Monograph No. 4

The Field Health Services Information System

Its Role in Decentralizing Health Services in the Philippines

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The Field Health Services Information System

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Contents

Abbreviations used

BHS	Barangay Health Station
CDD	Control of Diarrheal Disease
DOH	Department of Health (Philippines)
EPI	Expanded Program for Immunization
FHSIS	Field Health Services Information System
HIS	Health Intelligence Service
I/FTR	Individual/Family Treatment Record
LGC	Local Government Code
LGO	Local Government Official/s
LGU	Local Government Unit/s
MCH	Maternal and Child Health
MW	Midwife
NCR	National Capital Region
OT	Output Table/s
PCO	PHO Computer Operator
PHN	Public Health Nurse
PHO	Provincial Health Office
RF	Reporting Forms; Reports/Forms
RCO	RHO Computer Operator
RHO	Regional Health Office
RHU	Rural Health Unit (Municipality)
SOT	Simplified Output Table/s
SumTab	Summary Table
TCL	Target Client List
USAID	United States Agency for International Development
WHO	World Health Organization

Introduction

*T*he Field Health Services Information System (FHSIS) is the only information system for public health operating throughout the Philippines today. Nowhere in the government system can one find an information system that reaches to the very roots of the political/social structure -- the barangays. It was implemented after considerable time spent studying the country's public health information requirements and thereafter studying and installing the system design and finally training its implementors and users.

Barely a year in full operation, the FHSIS had to contend with a development of national importance: the implementation of the Local Government Code (LGC), which devolved the management of public health facilities to the Local Government Units (LGUs).

Because FHSIS is facility-based, the LGC presented a new design consideration. However, because of the inherent strengths of the recording and reporting subsystems of the FHSIS, the system has been assessed as workable by the very people who must oversee it in the regions.

National information systems, it is said, settle down after five years. FHSIS is still in its infancy, and it is still in the process of adjustment and improvement. But because it is a system developed specifically for the local community, it is only right that in the process of adjustment and improvement, it adjusts and improves in the direction of effectively serving and promoting the devolution of health services.

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The FHSIS
in Perspective

*"The first attemps at putting together an information
system for the DOH began as a response to the need for
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*F*HSIS is the result of
the joint efforts of many
sectors within and
outside the Department
of Health (DOH). The
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burdensome, time-consuming,
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them from discharging their service
delivery functions fully. At least two
attempts were made between 1976 and
1982 to create an information system that would orchestrate all existing
reports, but neither of these attemps prospered beyond the design stage.

A health information system had been conceptualized in 1987 by the
World Health Organization (WHO). The present information system – the
FHSIS – was developed primarily because of a grant provided by the United
States Agency for International Development (USAID) to the WHO in 1988
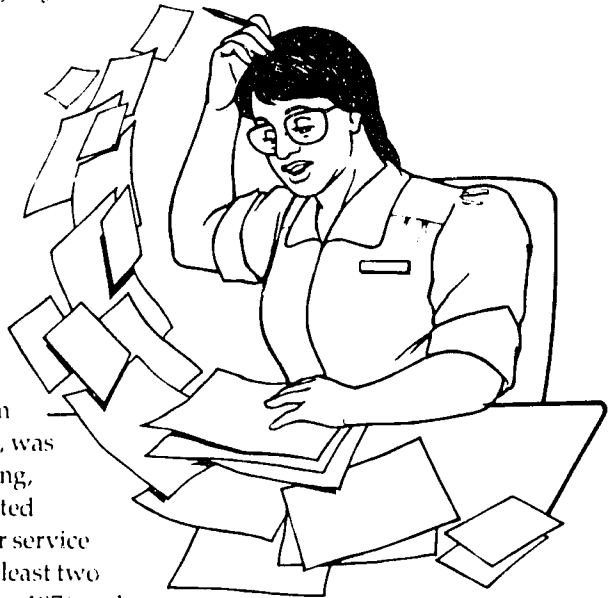
to continue what it had started. WHO consultants spent the whole year of 1988 conducting workshops among program areas, gathering health workers' information requirements, determining the readiness of midwives for the FHSIS, formatting and testing reporting forms, preparing the procedures manual, designing the training program, and pre-testing the system in Regions 4 and 7. By 1989, the manuals and forms had been revised and finalized; training sessions had been conducted for system implementors, which lasted until the middle of 1990); and the system was being implemented in five regions. Two years later, by April 1990, the system was operational in all regions except the National Capital Region (NCR). (Because of the urban setting and unique environment in the NCR, pre-testing had not been concluded at the time. Implementation of the system in the NCR finally took place in 1991.) The Department of Health, through the USAID Child Survival Program (CSP) grant, continued implementing the system in 1990 and, toward the latter half of the year, acquired the services of an advisor to assist the Health Intelligence Service (HIS) manage the system.

The FHSIS was conceived as a computer-based system from the start. An essential component was the development of computer programs for data entry, processing, and report generation, which started in late 1989. The resulting software was then installed in the provincial health offices (PHOs), which had been identified beforenand as the system's processing nodes. The installation of the software in the PHOs took place in 1991, although several versions of the software were made afterwards, between 1990 and 1992, to satisfy the requirements of the system. After the software has been installed, training sessions were conducted for computer operators. Since there were no official positions for computer operators in the PHOs, personnel identified for training were either pulled out from existing assignments or simply given additional duties. By mid-1991, most of the 75 provinces were able to produce their first computer-generated output tables (OTs).

Initial monitoring of the system was done in early 1991. The conclusion arrived at was that inspite of technical problems, the midwives appreciated the system, particularly in relation to their work that had to do with recording and reporting.

A memorandum issued in 1991 by the DOH Undersecretary and Chief of Staff is particularly relevant to the character and development of the FHSIS. Among other things, it pointed out that the FHSIS is the only reporting system sanctioned for all programs covered by the FHSIS, and that any changes in the system cannot be undertaken until after two years of its full nationwide implementation, which would be the year 1993.

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The FHSIS
and its components

*"There are five component
activities that together comprise
the FHSIS. These are recording,
reporting, data entry, processing,
and the production and
dissemination of output
tables."*

Objectives of the FHSIS

The FHSIS has the following
objectives:
* To provide summary data
  on health service delivery
  and selected program
  accomplishment
  indicators at the barangay,
  municipality/city, district,
  provincial, regional, and
  national levels;
* To provide data which,
  when combined with data
  from other sources, can be
  used for program monitoring
  and evaluation purposes;
* To provide a standardized,
  facility-level database which can be accessed for more in-depth studies;
* To ensure that the data reported are useful and accurate and are
  disseminated in a timely and easy fashion; and
* To minimize the burden of recording and reporting at the service delivery
  level in order to allow more time for patient care and promotive activities.
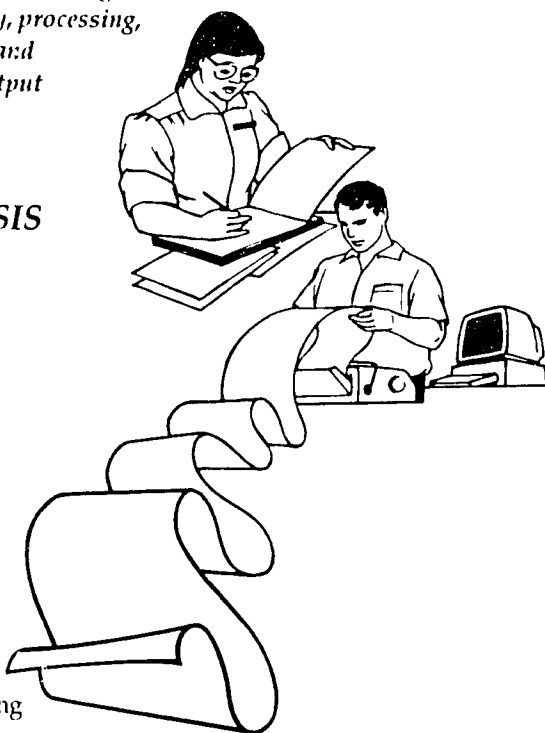
Programs covered by the FHSIS

The Department of Health has a network of information systems, and the FHSIS was conceived as a major component of this network. In particular, the FHSIS is a facility-based system designed to provide basic health-service delivery data for the following programs:

- Maternal and Child Health (MCH), which includes Pre-natal Care, Post-partum Care, Expanded Program on Immunization (EPI), and Control of Diarrheal Diseases (CDD)
- Nutrition
- Family Planning
- Tuberculosis
- Malaria Control
- Schistosomiasis Control
- Leprosy Control
- Dental Health
- Environmental Health
- Vital Statistics, which includes Natality, Mortality, and Population
- Notifiable Diseases
- Logistics

The component activities of the FHSIS

There are five component activities that together comprise the FHSIS. These are recording, reporting, data entry, processing, and the production and dissemination of output tables.

Recording

Two basic records are kept in the health facility: the Individual/Family Treatment Record (I/FTR) and the Target Client List (TCL).

The I/FTR documents the patient's consultation with the health personnel. It is a record of the patient's symptoms/complaints and the corresponding diagnoses, treatments, and dates of encounter with the health provider. Some programs have their own recording specifications, but each facility is encouraged to maintain a file for each individual/family as part of the system. The TCL, on the other hand, is a facility-based ledger which records health services rendered to specific patients (clients, "targets", or "eligibles") and as such serves several purposes:

1. To help the health service provider plan and carry out patient care and service delivery;
2. To facilitate the monitoring and supervision of service delivery activities;
3. To report services delivered;
4. To provide a clinic-level data base which can be accessed for further studies.

The client lists maintained by the health facility are :
1. Target Group List for EPI
2. Target/Client List for Children 0 to 59 months
3. Target/Client List for Nutrition
4. Client List for Prenatal Care
5. Client List for Postpartum Care
6. Client List for Family Planning (Non-surgical Methods)
7. List for TB Symptomatics
8. Client List for TB Cases under Short Course Chemotherapy (SCC)
9. Client List for TB Cases under Standard Regimen (SR)
10. Client List for Leprosy Cases

Specific instructions for recording data in the TCLs are found in the FHSIS Manual of Procedures.

Reporting

In the FHSIS, data and information are transmitted from one reporting unit to another primarily through the FHSIS reporting forms (RFs). Majority of the RFs are prepared and submitted either monthly or quarterly. There is one RF that is prepared weekly, there are several that are prepared annually, and a few that are prepared upon the occurence of specific events. In addition, the FHSIS RF also records services which are not "client"-specific and therefore cannot be found in the TCL. A list of the FHSIS RFs and their schedules of submission can be found in Annex A, together with a sample of some of the RFs.

The RFs have boxes for tallying the services that have been provided during the period for which the report is being prepared. This tally box facilitates the recording and transfer of accurate data. Complete guidelines for filling up the FHSIS RFs are found in the FHSIS Manual of Procedures.

RFs are filled up by all midwives (MWs) in the Barangay Health Stations

(BHSs). The data is then transferred onto a Summary Table (SumTab), which the Midwives keep on file in the BHS or health facility. These SumTabs comprise the database for the Midwives. Sample pages of the SumTab are found in Annex B. Finally, the Midwives submit their RFs to the Public Health Nurse (PHN) for validating and forwarding to the Provincial Health Office (PHO).

Data Entry and Processing

The PHO is the processing node of the FHSIS. It receives all the RFs from the rural health units (RHUs) of municipalities and from the city health offices (CHOs) of the component cities in the province, and a designated Provincial Computer Operator (PCO) in the PHO performs the data entry using DOH-developed software. The RFs submitted to the PHO serve as the source documents for data entry. When the PCO enters the data in the PHO computers, the newly-entered data automatically updates and consolidates all previous records of each public health program on a year-to-date basis.

The PCO submits soft copies (diskettes) to the Regional Health Office (RHO) for further consolidation and processing by the RHO Computer Operator (RCO). The CHO submits directly to the RHO.

Production and Dissemination of Output Tables

After all the data from all the RFs have been entered, the Provincial Computer Operator (PCO) produces the Output Tables (OTs) using computers and printers located in the Provincial Health Office or the City Health Office. Since the OT is the product of the software using current data, it is a mirror of all the data submitted by the different reporting units. In addition, it also includes calculations that are automatically made by the PHO computer, based on predetermined and pre-defined indicators.

Copies of the OT are given to all District Health Offices (DHOs) and Rural Health Units (RHUs) for the use of health managers in monitoring, supervision and administration. The RHO likewise produces consolidated OTs from the PHO diskettes for its own use in monitoring, supervision and management. Technical coordinators at both the PHO and RHO levels are also given copies of the OTs.

The FHSIS was originally intended to assist the health service delivery managers of the DOH. Because of the passage of the Local Government Code (LGC) in 1991 and the projection of its full implementation in 1993, the focus of the reporting system had to shift in part.

Under the LGC, the management and provision of health services was transferred to local government officials (LGOs). Consequently, the FHSIS now serves the LGO rather than the DOH. While the elements of the system remain basically unchanged, the whole system must now be viewed in a new way, keeping in mind that its primary user and implementor is now the LGO, with the DOH merely providing appropriate technical support.

Under the LGC, it has become more necessary than ever that the elements of the FHSIS all operate at the local government unit (LGU). Fortunately, the designers of the FHSIS gave primary importance to the design of the Target Client List (TCL), which has now become the principal data base at the LGU. With only minor modifications in the TCLs and RFs, reporting, processing and the production of reports can now take place at the LGU, sometimes even without involving computers at all.

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The FHSIS
and the LGO

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other concerns."*

The LGO and
health services for
the community

Under the Local Government Code, the responsibility for the management
and provision of health services to the community has shifted to the LGO. In
order to carry this out, the LGO must effectively address the following :
1. **availability** of services and manpower
2. **quality** of services and manpower
3. **readiness** of resources when needed.

The LGO may find it useful, if not necessary, to know the answers to the
following questions:
1. Who are the beneficiaries of the health services?
2. Where are they located?
3. What are the services that they need?
4. How much load can the midwife bear?
5. What resources support -- financial, in kind, transportation -- does he
    need to effect these services?

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The FHSIS provides the answers to these questions, and all the LGO has to do is use it.

The health situation in the community as shown by the TCL and the RFs

The Target Client List (TCL) is a veritable fixture of the barangay health station (BHS), invariably prominently displayed on a table. The TCL is a carefully tended document; it is in a sense the definitive document regarding the health situation in the community, and the midwives in particular are very much aware of how important it is. It is always carried in the midwife's kit and brought along during the her visits to her "targets" or "clients". Stories are told about the care that midwives have demonstrated towards the TCL, involving floods, fires, capsized bancas, runaway horses, etc.

The Target Client List (TCL) is in the form of a ledger that records all services, covering various health programs, that are rendered to specific persons, patients or clients. Services which are not client-specific are directly recorded in the tally/reporting form or RF. Indeed, it can truly be said that the TCL and the RFs are, together, comprehensive and faithful documents of the service history of the BHS. Specifically, the TCL contains a record of :
1. all pregnant women eligible for pre-natal care/service within the catchment area
2. all women delivering babies within the catchment area
3. all eligible men and women aged 15-49 receiving family-planning service provided by the reporting facility
4. all children from birth upwards eligible for immunization against the seven immunizable diseases
5. all children aged 0-59 months classified as health-risk children
6. all pre-school children 0-83 months diagnosed as second- or third-degree malnourished and risk-children in need of food/micronutrient supplementation
7. all symptomatics for tuberculosis falling under the definition made by the TB program and identified by health workers in consultations at the clinic and in visitations to the community/field
8. all leprosy cases from any source.

The RF is basically a data-transmission medium. However, some forms are practically extensions of the TCL because they record data that are not person- or client-based and are therefore not included in the TCL.

Examples of this are :
1. number of patients seen with an episode of diarrhea
2. number of stool specimen examined for schistosomiasis
3. number of malaria suspects identified
4. number of streams cleared and seeded, number of bioponds constructed, and number of houses sprayed for malaria
5. number of services, treatments, and consultations not recorded in the TCL or other RF
6. number of laboratory exams
7. number of births
8. number of maternal, neonatal and stillbirth deaths; number of deaths by age, sex and cause of death
9. population by age, sex; number of MCRA (married couple of reproductive age)
10. number of dental patients and services rendered
11. household survey on environmental sanitation
12. clinical information and laboratory results for sexually transmitted diseases.

It is really quite easy for the local governement official (LGO) to see the health situation of the community by examining the TCL and the RFs. Some examples of the kind of information that the LGO would be able to get are :
1. the **client base** of health services identified as individuals and also presented as demographic profiles
2. the **nature** and **capabilities** of the health services
3. the **quality** of health services
4. the **scope** and **volume of work** of the health worker, particularly the midwife
5. the geographic **reach** of the midwife (it is an established fact that a midwife visits all the barangays in her catchment area)
6. the **history** of services given to each client
7. the **quantity** of logistics and resources used.

In addition, there is the Summary Table (SumTab). Data in the TCL and the RFs are summarized in the SumTab, which stays in the health facility, be it a barangay health station, a rural health unit, a major health center in the city, or an outpatient department of a government hospital. The SumTab has twelve columns. Each column corresponds to one month of the year, and it contains a summary of all the data that the midwife submitted in the RF for that month. All the LGO needs to do in order to gauge the performance of

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the health facility within his area of responsibility is to study the SumTab. Of course, because the SumTab contains raw data, it requires further processing for the data to become meaningful information.

"...the LGO will... have to make a lot of major management decisions for which he will need other sources of information...
...the FHSIS can effectively reduce his work by half."

The TCL, the SumTab, and the SOTs

When an LGO visits the BHS, he will find that there are two documents there that together will be able to provide him with a wealth of information about the health situation in his community : the TCL, and the SumTab. The SumTab, which is the data base of the facility, will be able to provide him with raw data. This raw data can in turn be complemented by details that can be found in the TCL.

To round out his understanding of the SumTab data, the LGO can also refer to the SOT at the BHS. However, a better reference document for the LGO of the municipality would be the SOT prepared at the RHU rather than the SOT prepared at the BHS itself. This is because the data in the RHU SOT covers the whole municipality; therefore, it yields better indicators than the indicators in the BHS SOT. In the same manner, the better reference document for the provincial LGO would be the provincial SOT.

Information that can be found in the SOT include :
* year-to-date percent accomplishments of each program
* cumulative coverage of the "targets" or "clients" of each program in the community
* assessment of work to be finished for the remainder of the year
* number of births
* number of deaths and causes of deaths.

Armed with the above information, the LGO would be better equipped to deal with the three aspects of health service delivery that had been identified earlier : **availability** of services and manpower, **quality** of services and manpower, and **readiness** of resources when needed. More specifically, the LGO would be in a better position to answer the following questions :

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- Knowing how much more has to be covered and accomplished for the year, how can the LGU sustain or make available the services and manpower for this year and the succeeding years?
" Knowing what services to sustain or make available, how can the LGU ensure the quality of these services?
- What resources can the LGU make available to guarantee the quality of these services?

"A new challenge for health workers -- particularly the PHN and the MHO at the municipal level and the PHO and the program coordinators at the provincial level. -- now lies in helping the LGO appreciate and use the FHSIS."

It can only be expected that the LGO will have various other concerns and priorities. He will have to make a lot of major management decisions for which he will need other sources of information, other systems, other management tools. The FHSIS can effectively reduce his work by half.

It cannot be over-emphasized that the FHSIS is a an existing system that is immediately available to the LGO. He can use the system as it is, or he can adapt it to address his other concerns. As it is, the FHSIS already yields health indicators useful to the LGU, such as population, births, social hygiene, and causes of deaths. By adapting and expanding the FHSIS, it can become even more useful. For example, the SOTs can be expanded to include other concerns identified by the LGO. Or, other tables can be designed so that health indicators can be examined side by side with other LGU indicators such as financial indicators or indicators that have to do with materials, infrastructure, peace and order, and others.

Indeed, the LGO could even eventually conclude, and rightly so, that with the FHSIS alone he can get a good grasp of the health situation of the community that he is serving. A new challenge for health workers -- particularly the PHN and the MHO at the municipal level and the PHO and the program coordinators at the provincial level. -- now lies in helping the LGO appreciate and use the FHSIS.

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The FHSIS and devolution

"The FHSIS is an existing and working health information system that can help the LGO in the management and provision of health services in the community."

The FHSIS is an existing and working health information system that can help the LGO in the management and provision of health services in the community. The system -- the FHSIS -- and the tools -- the TCL, the RFs, and the SumTab -- are at the the LGO's disposal and it is up to him to either use them or adapt them.

In order to make the FHSIS adapt to the changes brought about by the Local Government Code, the FHSIS technical staff formed study teams and undertook activities aimed at improving, simplifying, and making the system more responsive and relevant to devolution. The direction of study followed two tracks: the outputs of the system and the architecture of the linkages.

Improving and Simplifying the Output Tables

If FHSIS were a television set, the Output Tables (OTs) would be the images on the screen. The OTs are the tangible and usable elements of the system that enable the users to grasp the information that the system offers.

However, there were a couple of problems with the production of the OTs. First, the OTs were not available in many provinces for a long time because of the inability of the computers to produce them. Second, for those provinces that were fortunate enough to produce the OTs, the users found the OTs forbidding, intimidating, and generally not user-friendly. Filled with long tables and numerous columns in very small print, the OTs were really intended to help health workers in provinces, cities, municipalities and barangays analyze their operations and thereafter take action to improve service delivery, supervision, monitoring and evaluation. It might have helped if the OTs had first been produced and disseminated to all districts and RHUs just to get feedback for the reporting system.

The Health Intelligence Service (HIS) technical team worked towards improving the OTs with these two problems in mind. The team focused on two objectives: to simplify and shorten the tables as much as possible, and to make the OTs generally more user-friendly. There was actually a third objective, which was to reduce the over-dependence on computers in the production of the OTs. As it turned out, this third objective was met in the course of attaining the first two objectives.

Since the OTs are program-oriented, it was the program managers that the HIS team primarily worked with. The HIS team asked the program managers to aim towards reducing the OTs to eight columns or less, and this meant drastically reducing their information requirements. It took a series of negotiations to design a simpler output table for each program, but in the end it all resulted in what are now called Simplified Output Tables or SOTs. It must be noted that this time, in the process of designing the SOTs, the requirements of the LGUs were taken into account.

The SOTs now average ten columns, and the text is printed in big bold letters. The SOTs were also designed so that each one can fit into one page measuring 8.5 by 11 inches, which are the dimensions of a sheet of standard short-size bond paper. Furthermore, the SOTs do not have to be generated or printed by a computer. When the SOTs were shown to the PHOs in late 1992, the unanimous agreement was that the SOTs are now indeed simpler and more user-friendly, and that there was every reason to expect that they will also appeal to the LGOs who will be the direct users of the system under devolution.

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Because the SOTs are simpler, more user-friendly, and do not have to be produced by a computer, the midwife can, on her own, compute her facility's service indicators by simply following procedural instructions. For instance, since the TCL and the RFs provide the year-to-date number of pregnant women attended to and also the target number of pregnant "clients" for the year, the midwife can very well compute her year-to-date accomplishment indicator for visitations to the pregnant population. The midwife can also do this for the rest of the SOT. It must be noted, however, that some indicators should not be computed for the barangay alone. There are some indicators that are only meaningful when computed for the whole municipality, or for a cluster of municipalities, or for the entire province.

"...user-friendly non-computerized SOTs and the concept of information processing capability at the municipal level go hand in hand very well."

Samples of the Simplified Output Tables can be found in Annex D.

The Linkages of the System

There remains the other direction of study that the HIS team decided to follow at the start : the linkages of the system. The team concluded that under devolution, the responsibility and initiative for using the system has shifted from the health program manager to the LGO, and that it is now up to the LGU to use the data generated by the FHSIS for its own decision making process.

Nevertheless, it is heartening to note at this point that the SOTs were so designed that they do not fall short of the still changing requirements that are part of the consequences of devolution. For example, the capability to process information -- not necessarily computer processing -- is no longer a preserve of levels above the municipality, such as the province. In fact, user-friendly non-computerized SOTs and the concept of information processing capability at the municipal level go hand in hand very well.

5

The FHSIS , APBHP, and other DOH technologies

"...there are other technologies aside from the FHSIS that have been developed by the DOH that can also be very useful to the LGO."

T he FHSIS is a facility-based system, and data generated by the system mostly comes from public health facilities, notably the BHS and the RHU. The LGO is in a position to extend the reach of the system by including data from private or non-government units, clinics, and institutions rendering the same services as the BHS and the RHU, and as a result get an even better picture of the state of public health in the community, or for that matter, the status of any specific program in the community. In addition, the LGO can also ask for the assistance of the Health Intelligence Service (HIS) of the DOH. Finally, there are other technologies aside from the FHSIS that have been developed by the DOH that can also be very useful to the LGO.

The APBHP Methodology

One technology developed by the DOH that the LGO can also use is Area/Program-Based Health Planning (APBHP). APBHP is a planning methodology that is now extensively used by the DOH nationwide. Although APBHP was initially developed for health planning, the LGO can also apply its principles and processes to sectoral concerns other than health.

Decentralization is fundamental to APBHP, and it cannot but involve the active participation of all BHS, RHU and CHO health workers and, especially with devolution, the LGO. This was amply demonstrated just recently, during the last three years, when all provinces and cities used the APBHP methodology to produce health plans that passed quality standards.

APBHP relies heavily on a wide range of public health data, and it uses the FHSIS extensively. For one thing, APBHP considers preventable causes of mortality and morbidity top priorities; also, APBHP targets geographic units with low levels of coverage for key programs and programs with low performance ratings in the barangays. The database produced by the FHSIS

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is particularly useful, if not essential, for APBHP as a source of various information inputs such as causes of mortality and morbidity, prevalence and incidence rates, geographic data, program performance data, and others. Much, if not all, of this data can be gathered from the FHSIS -- the TCL, the RFs, the SumTabs and the SOTs.

"Decentralization is fundamental to APBHP, and it cannot but involve the active participation of all BHS, RHU and CHO health workers and, especially with devolution, the LGO."

Other Technologies

In addition to the FHSIS and APBHP, there are still other technologies developed by the DOH that can also be very useful to the LGO.

*   A geographic information system, which projects FHSIS data and other socio-economic-political data on a physical/geographic map of the community. This computer-based system is currently being pilot-tested in the province of Cebu and will soon be available to other LGUs.
*   An infectious disease surveillance system, which is linked with the DOH field epidemiology program. Every regional health office has a field epidemiology unit responsible for this system. The LGO can coordinate with this unit for any information on infectious diseases in his community. (FHSIS has a special form for reporting notifiable diseases.)
*   A hospital information system, which can be very useful to the provincial governor, especially since all government hospitals in the province now fall under his office.
*   Household surveys, which are conducted by the National Statistics Office in collaboration with the DOH.
*   Population-based surveys or rapid assessment surveys, which are conducted by the DOH on subject areas not covered by the FHSIS.
*   Surveys which are conducted to validate FHSIS data.

All these technologies involve data-generation activities in which the LGO can actively participate whenever they occur within his LGU. The results of the data-generation activities of these technologies can be very useful to the LGO in his decision-making, just like the SOTs and the other elements of the FHSIS.

■

Annex A

Sample pages of aTarget Client List (TCL) ledger

CLIENT LIST FOR

ADDRESS (4)	AGE (5)	LMP/G-P (6)	EDC (7)	PRE-NATAL VISITS (DATE) (8)			RISK CODE/ DATE DETECTED (9)
				FIRST TRIMESTER	SECOND TRIMESTER	THIRD TRIMESTER	

PRE-NATAL CARE

TETANUS STATUS DATE (RECEIVED) (10)	TT IMMUNI- ZATION GIVEN (11)	ELIGIBLE FOR (12)	FOOD & MICRONUTRIENT SUPPLEMENTATION (13)				PREGNANCY (14)			LIVE BIR (15)
			TFAP	OTHER FOOD SOURCE	IRON	IODINE	DATE TERMI- NATED	OUTCOME	BIRTH WEIGHT	PLACE C DELIVER

CLIENT LIST FOR FAMILY PLANNING

ENT'S NAME (3)	ADDRESS (4)	METHOD ACCEPTED (5)	TYPE OF CLIENT (6)	PREVIOUS METHOD (7)	1	2

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Annex B

List of FHSIS Reports/Forms (RFs)

Upon occurrence of event
FHSIS/E-1   Notification of Death Form
FHSIS/E-2   Maternal Death Report
FHSIS/E-3   Perinatal Death Report

Weekly
FHSIS/W-1   Weekly Report of Notifiable Diseases

Monthly
FHSIS/M-1   Monthly Field Health Services Activity Report
FHSIS/M-2   Monthly Natality Report
FHSIS/M-3   Monthly Mortality Report
FHSIS/M-4   Monthly Laboratory Report
FHSIS/M-5   Monthly Dental Health Service Report
FHSIS/M-6   Family Planning Subsidized Surgical Procedure Report
FHSIS/M-7   Monthly Social Hygiene Clinic Activity Report

Quarterly
FHSIS/Q-1   Quarterly Field Health Services Activity Report
FHSIS/Q-2   Quarterly Dental Facility Inspection Report
FHSIS/Q-3   Quarterly Report of Environmental Health Activities
FHSIS/Q-4   Quarterly Report of Malaria Control Activities
FHSIS/Q-5   Drugs and Supplies Quarterly Status Report
FHSIS/Q-6   Laboratory Supplies Quarterly Status Report

Annual
FHSIS/A-1   Annual Catchment Area OPT Tally Sheet & Summary Report
FHSIS/A-1   Annual Catchment Area Population Survey Form
FHSIS/A-2   Annual Catchment Area Population Summary Report
FHSIS/A-2   Annual Catchment Area OPT Form
FHSIS/A-3   Annual Household Environmental Sanitation Report
FHSIS/A-3   Annual Environmental Household Survey Form
FHSIS/A-4   Annual Nutrition Report: Food Supplementation

Annex B

Samples of FHSIS Reports/Forms (RFs)

DEPARTMENT OF HEALTH   FORM FHSIS/M-1
MONTHLY FIELD HEALTH SERVICE ACTIVITY REPORT

Indicate Name   Code

PROVINCE :   Month   Year

CITY :

Check (✓) only one box, indicate name and enter corresponding code(s).

☐ BHS/BHC :   ☐ DH/CH :

Catch RHU/MHC :   ☐ PH/CHO :

☐ RHU/MHC :   ☐ RH :

Section 1 - PRE-NATAL CARE

1. Pre-natal visits by type of pregnancy (normal, risk, risk referred),
   trimester and visit number.

TRI-MESTER	NORMAL			RISK			RISK REFERRED		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
1st Visit									
2nd Visit									
3rd Visit									
4th or More Visits									

2. Tetanus toxoid
   TT1

3. Number of pre
   IRON SUPP

FORM FHSIS/M-1

☐ RN   ☐ PH/CHO   ☐ DH/CH   ☐ RHU/MHC   ☐ BHS/BHC

Section 2 - POST PARTUM CARE

1. Number of post-partum home visits made
   this month

2. Number of women reaching 6 weeks post-
   partum this month

3. Number of women receiving at least one
   post-partum home visit this month

4. Number of women who have initiated
   breastfeeding this month

5. Number of mothers eligible and those receiving this month -

	TFAP	OFS	VIT. A	IRON
Eligible				
Receiving				

Annex C

Sample pages of a Summary Table (SumTab)

FHSIS SUMMARY REPORT

NUM CARE	TARGET	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	TOTAL	% CG
noire visit															
are postpartum vis															
ted breastfeeding															
4P / Q1 5															
on-in A															
I'															
Q A															
in 4 - 6 wks Se															
s PP															
aving had all															

FHSIS SUMMARY REPORT

FACILITY

EPI	TARGET	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	TOTAL	% CG
1 Yes															
Other Ages															
1 Year															
Other Ages															
1 Year															
Other Ages															
1 Year															
Other Ages															
1 Year															
Other Ages															
2 1 Year															
Other Ages															
1 Year															
Other Ages															
ES 1 Year															
Other Ages															
of children 1 year															
pletely immunized															
chool Entrance immunized															
even this month															
of children reaching their															
birthday this month															
of tildren reaching															
first birthday this															
fur, immunized															

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FHSIS SUMMARY REPORT

Annex D

Samples of Simplified Output Tables (SOTs)

PRE-NATAL ACCOMPLISHMENT REPORT						
		(Region or Name of Province or Municipality)				
AREA	POPULATION OF PREGNANT WOMEN	PREGNANT WOMEN SEEN (1ST VISIT)		% OF 1ST VISITS IN THE 1ST SEMESTER OF PREGNANCY		PRE SEE PF
		NUMBER YTD	% ACCOMP YTD Col 3 Col 2	NUMBER YTD	% ACCOMP YTD Col 5 Col 3	NUMBE YTD
	TP · 35					
(1)	(2)	(3)	(4)	(5)	(6)	(7

			(Region or Name of Province or Municipality)			QUARTER	
PREGNANT WOMEN SEEN (1ST VISIT)		% OF 1ST VISITS IN THE 1ST SEMESTER OF PREGNANCY		PREGNANT WOMEN SEEN ON THEIR 3RD PRE-NATAL VISIT		PREGNANT WOMEN WHO HAVE TT2+ IMMUNIZATION	
NUMBER YTD	% ACCOMP YTD Col 3 Col 2	NUMBER YTD	% ACCOMP YTD Col 5 Col 3	NUMBER YTD	% ACCOMP YTD Col 7 Col 2	NUMBER YTD	% ACCOMP YTD Col 9 Col 2
(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)

E.P.I. ACCOMPLISHMENT REPORT

(Region or Name of Province or Municipality)

AREA	IMMUNIZATION GIVEN TO OTHER AGES				CHILDREN OVER 1 YR COMPLETELY IMMUNIZED	BCG SCHO ENTRAN GIVEN IMMUNIZATIO
	BCG	DPT3	OPV3	MEASLES		
	NO YTD	NO YTD	NO YTD	NO YTD	NO YTD	NO YTD
(1)	(2)	(3)	(4)	(5)	(6)	(7)

(Region or Name of Province or Municipality)　　　　　___QUARTER__

MUNIZATION GIVEN TO OTHER AGES			CHILDREN OVER 1 YR COMPLETELY IMMUNIZED	BCG SCHOOL ENTRANTS GIVEN IMMUNIZATION	CHILDREN 0-1 GIVEN HEPA B3 IMMUNIZATION	CHILDREN 0-1 GIVEN VIT. A DURING MEASLES IMMUNIZATION
DPT3	OPV3	MEASLES				
YTD	NO YTD	NO YTD	NO YTD	NO YTD	NO YTD	NO YTD
3)	(4)	(5)	(6)	(7)	(8)	(9)