Module 9
Part 1 - Antenatal Care

CONTENTS

ILLUSTRATED GUIDES

Antenatal Care

9.1 WHAT ARE THE TOOLS USED FOR DATA COLLECTION?

The data collection tools used in the antenatal programme are shown below. They are classified as follows:

Primary Tools

Primary data sources are essential to routine monitoring within the HIS and are prerequisite to the calculation of indicators. They form the basis of the guidance and training within this manual and are described in detail in the Illustrated Guides at the end of the module.

Secondary Tools

Secondary data sources have important functions within the HIS, but are not directly used to calculate indicators. They play vital roles informing clinical decision-making and promoting service quality and performance. They are described in information boxes in the supporting text.

> Data collection and monitoring tools

Antenatal Care

Primary Tools
1. Antenatal Care Register
2. Antenatal Care Tally Sheet
3. Reproductive Health Report

Secondary Tools
1. Antenatal Card
2. Tetanus Toxoid Card

9.2 WHO IS RESPONSIBLE FOR COLLECTING THE DATA?

All antenatal visits should be documented in an antenatal care register, and the task of filling each entry should be designated to trained health staff in each antenatal clinic. Each staff member should understand how to accurately record each visit, and should take responsibility for maintaining neat and legible records.

At the end of each week, the clinic supervisor should coordinate the completion of the Reproductive Health report and ensure that respective sections have made their submission in full and on time. The clinic supervisor is also responsible for monitoring the upkeep of the registers, and for ensuring the completeness of record entries each day.

9.3 WHAT DATA SHOULD BE COLLECTED AND HOW?

It is essential that the complete antenatal history of each pregnant mother is recorded in an antenatal register. The way in which antenatal care services are organised and managed will differ between countries and between health partners and can have consequences for the collection and reporting of antenatal care information.

The system of delivering antenatal care should be reviewed in each health agency and monitoring requirements adapted accordingly (refer to Country Considerations Box).

9.3.1. Antenatal Register

The antenatal register chronicles each visit made during the antenatal period. It assists staff to monitor pregnancy risk and to log the delivery of routine preventive services; including deworming, intermittent preventive treatment for malaria (IPT), tetanus toxoid vaccination, RPR screening for syphilis and insecticide treated net (ITN) distribution. At least four antenatal visits are recommended ideally with the first visit in the first trimester of pregnancy. The schedule may vary between countries and monitoring requirements should be adapted to the policy of the MoH.

A single entry in the Antenatal Register should contain information from registration at the first visit, to details of pregnancy outcome at the time of delivery. This is an extremely important principle and is the basis on which quality of antenatal care is retrospectively monitored at the time of delivery.

> Registration

At registration, basic identifying information and an obstetric history should be taken and recorded. Each expectant mother should also be assigned a unique identifying code (or antenatal number). The same antenatal number should be used throughout pregnancy and also recorded in the antenatal card (see Secondary Tools: Antenatal Card). During repeat visits, this code number can then be used to easily reference and update case-information in the register.

> Risk Factors

The date and the presence of antenatal risk factors should be logged at the first and all subsequent visits. The baseline haemoglobin should also be recorded at the first visit and, if indicated, at each repeat visit.

Abbreviations of commonly reported antenatal risk factors are shown in a key at the bottom each page. This listing can be expanded further to include more cause-specific risk factors, as demanded by staff needs.

> Service delivery

The provision of deworming and malaria prophylaxis (IPT) should be recorded by entering the date that each dose was administered in the register. The precise drugs, dosage and schedule should be determined by national guidelines. In countries where mass distributions of insecticide treated nets (ITN) for malaria are organised receipt should be logged in a similar fashion in the register.

Rapid plasma reagin (RPR) screening for syphilis should be recorded by entering the date in the column that corresponds to the test result (+ve / -ve). The date of partner tracing and presumptive STI treatment should be documented alongside the record of any women who test RPR positive.

The administration of Tetanus Toxoid (TT) vaccine during pregnancy should follow the national TT immunization schedule. The dates of the most recent doses, as indicated in the schedule, should be recorded in the Antenatal Register. For more information on TT vaccination schedule and the TT vaccination card see Module 7: EPI.

> Pregnancy Outcome

Staff should update pregnancy outcome in the Antenatal Register at the end of each day with details of all women who have delivered on the maternity ward. Pregnancy outcome information should be filled using the Delivery Register (see Part 2: Delivery Care). These registers should use the same antenatal number code to enable easy referencing of information between the two books.

The Antenatal record should only be considered complete when pregnancy outcome data has been filled. The entire pregnancy history can be retrospectively reviewed at this stage, and coverage of antenatal care services evaluated. The relevant standards and indicators for preventive services in antenatal care are discussed below (see 9.5 How should the data be interpreted and used?).

> Country Considerations

How are Antenatal care services organised and managed?

The way antenatal care services are arranged will differ between countries and between health partners and can have consequences for the collection and reporting of antenatal care information.

The contrasting styles of service delivery often arise as women require a range and complexity of services at the first ANC visit that are not routinely demanded at repeat visits. For example, on registration an expectant mother may receive screening for RPR, counselling for PMTCT services, and testing for baseline haemoglobin. For this reason, first-time services are only offered at locations such as a dispensary or a hospital, where the complete range of preventive services is available.

This makes most efficient use of resources and staff in otherwise resource poor setting but can have significant consequences for the collection and reporting of health information. The priority is to preserve the practice of entering a complete antenatal history into the same register entry. If an expectant mother accesses care at different locations in a camp, a mechanism should be established whereby antenatal registers are maintained in a central location and updated from peripheral locations at the end of each day.

It is the responsibility of the clinic supervisor to ensure that all ANC registers are updated. This should be done regularly to ensure that all data is documented. Separate registers can be kept in this central location, according to the mothers' address in the camp.

9.3.2 Antenatal Tally Sheet

In addition to an antenatal register, staff should maintain an Antenatal Tally Sheet each day. Both data sources are required because the entire antenatal history of a pregnant mother is entered in the same row of the register. This means that events in the future (such as repeat visits and delivery) will be recorded alongside the first entry at the date of registration.

The variable time intervals between repeat visits, and the non-sequential ordering in registers, can make this information difficult to retrieve from the register alone at the end of a reporting week.

To assist staff, the Antenatal Tally Sheet should therefore be used to record the number of repeat visits, details of syphilis testing, results and contact treatment, detection of high-risk pregnancies and reporting of complicated abortions. The Antenatal Tally Sheet should also be used to record the coverage of antenatal services for each delivery outcome that is updated into the Antenatal Register.

An Illustrated Guide to the Antenatal Register and Antenatal Tally Sheet, and an explanation of the information that should be recorded in each, is shown at the end of the module.

> Secondary Tools

Antenatal (ANC) Card

The ANC card is a important source of health information. It complements information in the Antenatal Register and provides each expectant mother with an individual record of her medical and obstetric history. It should be carried at all times and updated at each visit alongside the Antenatal Register.

The design and content of the ANC card varies from country to country, and supplies should be requested from the national Ministry of Health. The card often includes additional information on delivery and post-natal care. It can also facilitate the delivery of integrated health care, by serving as a unique identifying document for the receipt of other health services related to pregnancy (e.g. PMTCT, supplementary feeding).

Often the ANC card contains a partograph for graphic recording of progress of labour. It is used as an early waning system to detect labour that is not progressing normally, to indicate when augmentation of labour is inadequate, and to recognise cephalo-pelvic disproportion long before labour comes obstructed. It also increases the quality and regularity of all observations on the fetus and the mother in labour and aids early recognition of problems in either. A partograph should be kept for expectant mothers admitted to the maternity ward in labour (see Module 9 - Part 2: Delivery Care).

9.4 HOW AND WHEN SHOULD THE DATA BE REPORTED?

At the end of each week the Antenatal Register and Antenatal Tally Sheet should be used to compile the antenatal tables within the Reproductive Health Report.

The dates of the reporting weeks are shown in the Reporting Calendar. It is important that all staff are aware of these dates, and that copies the calendar are distributed to all antenatal clinics.

9.4.1 Weekly Report

The clinic supervisor is responsible for ensuring complete and timely submission of the Weekly Reproductive Health Report from each section. The number of new antenatal visits, before and after the first trimester, should be reported in the corresponding table in the weekly form using the Antenatal Register. The remaining information in the table, relating to RPR screening, detection of high-risk pregnancy and abortion complications, should be reported using the front page of Antenatal Tally Sheet. The reverse of the Antenatal Tally Sheet should be used to complete the section concerning coverage of antenatal services as reported at the time of delivery. All entries should be appropriately disaggregated by age (<18, ≥18) and status (refugee and national).

If there is more than one antenatal clinic in the camp, the information from each unit should be combined to create one weekly report for the entire camp. Photocopies of the weekly form may be required to assist units compile their individual reports prior to aggregation into the camp totals.

An Illustrated Guide to the Reproductive Health Report, and an explanation of how the information should be reported from daily sources, is given at the end of the module.

9.4.2 Monthly Report

At the end of each week the paper-based report forms can be directly entered into the computer. The database will then automatically combine these into a monthly report composed of 4 or 5 weekly reports, depending on the reporting calendar. More information on data management and is given in Part 3 of the manual.

9.5 HOW SHOULD THE DATA BE INTERPRETED AND USED?

The indicators for antenatal care are shown below. Each is classified according the five core objectives of the HIS given in Part 1 of this manual. A summary of each indicator, including formulae, units of expression, and the corresponding standard (where available) is given in the Standard and Indicator Guide that accompanies this manual.

It is essential that staff are familiar with how these indicators are calculated, and understand how they should be used to evaluate programme performance and to inform public health decision-making. A group exercise on how to calculate and interpret the indicators, using sample data, is given on the CD-ROM which accompanies this manual.

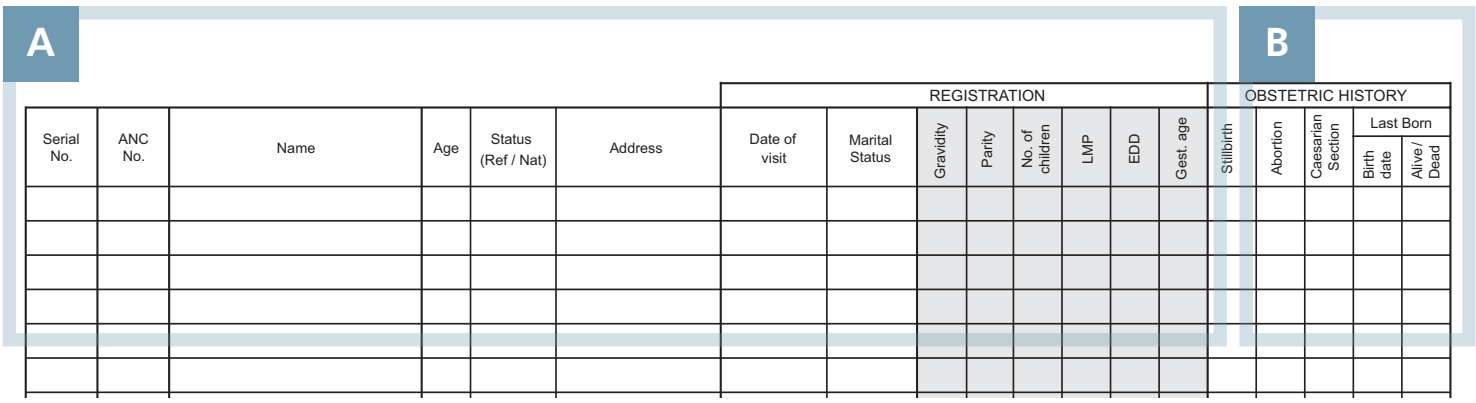
> Indicator Summary

Antenatal Care

Objective	Indicator	Source
2. Monitor trends in health status and continually address healthcare priorities	Prevalence of maternal syphilis	UNHCR/UNICEF/UNFPA
	Incidence of complications of abortion	UNHCR/UNICEF/UNFPA
3. Evaluate the effectiveness of interventions and service coverage	Coverage of complete antenatal care	UNHCR/UNICEF/UNFPA
	Coverage of syphilis screening in pregnancy	UNHCR/UNICEF/UNFPA
	Ratio of contacts treated : RPR positive cases	HIS
	Coverage of antenatal tetanus immunization	UNHCR/UNICEF/UNFPA
	Coverage of intermittent presumptive treatment (IPT) for malaria	UNHCR/UNICEF/UNFPA
	Coverage of insecticide treated net (ITN) distribution	HIS
	Coverage of deworming	UNHCR/UNICEF/UNFPA
	Proportion of antenatal visits made by host population	HIS
4. Ensure that resources are correctly targeted to areas and groups of greatest need	Proportion of abortion complications among under 18s	HIS

* Disaggregated by antigen, as specified in national schedule

> Illustrated Guide to Antenatal Register



						REGISTRATION								OBSTETRIC HISTORY				
Serial No.	ANC No.	Name	Age	Status (Ref / Nat)	Address	Date of visit	Marital Status	Gravidity	Parity	No. of children	LMP	EDD	Gest. age	Stillbirth	Abortion	Caesarian Section	Last Born	
																	Birth date	Alive / Dead

A REGISTRATION:

Serial No.:
> Enter sequence number in register

Antenatal No:
> Enter unique identifying number

Name:
> Print name of expectant mother

Age:
> Enter age (in years)

Status:
> Classify as Refugee (Ref) / National (Nat)

Address:
> Print Camp Address (Refugee) / Nearest Village (National)

Date of visit:
> Enter date (dd/mm/yy)

Marital Status:
> Classify as Married / Single / Widowed / Separated

B OBSTETRIC HISTORY:

Gravidity:
> Number of pregnancy

Parity:
> Number of previous deliveries

No. of children:
> Number of surviving children

LMP:
> Date of Last Menstrual Period (dd/mm/yy)

EDD:
> Expected Delivery Date (dd/mm/yy)

Gest. Age:
> Gestational Age in weeks (XX / 36)

Stillbirth:
> Number of stillbirths (see glossary)

Abortion:
> Number of abortions (see glossary)

Caesarian Section:
> Number of caesarian sections

Last born:

1. Birth date
> Birth date of last born (dd/mm/yy)

2. Alive / Dead:
> Status of last born (Alive / Dead)

C D

RISK FACTORS																SERVICES (Enter Date Provided)												PREGNANCY OUTCOME		
1st Visit				2nd Visit				3rd Visit				4th Visit				Fansidar			Syphilis screening			TT					Mebend.	ITN	Abortion		Date of Delivery
Date	Gest. age	Hb (g/dl)	ANC RF*	Date	Gest. age	Hb (g/dl)	ANC RF*	Date	Gest. age	Hb (g/dl)	ANC RF*	Date	Gest. age	Hb (g/dl)	ANC RF*	1	2	3	– ve	+ ve	Partner Treated	1	2	3	4	5			Compl.	Un-Compl.	

C RISK FACTORS AND SERVICES:

Risk Factors and Services:

For each antenatal visit:

1. Date:
>Enter date (dd/mm/yy)

2. Gest age:
> Enter gestational age

3. Hb
> Enter haemoglobin result (g/dl) (where appropriate)

4. ANC RF:
Enter antenatal risk factor abbreviation from list (to be adapted):

X = No risk factor
A = Anaemia
O = Oedema
P = Proteinuria
H = High BP (above 140/90)
U = Not gaining weight
APH = Antepartum Haem.
M = Abnormal Lie (after 32 weeks)
Ot = Other

Fansidar:
> Enter date on which 2 (or 3) doses of fansidar were given (dd/mm)

Syphilis screening:
> Enter test date in box that corresponds with result (+ve / -ve). For +ve results, enter date partner was treated (dd/mm).

TT:
>Enter dates on which most recent doses of TT vaccine were given (dd/mm/yy)

Mebend:
> Enter date on which dose of mebendazole was given (dd/mm)

ITN:
> Enter date on which insecticide treated net was provided (dd/mm)

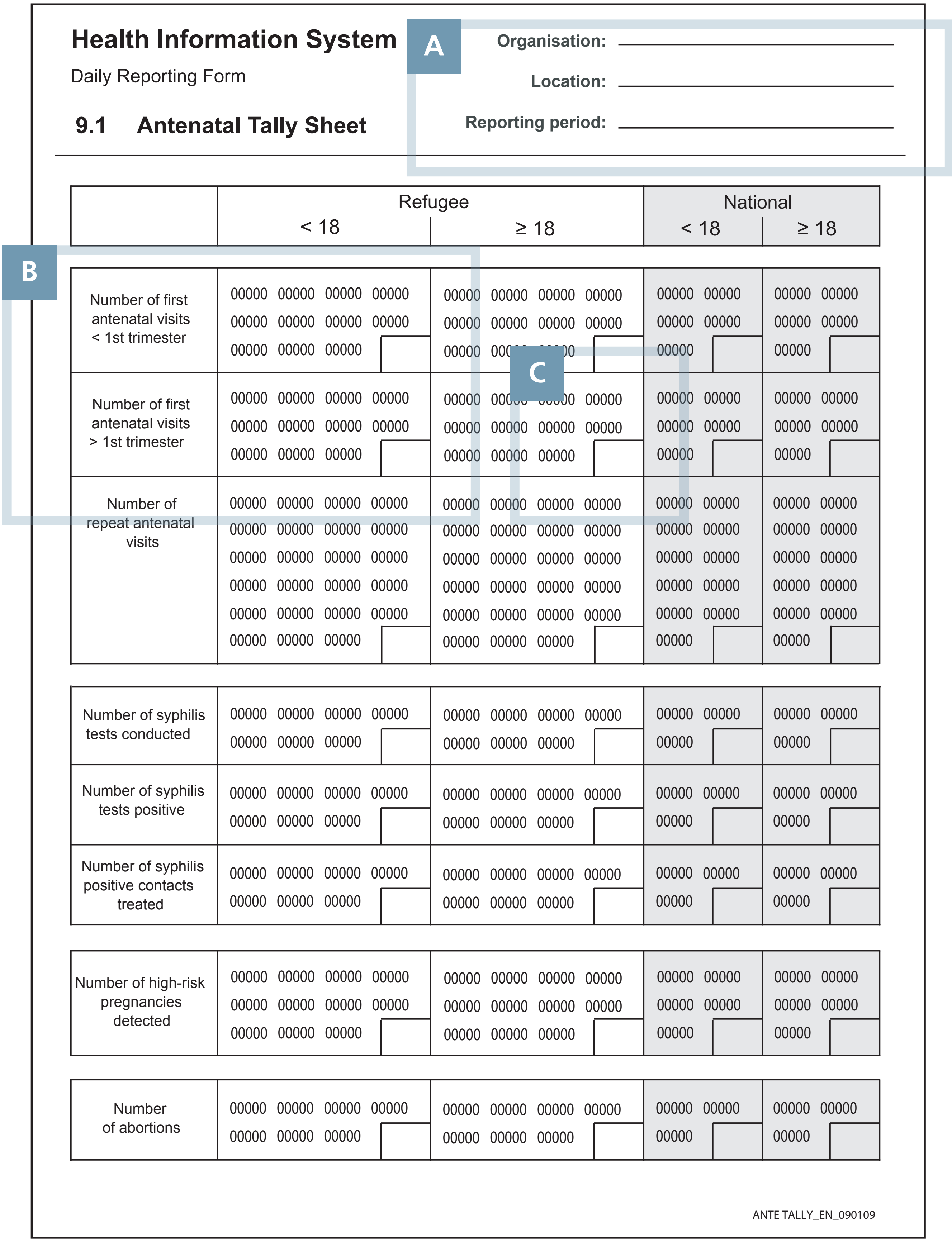
D PREGNANCY OUTCOME:

Compl/Un-Compl.:
> Enter delivery complication abbreviation from list (as indicated):

X = No complication
PPH = Postpartum Haem.
E = Eclampsia
PS = Puerpueral Sepsis
OL = Obstructed Labour
B = Breech
T = Third Degree Tear
Ot = Other

Delivery:
> Enter date of delivery (dd/mm/yy)

> Illustrated Guide to Antenatal Tally Sheet (FRONT)



Health Information System

Daily Reporting Form

9.1 Antenatal Tally Sheet

A

Organisation: ____________________

Location: ____________________

Reporting period: ____________________

B

C

	Refugee < 18	Refugee ≥ 18	National < 18	National ≥ 18
Number of first antenatal visits < 1st trimester	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000	00000 00000 00000 00000 00000
Number of first antenatal visits > 1st trimester	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000	00000 00000 00000 00000 00000
Number of repeat antenatal visits	00000 00000	00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000
Number of syphilis tests conducted	00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000	00000 00000 00000	00000 00000 00000
Number of syphilis tests positive	00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000	00000 00000 00000	00000 00000 00000
Number of syphilis positive contacts treated	00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000	00000 00000 00000	00000 00000 00000
Number of high-risk pregnancies detected	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000	00000 00000 00000 00000 00000
Number of abortions	00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000	00000 00000 00000	00000 00000 00000

ANTE TALLY_EN_090109

A HEADER:

Organisation:
Print name of health partner

Location:
Print name of Camp and Reporting Unit

Reporting period:
Enter number of week and month (e.g. Week 1 March)

NOTES

It is the responsibility of a designated ANC staff member to ensure each tally sheet is maintained correctly. A new sheet should be used if any one of the tally sections is filled.

No single tally sheet should be used for more than one reporting week.

B SERVICE PROVISION:

Strike a tally corresponding to:

> Variable:

- Number of first antenatal visits (before / after first trimester)
- Number of repeat antenatal visits
- Number of RPR tests conducted
- Number of RPR tests positive
- Number of RPR positive contacts treated
- Number of high risk pregnancies detected
- Number treated for complications of abortion

> Status (Refugee / National);

> Age (< 18, ≥ 18; for refugees only)

C NUMBER BOXES:

Before submitting the tally sheet at the end of the week, count the number of tallies in each box and convert to a number.

> Write number clearly in the black square in the bottom right hand corner of each tally box

NOTES

It is the responsibility of the designated ANC staff member responsible for the form to convert tallies to numbers PRIOR to submission at the end of the week.

The clinic supervisor should check a random sample of 10 - 20 tally conversions for accuracy at the end of each week.

> Illustrated Guide to Antenatal Tally Sheet (REVERSE)

For *each* pregnancy outcome entered in the Antenatal Register, review the antenatal history and tally below if standards of care have been met.

The pregnancy outcome section should be *regularly* updated in Antenatal Register, from ANC cards and/or Delivery register.

D

E

	Refugee		National	
	< 18	≥ 18	< 18	≥ 18
Number of pregnant women at time of delivery who:				
Received 4 or more antenatal visits	00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000
Received 2 doses of tetanus toxoid vaccine	00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000
Received at least 2 doses of fansidar	00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000
Were screened for syphilis	00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000
Received 1 dose of mebendazole	00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000
Received 1 insecticide treated net (ITN)	00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000

D SERVICE COVERAGE:

For each delivery outcome entered in the Antenatal Register, review the antenatal history and tally if the following standards have been met:

> Standard of care during antenatal period*:

At least 4 antenatal visits
2 doses of TT vaccine
2 doses of malaria prophylaxis
1 dose of deworming
1 insecticide treated net

> Age (< 18, ≥ 18; for refugees only)

* should be adapted to Ministry of Health guidelines

NOTES

Coverage of antenatal care services are recorded among refugees only.

TT doses should be administered according to the TT schedule. If an expectant mother had completed a schedule upto and including TT5 prior she should be tallied as having had received 2 doses of vaccine (i.e. being fully immunized within the current pregnancy).

E NUMBER BOXES:

Before submitting the tally sheet at the end of the week, count the number of tallies in each box and convert to a number.

> Write number clearly in the black square in the bottom right hand corner of each tally box

NOTES

It is the responsibility of the designated ANC staff member responsible for the form to convert tallies to numbers PRIOR to submission at the end of the week.

The clinic supervisor should check a random sample of 10 - 20 tally conversions for accuracy at the end of each week.

Module 9
Part 2 - Delivery Care

CONTENTS

ILLUSTRATED GUIDES

Delivery Care

9.6 WHAT ARE THE TOOLS USED FOR DATA COLLECTION?

The data collection tools used in delivery care are shown below. They are classified as follows:

Primary Tools

Primary data sources are essential to routine monitoring within the HIS and are prerequisite to the calculation of indicators. They form the basis of the guidance and training within this manual, and are described in detail in the Illustrated Guides at the end of the module.

Secondary Tools

Secondary data sources have important functions within the HIS but are not directly used in the calculation of indicators. They play vital roles informing clinical decision-making and promoting service quality and performance. They are described in information boxes in the supporting text.

> Data collection and monitoring tools

Delivery Care

Primary Tools
1. Delivery Register
2. IPD (Pregnancy) Register
3. IPD Register
4. Reproductive Health Report

Secondary Tools
1. Partograph
2. Apgar Scoring Chart
3. Antenatal Card
4. Ward Book and Clinical Notes

9.7 WHO IS RESPONSIBLE FOR COLLECTING THE DATA?

A Delivery Register should be used to record all births within each camp. The member of clinical staff present at the time of the delivery is responsible for updating the entry into the register. Each staff member on the maternity ward should therefore understand how to accurately record each delivery, and should take responsibility for maintaining neat and legible records.

At the end of each week, the Nurse/Midwife in-charge should coordinate the completion of the Reproductive Health Report and ensure that delivery section has been submitted in full and on time. This report should include all deliveries in the camp, including home deliveries, births before arrival, and births in referral centres (see below).

This person is also responsible for monitoring the upkeep of register entries, and for ensuring the completeness of record entries each day.

9.8 WHAT DATA SHOULD BE COLLECTED AND HOW?

It is essential that all births within each camp are recorded in the Delivery Register. This includes home deliveries, births before arrival, and deliveries in referral centres outside the camp.

9.8.1 Delivery Register

The comprehensive reporting of births has two important purposes:

1. Population Data:

Birth data are the basis on which camp population figures are updated each week. Accurate reporting is vital to ensure that each camp's demographic statistics and trends are tracked reliably.

2. Birth Certification:

The registration of every birth at, or shortly after birth, is fundamental to protecting the rights and identity of each child. The delivery register is an important reference source for the Under Five Register, which is used to issue birth certification (see Module 7: EPI).

Careful attention should be made to ensure that double-reporting of births does not occur. This is particularly the case for referrals between camps for advanced care and management of delivery complications. Irrespective of the delivery location, every birth should be reported within the weekly statistics in the mother's camp of origin.

> Registration

At registration, basic identifying information, an obstetric history and vital maternal and fetal signs should be recorded. The same antenatal number should be used as was issued as in the Antenatal Register and on the Antenatal Card.

A partograph must be used to monitor the of progress of each labour, and should be started immediately upon registration in the Delivery Register. A partograph increases the quality and regularity of all observations on the fetus and the mother in labour and aids early recognition of problems in either. It is used as an early warning system to detect labour that is not progressing normally, to indicate when augmentation of labour is inadequate, and to recognise cephalo-pelvic disproportion before labour comes obstructed.

The partograph is often included on the antenatal card issued by the Ministry of Health (see Secondary Tools: Antenatal Card). It should be used in conjunction with detailed clinical records and updated regularly during nursing ward rounds.

> Delivery Details

The date, time and mode of delivery should be filled in the Delivery Register immediately after birth. The location should be recorded as the name of the health-facility and/or hospital where the delivery occurred. The location of home birth, or births before arrival, should be noted accordingly. The record should also indicate whether or not the delivery was attended by a skilled health worker. This should be done by entering the grade of staff that was present at the time of birth into the register (e.g. Doctor / Nurse-Midwife / Nurse / TBA / None).

> Delivery Outcome

Pregnancy outcome and the presence of delivery complications should be documented in the register. An abbreviated key of the most commonly reported delivery complications is shown in a key at the bottom each register page. This listing can be further expanded, to include more cause-specific reasons, according to the needs of each health partner.

Estimated blood loss (in mls) and a comment on the state of the perineum should also be entered in this section. Perineal state should indicate whether intact or not. If applicable, the degree of tear and a record of repair should be noted.

> Newborn Status

Newborn sex and condition should be assessed immediately after delivery and indicated in the register with a written remark and the Apgar Score. The Apgar Score (a number between 1 and 10) is designed to quickly evaluate a newborn's physical condition after delivery and to determine

any immediate need for extra medical care. It should determined by delivery room staff at one and five minutes of age. The Apgar criteria and scoring chart should be clearly visible on the wall of every delivery room (see Secondary Tools: Apgar Score). Only the five-minute score should be entered into the register.

The birth weight should be entered in grams in the column indicating a measured weight of above or below 2500g. A comment of Yes or No should be written to indicate if the newborn was weighed within 72 hours of the time of delivery. This is particularly applicable to home deliveries and births before arrival. The member of staff who attended the delivery and updated the register should print their name clearly next to each entry. If the delivery occurred outside the maternity unit, this should be filled by the staff member who completed the record.

9.8.2 IPD Registers

Pregnant women, post-natal mothers and newborns are often admitted to the maternity unit for medical care. To safeguard complete recording of this data, two additional registers need to be kept alongside the Delivery Register on each unit.

1. IPD (Pregnancy) Register:

This should be used to record medical admissions in pregnancy. This a modified version of the regular IPD Register, and includes specific details related to obstetric history and vital signs of the mother and fetus. Women admitted in false labour should be included in this book and remain until discharge. If they progress to true labour during the same admission, they should be transferred into the Delivery Register.

2. A regular IPD register should be used to record admissions by postnatal mothers or newborns.

An Illustrated Guide to the Delivery Register and an explanation of the information that should be recorded in both is given at the end of this module. Illustrated Guides to the IPD and IPD (Pregnancy) Registers can be found in Module 4: IPD and Referral.

> Secondary Tools

Apgar Score Chart

The Apgar score is determined by evaluating the newborn baby on five simple criteria on a scale from zero to two and summing up the five values thus obtained. The resulting Apgar score ranges from zero to 10 (see table 1). The Apgar criteria and scoring chart should be clearly visible, in poster format, on the wall of every delivery room.

Table 1. Common dose-vial sizes

Acronym	Criterion	Score of 0	Score of 1	Score of 2
Appearance	Skin color	Blue all over	Blue at extremities	Normal
Pulse	Heart rate	Absent	<100	>100
Grimace	Reflex irritability	No response to stimulation	Grimace/feeble cry when stimulated	Sneeze/cough/ pulls away when stimulated
Activity	Muscle Tone	None	Some flexion	Active movement
Respiration	Respiration	Absent	Weak or irregular	Strong

Notes

- The test is generally done at one and five minutes after birth, and may be repeated later if the score is, and remains, low. Scores below 3 are generally regarded as critically low, with 4 to 7 fairly low and over 7 generally normal.
- Low scores at the one minute test may require medical attention, but are not an indication of longer term problems, particularly if there is an improvement by the stage of the five minute test.
- If the Apgar score remains below 3 at later times such as 10, 15, or 30 minutes, there is a risk that the child will suffer longer term neurological damage. There is also a small but significant increase in the risk of cerebral palsy.

9.9 HOW AND WHEN SHOULD THE DATA BE REPORTED?

At the end of each week the Delivery Register should be used to compile the delivery table in the Reproductive Health Report. Community Health Worker, Traditional Birth Attendant, and referral hospital records should be used to update entries for deliveries which take place outside the maternity unit.

The dates of the reporting weeks are shown in the Reporting Calendar. It is important that all staff are aware of these dates, and that copies the calendar are distributed to all maternity wards.

9.9.1 Weekly Report

The Nurse/Midwife in-charge is responsible for using the Delivery Register to complete the delivery table in the Weekly Reproductive Health Report. Photocopies of the weekly form may be required to assist units compile their individual reports prior to aggregation into the camp totals.
Each entry should be carefully retrieved from the registers, and appropriately disaggregated by age (< 18, ≥18), status (refugee or national) and location of delivery (home or health facility).

An Illustrated Guide to the Reproductive Health Report, and an explanation of how the information should be reported from daily sources, is given at the end of the module.

9.9.2. Monthly Report

At the end of each week the paper-based report forms can be directly entered into the computer. The database will then automatically combine these into a monthly report composed of 4 or 5 weekly reports, depending on the reporting calendar. More information on data management and is given in Part 3 of the manual.

9.10 HOW SHOULD THE DATA BE INTERPRETED AND USED?

The indicators for delivery care are shown below. Each is classified according the five core objectives of the HIS given in Part 1 of this manual. A summary of each indicator, including formulae, units of expression, and the corresponding standard (where available) is given in the Standard and Indicator Guide that accompanies this manual.

It is essential that staff are familiar with how these indicators are calculated, and understand how they should be applied to public health practice. A group exercise on how to calculate and interpret the indicators, using sample data, is given on the CD-ROM which accompanies this manual.

> Indicator Summary

Delivery Care

Objective	Indicator	Source
2. Monitor trends in health status and continually address healthcare priorities	Crude birth rate	UNHCR/UNICEF/UNFPA
	Stillbirth rate	UNHCR/UNICEF/UNFPA
	Maternal mortality rate	UNHCR/UNICEF/UNFPA
	Neonatal mortality rate	UNHCR/UNICEF/UNFPA
	Incidence of obstetric complication	UNHCR/UNICEF/UNFPA
3. Evaluate the effectiveness of interventions and service coverage	Proportion of births attended by a skilled health worker	UNHCR/UNICEF/UNFPA
	Proportion of deliveries at a health centre	UNHCR/UNICEF/UNFPA
	Proportion of newborns weighed within 72 hours of birth	UNHCR/UNICEF/UNFPA
	Proportion of live births to nationals	HIS
4. Ensure that resources are correctly targeted to areas and groups of greatest need	Proportion of births among under 18s	HIS
	Proportion of obstetric complications among under 18s	HIS
	Proportion of low birth weight deliveries	UNHCR/UNICEF/UNFPA

> Illustrated Guide to Delivery Register

A

B

						REGISTRATION											
Serial No.	ANC No.	Name	Age	Status (Ref / Nat)	Address	Date of admission	Time of admission	Gravidity	Parity	No. of children	LMP	EDD	Gest. age	Blood Pressure	Fetal HR	Present'n	Syphilis
																	– ve / + ve

A BASIC INFORMATION:

Serial No.:
> Enter sequence number in register

Antenatal No:
> Enter unique identifying number

Name:
> Print name of expectant mother

Age:
> Fill age (in years)

Status:
> Classify as Refugee (Ref) / National (Nat)

Address:
> Print Camp Address (Refugee) / Nearest Village (National)

Date of admission:
> Enter date (dd/mm/yy)

Time of admission:
> Enter time (hh:mm)

NOTES

ALL deliveries should be recorded in this register, including those outside the maternity ward.

Deliveries at home, births before arrival and births in referral facilities should be updated into the register using relevant data sources (e.g. CHW and TBA reports, hospital records).

B OBSTETRIC HISTORY:

Gravidity:
> Number of pregnancy (see glossary)

Parity:
> Number of previous deliveries (see glossary)

No. of children:
> Number of surviving children

LMP:
> Date of Last Menstrual Period (dd/mm/yy)

EDD:
> Expected Delivery Date (dd/mm/yy)

Gest. Age:
> Gestational Age in weeks (XX / 36)

Blood Pressure:
> Enter Blood pressure of mother (mmHg)

Fetal HR:
> Enter Fetal heart rate (beats per minute)

Presentation:
> Classify as Cephalic / Breech / Oblique / Transverse

RPR:
> Enter date of test in column that corresponds with result (-ve / -+e).

C D

DELIVERY DETAILS					DELIVERY OUTCOME				REFERRAL	NEWBORN						
Date of delivery	Time of delivery	Mode of delivery	Location of delivery	Att'd by skilled hlth worker	Normal Delivery	Delivery Compl.*	Stillbirth		Was referral needed? If Yes, give reason.	Sex (M / F)	Condition	Apgar Score	Birth Weight		Vitamin A 200 000 IU	Name of newborn
							Macer.	Fresh					< 2500g	> 2500g		

C DELIVERY DETAILS AND OUTCOME:

Date of delivery:
> Enter date (dd/mm/yy)

Time of delivery:
> Enter time (hh:mm)

Mode of delivery:
> Spontaneous Vaginal Delivery (SVD) / Vacuum Extraction (VE) / C-Section (CS)

Location
> Specify Health facility (Name) / Birth before arrival / Home

Att'd by skilled hlth worker
> Doctor / Nurse-Midwife (NM) / Nurse / TBA / None

Normal Delivery
> Yes (Y) / No (N)

Delivery compl:
> Enter delivery complication abbreviation from list (to be adapted):

X = No complication
PPH = Postpartum Haem.
E = Eclampsia
PS = Puerpueral Sepsis
OL = Obstructed Labour
B = Breech
T = Third Degree Tear
Ot = Other

Still birth:
> If stillbirth, enter date to indicate macerated or fresh (dd/mm/yy)

Blood loss:
> Enter estimated loss (in mls)

Perineum State:
> Intact / Tear (1st, 2nd, 3rd Degree / Repaired / Not repaired)

D NEWBORN CONDITION:

Newborn sex:
> Enter Male (M) / Female (F)

Newborn Condition:
> Enter comment on physical state of newborn: Good / Poor / Critical

Apgar Score:
> Enter Apgar Score (1 - 10)

Birth Weight:
> Enter weight (g) in column corresponding to above or below 2500g

Weighed < 72 hours
> Enter Yes (Y) / No (N) to indicate if birth weight was measured within 72 hours of time of delivery

Name:
> Print name of person who conducted delivery (or for deliveries outside maternity unit, name of person who updated information)

Module 9
Part 3 - Postnatal Care

CONTENTS

ILLUSTRATED GUIDES

Postnatal Care

9.11 WHAT ARE THE TOOLS USED FOR DATA COLLECTION?

The data collection tools used in postnatal care are shown below. They are classified as follows:

Primary Tools

Primary data sources are essential to routine monitoring within the HIS and are prerequisite to the calculation of indicators. They form the basis of the guidance and training within this manual, and are described in detail in the Illustrated Guides at the end of the module.

Secondary Tools

Secondary data sources have important functions within the HIS but are not directly used to calculate indicators. They play vital roles informing clinical decision-making and promoting service quality and performance. They are described in information boxes in the supporting text.

> Data collection and monitoring tools

Postnatal Care

Primary Tools
1. Postnatal Register
2. Reproductive Health Report

Secondary Tools
1. Postnatal Appointments Books
2.. Antenatal Card
3. Clinical Notes

9.12 WHO IS RESPONSIBLE FOR COLLECTING THE DATA?

All postnatal visits should be documented in a postnatal care register. The task of filling the register should designated to a trained postnatal counsellor in each clinic. This person should understand how to accurately record each visit, and should take responsibility for maintaining neat and legible records.

At the end of each week, the clinic supervisor should coordinate the completion of the Reproductive Health Report and ensure that respective sections have made their submission in full and on time. The clinic supervisor is also responsible for monitoring the upkeep of the registers, and for ensuring the completeness of record entries each day.

9.13 WHAT DATA SHOULD BE COLLECTED AND HOW?

All visits made during the first 6 weeks after delivery should be documented in the postnatal register. The exact schedule of visits will depend on the policy of the national MoH. The recommended standard in most countries is to provide three visits within the first six weeks after birth (at 6 hours, 6 days and 6 weeks).

During postpartum visits, the health and well being of the newborn should be assessed. Newborns should also be referred to the under-five clinic to start immunisations, growth monitoring and other well-child services (see Module 7: EPI; Secondary Tools: Under Five Register).

9.13.1 Postnatal Register

The procedure for data entry in the Postnatal Register follows a similar principle to Antenatal care. A single register entry should contain information on all visits made during the postnatal period. This is the basis on which quality of postnatal care is retrospectively monitored and evaluated at the time of discharge.

> Registration

At registration, basic identifying information and details of the date and mode of delivery, the presence of delivery complications and sex of the newborn should be recorded. Each mother should continue to use the same Antenatal number for her unique identifying code as was given at the beginning of the pregnancy

The expected date of discharge should also be recorded at the time of admission. This should be calculated using a calendar and fixed for approximately six weeks after the recorded date of delivery (there may be exceptions to this rule, as discussed below).

> Risk Factors

The date and the presence of postnatal risk factors should assessed and entered at each visit. Abbreviations of commonly reported postnatal risk factors are shown in a key at the bottom each page. This listing can be further expanded, to include more cause-specific risk factors, according to the needs each health partner.

A comment should be made at each appointment to indicate the timing of the visit according to the recommended schedule. Mothers who do not attend for appointments on the scheduled date should receive appropriate follow-up through the community health department (see Secondary Tools: Postnatal Appointments Book).

The postnatal register is a summarised source of data and is used for monitoring purposes only. Detailed clinical assessment of mother and newborn should be entered into separate medical notes and updated at each visit (see Secondary Tools: Medical Records).

> Secondary Tools

Postnatal Appointments Book

An appointments book should be kept alongside each postnatal register. At the end of each visit, the name and address of the mother should be entered into this book together with the scheduled date of the next visit.

This is important, as it allows the postnatal counsellor to know in advance how many women are expected to attend each day for repeat postnatal visits. Each day, the names of the mothers that attend should be compared with those listed in the appointment book. Those who default can be identified in a timely and systematic manner, and referred for prompt tracing and follow-up by the community health workers.

The community health team should make further enquiries at home, seek the reasons why the mother did not attend for the visit, and provide health education to encourage re-attendance. This process is essential to ensure that outstanding visits are completed before 6 weeks after delivery and that postnatal care meets recommended standards.

> Discharge

The expected date of discharge from the programme should be fixed at the time of registration and postnatal visits scheduled and followed up accordingly in the intervening weeks. Most postnatal mothers will be discharged six weeks after delivery. This deadline is flexible, however, and staff should consider other factors when determining the exact date. For example:

1. Late Entry

Under normal circumstances a mother should attend for her second postnatal visit 6 days after the date of delivery. This should be adjusted if either the mother or the newborn develop complications that require in-patient admission post-natally.

2. Late Exit

In the event that a mother develops a post-natal complication, her discharge date may need to be adjusted beyond the normal six weeks to accommodate in-patient admission and/or additional postnatal visits.

When the discharge date is reached, the postnatal history should be reviewed and the number of visits written in the appropriate column in the register. Only women who attend for the required three postnatal visits within six weeks should be entered in the Reproductive Health report at the end of each week. Reason for exit should be recorded for all women who leave the programme, using the classification provided on the bottom of each register page (see Illustrated Guide at the end of the module).

9.13.2 Postnatal Appointments Book

In order to trace individual mothers who do not attend for scheduled visits, an appointments book should to be kept alongside the postnatal register (refer to Secondary Tools Box). This tool facilitates the early identification of defaulters and provides a means to trace and return individuals to the clinic in a timely and consistent manner, therefore increasing adherence to the recommended postnatal visit schedule.

9.14 HOW AND WHEN SHOULD THE DATA BE REPORTED?

At the end of each week the Postnatal Register should be used to complete the postnatal table in the Reproductive Health Report.

The dates of the reporting weeks are shown in the Reporting Calendar. It is important that all staff are aware of these dates, and that copies the calendar are distributed to all postnatal clinics.

9.14.1 Weekly Report

The clinic supervisor is responsible for ensuring complete and timely submission of data from each section. All postnatal mothers whose date of discharge falls within the reporting week are eligible to be reported, and the postnatal history should be reviewed for each to certify the number and timing of postnatal visits.

Only the number who achieved 3 visits within 6 weeks of delivery should be entered into the report. Note that this is NOT equivalent to the total number of postnatal visits held each week.

If there is more than one postnatal clinic in the camp, the information from each unit should be combined to create one weekly report for the entire camp. Photocopies of the weekly form may be required to assist units compile their individual reports prior to aggregation into the camp totals.

9.14.2 Monthly Report

At the end of each week the paper-based report forms can be directly entered into the computer. The database will then automatically combine these into a monthly report composed of 4 or 5 weekly reports, depending on the reporting calendar. More information on data management and is given in Part 3 of the manual.

9.15 HOW SHOULD THE DATA BE INTERPRETED AND USED?

The indicator for postnatal care is shown below. It is classified according the five core objectives of the HIS given in Part 1 of this manual. A summary of the indicator, including formulae, units of expression, and the corresponding standard (where available) is given in the Standard and Indicator Guide that accompanies this manual.

> Indicator Summary

Postnatal Care

Objective	Indicator	Source
3. Evaluate the effectiveness of interventions and service coverage	Coverage of postnatal care	HIS

> Illustrated Guide to Postnatal Register

A

Serial No.	ANC No.	Name	Age	Status (Ref / Nat)	Address	DELIVERY DETAILS			
						Date of delivery	Mode of delivery	Delivery Compl.	Newborn Sex (M / F)

A REGISTRATION:

Serial No.:
> Enter sequence number in register

ANC No:
> Enter unique identifying number

Name:
> Print Name of mother

Age:
> Fill Age (in years)

Status:
> Classify as Refugee (Ref) / National (Nat)

Address:
> Print Camp Address (Refugee) / Nearest Village (National)

Date of delivery:
> Enter date (dd/mm/yy)

Mode of delivery:
> Spontaneous Vaginal Delivery (SVD) / Vacuum Extraction (VE) / Forceps (F) / C-Section (CS)

Delivery compl:
> Enter abbreviation to indicate presence of delivery complication (refer to delivery register)

Newborn sex:
> Enter Male (M) / Female (F)

B ATTENDANCE HISTORY:

For each postnatal visit, enter:

Date:
> Enter date (dd/mm/yy)

PNC RF:
> Enter postnatal risk factor abbreviation from list (to be adapted):

X = No complication
PPH = Postpartum Haem.
PS = Puerpueral Sepsis
A - Anaemia
L = Lactational Prob.
CS = Cord Sepsis
E = Eclampsia
Ot = Other

Comment:
> Enter comment on timing of postnatal visit according to recommended schedule

NOTES

The timing of each visit should be reviewed at each visit and remarked upon in the comments column.

A Postnatal Appointments book should be kept to trace women who default or do not attend on time, and should lead to appropriate follow-up through the community health department.

B

1st Postnatal Visit			2nd Postnatal Visit			3rd Postnatal Visit		
Date	PNC compl.*	Comment	Date	PNC compl.*	Comment	Date	PNC compl.*	Comment

C

Expected discharge date†	No. of visits made	Reason for exit **

C EXIT DETAILS:

Expected discharge date:
> Enter date (dd/mm/yy)

IMPORTANT this date should be fixed and entered into the register at the time of the first visit (see notes).

No of visits made within 6 weeks:
> Enter total number of visits made within the post-natal period, between date of delivery and ate of discharge. Certify the timeliness of each visit according to recommended schedule.

Reason for exit:
> The following reasons for exit are also listed in a key at the bottom of each register page. Enter reasons listed in the key ONLY:

> Discharge / Death / Default / Referral

NOTES

Reasons for exit are listed in a key on each register page. Enter reasons listed in the key ONLY.

Repatriation is included within referral as a reason for exit.

NOTES

The expected date of discharge from the programme should be fixed at the time of the first visit.

Most postnatal mothers will be discharged six weeks (42 days) after delivery, and postnatal visits should be scheduled and followed up accordingly.

When the discharge date is reached, the postnatal history should be reviewed and the number of visits written in the appropriate column in the register. Only women who attend for the requisite three postnatal visits within six weeks should be entered into the Reproductive Health report at the end of each week.

In order to trace mothers who do not attend for scheduled visits, an appointments book should to be kept alongside the postnatal register (refer to Secondary Tools Box). This tool facilitates the early identification of defaulters, and provides a means to trace and return individuals to the clinic in a timely and consistent manner; therefore increasing adherence to the recommended postnatal visit schedule.

Module 9
Part 4 - Family Planning

CONTENTS

ILLUSTRATED GUIDES

Family Planning

9.16 WHAT ARE THE TOOLS USED FOR DATA COLLECTION?

The data collection tools used in family planning are shown below. They are classified as follows:

Primary Tools

Primary data sources are essential to routine monitoring within the HIS and are prerequisite to the calculation of indicators. They form the basis of the guidance and training within this manual, and are described in detail in the Illustrated Guides at the end of the module.

Secondary Tools

Secondary data sources have important functions within the HIS but are not directly used to calculate indicators. They play vital roles informing clinical decision-making and promoting service quality and performance. They are described in information boxes in the supporting text.

> Data collection and monitoring tools

Family Planning

Primary Tools
1. Family Planning Register
2. Family Planning Appointments Book
3. Reproductive Health Report

Secondary Tools
1. Family Planning Card
2. Contraceptive Methods Calendar
3. Reporting Calendar

9.17 WHO IS RESPONSIBLE FOR COLLECTING THE DATA?

All visits to a family planning clinic should be documented in a Family Planning Register and recorded by a trained family planning counsellor. This person should understand how to accurately record each visit and should take responsibility for maintaining neat and legible records.

At the end of each week, the clinic supervisor should coordinate the completion of the Family Plannng Report and ensure that respective sections have made their submission in full and on time. The clinic supervisor is responsible for monitoring the upkeep of the registers, and for ensuring the completeness of record entries each day.

9.18 WHAT DATA SHOULD BE COLLECTED AND HOW?

A Family Planning Register should be used to log all family planning visits according to the type of user and the method of contraception supplied. The methods of contraception available for use in each refugee setting will be determined by the national population and family planning legislation within the host country.

The design of the HIS should take national policy into consideration and adapt registers and reporting requirements accordingly (refer to Country Considerations Box).

9.18.1 Family Planning Register

Basic identifying information should be entered for each client and the visit classified according to New or Revisit. A new visit refers to clients who have never attended at the Family Planning Clinic before. These individuals should be assigned a unique identifying code (or family planning number). This number should also be written on a family planning card that should remain with the client as long as s/he is registered with the clinic (see Secondary Tools Box).

Revisit refers to users who have attended for at least one prior visit in the same clinic. The same family planning code should be used for this and all subsequent visits. Note that the classification of New or Revisit is based on prior attendance. It is not related to the type of method used.

> Types of method

The types of method should be listed in the register according to both their generic classification and the trade-names used within each country. Different types of information should be recorded, according to the type of method that is issued:

- For oral contraceptives, enter the number of cycles provided;
- For injectable contraceptives, enter the number of the dose provided;
- For condoms, enter the number of pieces provided;
- For intra-uterine devices, enter the date of insertion;
- For sterilization, enter the date on which the procedure was accepted AND the date on which the procedure was performed

The date of the procedure (NOT the date of acceptance) should be reported as the sterilisation figures each week. To ensure accuracy, it is good practice to compare this figure with the number of sterilisations logged in theatre records.

> Country Considerations

What is the population and family planning policy of the host government?

The types of family planning method used in each country will be defined by national legislation and influenced by a range of cultural, religious, financial and political considerations. The HIS should reflect national policy and adapt reporting requirements accordingly.

To facilitate standardisation and comparison of data, the family planning methods in each national inventory should be listed according to generic terms, and not trade names. The generic classification used is shown in Table 1.

Table 1. Generic classification of Family Planning Methods used in the HIS

Classification	Sub-Classification
1. Oral	COCP* - High Dose COCP* - Low Dose Progestogen Only Pill (POP) Emergency Contraceptive Pill (ECP)
2. Injectable	
3. Implantable	
4. Inter-uterine	
5. Condom	Male Female
6. Sterilization	Male Female

* Combined Oral Contraceptive Pill

> Secondary Tools

Family Planning Card

This card provides each family planning client with an individual record of his/her contraceptive history. Details include family composition, the types of methods used, side-effects or contraindications, and dates of future appointments.

It should be carried at all times and brought updated alongside the Family Planning Register during each counselling session.

> Types of user

The type of user is classified into three categories: New, Repeat and Discontinued. The definitions of each should be standardised among health agencies and applied consistently during each counselling session. Recommended definitions are shown in the Country Considerations box below.

If a user receives more than one method of family planning during a single visit, each method should be entered into a separate row in the register. This is to ensure that each method, and the corresponding type of user, is reported separately. For example, a client may be a new user of one method, and a repeat user of another. In this case both methods need to be distinguished and reported independently of one another (the same rule applies for clients who discontinue and start a new method during the same visit).

A client may discontinue a method for reasons that are both authorised (e.g. repatriation, decision to have a child, side-effects) and unauthorised (e.g. defaulting). The reliable classification of a discontinued user therefore requires efficient and organised data management. A Family Planning Appointments book is essential to this process (see below).

9.18.2 Family Planning Appointments Book

In order to track the number of users who do not return for scheduled appointments in a methodical and predictable manner, an appointments register should be maintained. This helps family planning counsellors to confirm whether or not a client has attended for a scheduled visit on time (see Secondary Tools: Family Planning Appointments Book).

> Country Considerations

Table 1. Definitions of Types of Family Planning User

New user	A client who has never used the method before; or A user who has discontinued a method (see below), and since decided to re-start the same method
Repeat user	A client who has used the method on at least one previous visit, and has not missed a scheduled appointment by more than seven days*
Discontinued	A client who has not attended for a scheduled visit within seven days* of the appointment date

* The exact number of days should be adapted to the country context and standardised among all health partners in written Reproductive Health policy guidelines

If client discontinues a method, a cross (or "X") should be written in the column corresponding to the type of method. The date on which the client discontinued should also entered in the column corresponding to the type of user (see Illustrated Guide to Family Planning Register). A user who opts to restart a method after discontinuation is termed a new user. A group exercise on how to calculate and interpret the indicators is given on the CD-ROM which accompanies this manual.

9.19 HOW AND WHEN SHOULD THE DATA BE REPORTED?

At the end of each week the Family Planning register should be used to fill the Family Planning report. This is a separate report which needs to be filled separately from the Reproductive Health Report.

The dates of the reporting weeks are shown in the Reporting Calendar. It is important that all staff are aware of these dates, and that copies the calendar are distributed to all family planning clinics.

9.19.1 Weekly Report

The clinic supervisor is responsible for ensuring complete and timely submission of the Family Plannig report. The number of new, repeat and discontinued users of each type of family planning method should be carefully retrieved from the register and reported in the family planning table.

> Secondary Tools

Family Planning Appointments Book

It is important to know in advance how many family planning clients are expected to attend for repeat counselling appointments each day. This enables the family planning counsellor to identify those who default in a timely and systematic manner and allows prompt tracing and follow-up by the community health workers.

An appointments book is indispensable to this process and should be kept alongside each family planning register. At the end of each visit, if a repeat appointment is required the date should be entered into the last column of the Family Planning Register. The contraceptive method, client name and address should also be written in the appointments book under the same date.

Each morning, the names of clients that are expected that day should be transferred from the appointments book into the Family Planning Register. Then, at the end of the day, all the appointments should be carefully reviewed. Those who did not attend should be referred immediately to the community health team. The community health workers should then make further enquiries at home, ascertain the reasons why the mother did not attend for the visit, and provide health education to encourage re-attendance.

If the community tracing is unsuccessful, and the client does not re-attend within seven days from the scheduled appointment date*, s/he should be classified as discontinued. An "X" should be written in the column corresponding to the type of method and the date on which the client discontinued entered in the column corresponding to the type of user.

* The exact number of days should be adapted to the country context, and standardised among all health partners within written Reproductive Health policy guidelines

In addition, the number of units of each contraceptive method distributed should be entered into the last column of the report.

If there is more than one family planning clinic in the camp, the information from each unit should be combined to create one weekly report for the entire camp. Photocopies of the weekly form may be required to assist units compile their individual reports prior to aggregation into the camp totals.

9.19.2 Monthly Report

At the end of each week the paper-based report forms can be directly entered into the computer. The database will then automatically combine these into a monthly report composed of 4 or 5 weekly reports, depending on the reporting calendar. More information on data management and is given in Part 3 of the manual.

An Illustrated Guide to the Family Planning report, and an explanation of how the information should be reported from daily sources, is given at the end of the module.

9.20 HOW SHOULD THE DATA BE INTERPRETED AND USED?

After the monthly report has been received at the health agency office, it should be entered into an electronic spreadsheet. The computer will automatically add together the table rows and columns, and calculate the indicators for each section. More information on data management and handling is given in Part 3 of the manual.

9.20.1 Standards and Indicators

The indicators for family planning are shown below. Each is classified according the five core objectives of the HIS given in Part 1 of this manual. A summary of each indicator, including formulae, units of expression, and the corresponding standard (where available) is given in the Standard and Indicator Guide that accompanies this manual.

It is essential that staff are familiar with how these indicators are calculated, and understand how they should be used to evaluate programme performance and to inform public health decision-making. A group exercise on how to calculate and interpret the indicators, using sample data, is given on the CD-ROM which accompanies this manual.

> Indicator Summary

Family Planning

Objective	Indicator	Source
3. Evaluate the effectiveness of interventions and service coverage	Contraceptive prevalence rate	UNHCR/UNICEF/UNFPA
	Proportion of all family planning users who are host nationals	HIS
4. Ensure that resources are correctly targeted to areas and groups of greatest need	Proportion of family planning users who are under 18	HIS
	Proportion of condom users who are under 18	HIS
	Proportion of discontinued users who are under 18	HIS

> Illustrated Guide to Family Planning Register

A

							REGISTRATION			
Serial No.	FP Code No.	Name	Age	Sex (M / F)	Status (Ref / Nat)	Address	Date of visit	Re-visit (Y / N)	Marital Status	No. of children

A REGISTRATION:

Serial No.:
> Enter sequence number in register

FP Code No:
> Enter unique identifying number

Name:
> Print Name of client

Age:
> Fill Age (in years)

Sex:
> Enter Male (M) / Female (F)

Status:
> Classify as Refugee (Ref) / National (Nat)

Address:
> Print Camp Address (Refugee) / Nearest Village (National)

Date of admission:
> Enter date (dd/mm/yy)

Time of admission:
> Enter time (hh:mm)

B TYPE OF METHOD:

For each postnatal visit, enter:

COCP Low Dose:
> Enter number of cycles supplied

COCP High Dose:
> Enter number of cycles supplied

POP:
> Enter number of cycles supplied

ECP:
> Enter number of pills supplied

Injectable:
> Enter number of the dose injected

IUCD:
> Enter date of insertion

Male Condom:
> Enter number of pieces supplied

Female Condom:
> Enter number of pieces supplied

Sterilization:
> Enter date that: (i) client decided to accept the procedure; and (ii) date procedure was performed

NOTES

If client discontinues a method, a cross (X) should be entered in the column corresponding to the type of method.

The date of discontinuation should also entered in the column corresponding to the type of user (see section C).

B

C

FAMILY PLANNING METHOD												
COCP Low Dose *Micro-gynon Nordette*	COCP High Dose *Lo-Femenal*	POP *Micro-val Micro-lut*	ECP *Postinor-2*	Injectable *Depo-Provera*	Implantable *Norplant*	IUCD	Condom		Sterilisation		Type of User*	Next appt. date
							Male	Female	Date of acceptance	Date of procedure		

C TYPE OF USER:

Type of User:
> Enter the type of user using the defintions given in the box opposite.

Options are: **New / Repeat / Discontinued**

Next appt date:
> Enter the date of the next scheduled appointment.

NOTES

Enter name, address, method and next scheduled date into Appointments Book.

The names of client expected each day should be updated from the appointments book into the register at the beginning of each day.

DEFINITIONS OF TYPES OF USER

New user
A client who has never used the method before;
or
A user who has discontinued a method (see below), and since decided to re-start the same method

Repeat user
A client who has used the method on at least one previous visit, and has NOT missed a scheduled appointment by more than seven days*

Discontinued
A client who has not attended for a scheduled visit within seven days* from the appointment date

* The exact number of days should be adapted to the country context, and standardised among all health partners within written Reproductive Health policy guidelines

> Illustrated Guide to Reproductive Health Report (FRONT)

Health Information System

Reporting Form

A

Organisation: _____

Location: _____

Reporting period: _____

9.0 Reproductive Health

B

9.1 Antenatal Care

9.1a

	Refugee		National	
	< 18	≥ 18	< 18	≥ 18
First antenatal visit < 1st trimester				
First antenatal visit > 1st trimester				
Repeat antenatal visit				
Number of syphilis tests conducted				
Number of syphilis tests positive				
Number of contacts of syphilis positive cases treated				
Number of high-risk pregnancies detected				
Number of abortions				

9.1b *Enter number of pregnant women at time of delivery who:*

	Refugee		National	
	< 18	≥ 18	< 18	≥ 18
Received 4 or more antenatal visits				
Received 2 doses of tetanus toxoid during antenatal period				
Received at least 2 doses of fansidar during antenatal period				
Were screened for syphilis during antenatal period				
Received 1 dose of mebendazole during antenatal period				
Received 1 ITN* during antenatal period				

C

9.2 Delivery Care

	Refugee				National	
	< 18		≥ 18		< 18	≥ 18
	Home	Health Facility	Home	Health Facility		
Live births						
Still births						
Low Birth Weight (< 2500g)						
Attended by a skilled health worker**						
Number of obstetric complications treated						
Number of caesarean sections performed						

* ITN = Insecticide Treated Net ** excluding TBA

A HEADER:

Organisation:
Print name of health partner

Location:
Print name of Camp and Reporting Unit

Reporting period:
Enter number of week and month (e.g. Week 1 March)

NOTES

The dates of the reporting weeks are shown in the Reporting Calendar. It is important that all staff are aware of these dates, and that copies the calendar are distributed to all antenatal clinics.

The clinic supervisor is responsible for coordinating the complete and timely submission of all sections contributing to the weekly report.

B ANTENATAL CARE:

Complete rows 1 and 2 in Table 9.1a, using the Antenatal Register.

Complete rows 5 to 7 in Table 9.1a by transferring the figures from the black number boxes on the front of the Daily Antenatal Tally Sheet(s) used during the week (data on front page).

Complete Table 9.1b by transferring the figures from the black number boxes on the reverse of the Antenatal Tally Sheet(s).

NOTES

To ensure that antenatal service coverage is reported fully and accurately, clinic staff should update pregnancy outcome in the Antenatal Register at the end of each day.

Details should be obtained for all women who have delivered on the maternity ward, using information in the Delivery Register.

C DELIVERY CARE:

Complete Table 9.2, using the delivery register.

NOTES

Community Health Worker, Traditional Birth Attendant and referral hospital records should be used to enter details of births outside the maternity ward.

> Illustrated Guide to Reproductive Health Report (REVERSE)

D

9.3 Postnatal Care

	Refugee		National	
	< 18	≥ 18	< 18	≥ 18
Attended for 3 postnatal visits within 6 weeks of delivery				

E

9.4 Family Planning (see separate reporting pad)

F

9.5 Sexual and Gender Based Violence (SGBV)

	Refugee				National
	< 18		≥ 18		
	Male	Female	Male	Female	
Total no. of rape survivors seen within 72 hours*					
Total no. of rape survivors seen within 72 - 120 hours*					
Total no. of rape survivors seen within 120 hours - 2 weeks*					
Total no. of rape survivors seen after 2 weeks*					
No. rape survivors given PEP** within 72 hrs					
No. female rape survivors given ECP*** within 120 hrs					
No. rape survivors given STI presumptive treatment < 2 wks					
No. cases of trauma in health post due to domestic violence					

* of an incident occuring; ** PEP = Post Exposure Prophylaxis; *** ECP = Emergency Contraceptive Pill

D POSTNATAL CARE:

Complete Table 9.3, using the Postnatal Care register

NOTES

Entries with dates of discharge that falls within reporting week are eligible for reporting.

Only those which achieve 3 visits, on time, within 6 weeks should be reported.

E FAMILY PLANNING:

Family Planning data should be entered into a separate report (see next page).

F SGBV:

Complete Table 9.5, using the SGBV register and/or individual case records.

A

Health Information System

Reporting Form

9.4 Family Planning

Organisation: _____

Location: _____

Reporting period: _____

B

	Cumulative number at start of period (a)	Refugee New Users (b) < 18	Refugee New Users (b) ≥ 18	Refugee Repeat Users <18	Refugee Repeat Users ≥ 18	Refugee Discontinued (c) <18	Refugee Discontinued (c) ≥ 18	Cumulative number at end of period (a + b - c)
COCP* - low dose *(Micro-gynon; Nordette)*								
COCP* - high dose *(Lo-femenal)*								
POP** *(Micro-val; Micro-lut)*								
ECP*** *(Postinor-2)*								
Injectable *(Depo-Provera)*								
Implantable *(Norplant)*								
Intra-Uterine Device (IUD)								
Condom (Male)								
Condom (Female)								
Sterilisation (Male)								
Sterilisation (Female)								
Other								

C

Quantity of each method distributed during period*	units
	cycles
	cycles
	doses
	doses
	doses (ml)
	implants
	IUDs
	pieces
	pieces
	sterilisations
	sterilisations

* include methods given to all types of users

XXXXX XXXXX_EN_ddmmyy

A HEADER:

Organisation:
Print name of health partner

Location:
Print name of Camp and Reporting Unit

Reporting period:
Enter number of week and month (e.g. Week 1 March)

NOTES

The dates of the reporting weeks are shown in the Reporting Calendar. It is important that all staff are aware of these dates, and that copies the calendar are distributed to all antenatal clinics.

The clinic supervisor is responsible for coordinating the complete and timely submission of all sections contributing to the weekly report.

B NUMBER OF USERS:

Maintain balance of users on each type of contraceptive using the Family Planning register.

NOTES

It is important to keep track of the number of registered users of family planning within each camp. This moving total should be updated each week as follows:

Open the balance for the current week, by transferring the number of beneficiaries registered at the end of the previous week into the first column (A).

Using a calculator, add the total number of new users seen in the clinic (column B) during the week. Subtract from this the number of discontinued users (column C) to find the new balance of beneficiaries using Family Planning within the camp:

= A + B - C

C NUMBER OF METHODS:

Enter total number of contraceptive methods issued during the reporting week. The units to be used for each method are shown in the final column.