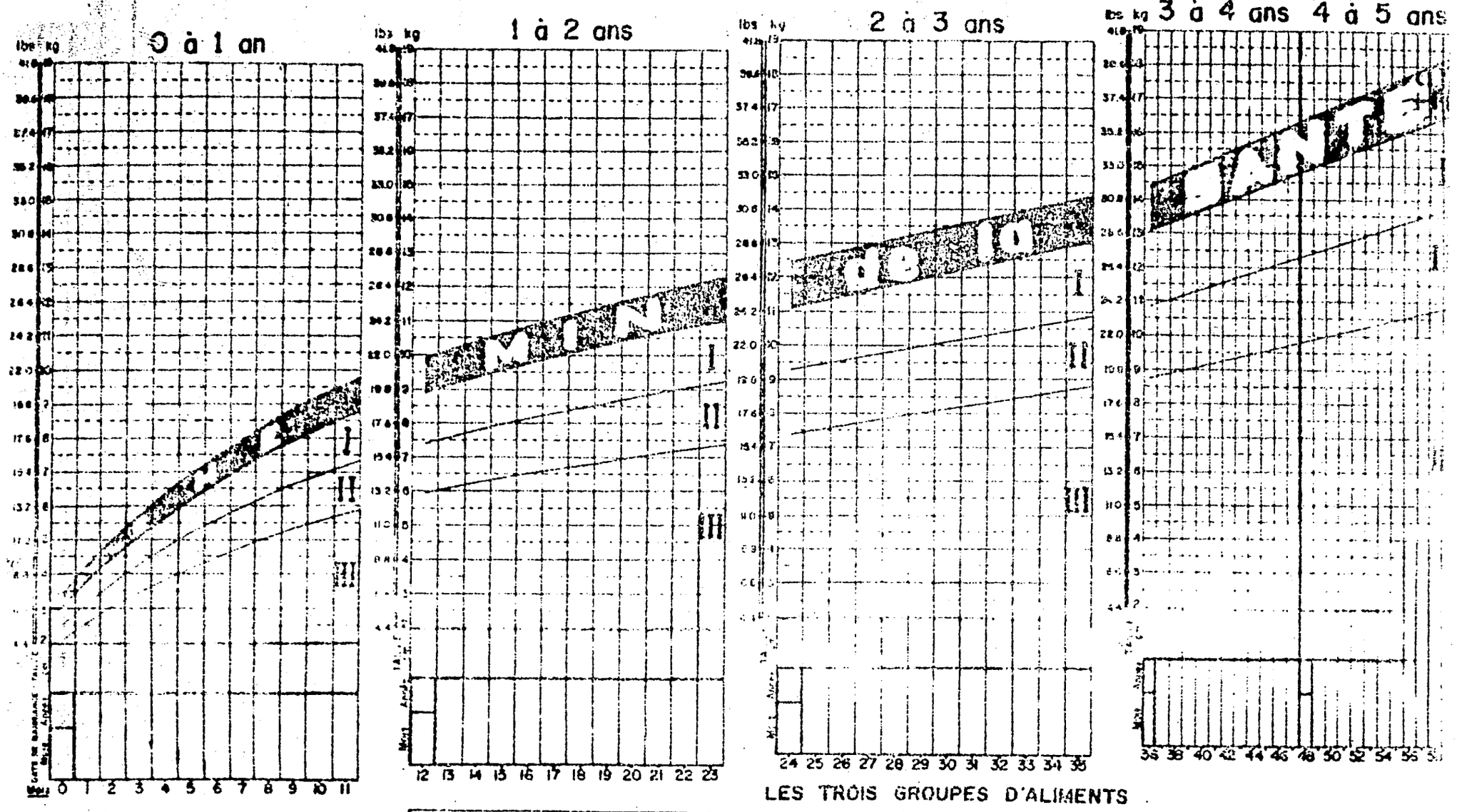
11. Move the cursor up and down two or three times in order to get the most accurate reading.

12. Read the height measuring by standing in front of the measuring tape and before letting the child go.

13. To measure the height of adults, follow the same instructions given in paragraphs a, h, i, j, k, and l.

14. Record the height on the file.

GRAPHIQUE DE POIDS/AGE DES ENFANTS de 0 à 5 ANS



LES TROIS GROUPES D'ALIMENTS

Suivre les normes décrites dans les instructions

CONSTRUCTION

Produits animaux	bœuf, cabri, porc, poulet, poissons, lait, œufs
Produits végétaux	haricots secs, pois, maïs, riz et petit-mil mélangés aux pois, pastèques, Acarali

PROTECTION

Légumes	tomates, gombos, carottes, feuilles vertes, etc
Fruits	orange, mangue, citron, papaye, figue mûre, melon, etc

FORCE et ENERGIE

Racines et Tubercules	igname, patate, pomme de terre
Céréales	maïs, petit-mil, riz
Graisses	huile, lard, margarine, beurre
Sucres	rapadou, sirop, etc

DEPARTEMENT DE LA SANTE PUBLIQUE ET DE LA PREVENTION
Réalisation: J. A. Jawain, IBD, Juin 1977

TABLE DE CONVERSION

(1 Kg=2.2 lb et 1 lb= 0.45 Kg)

LIVRE et ONCE	= KILO	LIVRE et ONCE	= KILO	LIVRE et ONCE	= KILO
5lb--8on(5.5)	=2.5kg	19lb (19.0)	= 8.5kg	33lb (33.0)	= 11.9kg
5lb-12on(5.75)	=2.6kg	19lb-4on(19.25)	= 8.6kg	33lb- 4on(33.25)	= 14.9kg
6lb- (6.0)	=2.7kg	19lb-8on(19.5)	= 8.7kg	33lb- 8on(33.5)	= 15.0kg
6lb- 4on(6.25)	=2.8kg	19lb-12-(19.75)	= 8.9kg	33lb-12on(33.75)	= 15.1kg
6lb- 8on(6.5)	=2.9kg	20lb- (20.0)	= 9.0kg	34lb- (34.0)	= 15.2kg
6lb-12on(6.75)	= .0kg	20lb-4on(20.25)	= 9.1kg	34lb-14on(34.25)	= 15.3kg
7lb- (7.0)	=3.2kg	20lb-8on(20.5)	= 9.3kg	34lb- 8on(34.5)	= 15.4kg
7lb- 4on(7.25)	=3.3kg	20lb-12-(20.75)	= 9.4kg	34lb-12on(34.75)	= 15.6kg
7lb- 8on(7.5)	=3.4kg	21lb (21.0)	= 9.5kg	34lb- (35.0)	= 15.8kg
7lb-12on(7.75)	=3.5kg	21lb-4on(21.25)	= 9.6kg	35lb- 4on(35.25)	= 15.9kg
8lb (8.0)	=3.6kg	21lb-8on(21.5)	= 9.7kg	35lb- 8on(35.5)	= 16.0kg
8lb- 4on(8.25)	=3.7kg	21lb-12-(21.75)	= 9.8kg	35lb-12on(36.75)	= 16.1kg
8lb- 8on(8.3)	=3.8kg	22lb (22.0)	= 9.9kg	36lb- (36.0)	= 16.2kg
8lb-12on(8.75)	=3.9kg	22lb-4on(22.25)	=10.0kg	36lb- 4on(36.25)	= 16.3kg
9lb (9.0)	=4.0kg	22lb-8on(22.5)	=10.1kg	36lb- 8on(36.5)	= 16.4kg
9lb- 4on(9.25)	=4.2kg	22lb-12-(22.75)	=10.2kg	36lb-12on(36.75)	= 16.5kg
9lb- 8on(9.5)	=4.3kg	23lb (23.0)	=10.4kg	37lb- (37.0)	= 16.6kg
9lb-12on(9.75)	=4.4kg	23lb-4on(23.25)	=10.5kg	37lb- 4on(37.25)	= 16.7kg
10lb- (10.0)	=4.5kg	23lb-8on(23.5)	=10.6kg	37lb-8on(37.5)	= 16.8kg
10lb- 4on(10.25)	=4.6kg	23lb-12-(23.75)	=10.7kg	37lb-12on(37.75)	= 16.9kg
10lb- 8on(10.5)	=4.7kg	24lb- (24.0)	=10.8kg	38lb (38.0)	= 17.1kg
10lb-12on(10.75)	=4.8kg	24lb-4on(24.25)	=10.9kg	38lb- 4on(38.25)	= 17.2kg
11lb (11.0)	=5.0kg	24lb-8on(24.5)	=11.0kg	38lb- 8on(38.5)	= 17.3kg
11lb- 4on(11.25)	=5.1kg	24lb-12-(24.75)	=11.1kg	38lb-12on(38.75)	= 17.4kg
11lb- 8on(11.5)	=5.2kg	25lb (25.0)	=11.2kg	39lb (39.0)	= 17.6kg
11lb-12on(11.75)	=5.3kg	25lb-4on(25.25)	=11.3kg	39lb- 4on(39.25)	=17.7kg
12lb- (12.0)	=5.4kg	25lb-8on(25.5)	=11.4kg	39lb- 8on(39.5)	=17.8kg
12lb- 4on(12.25)	=5.5kg	25lb-12-(25.75)	=11.5kg	39lb-12on(39.75)	= 17.9kg
12lb- 8on(12.5)	=5.6kg	26lb (26.0)	=11.6kg	40lb (40.0)	= 18.0kg
12lb-12on(12.75)	=5.7kg	26lb-4on(26.25)	=11.8kg	40lb- 4on(40.25)	= 18.1kg
13lb (13.0)	=5.8kg	26lb-8on(26.5)	=11.9kg	40lb- 8on(40.5)	= 18.2kg
13lb- 4on(13.25)	=6.0kg	26lb-12-(26.75)	=12.0kg	40lb-12on(40.75)	= 18.3kg
13lb- 8on(13.5)	=6.1kg	27lb (27.0)	=12.2kg	41lb (41.0)	= 18.4kg
13lb-12on(13.75)	=6.2kg	27lb-4on(27.25)	=12.3kg	41lb- 4on(41.25)	= 18.5kg
14lb (14.0)	=6.3kg	27lb-8on(27.5)	=12.4kg	41lb- 8on(41.5)	= 18.7kg
14lb- 4on(14.25)	=6.4kg	27lb-75-(27.75)	=12.5kg	41lb-12on(41.75)	= 18.8kg
14lb- 8on(14.5)	=6.5kg	28lb (28.0)	=12.6kg	42lb (42.0)	= 18.9kg
14lb-12on(14.75)	=6.[illegible]kg	28lb-4on(28.25)	=12.7kg	42lb- 4on(42.25)	= 19.0kg
15lb (15.0)	=6.8kg	28lb-8on(28,5)	=12.8kg	42lb- 8on(42.5)	= 19.1kg
15lb- 4on(15.25)	=6.9kg	28lb-75-(28.75)	=12.9kg	42lb-12on(42.75)	= 19.2kg
15lb- 8on(15.5)	=7.0kg	29lb (29.0)	=13.0kg	43lb (43.0)	= 19.3kg
15lb-12on(15.75)	=7.1kg	29lb-4on(29.25)	=13.1kg	43lb- 4on(43.25)	= 19.4kg
16lb (16.0)	=7.2kg	29lb-8on(29.5)	=13.2kg	43lb- 8on(43.5)	= 19.5kg
16lb- 4on(16.25)	=7.3kg	29lb-12-(29.75)	=13.4kg	43lb-12on(43.75)	= 19.7kg
16lb- 8on(16.5)	=7.4kg	30lb (30.0)	=13.6kg	44lb (44.0)	= 19.8kg

16lb-12on(16.75)=7.5kg	30lb-4on(30.25)=13.7kg	44lb- 4on(44.25)= 19.9kg
17lb- (17.0)=7.6kg	30lb-8on(30.5)=13.8kg	44lb- 8on(44.5)= 20.0kg
17lb- 4on(17.25)=7.8kg	30lb-12-(30.75)=13.9kg	44lb-12on(44.75)= 20.1kg
17lb- 8on(17.5)=7.9kg	31lb (31.0)=14.0kg	45lb (45.0)= 20.2kg
17lb-12on(17.75)=8.0kg	31lb-4on(31.25)=14.1kg	45lb- 4on(45.25)= 20.4kg
18lb (18.0)=8.1kg	31lb-8on(31.5)=14.2kg	45lb- 8on(45.5)= 20.5kg
18lb- 4on(18.25)=8.2kg	31lb-12-(31.75)=14.3kg	45lb-12on(45.75)= 20.6kg
18lb- 8on(18.5)=8.3kg	32lb (32.0)=14.4kg	46lb (46.0)= 20.7kg
18lb-12on(18.75)=8.4kg	32lb-4on(32.25)=14.5kg	46lb- 4on(46.25)= 20.8kg
	32lb-8on(32.5)=14.6kg	46lb- 8on(46.5)= 20.9kg
	32lb-12-(32.75)=14.7kg	46lb-12on(46.75)= 21.0kg

6. FAMILY PLANNING SHEET

D.S.P.P. FORM 07

On this form data on personal characteristics and gynecological backgrounds of all women in fertile age (WIFA) seeking family planning services are recorded On the front side of the form, all data obtained from the first visit are recorded, whereas the back side is used for subsequent visits.

Specifications

Admission Date

It is the date of the client's first visit to the service. Indicate the day, month, and year.

File Number

It is the number assigned to the client on her first visit to the institution: see similar instructions (index-card).

Last and First Names

See similar instructions (index-card).

Date of Birth

Indicate the client's day, month, and year of birth. In case there is any doubt, follow similar instructions for appointment-cards.

Marital Status

It is the client's marital status at the time she was admitted to the family planning service. As the case may be, write down clearly: single, married, placee, widow, divorced, other.

Full Address

Urban Areas

The number of the house, the name of the street, and if possible, the name of the neighborhood, and the name of the town where the client lives.

Rural Areas

The dwelling-place, the rural section, and the commune. If possible, give one or two mark spots that will enable to locate the client when there is a need for it.

Spouse's Last and First Names

Write down clearly the last and first names of the client's spouse. Follow the same instructions given for index-cards.

Mother's Last and First Names

Same instructions as for the foregoing.

Reference

Indicate clearly the last and first names, and if possible, the full address of the reference who can provide information and so on. If the reference has a telephone, give the number. Indicate the relationship between the patient and the reference.

Pregnancy

Number of Pregnancies

To be filled out by the auxiliary, nurse, or physician.
It is the amount of times when the client has been pregnant.
Write down, in the proper box, and as the case may be: /0/3, /0/8/,/1/2/.

Number of Miscarriages/Abortions

Miscarriage/abortion is defined as the interruption of a pregnancy before its 28th week, and the death of the fetus. Ask the client the number of miscarriages/abortions she has had. Enter this number in the appropriate box as indicated in the foregoing.

Number of Still-Born Babies

Ask the client the number of still-born babies she has given birth to after 28 weeks of pregnancy. Write down the number in the appropriate box, as indicated in the foregoing.

Number of Born Alive Babies

Ask the client the number of babies whom she has given birth to with some sign of life, no matter, the duration of the pregnancy or the duration of life after birth. Write down this number in the appropriate box, as indicated in the foregoing.

NOTE: The number of pregnancies is obtained by adding up the number of miscarriages/abortions, of still-born babies, and of born-alive babies. Consequently, except in the case of multiple births, it always helps to do this simple sum to make sure that the information given by the client is correct.

Number of Presently Living Children

Ask the client how many children she has given birth to and who are still living, even though some may not be living with her. Write down the number in the appropriate box, as indicated in the foregoing.

Most Recent Contraceptive Method Used

Ask the client if she has ever used a contraceptive method. If the answer is "yes", ask about the most recent method used only. Record it in the proper space. If the answer is "no", write down "none".

Gynecological Backgrounds

Age at First Menstruation

Ask the client her age when she first had her periods. Write it down in the appropriate space.

Cycle

Ask the client if ordinarily her periods occur regularly or irregularly. Write down as the case may be: "regular", "irregular".

Duration

Ask the client the average duration (in days) of her periods and write it down in the proper space.

Quantity

Ask the client if her periods are usually abundant. As the case may be, write down "abundant", "not abundant".

Menstrual Pains

Ask the client if she has menstrual pains. As the case may be, write down "yes" or "no" in the proper space.

Place Where the Most Recent Delivery Has Been Performed

Ask the client where she had her most recent delivery performed. As the case may be, write down in the proper space: hospital, private clinic, home.

If the client has never had a delivery, write down "none". In this case, questions g, h, i, j, k will not be asked.

Kind of Professional Attending Labor

Ask the client the kind of professional in charge of her most recent delivery. As the case may be, write down: "physician", "nurse", "auxiliary", "trained matron", "untrained matron", "other".

Date of Most Recent Delivery

Indicate the day, month, and year of the last delivery or of the latest child's birth (alive or still-born).

Existence of the Latest Born Child

Ask the client if her latest born child is presently living. As the case may be, write down "yes" or "no" in the proper space.

Present Breast-Feeding

Ask the client if presently she is breast-feeding. Write down "yes" or "no" as the case may be, in the proper space.

Date of the Latest Periods

Ask the client when she last had her periods. Write down the day, month, and year, in the proper space. If the client just gave birth recently and still does not have her periods, write down in the indicated space these three letters P.P.A. which stand for Post-Partum Amenorrhoea.

Medical Examination

Enter in the first column "Admission" the results of practical examinations done on the client when she was admitted, i.e. blood pressure, the result of general examination, the result of gynecological examination (breast, vulva, vagina, cervix, uterus), the results of Papanicolaou tests, and other laboratory tests.

Indicate pathological troubles or any other side effects caused by a specific method in a space intended for remarks.

Trained physician or nurse will always date the remarks. In case there is a need to repeat examinations made on the client during subsequent visits, use one of the subsequent columns each time such a need arises, making sure to date it every time.

First Method Used

It is the method that has been recommended to the client when she was admitted or which she has chosen during her first admission visit.

Give as much precision as possible concerning the method: For example, I.U.D., indicate its type: A,B,C,D. Pill: indicate its type - Eugynon, Nordiol, etc.

Quantity

Enter in the appropriate space, the amount of pill bags or cycles, the amount of condoms or tubes of cream given to the client.

Subsequent Visits

All data pertaining to the client's subsequent visits will be recorded in the indicated table. If possible, use only one line per visit. In the column "visit" write down the date of the visit, and, on the following line, in the previous column, write down the date of the set appointment. Six columns are provided for IUDs. The physician will write down, in a capital letter, etc. indications that follow the appropriate column for this case. This letter will represent the type of IUD used (A,B,C,D,). The latter "A" in the column "put in" will indicate that a type "A" IUD that has been put in has remained in its position. When the column "put in" has some kind of mark in it, no other columns are supposed to be marked. It is well understood that we are still on the same line. On the contrary, there are cases whereby two columns can be marked at the same time. Here are a few examples:

- Rejection of a type "A" IUD followed by the insertion of a "B" type (Therefore: "A" is in the column "rejected" and "B" in the column "reinserted".

- The removal of a type "B" IUD followed by a type "B" reinsertion. Put down "B" in the "removed" column, and "B" in the "reinserted" column.

- A rejection or a removal not followed by a reinsertion. (One or the other of these columns will be marked with the letter which stands for the type of the IUD used as well as the column meant for the new method prescribed to the client; this new method may consist of using pills or cream or condoms or others or none). In this case, there is a shift in the use of methods and the physician must give the reason for it.

When the "inserted" column is marked, no other columns are supposed to be. The letter "A" or "B" in the "inserted" column means that the client has shifted from the method she was using in favor of the IUD. One should never mix up this piece of information with the insertion of an IUD as initial or first method used.

The initial method used is already dealt with in (First Method Used, p.A-33).

In filling out the column "Pill", write down the name of the pill in an abbreviated form, and on the same line, and in the "quantity" column, enter the number of pill bags or cycles given to the client.

As far as the vaginal cream is concerned, mark down a cross (x) in the corresponding column and indicate in the "quantity" column the number of tubes given to the client.

As for the condom, mark a cross (x) in the corresponding column, and indicate in the "quantity" column the number of condoms given to the client.

If the client does not choose any method, mark a cross (x) in the corresponding column. If the "none" column is marked with a cross (x) and no appointment has been set for the client, fill out item (18) by marking an (x) in the corresponding box.

This question concerns the client who, after an interruption, comes back to the clinic in order to resume a contraceptive method. Therefore, it is a case of re-admission into the family planning service. Enter the date: day, month, and year in the indicated space.

1. DATE D'ADMISSION

2. NO. D'ADMISSION

3. NOM DE FAMILLE PRENOM 4. DATE DE NAISSANCE 5. CONDITION MATRIMONIALE

6. ADRESSE COMPLETE (Préciser pour les zones rurales : Habitation, Section Rurale et Commune)

7. NOM ET PRENOM DU CONJOINT 8. NOM ET PRENOM DE LA MERE

9. PERSONNE RESPONSABLE

a) Nom et Prénom _____ b) Adresse _____

c) Téléphone _____ d) Lien de Parenté _____

10.1. Nombre de Grossesses [ ] 10.2. Nombre d'Avortements [ ] 10.3. Enfants Morts-nés [ ]

10.4. Enfants Nés-Vivants [ ] 11. Nombre d'Enfants actuellement vivants [ ]

12. Dernière méthode contraceptive utilisée Avant _____

13. ANTECEDENTS GYNECOLOGIQUES

a) Age aux premières règles _____ b) Cycle (R. Irr.) _____ c) Durée (Jrs) _____

d) Quantité _____ e) Avez-vous des règles douloureuses? _____

f) Lieu dernier accouchement _____ g) Type professionnel ayant assisté à l'Acc. _____

h) Date dernier accouchement _____ i) L'Enfant vit-il actuellement _____

j) Allaitez-vous actuellement l'Enfant? _____ k) Date d'Apparition des dernières règles _____

14. EXAMEN MEDICAL

	A L'ADMISSION				
T.A.					
Examen Général					
EXAMENS GYNECOLOGIQUES					
Seins					
Vulve					
Vagin					
Col					
Utérus					
TESTS DE LABORATOIRE					
Type					
Résultat					
Observations-Médication					

Première Méthode adoptée _____ 16. Quantité _____

C.P.P. Form. 07

FEUILLE DE PLANIFICATION FAMILIALE

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VISITES SUBSEQUENTES

Date de rendez-vous	Date de la Visite	METHODES											Quantité	RAISONS DE CHANGEMENT DE METHODES		Vu par (Méd. Inf. Aux. AC)
		STERILET						Pilule (à spécifier)	Crème Vaginale	Préservatif (Condom)	Autres (à spécifier)	Aucune		Médicales	Personnelles	
		En place	Doute	Inséré	Expulsé	Extrait	Réinséré									

Si le Cas est ferme, indiquez la raison :

☐ Stérilisation; ☐ Ménopause; ☐ Enceinte; ☐ Désire un enfant

☐ Vie Sexuelle inactive; ☐ Mari pas d'accord; ☐ Contact perdu

☐ Autres.- Spécifiez _____

Date de Réactivation _____

[redacted]

. NOM DE FAMILLE _____ PRENOM _____ 4. SEXE _____ 5. DATE DE NAISSANCE _____

. ADRESSE COMPLETE (Préciser pour les zones rurales : Habitation, Section Rurale et Commune)

. NOM ET PRENOM DE LA MERE _____ 8. CONDITION MATRIMONIALE _____

. PERSONNE RESPONSABLE

a) Nom et Prénom _____ b) Adresse _____

c) Téléphone _____ d) Lien de Parenté _____

0. NOMBRE DE GROSSESSES _____ 11. NOMBRE D'AVORTEMENTS _____ 12. ENFANTS ACTUELLEMENT VIVANTS _____

3. ANTECEDENTS : a) Familiaux _____

b) Gynécologiques : Age aux premières règles _____ Cycle (R. Irr.) _____ Durée (Jrs) _____

Quantité _____ Leucorrhée _____ Douleurs _____ Opérations _____

c) Obstétricaux _____

4. DERNIER ACCOUCHEMENT

Date	LIEU		Durée de Grossesse (en mois)	Grossesse suivie? (Oui ou Non)	Complications de la grossesse	Mode d'accouchement	Etat de l'Enfant à la naissance	
	Hopit.	Domic.					Né-Vivant	Mort-Né

5. GROSSESSE ACTUELLE

a) Date des dernières règles _____

b) Date probable d'accouchement _____

c) Nombre de mois de grossesse _____

d) Est-ce une grossesse désirée? _____

Si non, type de contraceptif utilisé _____

7. EXAMENS PHYSIQUES A L'ADMISSION

a) Jambe _____

b) Yeux _____

c) Seins _____

d) Coeur _____

e) Poumon _____

f) Foie _____

g) Rate _____

h) Nez _____

i) Gorge _____

j) Abdomen _____

k) Peau _____

l) Respiration _____

16. TOUCHER VAGINAL

a) Vulve _____

b) G. de B. _____

c) G. de S. _____

d) Paroi ant. _____

e) Paroi post. _____

f) Utérus _____

g) Col _____

18. EXAMENS DE LABORATOIRE

a) Kahn _____

b) Urine _____

c) Selles _____

d) Hémogramme _____

19. CONSULTANT (Méd. Inf. Aux.) _____

Signature _____

D.S.P.P. Form. 06

FEUILLE DE GYNECOLOGIE

1. DATE D'ADMISSION

2. No. D'IMMATRICULATION

3. NOM DE FAMILLE PRENOM

4. SEXE

5. DATE DE NAISSANCE

6. ADRESSE COMPLETE (Préciser pour les zones rurales: Habitation, Section Rurale et Commune

ECOLE RUE

7. NOM ET PRENOM DE LA MERE

8. CONDITION MATRIMONIALE

9. PERSONNE RESPONSABLE

a) Nom et Prénom _____ b) Adresse _____

c) Téléphone _____ d) Lien de Parenté _____

Att. Il manque le graphique

EXAMEN DE LA BOUCHE

Date	Normale	Neutro	OCCLUSION				Gingivite	fr. anorm.	amygdalite	resp. bouche	suc. pouce	suc. lèvre	suc. langue	Hygiène de la bouche		
			Postéro		Antéro											
			unilatérale	bilatérale	unilatérale	bilatérale								bonne	Moyenne	pauvre

my/j

Feuille D'Odontologie

EXAMEN DES DENTS

Date	Cas de Prophy.	NOMBRE DE DENTS					
		Cariées	Abcédées	à obturer		à extraire	
				Perman.	Tempor.	Perman.	Temp.

TRAITEMENT

Date	Indication du traitement	Dents traitées	Genre d'anesthésie

DISPENSARY SHEET

D.S.P.P. FORM 09

This form is used only by dispensaries. Its purpose is to collect data from any person seeking medical attention. It must be filed in alphabetical order in a proper filing cabinet.

How To Fill Out The Form

1,2,3 First write down the client's last and first names, then his registration number (same instructions as for index-cards)

4,5,6 Then the names of the commune,the rural section, and the dwelling place. (Same instructions as for index-cards)

7,8 Then, write down the day, month, and year of birth, and the sex of the client.

Date of Appointment

9 It refers to the date set by the consultant for the patient's next visit to the dispensary. Write down the date: day, month, and year. For instance: 6/8/1978.

Date of Visit

10 Date on which the patient comes back according to the appointment set by the consultant. Write down the date as previously.

Type of Service

11 Write down in this column, opposite the corresponding date, the type of service needed by the patient. For example, General Examination, Prenatal, Podiatry, Family Planning examinations.

Disease or Symptom

12 The consultant will write down clearly the results of the auscultation in the corresponding box.

Treatment

13 Record the treatment or care recommended to the patient.

M.D., Inf., Aux., As.

14 The consultant will indicate his title in the corresponding box, i.e. he has to write only M.D. for a physician, Inf. for nurse (Infirmiere), Aux. for Auxiliary, or As. for Health Agent (Agent de Sante).

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1- NOM DE FAMILLE _____ 2- PRENOM _____ 3- No. D'IMMATRICULATION _____

4- Commune _____ 5- Section Rurale _____ 6- Habitation _____

7- Mois et Annee de Naissance _____ 8- Sexe _____

DATE de Rendez-vous	DATE de la Visite	TYPE de Service	MALADIE (ou Symptôme)	TRAITEMENT (Soins Donnés)	Md., Inf., Aux., As.

D.S.P.P. Form. 09

CARTE DE DISPENSAIRE

FEUILLE DE PSYCHIATRIE

Ce formulaire est destiné à la consignation par le psychiatre de ses appréciations de divers ordres résultant de la consultation du patient.

Ce formulaire comporte deux parties bien distinctes : la première comporte les modalités d'admission et la seconde concerne la consultation proprement dite par le psychiatre.

PREMIERE PARTIE

1- Date d'admission : C'est celle où le patient a été enregistré sous une immatriculation dans le centre de psychiatrie

2- Le No d'immatriculation : Celui-ci réfère à la matricule donnée au patient lors de son admission, soit comme patient externe soit comme interne.

3- Nom de famille : Inscrire le nom de famille du patient ainsi que son ou ses prénoms dan la case correspondante.

4. Sexe: Dans cette case, ou selon le cas indiquez par M (Masculin) ou F (Féminin) le sexe du patient.

5. Date de naissance: Indiquer le jour, le mois, l'année.

6- Adresse complette : (Tenir compte des recommendations pour les zones rurales) Preciser : Le lieu de résidence du patient, le numéro de la maison, la rue, et eventuellement son numero de téléphone

7- Nom et Prénon de la mère : Inscrire ces renseignements dans la case correspondante

8- Condition Matrimoniale : Preciser par M (Marié, C (Célibataire)

9- Personne Responsable: Notez dans cette case à coté des lettres a, b, c, d. tous les renseignements qui sont requis

CARACTERISTIQUES DE L'ADMISSION

11- Type de patient : a) Externe, cochez la case qui convient.

b) Hospitalisé

12- **CONDITION D'ADMISSION** : Cochez la case qui convient

AUTRES: Indiquer, en dehors des conditions precitées, s'il y en a d'autres à l'origine de l'admission du patient.

CASIER JUDICIAIRE : Cochez la case convenable.

Dans le cas où le casier judiciaire du patient n'est pas vierge, notez sur la ligne reservée à cette fin le délit commis: (Vol, crime, etc)

14- la conduite : Elle se réfère au comportement, à l'attitude du patient à l'admission

CARACTERISTIQUES PERSONNELLES

Lieu de naissance : Indiquer, le jour, le mois, l'année

Profession ou occupation: Mentionnez ici les activités habituelles ou les plus courantes du patient.

Etat Civil: Précisez par M, s'il est Marié, C, s'il est Célibataire ? ? ?

Religion: Elle se réfère à la secte frequentée : Adventiste, Catholique etc.

Education: Elle se réfère au niveau d'étude

Situation Economique: Se réfère au statut économique du patient

Usage d'alcool: En faire Mention s'il y a lieu

ou
de
Toxique

Le Partie du formulaire: L'Inscription des indications requises dans cette partie incombe au psychiatre consultant.

Intelligence : Indiquer sur cette ligne le degré d'intelligence du patient

Durée des symptomes mentaux: Les indiquer sur cette ligne.

Traitement: Preciser le mode de traitement et la date de réalisation

Impressions clinique: Consignez sous cette rubrique, les appreciations d'ensemble ou les résultats des observations sur le cas en question.

Diagnostic : En faire mention sous cette rubrique.

Exeat : Date, celle à laquelle le patient quitte l'hopital

Condition : Indiquer en regard si le patient est guéri, amélioré, non amelioré ou parti sans autorisation

1. DATE D'ADMISSION

2. No. D'IMMATRICULAT

3. NOM DE FAMILLE | PRENOM

4. SEXE

5. DATE DE NAISSANCE

6. ADRESSE COMPLETE (Préciser pour les Zones rurales : Habitation, Section rurale et Commune)

7. NOM ET PRENOM DE LA MERE

8. CONDITION MATRIMONIALE

9. PERSONNE RESPONSABLE

a) Nom et Prénom _____ b) Adresse _____

c) Téléphone _____ d) Lien de Parenté _____

CARACTERISTIQUES DE L'ADMISSION	CARACTERISTIQUES PERSONNELLES
11) Type de Patient : Externe ☐ Hospitalisé ☐	Lieu de Naissance _____
12) Condition d'Admission : Médicale ☐ Judiciaire ☐ Religieuse ☐ Volontaire ☐	Profession ou Occupation _____
Autres (à spécifier) _____	Etat Civil _____
13) Casier Judiciaire : Non ☐ Oui ☐	Religion _____
Si le patient a un casier judiciaire, indiquez le délit _____	Education _____
14) Conduite _____	Situation Economique _____
	Usage d'Alcool _____
	Ou
	de Toxique _____

(à remplir par le Psychiatre)

Intelligence _____

DUREE DES SYMPTOMES AVANT ADMISSION

- de 3 mois	3-12 mois	+ d'un an	Inconnue

MALADIES MODIFIANT LES SYMPTOMES MENTAUX

Syphilis	Convulsion	Traumatisme Crânien	Autres	Aucu

Episodes Psychopathologiques précédentes _____

S'il y a eu un traitement, indiquez Comment et Quand _____

IMPRESSION CLINIQUE

DIAGNOSTIC

SYMPT. : Date _____ Condition _____

D.S.P. Form. 11 **FEUILLE DE CONSULTATION PSYCHIATRIQUE**

MATERNITY SHEET

D.S.P.P. Form 12

This form will be used in maternity hospitals for women who come in for a delivery. It includes data about the woman's personal characteristics, summarized prenatal account, and the different stages of the delivery from the beginning to the end. It also includes a few data on the newly-born baby.

Specifications

1. Admission Date

Indicate the day, the month, and the year.

2. File or Registration Number

It is the number assigned to the woman as soon as she was admitted to the health institution. (See similar instructions: Index Card)

3. Last and First Names

See similar instructions: Index-Cards.

4. Date of Birth

Indicate the patient's day, month, and year of birth. In case there is any doubt, see similar instructions (Appointment-Card).

5. Marital Status

It is the status of the client at the moment of delivery. Write down clearly: single, married, placee, widow, divorced, others as the case may be.

6. Full Address

Urban Areas

The number of the house, the name of the street, and if possible the neighborhood and the town the patient lives in.

Rural Areas

The section and the commune. If possible, give some mark spots that will permit to locate the patient whenever needed.

7. Mother's Last and First Names

Write down clearly the last and first names of the patient's mother.

8. Reference

Mention clearly the first and last names, and if possible, the address of a person to whom one can refer for information and others.

If the reference has a telephone, give the number. Mention the relationship between the patient and the reference.

9. Prenatal Account

To be filled out by the auxiliary, the nurse, or the physician who is to perform the delivery.

[illegible]

[illegible] 4. DATE DE NAISSANCE 5. CONDITION MATRIMONIALE

6. ADRESSE COMPLETE (Préciser pour les zones rurales : Habitation, Section Rurale et Commune

7. NOM ET PRENOM DE LA MERE

8. PERSONNE RESPONSABLE

a) Nom et Prénom _____ b) Adresse _____

c) Téléphone _____ d) Lien de Parenté _____

9. HISTOIRE PRENATALE

Groupe sanguin et Rh _____ Sérologie _____ Para _____ Gravida _____

Histoire antérieure _____

Grossesses antérieures	Année	Durée	Résultat
1			
2			
3			
4			

Evolution de la présente grossesse (Médication, radiographie, maladie du Rh, intoxication gravidique, infection, systèmes cardio respiratoire etc...) _____

10. TRAVAIL ET ACCOUCHEMENT

Age du foetus en semaine _____ Date et heure du début du travail _____

Date et heure de la rupture des membranes _____ Heure de la naissance _____

Durée du travail _____ Qualité du travail _____ Présentation _____

11. MODE D'ACCOUCHEMENT

Normal : Spontané [ ] Naturel [ ] Inductionnel [ ]

Intervention : Forceps [ ]

Césarienne : - Epreuve de travail : _____

- Sélective [ ]
- Pathologique [ ]
- Indications _____

12. MEDICATION ANALGESIQUE :

Agent	Heure	Dose
_____	_____	_____
_____	_____	_____

13. ANESTHESIE :

Type	Agent	Heure	Dose
_____	_____	_____	_____

14. B D C F : A l'Admission_____ Au début du travail_____ Au cours du travail_____

2ème stade du travail_____ 1 minute après la naissance_____

5 minutes après la naissance_____

Si Césarienne : Avant départ pour S.O._____ A l'arrivée_____

Pendant préparation_____

Heure d'anesthésie_____ Heure de la naissance_____

Durée d'anesthésie avant naissance_____

15. NOUVEAU-NE

Sexe_____ Poids_____ TRR (Temps avant respiration régulière)_____

Apgar	1 minute	5 minutes
Couleur	_____	_____
Respiration	_____	_____
Tonus	_____	_____
Réflexes	_____	_____
Rythme Cardiaque	_____	_____
TOTAL	_____	_____

Présence de méconium_____

Résuscitation : Oxygène_____ Masque_____ Intubation Endotrachéale_____

Massage Cardiaque_____ Bicarbonate_____

Résultat_____

_____

Autres signes pertinents de l' examen du N.N._____

_____

16. PLACENTA : Complet_____ Incomplet_____ Anomalies_____

Date_____ Signature_____

HOSPITALIZATION AND EXIT SHEET

D.S.P.P. FORM 10

Specifications

1. Identification

The patient has to be identified by his last (in capital letters) and first (small letters) names and his file or registration number.

2. Admission Request

The ward has to be specified by its name written in the proper box, and the date on which the request has been made must consist of the day, the month, the year and the time, written down in different boxes intended for this purpose.

3. Provisional Diagnosis

The provisional diagnosis is written on horizontal lines reserved for this purpose, the name is written in the appropriate space. The request should always be signed by the physician who made it.

4. Exit (deceased included)

a. Date - Write down the day, the month, the year, and the time in appropriate boxes.

b. Final Diagnosis - Write down the final diagnosis clearly and completely inside the box, on horizontal lines.

c. Complications - Record all complications, according to medical criteria, on horizontal lines, inside the box.

d. Associated Diseases - Follow the same instructions as for final diagnosis.

5. Condition When Exited

Exit conditions having been enumerated in the table pertaining to this item, make a mark (x) in the box corresponding to the situation observed.

6. Transfer

a. To another service in the same hospital.

1. Date - Record the date by mentioning the day, the month, the year, and the time and write down the name of the service in boxes intended for each item. J: Day; M: Month; A: Year

2. Reason for transfer - Indicate the reason for the transfer inside the box.

b. To another hospital.

Follow the same instructions as for a. and write down the name of the institution next to "Other Hospital".

7. Conditions When Discharged

The consulting physician or the Chief of Service, as the case may be, will state the conditions in which the patient is when discharged. The file that is to be given to the patient will also be dated and signed.

1. INSTITUTION _____ 2. No. D'IMMATRICULATION _____ 1. [ ]

3. CARACTERISTIQUES PERSONNELLES

2. [ ]

3.1. Nom et Prénom _____ 3.2. Sexe _____ 3.2. [ ]

3.3. Age _____ 3.4. Condition Matrimoniale _____ 3.3. [ ]

3.5. Résidence Actuelle _____ 3.4. [ ]

3.5. [ ]

4. HOSPITALISATION

4.1. [ ]

4.1. Salle _____

4.2. DATE : Admission | Exéat | Décès 4.3. Nombre de Jours 4.3. [ ]

5. [ ]

5. ETAT A L'EXEAT

6. [ ]

7. [ ]

VIVANT		MORT	
Guéri	[ ]	Avant 48 Heures	[ ]
Amélioré	[ ]	Après 48 Heures	[ ]
Non Amélioré	[ ]		
Parti sans autorisation	[ ]		

8.1. [ ]

8.2. [ ]

6. AUTOPSIE

Oui [ ] Non [ ]

7. Diagnostic Final : Traitement sans opération

8. Diagnostic : Intervention Chirurgicale

8.1. Pré-opératoire _____

8.2. Post-opératoire _____

FICHE D'EXEAT

D.S.P.P. Form. 26

JOURNAL DES HOSPITALISES

Date D'admission	No du dossier	Nom et Prénom	Salle

TEMPERATURE SHEET

D.S.P.P. Form 14

This form, which is part of the hospitalization file, is meant for recording daily vital facts, during the patient's stay in the service and/or following any surgical operation.

Specifications

The six main components are:

1. Identification

Identify the patient by his last and first names, and his file or registration number, as well as his bed number.

2. Duration of Stay

Check on the duration of the patient's stay, after his admission as well as after a surgical operation by means of the following data.

a. Various Dates - Write down the dates in the "dates" boxes every day following the horizontal line. This will give the duration of the stay.

b. Duration of Stay After a Surgical Operation - Starting from the day of the operation, write down successive dates, following the horisontal line in boxes related to "Operations", until the day of the patient's exit.

3. Temperature Curve Graph

Use as fudicial points the various degrees recorded in the margin and draw the curve according to prescribed norms, taking the hours into consideration.

4. Pulsation - Indicate the method used.

5,6. Liquid - Indicate according to the norms.

Remark: Use as many sheets of paper as neede

Individualisation

Nom	Prénom	N°d'Ordre

FEUILLE DE TEMPERATURE

Date

Jours: Admission / Opérations

Heures: 6 8 10 12 14 16 18 20 22 24 2 4 6 8 10 12 14 16 18 20 22 24 2 4 6 8 10 12 14 16 18 20 22 24 2 4 6 8 10 12 14 16 18 20 22 24 2 4 6 8

TEMPERATURE: 41° 40° 39° 38° 37° 36°

TENSION ARTERIELLE: 260 250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10

PULSATION: 140 130 120 110 100 90 80 70 60 50

LIQUIDE ingéré:
- Respiration
- M.B.
- Matières
- Par Sondes
- Par Veine
- Par Peau
- Par Rectum
- TOTAL

LIQUIDE sortie:
- Vomissements
- Urine
- Drainage
- Crachats
- TOTAL

Autant que possible utiliser le couleur rouge pour indiquer la température et le couleur bleu pour la tension artérielle

FEUILLE DE TEMPERATURE — Imp. — Section Evaluation Dépt. Santé Publique A-64 — Form. AM-11

4/6

CONSULTATION REQUEST

D.S.P.P. Form 18

This form, including three components, is part of the in-patient's file. It enables the consulting physician to request, in a great hurry, the participation of another specialist in providing attendance to the in-patient, in order to get his view or advice in relation to the treatment being given to the patient.

Specifications

1. Identification

Mention should be made of the patient's file number, of the service he is in, and his bed number.

2. Consultation Request Per Se

a. Service or Physician - Write down the name of the service of of the physician requesting the consultation.

b. Indicate the day, month, year and time of the consultation request.

c. Put down score in the appropriate space, one of the small squares EMERGENCY.

d. Descriptions of the special nature of the case by the physician requesting the consultation. Signature of the requesting physician.

3. Notes from the consultant: Day and time. Write down the day and time in figures. Record observations, establishment of facts, conclusions made by the consultant physician along with his signature.

NOM DE FAMILLE

Prénom

No. du dossier

Service

Salle

No. Lit

DEMANDE DE CONSULTATION

SERVICE DU MEDECIN

DATE

URGENCE
OUI ☐
NON ☐

PARTICULARITES PRESENTEES PAR MALADE

Signature du Médecin requerant

NOTES DU CONSULTANT

Jour/Heure	OBSERVATIONS Signez chaque registre

FICHE DE CONSULTATIONS

ANAMNESES ET EXAMENS PHYSIQUES

Ce formulaire fait partie du dossier du patient hospitalisé. Il permet de connaitre les antecedents du patient, les motifs de sa visite à l'Hopital, ses conditions physiques actuelles. En un mot, c'est un résumé de l'histoire clinique du patient.

SPECIFICATIONS

IDENTIFICATION ET IMMATRICULATION : Procédez comme pour les autres formulaires. L'inscription des données requises dans les différentes parties du formulaire incombe au Médecin consultant. Sur les lignes reservées à cette fin et en tenant compte des diverses rubriques, il consignera toutes les constatations, observations et conclusions pertinentes relatives au patient, il apposera sa signature au bas de la forme et portera la date du jour.

NOM DE FAMILLE | Prénom | No. du Dossier

Service | Salle | No. Lit

ANAMNESES ET EXAMENS CLINIQUES

OBSERVATIONS

Signez chaque registre

Anamneses

Motif de la visite

Maladies Actuelles

Antec. Pathologiques

Enfance

Age Adulte

Opération

Accidents

Antécédant familiaux

Données Socio Economiques

EXAMENS CLINIQUES

Examen Général

Poids

Taille

Pression Artérielle

Pouls

Yeux Nez Gorge Oreilles

Cou

Syst. Respiratoire

Syst. Gastro vasculaire

Syst. Génito Intestinal

Syst. Génito Urinaire

Examen Gynécologique

Syst. Neuro psychiatrique

DIAGNOSTIC

Suggestions

Ordonnance

ORDONNANCES ET INSTRUCTIONS MEDICALES

Sur ce formulaire le Médecin consigne les ordonnances ou toutes autres instructions relatives au traitement du patient.

SPECIFICATIONS

1- **IDENTIFICATIONS**

NOM DE FAMILLE ET PRENOM : Transcrire les noms et prénom du patient.
No. D'IMMATRICULATION : Indiquer le numéro du dossier du patient.
No. DU LIT : Indiquer le Numéro du lit qu'occupe le patie

2- **OBSERVATIONS**

En regard de chaque ordonnance ou instruction, spécifiez le jour, l'Année et l'heure, suivant le contexte du formulaire. Le Médecin apposera ensuite sa signature

N.B. Une intervalle d'une ligne sera observée, avant de consigner toute nouvelle ordonnance ou instruction médicale.

NOM DE FAMILLE	PRENOM	No. D'IMMATRICULATION	No. DU LIT

JOUR / HEURE	OBSERVATIONS Signez chaque registre

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NURSE'S SHEET

D.S.P.P. FORM 16

This form is intended for the use of nurses or medical auxiliaries and for the recording of actions following medical prescriptions, personal remarks and establishment of facts about physchological, physical, and othe reactions of the in-patient.

Specifications

1. Identification

Identify the patient by his last and first names, his file or registration number and the bed number.

2. Notes Concerning the Patient

The sheet is divided by vertical lines into four parts in which will be written:

a. Full date
b. Medication
c. Observations
d. Signature

Use horizontal lines to record data related to the four columns. In the signature column, write down the nurse's or the auxiliary's last name.

Leave one line blank after each recording and use the reverse of the nurse's sheet whenever there is a need for it.

1- IDENTIFICATION :

NOM DE FAMILLE	PRENOM	No. D'IMMATRICULATION	No. DU LIT

2- MENTIONS DU PATIENT :

Jour/Heure	MEDICATION	OBSERVATIONS	SIGNATURE

FEUILLE DE GARDE-MALADE

D.G.P.P. Form. 16

NOM DE FAMILLE	PRENOM	No. D'IMMATRICULATION	No. DU LIT

E V O L U T I O N

Date et heure de l'examen	
Symptômes et signes cliniques observés à l'entrée	
Nouveaux symptômes et signes	
Complications	
Modifications du diagnostic	
Contrôle du traitement	
Résultat du traitement	
Modifications thérapeutiques et observations	
Signature du Médecin	

FEUILLE D'EVOLUTION

D.S.P.P. Form. 17

REQUEST FOR LABORATORY TESTS

D.S.P.P. FORM 18

This form will be used by medical staff to request that laboratory tests be made for the client.

Specifications

1. Identification

The client has to be identified by his last name (in capital letters), his first name (in small letters).

2. Service

Indicate the service by making a score and write down the name of the ward and the bed number in their respective boxes.

3. Request Date

Indicate the time, the day, the month, and the year in appropriate spaces.

4. Emergency

Mark down a score in an appropriate box according to cases.

5. Requested Laboratory Tests

Write down the requested tests to be done by the laboratory service on horizontal lines. The author of the request has to sign.

1- IDENTIFICATION :

NOM DE FAMILLE	PRENOM	No. D'IMMATRICULATION

2- SERVICE :

Hospitalisé ☐ SALLE _____ No. DU LIT _____

Externe ☐

3- DATE DE LA DEMANDE

Heure	Jour	Mois	Année

4- URGENCE

Oui ☐

Non ☐

EXAMENS DE LABORATOIRE DEMANDES

Signature

DEMANDE D'EXAMENS DE LABORATOIRE

D.S.P.P. Form. 18

RESULTS OF LABORATORY TESTS

D.S.P.P. FORMS 19;19.1/19.2;19.3;19.4

These forms are meant for recording laboratory test results.

19.1 - Special Chemical Tests

19.2 - Urinalysis, stools, encephalo-rachidian liquid, bacteriology

19.3 - Hematology and Serology

19.4 - Chemical Tests

Specifications

In the upper part of each form, identify the patient by his last and first names, his file or registration number, the service requesting the tests (in or out-patient), the bed number in case of an in-patient.

On horizontal lines, opposite each item, write down the results, the day's date and the signature. Do not use the back side of the sheet to write down results.

Remarks: Batches of forms will be stocked in the laboratory so that the technician can record the results. As soon as they are received, they will be filed in the respective client's files.

NOM DE FAMILLE	PRENOM	No. DU DOSSIER	No. DU LIT

EXAMENS DE LABORATOIRE

A ANNEXER TOUS LES FORMULAIRES DES DIFFERENTS EXAMENS DE LABORATOIRE
FORM. 19.1 - 19.2 - 19.3 - 19.4

RESULTATS DES EXAMENS DE LABORATOIRE

S.P.P. Form 19

NOM DE FAMILLE | PRENOM | No. DU DOSSIER

SERVICE | No. DU LIT

EXAMENS DE LABORATOIRE

EXAMENS CHIMIQUES SPECIAUX

EXAMEN	RESULTAT	NORMAL
Bilirubine directe		0
Bilirubine totale		0 - 8 mg 0/00
Amylase		40-130 Un somogyi
Lipase		1,2-1,8 Un Crandall
Phosphatase Acide		1 - 5 Un Plumel
Phosphatase Alcaline		1 - 5 Un Bodansky
Transaminase Oxaloacetique		8 -40 Un Karmen
Transaminase Pyruvique		8 -40 Un Karmen
Deshydrogenase Lactique		200-440 Un
Créatine Phosphokinase		25-35 Un
Temps de Prothrombine		12 sec
Taux de Prothrombine		100%
Hanger Test		0 à 2 plus
Test de Turbidite au Thymol		4 à 6 Un Mac Logan
Fer Serique		65-175 microgm
Capacité de Saturation en Fer		250-420 microgm
C6-P.D.		
Fibrinogène		4-5 gm 0/00

Date..... Signature.....

EXAMENS CHIMIQUES SPECIAUX

D.S.P.P. Form. 19.1

A-70

150

NOM DE FAMILLE _____ PRENOM _____ No. DU DOSSIER _____

RUE _____ No. _____

EXAMENS DE LABORATOIRE

URINES

Couleur _____ Densité _____

Ph _____ Albumine _____

Sucre _____ Acétone _____

Pigments Biliaires _____ Sels _____

Urobilinogène _____ Bence Jones _____

Sang occulte _____ Hb _____

Microscopie (Culot de centrifugation) _____

Galli-Mainini _____

Calcul Urinaire _____

Compte d'Addis _____

SELLES

Couleur _____ Consistance _____

Helminthes _____

Protozoaires _____

Sang occulte _____

Digestion _____

LIQUIDE CEPHALO RACHIDIEN

Aspect _____

Cytologie _____

Frottis _____

Chimie _____ Trouvé _____ Normal _____

Glucose _____

Chlorures _____

Protéines _____

V.D.R.L. _____

Mastic Test _____

BACTERIOLOGIE

Specimen _____

Frottis _____

Culture : 1-Qual _____

2-Quant. _____

Antibiogramme _____

Date..... Signature.....

URINES, SELLES, LIQ. CEPH. RACHIDIEN, BACTERIOLOGIE

D.S.P.P. Form. 19.2

[redacted]

TITRE

No. DU LIT

EXAMENS DE LABORATOIRE

HEMATOLOGIE

G.G.R.
G.G.B.
G.B.
Neutrophiles
Eosinophile
Basophiles
Lymphocytes
Monocytes

Malaria
Hematocrite
Reticulocytes
Sédimentation

Coagulation

Saignement

Plaquettes
V.C.M.
T.C.H.
C.C.M.C.
Fragilité globulaire

Fragilité capillaire

Retractilité du Caillot

Cellules L.E.
Micro-filaires
Compte d'Eosinophiles

Epreuve de Thorn

Sickling Test
Electrophorèse Hb

SEROLOGIE

Kahn Quant.
V.D.R.L. Quant.
Widal

Mono-Test
Paul-Bunnel
Type

Coombs
C.R.P.
Latex
A.S.O.

Autres Tests

.....

Signature.....

C.M.P. Form. 19.3 HEMATOLOGIE ET SEROLOGIE

NOM DE FAMILLE | PRENOM | No. DU DOSSIER

SALLE | No. DU LIT

EXAMENS DE LABORATOIRE

EXAMEN	RESULTAT	NORMAL
Azote de l'Urée		10-18 mg %
Urée		25-40 mg %
Créatinine		1-2 mg %
Glucose		70-120 mg %
Cholesterol total		150-200 mg %
Cholesterol esterifie		120-160
Rapport E/T		0,7-0,8
Acide Urique		40-50 mg o/oo
Réserve alcaline du Serum		50-70 vol %
Sodium		138-143 mE/L
Potassium		4-5 mE/L
Chlorures		110-113 mE/L
Calcium		9-11 mg %
Phosphore		3-4 mg %
Protéines Totales		6,8-8 mg %
Albumines		4-5 mg %
Globulines		2-3 gm %
Rapport A/G		1,2-1,8

Date..... Signature.....

EXAMENS CLINIQUES

U.S.P.P. Form. 19.4

X-RAY REQUEST AND REPORT

D.S.P.P. Form 20

This form will be used by medical staff to request an x-ray for the client from the radiography service, and to write down, according to the adopted principle, clinical information.

Specifications

Identification and Service

1. Identify the patient by his last (in capital letters) and first (in small letters) names and his file or registration number.

2. Mark down with a score the service, in small inner boxes. Write down the ward and the bed number in respective boxes.

Request for X-Ray

1. Date - Give precisely the day, month, year and time in appropriate spaces.

2. Requested Test - In appropriate boxes, write down the kind of x-ray to be done.

3. Clinical Information - Write down clinical information on horizontal lines in the box; then record the name of the person making the request and his signature.

X-Ray Report

In the margin, on the first column lines, write down the day and time. Write the record on the second column horizontal lines. For this purpose, several lines may be needed. Sign each record.

SERVICE

Hospitalisé ☐

Externe ☐

SALLE

No. DU LIT

DEMANDE DE RADIOGRAPHIE

DATE

Jour	Mois	Année	Heure

EXAMEN DEMANDE

Type d'Examen à réaliser

RENSEIGNEMENTS CLINIQUES

Signature du Médecin

PROTOCOLE RADIOLOGIQUE

Jour/ Heure	OBSERVATIONS Signez chaque registre

D.S.P.P. Form. 20 DEMANDE DE RADIOGRAPHIE ET PROTOCOLE RADIOLOGIQUE

REQUEST FOR PATHOLOGICAL TESTS

D.S.P.P. Form 21

This form, including three parts, is used for requesting histo-pathological tests on tissues and for recording the comprehensive report of these tests.

Specifications

Identification

The patient's file or registration number, the service he is in, and his bed number.

The Request Per Se

Date the test request (day, month, year).

Write down the clinical diagnosis.

Write down clinical and other information.

Histo-Pathological Report

Record in details, opposite the day and time, the establishment of facts and conclusions from the tissues test. Sign the report.

NOM DE FAMILLE	PRENOM	No. DU DOSSIER

SALLE	No. DU LIT

DATE			DIAGNOSTIC
Jour	Mois	Année	Diagnostic Clinique

RENSEIGNEMENTS CLINIQUES

Signature du Médecin

RAPPORT HISTO - PATHOLOGIQUE

Jour / Heure	OBSERVATIONS Signez chaque registre

DEMANDE D'EXAMENS PATHOLOGIQUES

D.S.P.P. Form. 22

REPORT ON ANESTHESIA

D.S.P.P. Form 22

This form, divided into four parts, is used to record the means used by the operating team in order to enable the patient to undergo the operation without pain, and to record the reactions of the patient during and after the operation.

Specifications

Identification

Identify the patient by his last and first names, his file or registration number.

Write down the name of the service he is in and his bed number.

Anesthesia Report

This part is filled out before the operation, taking into consideration various items and using appropriate terms.

Operative Risk - Indicate the risk by putting a circle around the appropriate figure according to the operating team's criteria.

Anesthesia Per Se and Its Evolution

Use proper boxes to record the duration of anesthesia, by taking into consideration its beginning and end. Record also the duration of the surgical operation.

Use different codes to indicate the proceeding of the surgical operation, of anesthesia, of vital signs, etc.

Record, by means of appropriate terms, data related to additional remarks and medications: therapy, aqueous solution, plasma, blood, etc.

Post Operative Condition - Indicate according to the operating team's criteria.

REPORT ON ANESTHESIA

Post Anesthetic Visits

Use the back side of the sheet of paper to write on the report on anesthesia by recording all post-anesthetic observations and establishment of facts, with date and time.

The author of the report will sign the sheet after each recording.

Note: Leave out one line after each recording.

NOM DE FAMILLE	PRENOM	No. DU DOSSIER

AGE	POIDS	T.A.	HB	URINES	ETAT GENERAL	RISQUE OPERATOIRE

OPERATION	PREMEDICATION	HEURE	EFFET

DIAGNOSTIC

ANESTHESIE : Commencée [Heure] Terminée [Heure] [Durée] Durée de l'Opération [ ]

	AGENTS	HEURE								
X Anest.	220									
	200									
X TA	180									
	160									
O Resp	140									
	120									
	100									
O Pouls	80									
	60									
	40									
	20									
	Remarques									

REMARQUES ET MEDICATION ADDITIONNELLES

VOIE	SOLUTE	PLASMA	SANG

INDUCTION	MAINTIEN
Agents	Agents
Méthode	Méthode

MEDICATION POST OPERATOIRE

Jour/Heure	VISITES POST-ANESTHESIQUES Signez chaque registre

S.P.P. Form. 22

RAPPORT D'ANESTHESIE

OPERATION RECORD

D.S.T.P. Form 24

This form is used to identify the team in charge of the surgical operation, the technique used, pre and post-operative conclusions. It is divided into four parts and is part of the surgical patient's file.

Specifications

Identification

Identify the patient by his last and first names, his file or registration number

Write down the name of the service the patient is in, and the patient's bed number.

Operation Record

Write down last and first names of persons included in the operating team: Surgeons, Anestheists, Nurses.

Pre- and Post-Operative Diagnosis

In this space, indicate:

1. The date, the time when the operation starts and ends. For this purpose, use small boxes.
2. Pre- and Post-operative diagnosis. Use horizontal lines to write down clearly the diagnosis.
3. Operation - In their respective spaces, write down the name and the type of the surgical operation.
4. Drainage - Specify the system used.
5. Bleeding - Indicate the amount.
6. Compresses Decrease - Whether it is alright or not.
7. Blood Transfusion - Quantity in cubic centimeters.

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OPERATION RECORD

Description of the Operation

Describe in details the technique used, the establishment of facts and conclusions. The front and back sides of the paper can be used for this purpose.

Note: At the end of the description, the chief-surgeon must sign his name.

NOM DE FAMILLE | PRENOM | No. DU DOSSIER

VILLE | No. DU LIT

Premier Chirurgien | Second Chirurgien | Troisième Chirurgien

Premier Anesthésiste | Second Anesthésiste | Troisième Anesthésiste

Première Infirmière | Seconde Infirmière | Troisième Infirmière

DATE

Jour	Mois	Année

OPERATION COMMENCEE | Heure

OPERATION TERMINEE | Heure

DIAGNOSTIC PRE-OPERATOIRE

DIAGNOSTIC POST-OPERATOIRE

OPERATION

DRAINAGE | PERTE SANGUINE

DECOMPTE DES COMPRESSES | TRANSFUSION SANGUINE

DESCRIPTION DE L'INTERVENTION

PROTOCOLE OPERATOIRE

C.S.P.P. Form. 24

DESCRIPTION DE L'INTERVENTION

DAILY CENSUS

In any hospital or health center with beds, the ward nurse should carry out a daily census of the ward. For this purpose, she must use the daily census sheet.

Specifications

Ward - Write out in full the name of the ward or of the service.

Date - In the appropriate box, write down the date of the census: day, month, and year.

Number of Available Beds - Write down the number of available beds, i.e. the number of beds ready for occupancy.

In the space intended for each admitted or in-patient to the ward, write down:

The patient's last and first names
The number of the patient's clinical account or file
A cross (x) in the column "admitted"

Fill, in the same space, for each re-admitted patient, write down:

His last and first names
The number of his clinical account
A cross (x) in the "Re-admitted" column
A re-admitted patient is the one who, after his exit, is admitted to the ward again during the same period.

Fill, in the same space, for each exited patient, write down:

His last and first names
The number of his clinical account
A cross (x) in one or the other columns "alive" or "deceased" as the case may be
The number of hospitalitation days in the proper column.

DAILY CENSUS

Still in the same large space, for any transferred patient, write down:

- His last and first names
- The number of his clinical account
- A cross (x) in the "transferred" column
- The number of hospitalization days in the corresponding box

At the end of the day, add up the number of crosses in each column and the numbers of hospitalization days. At the bottom, on the right side, carry over the (a) total and add up the grand total.

RESUME MENSUEL DU RECENSEMENT QUOTIDIEN

SALLE _____ DATE : Mois _____ Année ____

Jour	Nombre de lits disponibles	Patients Admis	Patients Réadmis	PATIENTS EXEATES		Patients Transférés	Nombre de jours d'hospitalisation
				Vivants	Décédés		
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
TOTAL							

BIRTH CERTIFICATE

D.S.P.P. Form

Specifications

1. Commune

Write down the name of the commune in which the town or the rural section is located and where the delivery took place.

2. Town

If the delivery took place in a town, write down the name of the town in its proper place. In this case, do not write anything beside the mention "Rural section".

3. Rural Section

If the delivery took place in a rural section, write the name of the section down in its appropriate space. In this case, do not write anything next to "town".

4. Indicate the day, month, and year of the delivery.

5. Mother

5.1 Name - Write out in full the last and first names of the woman who has given birth. (See similar instructions for index-dard)

5.2 Place of Residence - Do not mix up the mother's place of residence with the place where the delivery took place. The place of residence is the place where the mother usually lives, i.e. a rural section or a town. If it is a town, write down its name clearly. If it is a rural section, write down its name, and on the following line, write down the name of the commune in which this section is located.

5.3 Age - Write down the mother's age on the delivery day (See similar instructions) (reference form to mention ...)

5.4 Number of Deliveries - Write down the number of deliveries that the mother has had (including the present one).

6. New-Born Baby

6.1 Sex - Indicate the sex by making a cross (x) in the appropriate box.

6.2 Birth - Indicate whether the woman has given birth to an alive or still-born baby, by making a cross (x) in the appropriate box. The exact defintions of "born alive" and "still-born" must be repeated. It is advisable to redefine these expressions in a foot-note.

7. Signature of the Person Performing the Delivery

The person who performs the delivery (physician, nurse, auxiliary) must sign in the space intended for this purpose. The matron who is able to sign will do likewise. If the matron does not know how to sign, the health agent or the rural police officer who is filling out the certificate will write down the last and first names of the person who has performed the delivery and will also write down his own last and first names on the following line.

CERTIFICAT DE NAISSANCE

No. _____

1. Commune _____ 2. Ville _____

3. Section Rurale _____ 4. Date Accouchement _____

5. MERE	6. NOUVEAU-NE
5.1. Nom et Prénom _____	6.1. SEXE: Masculin ☐ Féminin ☐
5.2. Résidence _____	6.2. NAISSANCE: Vivante ☐ Mort-Né ☐
5.3. Age _____ Parité _____	

7. Signature de l'Accoucheur _____

D.S.P.P. Form.

CERTIFICAT DE NAISSANCE

No. _____

1. Commune _____ 2. Ville _____

3. Section Rurale _____ 4. Date Accouchement _____

5. MERE	6. NOUVEAU-NE
5.1. Nom et Prénom _____	6.1. SEXE: Masculin ☐ Féminin ☐
5.2. Résidence _____	6.2. NAISSANCE: Vivante ☐ Mort-Né ☐
5.3. Age _____ Parité _____	

7. Signature de l'Accoucheur _____ 7. Signature de l'Accoucheur _____

D.S.P.P. Form.

FICHE DE MAISON

Après avoir terminé le relevé de population, l'agent de santé remplira la fiche de maison qu'il laissera attachée à une porte (la porte principale) de la maison. Il serait bien aussi que l'agent avant de partir attire l'attention des occupants de la maison sur la présence de cette fiche. Car l'agent ~~peut aussi~~ demander à ces personnes de veiller à ce que la fiche reste toujours attachée à la porte.

La fiche de maison sera remplie en utilisant la fiche de relevé.

Porter :

— l'ordre de visite de la maison ou du logement .

— Le nombre de ménages dans le logement

— Le nombre total de personnes vivant dans la maison. Pour obtenir ce nombre, compter les noms de toutes les personnes inscrites sur la fiche relevé.

— La date du relevé.

Après avoir porté ces informations, l'agent écrira en toutes lettres et lisiblement ses noms et prénoms. Et sur la dernière ligne, l'agent porte sa signature.

Ne rien écrire dans le cadre à droite. Ce cadre est plutôt prévu pour les autres visites ou visites subséquentes. A chacune de ces visites subséquentes, l'agent utilisera une ligne de ce cadre pour porter :

— La date de la visite subséquente.

— La population (c'est à dire le nombre total de personnes vivant dans la maison au jour de cette visite subséquente. Noter bien que ce nombre ne sera pas forcément égal à celui trouvé lors du relevé.

— La signature (de l'agent).

DEPARTEMENT DE LA SANTE PUBLIQUE ET DE LA POPULATION

RELEVE DE POPULATION - FICHE DE MAISON

Ordre de visite du logement .....

Nombre de ménages dans le logement....

Nbre total de personnes dans le logement.....

Date du relevé .....

Nom de l'agent .....

Signature de l'agent .....

A chaque visite portez

Date	Population	Signature

DEPARTEMENT DE LA SANTE PUBLIQUE ET DE LA POPULATION

RELEVE DE POPULATION - FICHE DE MAISON

Ordre de visite du logement .....

Nombre de ménages dans le logement....

Nombre total de personnes dans le logement.....

Date du relevé .....

Nom de l'agent .....

Signature de l'agent .....

A chaque visite portez

Date	Population	Signatrue

FICHE DE REFERENCE

Cette fiche, qui sert de liaison entre l'Auxiliaire Responsable et les Agents de Santé, sera utilisée par ces derniers pour référer toute personne souffrante à l'Etablissement de Santé le plus proche de la communauté.

SPECIFICATIONS : - Inscrire dans les cases correspondantes les nom , prénom, age et sexe de la personne, si possible, mentionner la maladie ou le symptome relevé. En dernier lieu, apposer la signature.

N.B_ Avant la remise de cette fiche à l'intéressé, l'Agent de santé fournira au patient toutes indications pouvant aider à l'accès rapide de l'Etablissement de Santé.

FICHE DE RELEVE DE POPULATION

Dans la première phase de son travail, l'agent de santé doit visiter systématiquement toutes les maisons dans sa zone d'action. Il profitera donc de ces visites pour remplir la FICHE DE RELEVE DE POPULATION.

A la fin de chaque mois, l'ensemble des fiches remplies seront remises à l'auxiliaire du dispensaire auquel est rattaché l'agent. l'Auxiliaire suivra les filières hiérarchiques normales pour faire parvenir ces fiches au Directeur régional. Celui-ci fera son contrôle, tire les données qui l'intéressent et expédient finalement les fiches remplies au Service Centrale de Statistique du D.S.P.P.

Spécifications

Il faut remplir une fiche pour chaque maison c'est-à-dire pour chaque unité d'habitation quel que soit le nombre d'appartements que comprend cette maison ou le nombre de ménages qui l'habitent.

Indépendemment du nombre d'appartements que comprend une maison, il faut remplir une seule fiche pour cette maison.

Indépendemment du nombre de ménages vivant dans une maison, il faut remplir une seule fiche pour cette maison.

1) Commune———————————— Section rurale ——————— Habitation———————

Il est préférable de commencer par indiquer l'habitation en portant à la place convenable le nom de l'habitation où se trouve la maison pour laquelle vous remplissez la fiche.

Pour la Section rurale, porter le nom de la section rurale dans laquelle se trouve l'habitation en question.

Pour la commune, porter le nom de la commune dans laquelle se trouve la dite section rurale.

En cas de difficultés pour établir cette classification chercher à obtenir des renseignements auprès des Leaders communautaires, des chefs adjoints de section et même des personnes vivant dans la maison

2) Ordre de visite du logement

Il s'agit ici de savoir si c'est la 1ère, la 2ème, la 3ème, la 4ème maison visitée. si c'est la 2ème maison visitée, porter 2 ; si c'est la 15 ème maison visitée porter 15.

Visiter dans l'ordre toutes les maisons l'une après l'autre et surtout prendre toutes les précautions pour ne pas sauter une ou plusieurs maisons.

3) No. de S N E M.

Consulter la fiche de S N E M attachée le plus souvent à la porte principale de la maison. Porter le numéro qui s'y trouve. Parfois aussi, le numéro de S N E M est écrit directement sur la porte.

4) Date

C'est la date du jour. Surtout n'oublier pas de porter aussi le mois et l'année Exemple 20 Octobre 1978.

Nombre de ménages dans le logement

En général c'est le groupe de personnes, généralement, mais pas obligatoirement lié par la parenté, vivant dans un même local à usage d'habitation et prenant généralement leur repas en commun. Une personne vivant seule constitue à elle seule un ménage.

Pour simplifier les choses, basez-vous sur le nombre d'appartements pour savoir le nombre de ménages. Donc, autant de ménages que d'appartements distincts dans la maison. Sauf si certains appartements ne sont pas habités.

S'il y a 3 appartements dans une maison et que ces trois appartements sont habités, le nombre de ménages est : 3.

S'il y a 3 appartements dans une maison et que l'un d'entre eux n'est pas habité, le nombre de ménages est : 2 (c'est-à-dire 3 - 1).

N'oublier pas qu'une personne, quel que soit son sexe, vivant seul dans un appartement constitue a elle seule un ménage.

Y a t-il un matrone ?

Tous les agents de santé savent déjà ce que c'est qu'une matrone. Ce n'est pas nécessaire de reprendre la définition.

Poser la question en utilisant le langage courant : Femme sage Suivant la réponse porter oui ou non. Mais s'il arrive que dans la maison il y a plusieurs matrones (femmes sages après avoir écrit oui , porter à côté le nombre.

Si oui, est-elle entrainée ?

S'il n'y a pas de matrone vivant dans la maison, ce n'est pas nécessaire de poser cette question.

Si au contrire il y a une matrone, poser la question et suivant la réponse, porter oui ou non.

S'il y a plusieurs matrones dans la maison, il est absolument indispensable de donner une réponse pour chacune d'elles.

Y a t-il une latrine - - - - - - - - - ?

Poser la question et demander même la permission de voir cette latrine.

Suivant la réponse, porter oui ou non.

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Le grand cadre qui vient ensuite est destiné à l'enregistrement de toutes les personnes vivant habituellement dans cette maison, même s'il y en a parmi elles qui ne sont pas présentes au moment du relevé. Il faut toujours demander s'il n'y a pas d'autres personnes vivant dans cette maison mais qui sont allées au marché, au jardin ou qui sont provisoirement en voyage etc..... Car toutes ces personnes doivent être enregistrées dans le cadre.

Le cadre (la feuille) est prévu pour 25 personnes. Au cas où il y a plus de 25 personnes dans une maison, porter une croix (+) dans le petit carré au bas de la feuille et continuer sur une autre feuille. Après avoir terminé, attacher les deux feuilles ensemble.

Pour chaque personne, utiliser une ligne en portant toujours sur cette ligne et à la place convenable.

—— le nom et le prénom (à écrire en toutes lettres)

—— le Sexe . Si c'est un homme, porter une croix (+) dans la colonne "Masculin". Si c'est une femme, porter de préférence la croix dans la colonne "Féminin". Surtout éviter de cocher à la fois les deux colonnes pour la même personne

—— l'Age : Si c'est un enfant qui n'a pas encore 1 an c'est-à-dire qui n'a pas encore fêté son premier anniversaire de naissance porter une croix (+) dans la colonne "0-11 mois". Si c'est un enfant âgé de 1, 2,3, 4 ans, porter la croix (+) dans la colonne "1-4ans". Si c'est un adolescent de 5,6,7,- - - - - - - - - 14,15 ans, porter la croix dans la colonne "5.14 ans". Si c'est un adulte de 15,16,17, - - - - 48,49 ans, porter la croix dans la colonne "15-49 ans".
Si c'est une personne de 50 ans et plus porter la croix dans la colonne "50 ans et +". Si c'est une personne dont l'âge n'est pas connu porter la croix dans la colonne "Inconnu".
Se rappeler toujours que l'âge doit être indiqué par une croix dans l'une ou l'autre de ces colonnes.

Malade Suivant le cas, porter une croix (+) ou bien dans la colonne "Non" ou bien dans la colonne "oui". Au cas où c'est une personne malade (on a alors une croix dans la colonne "oui") spécifier dans la dernière colonne la maladie ou le symptome ressenti.

N O T E Remarquer bienque le cadre est conçu avec des lignes doubles séparant les diverses caractéristiques : Nom, Sexe, Age, malade. Cela veut dire que pour une même personne on ne peut pas avoir deux ou plusieurs croix entre deux lignes doubles.

Au bas du grand cadre et à droite se trouve un autre petit cadre dans lequel on demande "le nom et le prénom des personnes décédées dans ce logement ou cette maison au cours des 12 derniers mois". Surtout, n'oublier pas de demander ces informations qui sont extrêmement importantes.

Trois lignes sont prévues pour écrire les noms et prénoms des personnes décédées dans la maison au cours des 12 derniers mois. Au cas où il y aurait plus de 3 personnes décédées dans une maison, tracer une quatrième, une cinquième ligne suivant le cas afin d'écrire les noms de ces 4 ou 5 personnes décédées dans cette maison au cours des 12 derniers mois.

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DEPARTEMENT DE LA SANTE PUBLIQUE ET DE LA POPULATION

REGISTRE D'ACTIVITES DES AGENTS DE SANTE

REGION _____ ZONE D'AFFECTATION _____

DISTRICT _____ SECTION RURALE _____

NOM DU DISPENSAIRE _____

DATE	NOM ET PRENOM	HABITATION No DU SNEM	SEXE	A G E	SYMPTOME ou MALADIE	REFERENCE

RAPPORT MENSUEL DES ACTIVITES DU PERSONNEL INFIRMIER

DIRECTIVES:

BUT:

Ce formulaire No_____ a pour but de présenter, dans une seule page le
vités et le rendement du service du personnel infirmier, des infirmières
liaires et des infirmières diplômées. Un seul formulaire devra sortir j
lement et ce formulaire aura á englober tout le travail du personnel att
niveau d'établissement.

OBJECTIFS:

- Présenter systématiquement les activités effectuées par le personnel
- Assister l'Infirmière Régionale/Infirmière de District, essayer de co
  davantage le travail du personnel infirmier afin de mieux le supervis
- Offrir une justification additionnelle pour la présence du personnel
  en montrant leurs contributions aux services de santé en Haiti
- Assister l'administrateur Régional/Distrital et essayer de mieux con
  les besoins en service dans sa juridiction pour mieux les analyser.

PERSONNEL:

Ce formulaire, avec une orientation adéquate á tous les niveaux du perso
firmier, peut être rempli par une infirmière résidente diplômée, licenséen
liaire infirmière diplômée. Mais l'individu responsable ou l'individu d
doit faire la compilation dans un seul formulaire et l'envoyer au niveau
d'après les normes.

GUIDE ET DIRECTIVES A REMPLIR

Colonnes

1.1 **Date:** Chaque date aura une ligne (une ligne) ce qui signifi
le service a été dispensé

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1.2 Pédiatrie: Moins d'un an (o á onze mois) total de tous les enfants qu'on a vus durant la journée par PV (première visite) et tous les enfants vus dans une visite subséquente VS

1.3 1-4 ans le nombre d'enfants vus selon cette catégorie d'âge pour PV et VS.

1.4 5-15 tous les enfants vus dans cette catégorie d'âge PV et VS.

II.- PRENATAL

2.1 Toute vue PV première visite et subséquente visite VS

2.2 Toute femme entre 15 et 44 qui est venue pour une consultation de planification familiale (seulement)

III.- CONSULTATION GENERALE

3.3 Toutes les femmes 15-44 qu'on a vues pour d'autres raisons

3.4 Les hommes entre 15-44 qu'on a vus durant la journée

3.5 Homme et femme entre 45 et 59 (H et F sont mis ensemble ici) qu'on a vus durant la journée

3.6 Toute personne (homme et femme) qu'on a vus á l'établissement durant la journée.

IV.- TRAITEMENT

4.1 Indiquer le nombre de fois qu'un traitement spécifique a été fait

Exemple: Voir code en bas du formulaire

3-I trois injections

12-P douze pansements

4 autres (irrigation vaginale, etc)

N.B.- Si l'espace ne suffit pas, employez le verso et indiquer

V.- AUTRES ACTIVITES

5.1 Visite á domicile: une compilation de toutes les visites domiciliaires qui étaient faites durant la journée par le personnel attaché á l'établissement.

5.2 <u>Visite à l'école</u> - peut être pour:

Educ: (éducation , enseignement et information aux professeurs ou aux élèves)

Vacc: (Vaccination) Campagne à l'école ou dans un autre endroit pour les élèves.

5.3 <u>Conférence</u>:

Coll: (collective - aux groupes ou à plusieurs personnes

Ind : (individuel - Conférence avec un individu où à partir d'un individu)

5.4 <u>Supv.(Supervision)</u> Voir code en bas du formulaire

Exemple:

1	2
1- A Infirmière auxiliaire était supervisée sur place	2 " 1 A/S Deux matronnes et un A/S étaient supervisés au dehors de l'établissement.

APPENDIX B

LIST OF FORMS USED BY REGIONAL AND CENTRAL STATISTICS OFFICES TO COLLECT DATA

	Page
Monthly Progress Reports from Health Agents	B-5
Weekly Report on Communicable Diseases	B-6-11
Daily Registration of Out-Patient Examinations in Hospitals and Health Centers	B-13
Dispensary Monthly Progress Report Including Immunizations	B-18
Registration of Deliveries and Births Outside Health Institutions	B-34
Registration of Deliveries, Births and Miscarriages/Abortions in Maternity Services	B-37

RAPPORT MENSUEL D'ACTIVITES DE L'AGENT DE SANTE

Ce rapport sera rempli à la fin de chaque mois par l'agent de santé et remis à l'auxiliaire du Dispensaire dont relève l'agent. L'Auxiliaire rassemble les rapports mensuels de tous les agents de santé sous un contrôle et les expédie au siège de la région ou du district. Après avoir tiré les informations qui leur font besoin le bureau régional acheminera au Département de la santé Publique et de la Population Service Central de Statistique tous les rapports mensuels des agents de santé.

SPECIFICATIONS

REGION

Ecrire lisiblement et en toutes lettres le nom de la région sanitaire dans laquelle se trouve le dispensaire auquel est rattaché l'agent de santé.

DISTRICT

Ecrire lisiblement et en toutes lettres le district sanitaire dans lequel se trouve le dispensaire auquel est rattaché l'agent de santé.

COMMUNE

Ecrire lisiblement et en toutes lettres la commune dans laquelle se trouve la localité où est affecté l'agent de santé.

SECTION RURALE

Ecrire lisiblement et en toutes lettres la section rurale de laquelle dépend la localité où est affecté l'agent de santé.

HABITATION

C'est la zone de travail de l'agent. Ecrire en toutes lettres et lisiblement toutes les localités assignées à l'agent de santé.

AGENT DE SANTE

Ecrire en toutes lettres le nom et le prénom de l'agent.

MOIS ET ANNEE

C'est le mois pendant lequel sont effectuées toutes les activités qui vont être décrites. Porter aussi l'année. Exemple: Octobre 1978.-

ACTIVITES

La première partie du rapport est divisée en trois colonnes :

- Une 1ere colonne qui décrit les différents types d'activités.
- Une 2eme colonne dans laquelle sera consigné le nombre de personnes vues ou rencontrées pour chaque type de cas.
- Une 3eme colonne dans laquelle sera consigné le nombre de personnes vues et qui sont référées au dispensaire ou à tout autre établissement de santé.

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ENFANTS MALADES

Vomissements et diarrhées.

- Dans la colonne " Personnes vues", porter le nombre d'enfants atteints de vomissements et ou diarrhées.

- Dans la colonne " Personnes référées", porter le nombre de [illegible] enfants(Ateints de vomissements et ou diarrhées) référés au dispensaire ou à tout autre établissement de santé.

MALNUTRITION

Mêmes instructions que prédédemment, c'est à dire, dans la colonne "Personnes vues" vous portez le nombre de cas d'enfants atteints de malnutrition et dans la colonne "personnes réfèrées", vous portez le nombre de ces enfants réfèrés au dispensaire ou à tout autre établissement de santé.

TETANOS

Mêmes instructions que précèdemment.

AUTRES MALADIES.

Mêmes instructions que précèdemment.

FEMMES ENCEINTES

Mêmes instructions que précèdemment.

CLIENTES DE P.F. (Planification Familiale)

Il s'agit ici de toutes les femmes agées de 15 à 44ans et intéressées à pratiquer le planing familial. Il faut s'assurer aussi que ces femmes n'ont jamais bénéficié des services de planification familiale dans une clinique du programme de protection materno infantile et de planification familiale.

Dans la colonne"personnes vues", porter le nombre de femmes vues; dans la colonne "personnes réfèrées" porter le nombre de ces femmes qui sont réfèrées au dispensaire ou à tout autre établissement de santé.

APPROVISIONNEMENTS DE P.F.

Anciennes acceptantes

L'ancienne acceptante c'est une femme qui a déjà accepté une méthode de contra - ception dans une clinique quelconque du programme de protection materno-infantile et de planification familiale. L'une des tâches de l'agent de santé consiste à approvisionner en contraceptifs ces anciennes femmes dans sa zone toutes les fois que la méthode adoptée est la pilule ou la crême ou le condom.

Dans la colonne"personnes vues" porter le nombre d'anciennes acceptantes qui pre - senteraient certains problèmes et qui pour cela sont réfèrées au dispensaire ou à tout autre établissement de santé.

NOUVEAUX HOMMES

Dans la colonne "Personnes vues" porter le nombre de vouveaux acceptants, hommes ayant reçu du cordon.

Dans la colonne "Personnes référées porter le nombre de nouveaux acceptants hommes référés au Dispensaire.

ANCIENS HOMMES

Mêmes instructions que précédemment.

ACCOUCHEMENTS

Dans la colonne Personnes vues" porter le nombre d'accouchements effectués .

Dans la colonne "Personnes référées" porter le nombre de ces accouchements référés à un hopital pour causes de complications.

MALADIES TRANSMISSIBLES

Dans la colonnes "Personnes vues" porter le nombre de cas de maladies transmissibles rencontrés

Dans la colonne "Personnes référées" porter le nombre de ces cas référés au dispensai ou à tout autre établissement de santé.

ACCIDENTS

Soins d'urgence

mêmes instructions que précédemment .

AUTRES ACTIVITES

Jours de travail au dispensaire

Porter à la place convenable la nombre de jours de travail au dispensaire de base au cours du mois.

Jours de travail en clinique mobile

Porter à la place convenable le nombre de jours en clinique mobile

Pansements

Porter à la place convenable le nombre de pansements effectués au cours du mois au niveau de la communauté. Ne pas tenir compte des pansements effectués au dispensaire de base ou en clinique mobile.

Injections

Porter à la place convenable le nombre d'injections administrées au cours du mois au niveau de la communauté. Ne pas tenir compte des injections réalisées au dispensai de base ou en clinique mobile.

LAMES MALARIA

Porter à la place convenable le nombre de frottis faits pour les cas suspects de malaria. Ne pas tenir compte des frottis faits au dispensaire ou en clinique mobile.

VISITES DOMICILIAIRES EFFECTUEES

Porter à la place convenable le nombre de visites effectuées au cours du mois dans la communauté au niveau des familles.

DEPARTEMENT DE LA SANTE PUBLIQUE

RAPPORT MENSUEL D'ACTIVITES DE L'AGENT DE SANTE

Région _____ District _____

Commune _____ Section Rurale _____

Habitation _____

Agent de Santé _____ Mois et Année _____

I. Type d'activité	Nbre. de Personnes vues	Personnes référées
Enfants malades		
Vomissements et	_____	_____
Malnutrition	_____	_____
Tétanos	_____	_____
Autres maladies	_____	_____
II Type d'activité		
Femmes enceintes	_____	_____
Cliente de P.F.	_____	_____
Approvisionnements de P.F.	_____	_____
Anciennes acceptantes	_____	_____
Nouveaux Hommes	_____	_____
Anciens Hommes	_____	_____
Accouchement	_____	_____
III Maladies Transmissibles	_____	_____
IV Accidents		
Soins d'urgences	_____	_____

V Autres Activités _____ Nbre.

Jours de travail au Dispensaire _____

Jours de travail Clinique Mob. _____

Pansements _____

Injections _____

Echantillons crachats _____

Lames Malaria _____

VI Visites domiciliaires Effec. _____

Visites réçues par A.S _____

Assistances réunion Conseil Communautaire _____

Réunions organisées A.S. _____

Autres types de réunions _____

VII Latrines construites _____

Sources captées _____

OBSERVATIONS : _____

Auxiliaire _____ Médecin Responsable _____ Adm. District _____

NATIONAL SYSTEM FOR DISEASE NOTIFICATION

PRELIMINARY NOTES

The national system for disease notification serves a dual purpose.

The first purpose, of a general nature, includes the collection, analysis, and distribution of data that are indispensable to an epidemiological awareness and the establishment of a sanitary cordon around neighboring areas.

The second, of a specific nature, plans emergency sanitary measures in order to stem cases of certain diseases, in particular in places or areas that do not have adequate sanitary structures.

AT THE URBAN AND RURAL LEVELS

Those Who Must Write Weekly Reports:

All health institutions administered by physicians must send the Statistics Central Section on a weekly basis, a summary of cases of diseases that should be reported and that had been detected during the epidemiological week, written on special forms (Form 1.05).

Cases of quarantineable diseases (cholera, yellow fever, plague, smallpox) will be notified immediately to the hospital serving the health district, either by telegram, telephone, radio, or any other means of communication.

The report will be delivered directly to the Statistics Central Section every Monday.

RECOMMENDATIONS ON HOW TO FILL OUT FORM 1.05

Generalities

The form should be filled out in duplicate. The orginal will be transmitted to the Statistics Central Section, the copy filed in the medical records of the institution.

Name of the Institution - Write down the official name under which the institution is known.

Code - Write down nothing in this space.

Week - The epidemiological week lasts from Sunday through Saturday; even if the health institution does not operate on Saturday, Sunday or any other week day. The report will normally cover a one-week period., i.e. the report will mention the number of cases detected during the epidemiological week.

From - Write down the date of the first day of the epidemiological week: Sunday.

To - Write down the date on which it ends: Saturday.

Number - It is the epidemiological week number. Write nothing in this space.

NOTE - An ad-hoc calendar is drafted for the use of Statistics Services and distributed to all health institutions.

Diseases Which Must Be Notified

Among the diseases that appear on the list below, those belonging to the "quarantineable diseases" category will be confirmed by laboratory tests and classified according to the following headings:

- Age Group
- New Cases (N.C.)
- Deceased (D.C.D.)

Age Group - Means the completed age.

Months - The first two columns are intended for age groups varying from 0 through 5 months; from 6 through 11 months.

Year - The four following columns, from 1 through 4 years of age; the eight last columns, from 5 through 75 years of age and over.

Unknown - When the patient's name is not known or doubtful, mark the item "unknown".

Back Side

Quarantineable Diseases - Follow the same recommendations enumerated in the foregoing.

Epidemic Diseases - In case of an outbreak of contagious diseases, specify the name of the disease and the name of the area that has been hit. If the outbreak is of unknown etiology, just write down the disease symptoms.

Date - It is the date on which the form has been filled out.

Signature - The weekly report authenticity will be certified by the signature of the physician in charge of the Health Institution.

Title - Of the person who signs the report.

AT THE LEVEL OF THE STATISTICS CENTRAL SECTION

Reception of Weekly Reports

Each received form is marked with a dating stamp (day, month, year, number).

Reception Control

The institution and the epidemiological week numbers are noted down.

Notification dates are checked.

If, for a certain disease, the number of notified cases outnumbers the normal level, the Epidemiology Section is notified at once.

Health institutions, the reports of which contain mistakes or which have not sent reports altogether to the Central Office, will be reminded of their duties.

Congruent reports are put in "File of Reports received during the week".

Reports which are not signed are considered as not valid. In such a case, the Statistics Central Section reserves the right to remind the concerned institution of the rules concerning the matter. (See back side, quarantineable diseases).

REPORTS SUMMARY

The first reports summary will be done on form 1.30. It will include data collected during the previous week and will be forwarded to the Division of Public Hygiene every Tuesday.

Likewise, each month, reports summaries of the previous month will be forwarded, established by epidemiological weeks and notification dates.

International reports are dispatched to interested organizations at the end of each week, but cases of quarantineable diseases are notified by cable (with location of health district(s)).

All weekly reports received at the Central Office are indexed by health institution and health district.

Annual report is based on data given in weekly reports.

NOTE: The Statistics Central Section, in its efforts to control strictly the evolution of communicable diseases on a national scale, has established a system of written claims to health institutions in order to cause the latter to dispatch their unsent reports.

This procedure provides the possibility to draft the annual report on time and to expand the range of operations of those sectors which are involved in the fight against communicable diseases in Haiti.

DEPARTEMENT DE LA SANTE PUBLIQUE ET DE LA POPULATION
SECTION CENTRALE DES STATISTIQUES

Nom de l'Etablissement _____ Code _____

Semaine du _____ au _____

RAPPORT HEBDOMADAIRE

CAS DECLARES DE MALADIES

MALADIES	TOTAL		GROUPES D'AGE																									
			MOIS				ANNEES																					
			0-5		6-11		1		2		3		4		5-9		10-14		15-19		20-24		25-44		45-64			
	NC	DCD	NC	DCD	NC	DCD	NC	DCD	NC	DCD	NC	DCD	NC	DCD	NC	DCD	NC	DCD	NC	DCD	NC	DCD	NC	DCD	NC	DCD	NC	DCD
* Anthrax cutanéen																												
Bronchite pneumonie																												
Chancre mou																												
* Choléra																												
Dracunculose																												
* Dysenterie																												
* Dysenterie amibienne																												
* Dysenterie bacillaire																												
Dysenterie a.c.i.																												
Encéphalite infectieuse																												
Erysipèle																												
* Fièvres																												
Gastro-entérite																												
Gonococcies (Bl. Clinique)																												
Grippe (Influenza)																												
Ictère infectieux																												
* Leptospirose																												
* Lèpre																												
* Méningite à méningocoque																												
Oreillons																												
* Paludisme (malaria)																												
* Pian																												
Vers intestinaux																												
* Poliomyélite																												
Poliomyélite																												
Rage (Humaine)																												
Rhumatisme articulaire aigu																												
Rougeole																												
Scarlatine																												
* Syphilis																												
Teigne																												
Tétanos																												
Trachome																												
* Tuberculose pulmonaire																												
* Typhoïde et paratyphoïde																												
Ulcères Tropicaux																												
Varicelle																												
Fièvre DINGUE																												
* Rage animale																												

* Les maladies précédées d'une astérique doivent être confirmées par des examens de lab

BEST DOCUMENT AVAILABLE

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MALADIES QUARANTENAIRES

S	TOTAL		GROUPES D'AGE — ANNEES																			
	NC	DCD	[illegible]												35-44		45-64		65-74		75 & +		Inconnu	
															NC	DCD	NC	DCD	NC	DCD	NC	DCD	NC	DCD

EPIDEMIES

(Y compris les épidémies d'étiologie inconnue)

S	DESCRIPTION

Signature ______________________

Titre ______________________

...mplis que si l'établissement possède un médecin et doit mentionner tous les cas détectés dans toutes les [illegible] durant la semaine, même ... également envoyer le formulaire chaque semaine.
...res (choléra, fièvre jaune, fièvre récurrente, peste, typhus épidémique à poux, variole) transm[illegible] [illegible] à l hopital de base du district ..., radio ou n'importe quel autre moyen.

[illegible] Santé Publique

Form. No. 1-05

B-11

MALADIES
DENOTIFICATION OBLIGATOIRE
HAITI 1976 → 77

1- Ankylostomiase
2- Bronchite pneumonie
3- Chancre mou
4- Charbon
5- Coqueluche
6- Diphtérie
7- Dysenterie amibienne
8- Dysenterie bacillaire
9- Dysenterie S.A.I.
10- Encéphalite infectieuse
11- Erysipèle
12- Filariose
13- Gastro-entérite
14- Gonococcies (Ex. Clinique)
15- Grippe (Influenza)
16- Ictère infectueux
17- Leptospirose
18- Lèpre
19- Méningite à méningocoque
20- Oreillons
21- Paludisme (malaria)
23- Pian
24- Psittacose
25- Poliomyélite
26- Rage (Humaine)
27- Rhumatisme articulaire aigu
28- Rougeole
29- Scarlatine
30- Syphilis
31- Teigne
32- Tétanos
33- Trachome
34- Tuberculose Pulmonaire
35- Typhoide et paratyphoide
36- Ulcères tropicaux
37- Varicelle
38- Vers intestinaux

QUARANTENAIRES

1- Choléra
2- Peste
3- Variole
4- Fièvre Jaune

SIGNES CONVENTIONNELS

(...) Données non disponibles

(-) Zéro

DAILY REGISTRATION OF OUT-PATIENT EXAMINATIONS IN HOSPITALS AND HEALTH CENTERS WITH OR WITHOUT BEDS

As conveyed by its name, this form is devised for the use of hospitals, dispensary-hospitals, and health centers. It will not be used by dispensaries and specialized institutions such as sanatorium, mental hospital, etc. On a daily basis, it should be filled out by the Statistics Section for all types of out-patient examinations as examination files are given back to the record office.

Specifications

Health Region

Write down the region in which is located the health institution.

Health District

Write down the name of the health district in which the health institution is located.

Name of the Health Institution

Write out fully and clearly the name of the health institution.

Day-Month-Year

Write down the date: day in figure(s); month in letters, and year in figures.

NOTE - Before proceeding to fill out the registration sheet, classify files by services and for each service, classify the files by type of visits.

On the same line and in their respective columns, write down information concerning a patient or a file.

Write down the file number in column 2.

Mark a cross (x) in either column numbered 3 through 9.

Different diagnoses are written on the upper part of the columns.

Accidents, Burn, Carbuncle, etc.

For all patients belonging to one given age group, record in the appropriate column the number of cases of accidents, burns, carbuncle, whooping cough, etc.

Example: number 20 written in the square located at the intersection of the age group 1 through 4 and the diagnosis measles means that there are 20 children aged 1 through 4 who have had measles.

Educational Activities

They concern data about training courses for matrons, educational sessions in nutrition, child-rearing courses for young people aged 14 through 35, educational sessions in maternal child care, family planning, and any other educational session on a subject related to health in general. For each of these cases, record in appropriate spaces the number of sessions, the sessions average duration, and the average number of participants.

The author of the report will write down his last and first names and the date on which the report has been written on the last line. Then he will submit it to the person in charge of the dispensary for approval.

As for the reverse (immunization), refer to weekly-monthly report on immunization.

To Indicate the Service in Which a Patient Has Been Admitted

Adult Age 15 and Over for a General Examination

Mark down a cross (x) in column 3.

According to the type of visit, mark down a cross (x) either in column 10, or 11, or 12.

Mark down a cross (x) in column 13 if it is a woman; in column 14 if it is a man.

Indicate the age in completed years in column 15.

Write down the disease or the diagnosis in column 21.

Mark down a cross (x) in either one of the columns 22, 23, 24, according to the fact that the patient has been seen by a physician, a nurse, or an auxiliary.

All these data will be recorded in a general examination sheet.

Children age 0 through 14 for a Pediatric Examination

After having written down the file number in the appropriate column, mark down a cross in column 4.

Indicate the type of visit by marking down a cross in either one of the columns 10 through 12.

Indicate the sex by marking either column 13 or 14.

In column 15, indicate the age in completed years. Write down "0" for children less than 1 year of age, i.e. children who have not celebrated their first birthdays yet.

For all children age 0 through 5, indicate their nutritional conditions, by marking a cross in either of the columns 16 through 19.

In column 21, indicate the detected disease or diagnosis .

Indicate the type of medical staff that has seen the child by marking down a cross in either of the columns 22 through 24.

Prenatal (pregnant woman)

After having written down the file number in the corresponding column, mark down a cross in column 5

Indicate the type of visit by marking a cross in either one of the columns 10 through 12, as the case may be.

In column 15 indicate the age in completed years.

In column 21 indicate the detected disease or diagnosis.

Indicate the type of medical staff by whom the patient has been seen by marking a cross in either one of the columns 22 through 24, as the case may be.

All these data will be recorded on a sheet intended for gynecological examination or prenatal check-up.

Woman Seeking a Gynecological Examination

After having written down the file number,

mark down a cross in column 6.

Indicate the type of visit by marking a cross in either one of the columns 10 through 12, as the case may be.

Indicate the age in number of completed years in column 15.

Indicate the disease or diagnosis in column 21.

REGION SANITAIRE _____ DISTRICT SANITAIRE _____

NOM DE L'ETABLISSEMENT DE SANTE _____ JOUR _____ MOIS _____ ANNEE _____

ENREGISTREMENT JOURNALIER DES CONSULTATIONS EXTERNES DANS LES HOPITAUX ET CENTRES DE SANTE AVEC OU SANS LIT

NB.	NUMERO DU DOSSIER	SERVICE							TYPE VISITE			SEXE		AGE	ETAT NUTRITIONNEL Enfants 0-5 ans				Méthode Contraceptive (P.F.)	MALADIE OU DIAGNOSTIC	PATIENTS VUS PAR		
		Consultation Générale	Pédiatrie	Prénatal	Gynécologie	P.F.	Odontologie	O.R.L.	1ère Visite	Visite Subséq. N	Visite Subséq. A	Féminin	Masculin		Normal	M^1	M^2	M^3			Médecin	Infirmière	Auxiliaire
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
1																							
2																							
3																							
4																							
5																							
6																							
7																							
8																							
9																							
10																							
11																							
12																							
13																							
14																							
15																							
16																							
	TOTAL																						

DISPENSARY MONTHLY PROGRESS REPORT

This form is to be used only by dispensaries for collecting data concerning all the activities carried out during each month. It will be filled out by the auxiliary statistician by using notebooks or books for compiling daily data.

Specifications

Health Region

Write down the name of the region where the dispensary is located.

District

Write down the name of the health district where the dispensary is located.

Dispensary

Write out in full the complete name of the dispensary.

Month and Year

In the appropriate space, indicate the reference month (in letters) and year (in figures) of the activities the report is written about.

Staff: Med., Inf., A.D., A.B., Insp. Sanit., Others

As the case may be, write down in the appropriate space the number (not the names(of physicians, nurses, qualified auxiliaries, voluntary auxiliaries, health inspectors or any other type of medical staff working in the dispensary.

Monthly Weekly Report on Immunization

First of all this report exists as a separate form for the use of hospitals and health centers with or without beds. Then it exists as a form attached to the dispensary monthly report and, in this case, it constitutes the back side of the Dispensary Monthly Report. Finally, it exists as a summarized form (monthly data only) attached to monthly reports of hospitals and health centers with or without beds.

As a separate form for the use of hospitals and health centers with or without beds, the monthly weekly immunization report will be filled out by the institution Chief of Statistics Section using the sheets meant for the registration of daily data concerning immunization.

Daily registration sheets for data on immunization, should be considered as a work tool, like any other type of material used for immunization purposes (needles, syringes, etc.). Any person, giving the shot (physician, nurse, auxiliary) must record the information on these sheets. At the end of each week, all the sheets will be given to the institution Chief of Statistics Service who will then be responsible for recording these data in the monthly weekly report.

Physicians, nurses and auxiliaries should always keep in mind that immunization data must be recorded according to vaccine doses and the age of the immunized person.

Here is a sample of registration sheet for collecting data on immunizatio

Week Starting On _____ Through _____

Type if Vaccine _____

Dose/Age	-1	1-4	5-14	15&over	Unknown	Total
1st Dose						
2nd Dose						
3rd Dose						
Booster						

For each given dose, make a stroke (/) in the square representing the intersection of age and dose. The fifth stroke should always be made across the other four (////). At the end of the week, count the number of strokes in each square and transmit all the sheets to the Chief of the Statistics Section. The latter will transcribe the data on the monthly weekly report by writing down for each type of vaccine the number (not the strokes) of first doses given children under the age of one, to children aged 1 through 4, to youths aged 5 through 14, to adults aged 15 and over, to persons whose ages are unknown. The procedure will be the same for second and third doses and boosters. The statistician should keep in mind that this job is to be done each week regularly.

As a form attached to the Dispensary Monthly Report.

Instructions are the same as previously. Any person giving the shot of vaccine must record the information on the registration sheet for immunization data. At the end of the week, all these sheets are given to the auxiliary statistician who will transcribe the date on the reverse side of the Dispensary Monthly Report. Do keep in mind, as it has been stated earlier, the Immunization Monthly Weekly Report constitutes the reverse side of the dispensary's monthly reports.

As monthly summary attached to monthly reports of hospitals and health centers with or without beds.

At the end of each month, the institution Chief of Statistics Section must proceed to add up the total of data collected during the four weeks in order to get the monthly data. These data will then be simply reported in monthly reports of hospitals and health centers with or without beds.

DEPARTEMENT DE LA SANTE PUBLIQUE ET DE LA POPULATION

RAPPORT MENSUEL D'ACTIVITES DES DISPENSAIRES

SECTION CENTRALE DE STATISTIQUE

REGION SANITAIRE _____ DISTRICT _____

DISPENSAIRE _____ MOIS ET ANNEE _____

PERSONNEL : Méd.___, Inf.___, A.D.____, A.B.____, Insp. Sanit.____ Autres _____

ACTIVITES REALISEES

	NOUVEAUX	ANCIENS
Prénatal	_____	_____
Pédiatrie	_____	_____
Adultes	_____	_____
P.F. (Acceptantes)	_____	_____

Pilule _____ Crème _____ Condom _____

Hommes à P.F. _____ _____

TRAITEMENT EXTERNE	NOMBRE
Injections	_____
Pansements	_____
Petites Interventions	_____
Nbre d'Exam. de Lab.	_____
Urine	_____
Selle	_____
Hémogramme	_____

AGE / DIAGNOSTIC	Accidents	Brulûre	Charbon	Coqueluche	Diphtérie	Ictère Infect.	Normal	Malnutrition 1	Malnutrition 2	Malnutrition 3	Méningite	Paludisme	Rougeole	Rhumatismes	Sb. Diar.	Sd. Inf. Resp. Inf.	Tétanos	Tuberculose	Typhoïde	Urétrites	Varicelles	Autres	Inconnu	TOTAL
- 1 an																								
1- 4 ans																								
5-14 ans																								
15-44 ans																								
45 et +																								
Inconnu																								

ACTIVITES EDUCATIONNELLES

	Matrones	Nutrition	Puériculture	PMI	PF	Autres
Nombre de sessions						
Durée des sessions						
Nombre de participants						

Rédigé par _____ le _____ Approuvé par _____

D.S.P.P. Form.

RAPPORT MENSUEL DE VACCINATION

TYPE DE VACCIN	1ère dose					2e dose					3e dose					Rappel			
	moins de 1 an	1-4 ans	5-14 ans	15 ans et +	TOTAL	moins de 1 an	1-4 ans	5-14 ans	15 ans et +	TOTAL	moins de 1 an	1-4 ans	5-14 ans	15 ans et +	TOTAL	moins de 1 an	1-4 ans	5-14 ans	15 ans et +
Première Semaine																			
DI-Te-Per																			
Vaccin Polio																			
Rougeole																			
TAB																			
DI Te TAB																			
Tetanus Toxoid																			
Tetanus Toxoid (gestante)																			
BCG																			
Variole																			
Deuxième Semaine																			
DI Te Per																			
Vaccin Polio																			
Rougeole																			
TAB																			
DI Te TAB																			
Tetanus Toxoid																			
Tetanus Toxoid (gestante)																			
BCG																			
Variole																			
Troisième Semaine																			
DI Te Per																			
Vaccin Polio																			
Rougeole																			
TAB																			
DI Te TAB																			
Tetanus Toxoid																			
Tetanus Toxoid (gestante)																			
BCG																			
Variole																			
Quatrième Semaine																			
DI Te Per																			
Vaccin Polio																			
Rougeole																			
TAB																			
DI Te TAB																			
Tetanus Toxoid																			

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MONTHLY PROGRESS SUMMARY

HOSPITALS, DISPENSARY-HOSPITALS, AND HEALTH CENTERS

This report must be written in one original and two copies, by the person in charge of the statistics section in each of the hospitals, dispensary-hospitals and health centers. One copy will be kept in the institution itself whereas the original and the other copy will be sent to the headquarters or the regional office where one copy will be kept and the original sent on to the D.S.P.P. statistics central service.

This form of monthly summary is not used by dispensaries or specialized health institutions. Other forms of reports are devised for these institutions: dispensary report, special reports for specialized institutions such as a sanatorium, mental hospital, etc.

Specifications

Health Region

In the proper space, write down the name of the region where the health institution is located.

Health District

In the proper space, write down the name of the health district where the health institution is located.

Health Institution

Write out in full the name of the health institution clearly.

Month, Year

Write down in letters the month to which all the data included in the report refer. Write down the year in figures.

1. Total Number of Examinations by Service

To fill out this item, use the daily registration sheets used for outpatient examinations.

1.1 General Examination

This information corresponds to column 3 of the registration sheet. The number of crosses (x) in this column gives the total number of general examinations.

1.2 Pediatric Examination

This information corresponds to column 4 of the registration sheet. Add up the total number of crosses in this column to get the total number of pediatric examinations.

1.3 Prenatal Examination

See column 5 of the registration sheet and proceed as instructed previously.

1.4 Gynecological Examination

See column 6 of the registration sheet and proceed as instructed earlier.

1.5 Family Planning

See column 7 of the registration sheet and proceed as indicated in the foregoing.

1.6 Odontological Examination

See column 8 of the registration sheet and proceed as instructed previously.

1.7 Ear-Nose-Throat Examination

See column 9 of the registration sheet and proceed the same way as indicated previously.

Total

Add up the general, pediatric, prenatal, gynecological, family planning, odontological, and ear-nose and throat examinations in order to get the grand total for examinations performed by the institution out-patient services.

2. Check on Nutritional Conditions of Children Aged 0 Through 5

This item will be filled out by using columns 16, 17, 18, 19 of the registration sheet.

2.1 Cases of Normal Children

They are the total of crosses marked in column 16 of the registration sheet.

2.2 Cases of First Degree Malnutrition

They are the total of crosses marked down in column 17 of the registration sheet.

2.3 Cases of Second Degree Malnutrition

They are the total of crosses marked down in column 18 of the registration sheet.

2.4 Cases of Third Degree Malnutrition

They are the total of crosses marked down in column 19 of the registration sheet.

3. External Treatment

The service in charge of dressing wounds and giving shots must have a register (book or notebook) on which to record the number of dressed wounds and shots given. The dresser, the auxiliary, or the nurse in charge will add at the end of each month, the total of dressings and shots. This total will be transmitted to the statistics service.

3.1 Number of Dressings

In the indicated space, write down the number of dressings applied during the month.

3.2 Number of Injections

Write down the number of injections given during the month.

4. Laboratory Tests

The laboratory tests service must have a register on which will be mentioned every day the number of different tests done: urinanalysis, blood chemistry, Kahn, stools, herograms, malaria (positive, negative), bacteriology, sputum (positive, negative), other. At the end of each month, the total must be added up for each type of test and the data will be transmitted to the statistics service.

4.1 Urinanalysis

At the indicated space, write down the number of urinanalyses done.

4.2 Blood Chemistry

At the indicated space write down the number of blood chemistry tests done.

4.3 Kahn tests

At the indicated space, write down the number of Kahn tests done.

4.4 Stools

Proceed as indicated previously

4.5 Hemograms

Proceed as indicated previously.

4.6 Malaria

Here the number of positive results and negative results must be indicated.

4.7 Bacteriology

At the indicated space, write down the number of bacteriological tests done.

4.8 Sputum

Indicate the number of positive and negative results.

4.9 Others

By others it is meant tests besides those specified earlier. Write down the number of other tests done.

5. X-Ray Tests

The methodology is the same as previously. The x-ray test service keeps a register in which is recorded every day the number of photographs taken and the number of plates used. For each case, the total is added up at the end of the month and the data are forwarded to the statistics service by the chief of service or any other person appointed by him.

5.1 Number of Photographs Taken

At the indicated space, write down the number of photographs taken during the month.

5.2 Number of Plates Used

At the indicated space, write down the number of plates used during the month.

6. Dental Activities

The odontology service will also keep its own register in which will be recorded every day numbers of extractions, amalgams, enamels, and prophylaxis. At the end of each month, the total is added up for each of these cases and the chief of service or any employee appointed by him will transmit these data to the statistics section.

6.1 Number of Extractions

At the indicated space, write down the number of extractions.

6.2 Number of amalgams

Proceed as indicated previously

6.3 Number of Enamels

Proceed as indicated previously

6.4 Number of Prophylaxis

Proceed as indicated previously

Items 7, 8, 9, 10, 11, 12 concern only institutions endowed with hospitalization facilities, i.e., hospitals and health centers with beds.

7. Hospitalization and Exit

Each hospitalization ward must have a register in which the ward nurse will record among other data, admissions, exits (alive or dead), transfers and readmissions. At the end of each month, the physician chief of service of each ward or the chief nurse will transmit these data to the statistics section. The chief of the statistics section will never fail to compare these data with those in the in-patient record and the filled out exit reports. Therefore, there should be a very close collaboration between hospital wards and the statistics section, particularly in the field of transmission of files (properly filled out and signed) to the statistics section immediately following the patient's exit.

7.1 Medicine Ward (Men)

In the proper column, on the same line, write down the numbers of in-patients, alive exited patients, deceased exited patients, transferred patients, re-admitted patients.

NOTE: A transferred patient is an in-patient who, on the order of the consulting physician is moved to another hospitalization ward or service.

A re-admitted patient is a patient who has been discharged and who for one reason or another is admitted in the ward again.

7.2 Medicine Ward (Women)

Proceed as indicated previously.

Total

Proceed to add up the total in each column.
Item 8, 9, and 10 will be filled out by using registration sheets for deliveries, births and miscarriages/abortions in maternity services.

8. Deliveries

8.1 Total of Deliveries

It is the sum of all deliveries (normal, forceps, cesarean, others).

8.2 Normal Deliveries

This information corresponds to column 8 of the registration sheet. By counting the number of crosses marked in this column the number of normal deliveries is obtained.

8.3 Deliveries By Means of Forceps

See column 9 of the registration sheet and proceed as indicated previously.

8.4 Cesarean Deliveries

See column 10 of the registration sheet and proceed as indicated previously.

8.5 Others

By others is meant any type of delivery that is neither normal, by means of forceps, nor by cesarean. This information corresponds to column 11 of the registration sheet. Count the number of crosses in this column and write down this number in the indicated space.

9. Miscarriages/Abortions

9.1 Total of Miscarriages/Abortions

It is the sum of all miscarriages/abortions: abortion, miscarriage unspecified.

9.2 Miscarriages

See column 20 of the registration sheet. Add up the total of crosses in this column and write down the number in the proper space

9.3 Abortions

See column 21 of the registration sheet and proceed as indicated in the foregoing.

10. Births

10.1 Alive Births

They are the total of alive births: boys and girls

Boys - See column 12 of the registration sheet. Add up the total of crosses marked down in this column and record this figure in the appropriate space.

Girls - See column 13 of the registration sheet and proceed as indicated previously.

10.2 Still-born Babies

They are the total of still-born babies: Boys and girls

Boys - See column 14 of the registration sheet and proceed as indicated previously.

Girls - Same instructions as previously. Use column 15 of the registration sheet.

11. Surgical Operations

The service in charge of surgical operations should also have its own register in which it will record, among other data, successful or unsuccessful minor or major operations. At the end of each month, the total will be added up for each of these cases and the chief of service, or any other employee appointed by him, will transmit these data to the institution's statistics service.

11.1 Minor Operations

In the appropriate space, write down the number of minor operations that have been performed.

11.2 Major Operations

Same instructions as previously

a. Successful (same instructions)
b. Unsuccessful (same instructions)

12. Autopsy

The appropriate service records the number of autopsies performed in a special register every day. At the end of the month, these data will be transmitted to the statistics section.

Write down the total number of autopsies performe during the month.

Drafted By/Date

The chief of the statistics section will write down in the indicated space his last and first names and the date on which the report has been drafted.

Signature

The report should be submitted to the institution administrator who will sign it after having systematically checked on all information in it.

REGION SANITAIRE _____ DISTRICT SANITAIRE _____

ETABLISSEMENT SANITAIRE _____ MOIS _____ ANNEE _____

RESUME MENSUEL D'ACTIVITES (HOPITAUX, DISPENSAIRES-HOPITAUX ET CENTRES DE SANTE)

1. NOMBRE TOTAL DE CONSULTATIONS PAR SERVICE ET PAR CATEGORIE DE PERSONNEL

No.	SERVICE	NOMBRE TOTAL DE CONSULTATIONS			
		Total	Médecin	Infirmière	Auxiliaire
1.1.	Consultation Générale				
1.2.	" Pédiatrique				
1.3.	" Prénatale				
1.4.	" Gynécologique				
1.5.	" P.F.				
1.6.	" Odontologique				
1.7.	" O.R.L.				
	TOTAL				

2. CONTROLE DE L'ETAT NUTRITIONNEL DES ENFANTS DE 0 A 5 ANS

2.1. Cas d'Enfants Normaux _____	2.3. Cas Malnutrition du 2e degré _____
2.2. " Malnutrition du 1er degré _____	2.4. " " " 3e degré _____

3. TRAITEMENT EXTERNE

3.1. Nombre de Pansements _____	3.2. Nombre d'Injections _____

4. EXAMENS DE LABORATOIRE

4.1. Urines _____	4.4. Selles _____	4.7. Bactériologie _____
4.2. Chimie Sanguine _____	4.5. Hémogrammes _____	4.8. Crachat: Positif _____
4.3. Kahn _____	4.6. Malaria : Positif _____	Négatif _____
	Négatif _____	4.9. Autres _____

5. EXAMENS DE RADIOGRAPHIE

5.1. Nombre de clichés réalisés _____	5.2. Nombre de plaques utilisées _____

6. ACTIVITES DENTAIRES

6.1. Nombre d'Extractions _____	6.3. Nombre de Porcelaines _____
6.2. Nombre d'Amalgames _____	6.4. Nombre de Prophylaxie _____

INFORMATIONS RELATIVES SEULEMENT AUX HOPITAUX ET DISPENSAIRES-HOPITAUX

7. HOSPITALISATION ET EXEAT

SALLE	NOMBRE DE PATIENTS				
	Hospitalisés	Exéatés		Transférés	Réadmis
		Vivants	Décédés		
7.1. Salle de Médecine (Hommes)					
7.2. " " " (Femmes)					
7.3. " " Chirurgie (Hommes)					
7.4. " " " (Femmes)					
7.5. " " Maternité					
7.6. " " Pédiatrie					
7.7. " d'Orthopédie (Hommes)					
7.8. " " " (Femmes)					
7.9. " de Dermatologie (Hommes)					
7.10. " " " (Femmes)					
7.11. " d'Urologie (Hommes)					
7.12. " " " (Femmes)					
7.13. O.R.L.					
7.14. Autres					
TOTAL					

8. ACCOUCHEMENTS

8.1. Total d'Accouchements _____

8.2. Normaux _____

8.3. Forceps _____

8.4. Césariennes _____

8.5. Autres _____

9. AVORTEMENTS

9.1. Total d'Avortements _____

9.2. Spontanés _____

9.3. Provoqués _____

9.4. Non Spécifiés _____

10. NAISSANCES

10.1. Naissances Vivantes _____

a) Garçons _____

b) Filles _____

10.2. Morts-Nés _____

a) Garçons _____

b) Filles _____

11. INTERVENTIONS CHIRURGICALES

11.1. Nombre de Petites Interventions _____

11.2. Nombre de Grandes Interventions _____

a) Réussies _____

b) Non réussies _____

12. AUTOPSIE

12. Nombre total d'Autopsie _____

Préparé par _____

Date _____ Signature Administrateur _____

D.S.P.P. Form. 103

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REGISTRATION OF DELIVERIES AND BIRTHS
OUTSIDE HEALTH INSTITUTIONS

This form will be filled out by the Regional Office Statistican or any other employee appointed by him. As soon as the birth certificates stubs are received, the data will be recorded in this form.

Specifications

Health Region

Mention the health region in which the deliveries took place.

Month and Year

Write down in letters the name of the month during which the deliveries took place. The year will be written in figures.

For each delivery, use only one same line by writing in the respective columns:

The certificate number in column 1.

Indicate the (urban, rural) area where the delivery took place by making a cross in either column 2 or 3 as the case may be.

In column 4 specify the commune where the town or rural section in which the delivery took place is located.

Indicate the (urban, rural) area where the whoman who has given birth lives by marking down a cross in either column 5 or 6 as the case may be.

Specify the commune where the town or rural section of the woman's residence is located (column 7).

In column 8 indicate the day of the delivery, or more precisely the date of the delivery day. The day's date, for the month as well as the year are already recorded in the heading.

In column 9 indicate the woman's age in number of completed years. If age is not included in the certificate stub, write down "I" which stands for "Inconnu" or unknown.

In column 10 indicate the number of deliveries (the present one included) that the woman has had.

Columns 11, 12, 13, and 14 are reserved for recording the sex and type of both. In either one of these columns, mark down a cross according to each case. Column 11 in the case of an alive boy
Column 12 in the case of an alive girl
Column 13 in the case of a still born baby
Column 14 in the case of a still-born girl

The person in charge of the delivery is mentioned by a cross marked down in either one of columns 15, 16, 17, 18, and 19.

ENREGISTREMENT DES ACCOUCHEMENTS ET NAISSANCES

EN DEHORS DES ETABLISSEMENTS DE SANTE

REGION SANITAIRE _____ MOIS ET ANNEE _____

Numéro du Certificat	Lieu de Production de l'Accouchement			Résidence de la mère			Jour de l'Accouchement	MERE		NOUVEAU-NE				ACCOUCHEUR				
	Zone		Commune	Zone		Commune				Né-Vivant		Mort-Né						
	U	R	(à spécifier)	U	R	(à spécifier)		Age	Parité	Garçons	Filles	Garçons	Filles	Médecin	Infirmière	Auxiliaire	Matrone	Ag. Santé
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19

D.S.P.P. Form.

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REGISTRATION OF DELIVERIES, BIRTHS AND MISCARRIAGES/ABORTIONS IN MATERNITY SERVICE

This form must be filled out for deliveries, births and miscarriages/abortion that take place in maternity services. For this purpose, the chief of service physician will have a sufficient stock of forms at his disposal. He is responsibl for having any physician, nurse or auxiliary assisting a delivery or a miscarriage or performing an abortion, fill it out.

At the end of each month, all these filled out forms will be transmitted to the institution's statistics section for further actions.

Specifications

Health Region

Write down the name of the health region where the health institution is located.

Health District

Write down the name of the health district where the health institution is located.

Health Institution

Write out in full and clearly the name of the health institution.

Month and Year

Write down the referred month in letters, the year in figures. For each delivery or miscarriage/abortion, use one line by writing down in the respective columns:

Column 2 - medical file number

Residence - Mark down a cross in either column 3 or 4, depending on whether the patient lives in an urban or a rural area.

In column 5, specify the commune in which the town or rural section of the patient's residence is located.

Mark down a cross in either column 6 or 7, depending on whether the pregnancy has been followed upon or not.

Indicate the mode of delivery by marking down a cross in either one of the columns 8, 9, 10, and 11.

Indicate the type of birth and the new-born baby's sex by marking down a cross in either one of the columns 12, 13, 14 and 15, as the case may be.

Indicate the mother's exit condition by marking down a cross in either column 16 or 17.

Indicate the new-born baby's exit condition by marking down a cross in either columns 18 or 19.

In the case of an abortion/miscarriage, indicate its type by marking either one of columns 20, 21, and 22.

NOTE - In the case of miscarriage or abortion, do not take into consideration data on: follow-up on pregnancy, mode of delivery, child, baby's exit condition. The only information of interest, in such a case are: the patient's file number, her exit condition, and the type of miscarriage or abortion.

DEPARTEMENT DE LA SANTE PUBLIQUE ET DE LA POPULATION

SECTION CENTRALE DE STATISTIQUE

...ION SANITAIRE ____________________ DISTRICT SANITAIRE ____________________

...BLISSEMENT SANITAIRE ____________________ MOIS ET ANNEE ____________________

ENREGISTREMENT DES ACCOUCHEMENTS, NAISSANCES ET AVORTEMENTS DANS LES SERVICES DE MATERNITE

NB	NUMERO DU DOSSIER	RESIDENCE			GROSSESSE SUIVIE		MODE D'ACCOUCHEMENT				ENFANT				CONDITION DE SORTIE				AVORTEMENT		
		ZONE		COMMUNE (à spécifié)							Né Viv.		Mort Né		DE LA MERE		DE L'ENF.				
		Urbaine	Rurale		OUI	NON	Normal	Forceps	Césarienne	Autres	Garçon	Fille	Garçon	Fille	Vivant	Décédé	Vivant	Décédé	Spontané	Provoqué	Non spécifié
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
	TOTAL																				

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REGISTRATION OF DEATHS OCCURRING OUTSIDE HEALTH INSTITUTIONS

This form will be filled out by the Regional Office Statistician or any other employee appointed by him. As soon as death certificates (deaths occurring outside health institutions) are received, the data will be recorded on this form.

Specifications

Health Region

Write down the name of the health region in which deaths (which are going to be recorded) took place.

Month and Year

Write down in letters the month during which deaths took place (deaths which are to be recorded). The year will be written in figures.

For each death, use only one same line, by marking down in the respective columns:

The certificate number in column 1.

Indicate the (urban or rural) area where death took place by marking down a cross in either column 2 or 3 as the case may be.

In column 4, specify the commune in which the town or rural section where death took place is located.

Indicate the (urban or rural) area where the deceased lived by marking down a cross in either column 5 or 6 as the case may be.

In column 7, specify the commune in which the town or rural section of the deceased's residence is located.

In column 8, indicate the date of death day.

In column 9, enter the dead person's age in number of completed years. If age is not included in the certificate, write down "I" which stands for "Inconnu" or unknown.

Indicate the dead person's sex by marking a cross in either column 10 or 11 as applicable.

In column 12, enter the death causes

a. _____ Initial causes

b. _____ Intermediate causes

c. _____ Final causes.

No.

Région Du : _____ Ville _____

District Sanitaire _____ Commune _____ Section Rurale _____

Nom de l'Etablissement de Santé _____

Prénom _____ Nom _____

Adresse _____

SEXE		Etat Civil	
Mas	Fem	M	C

CERTIFICAT MEDICAL

Je soussigné, Docteur en Médecine certifie par ces présences, avoir soigné la personne identifiée ci-dessus qu'elle est morte le:

Date	Mois	Année

à _____ Ayes _____ M _____

et qu'autant que je sache, les causes du décès étaient les suivantes: Maladie ou affection morbide ayant directement provoqué le décès.

* Cause finale a) _____

(1) Due à b) _____

(1) Due à c) _____

DECLARATION DE DECES

Je soussigné certifie par la présente, avoir vu aujourd'hui le corps de la personne identifiée ci-dessus, constaté qu'elle est morte et qu'autant que je sache le décès est survenu

Date	Mois	Année

Provoqué par: _____

Signature

Titre _____

(1) Affections morbides ayant éventuellement conduit à l'état précité, l'affection morbide initiale étant indiquée en dernier lieu.

* Il ne s'agit pas ici du mode de décès par exemple: défaillance cardiaque, syncope au cours de la maladie du traumatisme ou de la complication qui a entrainé la mort.

CERTIFICAT DE DECES

P.S.P.P.

Signature du Médecin.

B-42°

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ENREGISTREMENT DES DECES

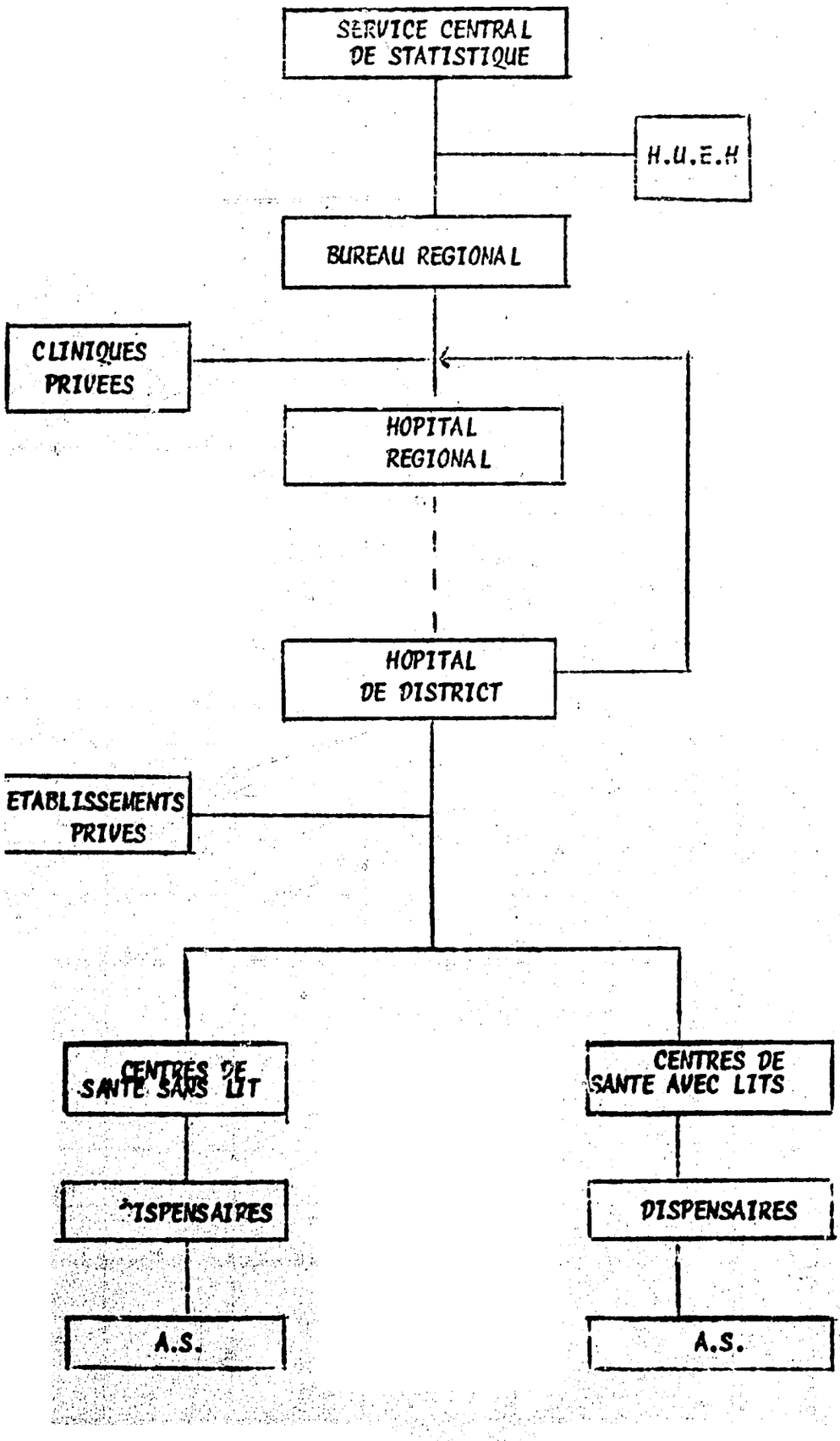
EN DEHORS DES ETABLISSEMENTS DE SANTE

REGION SANITAIRE _____ MOIS ET ANNEE _____

Numéro du Certificat	Lieu de Production du Décès			Résidence du Décédé			Jour du Décès	Le Décédé			CAUSES DU DECES
	Zone		Commune (à spécifier)	Zone		Commune (à spécifier)		Age	SEXE		
	U	R		U	R				M	F	
1	2	3	4	5	6	7	8	9	10	11	12

DEPARTEMENT DE LA SANTE PUBLIQUE ET DE LA POPULATION

DIAGRAMME DE FLUX DE L'INFORMATION STATISTIQUE



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Région Sanitaire _____

District _____

Etablissement de Santé _____

Mois _____ Année _____

	PEDIATRIQUES						PRENATAL				CONSULTATION GENERALE								AUTRES ACTIVITES						SUPERVISION			
	Moins d'un an		1-4 ans		5-14 ans		Femme Enceinte		15-44 Planif. Famil.		Femme 15-44		Homme 15-44		Homme / Femme 45-59		60 et +		Trait. Fait	Visite à Domicile	Visite à l'Ecole Educ Vacc		Conf. Coll. Ind.		1 #	Code	2 #	Code
Date	PV	VS	PV	VS	PV	VS	PV	VS	PV	VS	PV	VS	PV	VS	PV	VS	PV	VS										

CODE : VISITE A DOMICILE
- PN = Prénatal
- PSN = Post natal
- CC = Contrôle Croissance
- PF = Planification Familiale
- TB = Tuberculose
- MAIN = Malnutrition
- CH = Cas Sévère

TRAITEMENT
- I = Injections
- P = Pansement
- PO = Pansement Ombilical
- A = Autres (spécifier)

SUPERVISION
- I = aux Infirmières
- A = aux Auxiliaires
- M = aux Matronnes
- A/S = aux Agents de Santé

1 = Sur place
2 = Déplacement

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