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**HEALTH MANAGEMENT INFORMATION SYSTEM  
FOR FIRST LEVEL CARE FACILITIES**

**INSTRUCTION MANUAL**  
For First Level Care Facility Staff

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**Government of Pakistan**  
Ministry of Health, Special Education and  
Social Welfare (Health Division)  
Feroz Centre, 14-D West, Blue Area, Islamabad

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*All names used in the examples of the manual are fictitious and are by no means based on patient records.*

*This manual is intended for all first level care facilities in Pakistan, and should remain in the health institution as a reference manual for the staff.*

**NOVEMBER 1992**

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## LIST OF ABBREVIATIONS

ADHO	Assistant District Health Officer
ADP	Annual Development Plan
AFB	Acid Fast Bacilli
AIDS	Acquired Immune Deficiency Syndrome
AJK	Azad Jammu and Kashmir
ARI	Acute Respiratory Infection
BHS	Basic Health Services
BHU	Basic Health Unit
CA	Catchment Area
CD	Civil Dispensary
CDC	Communicable Diseases Control
CHW	Community Health Worker
CIDA	Canadian International Development Agency
COs	Commanding Officers
CRP	Central Registration Point
DCP	District Coverage Plan
DHO	District Health Officer
DHQH	District Headquarter Hospital
EDD	Expected Date of Delivery
EPI	Expanded Programme on Immunization
FAP	First Aid Post
FHT	Female Health Technician
FLCF	First Level Care Facilities
HG	Haemoglobin
HIS	Health Information System
HMIS	Health Management Information System
HT	Health Technician
I/C	Incharge
IDD	Iodine Deficiency Diseases
IUCD	Intra Uterine Contraceptive Device
LC	Leprosy Centre
LHV	Lady Health Visitor
LMP	Last Menstrual Period
MCH	Maternal and Child Health
MMO	Male Medical Officer
MOIC	Medical Officer Incharge
MS	Medical Superintendent
MSD	Medical Store Department
MW	Midwife
NA	Northern Areas
NCHS	National Center for Health Statistics (USA)
NWFP	North West Frontier Province
OPD	Out-Patient Department
ORS	Oral Rehydration Salt

ORT	Oral Rehydration Therapy
PCSP	Pakistan Child Survival Project
PHC	Primary Health Care
RHC	Rurai Health Centre
RLCF	Referral Level Care Facility
SHC	Sub-Health Centre
SOs / SAs	Statistical Officers / Statistical Assistants
TB	Tuberculosis
TBA	Traditional Birth Attendant
TBC	Tuberculosis Centre
TB1	Thiacetazone
THQH	Tehsil Headquarter Hospital
TT	Tetanus Toxoid
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
WFP	World Food Programme
WHO	World Health Organization
WMO	Woman Medical Officer

# INTRODUCTION

This Instruction Manual has been published as a guide to the staff of the government managed first level care facilities in Pakistan, to help them use the Health Management Information System for First Level Care Facilities (HMIS/FLCF).

## A. Historical Overview

The improvement of existing health information systems is a major national strategy for the development of primary health care based service delivery systems in the country. A National Workshop on Health Management Information Systems was therefore held in Islamabad in May 1991 based on a comprehensive assessment study performed by the Health Information System (HIS) team of the Pakistan Child Survival Project (PCSP). One of the outcomes of the workshop was an agreement between the federal and provincial health officials to transform the existing routine reporting system for government managed First Level Care Facilities (FLCF) into a comprehensive and integrated Health Management Information System (HMIS). Priority was given to first level care facilities because they are the principal level for the delivery of child survival related services.

The Basic Health Services Cell of the Federal Ministry of Health, assisted by the Health Information System team from PCSP, received the mandate to coordinate the restructuring process of this **Health Management Information System for First Level Care Facilities**.

Between June 1991 and July 1992, the HMIS/FLCF design was finalized with active involvement of the future users of the system. National Programme managers, Provincial Directors, District Health Officers, Medical Officers in Charge, and representatives of the paramedical staff were consulted through the organization of workshops and meetings.

Starting from the actual functions of the first level care facilities, indicators were chosen for inclusion in the HMIS/FLCF. Data collection procedures, information flows, and data processing mechanisms were defined. Outdated data collection instruments were abolished, and new instruments were designed and field tested.

Data processing for the new system has been computerized at provincial, divisional, and, on an experimental basis, at district levels.

The overall HMIS/FLCF structure and the data collection instruments have been approved by the Federal Ministry of Health and by the Provincial Health Departments during two National HMIS Workshops, held in Islamabad in January and in July 1992.

## B. HMIS/FLCF Structure

### 1. Indicators

Indicators for the HMIS/FLCF are based upon actual functions and activities performed by personnel of first level care facilities and their supervisors. They are intended to help public health workers at all levels in the health services to make appropriate planning and management decisions. A complete list is given in Appendix I.

## 2. Data Collection Procedures

Data collection procedures have been reviewed at each management level of the health services, taking into account the selected indicators. A final list of data collection instruments is given in Appendix 2.

### a) Population Data Collection

For each district, a District Coverage Plan (DCP) has been developed which defines a catchment area around each first level care facility. The population living in this catchment area is the denominator in the calculation of morbidity/mortality rates, and of coverage for the services provided by the health institution: e.g. prenatal care, vaccinations, etc.

### b) Patient/Client Record Cards

The following Patient/Client Record Cards have been approved. Some of them existed and have been redesigned. Others were newly created:

1. OPD Ticket
2. Referral Form
3. Mother and Child Health Card
4. Family Planning Card
5. Investigation Request Form
6. TB Facility Card
7. TB Patient Card
8. Chronic Disease Facility Card
9. Chronic Disease Patient Card
10. Immunization Card (format unchanged)
11. IDD Card (format unchanged)

### c) Facility Record Keeping System

A serious effort has been undertaken to reduce the existing number of facility based registers. From an estimated 40 registers, only 19 were approved and developed in a final format:

#### SERVICE DELIVERY REGISTERS/CHARTS:

1. OPD Register
2. Abstract Register for priority diseases
3. Child Health Register
4. Mother Health Register
5. Family Planning Register
6. TB Register
7. IDD Register
8. Laboratory Register
9. Daily EPI Register (format unchanged)
10. Permanent EPI Register (format unchanged)

## ADMINISTRATIVE REGISTERS/CHARTS:

11. Population Chart of Catchment Area
12. Birth Register
13. Stock Register: Medicines/Supplies
14. Stock Register: Equipment/Furniture/Linen
15. Meeting Register
16. Daily Expense Register
17. Attendance Register (format unchanged)
18. Log Book (format unchanged)
19. Stock Register: Vaccines (format unchanged)

### d) Facility Reports

Most importantly, the reporting system has been substantially simplified. All programmatic reports have been abolished and are replaced by three comprehensive reports:

1. Immediate Report for Epidemic Diseases
2. Monthly Report
3. Yearly Report

### 3. Report Transmission and Data Processing System

All reports are to be transmitted through regular line management channels: from First Level Care Facility to district, then to division, to province, and to federal levels. Time-tables for transmission have been agreed upon (see Module 3).

All data processing is computerized, in an initial stage at provincial and at divisional levels, ultimately also at district levels.

### 4. Feedback Mechanisms

Personnel of FLCFs and their supervisors are encouraged to use the data collected on an immediate basis for management of the health facilities:

- Keep copies of Monthly and Annual Reports at the facility level.
- Graphic displays of trends in key indicators.
- Action oriented Patient/Client Records

Standardized computerized feedback reports will be provided at all levels. Examples are:

- FLCF level: Yearly Summary Report
- District and divisional level: Monthly Report comparing performance of FLCFs, Yearly Summary Report
- Provincial Level: Program specific reports, Statistical Yearbook
- Federal Level: Program specific reports, Planning reports, Statistical Yearbook.

M O D U L E 1

# **Data Recording**

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## **Chapter I**

# **GENERAL INSTRUCTIONS**

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### **A. GENERAL DEFINITIONS**

#### **1. Health Institution**

Any institution where health care is provided. Health institutions can be further divided in **first level care facilities** and in **referral level care facilities**.

#### **2. First Level Care Facilities (FLCF)**

Health institutions where first contact between the patient and the professional health care providers take place.

They include: Rural Health Centers (RHCs), Basic Health Units (BHUs), Sub-Health Centers, Dispensaries, MCH Centers, and Out Patient Departments (OPDs) of hospitals.

#### **3. Referral Level Care Facilities (RLCF)**

Health institutions where a patient is referred from a first level care facility because the care needed was not available at the first level (specialized care or in patient care).

Referral Level Care Facilities are mostly hospitals (civil, municipal, tehsil/taluka, district, provincial, teaching). Sometimes a patient has to be referred to an RHC or even a BHU, because not all routine first level care services ("minimum package") are available in all first level care facilities (e.g. routine dental care, routine eye care, family planning, etc.).

#### **4. Central Registration Point (CRP)**

In FLCFs where several care activities are provided simultaneously, a Central Registration Point (CRP) is located at the entry of the facility. A receptionist (clerk, dispenser, etc.) will guide patients to the appropriate care provider. This

receptionist will eventually provide the patient/client with a patient/client record card, and also cash the "purchee" fee.

### 5. Care Provider

A care provider is any person providing directly curative or preventive care to a patient/client.

Mostly **care providers for curative care** are medical officers or qualified paramedics. Sometimes they are dispensers.

**Care providers for preventive care** are medical officers, qualified paramedics, vaccinators, CDC supervisors, and dispensers.

6. **Patient** Used for person seeking curative care

7. **Client** Used for person seeking preventive care

### 8. Month

Means calendar month, starting the first day and ending the last day. Recording therefore starts the first day of the month and ends the last day of the month.

Data reported in the monthly FLCF report were recorded within the same month.

### 9. Age

For curative activities as well as for preventive activities, patients/clients seen are classified according to standard age categories. Age categories to be recorded are specified in the instructions specific to each register.

Especially for children, exact age is not always known. In order to determine age as precisely as possible, the following guidelines helpful:

- Refer to the local calendar (political events, local cultural events, religious holidays)
- For children below 3 count the number of teeth:
  - No teeth: child probably below 6 months
  - Number of teeth + 6 = approximate number of months

For example:

4 teeth = child of 4 + 6 = 10 months

## 10. Address

Specify village in rural areas.

Address should be as precise as possible in the Child and Mother Health Register and on the Tuberculosis Facility Card, so that home visits could eventually be performed to defaulters.

## 11. Tally System

For tallying, the following system is used:

- Each item is noted with one vertical line
- The fifth item is noted with a line crossing the preceding four vertical lines.

For example:

  $\text{||||} \text{|||} = 8$

## B. PATIENT/CLIENT FLOW IN A FIRST LEVEL CARE FACILITY

Upon arrival at the health facility a patient is received at the Central Registration Point (CRP), except in facilities (dispensaries or sub-health centers) where mostly only one person is dispensing only curative care.

Figure 1 gives an overview of possible routings that patient/clients can follow based on the age and sex of the patient/client, and on his/her initial demand for care:

### ➤ *At the Central Registration Point (CRP)*

In health institutions with only one person dispensing care, the following instructions for the receptionist at the CRP will be applicable to the health care provider.

After having cashed the appropriate fees, the receptionist guides the patients to the appropriate care provider according to age and sex. In case the patient needs urgent medical attention, the receptionist will himself guide the patient immediately into the room of the appropriate care provider.

#### 1. Male patient of three years and more:

If the patient/client comes for a preventive visit, the receptionist will direct him to the appropriate preventive care provider if available (e.g. Vaccinator, Family Welfare Worker).

If the patient/client comes for a curative visit, he determines if the patient is a new case or an old case.

- For a new case, an Outdoor Patient's Ticket will be issued. He then directs the patient to the curative care provider.
- For an old case, the patient is directed to the curative care provider who saw him before, or to the care provider that handles the OPD Register, where the patient was recorded as a new case.

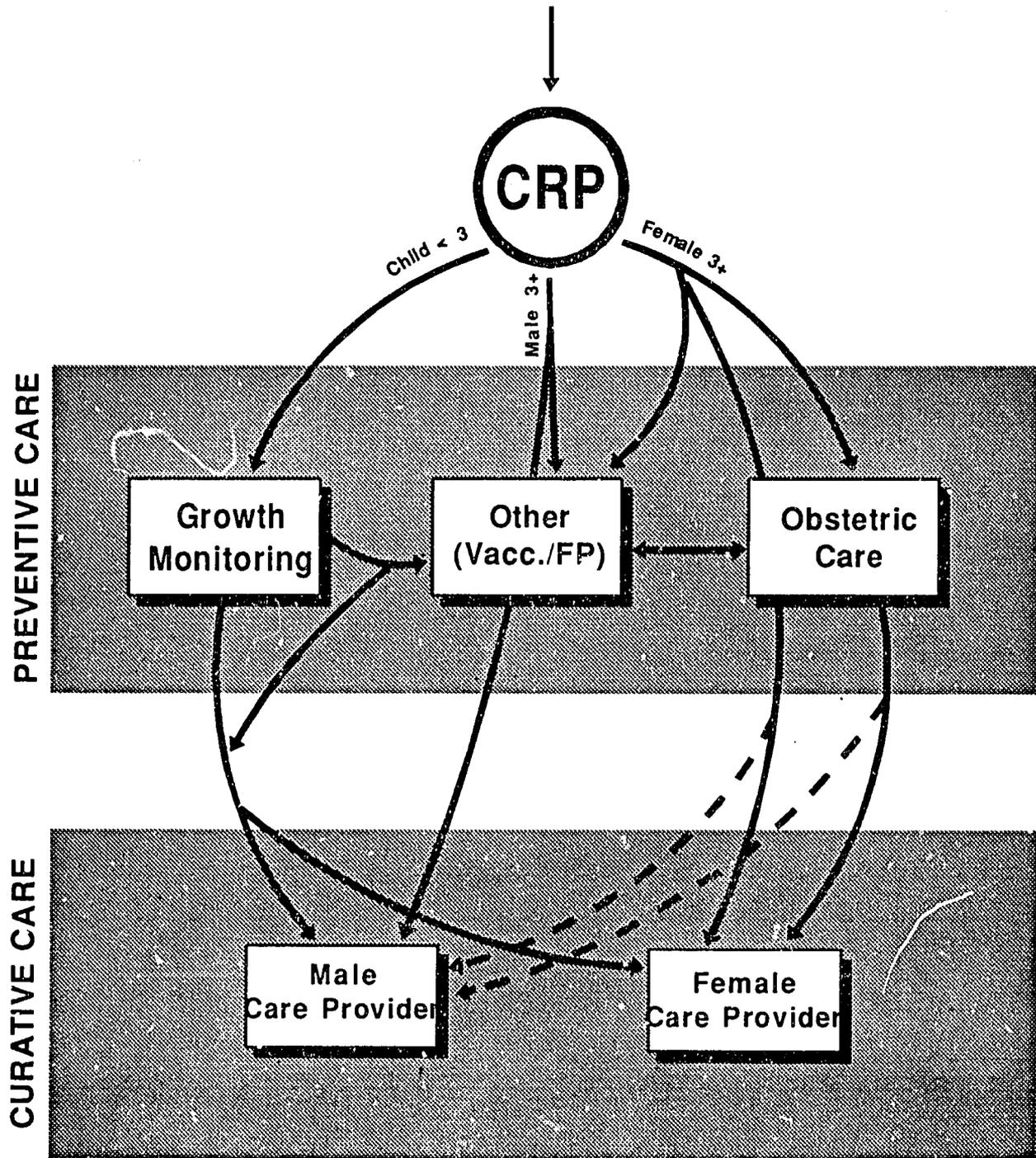
#### 2. Female patient of three years and more:

##### **ALWAYS**

Guide to female care provider if available; to male care provider if no female care provider is available.

# FIGURE 1

## PATIENT/CLIENT FLOW IN FIRST LEVEL CARE FACILITY



If the patient/client comes for a preventive visit, the receptionist will direct her to the appropriate preventive care provider if available (e.g. Lady Health Visitor or Women Medical Officer if pregnancy).

If the patient/client comes for a curative visit, he determines if the patient is a new case or an old case.

- For a new case, an Outdoor Patient's Ticket will be issued. He then directs the patient to the curative care provider.
- For an old case, the patient is directed to the curative care provider who saw her before, or to the care provider that handles the OPD Register, where the patient was recorded as a new case.

3. Child under three years:

**ALWAYS**

- Ask if the child was registered for preventive child care.  
If yes, verify if the mother has brought the Mother and Child Health Card. If she has not brought it, tell her to do so the next time!
- Ask if the child was vaccinated through outreach activity.  
If yes, verify if the mother has brought the vaccination card. If she has not brought it, tell her to do so the next time!

In case of a visit of a child under three, for curative or for preventive care, the receptionist **ALWAYS** guides the mother and the child to the care provider(s) for preventive child care if available; to the care provider for curative care, if no separate care provider for preventive child care is available.

➤ ***At the Care Provider(s) for Preventive Child Care***

In facilities where no separate care provider for preventive care is available, the following instructions will be applicable to the curative care provider

If the child comes for the first time for care, the care provider(s) for preventive child care will issue a Mother and Child Health (MCH) card, and register the child in the Child Health Register. He then will perform the following tasks:

- Determine the age of the child;
- Weigh the child and plot its weight at the appropriate age column on the growth chart;
- Verify the immunization status of the child and offer appropriate vaccination on the spot, except if the condition of the child needs urgent attention of the curative care provider;
- Give appropriate advice and explanations to the parents;
- Give an appointment for the next visit

He records findings and actions taken on the MCH card and in the Child Health Register. If the child was brought for a curative problem, or if a curative problem was found, the preventive care provider guides mother and child to the curative care provider (if different).

➤ ***At the Care Provider(s) for Preventive Obstetrical Care***

In facilities where no separate care provider for preventive obstetrical care is available, the following instructions will be applicable to the curative care provider

If the mother comes for the first time for care, the care provider(s) for preventive obstetrical care will issue a Mother and Child Health (MCH) card, and register the mother in the Mother Health Register. She then will perform the necessary tasks related to the pregnancy follow-up and records findings and actions on the MCH card and in the Mother Health Register. She also gives an appointment for the next visit.

If a curative problem exists, the mother is then guided to the curative care provider, if this provider is different from the preventive care provider.

➤ ***At other Preventive Care Provider(s) (if available)***

Examples of other preventive care providers are Family Welfare Workers or Vaccinators

In facilities where no such care providers are available, the following instructions will be applicable to the other care providers.

The care provider issues the appropriate client card to the client and registers the client in the appropriate registers.

If a curative problem exists, the mother is then guided to the curative care provider, if this provider is different from the preventive care provider.

**➤ *At the Curative Care Provider***

The curative care provider takes the history and performs the physical examination of the patient. He records his findings on the Outdoor Patient's Ticket and on the OPD register.

If needed, he will also issue and fill in a Outpatient Investigation Request Form (see under 2) or a Referral Form (see under 3).

He will then explain to the patient the treatment prescribed and give appropriate counseling. If any additional care provider needs to be consulted, or if investigations need to be performed, he will explain the patient where to go.

For children under 3 and for pregnant women, he will give an appointment date for the next preventive visit.

For married men and women in child bearing age, he will counsel on family planning on appropriate times, and offer an appointment for service.

## Chapter II

# ***CURATIVE CONSULTATIONS (Acute Episodes)***

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During curative consultations the following instruments are used:

1. Outdoor Patient's Ticket (OPD Ticket)
2. Outpatient Investigation Request Form
3. Referral Form
4. Outdoor Patient Register (OPD Register)
5. Abstract Register Priority Diseases
6. Laboratory Register

For each of these instruments a detailed set of instructions is given in this chapter.

### **DEFINITIONS**

---

- New Case**      A patient who visits the FLCF for a new episode of illness.

**NOTE:**

A patient, without being referred, seeking care for an episode of illness for which he has already been registered in another FLCF, will be registered again as a new case (in order to ensure continuity of care).

- Old Case**      A patient already registered as a new case of a particular illness, who visits the facility for the same illness, because he needs additional care

- Referred Case** A patient, new case or old case, for which solution of his health problem requires referral to a secondary or tertiary health facility, or for which the necessary first level care service is not available in the FLCF where he visits.

**NOTE:**

1. Patients sent to another facility for laboratory or x-ray examination are not considered as referred cases.
  2. At the referral health facility, a referred case is considered as a new case.
-

## 1. OUTDOOR PATIENT'S TICKET (OPD TICKET)

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**Purpose** To ensure continuity of care for acute episodes of illness

### Features

Maintained By	<ul style="list-style-type: none"> <li>■ Receptionist at CRP for identification data</li> <li>■ Care provider (physician, paramedic) for Yearly OPD No and for clinical data</li> </ul>
Data Origin	Patients visiting the health facility for a curative problem
Location	Patient retained
Initial Recording	For each new episode of illness
Updating	Subsequent visits until end of episode

**Definitions** No specific definitions

### Instructions For Filling In (see model)

An OPD Ticket will be issued to each **new case** of a particular health problem.

For old cases the OPD ticket that was issued earlier is used to record further information. If the patient lost the OPD ticket, another OPD ticket can be issued (preferentially with the same OPD number if it can be found in the OPD register).

In health facilities where several care activities are provided simultaneously, the OPD ticket will be issued at the CRP.

In facilities (dispensaries or sub-health centers) where mostly only one person is dispensing only curative care, the care provider himself issues the OPD ticket.

### ► *Recording of a New Case*

Institution/ District	Put stamp of the institution or fill in.
--------------------------	--

(FC1)

## OUT-DOOR PATIENT'S TICKET

Institution: <u>BHU Mirpur</u>
District: <u>Duella</u>

Yearly OPD No. <u>5432/92</u>
----------------------------------

Name: Tariq Hamid  
 Father's/Husband's Name: Hamid Jan  
 Age: 13m Sex: M Address: Pasni  
 Health Problem / Diagnosis: Diarrhea with some dehydration  
 Patient Seen By: Dr. Aziz Ullah

Date(s)	History / Clinical Findings / Action Taken
9. Sep. 1992	Diarrhea since 3 days - No blood Sunken eyes - Skin pinch + weight 9.8 kg = N Rx ORS continue normal feeding.
11 Sep. 1992	Improved +H Weight 10.2 kg Rx Appointment for growth monitoring on Oct 11 92

Yearly  
OPD Number

The Yearly OPD Number is copied from the OPD register on the OPD ticket, adding the last two numbers of the current year:

For example:

135/92 = the 135th new case of 1992  
or 4567/93 = the 4567th case of 1993

In health facilities where several OPD registers are in use at the same time, the letter identifying the OPD register where the new case was registered should PRECEDE the serial number:

For example:

A/2456/92 = the 2456th case of 1992 in OPD register A  
or  
F/3465/93 = the 3465th case in 1993 in OPD register F

Name

Write the name of the patient.

Father's/  
Husband's name

Write the name of the father/husband as appropriate

Age

Write the age of the patient in years. For children under two, age should be written in months; for infants under 1 month, age should be written in days.

Sex

Fill in M for males and F for females

Address

Write briefly the address of the patient

Health problem /  
Diagnosis

Write here the content of column 16: Health problem/Diagnosis of the OPD register

Patient seen by

Write the name of the care provider who consulted the patient. If the patient returns for care, it will be easier to guide him to the same care provider.

Date(s)

Write the date of the visit

History /Clinical  
Findings/Action  
taken

Write a summary of the history, of the clinical findings, and of the action taken as recorded on the OPD register in column 19: Action Taken.

➤ ***Recording of an Old Case***

For an old case, further notes on the same episode of illness should be recorded ON THE SAME OPD ticket under **date** and **action taken**.

The OPD ticket can also be used on the back side if no place is available on the front side.

**IMPORTANT NOTE:**

For follow-up of chronic episodes of illness, do not use the Outdoor Patient's Ticket; use the Chronic Disease Facility and Patient Card (see under Chapter IV)

## 2. INVESTIGATION REQUEST FORM

---

**Purpose** To facilitate communication between the care provider and the laboratory/x-ray staff

### Features

Maintained By	<ul style="list-style-type: none"> <li>■ Care provider (physician, paramedic) for request;</li> <li>■ Laboratory or x-ray technician for results.</li> </ul>
Data Origin	Patient whose health problem needs laboratory or x-ray investigation
Location	Patient retained

### Definitions

Internal	The request for investigation is directed to a department (laboratory, x-ray, etc.) situated in the same health institution as the care provider
External	The request for investigation is directed to a department (laboratory, x-ray, etc.) situated in another health institution as the care provider

### Instructions For Filling In (see model)

An Investigation Request Form is filled in for each patient requiring laboratory or x-ray investigations.

Preferentially **ONE** Investigation Request Form is issued for **ONE** laboratory or X-Ray investigation, except in case of investigations which are done at the same location in the laboratory.

For example:

- Blood slide for Malaria and Urine-examination:  
Write **TWO** Investigation Request Forms.
- Glycemia and Uremia:  
Write **ONE** Investigation Request Form for both tests.

*The following items are filled in by the **care provider**:*

Institution/ District	Put stamp of the institution or fill in.
Name	Write the name of the patient.
Father's/ Husband's Name	Write the name of the father/husband

# INVESTIGATION REQUEST FORM

Institution <i>District Head Quarter Hospital Abbottabad</i> District: <i>ABBOTABAD.</i>
---

Name: *Gul Raim*

Father/Husband's Name: *Dilawar Shah* Age: *32* Sex: *M*

<input type="checkbox"/> In-patient	Ward: _____	Yearly Ward No.
<input checked="" type="checkbox"/> Out-patient	<input checked="" type="checkbox"/> Internal	Yearly OPD No.
<input type="checkbox"/> External	<input checked="" type="checkbox"/> New Case	<u><i>B/12532/92</i></u>
	<input type="checkbox"/> Old Case	

Health Problem / Diagnosis: *Fever since 1 week with  
shivering + rigors*

Examination Requested: <u><i>Blood slide for Malaria</i></u>	Results: <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 10px auto;">                     Serial Lab. No./ Serial X-Ray No.                 </div> <u><i>Plasmodium falciparum trophozoites ++</i></u>
<u><i>Dr. Faiz Ahmad</i></u> Name & Signature Date: <u><i>15.9.92.</i></u>	<u><i>Dr. Faiz Ahmad</i></u> Name & Signature Date: <u><i>15.9.92.</i></u>

- Age** Write the age of the patient in years. For children under two, age should be written in months; for infants under 1 month, age should be written in days.
- Sex** Fill in M for males and F for females.
- In Patient** Check this box if the patient is hospitalized. Fill in the name of the ward and the Yearly Ward Number.
- Out Patient** Check this box for ambulatory care patients.
- Internal/External** Check appropriate box:  
     Internal if investigation is done within the same health institution  
     External if investigation is done in another health institution
- New Case/  
Old Case** Check appropriate box. Very important for malaria and tuberculosis, since reporting from the laboratory will be used to calculate the number of new cases.
- Yearly Ward No** The Yearly Ward Number is copied from the Ward Register.
- Yearly OPD No** The Yearly OPD Number is copied from the OPD register on the Outpatient Investigation Request Form, adding the last two numbers of the current year:

For example:

    135/92 = the 135th new case of 1992  
 or    4567/93 = the 4567th case of 1993

In health facilities where several OPD registers are in use at the same time, the letter identifying the OPD register where the new case was registered should PRECEDE the serial number:

For example:

    A/2456/92 = the 2456th case of 1992 in OPD register A  
 or    F/3465/93 = the 3465th case in 1993 in OPD register F

**NOTE:**

If laboratory examinations are requested for a pregnant woman during a preventive visit, the **Serial No. of the Mother Health Register** is filled in.

**Health Problem/  
Diagnosis**

Write here the content of column 16: Health problem of the OPD register.

Examination Requested

Write the name of the examination requested:

For example:

X-Ray Chest

Sputum smear for AFB

In case several investigations are required, the requests can be combined on one form if the investigations are performed in the same department.

Name & Signature

Signature and name of care provider.

Date

Write date in dd/mm/yy format.

*(The following items are filled in by the **laboratory or x-ray technician**)*

Results

Write results of the examination performed.

Serial Lab. No./  
Serial X-Ray No.

This number is filled in **ONLY** in case the patient has to revisit the laboratory for the same test. It permits identification of the patient in the Laboratory Register (for example: for second sputum smear). The Serial Laboratory No. is copied from the Laboratory Register, starting with the page number, then the serial number of the concerned section, and ending with the last two numbers of the current year.

For example:

The Serial Lab. No of a AFB sputum exam is

32/245/92

with 32 = Page number in the Laboratory Register

245 = Serial number of AFB sputum Section

92 = Year of registration

Date

Write date in dd/mm/yy format

Name/Signature

Name and Signature of laboratory or x-ray technician, who performed the examination or under whose responsibility the examination was performed.

### 3. REFERRAL FORM

---

**Purpose** To ensure bidirectional communication between first level care and referral level care facilities (necessary for continuity of care).

#### Features

**Maintained By** ■ Care provider (physician, paramedic) for request;  
■ Consulting physician at referral facility for feedback.

**Data Origin** Patient whose health problem needs referral care.

**Location** Patient retained: Carried by patient from first level care facility to referral facility, and carried back by patient from referral facility to first level care facility.

**Definitions** No specific definitions.

#### Instructions For Filling In (see model)

A Referral Form is filled in for each patient (new case or old case) who needs referral care for the solution of his health problem.

The **top portion** and of the **left side** of the form are filled in by the referring care provider. The **right side** is filled in by the treating specialist in the referral facility.

Each time a referral form is handed to a patient, column 20 of the Outdoor Patient Register is filled in at the line where he was registered (as a new case or an old case).

#### ➤ *Top of the form*

**Name of Institution/  
District** Put stamp of the institution or fill in.

For example:

BHU Mirpur, District Thatta.

**Referred to** Write the name of the health institution/department to which the patient is referred. Eventually, write the name of the specialist to whom you want to refer the patient:

# REFERRAL FORM

Institution: <u>BHU Guju</u> District: <u>Mirpurkhas</u>	Name of Patient: <u>Nazir Khan</u> Yearly OPD No.: <u>574/92</u>
Referred to: <u>Dr. Ammar Khan Mirpurkhas</u>	Age: <u>18 months</u> Sex: <u>M</u>
<p style="text-align: center;"><b>REFERRAL INFORMATION</b> (to be filled by referring care provider)</p> Reasons for Referral: <u>Severe pneumonia with hyponia</u>  History and Clinical Findings: <u>cough + breathing problem since 1 week / Temp. 104°F</u> <u>Resp. rate 60/min</u> <u>Chest indrawing ++</u> <u>Nutritional Status = M</u>	<p style="text-align: center;"><b>FEEDBACK FROM REFERRAL INSTITUTION</b> (to be filled by treating specialist)</p> Diagnosis: <u>Severe pneumonia</u>  Treatment: <u>Oxygen therapy</u> <u>Gentamycin 35mg x 2/1M</u> Follow-up: <u>Proc. pleni. 500.000 U/CO D</u>  <u>Nutritional follow-ups</u> <u>weight at discharge 9.6 kg</u>
Date: <u>9.9.92</u> Signature: <u>F. Abdul</u> Name: <u>Dr. Faisal Abdul</u>	Date: <u>16/9/92</u> Signature: <u>[Signature]</u> Name: <u>Dr. Munir Ahmed, Paediatrics</u>

For example:

District Hospital Jhelum/Pediatrics Ward  
 Prof. Khan, King Edward Medical Hospital Lahore/  
 Department Neurology

Name of Patient Write name of patient

Yearly OPD number The Yearly OPD Number is copied from the OPD register, adding the last two numbers of the current year:

For example:

135/92 = the 135th new case of 1992  
 or 4567/93 = the 4567th case of 1993

In health facilities where several OPD registers are in use at the same time, the letter identifying the OPD register where the new case was registered should PRECEDE the serial number:

For example:

A/2456/92 = the 2456th case of 1992 in OPD register A  
 or F/3465/93 = the 3465th case in 1993 in OPD register F

Age Write the age of the patient in years. For children under two, age should be written in months; for infants under 1 month, age should be written in days.

Sex Fill in M for males and F for females.

➤ **Left side**

REFERRAL INFORMATION  
*(to be filled by referring care provider)*

Reasons for referral Write a brief summary about the problem of the patient and the care he needs in the referral facility:

For example:

Hospitalization for diarrhoea with severe dehydration

**MODULE 1: DATA RECORDING**

History and Clinical Findings	Write summary of history and clinical findings relevant for the consultant.
Date	Write date in dd/mm/yy format.
Signature/Name	Signature and Name of the referring care provider.

**➤ Right side**

**FEEDBACK FROM REFERRAL FACILITY**  
*(to be filled by treating specialist)*

This part of the form is filled by the treating specialist at the referral facility. It is addressed to the I/C of the FLCF who referred the patient. The patient himself brings back this form to the FLCF, eventually sealed in a closed envelope.

Diagnosis/ Treatment	Write diagnosis and treatment provided at the referral facility.
Follow-up	Write any follow-up actions that have to be taken by the staff of the FLCF:  For example:  Control visit in your facility in two weeks.  Patient needs to take Aldomet 250mg daily for the next three months. Please check BP every two weeks.
Date	Write date in dd/mm/yy format.
Signature/Name	Signature and name of the treating specialist in the referral facility

#### 4. OUTDOOR PATIENT REGISTER (OPD REGISTER)

---

<b>Purpose</b>	To facilitate aggregation and reporting on curative activities;  To serve as a supervision tool (supervisor can verify when visiting the facility);  To constitute archives of curative activities in the health facility (for example for information on non-reportable diseases).
<b>Features</b>	
Maintained by	The care provider (MO, paramedic).
Location	One OPD Register should available at each consultation point (including at emergency OPD in hospitals).
Data origin	Patients visiting the health facility for a curative problem.

Preventive visits for pre- and post-natal care or for growth monitoring are **NOT** registered in the OPD register, but in the appropriate register (Mother Health Register or Child Health Register).

**Definitions** No specific definitions.

**Instructions for filling in (see model)** Each patient visiting the facility for a curative problem shall be recorded on the OPD Register **by the care provider himself**.

Following is a model of the OUTDOOR PATIENT REGISTER. All columns of the register are numbered and the content to be recorded in each column is explained below. In reading the instructions, compare with the examples given in the model.

If several OPD registers are in use in the same facility, a letter will be assigned to each register, e.g. OPD register A, OPD Register B, etc. This letter will be filled in on the cover of the Register and on top of each page. The letter will also be added to the yearly OPD number on the OPD ticket.

Each month, registrations start on a new page of the register. Each day, in the beginning of the curative consultation, the care provider draws a full horizontal line to mark the end of the preceding day. He then records

OUTDOOR PATIENT REGISTER (FR1) 13

1 OLD CASES* (Write Old OPD Yearly Number)	2 NEW CASES		4 NAME	5 LOCALITY	6-15 AGE CATEGORY									
	Yearly Number	Monthly Number			Male					Female				
					<1	1-4	5-14	15-44	45+	<1	1-4	5-14	15-44	45+
Total: 3	945	21	← Totals from Previous Page →		1	5	2	5	-	4	2	2	-	-
	946	22	Yaseer Khan	Chacela dand			✓							
	947	23	Yaseen Malik	Babu Mahallu					✓					
702	-	-	Maqsood Ahmed											
	948	24	Iqbal Raheem	Jamabad	✓									
			5. 9. 1992											
	949	25	Naila Begum	Naz Pura							✓			
	950	26	Masood Ahmed	Balapur				✓						
	951	27	Talira Naseem	Jamnagar								✓		
	952	28	Arshad Baig	Shahmari			✓							
	953	29	Nadeem Khan	Kottari	✓									
	954	30	Sumera Bisi	Rampus										✓
			7. 9. 1992											
	955	31	Asia Begum	Tariqabad								✓		
	956	32	Ghaffar-ud-Din	Dadu Shalu	✓									
890	-	-	Iftikhar Saeed	-										
	957	33	Kamran Mahmood	Ranikot				✓						
	958	34	Ayub Shalu	Jamnagar	✓									
899	-	-	Sultana Bisi	-										
	959	35	Robina Naseem	Shamari							✓			
			8. 9. 1992											
	960	36	Imran Ali	Kottari	✓									
	961	37	Akbar Shalu	Gharibabad				✓						
	962	38	Shahreen Begum	Kharikot							✓			
	963	39	Saqib Malik	Pohri Shalu				✓						
927	-	-	Sajjid Mohammad	-										
	964	40	Haider Raza	Balam Shalu	✓									
Total: 7	964	40	← Transfer Totals to Next Page →		4	8	4	3	2	6	4	3	-	1

\* For OLD CASES, fill in ONLY columns 4 and 19, and, if appropriate 20-21. Do not write in other columns.

Verify at the end of each page if (3) = (6) + (7) + (8) + (9) + (10) + (11) + (12) + (13) + (14) + (15)

CHAPTER II: CURATIVE CONSULTATIONS (ACUTE EPISODES)

MONTH: September YEAR: 1992

16	17	18	19	20	21
HEALTH PROBLEM / DIAGNOSIS	CODE	NUTRI-TIONAL STATUS (under 3 years)	ACTION TAKEN	REFERRAL	
				Tick If Referred	Feedback (Y/N)
Fever (clinical Malaria)	104.2	-	Syp. Chloroquine Sulphate, Syp. Ibrel		
Fever (clinical Malaria)	104.1	-	Tab. Paracetamol, Cap. Fe.		
	-	-	Cap. Ampiclox Strong, B-Complex		
ARI (Pneumonia)	103.1	M	Syp. Cotrimoxazole, Syp. Ventolin, Breast feeding		
Probable Measles	109.1	N	IRFD, Syp. phenegon, Syp. Calpol		
Scabies	118		Sol. Escobol, Tab. Anal.		
Rheumatoid Arthritis	-	-	Tab. Penicillin, Tab. Fortigesin	✓	Y
ARI	103		Advice admission	✓	
Suspected Scabies	118	N	Escobol Sol. Syp. Ampicillin		
Fever (clinical malaria)	104.1		Tab. Chloroquine Sulphate, paracetol		
Acute watery diarrhoea Dehydration	102.0	N	Syp. Septon, Syp. Vidyline		
ARI (NO pneumonia)	103.0	M	Nutritional Advice & Syp. Paracetamol		
			Tab. Flagyl strong, Cap. Tetracycline		
Symphodentis, Rt. Inguinal			Cap. Velosol, Tab. Bessel + Tramadol		
Diarrhoea with some Dehydration	101.1	M	ORS, Syp. Ledexplex, Breast feeding		
	-	-	Tab. Nalgine, Sus. Mucaine		
ARI (Pneumonia)	103.1	N	Syp. Cotrimoxazole, Syp. Ventolin		
Worm Infestation		M	Syp. Combantim, Nutritional Advice		
ARI (no pneumonia)	103.0		Syp. Hyperlin, Tab. paracetamol		
Worm Infestation		M	Syp. Combantim, Nutritional Advice		
Eczema	-	-	Nersure Coat, Tab. Erythrocin	✓	
	-	-	Advice to continue old treatment		
Scrotal Swelling Hydro	-	-	Advice Hemorectomy	✓	Y

the **date of the present day** on the first row available (see model).

Before making any recording, first has to be determined if a patient is an **new case** or an **old case**. Definitions have been given in the beginning of this chapter, but practically speaking it is not always easy to determine what is a new case, or what is an old case. Following are some guidelines:

1. A patient who comes in with a new episode of an illness for which he was never recorded previously is obviously a **new case**, and an OPD ticket will be issued to him.
2. If a patient comes in for an episode of an illness for which he was recorded previously (as confirmed by an OPD ticket or by a chronic disease card), he is recorded as an **old case**:
  - If the symptoms of the disease were continuously present since his last visit;
  - In case of intermittent symptoms, if the time-period between recording of the new case and the present visit is **less** than indicated in table 1 which gives these time periods for the most common diseases (for other diseases, individual judgment of the care provider is required);
3. For cases of traumatism (including dog bites and snake bites), each **new** traumatism is recorded as a **new case**
4. If a patient comes in for the same disease, but he forgot /lost his OPD ticket, a search can be done in the OPD register to find a record of the case, based on the date he thought he came previously. If the record is not found, the patient is recorded as new case, and a new OPD ticket is issued.

### ► **Recording of new cases**

New cases will be recorded in columns 2 to 21 of the OPD Register.

#### Columns:

2: Yearly number To each new case, a serial yearly number will be given starting from 1 on January 1 and ending on December 31. Each OPD register will have its own serial numbering.

This number will be recorded on the OPD ticket, specifying the year and the letter of the OPD register where appropriate, and therefore

**Table 1**  
**Time-periods to define new episodes of illness**  
**for patients returning with the same disease**  
**(except if continuous symptoms)**

AFTER 1 WEEK OR MORE	AFTER 1 MONTH OR MORE	AFTER 1 YEAR OR MORE	LIFELONG EPISODES (OR 1 EPISODE IN A LIFE TIME)
Diarrhoea	Cough more than 2 weeks (if AFB -ve)	Goiter	Tuberculosis
Dysentery	Skin Infection	Meningococcal Meningitis	Poliomyelitis
Acute Respiratory Infection	Gastritis	Viral Hepatitis	Measles
Fever	Muscular/articular pains		Neonatal Tetanus
Conjunctivitis			Diphtheria
Urinary Infection			Whooping Cough
			Cholera
			AIDS
			Diabetes
			Hypertension

identifying the patient when he returns to the facility for additional care for the same episode of illness.

Each year numbering will start again from 1.

- 3: Monthly number To each new case, a serial monthly number will be given starting from 1 on the first day of the month, and ending on the last day of the month. The purpose of this number is to facilitate aggregation at the end of the month.

Each month numbering will start again from 1.

- 4: Name Write the name of the patient.

- 5: Address Write the address of the patient.

- 6-15: Age Category Tick the column of the age category in which the patient belongs on the left side for a male patient, and on the right side for a female patient.

- 16 & 17: Health Problem/ Diagnosis and Code

**PRIORITY HEALTH PROBLEMS**

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Under HMIS/FLCF, only priority health problems as defined in the list of indicators during the 2nd National HMIS Workshop will be reported to higher levels. In order to have comparable reporting throughout the country, standard definitions for each of these priority health problems have been developed (see Chapter III), recording has been standardized, and a coding system developed.

Following is a list of the priority health problems. To each of these priority health problems a special three digit code has been assigned. If more specification is needed, the main three digit code is followed by a fourth digit, separated from the three digit code by a dot.

HMIS/FLCF CODE	HEALTH PROBLEM
101.	Diarrhoea
	<i>For children of less than five years specify:</i>
101.0	Without dehydration
101.1	With some dehydration
101.2	With severe dehydration
101.9	Dehydration status not specified
102.	Dysentery
	<i>For children of less than five years specify:</i>
102.0	Without dehydration
102.1	With some dehydration
102.2	With severe dehydration
102.9	Dehydration status not specified
103.	Acute Respiratory Infections
	<i>For children of less than five years specify:</i>
103.0	No pneumonia
103.1	Pneumonia
103.2	Severe pneumonia
103.3	Very severe disease
103.9	Without specification
104.	Fever (Clinical Malaria)
104.0	Blood slide examined in facility
104.1	Blood slide sent out
104.2	Blood slide not taken

HMIS/FLCF CODE	HEALTH PROBLEM
105.	Cough more than two weeks
105.0	Sputum smears done within facility
105.1	Patient referred for sputum smear
106.	Suspected Cholera
107.	Suspected Meningococcal Meningitis
108.	Probable Poliomyelitis
108.0	Not vaccinated
108.1	Partially vaccinated
108.2	Fully vaccinated (by card)
108.9	Vaccination status unknown
109.	Probable Measles
109.0	Not vaccinated
109.1	Partially vaccinated
109.2	Fully vaccinated (by card)
109.9	Vaccination status unknown
110.	Probable/Confirmed Neonatal Tetanus
110.0	Not vaccinated
110.1	Partially vaccinated
110.2	Fully vaccinated (by card)
110.9	Vaccination status unknown
111.	Probable Diphtheria
111.0	Not vaccinated
111.1	Partially vaccinated
111.2	Fully vaccinated (by card)
111.9	Vaccination status unknown
112.	Probable Whooping Cough
112.0	Not vaccinated
112.1	Partially vaccinated
112.2	Fully vaccinated (by card)
112.9	Vaccination status unknown
113.	Goiter
114.	Suspected Viral Hepatitis
115.	Suspected AIDS

HMIS/FLCF CODE	HEALTH PROBLEM
116.	Snake bite with signs & symptoms of poisoning
117.	Dog bite
118.	Scabies

Standard definitions for of each of these problems are given in Chapter III, Priority Health Problems.

**16: Health Problem/  
Diagnosis**

In this column a brief description of the health problem that brought the patient to the health facility is recorded.

If the patient has a priority health problem listed in the preceding list, the exact name of the problem should be recorded, and further specification given where required, so that coding is possible. In addition to these specifications, the care provider can record any other information that he judges relevant for the diagnosis of the case.

For example:

A patient of 2 years with a pharyngitis is recorded:  
ARI/No pneumonia

A patient with cough more than two weeks is recorded:  
Cough > 2 weeks/sputum smears done

Other health problems are recorded according to the habit of the care provider, or according to instructions from district supervisors.

**17: Code**

Only new cases of priority problems are coded according to the list given above. *For other health problems, this column is not filled in!*

For example:

A patient consulting for dog bite is coded 117.

**18: Nutritional Status  
(under 3 years)**

For each child under three brought to the curative consultation, weight and age will be determined (see instructions above).

The child will be classified according to the NCHS/WHO Classification. Expected weight-for-age is according to NCHS standards. Depending on

the nutritional status of the child, one of the following codes has to be filled in column 18: N, M, S, U.

NUTRITIONAL STATUS	WEIGHT FOR AGE (W/A)	CODE
Normal	Within 2 Standard Deviations (SD) from the NCHS median	N
Moderate malnutrition	Weight between 2 SD and 3 SD from the NCHS median	M
Severe malnutrition	Weight 3SD and more from the NCHS median	S
Unknown	Not recorded	U

**Column 18 is NOT filled in for new cases of three years and more!**

19: Action Taken Summarize different actions taken to solve the health problem of the patient:

1. Drugs issued: Indicate the name (with abbreviation) and the quantity of drugs issued.

For example:

Cotr/Sir 1btle = Cotrimoxazole syrup, 1 bottle of 80cc at .../5cc

Chloro/12 = Chloroquine, 12 tablets of 150mg base

2. Preventive counseling: Family planning counseling, nutritional advice, appointment for vaccination

20 & 21: Referral If the patient has a health problem for which more qualified staff or more sophisticated equipment is needed than available at the first level, or for which hospitalization is necessary, the patient is referred to the nearest health facility where required staff, equipment or hospital beds are available.

Even in OPDs of hospitals where this staff, equipment, or beds are eventually available within the facility, the patient is considered referred, meaning that his problem cannot be solved at the first level.

For each referred patient column 20 and 21 are filled in and a referral form is issued to the patient (see under 3. REFERRAL FORM).

20: Type of Referral

Tick this column if the patient is referred.

21: Feedback

If the patient returns to the facility with a feedback form filled in by the treating physician at the referral facility, write Y (YES) in this column.

➤ **Recording of old cases**

Information on old cases will be recorded **ONLY** in column 1, 4, 19, and if appropriate in column 20 and 21.

Do not fill in the other columns when recording old cases!!!

Columns:

1: OLD CASES

Fill in the Yearly OPD Number that was recorded on the OPD ticket. If the patient has forgotten his OPD ticket, try to find the Yearly OPD number on the previous pages of the OPD number, by questioning the patient on the date of his first visit for this episode of illness.

Note: If no initial recording can be found for the patient, consider the patient as a new case, and register him accordingly.

At the end of the page, the number of Yearly OPD numbers is counted and added to the number on top of the column. The total is then recorded on the last line of the page, and transferred to the next page.

4: Name

Write name of the patient

19: Action taken

Record treatments or counseling during this visit.

20 & 21: Referral

If the patient is referred, column 20, and later column 21 are filled in.

**NOTE:**

In case the diagnosis of the old case has changed substantially, compared to the initial diagnosis, the initial coding of priority health problems as recorded earlier in the OPD Register can be corrected.

For example:

A child with a simple cough (recorded as 103.0) returns to the health facility with severe pneumonia. The initial coding can be changed into 103.2.





## LABORATORY REGISTER (FR8)

Page No.: 43

Examination: BLOOD: Malaria Parasite

Serial No.	Date	Name	Fee (Y/N)	OPD No./ Ward No.	Out Patient		Result
					Internal/ External (I/E)	New/Old Cases (N/O)	
243	28/8/92	Rahman Aslam	N	432/92			MP neg
244	28/8/92	Nusrat Khan	N	B2431/92	I	N	MP pos ++
245	28/8/92	Karim Siddiqi	N	A2334/92	I	N	P. falc ++
246	30/8/92	Noori Shabir	N	414/92			MP pos +
247	1/9/92	Karim	N	B2446/92	I	N	MP neg
248	3/9/92	Husain Akbar	N	B2449/92	I	N	MP neg
249	5/9/92	Rahmat Khan	N	1444/92	E	N	MP pos +++
250	6/9/92	Nadia Syed	N	774/92	E	N	MP neg
251	9/9/92	Muhammad Yasir	N	A2378/92	I	N	MP neg
252	9/9/92	Ayub	N	489/92			P. falc ++
253	10/9/92	Kayser	N	A2409/92	I	N	MP neg
254	15/9/92	Amir	N	982/92	E	N	MP pos +
255	17/9/92	Fajal Mubarek	N	471/92			MP pos +++
256	20/9/92	Muhammad Yasir	N	B2491/92	I	O	MP neg
257	22/9/92	Nasir Ahmad	N	B2513/92	I	N	MP neg
258	25/9/92	Haleem Bibi	N	434/92			MP neg
259	28/9/92	Juday Bano	N	A2519/92	I	N	P. falc +
260	30/9/92	Fahimara	N	937/92	E	N	P. falc +
261	2/10/92	Hameed Akbar	N	901/92	E	N	MP neg

## MODULE 1: DATA RECORDING

### Columns:

1. Serial No.                      When recording the information from the investigation request form, first a **serial yearly number** will be given starting from 1 on the first day of the year, and ending on the last day of the year. The purpose of this number is to facilitate identification of a patient and aggregation at the end of the month.  
  
Each new year, numbering will start again from 1.
2. Date                              Write the date on which the request form was received, according to the format dd/mm/yy
3. Name                              Write the name of the patient.
4. Fee (Y/N)                        Fill in Y (Yes) if fees were taken and N (No) if no fees were charged.
5. OPD No./  
Ward No.                            For outdoor patients write Yearly OPD Number  
For indoor patients write Ward No.
6. Out Patients  
Internal/  
External (I/E)                      Copy from the Investigation Request Form:  
  
"I" if the request comes from the OPD in the same health institution  
"E" if the request comes from another health institution.
7. Out-Patients  
New/Old Cases  
(N/O)                                Copy from the Investigation Request Form:  
  
New Case:    Write "N"  
  
Old Case:     Write "O"
8. Result                            Write a summary of the result.  
  
For TB sputum smear series, results of BOTH sputum smears should be reported on ONE line. (If the first sputum smear is positive, no second needs to be done).  
  
For example:  
  
Sputum 1 AFB negative/Sputum 2 AFB positive  
or shorter  
S1 AFB- / S2 AFB+

For malaria slides the following information should be provided:

Malaria parasite negative: if no parasites were found.

Malaria parasite positive: if any kind of plasmodium was found.

P. Falciparum positive: if forms of P. Falciparum were found.

## 6. ABSTRACT REGISTER PRIORITY DISEASES

---

**Purpose** To aggregate each month health problem data from OPD Register in preparation of the Monthly Report.

### Features

Maintained By In Charge or any person designated by the In Charge.

Location Office of In Charge.

Data Origin OPD Register.

**Definitions** No specific definitions.

**General Instructions** Each month, in preparation of the HMIS/FLCF Monthly Report, data on **reportable health problems** and the **nutritional status data** from the OPD Register will be tallied (see page 28 for tally system) into the Abstract Register.

To do this efficiently, it is preferable to have at least two persons available: one person reads the OPD Register, while the other is tallying the Abstract Register.

Reportable health problems are easily recognized because they have been coded in column 17 of the OPD Register. Nutritional status data have been recorded in column 18.

Normally, one double page has been foreseen for each month, but if the space available is not sufficient, additional double pages can be used.

If several OPD Registers are maintained in the same health institution, one or more Abstract Registers could be used to transfer data.

**IMPORTANT NOTE**

Before starting to tally coded health problems from the OPD Register into the Abstract Register, first VERIFY in the OPD Register if all priority health problems/diagnosis of the past month have been correctly coded. Correct where possible.

If for certain health problems where a fourth digit specification was required, this fourth digit has not been filled, fill in the fourth digit according to the following instructions:

1. The explanations in column 16 of the OPD Register permit to identify the correct digit:

Fill in the correct fourth digit

2. The explanations in column 16 of the OPD Register are not sufficient to identify the correct digit:

Fill in .9 as the fourth digit

**Instructions for filling in (see model)**

Columns:

1&2: Health Problem/Code

Columns 1 and 2 give a complete list of reportable health problems and respective codes.

3, 4, & 6: Age Groups

In these columns, each new case can be tallied from the OPD Register in the appropriate age group box and for the appropriate health problem. The age groups 5-14 years, 15-44, and 45 years and more have been merged in one group 5 years and more.

5: Subtotal Under 5 Years

For 101. Diarrhoea, 102. Dysentery, and 103. Acute Respiratory Infection no subcategories are reported for cases of 5 years and more.

Subtotals for cases under 5 years per subcategory can therefore be made in this column.

7: Total New Cases Current Month

For each health problem and its subcategory the total number of new cases seen during the current month is filled in.





**MODULE 1: DATA RECORDING**

At the end, when all reportable health problems have been transferred from the OPD Register into the Abstract Register, the number of tallies in each cell is counted, and the circled total written in the cell:

Totals per age group and per subcategory can be made now and filled in the appropriate cells.

**BOTTOM PAGE**

Nutritional Status  
in children under 3: Transfer all data from children who were weighed from Column 18 into the abstract register by tallying in the appropriate box:

Normal Nutritional Status: N  
Moderate Malnutrition: M  
Severe Malnutrition: S

At the end sum the tallies in each box and put the total in the little box at the left side (see filled in model)

Total children  
under 3 weighed: Make the total of the N, M and S categories.

## Chapter III

# PRIORITY HEALTH PROBLEMS

---

Of all new cases seen at the curative consultation, only new cases with a priority health problem as defined in the list of indicators, will be reported by the health facility in the monthly FLCF report. In order to improve the validity and the reliability of the reported cases, standard instructions for recording of priority health problems have been developed.

### 1. List of Priority Health Problems

Following is a list of priority health problems based on the list of HMIS/FLCF indicators.

To each of these priority health problems a special three digit code has been assigned. If more specification is needed, the main three digit code is followed by a fourth digit, separated from the three digit code by a dot. Codes for priority health problems will be recorded in a separate column in the OPD Register, so that later aggregation of these data in the abstract register would be facilitated.

#### HMIS/FLCF CODE HEALTH PROBLEM

101. Diarrhoea

*For children of less than five years specify:*

101.0	Without dehydration
101.1	With some dehydration
101.2	With severe dehydration
101.9	Dehydration status not specified

102. Dysentery

*For children of less than five years specify:*

102.0	Without dehydration
102.1	With some dehydration
102.2	With severe dehydration
102.9	Dehydration status not specified

**MODULE 1: DATA RECORDING**

**103. Acute Respiratory Infections**

*For children of less than five years specify:*

- 103.0 No pneumonia
- 103.1 Pneumonia
- 103.2 Severe pneumonia
- 103.3 Very severe disease
- 103.9 Without specification

**104. Fever (Clinical Malaria)**

- 104.0 Blood slide examined in facility
- 104.1 Blood slide sent out
- 104.2 Blood slide not taken

**105. Cough more than two weeks**

- 105.0 Sputum smears done within facility
- 105.1 Patient referred for sputum smear

**106. Suspected Cholera**

**107. Suspected Meningococcal Meningitis**

**108. Probable Poliomyelitis**

- 108.0 Not vaccinated
- 108.1 Partially vaccinated
- 108.2 Fully vaccinated (by card)
- 108.9 Vaccination status unknown

**109. Probable Measles**

- 109.0 Not vaccinated
- 109.1 Partially vaccinated
- 109.2 Fully vaccinated (by card)
- 109.9 Vaccination status unknown

**110. Probable/Confirmed Neonatal Tetanus**

- 110.0 Not vaccinated
- 110.1 Partially vaccinated
- 110.2 Fully vaccinated (by card)
- 110.9 Vaccination status unknown

**111. Probable Diphtheria**

- 111.0 Not vaccinated
- 111.1 Partially vaccinated
- 111.2 Fully vaccinated (by card)
- 111.9 Vaccination status unknown

- 112. Probable Whooping Cough
  - 112.0 Not vaccinated
  - 112.1 Partially vaccinated
  - 112.2 Fully vaccinated (by card)
  - 112.9 Vaccination status unknown
- 113. Goiter
- 114. Suspected Viral Hepatitis
- 115. Suspected AIDS
- 116. Snake bite with signs & symptoms of poisoning
- 117. Dog bite
- 118. Scabies

**Malnutrition (Children < 3y)**

For each child under three years brought to the curative consultation, weight and age will be determined (see Manual on Nutrition Training for Primary Health Care Workers).

The child will be classified according to the NCHS/WHO Classification. Expected weight-for-age is according to NCHS standards.

NUTRITIONAL STATUS	WEIGHT FOR AGE (W/A)	CODE
Normal	Within 2 Standard Deviations (SD) from the NCHS median	N
Moderate malnutrition	Weight between 2 SD and 3 SD from the NCHS median	M
Severe malnutrition	Weight 3SD and more from the NCHS median	S
Unknown	Not recorded	U

## 2. Choice of Priority Health Problem

Only **one** priority health problem can be selected for one **new** case. If **two or more health problems** are present in the same new case, **one** health problem should be chosen. In making the choice, preference should be given to the health problem for which the patient consulted in the first place, or to the one that provoked the other.

For example:

In a child of two years with acute respiratory infection (ARI) and diarrhoea, ARI should be chosen as the first problem, since diarrhoea is mostly secondary to ARI in children under five.

The only exception to the rule "one new case – one health problem" is malnutrition in children under three. Malnutrition can be combined with any of the priority health problems. For that purpose an additional column following the code column is added in the OPD Register.

### 3. Standard Case Definitions

Following is a list of standard case definitions for each of the priority health problems.

#### 101. Diarrhoea

A patient having 3 or more loose or watery stools (without blood) in one day (24h).

For each case of diarrhoea in a child under five years specify:

101.0	Without dehydration
101.1	With some dehydration
101.2	With severe dehydration
101.9	Dehydration status not specified

For differentiation between these subcategories, see following assessment chart for dehydration.

#### 102. Dysentery

A patient having 3 or more loose stools WITH BLOOD in one day (24h).

For each case of dysentery in a child under five years specify:

102.0	Without dehydration
102.1	With some dehydration
102.2	With severe dehydration
102.9	Dehydration status not specified

For differentiation between these subcategories, see following assessment chart for dehydration.

## DIARRHOEA OR DYSENTERY IN A CHILD UNDER FIVE FIRST, ASSESS YOUR PATIENT FOR DEHYDRATION

	A	B	C
<p>1. LOOK AT:    <b>CONDITION</b></p> <p style="text-align: center;">EYES</p> <p style="text-align: center;">TEARS</p> <p style="text-align: center;">MOUTH and TONGUE</p> <p style="text-align: center;">THIRST</p>	<p>Well, alert</p> <p>Normal</p> <p>Present</p> <p>Moist</p> <p>Drinks normally, not thirsty</p>	<p>★ Restless, irritable ★</p> <p>Sunken</p> <p>Absent</p> <p>Dry</p> <p>★ Thirsty, drinks eagerly ★</p>	<p>★ Lethargic or unconscious; floppy ★</p> <p>Very sunken and dry</p> <p>Absent</p> <p>Very dry</p> <p>★ Drinks poorly or not able to drink ★</p>
<p>2. FEEL:        <b>SKIN PINCH</b></p>	<p>Goes back quickly</p>	<p>★ Goes back slowly ★</p>	<p>★ Goes back very slowly ★</p>
<p>3. DECIDE:</p>	<p>The patient has <b>NO</b> <b>SIGNS OF DEHYDRATION</b></p>	<p>If the patient has two or more signs including at least one ★ sign ★, there is <b>SOME</b> <b>DEHYDRATION</b></p>	<p>If the patient has two or more signs, including at least one ★ sign ★, there is <b>SEVERE</b> <b>DEHYDRATION</b></p>
<p>4. TREAT:</p>	<p>Use Treatment Plan A</p>	<p>Weigh the patient, if possible, and use Treatment Plan B</p>	<p>Weigh the patient and use Treatment Plan C <b>URGENTLY</b></p>

**103. Acute Respiratory Infections**

A patient having an acute infection of the ear, nose (common cold), throat, larynx, trachea, bronchi, bronchiole or lung.

For each case of acute respiratory infection in a child under five years specify:

<b>103.0</b>	<b>No pneumonia</b>
<b>103.1</b>	<b>Pneumonia (not for a child under two months)</b>
<b>103.2</b>	<b>Severe pneumonia</b>
<b>103.3</b>	<b>Very severe disease</b>
<b>103.9</b>	<b>Without specification</b>

For differentiation between these subcategories, see the assessment charts on the following pages. Based on the history, use one of the four following charts:

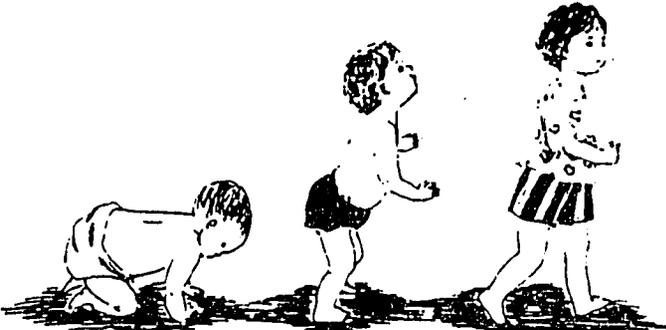
1. COUGH OR DIFFICULT BREATHING in young infant less than 2 months
2. COUGH OR DIFFICULT BREATHING in child age 2 months up to 5 years
3. EAR PROBLEM in child under five:
  - \* ALWAYS classify as 103.0
4. SORE THROAT in child under five:
  - \* ALWAYS classify as 103.0

**COUGH OR DIFFICULT BREATHING  
THE YOUNG INFANT  
(AGE LESS THAN 2 MONTHS)**

<b>SIGNS:</b>	<ul style="list-style-type: none"> <li>• Stopped feeding well,</li> <li>• Convulsions,</li> <li>• Abnormally sleepy or difficult to wake,</li> <li>• Stridor in calm child,</li> <li>• Wheezing, or</li> <li>• Fever or low body temperature.</li> </ul>	
<b>CLASSIFY AS:</b>	<p><b>VERY SEVERE DISEASE</b></p>	
<b>TREATMENT:</b>	<ul style="list-style-type: none"> <li>▶ Refer <b>URGENTLY</b> to hospital.</li> <li>▶ Keep young infant warm.</li> <li>▶ Give first dose of an antibiotic.</li> </ul>	

<b>SIGNS:</b>	<ul style="list-style-type: none"> <li>• Severe chest indrawing, or</li> <li>• Fast breathing (60 per minute or MORE).</li> </ul>	<ul style="list-style-type: none"> <li>• No severe chest indrawing, and</li> <li>• No fast breathing (LESS than 60 per minute)</li> </ul>
<b>CLASSIFY AS:</b>	<b>SEVERE PNEUMONIA</b>	<b>NO PNEUMONIA: COUGH OR COLD</b>
<b>TREATMENT:</b>	<ul style="list-style-type: none"> <li>▶ Refer <b>URGENTLY</b> to hospital.</li> <li>▶ Keep young infant warm.</li> <li>▶ Give first dose of an antibiotic.</li> </ul> <p>(If referral is not feasible, treat with an antibiotic and follow closely.)</p>	<ul style="list-style-type: none"> <li>▶ Advise mother to give the following home care:                             <ul style="list-style-type: none"> <li>▶ Keep young infant warm.</li> <li>▶ Breast-feed frequently.</li> <li>▶ Clear nose if it interferes with feeding.</li> <li>▶ Return quickly if:                                     <ul style="list-style-type: none"> <li>▶ Breathing becomes difficult.</li> <li>▶ Breathing becomes fast.</li> <li>▶ Feeding becomes a problem.</li> <li>▶ The young infant becomes sicker.</li> </ul> </li> </ul> </li> </ul>

## COUGH OR DIFFICULT BREATHING THE CHILD AGE 2 MONTHS UP TO 5 YEARS

<b>SIGNS:</b>	<ul style="list-style-type: none"> <li>• Not able to drink,</li> <li>• Convulsions,</li> <li>• Abnormally sleepy or difficult to wake,</li> <li>• Stridor in calm child, or</li> <li>• Severe malnutrition.</li> </ul>	
<b>CLASSIFY AS:</b>	<b>VERY SEVERE DISEASE</b>	
<b>TREATMENT:</b>	<ul style="list-style-type: none"> <li>▶ Refer <b>URGENTLY</b> to hospital.</li> <li>▶ Give first dose of an antibiotic.</li> <li>▶ Treat fever, if present.</li> <li>▶ Treat wheezing, if present.</li> <li>▶ If cerebral malaria is possible, give an antimalarial.</li> </ul>	

<b>SIGNS:</b>	<ul style="list-style-type: none"> <li>• Chest indrawing.</li> </ul> <p style="text-align: center;">[If also recurrent wheezing, go directly to ▶ <i>Treat Wheezing</i>]</p>	<ul style="list-style-type: none"> <li>• No chest indrawing, and</li> <li>• Fast breathing (50 per minute or more if child 2 months up to 12 months; 40 per minute or more if child 12 months up to 5 years).</li> </ul>	<ul style="list-style-type: none"> <li>• No chest indrawing, and</li> <li>• No fast breathing (Less than 50 per minute if child 2 months up to 12 months; Less than 40 per minute if child 12 months up to 5 years)</li> </ul>
<b>CLASSIFY AS:</b>	<b>SEVERE PNEUMONIA</b>	<b>PNEUMONIA</b>	<b>NO PNEUMONIA: COUGH OR COLD</b>
<b>TREATMENT:</b>	<ul style="list-style-type: none"> <li>▶ Refer <b>URGENTLY</b> to hospital.</li> <li>▶ Give first dose of an antibiotic.</li> <li>▶ Treat fever, if present.</li> <li>▶ Treat wheezing, if present.</li> </ul> <p style="text-align: center;">(If referral is not feasible, treat with an antibiotic and follow closely.)</p>	<ul style="list-style-type: none"> <li>▶ Advise mother to give home care.</li> <li>▶ Give an antibiotic.</li> <li>▶ Treat fever, if present.</li> <li>▶ Treat wheezing, if present.</li> </ul> <p style="text-align: center;">▶ Advise mother to return with child in 2 days for reassessment, or earlier if the child is getting worse.</p>	<ul style="list-style-type: none"> <li>▶ If coughing more than 30 days, refer for assessment.</li> <li>▶ Assess and treat ear problem or sore throat, if present (see chart).</li> <li>▶ Assess and treat other problems.</li> <li>▶ Advise mother to give home care.</li> <li>▶ Treat fever, if present.</li> <li>▶ Treat wheezing, if present.</li> </ul>

<b>Reassess in 2 days a child who is taking an antibiotic for pneumonia:</b>			
<b>SIGNS:</b>	<b>WORSE</b>	<b>THE SAME</b>	<b>IMPROVING</b>
	<ul style="list-style-type: none"> <li>• Not able to drink.</li> <li>• Has chest indrawing.</li> <li>• Has other danger signs.</li> </ul>		<ul style="list-style-type: none"> <li>• Breathing slower.</li> <li>• Less fever.</li> <li>• Eating better.</li> </ul>
<b>TREATMENT:</b>	▶ Refer <b>URGENTLY</b> to hospital.	▶ Change antibiotic or Refer.	▶ Finish 5 days of antibiotic.

# EAR PROBLEM

## ASSESS

### ASK:

- Does the child have ear pain?
- Does the child have pus draining from the ear? For how long?

### LOOK, FEEL:

- Look for pus draining from the ear or red, immobile ear drum (by otoscopy).
- Feel for tender swelling behind ear.

## CLASSIFY THE ILLNESS

SIGNS:	● Tender swelling behind the ear.	● Pus draining from the ear LESS than two weeks, or ● Ear pain, or ● Red, immobile ear drum (by otoscopy).	● Pus draining from the ear two weeks or MORE.
	CLASSIFY AS:	MASTOIDITIS	ACUTE EAR INFECTION
TREATMENT:	<ul style="list-style-type: none"> <li>▶ Refer URGENTLY to hospital.</li> <li>▶ Give first dose antibiotic</li> <li>▶ Treat fever, if present.</li> <li>▶ Give paracetamol for pain.</li> </ul>	<ul style="list-style-type: none"> <li>▶ Give an antibiotic for five days, as for pneumonia.</li> <li>▶ Dry the ear by Wicking.</li> <li>▶ Reassess in five days.</li> <li>▶ Treat fever, if present.</li> <li>▶ Give paracetamol for pain.</li> </ul>	<ul style="list-style-type: none"> <li>▶ Refer for one assessment if possible</li> <li>▶ Dry the ear by wicking.</li> <li>▶ Treat fever if present</li> <li>▶ Give paracetamol for pain</li> </ul>

## TREATMENT INSTRUCTIONS

### ▶ Give an Antibiotic

- ▶ Give first dose of antibiotic in clinic.
- ▶ Instruct mother on how to give the antibiotic for five days at home

AGE or WEIGHT	Cotrimoxazole		Amoxicillin		Ampicillin	
	Tablet	Syrup	Tablet	Syrup	Tablet	Syrup
Less than 2 months (< 5 kg)	1/4*	2.5 ml*	1/4*	2.5 ml	1/2	2.5 ml
2 months up to 12 months (5-9 kg)	1/2	5.0 ml	1/2	5.0 ml	1	5.0 ml
12 months up to 5 years (10-19 kg)	1	7.5 ml	1	10.0 ml	1	5.0 ml

\* If the child is less than 1 month old, give 1.25 ml syrup twice daily. Avoid cotrimoxazole in infants less than one month of age who are premature or jaundiced.

### ▶ Dry the Ear by Wicking

- ▶ To dry the ear:
  - ▶ Roll clean, absorbent cloth into a wick.
  - ▶ Place the wick in the child's ear.
- ▶ Remove the wick when wet.
- ▶ Replace the wick with a clean one until the ear is dry.

# SORE THROAT

## ASSESS

### ASK:

- Is the child able to drink?
- Does the child have a sore throat?

### LOOK, FEEL:

- Feel the front of the neck for nodes.
- Look for exudate on the throat

## CLASSIFY THE ILLNESS

### SIGNS:

- Not able to drink.

- Tender, enlarged lymph node on neck and
- White exudate on throat

### CLASSIFY AS:

#### THROAT ABSCESS

#### STREPTOCOCCAL SORE THROAT

### TREATMENT:

- ▶ Refer to hospital
- ▶ Give benzathine penicillin or amoxicillin/ampicillin
- ▶ Treat fever, if present.
- ▶ Give paracetamol for pain.

- ▶ Give benzathine penicillin or amoxicillin/ampicillin
- ▶ Give safe, soothing remedy for sore throat.
- ▶ Treat fever, if present.
- ▶ Give paracetamol for pain.

### ▶ Treat Fever

In a falciparum malarious area:

● Fever is high ( $\geq 39^{\circ}\text{C}$ )	● Fever is not high ( $< 39^{\circ}\text{C}$ )	● Any fever, or ● History of fever	● Fever for more than five days.
● Give paracetamol	● Advise mother to give more fluids.	● Give an antimalarial (or treat according to your malaria programme recommendations.)	● Refer for assessment

#### PARACETAMOL doses

Every six hours

Age or Weight	100 mg tablet	500 mg tablet
2 months up to 12 months 6 - 9 kg	1	0.25
12 months up to 2 years 10 - 14 kg	1	0.25
2 years up to 5 years 15 - 19 kg	1.5	0.5

FEVER ALONE IS NOT A REASON TO GIVE ANTIBIOTIC EXCEPT IN A YOUNG INFANT (LESS THAN 2 MONTHS)

### ▶ Give Benzathine Penicillin

for suspected streptococcal sore throat:

BENZATHINE PENICILLIN IM

A single injection

< 5 years	600,000 units
$\geq 5$ years	1,200,000 units

Or amoxicillin, ampicillin, for ten days

▶ Soothe the throat with safe, simple remedies.

▶ Give paracetamol for pain and fever.

**104. Fever (clinical malaria)**

A patient of any age:

- having axillary or oral temperature of 38°0 C or more, or rectal temperature of 38°5 C or more
- without clear origin (such as pneumonia, measles, meningitis, otitis, dysentery, etc.)

**NOTE:**

Of each patient with fever (clinical malaria), a (thin or thick) blood smear should be taken and sent to the laboratory. The OPD register will also specify if the slide was examined in a laboratory within the institution, or if the slide was sent out to an external laboratory.

For each case of fever specify:

- |              |   |
|--------------|---|
| <b>104.0</b> | <b>Blood slide examined in facility</b> |
| <b>104.1</b> | <b>Blood slide sent out</b>             |
| <b>104.2</b> | <b>Blood slide not taken</b>            |

**105. Cough more than two weeks**

A patient with a history of coughing since 15 days or more (see figure 2)

Note: 1. Try to determine as precisely as possible the time period during which the patient is coughing.

For example:

Refer to market days or to local holidays

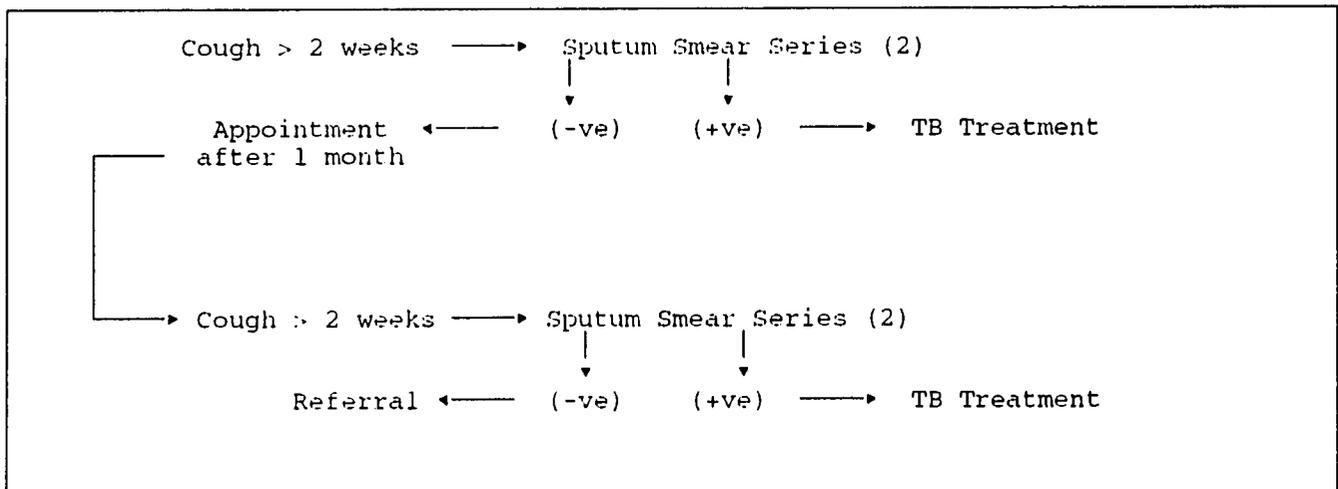
2. For every patient coughing since 15 days or more, a series of two sputum smears should be examined for AFB. If your facility has no microscope or stains to perform this examination, the patient should be sent to the nearest facility where an equipped laboratory is available. If the first sputum smear is positive, no second sputum smear needs to be done.
3. If both sputum smears are negative, a symptomatic treatment is prescribed, and the patient is given an appointment one month later. If cough symptoms are still persisting at that time a second sputum smear series is asked. If again both sputum smears are negative the patient is referred.
4. Children suspected of tuberculosis should always be referred (particularly children of family members suffering from tuberculosis).

For each case of cough: more than two weeks specify:

**105.0** Sputum smears done within facility

**105.1** Patient referred for sputum smear

**FIGURE 2: A PATIENT WITH COUGH MORE THAN 2 WEEKS**



**106. Suspected Cholera**

**IMPORTANT NOTE:**

For each case of Suspected Cholera an Immediate Report on Epidemic Diseases has to be drafted and sent to the District Health Officer (see Module on Reporting for instructions) .

A patient of **5 years and more**

with a **PROFUSE** diarrhea AND

with **SEVERE** dehydration

**NOTE:**

Do **NOT** report cases under five. If you suspect cholera in a child under five, you should naturally provide the appropriate treatment.

**107. Suspected Meningococcal Meningitis****IMPORTANT NOTE:**

For each case of Suspected Meningococcal Meningitis an Immediate Report on epidemic diseases has to be drafted and sent to the District Health Officer (see Module on Reporting for instructions).

A patient of **5 years and more** with a stiff neck and at least **TWO** of the following symptoms:

- Vomiting
- Headache
- Photophobia
- Axillary or oral temperature of 38.0° C or more, or rectal temperature of 38.5° C or more

**NOTE:**

1. Cases with Meningococcal Meningitis confirmed by gram stain of the cerebrospinal fluid should also be reported under this category, even if they were not in accordance with the clinical definition given above.
2. Do NOT report cases under five, unless confirmed by gram stain of the cerebrospinal fluid. If no laboratory facilities are available, refer cases under five to the nearest equipped health institution.

**108. Probable Poliomyelitis**

**IMPORTANT NOTE:**  
For each case of Probable Poliomyelitis an Immediate Report on Epidemic Diseases has to be drafted and sent to the District Health Officer (see Module on Reporting for instructions).

In a patient of any age:

- History of abrupt onset of weakness or paralysis of the leg(s), and/or trunk AND
- History of no progression of paralysis after the first 3 days AND
- History that paralysis was not present at birth or associated with serious injury or mental retardation AND
- Typical findings on physical examination by a qualified health worker: flaccid paralysis, no sensory abnormalities, muscle tenderness (early finding), wasting of the affected muscles (late finding), absent or depressed deep tendon reflexes, asymmetrical findings.

For each case of probable poliomyelitis specify:

**108.0 Not vaccinated**

No vaccinations were received.

**108.1 Partially Vaccinated**

1. The patient has received less than 3 doses

or

2. The patient received 3 doses but they were given without sufficient spacing

or

3. The patient is unable to provide written proof of vaccinations.

**108.2 Fully Vaccinated (by card)**

The patient has received at least 3 doses of vaccine with a minimum spacing of four weeks between the doses as confirmed by a written record of vaccinations (card).

**108.9 Vaccination status unknown**

No information was obtained on the vaccinations status of the case.

**109. Probable Measles**

**IMPORTANT NOTE:**

For each case of Probable Measles an Immediate Report on Epidemic Diseases has to be drafted and sent to the District Health Officer (see Module on Reporting for instructions)

In a patient of any age:

- History of a generalized blotchy rash lasting 3 or more days  
and
- History of fever 38°C or more  
and
- History of any of the following: cough, runny nose (coryza), red eyes (conjunctivitis)  
and
- Any one of the following:
  - typical findings on physical examination by a qualified health worker: fever 38°C or more, cough, runny nose (coryza), red eyes (conjunctivitis), blotchy (maculopapular) rash;
  - exposure to a suspect case of measles in the previous three weeks (incubation 1-2 weeks)
  - epidemic of measles in the area.

For each case of probable measles specify:

**109.0 Not vaccinated**

No vaccinations were received or vaccination took place less than two weeks before the onset of symptoms.

**109.1 Partially Vaccinated**

1. The patient has received vaccinations prior to the age of nine months  
or
2. The patient is unable to provide written proof of vaccinations.

**109.2 Fully Vaccinated (by card)**

The patient has received a vaccination at the age of 9 months or more and at least 2 weeks before the onset of symptoms, as confirmed by a written record of vaccination (card).

**109.9 Vaccination status unknown**

No information was obtained on the vaccinations status of the case.

**110. Probable/Confirmed Neonatal Tetanus**

In a child under 1 month of age:

- History of normal suck and cry for the first 2 days of life  
and
- History of onset of illness between 3 and 28 days of age  
and
- History of inability to suck followed by stiffness and/or "convulsions"  
and
- Death  
and
- Typical findings on physical examination by a qualified health worker: inability to suck (trismus), and/or stiffness (generalized muscle rigidity), and/or "convulsions" (muscle spasms).

For each case of probable/confirmed neonatal tetanus specify:

**110.0 Mother not vaccinated**

The mother has received no vaccination against tetanus.

**110.1 Mother partially vaccinated**

1. The mother has received less than two doses of vaccines or no booster dose during pregnancy

or

2. The mother is unable to provide written proof of vaccinations.

**110.2 Mother fully vaccinated**

The mother has received at least 2 doses of vaccine or a booster dose during pregnancy, as confirmed by mother's record of vaccination (card)

**110.9 Mother's vaccination status unknown**

No information was obtained as the vaccinations status of the case.

## 111. Probable Diphtheria

In a patient of any age:

- Acute pharyngitis, nasopharyngitis, or laryngitis **with a membrane**  
and
- Any of the following:
  - typical findings on physical examination by a qualified health worker;
  - airway obstruction;
  - myocarditis or neuritis (paralysis) 1-6 weeks after onset;
  - exposure to a case of diphtheria in the previous two weeks;
  - epidemic of diphtheria currently in the area;
  - death
  - common alternative diagnosis excluded by appropriate tests (e.g. negative throat culture for group A streptococci or negative blood tests for mononucleosis).

For each case of probable diphtheria specify:

**111.0 Not vaccinated**

No vaccinations were received.

**111.1 Partially Vaccinated**

1. The patient has received less than 3 doses  
or
2. The patient received 3 doses but they were given without sufficient spacing  
or
3. The patient is unable to provide written proof of vaccinations

**111.2 Fully Vaccinated (by card)**

The patient has received at least 3 doses of vaccine with a minimum spacing of four weeks between the doses as confirmed by a written record of vaccination (card).

**111.9 Vaccination status unknown**

No information was obtained as the vaccinations status of the case.

**112. Probable Whooping Cough**

- History of severe cough  
and
- History of anyone of the following:
  - cough persisting more than two weeks
  - bouts of coughing
  - vomiting following coughingand
- Any one of the following:
  - typical findings on physical examination by a qualified health worker: in young infants prolonged coughing (generally with a whoop) followed by a periods of apnea and cyanosis. In older children the paroxysms are often followed by choking and sometimes vomiting and the production of sticky and stringy mucus. Paroxysmal coughing is usually followed by a typical breath intake "whoop".
  - subconjunctival hemorrhages;
  - exposure to a suspect case in the previous 2 weeks;
  - epidemic of whooping cough in the area;
  - white blood cell count with 15,000 lymphocytes/mm<sup>3</sup> or more.

For each case of probable diphtheria specify:

**112.0 Not vaccinated**

No vaccinations were received.

**112.1 Partially Vaccinated**

1. The patient has received less than 3 doses  
  
or
2. The patient received 3 doses but they were given without sufficient spacing  
  
or
3. The patient is unable to provide written proof of vaccinations.

**112.2 Fully Vaccinated (by card)**

The patient has received at least 3 doses of vaccine with a minimum spacing of four weeks between the doses as confirmed by a written record of vaccination (card).

**112.9 Vaccination status unknown**

No information was obtained as the vaccinations status of the case.

**113. Goiter**

[The examiner faces the patient and places his two thumbs on either side of the subject's windpipe several centimeters below the notch of the thyroid cartilage (the "Adam's apple") and rolls his thumbs gently over the thyroid, which lies next to the windpipe. This technique is called "palpation."]

A patient has a goiter if each lobe of the thyroid is larger than the last joint (the "terminal phalanx") of the PATIENT's thumb.

CLASSIFICATION OF GOITER SIZE (*According to WHO*)

<u>Grade</u>	<u>Description</u>
0	No goiter
1A	Thyroid lobes larger than ends of thumbs
1B	Thyroid enlarged, visible with head tilted back
2	Thyroid enlarged, visible with neck in normal position
3	Thyroid greatly enlarged, visible from about 10 meters

**114. Suspected Viral Hepatitis**

A patient with ALL of the following symptoms.

- a. Nausea
- b. Jaundice (yellow conjunctivae)
- c. Axillary or oral temperature of 38.0°C or more, or rectal temperature of 38.5°C or more
- d. Percussion of liver is painful.

**115. Suspected AIDS****(WHO clinical case definition)**

AIDS in an **ADULT** is defined by the existence of at least **TWO** of the major signs associated with at least **ONE** minor sign, in the absence of known causes of immunosuppression such as cancer or severe malnutrition or other recognized etiologies.

**Major signs**

- (1) weight loss more than 10% of body weight;
- (2) chronic diarrhea more than 1 month;
- (3) prolonged fever more than 1 month (intermittent or constant).

**Minor signs**

- (1) persistent cough for more than 1 month;
- (2) generalized pruritic dermatitis;
- (3) recurrent herpes zoster;
- (4) oropharyngeal candidiasis;
- (5) chronic progressive and disseminated herpes simplex infection;
- (6) generalized lymphadenopathy.

The presence of generalized Kaposi's sarcoma or cryptococcal meningitis are in themselves sufficient for the diagnosis of AIDS.

All patients with suspected AIDS should be sent to the nearest reference center for HIV serology

**116. Snake bite with signs & symptoms of poisoning**

**117. Dog bite**

**118. Scabies**

A patient with the following symptoms:

- a. Itching, usually more severe at night.
- b. Erythematous papules and excoriations in areas of predilection such as the interdigital web spaces, wrists, elbows, buttocks, knees and sides of the feet.
- c. Classic linear burrows, particularly in the interdigital spaces.

**Malnutrition (Children < 3y)**

For each child under five brought to the curative consultation, weight and age will be determined (see Manual on Nutrition Training for Primary Health Care Workers).

The child will be classified according to the NCHS/WHO Classification. Expected weight-for-age is according to NCHS standards.

NUTRITIONAL STATUS	WEIGHT FOR AGE (W/A)	CODE
Normal	Within 2 Standard Deviations (SD) from the NCHS median	N
Moderate malnutrition	Weight between 2 SD and 3 SD from the NCHS median	M
Severe malnutrition	Weight 3SD and more from the NCHS median	S
Unknown	Not recorded	U

## **Chapter IV**

# **CURATIVE CONSULTATION (Chronic Episodes)**

---

During curative consultations for chronic episodes the following instruments are used:

For Tuberculosis:

1. TB Facility Card
2. TB Patient Card
3. TB Register

For Other Chronic Diseases:

4. Chronic Disease Facility Card
5. Chronic Disease Patient Card

For each of these instruments a detailed set of instructions is given in this chapter.

### **DEFINITIONS (for tuberculosis)**

---

#### **□ Case Definitions**

New case	A newly detected case of tuberculosis, who is registered for the first time
Relapsed case	A case of tuberculosis who was earlier classified as "cured" in whom active tuberculosis occurred again
Resumed case	A case of tuberculosis who was earlier classified as "lost as defaulter" who resumes treatment
Transferred case	A case of tuberculosis under treatment who comes from another health institution ( <b>transfer in</b> ), or who wants to pursue his treatment in another facility ( <b>transfer out</b> ).

## MODULE 1: DATA RECORDING

Cured case	The patient has completed the full course of treatment and has negative sputum controls.
Case Lost as Defaulter	The patient has not responded to two consecutive monthly default actions
Patient died	The death of the patient has been communicated to the health facility.

### ☐ Standard First Line Treatment:

- Initial Treatment: Daily for 90 days to be administered on an ambulatory basis in the facility.  
  
Streptomycin 1g  
Isoniazid 300mg  
Thiacetazone (TB1): 150mg
- Follow-up Treatment: Daily for 9 months through monthly drug supply  
  
Isoniazid 300mg  
Thiacetazone (TB1): 150mg

### ☐ Standard Follow-up Actions:

- Defaulter: A patient who at the monthly verification of the card is found not to have come to his last appointment since one or more days.
- 1st Default Action: To send a written message to a defaulter, inviting him to come and complete his treatment at the facility.
- 2nd Default Action: If the first default action was not successful, to visit a defaulter at home inviting him to come and complete his treatment at the facility.
- Lost as Defaulter: A patient who is not coming for treatment after two default actions.

#### **NOTE:**

Pulmonary tuberculosis is diagnosed by AFB testing of TWO sputum samples taken in the morning of two different days. In case the first sputum AFB test is found positive, no second test needs to be performed.

## 1. TUBERCULOSIS FACILITY CARD

---

**Purpose** To ensure follow-up of treatment for tuberculosis patients  
To facilitate monthly data aggregation

### Features

Maintained by	In charge of tuberculosis follow-up (MO)
Location	MO's room
Data Origin	Related to TB patient
Initial Recording	At the start of the treatment
Updating	At subsequent visits

**Definitions** See tuberculosis definitions in the beginning of this chapter

### Instructions for filling in (see model)

#### 1. At registration of the patient

Fill in the following items on the card:

- |                                |  |
|--------------------------------|--|
| Yearly No                      | Copy from the Tuberculosis Register and add the current year<br>For example: 24/92 |
| 1. Name                        | Write name of the patient.   |
| 2. Age                         | Write age of the patient in years.   |
| 3. Father's/<br>Husband's Name | Write name of father/husband as appropriate.                                       |
| 4. Sex                         | Fill in "M" for males and "F" for females.   |
| 5. Address                     | Write address of patient as detailed as possible, so that home visit is possible.  |

# TUBERCULOSIS FACILITY CARD

(FCC)

Yearly No:

41 191

1) Name: <i>Khair Gul</i>	2) Age: <i>30</i>	7) Name of Institution: <i>BHU Khairabad</i>										
3) Father's/Husband's Name: <i>Gul Taj</i>	4) Sex: <i>M</i>											
5) Address: <i>c/o Rangar Karyana store Dowail Valley P.O. Khairabad</i>	6) Case Status <input checked="" type="checkbox"/> New Case <input type="checkbox"/> Relapsed <input type="checkbox"/> Resumed <input type="checkbox"/> Transferred in	8) District: <i>Abbottabad</i>										
		9) Place of Diagnosis: <i>DHC Abbottabad</i>										
		10) Transferred from:										
		11) Date Card Issued: <table border="1"><tr><td>1</td><td>6</td><td>/</td><td>0</td><td>8</td><td>/</td><td>0</td><td>1</td><td>9</td><td>1</td></tr></table>	1	6	/	0	8	/	0	1	9	1
1	6	/	0	8	/	0	1	9	1			

12) DIAGNOSIS	13) PREVIOUS / FAMILY HISTORY	14) SPECIAL INVESTIGATIONS				
<i>Pulmonary Tuberculosis</i>	<i>Father had Tuberc. loias &amp; was cured 5 year ago.</i>	<i>Blood Complete: Hb 10mg TLC 8000 X-ray chest: TB cavities at upper lobes.</i>				
Sputum 1: AFB <table border="1"><tr><td>+</td><td>-</td></tr></table> 14/8 Sputum 2: AFB <table border="1"><tr><td>+</td><td>-</td></tr></table>	+	-	+	-		
+	-					
+	-					

15) INITIAL TREATMENT (First 3 months): <i>Strepto 750/INH 300mg oo/Thiac 150mg/OD</i>	16) OBSERVATIONS										17) DEFAULT ACTION	
	Write dates on which daily treatment is given →										1st	2nd
Continue daily treatment up to 90 days	16/8	17/8	18/8	19/8	20/8	21/8	22/8	23/8	24/8	25/8		
	26/8	27/8	28/8	29/8	30/8	31/8	1/9	2/9	3/9	4/9		
	5/9	6/9	7/9	8/9	9/9	10/9	11/9	12/9	13/9	14/9		
	15/9	16/9	17/9	18/9	19/9	20/9	21/9	22/9	23/9	24/9	16/9	<i>Improvement</i>
	25/9	26/9	27/9	28/9	29/9	1/10	4/10	5/10	6/10	7/10		
Sputum Smear Control at 3 months: <i>16/11</i>	8/10	9/10	10/10	11/10	12/10	13/10	14/10	15/10	16/10	17/10	16/10	<i>Continue treatment</i>
	19/10	20/10	21/10	22/10	23/10	24/10	25/10	26/10	27/10	28/10		
	29/10	30/10	31/10	1/11	2/11	3/11	4/11	5/11	6/11	7/11		
	8/11	9/11	10/11	11/11	12/11	13/11	14/11	15/11	16/11	17/11	16/11	<i>follow up treatment</i>

18) FOLLOW-UP TREATMENT (4th to 12th months): 16/11/91 1NH 300mg OD Isoniazid 150mg OD

19) MONTHS	20) DATE		21) DRUGS SUPPLY		22) DEFAULT ACTION		23) OBSERVATIONS
	Due	Taken	INH/Tb1		1st	2nd	
4.	16/12/91	20/12/91	30				
5.	21/1/92	7/2/92	30		2/2/92		Message sent
6.	8/3/92	3/5/92	30		3/4/92	30/4/92	Message sent +
7.	4/6/92	4/6/92	30				Home visit
8.	4/7/92	5/7/92	30				
9.	5/8/92	5/8/92	30				
10.	5/9/92	7/9/92	30				
11.	7/10/92	7/10/92	30				
12.	29/10/92	29/10/92					

Sputum Smear Control at 9 months:

Sputum 1: AFB  +  -  
 5/9/92 Sputum 2: AFB  +  -

24) FINAL STATUS OF PATIENT

- Cured
- Patient Lost as Defaulter
- Patient Died
- Patient Transferred/Referred
- To: \_\_\_\_\_

25) DATE

29/10/92

26) OBSERVATIONS

Patient in excellent clinical condition.

**MODULE 1: DATA RECORDING**

6. Case status      Tick appropriate box (see case definitions)
7. Name of institution      Write name of health institution.
8. District      Write name of district.
9. Place of Diagnosis      Write name of health institution where diagnosis was made, if different from the present place of treatment.
10. Transfer from      If applicable write name of health institution where patient was under treatment previously.
11. Date card issued      Write present date in format dd/mm/yy
12. Diagnosis      Write a more specific tuberculosis diagnosis if available.
- For example:
- Pulmonary Tuberculosis  
Renal Tuberculosis  
Pott Disease
- Encircle the appropriate boxes if sputum exams have been done.
13. Previous/Family History      Write any information relevant to this episode of illness, and to the family situation regarding tuberculosis.
- For example:
- Duration of previous treatment, previous defaulter, brother under treatment, etc....
14. Special Investigations      Write special investigations that were performed relative to the disease:
- X-ray examinations
15. Initial Treatment (First 3 months)      Write initial treatment prescribed.

Under the initial treatment line, a block of ninety cells permits to record the daily treatment given to the patient. The first daily treatment is entered in cell 1 by entering the day and the month of the treatment:

For example:

23 / 6
--------

## 2. At subsequent visits of the patient:

Fill in the following items on the card:

### a) During the first three months:

15. Initial Treatment For each daily treatment given, enter the day and the month in the first empty cell until the ninety cells have been filled.

16. Observations Write here the **WEIGHT** of the patient and any information relevant to the follow-up of the patient

Sputum Smear

Control at 3 months , At the end of the three months **two** sputum smears are taken for control examination

### b) During the next nine months:

18. Follow-up Treatment Write the follow-up treatment prescribed.

19. Months Number of the treatment months

20. Date due Write monthly appointment date on which the patient is supposed to collect his drugs supply.

20. Date taken Write date on which the patient was actually collecting his drug supply.

21. Drugs Supply Write the amount of drugs administered to the patient. If standard treatment, write under INH/TB1; if other, write in next column.

23. Observations Write here the **WEIGHT** of the patient and any information relevant to the follow-up of the patient

Sputum Smear

Control at 9 months At the end of nine months of treatment, **two** sputum smears are taken for control examination.

**3. At the beginning of each month**

At the beginning of each month, examine **all TB facility cards**. Entries are made on the card in the following situations:

a) The patient did not show up for his due appointment:

- 17. Default Action 1st
- 22. Default Action 1st

If no default action was taken in the previous month, write the date of the 1st default action.

- 17. Default Action 2nd
- 22. Default Action 2nd

If the patient has not responded to the 1st default action, write the date of the second default action.

b) The TB Facility Card is closed for any of the following reasons:

Patient Cured            The patient has completed the full course of treatment and has negative sputum controls.

Patient Lost as Defaulter            The patient has not responded to two consecutive monthly default actions

Patient Died            The death of the patient has been communicated to the health facility.

Patient Transferred/ Referred            The patient wants to pursue his treatment in another health institution, or his condition needs referral for treatment.

Make the following entries:

24. Final Status of Patient            Tick one of the boxes. For transferred or referred patients write the name of the health institution.

25. Date            Write date of closure of the card.

26. Observations            Write any information related to the final status of the patient.

## 2. TUBERCULOSIS PATIENT CARD

---

**Purpose** To ensure follow-up of treatment for tuberculosis patients, specially if the patient changes from one health institution to another.

### Features

Maintained by	In charge of tuberculosis follow-up (MO)
Location	Remains with the patient
Data origin	Related to TB patient
Initial recording	At the start of the treatment
Updating	At subsequent visits

**Definitions** See tuberculosis definitions in the beginning of this chapter

### Instructions for filling in (see model)

The Tuberculosis Patient Card is a pocket size document with four pages.

### Page 1 (Front page)

Institution/ District	Put stamp of the institution or fill in.
Yearly No	Copy from the Tuberculosis Register.
Name	Write name of the patient.
Father's/ Husband's Name	Write name of father/husband as appropriate.
Address	Write brief address of the patient.
Name of Institution:	In case of transfer of the patient to another institution, the same TB Patient Card can be used.



**Page 2 (Left Inside page)**

Diagnosis Write a more specific tuberculosis diagnosis if available:

For example:

Pulmonary Tuberculosis  
Renal Tuberculosis  
Pott Disease

Sputum Smear Series Encircle appropriate boxes

Treatment Start Date Write date (dd/mm/yy) when treatment was started.

Initial Treatment (daily) Write initial treatment prescribed.

Follow-up Treatment Write follow-up treatment prescribed.

Treatment Completion Date Write date (dd/mm/yy) when treatment was completed.

**Page 3 (Right inside page)**

**Page 4 (Back page)** Only visits AFTER the initial treatment are recorded.

Date of visit Write date (dd/mm/yy) of subsequent visits.

Treatment Received Write type and amount of drug supply provided to the patient.

Date next visit Write date of next visit.

Signature Of the care provider.

### 3. TUBERCULOSIS REGISTER

---

**Purpose** To facilitate data aggregation

**Features**

Maintained by In charge of tuberculosis follow-up (MO)

Location MO's room

Data origin TB patient, TB Facility Card

Initial recording For each new patient (left page)

Updating At the beginning of each month (right page)

**Definitions** see tuberculosis definitions in the beginning of this chapter

**Instructions for filling in (see model)**

Month/Year For each month a new page is started in the register

No. of patients under treatment at end of previous month (A) To be copied from the previous page: "No of patient under treatment at the end of this month"

**Left Page: Started Treatment During This Month**

Every time a patient is put under treatment fill in the following columns:

Column #

1. S.No Give **serial yearly number** to each patient for which tuberculosis treatment is started. Numbering starts with 1 in the beginning of the year and ends at the end of the year. Each year a numbering starts again from 1. This yearly number will also be recorded on the TB Facility Card and on the TB Patient Card.

2. Name Write the name of the patient

# TUBERCULOSIS REGISTER (FR6)

MONTH: September YEAR: 92

Number of patients under treatment at beginning of this month:

(A) 13

STARTED TREATMENT DURING THE MONTH						
Sr. No.	Name	Date	New	Relapsed	Resumed	Transferred in
214	Munis Akhtar	3.9.92	✓			
215	Said Ahmed	10.9.92	✓			
216	Pervaz	11.9.92		✓		
217	Said Ahmad Khan	22.9.92	✓			
218	Gozan Ali	24.9.92				✓
219	Haider Raza	27.9.92	✓			
220	Asia Hansan	27.9.92	✓			
221	Nawaz Khan	30.9.92	✓			
TOTALS >			6	1	0	1

Number of patients under treatment at end of this month:

DISCHARGED DURING THIS MONTH						
Sr. No.	Name	Date	Cured	Died	Lost as Defaulter	Transferred out
32/92	Naveed Ahmed	3.9.92		✓		
411/91	Asia Begum	16.9.92	✓			
111/92	Haider Jemal	20.9.92			✓	
33/92	Said Ahmed	30.9.92			✓	
302/91	Ashad Nadeem	30.9.92	✓			
215/91	Masood Jafar	30.9.92	✓			
401/91	Aftab Mohammad	30.9.92	✓			
177/91	Rashid Khan	30.9.92	✓			
20/92	Zubeida Begum	30.9.92			✓	
TOTALS >			5	1	3	

(B) 12

= (A) + (4) + (5) + (6) + (7) + (11) + (12) + (13) + (14)

## MODULE 1: DATA RECORDING

3.	Date	Write date (dd/mm/yy) on which the treatment was started.
4.	New	Tick for a new case
5.	Relapsed	Tick for a relapsed case
6.	Resumed	Tick for a resumed case
7.	Transferred in	Tick for a case transferred from another health institution
TOTALS		Total columns 4 to 7

### Right page: Discharged during this month

At the beginning of each month, information from all **closed** TB facility cards is transferred to the right page of the tuberculosis register:

<u>Column #</u>		
8	S. No	Copy the serial number from the tuberculosis facility card
9.	Name	Copy the name of the patient from the TB facility card
10.	Date	Write the date (dd/mm/yy) on which the TB facility card was closed
11.	Cured	Tick for a cured case
12.	Died	Tick for a patient who died
13.	Lost as Defaulter	Tick for a case lost as defaulter
14.	Transferred out	Tick for a patient that was transferred to another health institution for TB treatment
TOTALS		Total columns 11 to 14
Number of patients under treatment at end of this month (B)		Equals the number of patients under treatment at the end of the previous month

Increased by the totals of columns 4 to 7  
Decreased by the totals of columns 11 to 14

## 4. CHRONIC DISEASE FACILITY CARD

---

**Purpose** To ensure follow-up of treatment for patients with chronic diseases such as diabetes, hypertension, hemophilia, etc.

### Features

Maintained by	Medical Officer
Location	MO's room
Data origin	Information generated from the patient
Initial recording	At start of treatment
Updating	At subsequent visits

**Definitions** No specific definitions

### Instructions for filling in (see model)

For patients with chronic problems, who need regular follow-up visits, the OPD register is not an appropriate instrument to keep track of the patient's status. The chronic disease facility card permits MO's to make multiple entries on the same instrument, so that at every new visit, he can recall the past history of the patient and take appropriate measures for further follow-up.

Chronic Disease Facility Cards are filed in the office of the MO or at the Central Registration Point and are classified by Yearly OPD Number so that retrieval is easy when the patient returns.

#### 1. At registration of the patient

At the time of diagnosis of a chronic disease, the patient is recorded as a new case in the OPD Register. A chronic disease facility card is issued. Fill in the following items on the card:

Yearly OPD No. Copy the yearly OPD number on the card, specifying the OPD register letter if several are in use and the current year:

For example:

E/4715/92

## CHRONIC DISEASE FACILITY CARD

Yearly OPD No: A/2021/91

1) Name: <u>Suriya Begum.</u>	6) Name of Institution: <u>RHC Tanila</u>	10) Date Card Issued: <u>01/02/91</u>
2) Father's/Husband's Name: <u>Karim Buksh</u>		11) Date Card Closed: <u>    </u> / <u>    </u> / <u>    </u>
3) Age: <u>45 years</u> 4) Sex: <u>F</u>	7) District: <u>Ramalpindi</u>	12) Reason: Cured <input type="checkbox"/>
5) Address: <u>H # 103, Near Eye Hospital Tanila</u>	8) Place of Diagnosis: <u>RHC Tanila</u>	Died <input type="checkbox"/>
	9) Transferred from: <u>—</u>	Lost for follow-up <input type="checkbox"/>
		Transferred <input type="checkbox"/>

13) HISTORY	15) INVESTIGATIONS		16) DIAGNOSIS
	Date	Requested	Result
1. Generalized weakness			
2. ↑ weight gain	<u>01.2.91</u>	1. Fasting Blood Sugar	<u>150 mg%</u>
3. Painful Joints			
14) CLINICAL EXAMINATION		2- Urine for Sugar	<u>+++</u>
1. Obese woman Swelling Ankle			17) INITIAL TREATMENT
Joints BP 100/60 - Anaemia +ve			1. Control Diet/wt.
wt. 64kg			2. Tab. feldene 7 <sub>2</sub> +0+1
			3. Return after 2 weeks

FOLLOW-UP VISITS				
18) DATE	19) COMPLAINTS/CLINICAL FINDINGS	20) INVESTIGATIONS	21) TREATMENT	22) DATE NEXT VISIT
<u>15.2.91.</u>	<u>No improvement wt 65kg</u>	<u>BS 158 mg%</u>	<u>Start Diabene 100</u>	<u>29.2.91</u>
<u>7.3.91.</u>	<u>wt. 63 kg and improvement</u>	<u>BS 130 mg%</u>	<u>Continue Treatment</u>	<u>3-4.91</u>
<u>8.4.91.</u>	<u>wt. 63kg. Joint pain ↓</u>	<u>BS 102 mg%</u>	<u>Continue Treatment</u>	<u>4-5-91.</u>
<u>5.8.91.</u>	<u>wt. 61kg</u>	<u>BS 85 mg%</u>	<u>Continue Treatment</u>	<u>5-11.91.</u>

1. Name Write name of patient
2. Father's  
Husband's Name Write name of father/husband as appropriate
3. Age Write age of the patient in years
4. Sex Fill in "M" for males and "F" for females
5. Address Write address of patient as detailed as possible, so that home visit is possible
6. Name of Facility Write name of health institution or put rubber stamp
7. District Write name of district
8. Place of  
diagnosis Write name of health institution where diagnosis was made, if different from the present place of treatment
9. Transfer from If applicable, write name of health institution where patient was under treatment previously
10. Date card  
issued Write present date in format dd/mm/yy
13. History Write any information given by the patient relevant to this episode of illness:  
  
For example:  
  
Complaints, previous treatments, previous diseases, dietary information etc.
14. Clinical  
Examination Write a summary of findings through clinical examination
15. Investigations Write date, type of investigation, and results of laboratory, x-ray, or other investigations
16. Diagnosis Write the exact diagnosis of the patient:  
  
For example:  
  
Chronic Arterial Hypertension
17. Initial  
Treatment Write initial treatment prescribed

**2. At subsequent visits of the patient**

Register patient in OPD Register as an old case. Retrieve the chronic disease facility card of the patient based on the Yearly OPD Number that is recorded on the patient card.

Record under "FOLLOW-UP VISITS":

- |                                      |   |
|--------------------------------------|---|
| 18. Date                             | Date of visit in dd/mm/yy format                                    |
| 19. Complaints/<br>Clinical findings | Write summary of complaints and clinical findings during this visit |
| 20. Investigations                   | Write type of investigation and result                              |
| 21. Treatment                        | Write treatment or treatment changes prescribed                     |
| 22. Date next visit                  | Write date of next visit  |

Close Chronic Disease Facility Card in the following situations:

- |   |  |
|---|--|
| The patient is<br>declared cured                                    | Write date under 11. Date Card Closed and tick box under 12.<br>Reason Cured       |
| The patient requests to be<br>followed up in<br>another institution | Write date under 11. Date Card Closed and tick box under 12.<br>Reason Transferred |
| Information on the<br>death of the patient<br>has been received     | Write date under 11. Date Card Closed and tick box under 12.<br>Reason Died        |

**3. At the beginning of each year**

Verify all Chronic Disease Facility Cards and close cards when appropriate:

- |                      |  |
|----------------------|--|
| 11. Date Card Closed | Write date on which card was closed in dd/mm/yy format   |
| 12. Reason           |  |
| Cured                | Tick box if patient is considered as cured   |
| Died                 | Tick box if information on death of the patient has been received  |
| Lost for Follow-up   | Tick box if <b>more than six months</b> elapsed since the date of the next visit as recorded on the card |
| Transferred          | Tick box if patient is known to be followed up in another institution                                    |

Keep closed Chronic Disease Facility Cards in archives for potential research purposes.

## 5. CHRONIC DISEASE PATIENT CARD

---

### Purpose

To permit easy retrieval of the Chronic Disease Facility Card in case a patient with a chronic disease revisits the health institution.

To ensure continuity of care in case the patient decides to seek follow-up in another health institution

### Features:

Maintained by	Medical Officer
Location	Remains with the patient
Data origin	Information generated from the patient
Initial recording	At start of treatment
Updating	At subsequent visits

### Definitions

No specific definitions

### Instructions for filling in (see model)

The Chronic Disease Patient Card has four pages. The first two pages are filled in at the first registration of the patient, the last two pages at subsequent visits.

#### 1. At registration of the patient

At the time of diagnosis of a chronic disease, the patient is recorded as a new case in the OPD Register. A Chronic Disease Patient Card is issued. Fill in the following items on the card:

#### FRONT PAGE

Institution	Write name of health institution or put rubber stamp
Yearly OPD No	Copy the yearly OPD number on the card, specifying the OPD register letter if several are in use and the current year:

For example:

B/4715/92

Name	Write name of patient
------	-----------------------





## Chapter V

# PREVENTIVE CONSULTATIONS FOR MOTHER AND CHILD HEALTH

---

During preventive consultations for mother and child health the following instruments are used:

1. Mother and Child Health (MCH) Card
2. Immunization Card
3. Family Planning Card
4. IDD Card
5. Child Health Register
6. Mother Health Register
7. Family Planning Register
8. Daily EPI Register
9. Permanent EPI Register
10. IDD Register

### IMPORTANT NOTE:

A pregnant woman or child, visiting the health facility for preventive care, is **NOT REGISTERED** in the OPD Register, unless the mother or the child also has a curative problem.

For each of these instruments a detailed set of instructions is given in this chapter.

### DEFINITIONS

---

- Well Maintained Growth Monitoring Card**
  - Weighed at least once in three months
  - Birth date recorded
  - Weight plotted
  - Feeding status recorded
  - Morbidity recorded

**Malnutrition**

Child: NCHS/WHO standards by 2nd and 3rd standard deviations: see Chapter 3

Women: Height for weight: see Manual on Nutrition Training for Primary Health Care Workers

**Birth Weight**

Weight of the child taken within the one week after birth.

**Low Birth Weight**

Birth weight of less than 2.5 kgs.

**Adequate Weight Gain During Pregnancy**

Weight gain of greater than 1 kg but less than 2.25 kgs per month during 2nd and 3rd trimester of pregnancy.

**Assisted Deliveries**

Deliveries conducted by manpower who have had some formal training and in the case of traditional birth attendants are being supervised regularly.

**Methods to Measure Hemoglobin**

- |                      |   |  |
|----------------------|---|--|
| -Sahli:              |   | most practical   |
| -Calorimetric:       | } | more accurate but difficult in first level care facilities |
| -Electrophotometric: |   |  |
| -Spectrophotometric: |   |  |

## 1. MOTHER AND CHILD HEALTH (MCH) CARD

---

<b>Purpose</b>	To improve care and management of antenatal and postnatal mothers and children under 3 years of age.	
<b>Mother</b>	<ul style="list-style-type: none"> <li>■ To identify and monitor high risk pregnancies.</li> <li>■ To aid the health worker in assessing the need for special care and referral.</li> <li>■ To provide health education for the mother herself and help her monitor her own pregnancy.</li> <li>■ To establish better communication between the Dai, the mother, the health facility and the referral hospital.</li> </ul>	
<b>Child</b>	<ul style="list-style-type: none"> <li>■ To identify and monitor high risk children.</li> <li>■ To monitor the growth of the child and promote nutrition from birth up to three years of age.</li> <li>■ To aid the health worker in assessing the need for special care and referral.</li> <li>■ To prompt and help the mother monitor growth and development of her child.</li> </ul>	
<b>Features</b>	<p>The MCH card is a pictorial client card combining mother care, child care, immunizations, and family planning. It is used in follow up of the mother and her child from early pregnancy, through delivery until the child is three years of age.</p> <p>The MCH card is designed for use at various levels of care - by the mother at home, the dai or volunteer to the LHV or WMO at the Health Facility. Being an integrated card and client retained it allows vital information of the family to be carried wherever the mother and/or child seek care.</p> <p>The MCH Card should be filled on first contact with a pregnant women and later the child section should be filled for the child that is the outcome of this pregnancy. If a mother does not come to the care provider during pregnancy but brings her child after birth, some parts of the maternal side should still be filled: the identification information on Section I (till the number of births), and Section IV.</p>	
<b>Maintained by</b>	Mother Section:	Dai, FHT, LHV or WMO.
	Child Section:	Any literate Health Worker (Volunteer, vaccinator, HT FHT, LHV, WMO or MO).

**MODULE 1: DATA RECORDING**

Data Origin	Mother: Pregnant woman. Child: Parent of child.
Location	Client retained.
Initial recording	Mother: On first contact with pregnant woman. Child: On first contact with child.
Updating	Mother: On subsequent follow-up contacts by health personnel, volunteer or vaccinator (as applicable) either at home or the health facility.  Child: High Risk Children: On subsequent monthly contacts. Normal Children: On 3 monthly contacts.

**Definitions:** No specific definitions

**Instructions**

**For Filling In (see model)**

The Mother and Child Health Card is an action oriented, alert card. Alert means drawing attention to a problem. Each entry has a built in alert signal which is the shaded area. An entry in this area anywhere on the card makes the card holder a high risk case and calls for special attention and some action.

It consists of two sides:

- A) Mother
- B) Child

**A) MATERNAL**

The mother side has 4 sections of information

SECTION III (Labour & Delivery)	SECTION II (Present Pregnancy)	SECTION I (General Information)
SECTION IV (Postnatal/ Family Planning)		



These sections store information regarding health care given to the mother at different stages of her pregnancy as well as family planning offered to her in her inter-pregnancy period. The Child Health side is to monitor the health and development of the child from birth to three years of age.

➤ **SECTION I - General Information**

Institution/ District	Stamp this area with the name of health institution and the District, e.g Dhabeji BHU, Thatta.
ID No.	Write the ID. Number, which is made up of 3 parts, Sr. No.-EMD-EMD Yr. All of these can be obtained from the mother register as and when the woman is registered. The serial No. (Sr. No.) is found on the page of the expected month of delivery (EMD).
Name of Woman	Write the name of the mother.
Name of Husband	Write name of husband.
Address/ Village	Write exact address or village and house number as appropriate.
TBA/MW/LHV/MO	Write name of TBA, Midwife, FHT, LHV or MO providing antenatal and possible delivery care. In case these are different write both.
Births	<p>(This section is particularly designed for the care provider such as a TBA who would otherwise have difficulty with understanding the concept of gravidity and parity.) Tick the boxes which correspond with the number of births the woman has had. (Abortions are not considered as births.) For example, if the woman has had 6 births then you would tick boxes 1 through 6. Cross the box if the birth was a still birth or the child died soon after birth. Start with the oldest child.</p> <p>Tick the box reading 0 if the woman is a primigravida (meaning this is her first pregnancy).</p>
Gravida	Write the gravida of the woman i.e. the number of times the woman became pregnant including this pregnancy. Pregnancies leading to one or more live births, still births and/or abortions should be included.
Parity	Write the parity of the woman i.e. the number of times the woman delivered.
Abortions	Write the number of pregnancies that terminated as abortions or immature deliveries before 28 weeks of gestation.

Youngest Child less than 2 Yrs.

Write age of youngest child less than 2 years if there is one and tick the appropriate box.

3 or more Abortions

Tick appropriate box if the woman has had three or more abortions in the past.

No. of Still Births

Write the number of still births in the past if any and tick the appropriate box. A still birth is child born after 28 weeks of gestation and does not breath spontaneously after five minutes of birth and/or there is no detectable heartbeat.

Age of Mother

Write the woman's exact age, at the time of the pregnancy and tick the appropriate column for risk identification. If her age is less than 16 years or more than 35 years, tick the red shaded area.

If the exact age is not known, make a rough assessment by asking as follows.

- (a) How long have you been married ?
- (b) How old were you when you got married ?
- (c) Add (a) and (b) to get to the age of mother.

Height

Record the exact height of the woman in feet and inches and tick the appropriate column.

Weight less than 45 kgs.

Ask the woman her weight before she got pregnant and tick appropriate box. If she does not know her weight before pregnancy, weigh her at first contact, record date of weight and tick appropriate box.

Blood Group

Write the blood group of the woman if known and tick the appropriate column.

T.T. Immunization

Tick the appropriate box(es) when immunization was received and write the date(s) below it. If no immunization was received before this pregnancy tick the box marked zero.

**Protocol for Tetanus Toxoid Vaccination**

The course consists of two basic shots TT1 and TT2 and three boosters BI, BII and BIII. TT2 is to be given one month after TT1, BI six months after TT2, BII 1 year after BI and BIII one year after BII.

If the woman has not followed the above schedule then the following schedule should be followed:

- If the woman has received none or only 1 dose of TT before becoming pregnant then she must receive at least 2 doses during her pregnancy and then follow the above mentioned schedule.
- If the woman has received two or more but less than five doses of TT before becoming pregnant then she must receive at least one dose during pregnancy and then follow the above mentioned schedule for the remaining doses.

The woman should also be informed that if she has completed the 5 doses over the prescribed time period then she has attained lifelong immunity and does not require any further Tetanus Toxoid doses in her life-time.

The TT doses taken during pregnancy must be taken at least two weeks before delivery for them to be effective.

**EXISTING OR PAST  
MEDICAL HISTORY**

Any Chronic Medical  
Problems

Tick the shaded area if the woman is known to have a history of chronic diseases such as diabetes, hypertension, cardiac, renal diseases etc. You may specify if you have the information. Fill in the unshaded area if the woman has no history of chronic illness. Leave the area blank if you cannot assess or elicit any such history or if you are not sure, and ask MO for assistance.

Use of Any  
Medication

Tick the appropriate box and write the names of medicines if any are being used regularly by the woman at the time of interview.

I.D.D.

To be filled in only in areas where Iodine Deficiency Diseases are prevalent. Indicate whether or not the woman has undertaken treatment by ticking the appropriate box.

Previous  
Pregnancy

Tick in the red shaded area if there is any significant past obstetric history that renders the woman at risk for this pregnancy. Tick the risk factor appropriately. If the risk is other than those listed, specify next to 'Other', e.g. excessive bleeding after delivery, fits etc.

## ► SECTION II - Present Pregnancy

This section is pictorially represented so that it may be used :

- by the mother to monitor her pregnancy,
- by the dai as a checklist of conditions to be seen and in assessing the condition of the woman and referring if necessary,
- by the health facility provider in monitoring pregnancy, assessing risk and the need for referral.

**LMP** Write date (dd/mm/yy) when mother had the starting day of her last menstrual period. An important events calendar (see later) may be used to help the woman identify the LMP as accurately as possible.

**EDD** Calculate and write the Expected Date of Delivery. The method for calculating this is as follows: Add 40 weeks to the date of the last period. 40 weeks can be more easily calculated as 9 months and 7 days from the first day of the last menstrual period.

For example:

LMP = March, 4th, 1990.  
 March + 9 months = December.  
 4th + 7 days = 11.

Therefore EDD is 11th December 1990.

**Gestation** **Months:** This row of the table has numbers marked 1st Tri., 4,5,6,7,8,9,10 which correspond to the months of pregnancy (gestation). The 10th month is added because of possibility of mis-calculations.

**Weeks:** The second row of the table has numbers marked 13,18,...44 which correspond to the gestation in weeks.

**Date of Visit** Record here the date of visit of the mother to the health facility. More than one visit can be recorded in the 7th, 8th and 9th month of pregnancy. One column is to be filled for one visit.

The other items in the panel should be filled for each antenatal visit.

- For each item, if the women is at risk tick in the red shaded area.

**MODULE 1: DATA RECORDING**

- If the risk factor is not checked, leave the box blank.

Complaints	Write here any complaints of the woman, and consider whether these pose high risk, e.g. headache, fever, abdominal pain. Ask MO if necessary.
Weight	Record the weight of woman in kgs. in the white area.
Weight gain is less than 1 kg or more than 2.25 kgs per month	If weight gain is less than 1 kg or more than 2.25 kgs per month tick in corresponding shaded area.
B.P.	Record blood pressure in exact numbers e.g 140/80 or 120/80 in the white area.
More than 140/80 mmHg	If B.P. is more than 140/80 mm Hg, tick in the corresponding red shaded area.
Anemia (Hb less than 10g/dl)	Record Hb value if available or put a dash in the white area if the woman is not anaemic by clinical assessment.
Absent	
Present	Tick in the red shaded area if you have clinically assessed the woman as anaemic (pale conjunctivae) or if you have recorded a Hemoglobin value less than 10 g/dl in the white area.
Oedema	
Absent	Put a dash in the white area if there is no oedema.
Present	Tick the red shaded area if you assess the woman has swelling of lower feet. Then check for Pre-eclampsia (bp, urine).
Height of Fundus	This can only be measured if the pregnancy is over 16 weeks. Assess gestation age (period of pregnancy) based on LMP. Measure height of fundus in weeks and record in white area.
Not corresponding to gestational age	Compare assessed gestational age with the measured. If there is a difference of more than 2 weeks, tick in the corresponding red shaded area. (use row 2 at the top for comparison)

For example:

- Date of visit 15 March, 1992;
- LMP August 15, 1991; Gestation 7 month, or  $7 \times 4 \frac{1}{3}$   
= 30 wks.
- Measured height of fundus 24 weeks (at navel)

Conclusion: the difference is 6 weeks.

Position	Assessment is possible only after the sixth month of pregnancy. Put a dash in the white area if the position is cephalic (head down).
Malposition/ Twins	Tick in the red shaded area if the position of the foetus is not cephalic (head down), i.e transverse or breech, or if twins are detected.
Fetal Heart Sounds	
Present	This is relatively easy to do after the sixth month of pregnancy. Ask for decreased or absent fetal movements, then listen to the fetal heart sounds with a fetoscope. Put a dash in the white area if they are normal.
Absent	Tick in the red shaded area if fetal heart sounds cannot be heard after the sixth month or are absent.
Bleeding P/V	
Absent	Put a dash in the white area if there is no history of bleeding.
Present	Tick the red shaded area if there is a history of bleeding. Some women have a little bleeding (spotting) in the initial months of pregnancy, which is normal.
Leaking Liquor	
Absent	Put a dash in the white area in the absence of liquor.
Present	Tick the red shaded area if the woman gives a history of leaking watery fluid and confirm by physical or speculum examination.
Breast Exam	
Normal	Examine breasts during first contact. If normal, tick or record normal findings in white area.
Abnormal	Record any significant abnormal findings in the red shaded area.
Vaginal Exam	
Normal	Record or tick here for normal findings of a Vaginal Examination you may have done. It is not advisable to do many vaginal examinations. Usually, a vaginal examination is done at the time of first contact for assessment of the pelvis. Another examination may be done under strict sterile conditions as possible, just before delivery to assess for labour and fetal presentation.

Abnormal	Record any abnormal findings in the red shaded area.
Urine Exam	
Normal	Put a dash in the white area every time you do a Urine Examination and the result is normal.
Protein/ Glucose	In case of proteinuria or glycosuria tick the appropriate red shaded area.
<b>ACTION</b>	Based on your assessment and identified high risk factors, decide which action should be taken.
Advice & Treatment	Write the advice you give to the mother so that it helps her to remember and helps you to follow-up on a subsequent visit. Record also any treatment such as iron or folate, vitamin, iodine, panadol, tonic chloroquine etc. provided to the woman.
Follow-up /Referral TBA/MW/LHV/MO	This section asks you to decide who should be following the case of this mother. If you are a WMO and you see a mother with a normal, non-risk pregnancy, you may decide to ask the mother to do her subsequent follow-up visits with the TBA, MW (Midwife) or LHV. Alternatively, if you are a LHV, and you assess or suspect a woman to be high risk, you may decide to send her to a WMO for follow-up visits. Write here the initials of the care provider you refer to, e.g. WMO, LHV etc.
Date of Next Visit	Write here the date of a subsequent follow-up visit.
Advised Place of Delivery	Assess from your examinations and history whether the client needs special care at the time of delivery and record the advised place of delivery.

➤ **SECTION III - Labor and Delivery**

This section has information on the Labor, Delivery and Puerperium (up to the 14 days after delivery) and some information about the outcome of pregnancy.

The column for the 10th month in Panel II may be used to check the mother if she arrives in labour.

Labor Pains more than 12 hours	Tick the red shaded area if labor continues beyond 12 hours and seek expert help.
Presentation	Tick the appropriate column after assessing the presenting part. Tick the white area if the presenting part is the occipito-anterior part of the head (this is the normal back-top side position of the head of the baby while being delivered).
Date of delivery	Record the date of delivery.
Type of Delivery	Tick the appropriate box according to the type of delivery i.e. normal (spontaneous vaginal delivery), instrumental delivery (using forceps, vacuum extractor) or operative (caesarian section).
Place of Delivery	Tick appropriate box for place where delivery was conducted i.e. home, first referral level facility (usually RHC or BHU) or hospital.
Delivered by	Tick here if the delivery was conducted by a trained person (e.g WMO, LHV, MW or a trained TBA under supervision) or an untrained person (such as a local village dai or some relative).
Retained Placenta	Tick yes if you suspect that the total or part of the placenta is left in the uterus. If not tick no.
Postpartum Hemorrhage	Tick yes if postpartum bleeding continues more than usual after child birth. If not tick no.
Puerperal Sepsis	Tick yes if you think the mother has puerperal sepsis. This can be suspected by fever and smelly vaginal discharge / lochia. If not tick no.
Other Complications	Specify if complications other than the ones listed occur, and tick yes.
Outcome Stillbirth	Tick the appropriate column according to Live birth or still birth. In case of live births fill the child side of the card. In case of twin births fill in another MCH card for the second twin.

► **SECTION IV - Postnatal/Family Planning Follow up**

This section is to follow up the pregnant woman in her postnatal period and for advising family planning and breast feeding counselling. Record the following on every visit.

- |   |   |
|---|---|
| Date of Visit   | Write date of visit (dd/mm/yy) of the woman to the health facility.   |
| Comments/Examination/<br>Contraceptive Method<br>Used/Breast Feeding<br>Counselling | Write the contraceptive method presently being practiced by the woman. If the woman is not using any, but the husband is, then note it as such. Record advice given for family planning, breastfeeding etc., and any other significant findings such as important complaints, significant findings on examination, dose of contraceptive etc. |
| Date of Next Visit  | Record date (dd/mm/yy) on which you want the woman to come to the health facility for her next visit.   |

**B) CHILD**

The Child side consists of seven sections.

<p>SECTION I Child Information &amp; Risk factors</p>	<p>SECTION II Immunization</p>	<p>SECTION IV Standard Growth Curves</p>
<p>SECTION VI Date of next visit</p>	<p>SECTION III Time scale in months</p>	
<p>SECTION V Nutrition</p>		<p>SECTION VII Remarks</p>

The Child Health Card serves to monitor the development of the child in the critical first three years of life. During these three years, children grow very fast, and any health problem of the child or social problem in the child's home will slow down the child's growth, even to the point where it starts wasting. This will show as a downward growth line and reduced weight according to his/ her age on the growth curve. If the child has repeated events of ill health, the child will not be able to catch up with the growth, and may continue being wasted and stunted for life. If it does improve later, it may go on growing well and follow the growth of a healthy child. The extent to which weight by age is inadequate is expressed in grades of malnutrition, namely Grades N (normal), M (moderate), and S (severe).

بچے کے معلومات

بچے کا نام: **AISHA MUNIR**

سنواری نمبر: **178-92**

جنس:  مہ  پ

خطرے کی علامات

بہتر وقت دن: **3:0**

بوقت یہ نش چکی نہ مالت:  نہیں  ہیں

دستانے کو ہر دو سے زائد نہیں یا چھان:  نہیں  ہیں

پچھت پھر کی نوت:  نہیں  ہیں

کار دور دل سے:  نہیں  ہیں

کار استحال ہو جا:  نہیں  ہیں

آپ بچہ اور والدین کو نشان:  نہیں  ہیں

اگلی بار آنے کی تاریخ

15/10/92	
15/11/92	
16/12/92	
15/1/93	

بچے کو شہما خیر سے دل بکری چکیں۔

اچھی سے

بچے کو شہما خیر سے دل بکری چکیں۔

خطو ہے

بہت زیادہ خطو

دست کو ہر دو سے زائد نہیں یا چھان

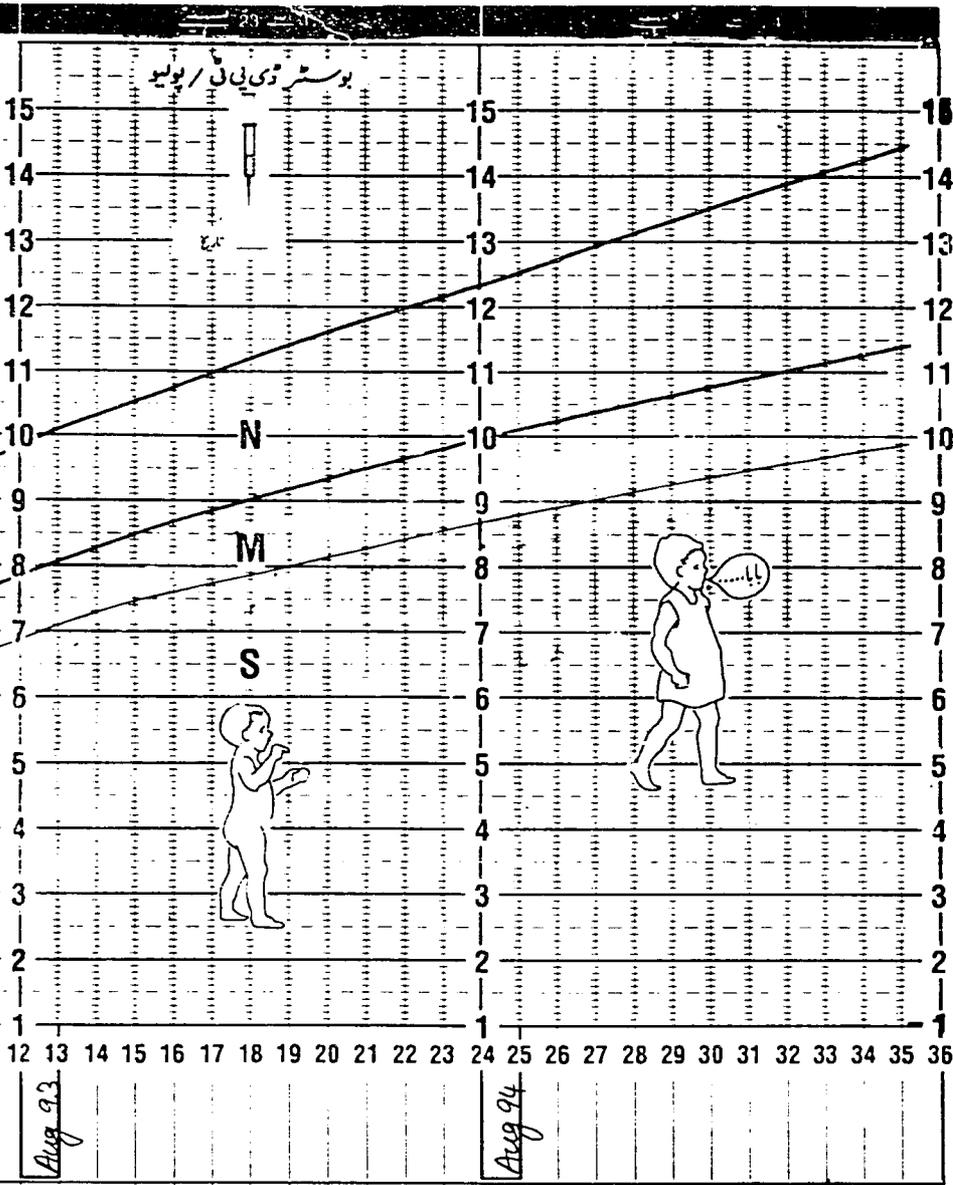
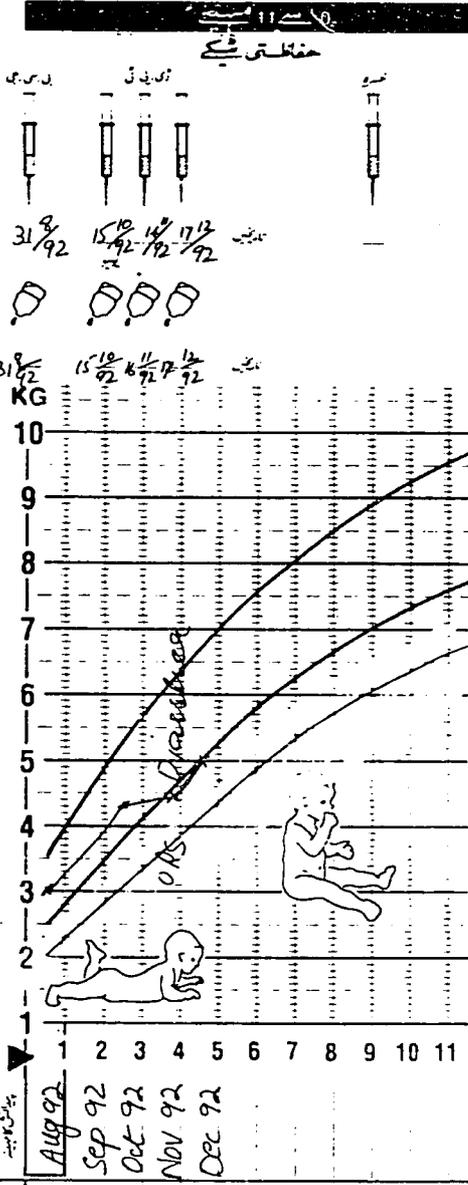
نیاور تھیل کیس

ماں کا درد: **✓**

ماں کو تک صرف ماں کا درد: **✓**

دست سے درد: **✓**

ماں کو تک کی ترکیب (دانی/دانی): **✓**



تصویر

Syndactyly left hand (birth) defect

► **SECTION I - Child Information & Risk Factors**

Basic information pertaining to the child.

Child's Name	Record name of child. Make entry in bold letters.
ID No.	Record identification number of the child as given on the Child Register i.e. Serial No.- Yr. of Registration.
Sex	Tick appropriate box for sex of the child.
Date of Birth	Write date of birth of child by day, month and year (dd/mm/yy).
Risk Factors	These are risk factors which affect the nutrition and health of the child. A child with one or more of these risk factors is considered high risk. The ticks in the risk factors should be updated if the particular status changes after first contact with child and before child is three years of age.
Birth Weight	If weight of the child was taken within a week after birth then tick appropriate box and record the weight. In child is less than 2.5 kgs he/she is a low birth weight baby and thus at high risk.
Poor condition of the child at birth	Tick here if the child was in poor condition (apnoeic, respiratory distress, cyanosed, not crying or poor Apgar score) at birth.
More Than 2 Brothers/Sisters under 5 yrs	Tick yes if mother has more than two children under 5 besides this one, otherwise, tick no.
Previous Infant/Child Death	If there has been a previous under 5 year old child death in the family tick yes otherwise tick no.
Mother Pregnant Again	If mother is pregnant again tick yes otherwise tick no.
Mother Dead	If mother is dead tick yes otherwise tick no.
Father Ill/Unemployed/Dead	If father has a chronic disease, is unemployed, or has died tick yes otherwise tick no.

➤ **SECTION II - Immunization**

Dates of  
Immunization

Record dates (dd/mm/yy) on which the child received the different doses of vaccination. Record dates below the pictorial representation. If the dates are not known but the child has received vaccine tick the appropriate space.

➤ **SECTION III - Time Scale**

The X-axis of the graph (the bottom horizontal line) is the age of the child in months. The Y-axis (the vertical line) is the weight of the child in kgs.

Month Of  
Birth

Month and year in which the child was born. If the mother does not remember the exact month her baby was born try to estimate the month. It may be easier for the mother to remember when her child was born.

- before or after a particular festival
- before or after some major event in her community

It will be helpful for you to prepare your own calendar of local events. Here is an example of finding the age of children based on local events.

<u>LOCAL EVENTS CALENDAR</u>	
MONTHS	LOCAL EVENTS/FESTIVALS
MARCH	Pakistan Day
APRIL	Ramzan
MAY	Eid-ul-Fitar
JUNE	Eid-ul-Azha
AUGUST	Independence Day
	Zia-ul-Haq's death
	Muharram

Once you know or have estimated the birth month and year, write this month & year in the box on the extreme left of the card.

This can then be used to fill in the 3 year calendar of the child at the bottom of the card. The way to do this is by first putting the date of birth in the first box on the left. Second put his birth month in the thick box at

the beginning of the other years. Change the year each time. Third fill in all the months between his birthdays. Each January, write the number for the New Year. The reason for completing the calendar is that it is easy to miss out a month of the child calendar since many will not come for regular monitoring. If birth months are already present, you can see a mistake at once.

► **SECTION IV - Growth Curve**

After weighing the child, record the weight by putting a large dot on the chart. The dot must be on the same level as the weight, directly above the month of the weighing and in the middle of the column for the month in which the weight is being taken. One of the methods of filling in weight dots is: Use the corner of a piece of paper, or card. Put one edge of the paper along the month column. Then fill in the dot next to the corner of the paper. Write the exact weight in brackets next to the dot.

When the child comes next time, weigh the child again enter the weight by putting another dot and the weight in the appropriate place on the card.

Join the new dot to the previous dot. The line thus formed by joining the two dots is the growth line of the child.

It is important to take the weight of a child for at least 2 consecutive months (one after the other) to decide whether the child is growing well or not. A single weight is not enough.

Explanations, Reasons  
for Growth Faltering  
and Action Taken

If the child's growth line goes down, it means the child is losing weight. This is very dangerous, even if the child's growth line is within the two reference lines of the chart. This child could be ill. Find out from the mother, the reasons for the loss. Record the reason (eg. diarrhoea) above the dot and if you took any action (eg. gave ORS) record action taken below the dot (there is an example on the child card).

► **SECTION V - Nutrition**

A nutrition section is at the bottom of the card. It is important to know and make note whether a child is being breast or bottle fed or if weaning foods have been started. If weaning has started it is also important to determine from the mother if the composition of the weaning diet is

appropriate or not. Once weight is recorded ask mother about feeding practice and record in appropriate box.

Breast Feeding	For the first four months it is advised to <b>exclusively</b> breastfeed the child i.e. without any other supplement intake like water, powder or animal milk. Mark 'E' if this is so. If the mother is breast feeding but also supplementing it with something else then just tick. After 4 months if the mother is breast feeding the child then tick. If she is not breast feeding then enter a cross.
Bottle Feeding	Tick if milk is being fed through a bottle and cross if not.
Weaning Food	For mothers who have started weaning their children ask for the composition of the weaning diet. Assess if these is appropriate (A) or inappropriate (I) . Accordingly, put A or I in the boxes. It is advised to begin weaning after the first 4 months.

➤ **SECTION VI - Dates of Next Visit**

Dates of Next Visit	Record dates of next visit (dd/mm/yy) for the child. If the child is high risk then a date one month from the present contact should be given. If the child is normal then a date 3 months from the present contact needs to be given.
---------------------	--

➤ **SECTION VII - Remarks**

Remarks	Record here any significant finding which you feel you need to remember. e.g. Child allergic to penicillin etc..
---------	--

**Interpretation of The Nutritional Status Lines** \_\_\_\_\_

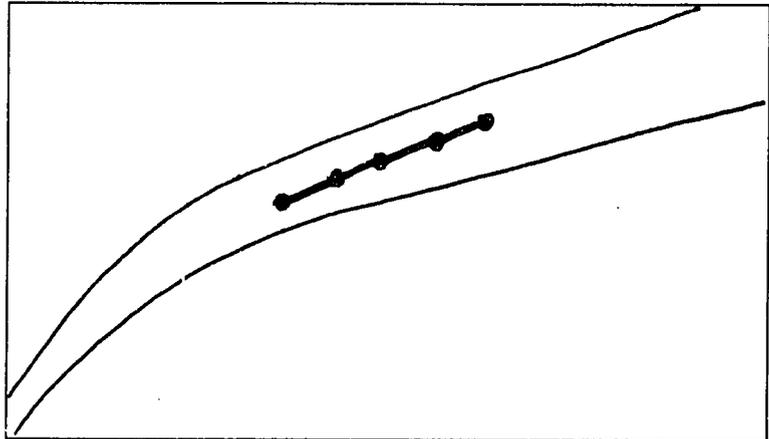
The direction of the growth curve is much more important than the position on the card at one time, but is not always known as it requires two visits of the child to the FLCF.

The grading of the nutrition (nutritional status lines - WHO/NCHS standards) is as follows:

<b>N</b>	=	Normal nutritional status (Median for boys and girls)
<b>M</b>	=	Moderate Malnutrition (2nd standard deviation)
<b>S</b>	=	Severe Malnutrition (3rd Standard deviation)

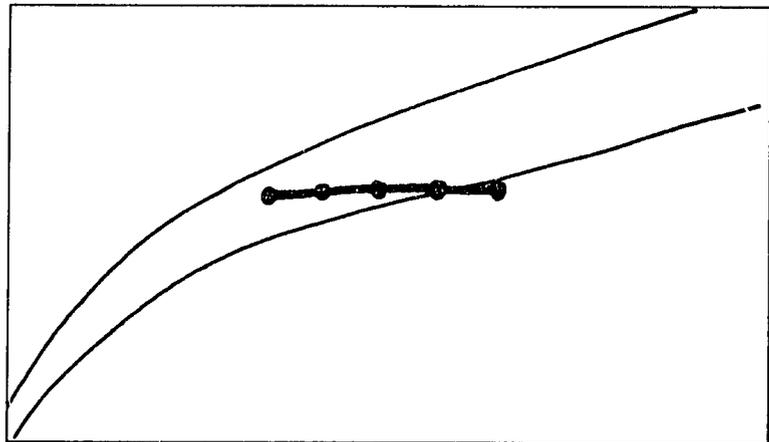
**Climbing Lines**

Good!, the child is growing and gaining weight.



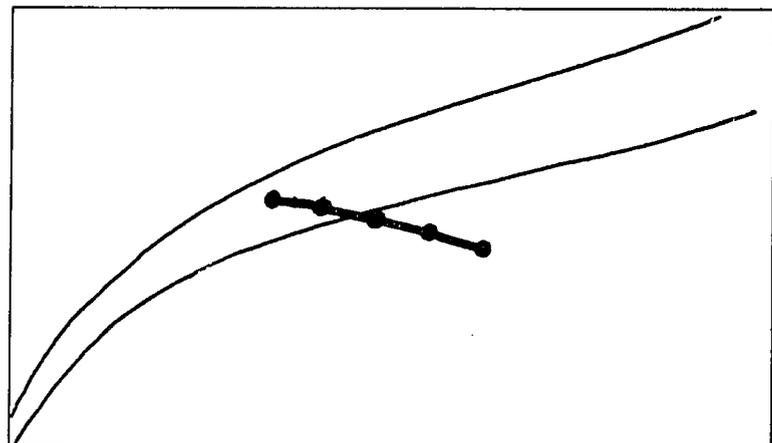
**Steady Lines**

Danger! If the child's growth line is flat, this means the child is not gaining weight. This is a danger signal. You should find out from the mother if the child is: eating well, active or not, has any symptoms of illness e.g. cold, cough, fever etc.



**Declining Lines**

A downward growth line indicates an acute illness, e.g. acute diarrhoea, respiratory infection, measles or a chronic disease e.g. tuberculosis. Or a social or nutritional problem. Tell the mother to give the child special care and feed the child well. You should also make it a point to give this child special attention.



## 2. IMMUNIZATION CARD

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*Use existing model*

### 3. FAMILY PLANNING CARD

---

**Purpose** To identify and follow-up Family Planning users by method.

#### Features

Maintained by	MO/WMO, LHV, FHT or MT
Data Origin	All adult men and child bearing age - non pregnant women.
Form Location	Client retained.
Initial Recording	On first acceptance of contraceptive method by client.
Updating	On subsequent follow-up visits for, complaints/ examinations or refill of contraceptive supplies.

**Definitions** No specific definitions provided

#### Instructions For Filing In (see model)

The Family Planning card is a small two sided card.

On the front side, the name of the client and registration number from the Family Planning register on acceptance and supply of contraceptives is recorded.

The other three sides are used for follow-up visits. On follow-up visits make sure you screen the client for any adverse effects of the contraceptive method by means of relevant history and examinations.

#### FRONT PAGE

Institution/  
District Put stamp of the institution or fill in.

Name of Client Write the name of the client.

Name of Spouse/  
Father Write name of spouse in case of a female client. Write name of father or spouse in case of a male client.

(FC4)	RHC Taxila	ادارہ/سینٹر:
	Ramalpindi	ضلع:
کارڈ پر اے حادثاتی بہبود		
	Rahmat	نام:
	Amur	شوہر/والد کا نام:
	113-92	فیملی پلاننگ رجسٹر نمبر:

دستخط	سنگی اگلی تاریخ	فیملی پلاننگ کے طریقے (جو بتائے گئے)	تاریخ
<del>SK</del>	2.3.92	pills x 3	20.12.92
<del>SK</del>	7.6.92	pills x 3	7.3.92
<del>SK</del>	4.9.92	pills x 3	10.6.92

FP Register No. Write the registration number as given from the Family Planning Register.

OTHER PAGES

Date of Visit Write the date of visit (including the first contact).

Contraceptive Method Used Write the method currently using/ accepted. You may also use this place to write any special comments that would be useful for follow-up.

Date of Next Visit Write the date when you would like to call the client for a follow-up visit.

Signature Write your name/initials so that you may be identified in subsequent visits if the client is being followed up by some other care provider.

#### 4. **IDD CARD**

---

ing model

## 5. CHILD HEALTH REGISTER

---

<b>Purpose</b>	To monitor and follow-up at risk and normal children.
	To maintain a concise history of the child at the health institution for supervision.
	To facilitate aggregation and reporting.

### Features

Maintained by	FHT, LHV, HT, WMO or MO.
Data Origin	Parent or guardian of child.
Location	Child Health Room.
Initial Recording	1st contact with child under 3 yrs.
Updating	Monthly for all High Risk children. Three monthly for all normal children.

### Definitions

High Risk Child	This is a child under three years identified as at risk from the MCH card. A child may be at risk if he is malnourished or his immunization is inappropriate or he has any other social risk factors or his diet is inappropriate (see instructions of child side of MCH card).
-----------------	---

### Instructions

#### For Filling

In (see model)

Start registration on a new page every year. You will see four sections (one for each year) of column 8. Write the current year (e.g. 1992) in the first section of column 8. Write the following 3 years (e.g. 1993, 1994 and 1995) in the remaining three sections of column 8.

Use a new line to register a child attending the preventive child health clinic for the first time.

For all children presenting for follow-up visits, locate by the ID number on the MCH card. If this is not available the child may be located by the name of the parent and address.

MODULE 1: DATA RECORDING

CHILD HEALTH REGISTER (FR3)

Year 1992

1	2	3	4	5	6	7	8															
							Age At Registration		Nutritional Status													
							Less than 1 Year	1 Year or more	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	High Risk	
0025	03/07/92	Siaz %o Inayat	Ghagen phatak	May 91		✓									M	M		N				
0026	08/07/92	Huma %o Hashmat	" "	23/08/91	✓										M	M	M					✓
0027	08/07/92	Sadira %o Qasim	Qureshi Goth	15/05/92	✓										N			N				
0028	09/07/92	Lakhi %o Ram	Raman Goth	June 92	✓										S	S	M		N			
0029	12/07/92	Huma %o Rahim	Dina Shali	01/01/92		✓									M			N				
0030	16/07/92	Habib %o Jan Din	Baluch Goth	10/07/92	✓										N							
0031	22/07/92	Amina %o Haji	" "	Dec 90		✓									M		M		M			✓
0032	25/07/92	Yousaf %o Qasim	Achar Salar	Jan 91		✓									M	S	M					✓
0033	29/07/92	Karim %o M. Buk	Ghagen Patak	19/05/92	✓										S				N			
0034	30/07/92	Khanum %o Hanif	Dhabeji	26/08/92	✓											N			N			
0035	01/08/92	Nabi Buk %o Shakad	Achar Salar	01/02/90		✓										M			M	N		
0036	02/08/92	Lajvanti %o Ram	Qureshi Goth	25/01/91		✓										N						✓
0037	05/08/92	Amina %o Rasheed	" "	Mar 92	✓											S	M		M			✓
0038	10/08/92	Zainab %o Rasool	Dhabeji	01/08/91		✓										M	M	N				
0039	11/08/92	Yaqoob %o Karim	Achar Salar	08/08/90		✓										M	N			M		✓
0040	12/08/92	Sadiq %o Amin	Qureshi Goth	09/10/91	✓											S	M	N				
0041	15/08/92	Shamim %o Kazim	Dhabeji	23/08/90		✓										N				N		
0042	12/09/92	Taj Buk %o Lal Buk	"	04/05/90		✓											N	M	M			✓
0043	15/09/92	Karam %o Nigar M	Achar Salar	05/06/91		✓											M		N			
0044	17/09/92	Rahim %o Jan M	Qureshi Goth	06/07/92	✓												S	M	M	N		
0045	20/09/92	M. Khan %o Qadir	Ghagen patak	09/06/90		✓											M		N	M		✓
0046	22/09/92	Nawaz %o	" "			✓											M	N				
0047	25/09/92	Mohammad %o Younar	Jute Mill	02/10/91	✓												N				N	





CHAPTER V: PREVENTIVE CONSULTATIONS FOR MCH

Year 1995

Nutritional Status													Immunization					Remarks		
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	High Risk	OPV-Zero & BCG	DPT & OPV					Measles	
														I	II	III	Booster			
/	/	/	/	/	/	/	/	/	/	/	/	/		May 91	-	-	Aug 91			
/	/	/	/	/	/	/	/	/	/	/	/	/		08/23/91	09/20/91	10/01/91	11/01/91	12/01/91	05/07/92	
/	/	/	/	/	/	/	/	/	/	/	/	/		15/42						
/	/	/	/	/	/	/	/	/	/	/	/	/		June 92						
/	/	/	/	/	/	/	/	/	/	/	/	/		01/01/91	02/01/91				12/1/92	
/	/	/	/	/	/	/	/	/	/	/	/	/		07/10/92	08/01/92	09/01/92			16/07/92	
/	/	/	/	/	/	/	/	/	/	/	/	/		Dec 90	Jan 91	-	-	April 91	12/07/92	
/	/	/	/	/	/	/	/	/	/	/	/	/		Jan 91					25/07/92	
/	/	/	/	/	/	/	/	/	/	/	/	/		05/19/92						
/	/	/	/	/	/	/	/	/	/	/	/	/		08/26/92	09/26/92					
/	/	/	/	/	/	/	/	/	/	/	/	/		01/01/90	03/01/90	05/01/90	-	09/01/91	01/08/92	
/	/	/	/	/	/	/	/	/	/	/	/	/		01/25/91	02/20/91	04/01/91			02/10/92	
/	/	/	/	/	/	/	/	/	/	/	/	/		Mar 92	April 92				25/01/93	
/	/	/	/	/	/	/	/	/	/	/	/	/		05/01/91	06/01/91	07/10/91		12/11/92	25/2/92	
/	/	/	/	/	/	/	/	/	/	/	/	/		08/08/90	09/10/90	01/01/91			11/08/92	
/	/	/	/	/	/	/	/	/	/	/	/	/		09/09/91	10/20/91				14/08/92	
/	/	/	/	/	/	/	/	/	/	/	/	/		08/23/90	09/20/90	10/20/90	-	01/01/92	15/08/92	
/	/	/	/	/	/	/	/	/	/	/	/	/		05/04/90	06/01/90	11/17/90	12/21/91	-	12/07/92	
/	/	/	/	/	/	/	/	/	/	/	/	/		06/05/91	07/01/91					
/	/	/	/	/	/	/	/	/	/	/	/	/		07/06/92						
/	/	/	/	/	/	/	/	/	/	/	/	/		09/10/90	10/21/91	01/01/91			20/4/92	
/	/	/	/	/	/	/	/	/	/	/	/	/		09/10/91	11/11/92				22/09/92	
/	/	/	/	/	/	/	/	/	/	/	/	/		10/02/91	11/01/91	11/01/91				

Column No.

- |       |   |  |
|-------|---|--|
| 1     | Serial No.  | Assign a serial registration number in chronological order. e.g 234 is the 234th child registered in the current year. After entering the child in the register, write this number together with the year of recording on the card e.g. 234/92 implying that this child may be located as the 234th child in the register of 1992. The ID number is given only once on registering a child for preventive care.  |
| 2     | Date of Registration  | Date (dd/mm/yy) the child was registered at the health institution.  |
| 3     | Name of Child with Father   | Write name of child with name of father for identification purposes.   |
| 4     | Address/Village   | Write exact address or village and house number as appropriate.  |
| 5     | Date of Birth   | Write the exact date of birth (dd/mm/yy) if this can be recalled by parent. If not use the local events calendar to arrive at an approximate date of birth.  |
| 6 & 7 | Age At Registration   | Tick the appropriate age column (under one year or greater than or equal to one year at the time of registration) as determined from the date of birth.  |
| 8     | Growth Monitoring/<br>Appointment Schedule<br>and High Risk<br>identification | <p>Four calendar years are allocated for the growth monitoring/appointment schedule to cover the child up to three years of age.</p> <p>On the first visit calculate from the date of birth when the child will be three years of age. Locate the month and year on the appointment schedule when the child will complete his three years. This is the time up to which you want to growth monitor the child. Cancel (draw a line or cross out) the remaining months indicating that the child will no longer be followed up. E.g. if the child is born in Feb. 1992 he will be 3 years in Feb. 1995. Cancel months from March 1995 onwards till the end of the appointment schedule.</p> <p>On every visit, write the nutritional status of the child as determined from the growth chart in the column of month of visit on the MCH card.</p> <p>e.g. If today is 5th March 1992, and the child weighs 4.2 kgs and is moderately malnourished, then write 'M' in the column of March 92. Now since this child is at risk, you would like to call him back in a month's time i.e. April 92. So circle the month of April 92 for this child.</p> |

This now tells you that this child is to come for a follow-up visit in April. If he does come at the scheduled date then write the nutritional status in the encircled area as above. This tells you that the child has been brought on the scheduled date. In case he does not show up, blank circles will indicate defaulters.

At the end of every month the empty boxes indicate defaulters of that month that need to be followed-up.

High Risk column  
(for every year):

Tick this column if the child has any risk factors for closer monitoring and follow-up. This you will find marked on the child part of the MCH card. High risk includes factors such as growth faltering, inappropriate immunization, social risks or inappropriate feeding etc.

If a child is identified as high risk he will remain high risk till the end of that year. A column for high risk has thus been provided for each year.

9-14 Immunization

Write dates when the immunizations were received by the child. In case dates are not known but the child has received the dose then tick the appropriate column. A child with incomplete immunization for age is also high risk child.

Note: Doses of DT vaccine can be recorded under DPT, specifying so.

15 Remarks

Write any information you think is important for follow-up of this child or for the supervisor.

After each month is over draw a line across the page so as to divide it from the next month. In this way new registrations of the month can be seen at a glance.

## 6. MOTHER HEALTH REGISTER

---

**Purpose**

To have a concise history of the antenatal women available at the health institution.

To follow-up and monitor high risk pregnancies regularly.

To facilitate aggregation and reporting.

### Features

Maintained by	FHT, LHV or WMO.
Location	Antenatal Care room.
Initial Recording	On first contact with pregnant woman.
Updating	Subsequent follow-up contacts (preferably at least once in first trimester). High risk to be monitored as per protocol.

### Definitions

Abortion	A pregnancy terminating before 28 weeks of gestation.
Trained Person	Trained Person may include WMO, MO, LHV or FHT or a Dai. A dai is a (Traditional Birth Attendant) who has received some formal training and is supervised regularly by the health facility staff.
Untrained Person	Untrained Person could be some relative, mother-in-law, neighbor or Dai who has had no formal training and is not supervised regularly.

### Instructions

#### For Filling

In (see model)

Each month of the year is allocated a page in the register starting from the current month. The information of each woman is recorded on the page of her expected month of delivery (EMD).

The expected month of delivery can be taken from the calculation made for the maternal and child health card. i.e. all women identified to deliver in June 92 will be recorded on the June 92 page and all expected to deliver in August 92 will be recorded on the August 92 page.

For the exact date of delivery calculation refer to instructions of Section II of the mother part of the MCH Card.

On follow-up visits the woman is located in the register by her EMD, the EMD year and then by her serial no. of the EMD page.

Column No.

1 Serial No. Assign a serial registration number in chronological order for each page of EMD e.g. Serial number 23 will be the 23rd woman registered for that EMD page. Record this number on the MCH card as follows:

Serial No. - EMD - EMD Yr.

2 Registration Date Write date (dd/mm/yy) the woman was registered at the health institution for antenatal care.

3 Name of Woman Write name of woman with the name of her husband. e.g. Zeenat w/o Allah Bux.

4 Address/Village Write exact address or village and house number as appropriate.

5 Age Write exact age of the woman as recorded on card.

**Prenatal care**

6 LMP Write date (dd/mm/yy) of the beginning of the last menstrual period.

7 EDD Calculate expected date of delivery from the date of the Last Menstrual period (please refer to Section II of the Mother part of the MCH card for calculation details) and record it in this column. If this is not known then attempt to find roughly the EMD - this will then give you an idea of the gestation and approximate month of delivery. Seek the help of the WMO for assessing the gestation and thus the approximate date of delivery by means of examination and investigations.

8 Total Pregnancies Write the total number of pregnancies including the present one. Pregnancies include abortions and still births as well. You may also write this in terms of gravida and para if you are comfortable with this concept.

9 High risk Specify or tick here if the woman is identified as High Risk from the MCH card.

10 & 11 Hemoglobin at 1st measurement Write the first measurement of hemoglobin. Measure the hemoglobin level if equipment is available and record in appropriate column. If hemoglobin level is not known leave both these columns blank.

MODULE 1: DATA RECORDING

MOTHER HEALTH REGISTER (FRA)

					PRENATAL																
1 Serial No.	2 Regist. Date	3 Name of Woman	4 Address / Village	5 Age	6 LMP	7 EDD	8 Total Pregnancies	9 High Risk	10 Haemoglobin at 1st measurement		12 Contacts										
									Less than 10g%	10g% or more	1st Tri	4	5	6	7	8	9	10			
																			Apr	May	June
001	17.3.92	Renne w/o Labok	Kayu Sallat Golla	24y	16.12.91	23.9.92	12	4 abortion			17/3	14									
002	17.3.92	Lakke w/o Kausi	Balauku Golla	37y	10.12.91	17.9.92	8	anaemia BP	✓		17/3	27		14	15						
003	17.3.92	Becki w/o Kalok	Jabi	32y	14.12.91	11.9.92	4				17/3			14			9				
004	17.3.92	Shamun w/o Mirani	Putauw Ullak	35y	12.9.91	Sep 92	8				17/3	10		20	20						
005	20.4.92	Shalima w/o Araf	VVR	20y	15.12.91	22.9.92	3	anaemia	✓		20	11									
006	20.4.92	Nanni w/o Lumbur	Lupok	17y	1.12.91	8.1.92	2				20			12	6	9	3				
007	20.4.92	Simu w/o Kukulok	Daro	16y	4.12.91	11.9.92	3				20			12	15						
008	27.4.92	Shuma w/o Keesim	Kanta	27y	16.12.91	13.9.92	6				27			6	15						
009	27.4.92	Raquya w/o Raj	Jesabli	40y	Dec 91	Sep 92	10	4 still births	✓		27	11		17							
010	27.4.92	Shakila w/o Ramer	Jungu Shabli	44y	Dec 91	15.9.92	4		✓		27	11		17		14					
011	21.5.92	Shumay w/o Ali Bar	Jungu Shabli	3y	5.12.91	12.9.92	3		✓		21			20	5						
012	21.5.92	Zuljan w/o Ramzan	Sabero	30y	16.12.91	23.9.92	4	anaemia	✓		21			15							
013	12.6.92	Kukulok w/o Juma	Sabero	32y	16.12.91	23.9.92	6	4 abortion	✓				12		14						
014	12.6.92	Shamun w/o Araf	Tass	33y	3.12.91	10.9.92	7		✓				12							5	
015	17.6.92	Fauzia w/o Mirani	Tass	30y	11.12.91	18.9.92	5						17							5	
016	17.6.92	Kani w/o Raja	Daro	24y	8.12.91	15.9.92	4		✓				17							5	
017	17.7.92	Soma w/o Stan	Ali Belas	31y	10.12.91	17.9.92	3	anaemia	✓					12						10	
018	17.7.92	Kasoo w/o Loo	Ali Belas	37y	2.12.91	9.9.92	6		✓				12		8					5	

CHAPTER V: PREVENTIVE CONSULTATIONS FOR MCH

EXPECTED MONTH OF DELIVERY: SEPTEMBER 1992

					DELIVERY										POSTNATAL		GENERAL INFORMATION			
I.T. (Date)					Abortion Date	Delivery Date	Livebirth Write Birth Wt. (kg)		Stillbirth	Delivered by		Place of Delivery			Contact Date		Complications	Referral Date	Date of Maternal Death	Remarks (including cause of death)
I	II	III	IV	V			Single	Twin *		Un-trained Person	Trained Person	Home	This Health Facility	Other						
					14.4.92											Bleeding & High B.P.				
✓	15	2				16.8.92	2.2kg			✓		✓			20/92					
✓	14	2	2			15.9.92	2.5kg			✓	✓									
	✓	✓	✓	✓		15.9.92	3kg			✓	✓									
✓	11	5				19.9.92	2kg			✓	✓			1/92						
✓	8	2				8.9.92	3.5kg			✓	✓									
✓	11	6														Fetus/Fils	15.7.92	16.7.92	(unstable died)	
✓	✓	✓	6			16.9.92	2.5kg			✓	✓									
✓	✓	✓	11			18.8.92			✓	✓	✓					High B.P Hemorrhage	17.8.92			
✓	✓	✓	✓			19.9.92	2.5kg			✓		✓								
✓	12	2				14.9.92	3kg			✓		✓								
✓	12	2				29.9.92	3kg			✓		✓								
✓	✓	✓	6			23.9.92	3kg			✓		✓								
✓	✓	✓	10			10.9.92	2.4kg			✓				✓						
✓	✓	✓	7			11.9.92	2.5kg			✓		✓								
✓	✓	✓	17			15.9.92	2.5kg			✓		✓								
13	2					10.9.92	3kg			✓		✓		20/92						
13	10					10.9.92	3kg			✓		✓								

**MODULE 1: DATA RECORDING**

**12 Contacts**

There are eight columns further divided into 13 column for dates of contact. Months corresponding to these are to be filled backwards i.e. if we are filling these for EMD March 1992, then write March '92 in column with subheading 9, Feb.'92 in the column with subheading 8 and Jan. '92 in column with subheading 7 until you come to the 1st column which is for the 1st trimester of the pregnancy. In the column with subheading 10 you would write April '92. The column 10 is provided in case the pregnancy continues beyond the 9th month.

See example below:

EMD March 92

Dates of Prenatal Visits												
1st Tri Jul-Sep 91	4	5	6	7		8		9				10
	Oct 91	Nov 91	Dec 91	Jan 92	Jan 92	Feb 92	Feb 92	Mar 92	Mar 92	Mar 92	Mar 92	Apr 92

Write the date (dd) of contact under the appropriate month of contact. There can be one or more contacts in a month. Space has been provided to record more than one visit in the 7th, 8th and 9th months of pregnancy. In other months, if there is more than one contact then write dates separated with commas.

e.g., if the woman has two contacts, one on the 2nd and the other on the 25th of Dec. 91, then enter 2, 25 in the column.

In the 1st Tri. column, write the day and the month (dd/mm) in which the contact takes place.

The first date of contact is also representative of the date of registration of the mother with the health center for the current pregnancy.

**13 Tetanus Toxoid Immunization**

Write the date when a particular dose of T.T. was given.

A woman who has inappropriate T.T. immunization for this pregnancy is considered high risk. (refer to protocol for TT immunization in the instructions of Section I of MCH card).

**Delivery**

- 14 Abortion date Write date of abortion (dd/mm/yy) if the pregnancy terminated before 28 weeks of gestation. If the abortion is reported in a later month write also the month of reporting and circle it.
- 15 Delivery Date Write date (dd/mm/yy) of delivery. If the child was post-term then circle the date of delivery. If the delivery is reported in a later month, write also the month of reporting and circle it.
- 16 Live birth  
Write birth Wt.  
(Single, Twins) Write the birth weight in kgs. of the child in the appropriate column. If twins are born then use the column of both single and twins to record their weights. Weights should be recorded only if they are taken within the first seven days after birth. If the weight is less than 2.5 kgs. (Low Birth Weight) then circle the weight. If birth weight is unknown then tick the appropriate box if it is a live birth.
- 17 Stillbirth Tick this column if the child is born after 28 weeks of gestation and does not breath spontaneously after five minutes of birth and/or there is no detectable heartbeat.
- 18 & 19  
Delivered By Tick the appropriate column for the kind of personnel conducting the delivery i.e trained or untrained (for definitions refer to first page of Maternal Register instructions).
- 20-22 Place of  
Delivery Tick the appropriate column for the place of delivery.

**Postnatal**

- 23-24 Contact Date Write dates (dd/mm/yy) of postnatal visits to the health institution after delivery.

**General Information**

- 25 Complications Write here any complications that occur during the pregnancy, labor or delivery and thereafter.
- 26 Date of  
Referral If referral was made for any reason during antenatal, delivery, or postnatal period, write date (dd/mm/yy) of referral.

**MODULE 1: DATA RECORDING**

28 Date of Maternal Death Write date of death of the woman if she died during pregnancy or within 6 weeks after giving birth due to a pregnancy related cause. If the death is reported in a later month, write also the month of reporting and circle it.

29 Remarks Record here all drugs from the MSD store that are given to the mother, for example iron, or folic acid.

Also record any special advice or instructions given to the woman. In case of maternal death, record the cause of death.

After each month is over draw a line across the page so as to divide it from the next month. In this way newly registered women during the month can be seen at a glance.

## 7. FAMILY PLANNING REGISTER

---

**Purpose**

- To monitor utilization of Family Planning Services
- To monitor utilization of Family Planning supplies.
- To facilitate aggregation and reporting.

### Features

Maintained by	MO / WMO, LHV, FHT or MT.
Location	Health Center.
Initial Recording	On contact with all clients/patients <b>accepting</b> any method of Family Planning or being referred for family planning.
Updating	Only when feedback received from Population Welfare Centers for clients referred.

### Definitions

New Case	A new case is one who is not using any contraceptive method at the time of contact.
Old Case	An old case is one who is using some contraceptive method (other than natural methods) at the time of contact and has come back for a follow-up visit for complaints / examination and refill.  The client is considered an old case even if he has been registered as a new case in some other health facility.
Acceptor	For the purpose of using this register, an acceptor is a client who after counselling accepts a certain method of Family Planning and is dispensed the same from the Health Facility. Please note that a client who accepts a method but is not dispensed with the supplies from the Health Facility for whatever reason is <b>not</b> counted as an acceptor.  In brief, an acceptor is one to whom supplies of Family Planning are dispensed.

### Instructions

#### For Filling

In (see model)

Register clients/patients who come for Family Planning services in order of attendance by date. Every opportunity (at the curative care clinic, at the antenatal clinic, etc) should be availed to counsel the client/patient for Family Planning. Those counselled but do not accept family planning or are not referred should not be registered.

## FAMILY PLANNING REGISTER (FR5)

1 Serial No.	2 Regist. Date	3 Name of Client	4 Case		6 Age	7 Sex		9 No. of Children	10-16 Contraceptive Method							17 Referral		19 Remarks	
			4a New	4b Old		7a M	7b F		10 Condom	11 Foam	12 Pills	13 Injectable	14 IUCD	15 Surgery	16 Other	17a Referred	17b Feedback Received		
89	4/7/92	Reliana/Aslam	✓		30		✓	7			01yc								
	6/7/92	Nusrat/Akbar		✓	35		✓	4					✓			✓	✓		
90	6/7/92	Karina/Akbar	✓		28		✓	5	20	1Bt									
91	10/7/92	Noori/Shahid	✓		30		✓	7						✓		✓			
92	12/7/92	Kasim	✓		40	✓		6	40	1Bt									
93	16/7/92	Husna/Nageer	✓		35		✓	3			01yc								
94	20/7/92	Rahmat/Amina	✓		35		✓	6						✓		✓	✓		
95	21/7/92	Humaira/Lal Mohd	✓		35		✓	8			2yc								
96	1/8/92	Naela/Safdar	✓		30		✓	6						✓		✓			
97	3/8/92	Shamim/Sharif	✓		35		✓	2	20	1Bt									
98	9/8/92	Azra/Salim	✓		38		✓	4	10	1Bt									
99	16/8/92	Salim Khan	✓		45	✓		9						✓		✓			
100	20/8/92	Shahreen/Oadiz	✓		33		✓	3			3yc								
	24/8/92	Sugra/Relian	✓		32		✓	6				✓							

Column No.

- 1 Serial No. This is a serial registration number in chronological order. For example, 243/92 is the 243rd client of 1992.
- For follow-up/old cases leave this column blank.
- If a mother after delivery accepts a contraceptive method, record on register the ID number from the MCH card with the mother.
- In case of referral write this number on the client card and referral form so as to facilitate location of client when feedback is received.
- 2 Registration Date Date (dd/mm/yy) the client was registered at the health institution for counselling.
- 3 Name of Client Name of person attending with the name father/husband. e.g. Zeenat w/o Allah Bux.
- 4 & 5 Case New/Old Tick the appropriate column according to definition above.
- 6 Age Write down the exact age of the client.
- 7 & 8 Sex Male/  
Female Tick the appropriate column.
- 9 Number of children Write down the number of living children the client has at the time of registration.
- 10 - 16 Contraceptive Method Write the quantity or amount issued to the client. At the end of the month, by counting the quantity in each column you can aggregate the amount of supply issued by method. Alternatively, you may count the rows in each column and aggregate acceptance of contraceptive by method.
- 17 & 18 Referral Fill this column if you refer a client for a procedure or if you do not have contraceptive supply in your facility. Write the referral slip no. in Column 17 and tick column 18 when you receive feedback form the Population Welfare Center.
- 19 Remarks Write any information that you think is important for follow-up of this client or for the supervisor.

**8. DAILY EPI REGISTER**

---

Use existing model

**9. PERMANENT EPI REGISTER**

---

Use existing model

## 10. IDD REGISTER

---

**Purpose** To facilitate aggregation and reporting of IDD related data

### Features

Maintained by LHV, FHT, MHT

Location Room for preventive care

Data origin Case management of patient/client

NOTE This register is maintained only in areas with IDD problems (mostly NWFP, Northern Areas, and AJK)

**Definitions** No specific definitions

### Instructions for Filling In (see model)

On top of each page fill in the year

At the beginning of each day, fill in the date of the day on the first line available.

1. Yearly number To each case, a serial yearly number will be given starting from 1 on January 1 and ending on December 31. This number will be put on the IDD card for identification purpose.

Each year numbering will start again from 1. Do not give a yearly number to clients returning for iodine capsules (old cases).

2. Monthly number To each case, a serial monthly number will be given starting from 1 on the first day of the month, and ending on the last day of the month. The purpose of this number is to facilitate aggregation at the end of the month.

Each month numbering will start again from 1.

3. Name Write the name of the patient.

4. Address Write the address of the patient.

5 to 8. Population category Iodized capsules are given preventively to three population categories

IDD REGISTER (FR7)

YEAR: 1992

1 Yearly No.	2 Monthly No.	3 Name of Client	4 Address	5 Population Category			8 Iodine Caps. (Qty.)	9 Remarks
				Population under 20	Pregnant Women	CBA Women		
1345	24	Nasir Khan	Gujar Kot	✓			2	
1346	25	Naila Kamal	Narowal	✓			2	
1347	26	Sohail Akram	Khairpura	✓			1	
	27	Khadija Bilal			✓		2	
NOVEMBER 8, 1992								
1348	28	Noor Khan	Wali Gotti	✓			1	
1349	29	Arif Ullah	Pind Shahzad	✓			2	
1350	30	Akram Brig	Noor pura	✓			2	
	31	Sharif Khan	Gujar Kot	✓			1	
1351	32	Kulsum Jan	Chak Nawar			✓	2	
NOVEMBER 9, 1992								
1352	33	Roshan Ara	Gujar Kot		✓		2	
	34	Noor Jehan	Pind Gujar	✓			1	
1353	35	Seema Sheikh	Bandi Bala		✓		2	Has lost card
	36	Juma Khan	Khairabad	✓			2	
NOVEMBER 11, 1992								
1354	37	Rehmat Javed	Tarigabad	✓			2	
	38	Akhsana Shauq	Chak Nona		✓		2	
	39	Kausar Mumtaz	Pind Gujar			✓	2	
1355	40	Gulnair Khair	Peeranwala	✓			1	
1356	41	Sarwat Noor	Chak Nawar		✓		2	
NOVEMBER 12, 1992								
1357	42	Tarig Mahmood	Narowal	✓			1	
	43	Nawaz Khan	Khairpura	✓			2	
NOVEMBER 13, 1992								
	44	Nasreen Biki	Chak Nona		✓		2	
1358	45	Kulsum Jan	Pind Gujar			✓	2	
1359	46	Tasneem Kausar	Khairabad			✓	2	
1360	47	Taswar Jehan	Peeranwala			✓	2	
	48	Yaqoob Ahmed	Bandi Bala	✓			2	
	49	Musarat Noor	Chak Nona			✓	2	
1361	50	Ghaz Bukhari	Khairabad	✓			1	
NOVEMBER 14, 1992								
	51	Pasneem Begum	Peeranwala			✓	2	
1362	52	Kausar Biki	Narowal			✓	2	
NOVEMBER 15, 1992								
1363	53	Nasreen Khan	Almad Wala	✓			1	
1364	54	Gsmat Begum	Pind Shahzad		✓		2	
1365	55	Rami Noor	Noor pura		✓		2	
TOTAL >				16	8	8	56	

- 5. Population < 20      Tick this column for each person less than 20 provided with iodized capsules
- 6. Pregnant ladies      Tick this column for each pregnant lady provided with iodized capsules
- 7. CBA women            Tick this column for each women of child bearing age provided with iodized capsules
- 8. Iodized Caps. (QTY)      Write the number of iodized capsules provided

**NOTE:**

The following doses are given every 2 years.

Child under 1:                      1 capsule  
Other children and adults:        2 capsules

- 9. Remarks                      Write any remarks relevant to case management

## ***Chapter VI***

# ***PHYSICAL RESOURCES MANAGEMENT***

---

During physical resources management the following instruments are used:

1. Stock Register (Medicines/Supplies)
2. Stock Register (Equipment/Furniture/Linen)
3. Daily Expense Register
4. Stock Register (Vaccines)
5. Log Book (Vehicles)

For each of these instruments a detailed set of instructions is given in this chapter.

## **DEFINITIONS**

---

## 1. STOCK REGISTER FOR EQUIPMENT/FURNITURE/LINEN

---

**Purpose** To help incharge of the facility to manage inventory of equipment/ furniture/linen.

To facilitate for reporting to higher levels.

### Features

Maintained by Store Keeper or Incharge of the Health Facility

Location Office of the store keeper.

Data Origin Items received and struck off during the year.

**Definitions** No specific definitions.

**General Instructions** All the pages of the register are to be serially numbered. The first pages are allocated for the index. The register is divided into three sections, one each for Equipment, Furniture, and Linen. Within each section, separate pages are allocated for each article.

On the top of the page, write the name of the article and eventual specifications.

For example:

Name of Article: Table  
Specifications: Metallic 8' x 3'

### Instructions For Filling In (see model)

DURING THE YEAR

#### Columns:

1: Date Use this column to write the date of each transaction.

2: Particulars Write the particulars of the transaction corresponding to the date. Eg. "Received chairs from DHO office against invoice/bill no. 5321".

3: Price Write price of the article as mentioned on invoice



4: Quantity Received Write quantity of the item as received.

5: Quantity  
Struck-off

Write quantity of the item that was struck off. This may have been due to the item being expended, broken and not repairable, disposed off, auctioned, etc. after being declared as unserviceable. For articles struck-off the signature of the District Health Officer is necessary (in column 7).

6: Quantity Balance Write the quantity that remains in inventory after the transaction is completed.

7: Name and  
Signature

This column is for verification of the transaction performed.

8: Remarks

This column is for any remarks the store keeper or the incharge may have regarding the transaction. For example a note from the District Health Officer for the items declared as unserviceable under rules.

#### AT THE END OF THE YEAR

At the end of each year, a physical inventory should be organized, with items received and items struck off verified with supporting documents.

In the register, the date of the physical inventory is recorded in column 1. In column 2 (particulars) write "physical inventory". Then record the total quantities received and struck off during the year, and the balance. This recording is signed by the incharge of the health institution.

The physical inventory will categorize remaining items of the balance into "unserviceable", "repairable", and "serviceable". This information will be transferred into the Yearly Report.

Based on this physical inventory, the register's balance should be updated if physical inventory's balance is different from the register's balance. Any such update should be signed by the District Health Officer.

## 2. STOCK REGISTER FOR MEDICINES/SUPPLIES

---

<b>Purpose</b>	To manage stocks of medicine and supplies in a First Level Care Facility.  To facilitate aggregation of quantities consumed on a yearly basis for reporting to higher levels.
<b>Features</b>	
Maintained by	The store keeper or incharge of the health facility.
Location	The store room or dispensary.
Data Origin	All medicines and supplies received and issued are to be recorded in the register, and the balance updated at each entry.
<b>Definitions</b>	No specific definitions.
<b>General Instructions</b>	<p>All the pages of the register are to be serially numbered. The first pages are allocated for the index. Items in the index could arranged alphabetically.</p> <p>The register is divided into two sections, one section for Medicines, and one for Supplies. Within each section, separate pages are allocated for each medicine or supply item. Allocate a sufficient number of pages for items with a high number of transactions. Every time a new item is being recorded in the register, the index should be updated.</p> <p>On the top of each page, write the name of the medicine or supply item and its unit.</p> <p>For example: <b>Name of Article:</b> Amoxicillin <b>Unit:</b> Capsule 500 mg.</p>
<b>Instructions for Filling In (see model)</b>	
<u>Columns:</u>	
1: Date	Write the date of the receipt, issue, or balance of the item.
2: Received from/ Issued to and Reference	Write the source of the medicine or supply. If the stock is being issued, then write the place to where it is issued. Reference number is the number on the receipt/folio/etc.



3: Quantity in units  
Received Write the quantity received in units as defined on the top of the page.

4: Quantity in Units  
Issued: For Care Write the quantity issued, in units as defined on the top of the page, for care.

Quantity in Units  
Issued: Discarded The quantities of the item that have expired, and have been discarded. Column 6 should then have signatures of the supervisor or the incharge of the health facility to verify this. In case if the item is stolen or lost, then it should still come under this column to distinguish it from the quantities issued "for care".

**IMPORTANT NOTE: Management of expiry dates**

1. Upon arrival of a new batch of medicines, ALWAYS put this new batch BEHIND the remaining medicines on the shelves, so that these will be consumed first.
2. Use bin-cards for each medicine in the store. Mark visibly the expiry date on the bin-card.

5: Quantity in Units  
Balance Write the quantity in balance remaining in the store after each transaction in units as defined on the top of the page.

6: Name & Signature The store keeper or the incharge of the health facility should sign each row at the end of each transaction. In case the article has expired and needs to be discarded, or in case of loss or theft, the supervisor and the incharge both sign in this column.

7: Remarks Record any remarks or comments here: e.g., expiry dates of received medicines.

NOTE:

1. It is suggested, for more efficient recording, to write with a RED INK pen for received items, and with a BLUE INK pen for issued items.
2. Stocks of "Essential Drugs and Supplies" are reported monthly in the monthly report. In order to facilitate reporting, a red line should be drawn at the end of each month, separating data entry in the previous month from that of the next month.

### 3. DAILY EXPENSE REGISTER

---

**Purpose** To verify the daily consumption of medicines and supplies issued from the MSD store to the dispensary room of First Level Care Facilities.

**Features**

- Maintained by The dispenser of the health institution.
- Location The dispensary room.
- Data Origin Medicine chits" written by the care provider for MSD drugs

**Definitions** No specific definitions.

**General Instructions** Every time a care provider prescribes MSD drugs, he writes them on a small "medicine chit" that is presented by the patient to the dispenser. The dispenser in turn provides the medicines to the patient.

At the end of the day, the dispenser, based on the "medicine chits" received, counts the quantities issued for care for each medicines and records them on the Daily Expense Register. The MOIC can verify daily if the quantities on the Daily Expense register correspond with the quantities on the 'medicine chits".

At the end of the month, the total quantities issued for each medicine or supply item as recorded on the Daily Expense Register, should be equal to the quantities "issued for care" during the month in the Stock Register (Medicines/Supplies)

**Instructions for Filling In** (see model)

- Columns
- Name of Article: Write name of medicine or supply item
- Unit Write supply unit of medicine or supply item
- 1,2,3,... Write under the appropriate date for each medicine or supply item the quantities issued during the day.
- Signature I/C Each day the I/C after verification signs the bottom of the page.

# DAILY EXPENSE REGISTER (FR16)

Month: September Year: 1992

Name of Article	Unit	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total
Aminophylline	inj	0	1	0	2	1	1	1	0	1	1	0																					
Aminophylline	tabl	10	12	13	14	20	15	21	16	25	5	7																					
Benzyl Benzoate	lotian	2	0	3	2	1	4	0	3	2	0	4																					
Chlapheniramine	tablet	15	25	35	15	25	10	25	30	15	5	10																					
Deazepam	tbl 2mg	10	16	19	17	9	15	16	24	3	6	9																					
Danicil Proj.	vial	8	4	12	3	11	11	9	7	14	8	7																					
Aspirine	tbl	45	60	40	35	45	60	60	35	45	40	50																					
Cambantin	tbl	12	15	18	15	12	12	18	21	18	15	12																					
Dramamine	tbl	4	7	14	31	15	19	9	21	4	7	7																					
Dramamine	syr	2	1	0	3	0	0	4	2	1	1	1																					
Paracetamol	tbl	62	42	41	45	50	49	37	43	62	44	37																					
Para Cetamol	syr	5	4	6	7	3	4	5	9	2	0	4																					
Ampicilline	caps	40	120	60	80	130	60	70	140	60	90	120																					
Ampicilline	syr	3	2	6	4	5	7	8	3	4	9	5																					
Busscopan	inj	1	0	2	0	2	2	3	0	1	4	3																					
Busscopan	tbl	12	15	18	18	18	9	3	15	21	12	12																					
Chlapheniramine	tbl	45	90	36	45	50	60	35	45	51	32	46																					
Signature I/C >		[Handwritten Signature]																															

**4. STOCK REGISTER (VACCINES)**

---

Use existing Model

**5. LOG BOOK (Vehicles)**

---

Use existing Model

## ***Chapter VII***

# ***HUMAN RESOURCES MANAGEMENT***

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During human resources management the following instruments are used:

1. Population Chart of Catchment Area
2. Birth Register
3. Meeting Register
4. Attendance Register

For each of these instruments a detailed set of instructions is given in this chapter.

## **DEFINITIONS**

---

---

## 1. POPULATION CHART OF CATCHMENT AREA

---

<b>Purpose</b>	<p>To summarize information about the population in the catchment area around each health facility. The population chart is a management tool to measure care provided to target populations.</p> <p>To facilitate aggregation of data on the population in the catchment area for reporting to the District Health Officer. A copy of the population chart should be sent to the DHO every year.</p>
<b>Features</b>	
Maintained By	The population chart of catchment area is filled in and maintained by the MO/IC of the health facility.
Location	Posted on the wall of the health facility.
Data Origin	Population living in the catchment area of the health facility per village and per risk group.
<b>Definitions</b>	No specific definitions.
<b>General Instructions</b>	<p>Initially, the most accurate estimates of population per village should be obtained, if possible by local surveys.</p> <p>Also, a map of the catchment area should be drawn, showing the location of villages and other main facilities in the area.</p> <p>Each year, the population chart of catchment area should be updated either by increasing the available population figures with the standard growth rate in Pakistan (3%), or by surveying the population. For example, each year a certain number of villages could be visited by the health workers and population figures estimated.</p>
<b>Instructions For Filling In</b> (see model)	<p>Write on top of the Population Chart:</p> <p>Institution name            Year            Union Council(s) to which the institution is providing services            District</p>
<u>Columns:</u>	
1. Sr. No	Give serial number to each village in the catchment area.

## POPULATION CHART OF CATCHMENT AREA

(FR11)

Institution: BHU BHANPUR I.D. No.: 345617 Year: 1992Union Council: BHATKELA District: GUARA

1 Sr. No.	2 Name of Villages	3 Population	4 Distance from Facility (Km)	5 No. of CHWs	6 No. of TBAs	
					Trained	Untrained
1	Sunjwal	474	5	0	1	0
2	Gariwala	1,438	3	0	1	0
3	Haji Golti	836	8	0	1	0
4	Bhanpur	2,847	0	0	2	0
5	Ghais	1,371	7	0	0	1
6	Gujra	931	13	0	1	0
7	Dhabeiji	1,749	21	2	2	0
8	Sori bazi	372	14	1	0	1
9	Kazampura	1,699	12	0	1	0
TOTAL >		11,711		3	9	2
% of population living more than 20 km. from Institution:		14.9 %				

TARGET RISK GROUPS	STANDARD DEMOGRAPHIC PERCENTAGES	ESTIMATED POPULATION
Expected Pregnancies	4.5	527
Expected Births	4.0	469
0 - 11 months	3.8	445
0 - less than 3 years	11	1,289
CBAs (15 to 44 years)	21	2,461
Married CBAs (15 to 44 years)	16	1,875

## MODULE 1: DATA RECORDING

2: Name of Villages	List the names of all the villages in the catchment area around the health facility. If not enough space is available, additional charts can be filled.
3: Population	Write the population per village.
4: Distance from facility (Km)	Write in Km. the estimated distance of the village from the health facility.
5: No. of CHWs	Write the number of trained Community Health Workers working in the catchment area and linked to the health facility.
6: No. of TBAs Trained/Untrained	Write the number of trained and untrained Traditional Birth Attendants working in the catchment area and linked to the health facility.
Total	<p>In the last row, calculate the total population for column 3, the total number of CHWs for column 5, and the total number of TBAs (Trained and Untrained) for column 6.</p> <p>Also, calculate the % of population living more than 20 km. from the institution. For that purpose, pick the villages at more than 20 km. from the institution out of column 3, add their populations, and calculate this sum as a percentage of the total population in the catchment area.</p>
Target Risk Groups	These are the given target risk groups.
Standard Demographic Percentages	The standard demographic percentages were derived from the age structure in the population sample of the Pakistan Demographic Survey (1984-1988).
Estimated Population	Based on the given standard demographic percentages, for each target risk group, calculate the estimated population by applying the given percentage to the total population of the catchment area as given at the bottom of column 3.

## 2. BIRTH REGISTER

---

<b>Purpose</b>	To monitor population growth in catchment area.
	To monitor delivery outcome in catchment area.
	To monitor birth weight as a proxy indicator of maternal nutritional status, and a risk for childhood morbidity and mortality.
	To identify newborns in catchment area for preventive follow-up.

<b>Features</b>	The Birth Register is an administrative register. It records all births (deliveries after 28 weeks of gestation) including still births.
Maintained by	MO/WMO, LHV, FHT or MT.
Location	MOs room.
Initial Recording	On report of all births in catchment area.
Updating	None. One time recording.

### Definitions

Birth	A delivery after 28 weeks of gestation including still births.
Low Birth Weight	Birth weight less than 2.5 kgs. Birth weight of 2.5 kgs. and over is considered normal birth weight.  If weight at birth is not available, the weight within the first <b>seven</b> days of birth may be recorded.

### Instructions For Filling In (see model)

Register all births reported within catchment area, by field staff or TBAs or other reliable sources such as village head etc. after verification.

### Column No.

1 Serial No.	This is serial number given in chronological order at the time of registration. e.g. 243/91 is the 243rd birth of 1991.
--------------	---

## BIRTH REGISTER (FR12)

1 Serial No.	2 Date of Birth	3 Name of Child	4 Name of Father & Mother	5 Address/Village	6 Sex (M/F)	7 Outcome		9 Birth Weight		11 Remarks	12 Registration Date	13 Registered By
						Live-birth	Still-birth	In Kg.	Tick if less than 2.5 Kg			
001		Kasliq	Yasmeed/Bilquis	Dhabeiji	M	✓		2.70			10/07/92	Kamala HV
002		Sakce	Dostmohd/Yasmin	Adrem Salen	M	✓		2.75			12/07/92	Dostmohd
003		Khusrum	Bashir/Aminah	Dhabeiji	M	✓					13/07/92	Humida dai
004		Halima	Rasim/Roshan	Ghais	F	✓		2.40	✓		17/07/92	Kaisar
005		Kasim	Peruqiz/Zeemat	Gujju	M	✓					22/07/92	Farooq
006		Nawaz	Nazir/Halima	Gijju phatalle	M			2.65			25/07/92	Hajira
007		Nazir	Yaqoob/Bajuman	Kasam pusa	M	✓		2.50			28/07/92	Kamran
008		Mohd Rasool	Meluhob/Najesa	Sajan pur	M	✓		2.90			31/07/92	Meluhob
009		Still birth	Ialbus/Bena	Rahimiyarkhan	-		✓				5/08/92	Rasool
010		Lakni Begum	Masood/Gulnaz	Mispu Ghaz	F	✓		2.30	✓		08/08/92	Gulshan HV
011		Gharala	Nabilax/Masim	Haji Gollu	F	✓		2.5			09/08/92	Fahimda HV
012		Hafeeza	Yarbus/Rahema	Nori Gollu	F	✓					17/08/92	Nabila HV
013		Still birth	Meluhob/Rozana	Gora Bari	-		✓				20/08/92	Zanab HV
014		Shereen	Rasool/Shekano	Gari uah	F	✓		2.9			22/08/92	Meluhob dai
015		Nadia	Mohammed/fatima	Sunjamal	F	✓		2.4	✓		23/08/92	Farooq
016		Mohd Yasim	Nazir/Kausar	Sunjam wali	M	✓					24/08/92	Hajira
017		Still birth	Hafeez/Kulsooj	Kari pur	M		✓	-			28/08/92	Meera Dai
018		Rasim	Yasmeed/Bilquis	Thalta	M	✓					27/08/92	Kamala

- 2 Date of Birth Self explanatory.
- 3 Name of Child For live births write the name of child if named. If not, leave column blank and identify by name of father and mother (Column 5). If it is a still birth write still birth.
- 4 Name of Father and Mother Write the name of the newborn child's father and mother for identification purposes.
- 5 Address/ Village Write down exact address or village and house number as appropriate.
- 6 Sex Write sex of child, M if male and F if female.
- 7 & 8 Outcome Tick in column 7 if the outcome is a live birth and in column 8 if the outcome is a still birth.
- 9 & 10 Birth Weight Record the weight in kgs. in column 9 if it has been taken within the first seven days of birth. If the weight is taken beyond seven days after birth, enter a dash in this column. Also enter a dash in this column if you are not sure of the weight. Put a line in this column if it is a still birth. Tick in column 10 if the weight recorded in column 9 is less than 2.5 kgs.
- 11 Remarks Write any information that you think is important for follow-up of this birth or delivery.
- 12 Registration Date Write down the date (dd/mm/yy) on which the birth was reported and registered in this register.
- 13 Registered By Write name of person giving information for registration of birth at the health institution.

### 3. MEETING REGISTER

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**Purpose** To keep a record of meetings, training, or field visits held at or organized by the First Level Care Facilities.

To facilitate aggregation of information about these activities for reporting to higher levels.

**Features**

**Maintained by** The person conducting the activity. Should periodically be checked by the incharge.

**Location** The Office of the Incharge of the facility.

**Data Origin** All types of meetings, training, field visits or other activities held at or organized by First Level Care Facilities.

**Definitions** No specific definitions.

**Instructions for Filling In (see model)**

Use a new page in the register for the start of each new month. Fill in the month and the year at the top of each page in the register.

**Columns**

- 1: Date** Fill in the date of the event or activity (meeting, training, field visit, etc.) in the format of dd/mm/yy.
- 2-9: Type of meetings** Check (✓) the appropriate column to specify the type of the meeting.
- 2: Supervisory visit** Check this column for visits by supervisors. Also note the designation of the supervisor in column 12.
- 3: Staff** Check this column if there is a meeting between the staff of the health facility.
- 4: TBA** Check this column if there is a meeting with Traditional Birth Attendants (Dais).
- 5: CHW** Check this column if there is a meeting with Community Health Workers.

# MEETING REGISTER (FR15)

Month: September Year: 92

1	2	3	4	5	6				9	10	11	12	13	14
					Type of Meetings	Health Committee	Health Talks	Home Visits						
Date	Supervisory Visit	Staff	TBA	CHW	Health Committee	Health Talks	Home Visits	Other (Specify)	Place	Number of Participants	Purpose	Action Taken	Name & Signature	
4.9.92		✓							Mo's Room	8	Routine weekly	Write letter to DHO on Vaccant CHV position	Dr. Ahmed Ali	
6.9.92						✓			School Rajpur	120	Hygiene / Scalpies		Dr. Ahmed Ali	
11.9.92							✓		Bahasa	-	Annual Heter/ TB patient	Write him to pursue treatment	Dr. Ahmed Ali	
13.9.92							✓		Rajpur	-	Asia Begum / pregnant	Control blood pressure	Shajia Iqbal	
16.9.92	✓									8	Quarterly visit	See Supervisory checklist	Dr. Ahmed Ali	
18.9.92		✓							Mo's room	8	Routine weekly	-	Dr. Ahmed Ali	
24.9.92					✓				Nazpura	20	Quarterly meeting	Organisation of mobile NCH clinic	Dr. Ahmed Ali	
27.9.92							✓		Kharakat		Sumera Bibi TB patient	Write to pursue treatment	Dr. Ahmed Ali	
27.9.92		✓							Mo's room	8	Routine weekly	Write letter to DHO on Chloroquine stock out	Dr. Ahmed Ali	

INSTRUCTION MANUAL For First Level Care Facility Staff — 1-161

CHAPTER VII: HUMAN RESOURCES MANAGEMENT

## MODULE 1: DATA RECORDING

- 6: Health Committee Check this column if there is a meeting with the health committee, with community leaders or with village chiefs.
- 7: Health Education Sessions Check this column if health education sessions were given in the Health Facility, in school or in the community, etc.
- 8: Home visits Check this column every time a staff member is performing a home visit.
- 9: Other field visits (specify) Specify if any type of meeting or activity took place other than specified in columns 2 to 8.
- 10: Place Specify name of the place where the meeting or the activity was held.
- 11: No. of Participants Write the number of participants who attended the meeting or activity.
- 12: Purpose Write the subject or purpose of the meeting or activity, i.e. why the event took place. For example, "training", "family planning counselling" or "field visit for ORS study".
- 13: Actions Taken Write the "action taken" if any, i.e., what was the outcome of the meeting, or what agreements were made, training given, decisions made, etc.
- 14: Name & Signature The register should be signed by the person conducting the activity.

#### 4. ATTENDANCE REGISTER

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Use existing model

M O D U L E 2

# **Data Reporting**

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## MODULE ON DATA REPORTING

Under the Health Management Information System for First Level Care Facilities, reporting has been simplified at a maximum.

Only 3 types of reports are required from first level care facilities:

1. The Immediate Report for Epidemic Diseases
2. The Monthly Report
3. The Yearly Report

For each of these instruments a detailed set of instructions is given in this module.

## 1. IMMEDIATE FLCF REPORT

---

The Immediate FLCF Report on Epidemic Diseases is sent out to the District Health Officer for ANY case of the following diseases reported to your health facility:

- 106. Cholera
- 107. Suspected Meningococcal Meningitis
- 108. Poliomyelitis
- 109. Measles

In case of outbreaks of any other disease with serious epidemic threat, this same report can be used for reporting.

For example:

Hemorrhagic Fever

The report is filled in double. A copy of the report is kept in the health facility.

The report form has three parts:

part 1 Institution Identification	part 2 Disease Specification
part 3 Case Listing	

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## **SPECIFIC INSTRUCTIONS FOR FILLING IN THE REPORT (See model)**

Write the **date on which the report was sent out** on the top **RIGHT** side of the form

### **Part 1: Institution Identification**

- A. Identification No.: Write the identification number of the health institution
- B. Institution name: Write the name and place of the institution
- C. Province:
- D. Division:
- E. District:
- F. Tehsil/Taluka:
- G. Union Council:
- H. In charge Name: Write the name of the In charge of the health institution
- I. Signature: Signature of the In charge of the health institution

### **Part 2: Disease Specification**

Tick one of the five boxes foreseen for disease identification. In case the box 'Other disease' is ticked, specify the name of the disease.

**IMPORTANT NOTE:**

Only ONE disease can be ticked!

### **Part 3: Case Listing**

For each case that was reported to the health institution, give the following specifications:

1. Sr.No: Assign case numbers starting with 1
2. Date Reported: Write the date on which the case reported to the health institution
3. Date of Onset: Write the date on which first symptoms appeared, based on the history taking.

# IMMEDIATE REPORT ON EPIDEMIC DISEASES

Date: 17/09/92

<p>A. Identification No.: <u>2456167</u></p> <p>B. Institution Name: <u>BHU Tariqabad.</u></p> <p>C. Province: <u>NWFP</u></p> <p>D. Division: <u>Gujranwala</u></p> <p>E. District: <u>Thatta</u></p> <p>F. Tehsil/Taluka: <u>Kawas</u></p> <p>G. Union Council: <u>Tariqabad</u></p> <p>H. Incharge Name: <u>Dr. Ahmed Khan</u> Signature: <u>[Signature]</u></p>	<p>Report within 24 hours to the District Health Officer any case of the following health problems. Use a separate sheet for each disease. Attach additional sheets if required.</p> <p>Tick one only</p> <p><input type="checkbox"/> 106. Cholera</p> <p><input type="checkbox"/> 107. Suspected Meningococcal Meningitis</p> <p><input type="checkbox"/> 108. Poliomyelitis</p> <p><input checked="" type="checkbox"/> 109. Measles</p> <p><input type="checkbox"/> Other disease which presents a serious epidemic threat, specify: _____</p>
---	--

1	2	3	4	5	6	7	8			11	12
							Not Vacc.	Part Vacc.	Fully Vacc.		
Sr. No.	Date Reported	Date of Onset	Name/Father's Name	Sex MF	Age	Address	Vaccination Status			Action Taken	Referred To
1	16.9.92	13.9.92	Nawaz Khan	M	11m	Balqa Mullah	✓			Rx	
2	17.9.92	10.9.92	Missa Biki	F	34	Tariqabad			✓		DHO Thatta
3	17.9.92	13.9.92	Radial Tariq	F	18m	Bandi Bala	✓			Rx	
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											

4. **Name/Father's Name:** Write the name of the patient and of the father of the patient
5. **Sex M/F:** Fill in M for male or F for female patients
6. **Age:** Write the age of the patient in years. For children under two, age should be written in months; for infants under 1 month, age should be written in days.
7. **Address:** Write the address of the patient as detailed as possible, so that home visit can be envisioned.
8. **Vaccination Status:** Give vaccination status for cases of suspected meningococcal meningitis, poliomyelitis and measles.
9. **Not Vacc.:** The case had no previous vaccination
10. **Part. Vacc.:** The case had received incomplete vaccination or vaccination status can be assessed only by history.
11. **Fully Vacc.:** The case was fully vaccinated as assessed through vaccination card.
12. **Action taken:** Write any action taken related to the case: e.g. stool specimen taken for a poliomyelitis case
13. **Referred to:** If the case was referred for hospitalization, write the name of the referral institution.

## 2. MONTHLY FLCF REPORT

The Monthly Report for First Level Care Facilities is a comprehensive four page document, addressing health problems seen, activities performed, and resources used during the previous month.

The report is divided in 8 sections. For each section, if applicable, first data source and instructions for aggregating are given. Then instructions follow on how the data from the source are transferred on the report form.

### GENERAL INSTRUCTIONS

1. Before drafting the report, VERIFY if the registers from which data need to be aggregated were filled in correctly. This is particularly true for the OPD Register: the total of New Cases in Column 3 should be equal to the number of New Cases per age category (Columns 6 to 15)
2. Under each section the source of the data is mentioned:  
  
For example: Growth Monitoring data from the Child Health Register
3. Fill in **ALL** items of the report. Never leave blank a possible entry. If the number of the item is zero, fill in 0.
4. For activities that are normally not performed in the health facility, the reporting section can be crossed out and overwritten by "Not Applicable"

For example \_\_\_\_\_

E. Family Planning												
Total Visits	Male	Female	New Cases	Old Cases	Visits by Contraceptive Method						Referred	
					Condom	Foam	Pills	Injection	IUCD	Surgery		
Units Distributed >												

NOT APPLICABLE

On the top right side of the report, fill in **month and year** of the reporting period.

**1. INSTITUTION IDENTIFICATION**

- A. Identification No: Write the identification number of the health institution
- B. Institution Name: Write the name and place of the health institution
- C. Province:
- D. Division:
- E. District:
- F. Tehsil/Taluka:
- G. Union Council:
- H. Incharge Name: Write the name of the person who is in charge of filling in the report
- I. Signature:

**2. POPULATION DATA**

**Data source:**                      **Population Chart**

J. Catchment area population                      Column 2 Total

K. Expected Births this month:                      Catchment area population divided by 300

$$\frac{\text{CA POP} \times 4 \%}{12} = \frac{\text{CA POP}}{300}$$

Ministry of Health  
**MONTHLY REPORT**  
For First Level Care Facilities

Month: **07** Year: **92**

**1. INSTITUTION IDENTIFICATION**

A. Identification No: **245678**

B. Institution Name: **RHC Nawa Kot**

C. Province: **Balochistan**

D. Division: **Sukkur**

E. District: **Mardan**

F. Tehsil/Taluka: **Bokara**

G. Union Council: **Nawakot**

H. Incharge Name: **Dr. Ahmad Kazi** *[Signature]*

**2. POPULATION DATA**  
*(From Population Chart)*

J. Catchment Area Population: **20,000**

K. Expected Births this month (CA population / 300): **67** (1)

*(From Birth Register)*

Number of Births Registered (2)	<b>22</b>	% of Expected Births (2) / (1)	<b>32.8</b> %
Number of Newborns Weighed (3)	<b>10</b>	% of Births Registered (3) / (2)	<b>45.5</b> %
Number of Low Birth Weight Babies (4)	<b>4</b>	% of Newborns Weighed (4) / (3)	<b>40</b> %

**3. MEETINGS / HEALTH EDUCATION SESSIONS / HOME VISITS** *(From Meeting Register)*

A. Number of Staff Meetings held: **4**

B. Meetings:

- 1. with TBAs **0**
- 2. with CHWs **0**
- 3. with Health Committee or Community Leaders **1**

C. Health Education Sessions:

- 1. in Institution **1**
- 2. in Schools **1**
- 3. in Community **0**

D. Home Visits by Facility Personnel: **3**

**4. ESSENTIAL DRUGS / VACCINES / SUPPLIES** *(From Stock Register)*

Item	Unit	Recd	Issued		Closing Balance	Days out of Stock	Other Essential Drugs/Supplies	Unit	Days out of Stock
			For Care	Discarded					
A. BCG Vaccine	dose	400	80	0	420	0	M. ORS	packet	0
B. DPT Vaccine	dose	200	200	0	320	0	N. Cotrimoxazole	tablet	0
C. Polio Vaccine	dose	200	220	0	290	0	O. Cotrimoxaz. syrup	bottle	0
D. TT Vaccine	dose	200	300	0	140	0	P. Chloroquine	tablet	14
E. Measles Vaccine	dose	100	90	0	270	0	Q. Primaquine	tablet	0
F. DT Vaccine	dose	50	20	0	130	0	R. Iron Tablets	tablet	0
G. Syringes	piece	400	350	0	850	0	S. Folate Tablets	tablet	0
H. Needles	piece	300	900	0	1735	0	T. Streptomycin	vial	31
I. Oral Contraceptive	cycle	0	15	0	45	0	U. Isoniazid (INH)	tablet	31
J. Condoms	piece	0	50	0	80	0	V. INH+Tb1	tablet	31
K. Inj. Contraceptive	dose	0	4	0	9	0	W. Ziehl-Nielsen	bottle	0
L. IUDs	piece	10	?	0	17	0	X.		

**5. COMMENTS / RECOMMENDATIONS / ACHIEVEMENTS**

*Third consecutive month without Tuberculosis drugs. Please send as soon as possible.*

**6. TRANSMISSION**

A. Received at District Health Office on: **07/08/92** Name/Signature: *Dr. Nassis Khan*

B. Received at Computer Center on: **03/08/92** Name/Signature: *Dr. Abdul Kazi*

C. Data Entered on Computer on: **14/08/92** Name/Signature: *Dr. Abdul Kazi*

**Data source:** Birth Register

After each month is over, draw a line across the page, so as to divide entries of this month from those of next month. In this way monthly registration can be seen at a glance.

**No. of Births Registered**

Count the number of children for which birth was registered in the current month (look at registration dates in column 12)

**% of Expected Births**

$$\frac{\text{No of Births Registered} \times 100}{\text{No of Expected Births}}$$

**No. of Newborns Weighed**

Count in column 9 the number of children weighed during the current month (look at registration date in column 12)

**% of Births Registered**

$$\frac{\text{No of Newborns Weighed} \times 100}{\text{No of Births Registered}}$$

**No. of Low Birth Weight Babies**

Count in column 10 the number of children with birth weight less than 2,500 grams during the current month (look at registration date in column 12)

**% of Newborns Weighed**

$$\frac{\text{No of Low Birth Weight Babies} \times 100}{\text{No of Newborns Weighed}}$$

### 3. MEETINGS/HEALTH EDUCATION SESSIONS/HOME VISITS

**Data source:** Meeting Register

Aggregate data from the page(s) related to the reporting month.

**A. Number of Staff Meetings held**

Count the number of staff meetings held in column 3



Closing Balance Copy the balance on the last date of the month from column 5 into the monthly report

Days out of Stock If the balance was zero at any point in time during the month, count the number of days the balance was zero. If the balance is still zero at the end of the month, count the number of days since the balance was zero until the end of the month.

For example:

Balance zero on April 14: 16 days out of stock

**NOTE:**

1. For drugs/vaccines/supplies not available in your facility, fill in "N.A."
2. Give only the number of days out of stock during the CURRENT month (meaning maximum 31 days)!

**For each of the items M to Z**

Days out of Stock If the balance was zero at any point in time during the month, count the number of days the balance was zero. If the balance is still zero at the end of the month, count the number of days since the balance was zero until the end of the month

For example:

Balance zero on April 14: 16 days out of stock

**NOTE:**

1. For drugs/vaccines/supplies not available in your facility, fill in "N.A."
2. Give only the number of days out of stock during the CURRENT month (meaning maximum 31 days)!

**5. COMMENTS/RECOMMENDATIONS/ACHIEVEMENTS:**

This space can be used to report on any subject not foreseen in the regular lay out of this report:

- Health problems not specified in the report
- Stock outs of drugs/supplies not specified in the report
- Administrative issues
- Communications to District Health Officer
- Recommendations to higher authorities
- Activities performed

## 6. TRANSMISSION

- A. Received at District Health Office on      Write date (dd/mm/yy) on which the report was received at the district office
- Name/Signature      Write name and signature of the person who received the report
- B. Received at Computer Center on      Write date (dd/mm/yy) on which the report was received at the computer center
- Name/Signature      Write name and signature of the person who received the report
- C. Data entered in Computer on      Write date (dd/mm/yy) on which data of the report were entered in the computer
- Name/Signature      Write name and signature of the person who entered the data

**PAGE 2 & 3**

**7. CURATIVE CARE**

**A. New Cases**

**Data source: OPD Register**

After each month is over, draw a line across the page, so as to divide new cases entered this month from those of next month. If totals are made from page to page, very little calculations have to be made to aggregate data for the monthly report.

- 1. MALE Copy totals per age category from columns 6 to 10 to the report. Then make total.
- 2. FEMALE Copy totals per age category from columns 11 to 15 to the report. Then make total.
- 3. Total New Cases Make the sum for each age category and for the total of the numbers under 1. and 2.
- 4. Old Cases Copy total from column 1 to the report.
- 5. Total visits Make the sum of 3. Total New Cases and 4. Old Cases.
- 6. Cases Referred Count the number of referred cases during the current month in column 20 and transfer the total to the report.
- 7. Feedback from Cases Referred Count the number of referred cases on which feedback was received in column 21 and transfer the total to the report.
- 8. % Referred of Total New Cases  
$$\frac{6. \text{ Cases Referred} \times 100}{3. \text{ Total New Cases}}$$
- 9. % Feedback on Referred Cases  
$$\frac{7. \text{ Feedback from Referred Cases} \times 100}{6. \text{ Total Cases Referred}}$$

## B. Health Problems (Priority Diseases)

**Data Source**                      **Abstract register**

Prior to the drafting of the monthly report, all cases of priority diseases are tallied in the abstract register.

The number of cases per age category and the total can now easily be transferred from the abstract register in the monthly report.

**% of New Cases**                      
$$\frac{\text{Total number of cases of a disease} \times 100}{3. \text{ Total New Cases}}$$

Total new cases  
priority diseases

Add up for each age category and for the total the number of new cases of all priority diseases

## C. Diarrhoea (New Cases < 5 years)

**Data source**                      **Abstract Register**

101.a. No. of  
Diarrhoea Cases  
under 5 years

Transfer totals in column 5 for 101.0, 101.1, 101.2, and 101.9, and make the total

101.b. % of total  
Diarrhoea Cases  
under 5 years

Calculate percentage for each Dehydration Status Category out of total New Cases of Diarrhoea under 5 years

## D. Dysentery (New Cases < 5 years)

**Data source**                      **Abstract Register**

102.a. No. of  
Dysentery Cases  
under 5 years

Transfer totals in column 5 for 102.0, 102.1, 102.2, and 102.9, and make the total

102.b. % of total  
Dysentery Cases  
under 5 years

Calculate percentage for each Dehydration Status Category out of total New Cases of Dysentery under 5 years

**MODULE 2: DATA REPORTING**

<b>7. CURATIVE CARE</b>						
<b>A. New Cases</b> (all diseases by age group) (From OPD Register)	Under 1	1 to 4	5 to 14	15 to 44	45 and over	Total
1. Male	91	95	46	182	37	451
2. Female	95	103	61	202	41	502
3. Total New Cases	186	198	107	384	78	953
4. Old Cases						243
5. Total Visits (3. + 4.)						1196
6. Cases Referred						73
7. Feedback from Cases Referred						24
8. % Referred of Total New Cases (6 / 3.) x 100						77 %
9. % Feedback on Referred Cases (7 / 6.) x 100						32.9 %

<b>B. Health Problems</b> (Priority diseases) (From Abstract Register)	Under 1	1 to 4	5 and over	Total	% of Total New Cases
101. Diarrhoea	16	31	19	66	6.9 %
102. Dysentery	2	5	18	25	2.6 %
103. Acute Respiratory Infections	26	32	41	99	10.4 %
104. Fever (Clinical Malaria)	14	24	17	55	5.8 %
105. Cough more than 2 weeks	0	0	15	15	1.6 %
106. Suspected Cholera	0	0	0	0	0 %
107. Suspected Meningococcal Meningitis	0	0	1	1	0.1 %
108. Poliomyelitis	0	2	0	2	0.2 %
109. Measles	14	4	0	18	1.9 %
110. Neonatal Tetanus	5			5	0.5 %
111. Diphtheria	1	0	1	2	0.2 %
112. Whooping Cough	0	0	0	0	0 %
113. Goiter	0	0	4	4	0.4 %
114. Suspected Viral Hepatitis	0	0	9	9	0.9 %
115. Suspected AIDS	0	0	1	1	0.1 %
116. Snake bite with signs of poisoning	0	3	6	9	0.9 %
117. Dog Bite	1	2	2	5	0.5 %
118. Scabies	0	0	12	12	1.3 %
Total new cases priority diseases	74	103	146	323	34.4 %

<b>C. Diarrhoea</b> (New Cases under 5 years) (From Abstract Register)	Dehydration Status				Total Diarrhoea Cases under 5 Years
	Without 101.0	Some 101.1	Severe 101.2	Not specified 101.9	
101. a. Number of Diarrhoea Cases under 5 years	19	17	4	7	47
b. % of total Diarrhoea Cases under 5 years	40.4 %	36.2 %	8.5 %	14.9 %	

<b>D. Dysentery</b> (New Cases under 5 years) (From Abstract Register)	Dehydration Status				Total Dysentery Cases under 5 Years
	Without 102.0	Some 102.1	Severe 102.2	Not specified 102.9	
102. a. Number of Dysentery Cases under 5 years	6	1	0	0	7
b. % of total Dysentery Cases under 5 years	85.7 %	14.3 %	0 %	0 %	

E. Acute Respiratory Infections (New Cases Under 5 years) (From Abstract Register)		No Pneumonia 103.0	Pneumonia 103.1	Severe Pneumonia 103.2	V. Severe Disease 103.3	Unknown 103.9	Total ARI Cases under 5 Years
103. a. No. of ARI Cases under 5 years		36	14	5	0	4	59
b. % of total ARI Cases under 5 years		62.1 %	24.1 %	8.6 %	0 %	6.9 %	

F. Malaria							
(From Abstract Register)	Blood Slides						Total Fever Cases
	104.0 Examined in Facility		104.1 Sent Out		104.2 Not Taken		
104. Number of Fever Cases (New cases all ages)	46	83.6 %	0	0 %	9	16.4 %	55
(From Laboratory Register) (Only Outpatient New Cases)	Internal		External				
	Number	% Positive	Number	% Positive			
1. Total Number of Slides Examined (New Cases)	44		14				
2. Number of Slides Malaria Parasite Positive	16	36.4 %	4	28.6 %			
3. Number of Slides Plasmodium Falciparum Positive	9	20.5 %	2	14.3 %			

G. Tuberculosis						
(From Abstract Register)	Sputum Smears Requested				Total Cases Cough more than 2 weeks	
	105.0 Examined in facility		105.1 Patient Referred			
105. Number of Cases of Cough more than 2 weeks (New cases all ages)	15	100 %	0	0 %	15	
(From Laboratory Register) Only Outpatient New Cases	Internal		External			
	Number	% Positive	Number	% Positive		
1. No of Sputum Smear Series Done	14		21			
2. Number of Smears Series AFB Positive	4	28.6 %	4	19.0 %		
(From Tuberculosis Register)					Number	
1. Tuberculosis Patients under Treatment at end of previous month					16	
2. Started Treatment this month	a	Total Number Started Treatment (Including new, relapses, transferred and resumed treatment)		2	% of Total Number Started Treatment ↓	
	b	Number of New Cases		2	100 %	
3. Discharged during this month	a	Total Number Discharged (Including cured, died, transferred and lost as defaulters)		7	% of Total Number Discharged ↓	
	b	Number Lost as Defaulters		6	85.7 %	
4. Tuberculosis Patients under Treatment at end of this month					11	

H. Immunizable Childhood Diseases (From Abstract Register)	Not Vaccinated	Partially Vaccinated	Fully Vaccinated	Vaccination Status Unknown	Total Cases	% of Cases Fully Vaccinated
108. Poliomyelitis	1	1	0	0	2	0 %
109. Measles	4	1	1	2	8	12.5 %
110. Neonatal Tetanus	3	2	0	0	5	0 %
111. Diphtheria	1	0	0	1	2	0 %
112. Whooping Cough	0	0	0	0	0	0 %

I. Distribution of Iodine Caps. (From IDD Register)	Number of Clients	
1. Under 20 years		5. Total Caps. distributed ↓
2. Pregnant women		
3. Child Bearing Age Women		
4. Total Number of Clients		

J. Malnutrition (Children under 3) (From Abstract Register)	Number	% of Total
1. Total Weighed	217	
2. Normal	141	64.9 %
3. Moderate Malnutrition	52	24.0 %
4. Severe Malnutrition	24	11.1 %

**E. Acute Respiratory Infection (New Cases < 5 years)**

**Data source:** Abstract Register

103.a. No of ARI Cases

under 5 years

Transfer totals in column 5 for 103.0, 103.1, 103.2, 103.3, and 103.9, and make the total

103.b. % of total  
ARI Cases under  
5 years

Calculate percentage for each category of disease severity out of total New Cases of Acute Respiratory Infection under 5 years

**F. Malaria**

**Data source:** Abstract Register

104. Number of  
Fever Cases

Transfer totals in column 7 for  
Blood Slides Examined in Facility (104.0)  
Blood Slides Sent Out (104.1)  
Blood Slides Not Taken (104.2)

Calculate Total of Fever Cases

Calculate percentage for each of the preceding categories out of total Fever Cases

**Data source:** Laboratory Register

Only OUTPATIENT  
NEW CASES

Go to the section in the Laboratory Register on Malaria Slides. After each month is over, draw a line across the page, so as to divide examinations of this month from those of next month.

1. Total No. of  
Slides Examined  
(New Cases)

Internal: Count of Internal (I) Out Patient cases under column 6 those who are new cases (N) under column 7 and transfer the total to the report

External: Count of External (E) Out Patient cases under column 6 those who are new cases (N) under column 7 and transfer the total to the report

**2. No. of Slides Malaria**

**Parasite Positive** Count the number and the percentage of Malaria Parasite Positive cases (as indicated in column 8) out of Internal and External New Cases of Fever for which a blood slide was examined

**3. No. of Slides P.**

**Falciparum Positive** Count the number and the percentage of P. Falciparum Positive cases (as indicated in column 8) out of Internal and External New Cases of Fever for which a blood slide was examined

**G. Tuberculosis**

**Data source: Abstract Register**

**105. Number of Cases of Cough more than two weeks**

Transfer totals in column 7 for  
Sputum Smears done within facility (105.0)  
Patient referred for sputum smear (105.1)

Make the Total Cases of Cough more than 2 weeks

Calculate percentage for each of the preceding categories out of Total Cases of Cough more than 2 weeks

**Data source: Laboratory Register**

**Only OUTPATIENT  
NEW CASES**

Go to the section in the Laboratory Register on Sputum Smear Results. After each month is over, draw a line across the page, so as to divide examinations of this month from those of next month.

**1. No. of Sputum**

**Smear Series Done** Internal: Count of Internal (I) Out Patient cases under column 6 those who are new cases (N) under column 7 and transfer the total to the report

External: Count of External (E) Out Patient cases under column 6 those who are new cases (N) under column 7 and transfer the total to the report

**2. No. of Smear**

**Series AFB Positive** Count the number and calculate the percentage of Sputum Smear Series AFB Positive out of the total Internal and External Out Patient new cases of cough > 2 weeks for which a sputum smear series was requested.

### Tuberculosis Treatment

**Data source:** Tuberculosis Register

Open the Tuberculosis Register on the pages of the last month.

1. Patients under Treatment at end of previous month

Transfer total from the top of the page (A)

2.a. Total Number Started Treatment

Make the sum of the totals of columns 4 to 7 and transfer to the report.

2.b. Number of New Cases

Transfer total of column 4 to the report and calculate percentage of new cases that started treatment out of total cases that started treatment (2.a.)

3.a. Total Number Discharged

Make the sum of the totals of columns 11 to 14 and transfer to the report.

3.b. Number Lost as Defaulters

Transfer total of column 13 to the report and calculate the percentage of "lost as defaulters" out of total cases discharged (3.a.)

4. Tuberculosis Patients under Treatment at end of this month

Transfer total from the bottom of the page (B)

### H. Immunizable Diseases

**Data source:** Abstract Register

108. Poliomyelitis

Transfer totals of column 7 for  
108.0 Not vaccinated  
108.1 Partially vaccinated  
108.2 Fully vaccinated  
108.9 Vaccination Status unknown  
and calculate the total number of cases.

Calculate the percentage of fully vaccinated cases out of the total of new cases.

109. Measles

110. Neonatal Tetanus

111. Diphtheria

112. Whooping Cough

Make the same calculations as for Poliomyelitis

### I. Distribution of Iodine Capsules

**Data source:**            **IDD Register**

After each month is over, draw a line across the page, so as to divide clients of this month from those of next month.

1. Under 20 years    Count the number of clients provided with capsules under column 5 and transfer the total to the report
2. Pregnant women    Count the number of clients provided with capsules under column 6 and transfer the total to the report
3. Child Bearing Age Women    Count the number of clients provided with capsules under column 7 and transfer the total to the report
4. Total Number of clients    Make the sum of 1.1, 1.2, and 1.3.
5. Total Capsules distributed    Count the number of Iodine capsules distributed in column 8 and transfer the total to the report

### J. Malnutrition (Children under 3)

**Data source:**            **Abstract Register**

1. Total Weighed    Transfer the total from the last line on the Abstract Register page.
2. No. Normal    Transfer from the Abstract Register the number of children with normal nutritional status (N). Then calculate the percentage out of 1. Total No. weighed.
3. Moderate Malnutrition    Transfer from the Abstract Register the number of children with moderate malnutrition (M). Then calculate the percentage out of 1. Total No. weighed
4. Severe Malnutrition    Transfer from the Abstract Register the number of children with moderate malnutrition (M). Then calculate the percentage out of 1. Total No. weighed

8. MOTHER AND CHILD CARE PREVENTIVE ACTIVITIES

Data Source: Mother Health Register for Sections A, B, C and D.

The pages of this register are labeled according to the expected month of delivery.

Each month, registration of new mothers in the register will therefore be spread out over several pages according to their EMD. Most women will register well in advance of their expected month of delivery. These will be registered in the pages following the current EMD month. Few women may also register post-term, whose EMD has already passed and therefore will be registered in the page preceding the current EMD month.

On completion of each month draw a line below all the cases registered this month, on all the pages, so that they may be differentiated from the previous months. Let us call it the 'End of month line'.

A. Prenatal Care

Expected New Pregnancies (1)

This figure is a calculation and is not derived from the Mother Health Register. Divide your Catchment area population by 270 and write the result in the box provided.

No. Newly Registered (2)

Count in Column 2, all women registered this month through all the pages. Count from current EMD page through the next 8 pages. (count between the last two "End of month lines").

% of Expected New Pregnancies

This is a calculation. Calculate:

(No. newly registered (2) / Expected new pregnancies (1)) x 100

## 8. MOTHER AND CHILD CARE PREVENTIVE ACTIVITIES

<b>A. Pre-natal Care</b> (From Mother Health Register)		Expected New Pregnancies this month (CA Population / 270) <span style="border: 1px solid black; padding: 2px;">74</span> <sup>(1)</sup>					
Number Newly Registered (2)	41	Newly Registered During 1st Trimester (3)	14	Haemoglobin under 10 gm% at 1st measurement (4)	18	Total Visits (5)	62
% of Expected New Pregnancies (2) / (1)	55.4%	% of Total Newly Registered (3) / (2)	34.1%	% of Total Newly Registered (4) / (2)	43.9%	No. of Re-visits (5) - (2)	21

<b>B. Deliveries</b> (From Mother Health Register)				Expected Deliveries this month (CA Population/300) <span style="border: 1px solid black; padding: 2px;">67</span> <sup>(1)</sup>		<b>C. Post-natal Care</b> (From Mother Health Register)	
Total Number of Deliveries (2)	34	No. of Deliveries by Trained Persons (5)	7	% of Expected Deliveries (5) / (1)	10.4%	Number of Deliveries in month previous to reporting month (7)	28
Number of Stillbirths (3)	3	No. of Deliveries in your Facility (6)	6	% of Deliveries by Trained Persons (6) / (5)	85.7%	Rec'd at least 1 Postnatal Visit (8)	12
Number of Abortions (4)	4					% of Deliveries in previous month (8) / (7)	42.9%

**D. Maternal Deaths** Number 2 (From Mother Health Register)

<b>E. Family Planning</b> (From Family Planning Register)												
Total Visits	Male	Female	New Cases	Old Cases	Visits by Contraceptive Method						Referred	
					Condom	Foam	Pills	Injection	IUCD	Surgery		
17	3	14	16	2	5	0	5	4	2	1	2	
Units Distributed >					50	0	15	4	2			

<b>F. Growth Monitoring</b> (From Child Health Register)		Expected Children under 1 year this month (CA Population / 320) <span style="border: 1px solid black; padding: 2px;">62</span> <sup>(1)</sup>			
No. Newly Registered under 1 year (2)	21	Total Visits (3)	40		
% of Expected under 1 year (2) / (1)	33.9%	No. Normal Nutrition Status (4)	22	% of Total Visits (4) / (3)	55%

<b>G. Vaccinations</b> (From EPI Register)		Catchment Area Population (if different from page 1): <span style="border: 1px solid black; padding: 2px;">                    </span>			
Number Fixed Centres: <span style="border: 1px solid black; padding: 2px;">1</span>		Number Outreach Teams: <span style="border: 1px solid black; padding: 2px;">1</span>		No. Mobile Units: <span style="border: 1px solid black; padding: 2px;">0</span>	
Vaccination Type	0-11 months	12-23 months	2 years and over	Total Children	
1. BCG	34	24	4	62	
2. DPT - 1	41	37		78	
3. DPT - 2	31	29		60	
4. DPT - 3	22	19		41	
5. DPT - Booster		8		8	
6. OPV - Zero	5			5	
7. OPV - 1	40	41	0	81	
8. OPV - 2	31	29	0	60	
9. OPV - 3	21	20	0	41	
10. OPV - Booster		7	15	22	
11. DT - 1	0	1	0	1	
12. DT - 2	0	0	1	1	
13. DT - Booster		0	15	15	
14. Measles	28	41	10	79	
15. Fully Immunized Children	19	18	4	41	
Target Group for TT Vaccines	TT - I	TT - II	TT - III	TT - IV	TT - V
16. Pregnant Women	72	45	53	11	2
17. Child Bearing Age Women	34	41	27	4	6
18. Total	106	87	80	15	8

**MODULE 2: DATA REPORTING**

**Newly Registered  
During 1st  
Trimester (3)**

Count in Column 12(1st Tri), the number of women registered for prenatal care this month who were in their first trimester, through all the pages. Count from current EMD page through the next 8 pages between the last two "End of the month lines".

**% of Total Newly  
Registered**

This is a calculation. Calculate:

$$= \frac{\text{Newly registered during 1st trimester (3)}}{\text{No. of newly registered (1)}} \times 100$$

**Hemoglobin Under  
10 gm% at 1st  
Measurement (4)**

Count in Column 10 the number of women registered this month with a Hemoglobin of under 10 gm% at 1st measurement, through all the pages. Count from current EMD page through the next 8 pages between the last two "End of the month lines".

**% of Total  
Newly Registered**

This is a calculation. Calculate:

$$= \frac{\text{Hemoglobin under 10 gm \% at 1st measurement (4)}}{\text{No. of Newly registered (1)}} \times 100$$

**Total Visits (5)**

Locate the current month in Column 12. Count the number of contacts in current month, through all the pages. Count from one page before current EMD page through the next 9 pages. This time you will count **over the whole page** rather than just within the two "end of month lines" of this month.

**No. of Re-visits**

This is a calculation. Calculate:

$$= \text{Total visits (5)} - \text{No. of Newly registered (2)}$$

**B. Deliveries**

You will have to count required columns matching them with deliveries in this month (since not all the women registered in the current month will deliver in the same month).

**Expected Deliveries  
this month (1)**

This figure is a calculation and is not derived from the Maternal Health Register. Divide your Catchment area population by 300 and write the result in the box provided.

Total Number of Deliveries (2)

Count the number of deliveries **reported** this month in column 15 by looking at the dates. The deliveries that are reported this month but not conducted this month will be circled and you must count them. Count from current EMD page, one preceding page and two subsequent pages.

Number of Still Births (3)

Count in column 17 the number of still births reported this month by looking at the date of delivery. Count current EMD page, one preceding & two subsequent pages.

Number of Abortions (4)

Count in column 14 the number of abortions reported this month by looking at the dates. The abortions that are reported this month but did not occur this month will be circled and you must count them. Count up to 8 pages after current EMD page.

No. of Deliveries by Trained Persons (5)

Count in column 19 the number of deliveries reported this month to have been conducted by trained persons by looking at the date of delivery in column 15 and 17. Count current EMD page, one preceding and two subsequent pages.

No. of Deliveries in your Facility (6)

Count in column 21 the deliveries conducted in your facility this month by looking at the date of delivery in column 15 and 17. Count current EMD page, one preceding and two subsequent.

% of Expected Deliveries

This is a calculation. Calculate:

$$= \frac{\text{No. of deliveries by trained persons (5)}}{\text{Expected deliveries this month (1)}} \times 100$$

% of Deliveries by Trained Persons

This is a calculation. Calculate:

$$= \frac{\text{No. of deliveries in your facility (6)}}{\text{No. of deliveries by trained persons (5)}} \times 100$$

**C. Postnatal Care**

Number of Deliveries in month Previous to Reporting Month (7) Enter here the number of women who delivered in the month previous to the reporting month. Count the number of deliveries by looking at the date of delivery in column 15 and 17 of the month previous to reporting. Look at the date of delivery and not the date of reporting (which is circled).

Received at least 1 Postnatal visit Of the women who delivered in the month previous to reporting, count those women who have at least 1 postnatal visit in column 23 or 24 this month. For this you will have to count in column 23 or 24 on the reporting month page and one before.

% of Deliveries in Previous Month This is a calculation. Calculate:

$$= \frac{\text{Received at least 1 postnatal visit (8)}}{\text{No. of deliveries in month previous to reporting}} \times 100$$

**D. Maternal Deaths**

Count the number of deaths reported this month (look at the dates) in column 28. You will have to look through the current EMD page, all the subsequent pages and one page before.

**E. Family Planning**

**Data Source:** Family planning register

After each month is over, draw a line across the page, so as to separate clients of this month from those of next month.

**Total Visits** Count the number of visits in column 1 between the last two 'End of month lines'.

**Male** Count the number of ticks in column 7 between the last two 'End of month lines'.

**Female** Count the number of ticks in column 8 between the last two 'End of month lines'.

**New Cases** Count the number of ticks in column 4 between the last two 'End of month lines'.

Old Cases	Count the number of ticks in column 5 between the last two 'End of month lines'.
Visits by Contraceptive Method	Count the number of visits noted in columns 10, 11, 12, 13, 14, and 15.
Referred	Count the ticks in column 17 between the last two 'End of month lines'.
Units distributed	Aggregate the amount noted in columns 10, 11, 12, 13 and 14 between the last two 'End of month lines' and transfer totals here.

**F. Growth Monitoring**

**Data Source**                      **Child health register**

After each month is over, draw a line across the page, so as to separate clients of this month from those of next month.

**Expected Children under 1 yr (1)**

This figure is a calculation and is not derived from the Child Health Register. Divide your catchment area population by 320 and write the result in the box provided.

**No. of Newly Registered under 1 yr (2)**

Count the ticks in column 6 between the last two "End of month lines".

**% of Expected under 1 yr**

This is a calculation. Calculate:

$$= \frac{\text{No. of newly registered under 1 yr. (2)}}{\text{Expected children under 1 yr. (1)}} \times 100$$

**Total Visits (3)**

Count the filled spaces in the column of the month and year of this report under column 8. (visits could have been recorded on several pages of the register).

**No. of Normal Nutrition Status (4)**

Locate in column 6 the current month and year and count the number of N's in the column.

**% of Total Visits**

This is a calculation. Calculate:

$$= \frac{\text{No. of normal nutrition status (4)}}{\text{Total visits (3)}} \times 100$$

**G. Vaccinations:**

Fill in according to instructions of the EPI programme (= same as monthly EPI report).

### 3. YEARLY FLCF REPORT

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The Yearly Report for First Level Care Facilities is intended to report on data for which more frequent reporting is not necessary: e.g. population data, status of building and equipment.

It is not meant to summarize the monthly reports. Yearly summaries on health problems, activities, and resource management data as reported in the monthly reports will be generated by the computer.

#### GENERAL INSTRUCTIONS

1. Fill in ALL items of the report. Never leave blank a possible entry. If the number of the item is zero, fill in 0.
2. For sections not applicable to the health facility, the reporting section can be crossed out and overwritten by 'Not Applicable'.

For Example \_\_\_\_\_

#### C. Equipment/Furniture/Linen

Item	Total Beginning of the Year	Received (during the year)	Struck Off (during the year)	Total End of the Year	Physical Inventory Status		
					Unservice-able	Repair-able	Service-able

NOT APPLICABLE

On the top left side of the report, fill in year of the reporting period

**1. INSTITUTION IDENTIFICATION**

- A. Identification No: Write the identification number of the health institution
- B. Institution Name: Write the name and place of the health institution
- C. Province:
- D. Division:
- E. District:
- F. Tehsil/Taluka:
- G. Union Council:
- H. Incharge Name: Write the name of the person who is in charge of filling in the report
- I. Signature:

**2. SUPERVISORY VISITS:**

**Data source: Meeting Register**

Date: Write dates of visits during the current year.

Supervisor: Write name of supervisors

**3. POPULATION DATA:**

**Data source: Population Chart**

Transfer data from population chart after having made the necessary updates.

**4. COMMENTS/RECOMMENDATION/ACHIEVEMENTS:**

This space can be used to report on any subject not foreseen in the regular lay-out of this report:

- Administrative issues
- Communications to District Health Officer
- Need for equipment
- Recommendations to higher authorities

**Ministry of Health**  
**YEARLY REPORT**  
For First Level Care Facilities

(FF3)

Year: **1992**

**1. INSTITUTION IDENTIFICATION**

A. Identification No: **345617**

B. Institution Name: **BHU BHANPUR**

C. Province: **SIND**

D. Division: **LAHORE**

E. District: **GUARA**

F. Tehsil/Taluka: **BHATKELA**

G. Union Council: **BHANPUR**

H. Incharge Name: **A. AHMED KHAN** Signature: *[Signature]*

**2. SUPERVISORY VISITS (From Meeting Register)**

Date	Supervisor
5/2/92	A. Sharif Nawaz / ADHO
11/3/92	A. Gul Shukla / DHO
7/5/92	M. Ghani Nawaz / ADHO
16/8/92	M. Ghani Nawaz / ADHO
22/9/92	A. Rashid Amin / Div. Dir. H.S.
29/10/92	M. Ghani Nawaz / ADHO

**3. POPULATION DATA (From Population Chart)**

Sr. No.	Name of Villages	Population	Distance from Facility (km)	No. of CHWs	No. of TBAs	
					Trained	Untrained
1	Gujiwal	474	5	0	1	0
2	Gujiwal	1,438	3	0	1	0
3	Haji Katti	836	8	0	1	0
4	Bhamban	2,877	0	0	2	0
5	Ghans	1,371	7	0	0	1
6	Ghans	931	13	0	1	0
7	Bhamban	1,744	21	2	2	0
8	Fari Kari	372	14	1	0	1
9	Paranpura	1,619	12	0	1	0
TOTAL:		11,717		3	9	2

% of population living more than 20 km away from the Institution: **14.9%**

**4. COMMENTS / RECOMMENDATIONS / ACHIEVEMENTS**

- With the involvement of TBA's in the preventive mother health program, nearly 60% of pregnant women have registered for prenatal care (compared to 27% last year)

- Please send us microscope as soon as possible. Our health technician has received training in tuberculosis and malaria microscopy in April this year

**5. TRANSMISSION**

A. Received at District Health Office on: **16/01/93** Name/Signature: *M. Nazir Khan*

B. Received at Computer Center on: **23/01/93** Name/Signature: *Dr. Abdul Kari*

C. Data Entered on Computer on: **28/01/93** Name/Signature: *Dr. Abdul Kari*

**5. TRANSMISSION:**

**A. Received at District**

Health Office on Write date (dd/mm/yy) on which the report was received at the district office

Name/Signature Write name and signature of the person who received the report

**B. Received at**

Computer Center on Write date (dd/mm/yy) on which the report was received at the computer center

Name/Signature Write name and signature of the person who received the report

**C. Data entered in**

Computer on Write date (dd/mm/yy) on which data of the report were entered in the computer

Name/Signature Write name and signature of the person who entered the data

**PAGE 2 & 3**

**6. BUILDING/EQUIPMENT/TRANSPORT:**

**A. Building:**

**Data source:** Physical verification at the end of the calendar year

■ Physical condition of the building: Tick the appropriate answer

■ Date last Renovated: Write year on which the building was last renovated

■ Approach Road: Tick the appropriate answer

■ Electricity: Tick the appropriate answer

■ Source of Water: Tick the most common source of water. If printed choices are not appropriate, tick the box 'Other' and specify the water source.

■ Public Toilet: Tick the appropriate answer

**B. Transport:**

**Data source:** Physical verification at the end of the calendar year

**TOTAL:** Fill in the total number of transport means for each type

**FUNCTIONING:** Fill in the number of functioning means of transport for each type

**C. Equipment/Furniture/Linen:**

**Data source:** Stock Register Equipment/Furniture/Linen

**Item:** List all items of equipment/furniture/linen

**Total Beginning of the Year:** From Stock Register

**Received (during the year)** From Stock Register

**Struck Off: (during the year)** From Stock Register

**Total End of the Year:** From Stock Register

**Physical Inventory Status**

**Data source:** Physical verification at the end of the calendar year

**Unserviceable:** Write number of unserviceable items

**Repairable:** Write number of repairable items

**Serviceable:** Write number of serviceable items

## 6. BUILDING/EQUIPMENT/TRANSPORT

**A. Building**

- Physical Condition of the Building     Good             Needs Repair             Poor
- Date last Renovated                      12/7/88
- Approach Road                             Metalled     Non-metal     Katcha     Footpath     None
- Electricity                                     Available/Functional     Available/Not functional     Not available
- Source of Water                             Piped             Hand-pump     Well     Stream  
      River             Pond             None  
      Other: \_\_\_\_\_
- Public Toilet                                 Exists/Functional     Exists/Non-functional     None

B. Transport	TOTAL	FUNCTIONING
a. Ambulances	0	0
b. Other Vehicles	0	0
c. Motor Cycles	0	0
d. Bi-cycles	2	2
e. Other: (specify)	0	0

**C. Equipment/Furniture/Linen** (From Stock Register — Equipment / Furniture / Linen)

Item	Total Beginning of the Year	Received (during the year)	Struck Off (during the year)	Total End of the Year	Physical Inventory Status		
					Unservice-able	Repair-able	Service-able
Refrigerator	1	0	0	1	0	0	1
Microscope binocular Obj 10-20-100x	0	1	0	1	0	0	1
Hemoglobinometer	1	0	0	1	0	1	0
Sphygmomanometer	2	0	1	1	0	0	1
Stethoscope	2	0	0	2	1	0	1
Electric Sterilizer	1	0	0	1	0	0	1
Baby Weighing Scale	1	0	0	1	0	0	1
Centrifuge Electric	1	0	0	1	0	1	0
Stove Electric (burner)	1	0	0	1	0	0	1
Revolving chair for MO	1	0	0	1	0	0	1
Office chairs	5	0	0	5	0	1	4
Office table for MO	1	0	0	1	0	0	1
Office table (cotton cloth)	2	1	0	3	0	0	3
Benches (with arm rest)	3	0	0	3	0	0	3
Examination table	1	0	0	1	0	0	1



**7. DRUGS/VACCINES/SUPPLIES:**

<b>Data source:</b>	<b>Stock Register Drugs/Vaccines/Supplies</b>
<b>Item:</b>	List all items of drugs/vaccines/supplies
<b>Unit:</b>	Give most commonly used unit
<b>Opening Balance:</b>	Copy from Stock Register (beginning of the year)
<b>Recd:</b>	Total the column 'received' of the Stock Register for the current year
<b>Issued for care:</b>	Total the column 'Issued for Care' of the Stock Register for the current year.
<b>Issued/discarded:</b>	Total the column 'Issued/discarded' of the Stock Register for the current year.
<b>Closing balance:</b>	Copy from Stock Register

7. DRUGS / VACCINES / SUPPLIES (From Stock Registers — Medicines, Supplies and Vaccines)						
Item	Unit	Opening Balance	Received	Issued		Closing Balance
				For Care	Discarded	
A. BCG Vaccine	dose	40	500	380	0	160
B. DPT Vaccine	dose	120	400	340	0	180
C. Polio Vaccine	dose	110	400	360	0	150
D. TT Vaccine	dose	140	900	930	50	60
E. Measles Vaccine	dose	30	500	370	0	160
F. DT Vaccine	dose	20	100	40	50	30
G. Syringes	piece	140	500	165	0	475
H. Needles	piece	200	2500	2380	0	320
I. Oral Contraceptive	cycle	64	100	132	0	32
J. Condoms	piece	320	1000	1260	0	60
K. Inj. Contraceptive	dose	24	50	37	0	37
L. IUDs	piece	10	0	7	0	3
M. ORS	packet	242	1500	1650	0	92
N. Cotrimoxazole	tablet	434	1000	1434	0	0
O. Cotrimoxazole Syrup	bottle	37	400	324	50	63
P. Chloroquine	tablet	600	2000	1600	400	600
Q. Primaquine	tablet	0	0	0	0	0
R. Iron Tablet	tablet	1150	1000	1850	0	300
S. Folate Tablets	tablets	400	2000	1810	0	590
T. Streptomycin	vial	60	300	320	0	40
U. Isoniazid (INH)	tablet	0	0	0	0	0
V. INH+Tb1	tablet	125	800	720	0	205
W. Ziehl-Nielsen	bottle	1	1	1	0	1
X.						
Y.						
Z.						
AA.						
AB.						
AC.						
AD.						
AE.						
AF.						
AG.						
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AP.						
AQ.						
AR.						
AS.						

M O D U L E 3

**Transmission  
of Reports**

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## MODULE ON TRANSMISSION OF REPORTS

All reports will be transmitted through **regular line management channels**: from FLCF to district, then to division, to province and to federal levels.

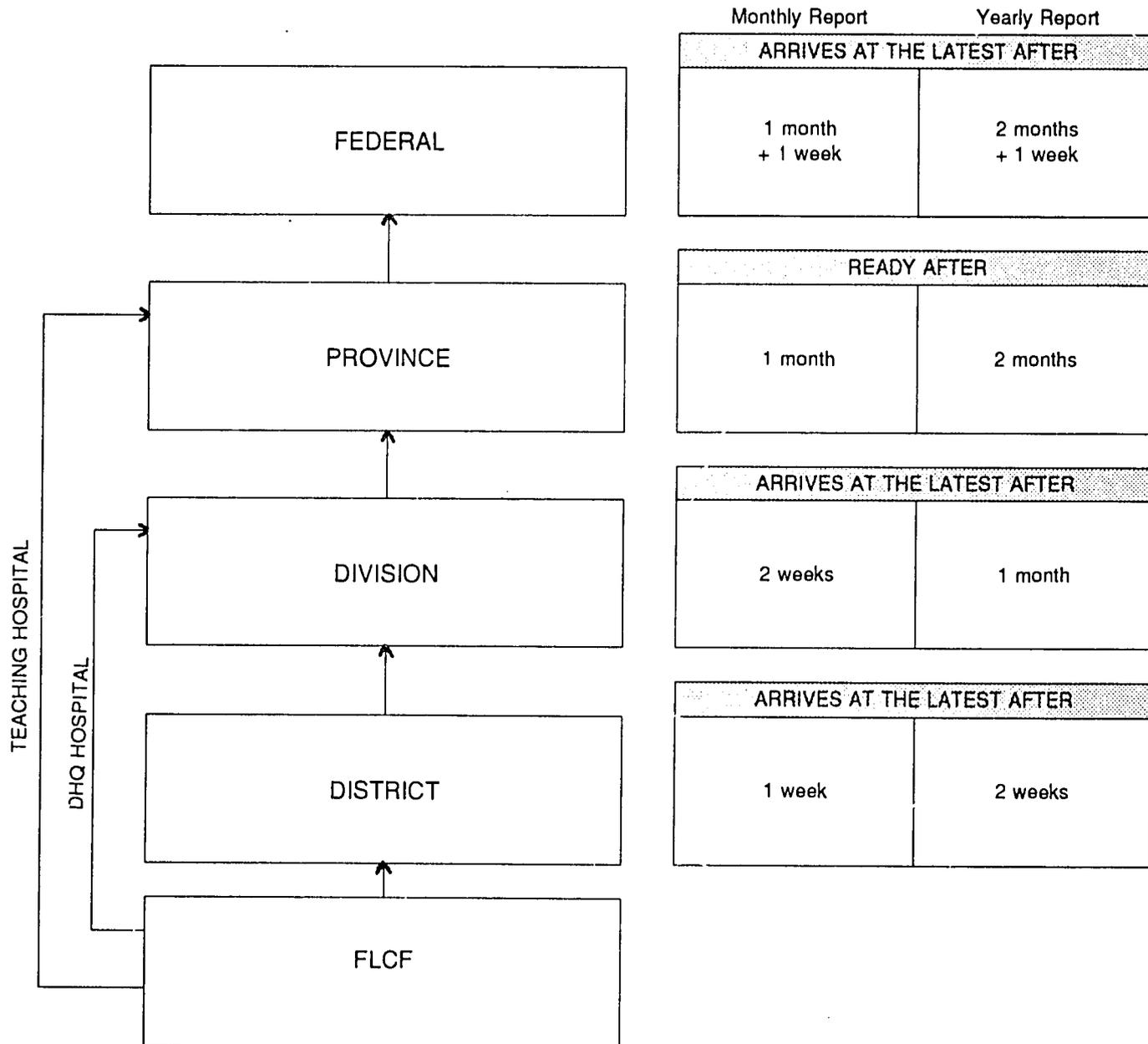
### 1. IMMEDIATE FLCF REPORT

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1. Immediate Reports are made up in **two copies**: one stays in the health institution (white copy); and one is sent to the District Health Officer (red copy).
2. Immediate Reports will be transmitted to the district level **within 24 hrs**. Disease outbreaks will also be reported to higher levels if required.

## 2. MONTHLY AND YEARLY FLCF REPORTS

1. Monthly and Yearly Reports will be made up in **three copies**: one stays in the health institution, and two are sent to the District Health Officer.
2. The following time tables will be applied:



4. All data processing for monthly and yearly reports is computerized. Computer centers have been established at provincial and divisional levels.
5. The quality of the data collected will be ensured by the DHO and his staff through regular supervision and through scrutiny of all reports before transmission for computerized data entry.

## Appendix I

# FINAL LIST OF INDICATORS

### INTRODUCTION

The following list of indicators has been developed through a process of consensus building between health planners and program managers at the national level and public health managers in the provincial Health Departments. It was approved in its final form during the Second National Workshop on Health Management Information System for First Level Care Facilities.

These indicators constitute a solid basis for further development of the Health Management Information System for First Level Care Facilities (HMIS/FLCF). They represent information needs identified through functional analysis of the health services as they are being provided in government managed first level care facilities. It was also recommended by the participants of the Second National Workshop to delimit catchment areas around first level care facilities, so that population denominators could be defined. These denominators will permit the calculation of coverage for priority curative and preventive activities delivered by the first level care facilities.

INDICATORS	FREQ
<b>1.0. POPULATION IN CATCHMENT AREA</b>	
1.1. Population in catchment area	Y
1.2. % of population in catchment area living more than 20 km from facility (B/FNA)	Y
1.3. Number of births registered	M/Y
<b>2.0. CURATIVE CARE/GENERAL</b>	
2.1. No. of new cases by age category	M
2.2. No. of total visits	M
2.3. % of new cases referred	M
<b>CURATIVE CARE/PRIORITY HEALTH PROBLEMS</b>	
<b>3.0 Diarrhoeal Diseases</b>	
3.1 % of new cases of diarrhoea (acute watery and bloody) out of total new cases < 5 yrs, by degree of dehydration	M/Y
3.2 % of diarrhoea cases referred for admission out of total new cases of diarrhoea < 5 yrs.	M/Y
3.3 No. of days of stock-outs of ORS	M/Im
3.4 % of diarrhoea cases receiving effective case management as verified by I/C	M
3.5 % of health facilities providing effective diarrhoea case management as verified through supervisory checklist	Q/Y
3.6 % of mothers attending FLCF who know correct use of ORT as verified through home based survey	Y
<b>4.0 ARI</b>	
4.1 % of ARI cases out of total new cases < 5 yrs.	M/Y
4.2 % of pneumonia cases out of total new cases of ARI < 5 yrs.	M/Y
4.3 % of pneumonia cases referred for admission out of total new cases of ARI < 5 yrs.	M/Y
4.4 No. of days of stock-outs of Cotrimoxazole	M/Im
4.5 % of ARI cases provided standardized case management as verified by I/C	M
4.6 % of health facilities providing the standard ARI case management as verified through supervisory checklist	Q/Y

INDICATORS	FREQ
<b>5.0 Malaria</b>	
5.1 % of new cases of fever out of total new cases	M/Y
5.2 % of cases for which slides were collected out of total new cases of fever	M/Y
5.3 % of MP positive cases out of total fever cases for which slides were collected	M/Y
5.4 % of P.Falciparum positive cases out of total MP positive cases	M/Y
5.5 % of cases clinically resistant to chloroquine out of total P. Falciparum positive cases	M/Y
5.6 No. of days of stock-outs of anti-malarial drugs	M/Im
5.7 % of slides with correct malaria diagnosis in centers with laboratory services as verified through supervisory checklist	Q
<b>6.0 Tuberculosis (Pulmonary)</b>	
6.1 No. of new cases of TB (AFB Positive)	M/Y
6.2 % of AFB positive cases out of total new cases with cough > 14 days	M/Y
6.3 % of defaulters out of total registered TB cases	M/Y
6.4 No. of days of stock-outs of TB drugs	M/Im
<b>7.0 Malnutrition</b>	
7.1 % of under weight children out of total new cases < 5 yrs.	M/Y
7.2 % of registered malnourished cases (women and children) followed-up regularly	M/Y
<b>8.0 IDD (Including prevention)</b>	
8.1 No. of new cases of goiter (P/N/FNA) by age category	M/Y
8.2 No. of persons provided with Iodine Capsules, by age category: population under 20, pregnant ladies, and CBAs (P/N/FNA)	M/Y
<b>9.0 Diseases for Immediate reporting</b>	
9.1 No. of new cases of diseases for immediate reporting: <ul style="list-style-type: none"> <li>- Probable Poliomyelitis (+ vaccination status)</li> <li>- Probable Measles (+ vaccination status)</li> <li>- Suspected Cholera</li> <li>- Suspected Meningococcal Meningitis</li> </ul>	Im/M/Y
9.2 % of health staff trained in disease outbreak control as verified through supervisory checklist	Q

INDICATORS	FREQ
<b>10.0 Other diseases (new cases)</b>	
10.1 No. of new cases of Probable/Confirmed Neonatal Tetanus (+ vaccination status)	M/Y
10.2 No. of new cases of Probable Diphtheria (+ vaccination status)	M/Y
10.3 No. of new cases of Probable Whooping Cough (+ vaccination status)	M/Y
10.4 No. of new cases of Suspected Viral Hepatitis	M/Y
10.5 No. of new cases of Suspected AIDS	M/Y
10.6 No. of new snake bite cases with signs & symptoms of poisoning	M/Y
10.7 No. of new dog bite cases	M/Y
<b>11.0 Other diseases (follow-up)</b>	
11.1 % of registered diabetic cases getting regular treatment	M/Y
11.2 % of known hypertensive cases getting regular treatment	M/Y
<b>12.0 PREVENTIVE CARE: EPI</b>	
12.1 % of fully immunized children < 1 yr. in C.A.	M/Y
12.2 % of children < 1 yr. in C.A. immunized, by antigen	M/Y
12.3 % of expected pregnancies in C.A. protected against tetanus	M/Y
12.4 No. of CBA women protected against tetanus	M/Y
12.5 % of drop-out in partially vaccinated children, pregnant ladies, and CBAs	M/Y
12.6 No. of days of stock-outs of vaccines, by antigen	M/Im
12.7 Maintenance of cold-chain as verified by supervisory checklist	Q/Y
12.8 No. of vaccines by antigen, syringes and needles supplied/used/in store	M
12.9 No. of children developing Adverse Effects Following Immunization (AEFI).	M
12.10 No. of new cases for EPI diseases: see under 9.0 and 10.0	Im/M/Y
<b>13.0 PREVENTIVE CARE: Children under 3 yrs.</b>	
13.1 % of mothers with children < 4m coming for immunization or growth monitoring, who are exclusively breast-feeding	M/Y
13.2 % of mothers with children 6-23m coming for immunization or growth monitoring, who have hygienic and timely weaning practices	M/Y

INDICATORS	FREQ
13.3 % of children < 1 yr. in C.A. registered for growth monitoring	M/Y
13.4 % of well-maintained growth monitoring charts as verified by I/C	M
13.5 % of well-maintained growth monitoring charts as verified through supervisory checklist	Q/Y
13.6 % of mothers with children < 4m who are exclusively breast-feeding as verified through household based survey	Y
13.7 % of mothers with children 6-23m who have hygienic and timely weaning practices as verified through household based survey	Y
<b>14.0 PREVENTIVE CARE: Pregnant Women</b>	
14.1 % of pregnant women registered out of total expected pregnancies in C.A.	M/Y
14.2 % of pregnancies registered during first trimester	M/Y
14.3 % of registered pregnant women with at least 2 prenatal visits	M/Y
14.4 % of registered pregnant women with at least 1 post-natal visit	M/Y
14.5 % of registered pregnant women who have received standardized prenatal and postnatal care as verified by I/C and through supervisory checklist	M/Q
14.6 % of registered pregnant women who have received antenatal iron/folate supplements and nutritional advice	M/Y
14.7 % of low birth weight babies out of total registered births in C.A.	M/Y
14.8 % of registered pregnant women with adequate weight gain during pregnancy	M/Y
14.9 % of registered pregnant women with hemoglobin < 10 gm.% upon 1st visit.	M/Y
<b>15.0 PREVENTIVE CARE: Family Planning</b>	
15.1 % of registered pregnant women who received family planning counseling	M/Y
15.2 No. of new and old family planning acceptors by contraceptive method in MCBA's	M/Y
15.3 No. of new and old family planning acceptors by contraceptive method in married men	M/Y
15.4 % of health care providers properly trained in family planning services as verified through supervisory checklist	Q
15.5 No of contraceptives supplied/used/in store	M
15.6 No. of days of stock-outs of contraceptives	M/lm

INDICATORS	FREQ
<b>16.0 DELIVERIES</b>	
16.1 % of assisted deliveries out of total expected pregnancies in C.A.	M/Y
16.2 % of assisted deliveries referred	M/Y
16.3 Total no. of meetings with TBAs in the catchment area	M/Y
16.4 TBAs' knowledge of aseptic and appropriate deliveries as verified by I/C and through supervisory checklist	M/Q
16.5 No. of days of stock-outs of TBA kit consumables	M/lm
<b>17.0 COMMUNITY DEVELOPMENT ACTIVITIES</b>	
17.1 No. of meetings with health committee and with community leaders held in C.A.	M/Y
17.2 No. of CHWs and TBAs in C.A. provided with training and linked to the facility	M/Y
17.3 No. of health education talks given (in school and in community)	M/Y
17.4 % of health facilities having appropriate health education material displayed/used as verified through supervisory checklist	Q
<b>18.0 PERSONNEL</b>	
18.1 Knowledge of workers about their job descriptions as verified by I/C	Q
18.2 Display of duty roster in health facility as verified by I/C and through supervisory checklist	C/Q
18.3 Availability of checklist for use by I/C	C
18.4 No. of staff meetings organized as reported by I/C and verified through supervisory checklist	M/Q
18.5 No. of sanctioned posts at each health facility	Y
18.6 No. of filled posts at each health facility	M
18.7 Proportion of transfers to the number of filled posts	Y
18.8 No. and type of training of health facility personnel	Y
<b>19.0 DRUGS/SUPPLIES/VACCINES</b>	
19.1 Quarterly physical inventory checks	Q
19.2 Consumption previous year	Y
19.3 No. of items which expired in the store	M

INDICATORS	FREQ
19.4 No. of days of stock-outs of essential drugs/vaccines/supplies	M/Y/lm
19.5 Refrigerator temperature sheet available and up to date (cold chain) as verified by I/C and through supervisory checklist	C/Q
<b>20.0 EQUIPMENT/TRANSPORT/BUILDINGS</b>	
20.1 Annual physical inventory checks	Y
20.2 Presence and functional status of building/equipment/transport	Y
20.3 Presence and functional status of water and electricity supply	Y
20.4 Proper use of vehicle as verified in logbook by I/C and through supervisory checklist	M/Q
<b>21.0 INFORMATION MANAGEMENT</b>	
21.0 Periodic quality checks of records and registers as verified by I/C and through supervisory checklist	C/Q
21.2 No. of reports sent out in time	M/Q/Y
21.3 Presence of updated graphic displays in the health facility as verified by I/C and through supervisory checklist	M/Q
21.4 Presence of updated information on population in C.A. as verified by I/C and through supervisory checklist	M/Q
21.5 Verification of stock of data collection instruments as verified by I/C and through supervisory checklist	M/Q
<b>22.0 COMMUNICATIONS</b>	
22.1 No. of letters, messages, reports sent and received by the facility as verified by I/C and through supervisory checklist	M/Q
22.2 No. of meetings held by the staff of health facilities as verified by I/C and through supervisory checklist	M/Q
22.3 No. of inter-departmental meetings recorded as verified by I/C and through supervisory checklist	M/Q
22.4 % of cases referred on whom feedback is received	M

## Appendix II

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### DESIGN OF HMIS/FLCF DATA COLLECTION INSTRUMENTS

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## Classification

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<b>INDIVIDUAL PATIENT / CLIENT RECORD CARDS</b>
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**FC = Facility Cards**

- FC1 - OPD Ticket
- FC2 - Referral Form
- FC3 - Mother and Child Health Card
- FC4 - Family Planning Card
- FC5 - Investigation Request Form
- FC6 - TB Facility Card
- FC7 - TB Patient Card
- FC8 - Chronic Disease Facility Card
- FC9 - Chronic Disease Patient Card
- FC10 - Immunization Card
- FC11 - IDD Card

<b>FACILITY RECORD KEEPING</b>
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**FR = Facility Records and Registers**

**I - SERVICE DELIVERY REGISTERS/CHARTS:**

- FR1 - OPD Register
- FR2 - Abstract Register for priority diseases
- FR3 - Child Health Register
- FR4 - Mother Health Register
- FR5 - Family Planning Register
- FR6 - TB Register
- FR7 - IDD Register
- FR8 - Laboratory Register
- FR9 - Daily EPI Register
- FR10 - Permanent EPI Register

## FACILITY RECORD KEEPING

**FR = Facility Records and Registers**

### II - ADMINISTRATIVE REGISTERS/CHARTS:

- FR11 - Population Chart of Catchment Area
- FR12 - Birth Register
- FR13 - Stock Register: Medicines/Supplies
- FR14 - Stock Register: Equipment/Furniture/Linen
- FR15 - Meeting Register
- FR16 - Daily Expense Register
- FR17 - Attendance Register
- FR18 - Log Book
- FR19 - Stock Register: Vaccines

## FACILITY REPORTING FORMS

**FF = Facility Forms**

- FF1 - Immediate Report
- FF2 - Monthly Report
- FF3 - Yearly Report

## DISTRICT RECORD KEEPING

**DR = District Records and Registers**

- DR1 - Supervisory Checklist
- DR2 - Training Register
- DR3 - Personnel Management Register

## DISTRICT REPORTING FORMS

**DF = District Forms**

- DF1 - Quarterly District Report: