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MONITORING AND EVALUATION
OF PRIMARY HEALTH CARE ACTIVITIES
OF THE FEDERAL MINISTRY OF HEALTH

LAGOS, NIGERIA
February 2 - 6, 1987

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I. SUMMARY AND RECOMMENDATIONS

At the request of the Federal Ministry of Health (FMOH) and AID/Nigeria, a brief consultancy visit was made to Lagos from February 2 - February 6, 1987, to participate in the initial meeting of the FMOH Committee on Monitoring and Evaluation of Health Activities. This trip was a followup to a previous Resources for Child Health (REACH) consultancy visit (June 3 - 18, 1986). The following pages assume that the reader is familiar with the REACH consultant's report from that trip.

The major conclusions and recommendations which the Committee had reached by the end of its first week's work are summarized in Section II of this report. These recommendations will be further amplified, revised, and fully documented in the Committee's own interim report, now scheduled for completion in early April, 1987. It should be noted that while the Committee's initial efforts concentrated on the Primary Health Care (PHC) program, consideration was also given to the present vertical programs, and to the need to develop systems that would meet the management needs of either structure.

Section III below details recommendations of the consultant based on issues identified during the Committee's initial meeting. It should be noted that while most of these issues were discussed during the meeting, the recommendations presented in Section III are those of the author, and do not necessarily represent the views of the entire Committee. In summary, the author's major recommendations are as follows:

1. It is suggested that the Committee weigh each proposed management indicator in light of the six characteristics of good management indicators discussed in Section III below, and omit any indicators which do not clearly relate to specific management decisions.

The basic question which should be asked is "How will managers modify the PHC service delivery system based on changes in this indicator?" If the answer is that they will not, the indicator should be dropped.

As the Committee recognized, however, different data and indicators will be required for different management purposes, and managers at different levels of the service system will have differing needs. The Committee's present concern is service and impact indicators for monitoring and evaluation at higher levels of the system, but other aspects of program management will also eventually require attention.

2. It is suggested that in further development of the PHC Monitoring System the Committee carefully distinguish between recording formats and reporting formats, and that the recording formats reflect exactly the way the services are actually

delivered, while the reporting formats reflect the actual management structure of the service system.

To minimize the data collection workload imposed on service delivery staff, recording formats must reflect exactly the way services are delivered. The reporting formats, on the other hand, and the procedures by which reports move from level to level, must reflect the actual management structure of the service system if managers are to use the reports. For this reason, it is essential that the Committee's small working group which is now being constituted to continue the forms design effort include service provider staff.

3. It is suggested that the Directorate for National Health Planning and Research and/or the Primary Health Care Coordinating Unit recruit and train appropriate staff to establish a Statistical Survey Unit at the Federal level of the Ministry.

This suggestion is considered in some detail in the June, 1986 consultant's report. If routine recording and reporting functions are to be minimized, it is essential that the FMOH develop the capability to conduct statistically sound periodic and one-time surveys.

4. It is suggested that automated processing for PHC and other systems be decentralized to the concerned directorates and sections of the Ministry, with microcomputer hardware and programming staff allocated based on the particular data processing requirements of each unit.

As subsequent sections of this report will show, the amounts of data to be processed are too massive, and the management needs of the various Ministry units are too different to allow centralization of automated data processing.

5. It is suggested that the Committee work with PHC program managers at each level of the system to design appropriate feedback reports for their supervision and management use as a part of the planned field test of PHC recording and reporting instruments.

As discussed in the June, 1986 consultant's report, feedback to lower levels is an essential component of any information system. The Committee very much recognized this fact, but time constraints at the initial meeting precluded design of such feedback reports.

6. It is suggested that the PHC Monitoring System field test currently planned for two LGA's be extended to six months in length, to allow sufficient time for training of service provider staff, development and revision of feedback reports at each level of the system, and

modification and improvement of recording and reporting formats based on initial implementation experience.

Given the need for additional design work, and the large number of service facilities which will require training in use of the new system in each LGA, the currently proposed three month field test seems much too short.

II. THE COMMITTEE ON MONITORING AND EVALUATION OF HEALTH ACTIVITIES

At the direction of the Honorable Minister of Health, Professor O. Ransome-Kuti, an intra-ministerial Committee on Monitoring and Evaluation of Health Activities has been established under the chairmanship of the Special Assistant to the Minister, Mr. K. S. Oyegbite. The Committee's first meeting, an intensive workshop on monitoring and evaluation for Primary Health Care (PHC) activities of the FMOH, was held from February 2 - 6, 1987 at the University of Lagos. The following pages describe the structure, scope, and objectives of the Committee, and summarize the major conclusions reached by the group during their first week's work.

A. BACKGROUND

Late in 1986 the Honorable Minister of Health established the Committee on Monitoring and Evaluation of Health Activities, and charged it with unifying the different record systems currently existing in the FMOH. As delineated in Mr. Oyegbite's letter to Professor Ransome-Kuti, the specific terms of reference of the Committee are:

- "(i) to state clearly the indicators for monitoring and evaluating (M&E) Primary Health Care;
- (ii) review indicators used by all projects and programmes in the Ministry and state how each can be incorporated into an Integrated Primary Health Care M&E System;
- (iii) review all M&E instruments available within the Ministry and its collaborators (WHO, UNICEF, USAID, etc.);
- (iv) develop instruments for M&E PHC system based on (ii) and (iii) above at the various levels of PHC (home, community, health centres) bearing in mind the level of personnel to use the instruments to collect information;
- (v) review the existing instruments for collecting baseline data;
- (vi) state methods for using instruments (who collects what information; how is information analysed, and for what decision/action is information used); and
- (vii) field test instruments before submitting report."

The membership of the Committee includes, in addition to the Chairman, staff of the Medical Statistics Division of the FMOH Directorate for National Health Planning and Research; staff of the FMOH Primary Health Care Coordinating Unit, staff of the FMOH Directorate for Public Health Services (including its Epidemiological Division and the Federal Nutrition Division), local consultants from the Polytechnic, Ibadan and the University of Ibadan, and staff of WHO and UNICEF. The Committee's members are listed in Attachment 1 of this report.

B. SCOPE AND OBJECTIVES OF FEBRUARY 2 - 6 COMMITTEE MEETING

At the beginning of the February 2 - 6 intensive workshop, the Honorable Minister of Health elaborated and expanded upon these terms of reference to the participants. In particular, Professor Ransome-Kuti stated that proper management of the Nigerian health services depends on a well designed and functioning Management Information System at the primary care level, and that the most important questions in designing such a system are who will use the information and how they will use it. He also noted that these systems must be designed by the Ministry itself, both so that Ministry decision-makers will understand and use the system, and so that Nigerians will be able to fix the system if things go wrong.

With this understanding, the Committee established its agenda for the initial week's work as follows:

- "1. Definition of objectives [of the eight components of PHC]
2. Review indicators and instruments
3. Define clearly indicators for M and E
4. Integrate instruments for M and E
5. State methods for using instruments
6. Review instruments for baseline."

Each of the eight components of the Nigerian PHC effort were reviewed in turn. The components are:

1. Health education;
2. Food and nutrition;
3. Maternal/child health, including family planning;
4. Immunization;
5. Control of local endemic diseases;
6. Water and sanitation;

7. Treatment of common ailments and injuries; and
8. Provision of essential drugs.

For each component, discussions included elaboration of objectives and presently used indicators, and review of existing data collection and reporting instruments as they relate to PHC activities of the FMOH. As key staff of the Epidemiological Division were out of the country during the time of the initial workshop, discussions of the immunization component could not be entirely completed during the initial week's work; the Committee Chairman will hold further discussions with Epidemiology staff upon their return.

The Committee's initial discussions specifically did NOT include any issues other than evaluation and monitoring of PHC activities. Hospital data collection instruments and systems, for example, were considered to be beyond the scope of the first week's work. Routine service delivery management functions unrelated to higher level monitoring and evaluation (e.g., logistics management, supervision, personnel management, financial management) were also not included.

A complete list of full- and part-time participants in the February 2 - 6 workshop is included in Attachment 2 of this report.

C. MAJOR CONCLUSIONS OF THE INITIAL COMMITTEE MEETING

The following paragraphs summarize the Committee's conclusions at the end of the first week's meeting. As discussed in Subsection D below, these conclusions will be further refined in the coming months.

1. Proposed PHC Monitoring System

As described in the author's June, 1986 consultant's report, the PHC effort of the FMOH has included Management Information Systems development from the outset. Based on a workshop held in Ogun State in 1981, the "Interim Manual of the Monitoring System for Primary Health Care" was developed, along with initial training materials for its use. Since that time, the proposed data collection and reporting instruments have undergone a number of modifications, culminating in the proposed formats included as Attachment 2 to the June, 1986 report. These proposed formats, along with the presently used recording and reporting systems for immunization, oral rehydration, and family planning, were taken as the starting point for the Committee's deliberations. For components of PHC which do not already have recording and reporting systems in place, the unit or division's stated objectives and indicators were used as the point of departure.

The basic structure of the proposed PHC system includes a daily tally sheet or a monthly log sheet for recording for each PHC component (e.g., tracer diseases, MCH/FP, etc.). These tallies and log sheets are meant to be kept at the service facility itself. In the case of daily tallies, a monthly summary sheet of the same data items is prepared, both for local use and for forwarding to the Local Government Area (LGA) level. An annual report summarizing the monthly data is similarly prepared. Identical

formats are also provided at the LGA level for aggregating service facility data for the whole LGA on a monthly and annual basis.

The Committee did not suggest any change to this basic recording and reporting structure. However, a large number of specific modifications to the PHC recording and reporting formats were proposed, both to simplify and reduce the data collected, and to ensure consistency of the management indicators used. Attachment 3 to this report shows the recording and reporting formats with the Committee's suggested modifications handwritten in. For purposes of clarity, formats for both health facility use and LGA use are included in Attachment 3, so that the same data may appear as often as five times (health facility daily tally, health facility monthly summary, health facility annual summary, LGA monthly summary, LGA annual summary). This is NOT duplicative, as these formats are intended to be used by different staff at different levels of the system at different times.

Only a few inconsistencies in the monitoring and evaluation indicators between existing recording and reporting systems and the proposed PHC system were identified by the Committee (e.g., differing age breakdowns between the accelerated EPI recording system and the proposed PHC system), and these were easily resolved. In several cases, existing operational systems allowed calculation of additional indicators beyond those initially envisioned by the proposed PHC system (e.g., couple-years of protection for family planning), and these were either added to the PHC reports or retained for further consideration by PHC management and evaluation staff.

Objectives and indicators for each PHC component will be elaborated in the Committee's interim report, scheduled to be available from the FMOH in April, 1987. Revised PHC recording and reporting formats will also be included in that report.

In reviewing the current operational systems for family planning, EPI, and ORT, the Committee realized that while these systems may provide data useful for monitoring and evaluation, their major uses are for other aspects of program management (e.g., logistics and supply); in consequence, such systems must continue to operate. The Committee therefore interpreted its charge of developing an "integrated" system to mean

1. That the various existing and proposed systems be constructed or modified so that at the service delivery level, raw data need not be recorded more than once, even though it may be reported through different channels for different management purposes. Wherever possible, duplication at the lowest level should be eliminated.
2. That the various FMOH units and divisions involved in PHC (e.g., PHC Unit, National Health Planning Unit, Epidemiological Division, Nutrition Division, Health Education Unit) use consistent indicators for monitoring and evaluation purposes for each component of PHC, even if they use

additional indicators or measures for other aspects of program management.

2. Village Health Worker Monitoring

The Committee also considered the need to monitor services delivered by Village Health Workers (VHW's), and reviewed a recording system for use by illiterate workers which has already been tested. These formats are included as Attachment 4 of this report. Discussions were hampered by lack of a specific job description for the VHW. However, the Committee generally agreed that a mechanism similar to that shown in Attachment 4 should be developed, using the tally sheet/tick mark mechanism, but recording only those activities specifically included in the VHW's job description. It was also felt that pictures used should be clearer, and that descriptive text, if included, should be in the local language, not in English.

3. Primary Health Care Pilot Survey and Situation Analysis

In addition to these routine recording and reporting systems, data collected on a periodic or one-time survey basis will also be needed, both to assess changes in health status and to provide denominator data for many of the management indicators. Time did not permit a full discussion of such data requirements in the Committee's initial meeting, but considerable effort was spent in review and simplification of the Primary Health Care Pilot Survey, for which data have already been collected in the 52 pilot districts. The PHC Situation Analysis was similarly reviewed and modified.

Based on results which were obtained in the initial 52 districts, the Committee felt that the length of this Survey should be drastically reduced, eliminating all redundancy in questions included, as well as those questions which might be of academic interest but which have no immediate implications for PHC program management. Specific suggestions for revision of this Survey were developed, and will be documented in the Committee's final report.

4. Institutional Reporting Arrangements

The Committee also considered options for reporting channels from the service facilities up through the LGA's and state governments to the FMOH. As mentioned above, this discussion was limited to indicators for monitoring and evaluation purposes. Indicators for other management purposes and routine management functions within the health facilities themselves were not addressed in depth.

For monitoring and evaluation purposes, each health facility would forward copies of its monthly summary sheets to the LGA, where they would be aggregated across all LGA health facilities for analysis and forwarding to higher levels. There are, however, significant constraints at the LGA level which will make institutionalization of monitoring and evaluation capability difficult. First, the LGA, the Ministry of Health, and the Health Management Board all have offices at the LGA level, and the division of responsibilities among these offices is unclear. Second, it is unlikely that personnel with training or experience in health statistics are already

in place at the LGA level, and it will be difficult to obtain funding for recruitment of new trained staff for this purpose.

For these reasons, the Committee felt that each LGA (beginning with the initial 52 already included in the PHC pilot test) should be asked to nominate a current staff member who will be in charge of monitoring and evaluation for PHC facilities, and that the FMOH working with the state governments should provide initial training for these personnel. Materials needed for operationalizing the system (e.g., blank recording and reporting forms) would also have to be provided by the FMOH.

The FMOH would also need to formally request the state governments to instruct their health facilities to begin reporting directly to the LGA, and should itself instruct Federal facilities which provide PHC services (e.g., Federal teaching hospitals) to provide reports to the concerned LGA.

At the LGA level, PHC monitoring and evaluation reports would be aggregated across all health facilities, and consolidated monthly and annual reports would be forwarded simultaneously to the state and Federal levels. This dual reporting channel would substantially reduce time delays in obtaining nationwide monitoring and evaluation data at the FMOH, and would allow LGA-specific feedback reports to be developed at the Federal level.

At the state level, as at the LGA, multiple organizations are involved in the PHC management effort. The state PHC Coordinator would be the primary person responsible for receipt, aggregation, and analysis of statewide LGA reports. One additional person to serve as backup for these activities should be designated by each state, and the FMOH should again provide training and materials needed for system implementation.

Finally, each state should forward its aggregated reports to the FMOH, and the FMOH should compare these receipts with the reports sent directly by the LGA's, resolving any discrepancies to ensure that Federal level reports are as complete as possible.

This strategy should allow rapid processing of field data at the Federal level, while at the same time providing disaggregated data to each intermediate level for processing and analysis. This mechanism will also allow FMOH technical staff to work at each intermediate level to gradually improve management capability at the service facilities, LGA's, and states.

The role of the Zonal level now being established in Nigeria was also discussed. The Committee felt that the Zone should NOT be added as a separate management level in the system, since such a strategy would add further time delays in moving data up the system. Rather, the Zone should be considered as a clearinghouse for PHC (and other) reports, with states sending copies of reports simultaneously with those sent to the Federal level, and with Zonal staff assisting FMOH staff in troubleshooting, obtaining missing data, and so forth.

The need for feedback reporting down the system was also recognized by the Committee, but time did not permit a full discussion or definition of feedback reports.

5. Automated Processing at the FMOH Level

The Committee briefly discussed automated processing needs at the FMOH level for PHC monitoring and evaluation. Possible microcomputer configurations for such processing are detailed in the author's June, 1986 consultant report, Attachments 6 and 7. It was felt that four microcomputers of the capacity described in that report would be sufficient for data entry and processing of PHC monitoring and evaluation data at the FMOH level. One of the machines should be reserved unused for emergency backup in case of system failure. The remaining three should be adequate for data entry, processing, and some training of FMOH staff. These estimates do NOT include any processing of non-PHC data. Additional equipment would be required, for example, to meet the needs of the Medical Statistics Division for hospital data processing.

Required staffing for such an automation effort was also discussed. Three levels of staff would be needed:

1. Computer/Systems Analyst, the highest level position. Candidates should have postgraduate training in computer science and training and experience in health statistics.
2. Data Processing Officer, the mid-level position. Candidates should have demonstrated computer programming experience, preferably but not necessarily in health.
3. Assistant Data Processing Officer, the lowest level position. Data entry and computer operation would be the primary responsibilities of staff at this level.

Numbers of staff at each level were not estimated by the Committee, pending further analysis of volumes of data which would actually be received by the FMOH. The Committee noted that turnover of trained staff is likely to be a problem, given the higher salaries available in the private sector, and that such turnover should be considered in any recruitment and training plan. Explicit mechanisms for further training and advancement to higher levels might provide incentive for staff to stay in the Ministry.

D. SHORT TERM PLAN FOR COMMITTEE ACTIVITIES

The Committee felt that the revised PHC recording and reporting formats should be field tested in two LGA's before wider implementation of the system is begun. The field test should run for a minimum of three months, and should include all levels discussed above.

The Chairman will appoint a smaller working group of three to four persons to refine the recommendations summarized above, and to redraft PHC recording and reporting formats accordingly. This group will include staff

whose normal responsibility is service delivery in the field, to ensure that recording formats are appropriate for field use. It is hoped that this working group can finish its redesign effort by the end of February, so that the field test can begin in early March. An interim Committee report will be prepared by the end of March.

III. MAJOR ISSUES AND RECOMMENDATIONS

The following pages detail major issues identified in the course of the above discussions, along with the consultant's recommendations for addressing each one. Most of these issues were discussed at least briefly during the Committee's initial meeting. Again, however, the suggestions presented below represent the views of the author, and not necessarily those of the entire Committee.

A. MANAGEMENT INDICATORS AND THEIR USES FOR MONITORING AND EVALUATION

During the Committee's initial week of deliberations, some confusion was evident among the outsiders who attended regarding the scope of the discussions and of the PHC monitoring and evaluation effort itself. The term "indicator" was loosely used to include management indicators, performance indicators, impact indicators, health status indicators, and so forth. Some of the recording formats reviewed were very worthwhile, but were only peripherally related to monitoring and evaluation. The Child Health Card, for example, is an excellent system, but its major use is in direct provision of nutrition services to individual clients, not in higher level monitoring and evaluation.

A full discussion of the theory of management indicators is beyond the scope of this document. A brief review of the most important practical points might however be helpful. By definition,

A management indicator is a single number or a combination of several numbers which can, for the purposes of management decision-making, be used to represent a complex series of program activities.

The advantage of using management indicators is that they reduce drastically the amount of data which must be recorded and reported. Monitoring of "tracer" diseases rather than a complete list of conditions seen at the health facility is a good example of such a reduction.

The success of any information system, however, depends largely on the skill with which such indicators are chosen. In particular a good management indicator:

1. Clearly relates to specific management decisions;
2. Reflects the highest priority activities of the organization in a way which is obvious to all;
3. Can be easily related to specific program functions or to individual operating units;

4. Focuses managers' attention on places where performance differs from expectations;
5. Is sufficiently sensitive to adequately reflect changes in the underlying process it is meant to measure; and
6. Can be displayed in a clear, concise form which facilitates decision-making.

Of these points, the most important is that indicators must be usable for specific management decisions. As noted above, the Honorable Minister of Health has charged the Committee with specifying who will use the indicators, and how they will be used. The most important recommendation for the Committee's consideration is thus as follows:

1. It is suggested that the Committee weigh each proposed indicator in light of the above six characteristics of good management indicators, and omit any indicators which do not clearly relate to specific management decisions.

The basic question which should be asked is "How will managers modify the PHC service delivery system based on changes in this indicator?" If the answer is that they will not, the indicator should be dropped. For example, one consultant to the Committee has proposed a lengthy survey including family basic data, household health status data, community health activity data, and health institution manpower and activity data. Although the necessity of measuring health status is clear, the specific questions proposed would yield very little information on which action could be based. This survey accordingly should be dropped from further consideration.

As the Committee recognized, however, different data and indicators will be required for different management purposes, and managers at different levels of the service system will have differing needs. Indicators will be required for monitoring types and levels of services provided, for measuring the impact which those services have on community health status, for managing the resources used to provide the services (finance, personnel, medicines and supplies), and so forth.

The Committee's present concern is service and impact indicators for monitoring and evaluation at higher levels of the system, but these other aspects of program management will also eventually require attention. As discussed in Section II above, the practical implication of this statement is that systems designed for other purposes (e.g., health centre level logistics management) must continue to operate. The Committee's task should be to see that any modifications required to ensure consistency among indicators used by different program managers or to eliminate duplicative recording of raw data are made.

B. FURTHER DEVELOPMENT OF RECORDING AND REPORTING SYSTEM FORMATS

As discussed in Section II above, the next immediate activity of the Committee is further refinement and revision of recording and reporting formats for PHC monitoring and evaluation. The second recommendation is as follows:

2. It is suggested that in further development of the PHC Monitoring System the Committee carefully distinguish between recording formats and reporting formats, and that the recording formats reflect exactly the way the services are actually delivered, while the reporting formats reflect the actual management structure of the service system.

In the proposed PHC Monitoring System shown in Attachment 3 of this report, raw data are recorded on the tally sheets or log sheets for each PHC component. The system must of course record events at the time they happen; thus the frequency and timing of data recording are fixed not by choice, but by the activities being recorded. To minimize the data collection workload imposed on service delivery staff, these recording formats must reflect exactly the way services are delivered. The system as shown in Attachment 3 has a separate recording format for each PHC component, and thus presupposes that each component service is delivered by a different person, or by the same person at a different time. If this is true, then the recording structure as proposed should be kept. If, on the other hand, a single person provides all services all the time in a multipurpose clinic setting, then an integrated recording format which combines all services would be more appropriate.

For this reason, it is essential that the Committee's small working group which is now being constituted to continue the forms design effort include service provider staff.

The reporting formats, on the other hand, and the procedures by which reports move from level to level, must reflect the actual management structure of the service system. Thus EPI managers concerned with vaccine logistics must continue to receive their logistics data, while both EPI staff and PHC managers must receive EPI monitoring and evaluation indicators. Depending on the assignment of management responsibilities, different managers may be able to use the same reports, or may require partially or entirely different reports. The timing, content, frequency, and level of detail of the reporting system should be dictated by these management requirements.

It is imperative that FMOH systems meet these differing needs, and therefore that the Committee continue to view their goal as establishment of consistent, nonduplicative, interconnected information systems, and not as development of a single monolithic recording and reporting structure. This latter concept, the "Total Management Information System," has been attempted in both public and private sector organizations around the world. Due to the size and complexity of the management task such efforts have never succeeded.

C. USE OF STATISTICAL SURVEY TECHNIQUES FOR COLLECTION OF INDICATOR DATA

A major recommendation from the consultant's previous visit was that the FMOH develop a capability to undertake periodic and one-time surveys. The Committee's initial deliberations indicated clearly that such a mechanism would be most appropriate for collection of baseline data at the beginning of the PHC intervention in each LGA, for periodic collection of health status and other required community level data, and for collection of denominator data needed for calculation of many of the proposed management indicators. Applications outside of the PHC monitoring effort itself are also apparent.

However, the Committee also identified serious concerns regarding the implementation of the Primary Health Care Pilot Survey in the initial 52 pilot LGA's. Although some effort was made to establish a stratified sample, exactly 200 households were surveyed in each LGA, regardless of population size, number of service delivery units, or other factors. It is highly questionable whether this methodology produced a representative sample of households, and in consequence the validity of all the survey results must be re-examined.

If routine recording and reporting functions are to be minimized, it is imperative that the FMOH have the capability to conduct statistically valid and methodologically sound surveys. The third recommendation is as follows:

3. It is suggested that the Directorate for National Health Planning and Research and/or the Primary Health Care Coordinating Unit recruit and train appropriate staff to establish a Statistical Survey Unit at the Federal level of the Ministry.

This suggestion is covered in some detail in the June, 1986 consultant's report. The International Statistical Programs Center of the U.S. Bureau of the Census has substantial experience in providing short-term assistance in statistical survey techniques, and also manages short- and long-term training programs in survey methodologies. Such outside assistance, if desirable, would have to be negotiated directly through AID/Lagos.

D. AUTOMATION OF PHC RECORDING AND REPORTING SYSTEMS

The consultant's June, 1986 report reads in part as follows:

"The purpose of [the Health Management Information Systems Working Group] SHOULD NOT BE creation of a centralized data collection system, but rather coordination of the design, and approval of the dissemination of data reporting formats and instructions. Data collection and analysis should

remain decentralized in the concerned directorates and sections of the Ministry, as is currently the case."

The implication of this statement is that any automated data processing capability must be similarly decentralized. As the above discussion indicates, the amounts of data to be processed are too massive, and the management needs of the various units are too different to allow centralization of automated processing. The fourth recommendation is therefore as follows:

4. It is suggested that automated processing for PHC and other systems be decentralized to the concerned directorates and sections of the Ministry, with microcomputer hardware and programming staff allocated based on the particular data processing requirements of each unit.

Such hardware capacity and staffing requirements can only be determined as computer applications in each unit are defined. Initial hardware requirements for PHC monitoring are discussed in Section II above. Section II of this report, and Section IV of the consultant's June, 1986 report discuss staffing and training requirements for automation. It is emphasized again that skilled staff, not hardware, will be the major constraint in any automation effort.

E. DESIGN OF FEEDBACK REPORTS

As mentioned above, the Committee did not have sufficient time in its initial meeting to fully discuss the issue of feedback reporting. The PHC Monitoring System as currently envisioned provides data in sufficient detail at all levels to allow design of feedback reports which could provide comparisons of performance between states, LGA's, or service facilities, as well as analysis of an individual service facility's performance over time. If statistically sound periodic surveys can be implemented to collect denominator data, managers at higher levels can calculate more meaningful indicators of coverage for feedback to lower levels. The fifth recommendation is therefore as follows:

5. It is suggested that the Committee work with PHC program managers at each level of the system to design appropriate feedback reports for their supervision and management use as a part of the planned field test of PHC recording and reporting instruments.

F. PHC MONITORING SYSTEM FIELD TEST

Given the need for this additional design work, and the large number of service facilities which will require training in use of the new system in each LGA, the currently proposed three month field test seems much too

short. With an estimated 40 - 50 service facilities in each LGA, the startup process alone is likely to take several months, with an additional month or more before the recording and reporting processes stabilize. Moreover, any revisions which may be required would also have to be further tested. The sixth recommendation is therefore as follows:

6. It is suggested that the PHC Monitoring System field test currently planned for two LGA's be extended to six months in length, to allow sufficient time for training of service provider staff, development and revision of feedback reports at each level of the system, and modification and improvement of recording and reporting formats based on initial implementation experience.

IV. CONCLUSION

As the above discussion implies, the Committee was able to make substantial progress in design of PHC monitoring and evaluation tools in a very short period of time. Its efforts, and especially those of its Chairman, are to be commended. The process begun here, if carefully managed to conclusion, should produce a simple, workable system for PHC monitoring and evaluation which is not duplicative of systems designed to support the Ministry's other management tasks.

At the opening session of the Committee's initial meeting, the Honorable Minister of Health stated strongly his desire that the system should be designed by Nigerians, for Nigeria's needs. The Committee's efforts to meet this goal were somewhat hampered by the large number of outside participants at the initial meetings, most of whom had limited understanding of the details of Nigeria's service delivery system. It is suggested that outside consultants are appropriately used to perform specific technical tasks (e.g., forms design, development of statistically sound sampling techniques, specification of computer requirements), but that the management indicators and their uses must be specified by Ministry decision makers themselves. Only in this way will the resulting systems be used for their only legitimate purpose -- to make decisions.

ATTACHMENT 1:

MONITORING AND EVALUATION COMMITTEE MEMBERS

MONITORING AND EVALUATION COMMITTEE MEMBERS

- | | | |
|-----|----------------------------------|---|
| 1. | Mr. K.S. Oyegbite (chairman) | Special Assistant to Minister
Federal Ministry of Health |
| 2. | Dr. B.A. Dada (member) | Chief Consultant
Medical Statistics Division |
| 3. | Dr. A.D. Kolawole (member) | Chief Coordinator
PHC Coordinating Unit |
| 4. | Dr. A.O.O. Sorungbe (member) | Chief Consultant
Epidemiological Division |
| 5. | Dr. (Mrs.) O.A. Adelaja (member) | Senior Consultant
Medical Statistics Division |
| 6. | Dr. O.O. Solanke (member) | Assistant Director
Public Health Services |
| 7. | Dr. H.O. Adesina (member) | Dean of Environmental Studies
Ibadan Polytechnic |
| 8. | Mrs. Doyin Desalu (member) | Senior Health Planner
National Health Planning Unit |
| 9. | Mr. Ahmed Magan (member) | UNICEF |
| 10. | Dr. H.C.A.M. van Vliet (member) | Epidemiologist
WHO |
| 11. | Dr. P. Okungbowa (co-opted) | Senior Consultant
Federal Nutrition Division |
| 12. | Mr. I.A. Olayinka (co-opted) | Research Fellow
University of Ibadan |

ATTACHMENT 2:

FEBRUARY 2 - 6 WORKSHOP PARTICIPANTS

NAMES OF PARTICIPANTS
February 2 - 6, 1987 Meeting

	<u>Name</u>	<u>Address</u>
1.	Dr J. W. Nelson	CCCD Project Coordinator, USAID
2.	Dr. Eugene Weiss	Centre for Population and Family Health, Columbia University
3.	Dr. P. Okungbowa	Senior Consultant Nutritionist, Federal Ministry of Health
4.	Dr. A. D. Kolwawole	Chief Coordinator (PHC) Federal Ministry of Health
5.	Dr. Timothy Johnson	Centers for Disease Control
6.	Mr. Brice D. Atkinson	Family Planning Logistics Management Project Analyst
7.	Dr. O. Salawu	Epidemiological Division Federal Ministry of Health
8.	Dr. S. K. Dola	WHO Consultant
9.	Mr. A. N. Osa-Afiana	Under Secretary, PHC Federal Ministry of Health
10.	Ms. Bedisone Pension-Smith	PHC Unit Federal Ministry of Health
11.	Dr. J. M. Adekeye	Directorate of National Health Planning and Research Federal Ministry of Health
12.	Mr. R. E. Dei	Medical Statistics Division Federal Ministry of Health
13.	Mr. C. O. Do-Regos	Medical Statistics Division Federal Ministry of Health
14.	Dr. Moye W. Freymann	University of North Carolina
15.	Mr. Ahmed Magan	UNICEF
16.	Dr. Kwame M. Kwofie	FAO/WHO
17.	Dr. O. O. Solanke	PHC Unit Federal Ministry of Health

18. Mr. K. S. Oyegbite
Special Assistant to the Minister
Office of the Honourable Minister
of Health
19. Richard C. Owens, Jr.
REACH Project, John Snow Inc.
20. Dr. H. C. A. M. Van Vliet
WHO
21. Mr. Dayo Adegorusi
National Health Planning Unit
Federal Ministry of Health
22. Dr. V. A. Oluyemi
PHC Unit
Federal Ministry of Health
23. Dr. H. O. Adesina
Faculty of Environmental Studies
The Polytechnic, Ibadan
24. Mr. I. A. Olayinka
Dept. of Preventive and Social
Medicine
University of Ibadan
25. Dr. (Mrs.) S. O. Omojokun
Nutrition Division
Federal Ministry of Health
26. Ms. A. O. Alebi
Health Education Unit
Federal Ministry of Health

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ATTACHMENT 3:

COMMITTEE'S INITIAL RECOMMENDATIONS FOR PHC
RECORDING AND REPORTING FORMATS

DATE: _____

TALLY SHEET FOR PHC (No. 1)

Name of Unit.....Name of L.G.A.....

Tally Sheet for OUT-PATIENT CLINIC and 'Tracer' Diseases

	Under 1 Yr.	1-4 years	5-14 years	15 yrs and above	TOTAL NEW ATTENDANCES
MEAS- LES	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
TOTAL					
WHOO- PING COUGH	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
TOTAL					
MAL- ARIA (FEVER)	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
TOTAL					
DIARR- HOEA	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
TOTAL					
MALNU- TRITI- ON	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
TOTAL					
ACCI- DENTS	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
TOTAL					
OTHERS	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	
TOTAL					

→ Add Respiratory Diseases

FOR ^{New} ~~NEW~~ ATTENDANCE (MARK /)
FOR RE-ATTENDANCE (MARK X)

TOTAL REATTENDANCES _____
TOTAL ATTENDANCES _____

Out-Patient Attendance and Tracer Diseases: Monthly Record of Health

NB: "Attendance" =
New Attendance Only

Health Unit..... Name of LGA..... Month & Year.....

Date Day of Month	TRACER DISEASES BY AGE GROUPS - New Attendances															Total New Attendances	TOTAL RETURNS								
	Measles				Whooping Cough			Malaria			Diarrhoea			Malnutrition				Accidents			Others				
	1yr.	1-4 yrs.	5-14 Yrs	15 yrs.	1yr.	1-4 yrs.	5-14 yrs.	15 yrs.	1yr.	1-4 yrs.	5-14 yrs.	15 yrs.	1yr.	1-4 yrs.	5-14 yrs.	15 yrs.	1yr.	1-4 yrs.	5-14 yrs.	15 yrs.	1yr.	1-4 yrs.	5-14 yrs.	15 yrs.	
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Admission
Diseases

Sub
Total for ...
Total for ...

Annual Record of Out-Patient Attendance and 'Tracer' Disease at the Health Unit

Health Unit..... Name of IGA..... Month & Year.....

TRACER DISEASES BY AGE GROUPS

Date Month & Year	Measles			Whooping Cough			Malaria			Diarrhoea			Malnutrition			Accidents			Others			Total New Attendees
	1yr.	1-4 yrs.	5-14 yrs.	1yr.	1-4 yrs.	5-14 yrs.	1yr.	1-4 yrs.	5-14 yrs.	1yr.	1-4 yrs.	5-14 yrs.	1yr.	1-4 yrs.	5-14 yrs.	1yr.	1-4 yrs.	5-14 yrs.	1yr.	1-4 yrs.	5-14 yrs.	
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97																						
98																						
99																						
100																						
Subtotal																						
Total for disease																						

Total
Recitables

Subtotal
Total for disease

Monthly Record of Out-Patient and 'Tracer' Disease in the L.G.A.

Code of L.G.A. Name of L.G.A. Month & Year

List of health unit	TRACER DISEASES BY AGE GROUPS																Total													
	Measles				Whooping Cough				Malaria				Diarrhoea					Malnutrition				Accidents				Others				
	1yr	1-4 yrs	5-14 yrs	15 yrs	1yr	1-4 yrs	5-14 yrs	15 yrs	1yr	1-4 yrs	5-14 yrs	15 yrs	1yr	1-4 yrs	5-14 yrs	15 yrs	1yr	1-4 yrs	5-14 yrs	15 yrs	1yr	1-4 yrs	5-14 yrs	15 yrs	1yr	1-4 yrs	5-14 yrs	15 yrs	New Attendees	
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Add Respiratory Diseases

Total Attendees

STC/M

ANNUAL RECORD OF OUT-PATIENT ATTENDANCE AND 'TRACER' DISEASES IN THE L.G.A.

Name of L.G.A. Name of L.G.A. Year

Add Respiratory Infections

TRACER DISEASES BY AGE GROUPS

Date	Measles			Whooping Cough			Malaria			Diarrhoea			Malnutrition			Accidents			Others			Total
	1yr	1-4 yrs	5-14 yrs	15 yrs	1yr	1-4 yrs	5-14 yrs	15 yrs	1yr	1-4 yrs	5-14 yrs	15 yrs	1yr	1-4 yrs	5-14 yrs	15 yrs	1yr	1-4 yrs	5-14 yrs	15 yrs		
January																						
February																						
March																						
April																						
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July																						
August																						
September																						
October																						
November																						
December																						
TOTAL																						

Add Respiratory Infections

Newly Attacked

22

NAME OF UNIT NAME OF LGU.....

TALLY SHEET FOR MATERNAL HEALTH AND FAMILY PLANNING

NEW ATTENDANCE		2ND ATTENDANCE	3RD ATTENDANCE	4TH ATTENDANCE
00000	00000	00000	00000	00000
00000	00000	00000	00000	00000
00000	00000	00000	00000	00000
00000	00000	00000	00000	00000
00000	00000	00000	00000	00000
00000	00000	00000	00000	00000

FOR NEW ATTENDANCE ONLY (FAMILY PLANNING METHODS)

ORALS	00000	00000	00000	00000
	00000	00000	00000	00000
I.U.D.	00000	00000	00000	00000
	00000	00000	00000	00000
SPERMICIDE	00000	00000	00000	00000
	00000	00000	00000	00000
CONDON	00000	00000	00000	00000
	00000	00000	00000	00000
PERIODIC ABSTINENCE	00000	00000	00000	00000
	00000	00000	00000	00000
NONE	00000	00000	00000	00000
	00000	00000	00000	00000

MATERNAL HEALTH & FAMILY PLANNING MONTHLY RECORD AT HEALTH UNIT

HEALTH UNIT..... NAME OF IGA..... MONTH & YEAR.....

Date Days of Month	A N T E N A T A L					F A M I L Y P L A N N I N G B Y M E T H O D S						
	New Atten- dance	Re-Attendance			Total	Oral	IUD	Spermi- cides	Condoms	Periodic Absten- ance	None	Total
		2nd	3rd	4th								
1												
2												
3												
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ANNUAL RECORD OF MATERNAL HEALTH AND FAMILY PLANNING AT THE HEALTH UNIT

HEALTH UNIT..... NAME OF IGA..... YEAR.....

Date		ANTEPARTAL			FAMILY PLANNING BY METHODS							
Month of the year	New Attendance				Total	Orals	IUD	Spermicides	Condoms	Periodic Abstinence	None	Total
		2nd	3rd	4th								
January												
February												
March												
April												
May												
June												
July												
August												
September												
October												
November												
December												
TOTAL												

22

ANNUAL RECORD ON MATERNAL HEALTH AND FAMILY PLANNING WITHIN THE LGA

NAME OF LGA.....

YEAR.....

This calendar year	New Attendance	ATTENDANCE			Total	FAMILY PLANNING BY METHOD							
		1st	2nd	3rd		4th	Orals	IUD	Steroids	Condoms	Abstinence	None	Total
January													
February													
March													
April													
May													
June													
July													
August													
September													
October													
November													
December													
TOTAL													

Officer-in-Charge

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MAKE LIKE page 1
or replace w FP Form 2

TALLY SHEET FOR FPD NO. 2B

NAME OF UNIT.....NAME OF LG.....
TALLY SHEET ON FAMILY PLANNING BY TYPE

FAMILY PLANNING METHODS	NEW ATTENDANCE		RE-ATTENDANCE		TOTAL
GRALS	00000	00000	00000	00000	
	00000	00000	00000	00000	
	00000	00000	00000	00000	
<hr/>					
I. U. D.	00000	00000	00000	00000	
	00000	00000	00000	00000	
	00000	00000	00000	00000	
<hr/>					
SPERMICIDE	00000	00000	00000	00000	
	00000	00000	00000	00000	
	00000	00000	00000	00000	
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LORDON	00000	00000	00000	00000	
	00000	00000	00000	00000	
	00000	00000	00000	00000	
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PERIODIC ABSTINENCE	00000	00000	00000	00000	
	00000	00000	00000	00000	
	00000	00000	00000	00000	
<hr/>					
NONE	00000	00000	00000	00000	
	00000	00000	00000	00000	
	00000	00000	00000	00000	

FAMILY PLANNING CLINIC MONTHLY RECORD AT HEALTH UNIT

HEALTH UNIT NAME OF IGA MONTH AND YEAR

Date	Family Planning Methods by Type												TOTAL
	Orals		I. U. D.		Spermicides		Condoms		Periodic Attendance		Others		
	New Attendance	Re-Attendance	New Attendance	Re-Attendance	New Attendance	Re-Attendance	New Attendance	Re-Attendance	New Attendance	Re-Attendance	New Attendance	Re-Attendance	
1													
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28													
29													
30													
TOTAL													

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ANNUAL REPORT OF FAMILY PLANNING CLINIC AT THE HEALTH UNIT

DATE UNIT OF YEAR.....

Date	Family Planning Methods by Type											TOTAL	
	Orals		I. U. D.		Spermicides		Condoms		Periodic Abstinence		Others		
	New attendance	Re-attendance	New attendance	Re-attendance	New attendance	Re-attendance	New attendance	Re-attendance	New attendance	Re-attendance	New attendance		Re-attendance
January													
February													
March													
April													
May													
June													
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August													
September													
October													
November													
December													
TOTAL													

Officer-in-Charge

ANNUAL RECORD ON FAMILY PLANNING CLINIC AT IGA

NAME OF IGA.....

YEAR.....

DATE	FAMILY PLANNING METHODS BY TYPE OF ATTENDANCE												
	Orals		I.U.D.		Spermicides		Condoms		Periodic Abstinence		Others		TOTAL
Month of Year	New attendance	Re-attendance	New attendance	Re-attendance	New attendance	Re-attendance	New attendance	Re-attendance	New attendance	Re-attendance	New attendance	Re-attendance	
January													
February													
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TOTAL													

Officer-in-Charge

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TALLY SHEET FOR PHO NO. 3

NAME OF UNIT.....NAME OF IGA.....

Tally Sheet for Deliveries Attended and Health Problems of
Reproduction

		DELIVERIES ATTENDED BY		
		SEX	Trained Staff at Health Unit	Trained TBA's at Home
TYPE AND PROBLEM OF DELIVERY	LIVE BIRTHS	MALE	00000	00000
			00000	00000
			00000	00000
			00000	00000
	TOTAL			
	STILL BIRTHS	FEMALE	00000	00000
			00000	00000
			00000	00000
00000			00000	
TOTAL				
MATERIAL DEATH		00000	00000	
		00000	00000	
		00000	00000	
		00000	00000	
		00000	00000	
		00000	00000	
		00000	00000	
		00000	00000	
TOTAL				

cm

total

DELIVERIES AND HEALTH PROBLEMS OF REPRODUCTION MONTHLY RECORD AT HEALTH UNIT

HEALTH UNIT..... NAME OF IGA..... MONTH & YEAR.....

Total

Total

Date Days of the Month	Deliveries Attended (Live Births)						Deliveries Attended (Still Births)				Maternal Death	
	By Formally Trained Staff			By Trained TB.s			TOTAL		By Trained Staff		By TB.s	
	M	F	F	M	F	F	M	F	M	F		
1												
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TOTAL												

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ANNUAL RECORD OF DELIVERIES AND HEALTH PROBLEM OF REPRODUCTION AT THE HEALTH UNIT

HEALTH UNIT..... NAME OF LGU..... YEAR.....

Date Month of the Year	DELIVERIES ATTENDED (LIVE BIRTHS)						DELIVERIES ATTENDED (STILL BIRTHS)				MATERNAL DEATH	
	By Formally Trained Staff		By Trained TBAs		TOTAL		By Trained Staff		By TBAs		By Trained Staff	By TBAs
	M	F	M	F	M	F	M	F	M	F		
January												
February												
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December												
TOTAL												

Total

Total

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MONTHLY RECORD ON DELIVERIES AND HEALTH PROBLEMS OF REPRODUCTION WITHIN THE LGA

NAME OF LGA.....

MONTH AND YEAR.....

Total

Total

Date	Deliveries Attended (Live Births)						Deliveries Attended (Still Births)				Maternal Death	
	By Formally Trained Staff		By Trained TB's		T O T A L		By Trained Staff		By TB's		By Trained Staff	By TB's
	M	F	M	F	M	F	M	F	M	F		
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TOTAL												

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ANNUAL RECORDS ON DELIVERIES AND HEALTH PROBLEMS OF REPRODUCTION WITHIN THE LGA

NAME OF LGA.....

YEAR.....

Total

Total

Months of the year	Deliveries Attended (Live Births)						Deliveries Attended (Still Births)				Maternal Death	
	By Formally Trained Staff		By Trained TBAs		T O T A L		By Trained Staff		By TBAs		By Trained Staff	By TBAs
	M	F	M	F	M	F	M	F	M	F		
January												
February												
March												
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October												
November												
December												
TOTAL												

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TALLY SHEET FOR PHC NO. 4

NAME OF UNIT.....NAME OF DSA.....

Tally Sheet on Immunization

	Doses	Under 1 year		Above 1 year	
DPT	1st	00000	00000	00000	00000
		00000	00000	00000	00000
	2nd	00000	00000	00000	00000
	3rd	00000	00000	00000	00000
	1st	00000	00000	00000	00000
POLIO	2nd	00000	00000	00000	00000
		00000	00000	00000	00000
	3rd	00000	00000	00000	00000
	4th	00000	00000	00000	00000
BCG		00000	00000	00000	00000
		00000	00000	00000	00000
MEASLES		00000	00000	00000	00000
		00000	00000	00000	00000
TT	1st	00000	00000	00000	00000
		00000	00000	00000	00000
	2nd	00000	00000	00000	00000
		00000	00000	00000	00000

Just Introduced by WAO

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IMMUNIZATION MONTHLY RECORD AT HEALTH UNIT

HEALTH UNIT..... NAME OF IGA..... MONTH AND YEAR.....

DATE :	I M M U N I Z A T I O N S																			
	D. P. T.						P O L I O								B. C. G.		MEASLES		T. T.	
	Under 1 year			1 year & above			Under 1 year				1 year and above				1 yr.	1	1	1	1st dose	2nd dose
Days of th. Month	1st dose	2nd dose	3rd dose	1st dose	2nd dose	3rd dose	1st dose	2nd dose	3rd dose	4th dose	1st dose	2nd dose	3rd dose	4th dose						
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ANNUAL RECORD OF VACCINATION AT THE HEALTH UNIT

HEALTH UNIT..... NAME OF PLACE..... MONTH OF THE YEAR.....

DATE	I M M U N I Z A T I O N S														D. P. T.		POLIO				T. T.			
	Under 1 year			1 year & above			Under 1 year				1 year and above				1 yr	1	1	1	1st dose	2nd dose				
	1st dose	2nd dose	3rd dose	1st dose	2nd dose	3rd dose	1st dose	2nd dose	3rd dose	4th dose	1st dose	2nd dose	3rd dose	4th dose										
January																								
February																								
March																								
April																								
May																								
June																								
July																								
August																								
September																								
October																								
November																								
December																								
TOTAL																								

Officer-in-Charge

27

MONTHLY RECORD ON IMMUNIZATION WITHIN THE LGA

NAME OF LGA.....

MONTH AND YEAR.....

DATE	I M M U N I Z A T I O N S														B. C. G.		M. I. S. S. L. E. S.		T. T.	
	D. P. T.			1 year & above			Under 1 year				1 year and above				1 yr.	1	1	1	1st dose	2nd dose
	Under 1 year	Under 1 year	Under 1 year	1st dose	2nd dose	3rd dose	1st dose	2nd dose	3rd dose	4th dose	1st dose	2nd dose	3rd dose	4th dose						
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27																				
TOT.																				

Dr.

ANNUAL RECORD ON IMMUNIZATION WITHIN IGA

NAME OF IGA..... YEAR.....

DATE	I M M U N I Z A T I O N														B. C. G.		M E A S L E S			T. T.	
	D. P. T.			P O L I O											1 yr.	1	1	1	1st dose	2nd dose	
	Under 1 year			1 year & above				Under 1 year				1 year and above									
Month of the Year	1st dose	2nd dose	3rd dose	1st dose	2nd dose	3rd dose	1st dose	2nd dose	3rd dose	4th dose	1st dose	2nd dose	3rd dose	4th dose							
January																					
February																					
March																					
April																					
May																					
June																					
July																					
August																					
September																					
October																					
November																					
December																					
TOTAL																					

Officer-in-Charge

162

2 Monthly
DAILY DIARY NO. 1

NAME OF UNIT NAME OF LGA.....

DAILY DIARY OF IN-PATIENT CASE

Date	Name of Health Unit	Number of Admissions	Number of Discharges	Number of Deaths
		<i>UNIT Continue with following page.</i>		

Officer-in-Charge

MONTHLY REPORT OF ALL DEATHS OCCURRING IN THE HEALTH UNIT

HEALTH UNIT.....NAME OF I.C.A.....

Month _____ YEAR.....

Day of Month	Names of Health Unit	Number of Admissions	Number of Discharges	Number of Deaths
1				
2				
3				
4				
5				
6				
7				
8				
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30				

~~Correct~~
 combine with
 daily diary #1

ANNUAL RECORD OF IN-PATIENT CARE IN THE HEALTH UNIT

HEALTH UNIT.....NAME OF LGA.....

MONTH AND YEAR.....

Months of the year	Name of Health Unit	Number of Admissions	Number of Discharges	Number of Deaths
January				
February				
March				
April				
May				
June				
July				
August				
September				
October				
November				
December				

Officer-in-Charge

50

MONTHLY RECORDS OF IN-PATIENT CARE IN THE L.G.A.

L.G.A. YEAR

Date	Names of Health Unit	Number of Admissions	Number of Discharges	Number of Deaths
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
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Officer-in-Charge

ANNUAL RECORD ON IN-PATIENT CARE IN THE LGA

NAME OF LGA YEAR.....

Month of the Year	Names of Health Unit	Number of Admissions	Number of Discharges	Number of Deaths
January				
February				
March				
April				
May				
June				
July				
August				
September				
October				
November				
December				

Officer-in-Charge

ENVIRONMENTAL HEALTH MONTHLY RECORD AT HEALTH UNIT

HEALTH UNIT..... NAME OF LGA..... MONTH AND YEAR.....

DATE Day & Night Month of the Year	ENVIRONMENTAL HEALTH ACTIVITIES				No. of Sanitary Inspection	No. of Food hygiene Inspections
	New Bore Holes	New dug Wells	New Stand Pipes	New Latrines		
1						
2						
3						
4						
5						
6						
7						
8						
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27						
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29						
30						
31						
TOTAL						

ANNUAL RECORD OF ENVIRONMENTAL HEALTH AT THE HEALTH UNIT

NAME OF LGA.....

YEAR.....

DATE	ENVIRONMENTAL HEALTH ACTIVITIES					No. of P Hygiene Inspecti s
	Month of the Year	New Bore Boles	New Dug Wells	New Stand Pipes	New Latrines	
January						
February						
March						
April						
May						
June						
July						
August						
September						
October						
November						
December						
TOTAL						

Officer-in-Charge

MONTHLY RECORD ON ENVIRONMENTAL HEALTH ACTIVITIES WITHIN IGA

NAME OF IGA.....

MONTH AND YEAR.....

DATE	ENVIRONMENTAL HEALTH ACTIVITIES					
	Names of Health Unit	New Bore Holes	New Dug Wells	New Stand Pipes	New Latrines	No. of Sanitary Inspection
1						
2						
3						
4						
5						
6						
7						
8						
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30						
TOTAL						

Officer-in-Charge

ANNUAL RECORD ON ENVIRONMENTAL HEALTH ACTIVITIES WITHIN THE LGA

NAME OF LGA.....

YEAR.....

DATE	ENVIRONMENTAL HEALTH ACTIVITIES					
	New Bore Holes	New Dug Wells	New Stand Pipes	New Latrines	No. of Sanitary Inspection	No. of Food Hygiene Inspections
January						
February						
March						
April						
May						
June						
July						
August						
September						
October						
November						
December						
TOTAL						

Officer-in-Charge

10/21

36

~~D. H. BIRNBAUM~~ NO. 3

NAME OF UNIT.....NAME OF IGA.....

Diary on Health Education Activities by the Public Health
Personnel

Date	Place	Number of homes newly Visited	Number of Re- Visits	Number of Health Education Sessions	Number of Nutrition Demonstra- tion

60

ANNUAL RECORD OF HEALTH EDUCATION ACTIVITIES OF THE HEALTH UNIT

HEALTH UNIT..... NAME OF LGA..... YEAR.....

DATE	HEALTH EDUCATION ACTIVITIES			
	No. of Homes Visited	No. of Homes Re-Visited	No. of Health Education Sessions	No. of Nutritional Demonstrations
January				
February				
March				
April				
May				
June				
July				
August				
September				
October				
November				
December				
TOTAL				

Officer-in-Charge

62

MONTHLY RECORDS ON HEALTH EDUCATION ACTIVITIES AT THE IGA

NAME OF IGA.....

MONTH AND YEAR.....

Names of Health Units	HEALTH EDUCATION ACTIVITIES			
	No. of Homes Visited	No. of Homes Re-Visited	No. of Health Education Sessions	No. of nutritional demonstrations
1				
2				
3				
4				
5				
6				
7				
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9				
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19				
20				
TOTAL				

Officer-in-Charge

100

ANNUAL RECORD ON HEALTH EDUCATION ACTIVITIES AT THE LGA

Month of the Year	HEALTH EDUCATION ACTIVITIES			
	No. of Homes Visited	No. of Homes Re-Visited	No. of Health Education Sessions	No. of Nutritional Demonstrations
January				
February				
March				
April				
May				
June				
July				
August				
September				
October				
November				
December				
TOTAL				

Officer-in-Charge

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HEALTH UNIT MONTHLY SUMMARY REPORT ON
SELECTED SUPPLIES TO HEALTH UNIT

HEALTH UNIT NAME OF ICA.....
MONTH AND YEAR

I T E M S	Q U A N T I T I E S		
	Received during the month	Used during the month	Balance at end of month
Procaine-Penicillin G (vials of) 4 mega Unit			
Chloroquine tablets (in thousands)			
Measles Vaccine doses			
Vaccine (dose) BCG			
DPT Vaccine (Doses)			
Polio Vaccines (Doses)			

Replace with complete list of essential drugs, or with most important essential drugs

Officer-in-Charge

ANNUAL RECORD OF HEALTH UNIT SUPPLY OF SELECTED SUPPLIES
AT THE HEALTH UNIT

HEALTH UNIT..... NAME OF LGU.....

YEAR.....

I T E M S	Q U A N T I T I E S		
	Received during the month <i>Year</i>	Used during the month <i>Year</i>	Balance at end of month <i>Year</i>
Procaine-Penicillin G (vials of) 4 mega unit			
Chloroquine tablets (in thousands)			
Measles vaccine doses			
Vaccine (doses) BCG			
DPT Vaccine (Doses)			
Polio Vaccine (Doses)			

Replace with complete list of essential drugs, or with most important essential drugs.

Officer-in-Charge

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MONTHLY SUMMARY REPORT ON SELECTED SUPPLIES IN THE VARIOUS HEALTH
UNITS WITHIN THE ICA

NAME OF ICA..... MONTH AND YEAR.....

I T E M S	Q U A N T I T I E S		
	Received During the month	Used during the month	Balance at end of month
Procaine-Penicillin G (vials of) 4 mega unit			
Chloroquine tablets (in thousands)			
Measles Vaccine doses			
Vaccine doses BCG			
DPT Vaccine (Doses)			
Polio Vaccine (doses)			

↓
replace with
complete list
of essential
drugs, or with
most important
essential drugs

Officer-in-Charge

QUARTERLY AND/OR ANNUAL REPORT ON THE CURRENT & SELECTED

NAME OF LGA..... QUARTER/YEAR.....

complete list of essential drugs
most important

MONTHS	QUANTITIES	Procaine-Penicillin C (vials of) 4 mega units	Chloroquine tablets (in thousands)	<i>Replace with</i>			
				PCBS Vaccine (Doses)	REG VACCINE (Doses)	DPT Vaccine (Doses)	Polio Vaccine
January	Received						
	Used						
	Balance						
February	Received						
	Used						
	Balance						
March	Received						
	Used						
	Balance						
April	Received						
	Used						
	Balance						
May	Received						
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June	Received						
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July	Received						
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August	Received						
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	Balance						
September	Received						
	Used						
	Balance						
October	Received						
	Used						
	Balance						
November	Received						
	Used						
	Balance						
December	Received						
	Used						
	Balance						

ANNUAL PERSONNEL RECORD AT A HEALTH UNIT

HEALTH UNIT..... NAME OF IGA..... YEAR.....

PERSONNEL	NUMBER <i>of MEMBERS</i>	
Doctors		
Nurses		
Midwives		
Environmental Health Staff		
Community Health Staff)	<i>expand to complete list</i>	
Pharmacy Staff		
Admin. and General		
Services Staff		
Trained TBAs		
Others		
TOTAL		

Officer-in-Charge

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ANNUAL REPORT ON HEALTH PERSONNEL IN THE IGA

NAME OF IGA..... YEAR.....

NUMBER BY CATEGORIES

W. R. D.	Health Units	Doctors	Nurses	Midwives	Environmental Health Staff	Community Health Staff	Pharmacy Staff	Admin. & Gen. Services Staff	Other TB's	Trained TB's	TOTAL
1											
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Expanded to complete list

Officer-in-Charge

ANNUAL REPORT ON HEALTH UNITS BEDS BY CATEGORY IN THE IGA

NAME OF IGA.....

YEAR.....

Wards	Health Unit	Number of Maternity Beds	Other Beds
1			
2			
3			
4			
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TOTAL FOR THE IGA			

officer-in-Charge.

22

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ANNUAL REPORT ON REVENUE (FOR RECURRENT EXPENDITURE) FOR IGA

NAME OF IGA.....

YEAR.....

AMOUNTS OF NIRA SOURCES							
Wards	Health Unit	IG Council Contribution	State Govt. Grant to IGA	Ministry of Health	State Health Management	Others	Total
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SAMPLE VBA RECORDING SYSTEM

ATTACHMENT 4:

Monthly Record of Work

Village _____ Month _____ Year _____

Name of P.H.C. Worker _____

No of children treated for malaria



○○○○ ○○○○ ○○○○
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○○○○ ○○○○

No of adults treated for malaria



○○○○ ○○○○ ○○○○ ○○○○
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No of children treated for diarrhoea



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No of adults treated for diarrhoea



○○○○ ○○○○ ○○○○ ○○○○
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○○○○ ○○○○ ○○○○ ○○○○

No of children treated for cough



○○○○ ○○○○ ○○○○
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○○○○ ○○○○ ○○○○
○○○○ ○○○○ ○○○○

No of adults treated for cough



○○○○ ○○○○ ○○○○ ○○○○
○○○○ ○○○○ ○○○○ ○○○○
○○○○ ○○○○ ○○○○ ○○○○

No. of persons with Wounds treated



00000 00000 00000
00000 00000 00000

No. of people treated for headache.



00000 00000
00000 00000

No. of adults treated for Backache



00000 00000 00000
00000 00000 00000
00000 00000 00000

No. of malnourished children treated



00000 00000
00000 00000

No. of children seen with measles



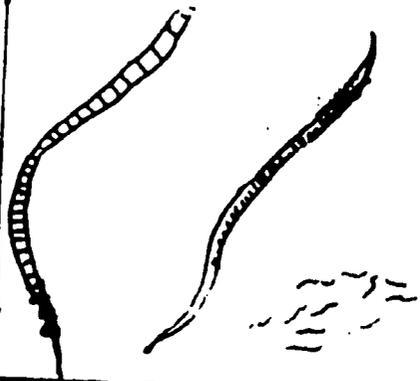
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No. of children seen with Vomiting.



00000 00000
00000 00000

No. of children seen for Worms



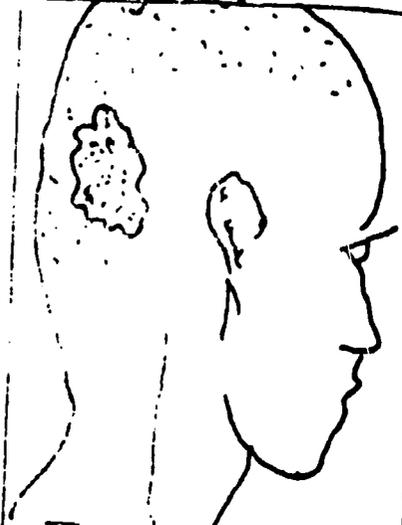
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No. of children treated for Scabies



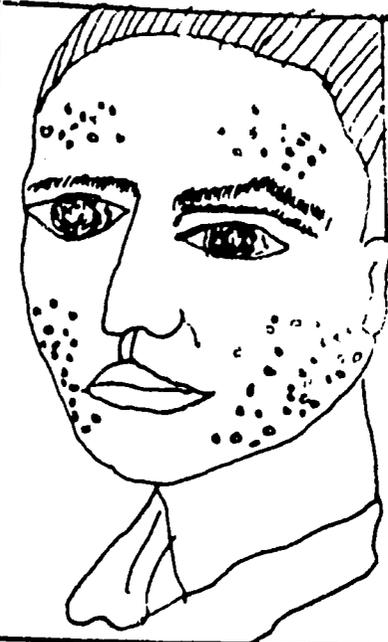
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No. of patients with ringworm



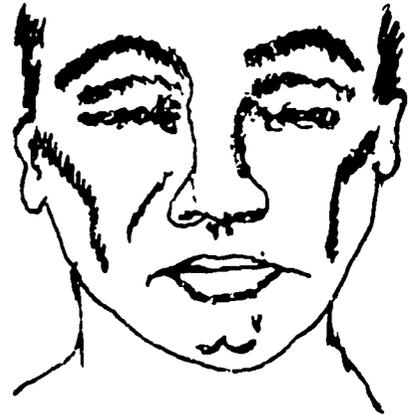
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No. of patients seen with septic spots



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No. of patients with eye infection



●●●●● ●●●●● ●●●●● ●●●●●
●●●●● ●●●●● ●●●●● ●●●●●
●●●●● ●●●●● ●●●●● ●●●●●
●●●●● ●●●●● ●●●●● ●●●●●

No. of births reported



●●●●● ●●●●● ●●●●● ●●●●●
●●●●● ●●●●●

No. of deaths reported



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No. of patients referred to health centre



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No. of Compound visits made

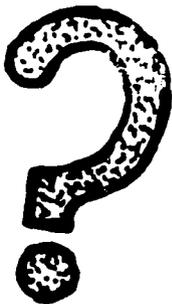


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No. of Village Committee meetings held



○ ○ ○ ○ ○
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Others

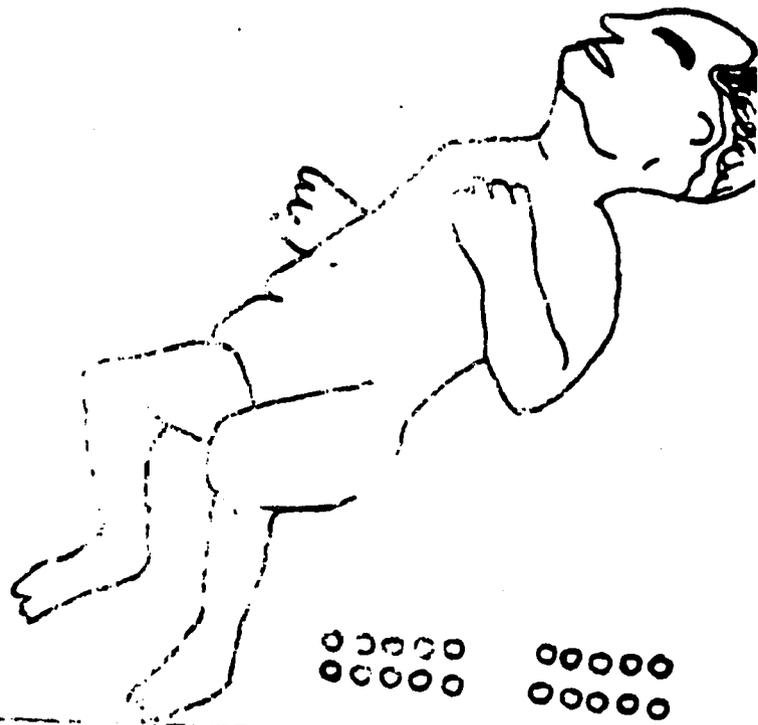
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NO OF CHILDREN SEEN WITH EAR CONDITION



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NO OF CHILD SEEN WITH STANDBY



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NO OF PREGNANT WOMEN SEEN



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○○○○○ ○○○○○

NO OF FAMILY PLANNING SEEN



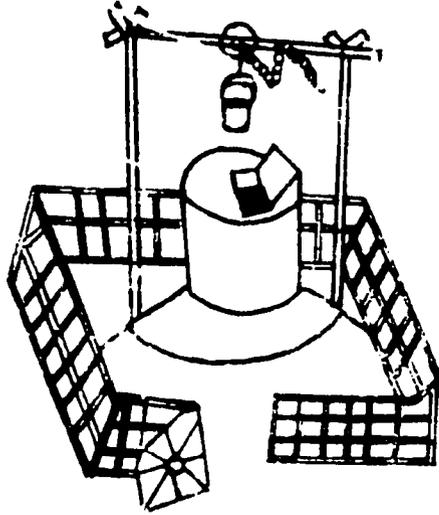
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NO OF BELLY PAIN SEEN



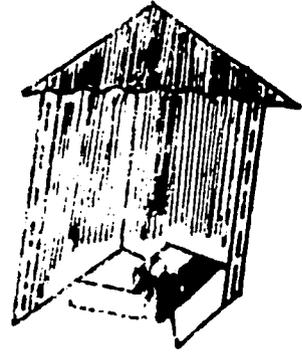
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NO OF WELLS PROTECTED



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NO OF LATRINES DUG



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