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MINISTRY OF HEALTH - ETHIOPIA

ETHIOPIAN HEALTH MANAGEMENT INFORMATION SYSTEM:

DATA RECORDING AND REPORTING PROCEDURES MANUAL

POLICY, PLAN, MONITORING AND EVALUATION DIRECTORATE (PPMED)

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SEPTEMBER 2021

ADDIS ABABA

CONTENTS

ACRONYMS

ANC	Antenatal Care
ART	Antiretroviral Therapy
AT	Assistive Technology Register
BF	Breast Feeding
BMI	Body Mass Index
CHIS	Community Health Information System
DHS	Demographic and Health Survey
DST	Drug Sensitivity Test
EMR-MRU	Electronic Medical Record-Medical Record Unit
EPI	Expanded Program of Immunization
FP	Family Planning
GA	Gestational Age
GBV	Gender-based Violence
GMP	Growth Monitoring and Promotion
HC	Health Centre
HIS	Health Information System
HMIS	Health Management Information System
Hosp	Hospital
HTS	HIV Testing Services
ICU	Intensive Care Unit
IMNCI	Integrated management of newborn and childhood illness
IPD	Inpatient Department
IPPFP	Immediate Postpartum Family Planning
LAFP	Lon-acting Family Planning
MDR-TB	Multi-Drug Resistance TB
MoH	Ministry of Health
MPI	Master Patient Index
MRN	Medical Record Number
MRU	Medical Record Unit
NCoD	National Classification of Disease
OPD	Outpatient Department
PHEM	Public Health Emergency Management
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
RHBs	Regional Health Bureau
Td	Tetanus diphtheria
TPT	Tuberculosis (TB) preventive treatment
VAS	Vitamin A Supplementation
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
WoHO	Woreda Health Office
ZHDs	Zonal Health Office

INTRODUCTION

The Ethiopian Ministry of Health (MoH) is currently implementing the Health Sector Transformation Plan (HSTP II) covering the period between Ethiopian Fiscal years 2013 and 2017 (July 2020-June 2025). The introduction of new health initiatives in the HSTP II results in additional indicators, which have to be monitored regularly. In order to respond to the additional monitoring and evaluation (M&E) requirements, the MoH has reviewed the existing health management information system (HMIS) indicators, which in turn introduce new indicators, modify and/or omit the existing indicators. Following the revision, the existing recording and reporting formats have been modified and new recording formats are developed.

The recording instruments are developed based on the level of the health institutions and the scope of health services they deliver. Health posts in agrarian areas use a family folder to record health services that they provide while health centers and hospitals (including private for-profit and private for-not profit facilities) use individual medical records to capture medical and health services from each individual. Registers are used to capture selected data elements from individual medical records that are important for reporting. In order to simplify report compilation, tally sheets are developed for some of the services where some of the reportable data elements are directly compiled from registers. Routine aggregated reports are submitted through district health information software (DHIS2), which also serves as a tool for analysis to enhance data use practice.

This manual is dedicated to detail the descriptions of revised recording and reporting tools and procedures, excluding the tools used at health posts that will be addressed separately. Therefore, all health workers at health facilities (Health centers, Hospitals, and private health facilities) and administrative health units (WoHOs, ZHDs, RHBs, MOH) will use this manual in the implementation of the revised HMIS indicators and tools.

Given the very dynamic nature of the health system, this manual will be updated whenever changes made to HMIS indicators; recording and reporting tools and procedures. The manual is organized into four chapters:

Chapter 1: ***Overview of Health System and Health Information Systems:*** provide information about the basic concepts of health information system (HIS), and Health Management Information system (HMIS) in the Ethiopian context

Chapter 2. ***Individual Medical Recording tools and its procedures:*** Describes the individual recording tools and basic procedures to be followed in using the forms

Chapter 3: ***Registers and tally sheets and their completing procedures:*** Provides a detailed description of all HMIS registers and tally sheets and their recording procedures

Chapter 4: ***Reporting tools and Procedures:*** Provides description of the reporting formats, reporting channel, period, and reporting hierarchy.

Annexes: This includes different forms that are described in the previous sections

CHAPTER 1

Overview of Health System and Health Information Systems: Basic Concept

CHAPTER 1: OVERVIEW OF HEALTH SYSTEM AND HEALTH INFORMATION SYSTEMS: BASIC CONCEPT

Health System

A health system consists of all organizations, people, and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities. A health system is, therefore, more than the pyramid of publicly owned facilities that deliver personal health services (WHO, 2007). Health systems have a responsibility not just to improve people's health but also to protect them against the financial cost of illness and to treat them with dignity (WHO, 2000). It has three fundamental objectives.

- Improving the health of the population
- Responding to people's expectations (Responsiveness)
- Providing financial protection against the costs of ill-health (Risk Protection)

A health system has six components/building blocks. These include service delivery, health workforce, health financing, health information system, medical products, and governance & leadership (See figure 1 below). The health system framework below shows the six building blocks of a well-functioning health system and the impact that it intends to bring (Responsiveness, Risk Protection, and Improved health). A Health Information system is a cross-cutting component that helps us to measure the performance of the other components of a health system.

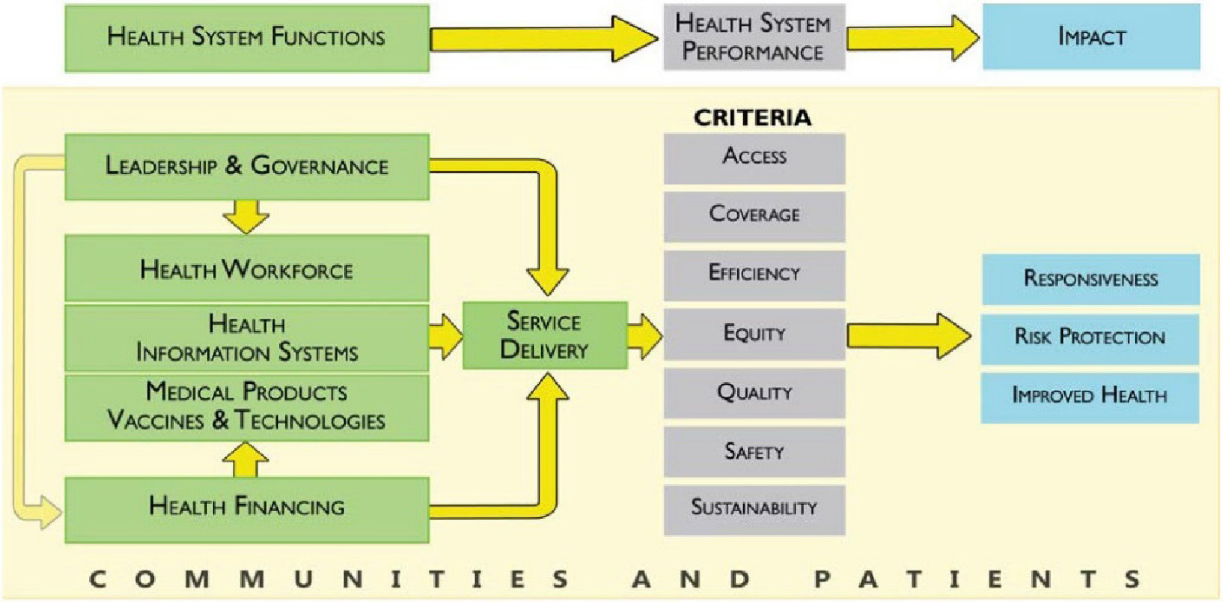


Figure 1: Building blocks of a well-functioning health system (From WHO)

The Ethiopian health service delivery is structured into three tiers providing primary-, secondary-, and tertiary-level health care (Figure 2).

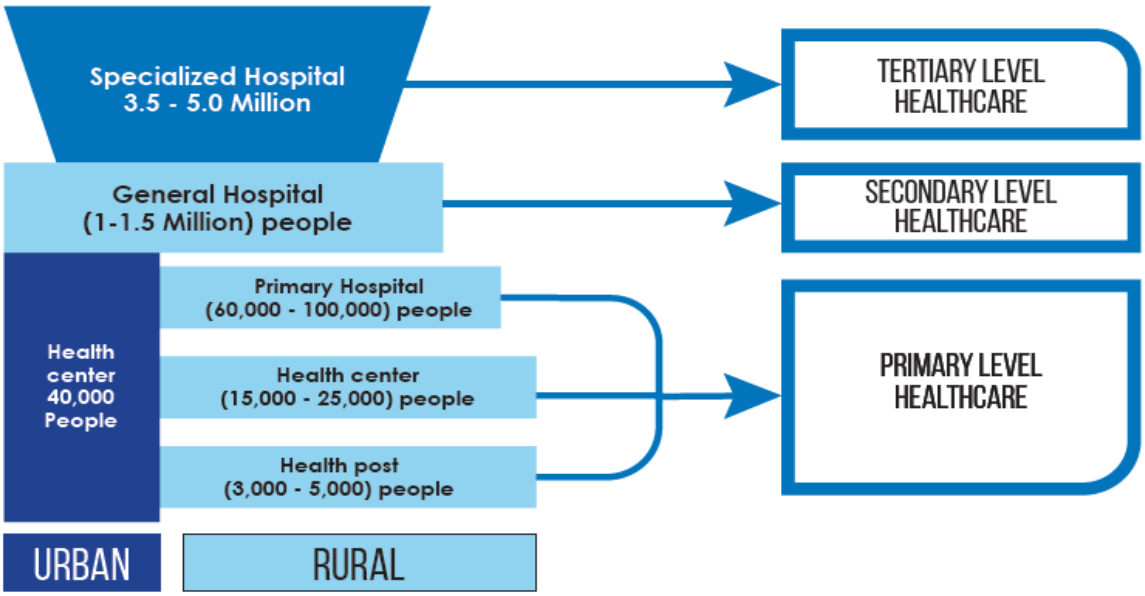


Figure 2: Ethiopian Health Tier System

Health Information System (HIS)

Health Information System (HIS) refers to any system that captures, stores, manages, or transmits information related to the health of individuals or the activities of organizations, which will improve health care management decisions at all levels of the health system. It is used to avail and use timely information on health determinants, health systems performance, and health status

Information is crucial to inform on the performance of the health system and about health challenges. HIS is required for timely intelligence on the other building blocks of the health system:

- Progress in meeting health challenges and objectives
- Health financing, through National Health Accounts (NHAs) and analysis of financial catastrophes and of financial and other barriers to health services for the poor/vulnerable
- Trends and needs for human resource for health (HRH); on the consumption of and access to pharmaceuticals; on appropriateness and cost of technology; on distribution and adequacy of infrastructure
- Access to care and on the quality of services provided

Components of Health Information System

A health information system has different components, which include health information system, resources, indicators, data sources, data management, information products, and dissemination and use. The six components of a health information system are the following.

1. **Health information system resources:** these include the legislative, regulatory, and planning frameworks required to ensure a fully functioning health information system, and the resources that are prerequisites for the system to be functional. The resources include personnel, financing, logistics, information and communications technology, and coordinating mechanisms within and between the six components.

2. **Indicators**: - a core set of indicators and related targets for the health information system. Indicators need to include determinants of health, health system inputs, outputs and outcomes, and health status.

3. **Data sources:** This includes population-based or facility-based sources for the health information system

4. **Data management:** this covers all aspects of data handling from the collection, storage, quality assurance, and flow, to processing, compilation, and analysis

5. **Information products:** data must be transformed into information that will become the basis for evidence and knowledge to shape health action

6. **Dissemination and use:** the value of health information can be enhanced by making it readily accessible to decision-makers (giving due attention to behavioral and organizational constraints) and by providing incentives for information use.

1.3.1. Sources of data

Data sources for health information systems can be categorized into two. These are:

- **Population-based**: This includes census data, vital registration system, and population-based surveys, researches, etc.
- **Institution-based:** This includes institution-based data sources such as administrative records, individual records, service records, etc.

In Ethiopia, Health Information System (HIS) captures and utilizes data from different sources and managed under different authorities. The sources of data include the routine HMIS, population and housing census, surveys including the demographic and health survey, and different researches. Primarily the ministry of health manages the routine HMIS where population-based information is mainly from the central statistical authority (CSA). Moreover, the Ethiopian Public Health Institute (EPHI), Universities, and individuals conduct various research activities.

Data sources of the Ethiopian health system can be categorized as follows based on the above framework.

- Community-level: Community Health Information System (CHIS), surveys, and different household studies
- Facility level Health Centers (HCs), hospitals and private health facilities: Routine HMIS report & surveillance report from Public Health Emergency Management (PHEM), facility-based researches and surveys
- Woreda, Zonal and Regional levels: HMIS, Surveillance data, administrative data, surveys
- National level: HMIS, Census, demographic and health surveys (DHS), national household surveys, different national level researches, modeling, and estimates

Health Management Information System (HMIS)

Health Management Information System (HMIS): is the routine collection, aggregation, analysis, presentation, and utilization of health and health-related data for evidence-based decisions for health workers, managers, policymakers, and others. It is the processing of converting data from various health components into information, which enables health workers & managers, planners, policymakers, and other stakeholders to make informed decisions.

Purposes of HMIS:

- Availing accurate, timely, and complete data to support decision making at each level of the health system
- Strengthening the use of locally generated data for evidence-based decision making

Components of HMIS

HMIS has two main components: information management component and use of the information for evidence-based decision-making.

1. **Information management**

- **Data collection**: Recording of health data using individual and family folder, registers, tally, and reporting formats
- **Data processing**: is a process of cleaning, entering, and aggregating data.
- **Data analysis and presentation** is a process of interpretation and comparison of generated information in the form of sentences, tables, and graphs.

2. **Using information for management purposes**

- **Problem identification:** identifying problems using key indicators
- **Prioritizing problems and decision-making:** Problems identified should be prioritized and decide what types of actions need to be taken.
- **Action taking:** Implementing the agreed action.
- **Result monitoring:** assessing whether the desired result has been achieved or not.

CHAPTER 2

Individual Medical Recording tools and its procedures

CHAPTER 2: INDIVIDUAL MEDICAL RECORDING TOOLS AND PROCEDURES

Individual Medical Recording tools are those, which are used to record the medical and clinical information of individual clients and/or patients. At health center and hospital levels, each client/patient is expected to have an individual record where all the services provided are recorded & kept. In this section, each medical recording tool and its contents are discussed in detail.

Individual folder

A folder is used as a pouch to contain all the medical records of each patient/client. The data elements at the front part of the folder include personal identification data elements (socio-demographic characteristics of the individual) and should be filled by Medical Record Unit workers at the time of registration. The inside part of the folder contains a summary sheet to summarize the medical record of patients/clients at each visit and should be filled by service providers immediately after the service is provided.

Therefore, an integrated folder is used to integrate all medical & health service records of an individual patient or client so that the holistic medical data of individuals can be accessed in one folder, whenever required.

A sample of the information to be completed on the individual integrated folder are:

- The health facility name, MRN, date of registration, client name, age (preferably date of birth); address, etc on the front page
- List of Services given to the client/patient on the Summary sheet, inside the page of the folder.

Where used: Health Center / Primary clinic / Medium clinic/ All types of specialty clinics/ All types of specialty centers, and All types of Hospitals

Format of instrument: Paper file folder with expandable spine and fastener on the left side. Registration information is printed on the front, with the summary sheet on the inside front cover.

Location in the facility: Kept in Card Room and filed by individual's MRN. When the patient receives care in the facility, the folder is taken to the appropriate service room. The tracer card tracks the folder's location.

Who maintains:

a. Cardroom clerk/ receptionist issues the folder upon registration of a new individual, retrieves the folder from the filing shelves for a registered patient returning for service, tracks its location until it returns to the card room, then files it in its normal location.

b. Care providers use the instruments already in the folder or add new forms while providing service. At the end of service, the care provider adds any new forms to the top and makes a notation in the summary sheet regarding the care provided.

Archival procedures: National and regional regulations for retention should be observed. If these regulations are unknown, records may be retained in active storage for 5 years after the last visit, and retained in inactive storage for 10 years after the last visit or death.

Medical Record Number (MRN):

MRN is a unique number given to an individual in a health facility. It is written on the front part of the folder and on the summary sheet section of the folder. It identifies an individual client/patient to the specific facility.

It helps to trace an individual folder during repeated visits to the facility (using the service ID card, where MRN is written on it).

Only one MRN is assigned to one client in one health facility. MRN should be a 5-digit number for a health center and a 6-digit number for a hospital, e.g. at a health center, MRN starts with 00001, and at a hospital with 000001.

Notes:

- An individual should obtain an individual folder to get any single service at the facility, and it should be kept in the medical recording unit (MRU) with a unique individual MRN (Medical Record Number).
- All individual medical records, i.e. cards that have clinical notes, request forms, etc. must be kept in the integrated folder.
- The folder is replaced by a tracer card when it is distributed out for service and rearranged with the tracer card inserted in when it is back shelved. Meanwhile, the respective service unit that received them should sign the receipt of distributed folders. When the folder returns to the reception area, the tracer card must be inserted in the folder and the folder takes its position to where it was before the distribution.
- If the summary sheet becomes full, another form can be prepared and be kept in the folder.
- The folder is preferably shelved in its spine by the sequential order of medical record numbers in the MRU.
- The folder is distributed to individual service rooms/departments based on showing up the request of an individual client/patient for required service
- No folder kept out of MRU after completion of service. However, folders of admitted patients can be kept in the respective department until the patient is discharged.

Individual summary sheet

It is available in the inside section of the folder and filled by the service provider at the time of service provision.

Purpose:

a. Contains a summary of services received from the facility by the individual and helps to fast track an individual's service history. In order to plan investigation and treat appropriately, the clinician/service provider can see the details of the history inside the folder

b. Links individual and MRN to service registers.

Where used: Health Center / Primary clinic / Medium clinic/ All types of specialty clinics/ All types of specialty centers, and All types of Hospitals

Format of instrument: Printed on the inside front cover of the individual folder, with additional sheets on pre-printed A4 paper added when more space is required.

Location in the facility: Kept in individual folder.

Who maintains: Care provider makes a notation in the summary sheet regarding the care provided at the end of the service.

Archival procedures: Same procedure as for individual folders.

Patient form/Patient card

Purpose: Contains care provider's clinical observations, notes, diagnosis, and HMIS disease classification for every outpatient encounter and admission.

The patient card is a free form and has three sections:

1. Section to write a chief complaint and detailed clinical notes
2. Section to write the main diagnosis and other diagnoses (if any).
3. Section to write NCoD (National Classification of Disease)/

(**Note**: The main diagnosis may or may not exactly fit NCoD; however, it should be made to match into the NCoD for national reporting. The main diagnosis is always one disease entity; however, a patient can have one or more other diagnoses for clinical management, and to be recorded in the card but not to be reported).

In case of death, the clinician is expected to write the cause of disease in three levels based on ESV-ICD 11 conventions to link the information with the 'death notification form'.

Immediate /terminal cause: Write the final disease or condition resulting in death directly

Intermediate Cause: Write the conditions that resulted from the underlying cause of death and led to the immediate cause of death

Underlying cause: Write the disease or injury, which initiated the train of death events leading directly to death, or the circumstances of the accident or violence, which produced the fatal injury. This is the '**Main Diagnosis**' that should be transcribed to OPD, IPD, Emergency, and ICU registers, then to tally sheets and eventually entered into DHIS2 and reported to next levels.

Where used: Health Center / Primary clinic / Medium clinic/ All types of specialty clinics/ All types of specialty centers, and All types of Hospitals

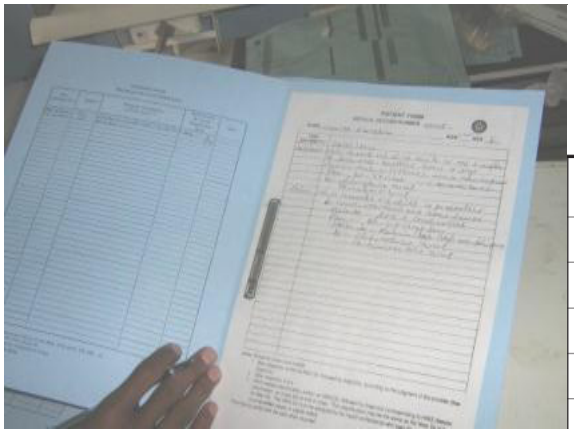
Format of instrument: Preprinted, front and back, on heavy stock A4.

Location in the facility: Kept in individual folder.

Who maintains: Care providers make observations, notes, and diagnoses when care is provided.

Archival procedures: Same procedure as for individual folders.

Fig 1: Individual medical folder and Summary sheet



SUMMARY SHEET
(one line per visit – not for clinical notes)

Date (DD/MM/YY)	Service*	Diagnosis / Complication or Service Detail **	Serial number in service registration book	Cost

Service ID card

A service Identification (ID) Card is a small card, which is used as an identification for patients/clients. It is issued at the time of registration at the Medical Record Unit (MRU). Whenever the patient/client visits the facility on subsequent visits, he/she will show the service ID card so that the MRU worker can find the folder by using the MRN on the service ID card.

Purpose: Identify individuals registered at specific health facilities. The Service identification card contains the Medical Record Number (MRN) and basic demographic information on the individual (Name, age, sex, MRN, date of registration, address, etc.). It is the primary tool for finding an individual's medical record using the MRN.

Where used: Health Center / Primary clinic / Medium clinic/ All types of specialty clinics/ All types of specialty centers, and All types of Hospitals

Format of instrument: Preprinted, front and back, on heavy stock, approximately 1/8 A4 size.

Location in a facility: Client/patient keeps the card.

Who maintains: Card room clerk/ receptionist issue the service identification card when the individual first registers at a clinic.

Archival procedures: None needed.

Fig. 2: Service Identification Card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Federal Ministry of Health

SERVICE IDENTIFICATION CARD

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FACILITY NAME_____

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DATE OF REGISTRATION_____

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MEDICAL RECORD NUMBER_____

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NAME_____ AGE___ SEX__

Appointment card

This is a small card, which is used to remind for services that require appointments (Example: For FP, ANC, ART, TB patients…). It should be made available in service departments, which provide appointments. It is completed/filled by service providers and is provided to patients/clients who are given an appointment for another service.

Purpose: Remind individuals of the next appointment at the facility. The same card is used by all services at the facility.

Where used: Health Center / Primary clinic / Medium clinic/ All types of specialty clinics/ All types of specialty centers, and All types of Hospitals

Format of instrument: Preprinted, front and back, on heavy stock, approximately 1/8 A4 size. The front side identifies the patient; the reverse includes space for 9 appointments.

Location in the facility: Client/patient keeps the card.

Who maintains: Service provider completes the date and service for the appointment and issues a new appointment card as required.

Archival procedures: None needed.

Master Patient Card

It is a small card, which is used to retrieve patient folders when MRN is unknown (if the service ID is lost). A file box (MPI box) should be prepared in a way that can accommodate all the English alphabets, so that a name, which starts with each letter, can be put together. It is placed in MRD (in file box) and it is archived based on English alphabetical order

The Electronic Medical Record-Medical Record Unit (EMR-MRU) electronic system can simplify the arduous MPI archiving system. In facilities where electronic systems are implemented, manual MPI archiving will not be necessary. EMR-MRU Module is an electronic system, which is used in MRUs to register and retrieve patients' folders using computers.

Purpose: Card index of all individuals registered at the facility, ordered by patient name. The index links an individual's name with their MRN. This index supports retrieval of an individual's file when their MRN is unknown.

Where used: Health Center / Medium clinic / All types of specialty clinics/ All types of specialty centers, and All types of Hospitals

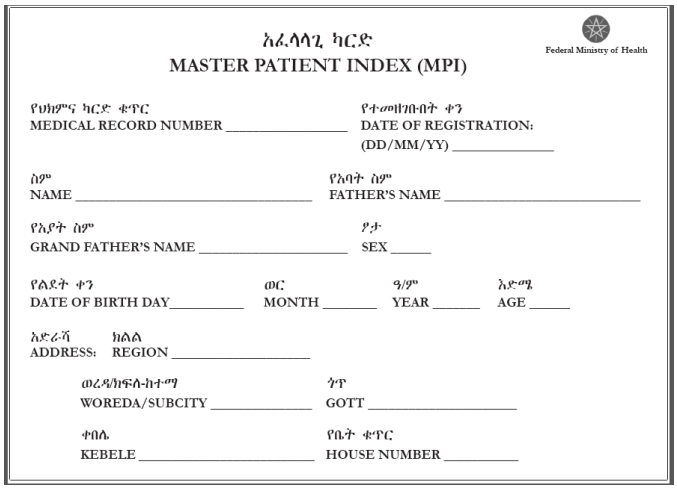
Format of instrument: Preprinted, front and back, on heavy stock, approximately ¼ of A4 size.

Location in the facility: Kept in a file box in the card room.

Who maintains: The card room clerk fills the MPI card when the individual registers for the first time. The cardroom clerk is responsible for maintaining the index.

Archival procedures: An individual's card should not be removed from the MPI. If an individual's folder is moved to inactive storage, the card should be moved to an inactive MPI.

Fig. 3: Master Patient Card



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MASTER PATIENT INDEX (MPI)
Federal Ministry of Health

የህክምና ካርድ ቁጥር
MEDICAL RECORD NUMBER _____
የተመዘገቡበት ቀን
DATE OF REGISTRATION:
(DD/MM/YY) _____

ስም
NAME _____
የአባት ስም
FATHER'S NAME _____

የአያት ስም
GRAND FATHER'S NAME _____
ፆታ
SEX _____

የልደት ቀን
DATE OF BIRTH DAY_____
ወር
MONTH _____
ዓ/ም
YEAR _____
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AGE _____

አድራሻ
ADDRESS:
ክልል
REGION _____

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WOREDA/SUBCITY _____
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GOTT _____

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KEBELE _____
የቤት ቁጥር
HOUSE NUMBER _____

Tracer Card

This is an A4 size card, which helps us to track the folder when it is not in the MRU. It is assigned during the first registration at the MRU, immediately after a folder is issued. The folder must always be replaced by its tracer card when it is distributed out to service units. It should be signed by the folder receiving unit. When the folder is returned back to the MRU, the tracer card should be replaced by the folder, and it is reinserted in the folder.

Where used: Health Center / Medium clinic / All types of specialty clinics/ All types of specialty centers, and All types of Hospitals

Format of instrument*:* Preprinted, front and back, on heavy A4 stock.

Location in a facility*:* Kept in the individual folder when the folder is filed on card room shelf; replaces folder on card room shelf when the individual folder is moved.

Who maintains*:* The card room clerk maintains the tracer card by recording the location of the folder.

Archival procedures*:* The tracer card replaces the individual folder on the card room shelf when the folder is moved to inactive storage

Other individual medical Records

There are different types of individual medical recording tools other than the above-mentioned ones that are used for different services. These clinical and service records are handwritten on different forms by health professionals and administrative staff, and they are kept together and are put into the client's integrated medical record folder. Though detailed description given with the registers corresponding to it, some of the basic sets of forms in the patient's medical record folder include:

Integrated ANC, delivery, Postnatal, and neonatal Card: This card is used to document services like pregnancy follow-up, labor and delivery, and postnatal services.

Woman's Card: This card is used to document the data for services of Family planning, tetanus toxoid vaccination, and abortion care service.

Clinical Progress Notes: This is a blank sheet used to review and document the progress of an already examined patient who is kept in a certain unit.

Clinical Procedures: Used to document different clinical procedures that are carried out in the different clinical service units.

Follow-up Card: This is used when an individual's health status is documented on a periodic basis for a follow-up of a certain chronic illness. E.g. HIV/AIDS

Consent Forms: This is a form signed by the patient or a relative when authorization **is** needed to carry out a certain clinical task.

Operation Notes: a sheet of paper is used to document detailed procedure notes by the clinician who has carried out the operation.

Laboratory Results: are collections of investigation results that are sent back to the requesting client. Should be attached to an individual's medical record.

Radiology Reports: a series of body images sent back to the requesting unit after the images are read and commented on by radiologists.

Pathology Report: different specialized reports are also reported from other units including the pathology unit.

Admission Card: lists services that will be offered for the patient and also terms of agreements for service utilization set by the facility on admission.

Admission Notes: records of presenting symptoms, examination, notes, proposed care, and follow-up summaries.

Follow-up Chart: This is usually part of the record of an admitted patient where certain elements of hourly/ daily progress are documented.

Medication chart: is used to record the daily medication given to a patient after admission**.**

Discharge Summary: This is the summary of all records documented when an admitted patient is sent out from the healthcare institution

Death Summary: patient's health records are reviewed and documented for various purposes if the patient dies while admitted.

Other forms: forms that are not listed above but may be used during clinical contact

MDR-TB Treatment card

Purpose: A record of the MDR-TB patients on personnel information, treatment supporter, drug sensitivity test (DST), x-ray, smear and culture result, a medical diagnosis other than TB, contact investigation, treatment and treatment outcome, during treatment and drug administration monitoring.

Where used: Health Center, all types of Hospitals, and if permitted to provide the special service any clinic or center

Format of instrument*:* Preprinted on standard A3 paper folded into two.

Location in the facility*:* kept in an integrated individual folder.

Who maintains: Service provider completes the information required by the register as service is provided.

Archival procedures: Same procedure as for individual folders.

Leprosy patient record card

Purpose: A record of leprosy patients on personnel information, history, medical condition (skin, nerve, eye, muscle), level of disability, and review at the completion of treatment.

Where used: Health Center, all types of Hospitals, and if permitted to provide the special service any clinic or center

Format of instrument: Preprinted on standard A4 paper.

Location in the facility: kept in an integrated individual folder.

Who maintains: Service provider completes the information required by the register as service is provided.

Archival procedures: Same procedure as for individual folders.

VMT/ST for monitoring of nerve function card

Purpose: A record of leprosy patients on medical conditions (skin, nerve, eye, muscle) every month.

Where used: Health Center, all types of Hospitals, and if permitted to provide the special service any clinic or center

Format of instrument: Preprinted on standard A4 paper.

Location in the facility: kept in an integrated individual folder.

Who maintains: Service provider completes the information required by the register as service is provided.

Archival procedures: Same procedure as for individual folders.

HIV care/ART clinic intake form

Purpose: A record of new HIV positive individual basic demographic information, referral information, and family members HIV status at enrollment and follow-up visit.

Where used: Health Center, all types of Hospitals, and if permitted to provide the special service any clinic or center

Format of instrument: Preprinted on standard A4 paper.

Location in the facility: kept in an integrated individual fold.

Who maintains: Service provider completes the information required during enrollment to HIV care and treatment.

Individual medical recording procedures (Medical Records Unit Procedures)

There are several chains of procedures in place to register clients/patients, record keeping, and retrieving records for services whenever required. The following are the common procedures that should be carried out to ensure individual records' safety, easy access, confidentiality, and safe time in document management.

1. Patient Identification and registration Procedure
2. Medical Record Numbering and Indexing Procedure
3. Medical Record Filing Procedure
4. Medical Record Retrieval and Tracking Procedures
5. Patient Scheduling Procedure
6. Discharge Procedure
7. Maintenance Procedure
8. Culling Procedure

Patient Identification and registration Procedure

When a client/ patient arrives at a facility, he/she first stops at the Registration point of MRU. The first step is the patient identification and registration procedure, which is an important part of a patient's medical record. It should include enough information to uniquely identify an individual patient/client. The information is obtained from the patient, if possible, or otherwise from the person accompanying the patient to the hospital or Health Centre.

The patient identification data that is collected during the patient registration process is also used to fill the Master Patient Index (MPI). The patient identification data may be entered into a computerized database, or manually typed onto a registration form.

i. Medical record numbering and Indexing Procedure

After collecting the correct patient identification information, the next step is assigning a unique individual identifier, i.e., Medical Record Number (MRN), and then completing the master patient index (MPI).

Medical Record Number (MRN) and numbering procedure

The most important functions of the MRU are the numbering and filing of medical records. The best way to manage the large number of records that facilities might have is to use a numbering system.

MRN is a permanent and unique identification number assigned in a straight numerical sequence. This number is used to identify individuals and to file the medical records in the MRU. Thus, it is important to make sure that the number is correctly assigned and recorded on all forms in the patient's medical record.

The medical record numbering system is how we give a number to individual medical records and the Filing system is how we file the record after a number has been given.

In a numbering system, each patient has a unique identification number which becomes the medical record number. In some facilities, a computer is used to generate numbers in sequence to use as a medical record number.

The number of digits for MRN is based on an individual health facility catchment population i.e. at least 5 digits and 6 digits in health centers and hospitals respectively

An example of a medical record number would be as follows: MR# 000106. This record number is unique; it would not be given to anyone else, and each time this patient comes to the health facility, all forms would use this number and the documents would be filed in MR#/Chart folder number #000106. When this patient arrives at the facility, the registration clerk will verify the name and medical record number of the patient and locate the record to begin the patient visit. The record is then delivered to the area where the patient will be seen.

- If the patient has been registered previously, the MRU clerk must look for and find the old number from the service ID card of the individual or from the MASTER PATIENT INDEX, if the service ID is lost.
- MRN should belong to the patient for the rest of his or her life and should never be given to another patient. Even if a patient has died, the number should NOT be given to another patient.
- If an error has occurred and a patient is found to have two medical record numbers/two medical records, the DUPLICATE number should be canceled and NOT used again. The medical records should be combined into the FIRST number/medical record. A cross-reference must be made to the duplicated number and medical record.

ii. The Master Patient Index (MPI) Card and indexing procedure

Master patient index (MPI) is an A5-sized card meant to index client records in alphabetical order. The card is used to trace a client record when he/she appears to have lost service ID/MRN in order to not deny the right of sought service.

All new patients should have a master patient index (MPI) card filled out with their identifying information and a medical record number on arrival to the MRU. It is important that each patient have an MPI card. In order to minimize errors, the MPI should be completed by the same person who recorded the information in the folder. MPI cards should be filed in a card drawer in strict alphabetical order. Each drawer should contain guides, which are empty cards with a tab protruding above the other MPI cards.

The master patient index (MPI) is prepared by MRU clerks. In paper-based systems, it is a card index. It can also be computerized to facilitate and enable fast searching. MPI cards are small-sized, stock cards like hard papers which contain only the information necessary to identify the patient. MPI cards also contain the patient's medical record number. They should not contain any medical information.

If patients/clients know their medical record number/have their service ID card, it can be used to find the patient's medical record. If MRN is not known, Patients/clients should be asked about their identification information, which can be used to find their MPI card. The medical record number from the MPI card can then be used to find the patient's medical record in the MRU.

iii. Cross-Referencing

There are situations where the patient's identification might be changed, for instance, the name/father's name is changed. In such cases, the medical record unit should apply cross-referencing.

Cross-referencing is the method of linking one MPI record with another MPI record. This is usually done in cases in which the patient has changed their name, or when there are two medical record numbers (i.e. two medical record folders) for one patient. In cases of a name change, the new MPI card should possess the same information as the previous card except that the name is changed. One has to make sure that the medical record number remains the same. In cases of duplicate medical record numbers, one number should be chosen and a note made on the other MPI card referring searchers to the chosen number. The medical records contained in the folders should be combined. In both cases, the MPI cards (either with an old name or an old medical record number) should not be discarded.

Medical Record Filing Procedures

Filing is a method of storing medical records in a systematic manner. There are many accepted methods for filing medical records ranging from the simple to the complex. The type of system selected is based on facility-specific factors such as the volume of filing, admissions, discharges, requests for records, filing space, storage (open shelf filing vs filing cabinets) and security concerns, and also a good understanding of the predicted number of patients that could come to get service in the healthcare institution.

Medical records, which are too big to easily file, should be separated into two or more volumes and clearly marked as VOL. 1, VOL 2, etc., and filed together in the correct place. When filing medical records folders, which are torn or damaged, should be replaced and any loose forms secure.

All medical records should be filed as soon as possible when returned to the MRU or completed following the discharge of the patient. At the end of every day, there should be no medical records waiting for filing; all completed and returned medical records should be filed.

Regular checks should be in place to check the file for missing medical records or medical records filed in the wrong place. To check for a misplaced file the staff should:

- Look for the transposition of digits in a number
- Check the medical record just before and just after the one needed.
- Check the shelf immediately above/below where the record should be filed.

There are different types of filing that include alphabetical filing (not at all recommended), straight numeric filing, and terminal digit filing. Straight numeric filing is the best filing method in most resource-limited setups like in the Ethiopian context and is currently used in all health facilities. In this method medical records are filed in strict order according to the medical record number (MRN), starting with the lowest number and ending with the highest number. Medical records for new patients are always added at the end of the file. With this method of filing the training time for staff is short as it is generally easy to train medical record staff to fill in straight numeric order. With the straight numeric filing, it is a good idea to have one medical record clerk responsible for the filing procedure (depending on the volume of work). If there are too many files for one person it could be shared between the clerks.

Medical Record Retrieval and Tracking Procedures

It is very important that standard procedures be followed while searching for and retrieving medical records. Policies and procedures exist to facilitate the prompt, uniform, and efficient retrieval of all health records. These policies and procedures also ensure that confidentiality is maintained and only authorized persons perform retrieval.

The retrieval system has been designed and should be implemented to

- Ensure the safety, security, and accuracy of health records and resident –identifiable data
- Keep track of locations and holders of records removed from folders
- Follow-up at appropriate intervals on the return of records and data, and
- Identify health records and data to be converted to an alternative medium and moved to inactive storage.

Assuming patients come with their service card, the clerks should follow these steps in order to retrieve the medical record.

1. Collect the service cards.
2. If the client does not bring a Service card, ask the client's name, access the patient's profile from the MPI, and determine the medical record number.

3. Locate the medical record using the information obtained from the Service card or MPI/EMR-MRU module using a computer
4. Remove the medical record from the shelf & replace it with its tracer card.

Every facility should have a process in place until the retrieval of records in case of an emergency. Since evening and night shift, staff may not be available in some health facilities; alternate arrangements may be required for duty staff to be able to access medical records. One solution is for a set of keys to the MRU to be made available to after-hours duty staff. These staff must also be trained in retrieval, the sign-out process, and other relevant procedures; and this training must be documented. Department procedures should track who has keys to the department.

Tracer cards are extremely important as they enable medical records to be traced when they are not in the MRU. The tracer card is usually the same size or slightly larger than the medical record, on which should be written: patient's name, patient's MRN, where the medical record is going (department/responsible healthcare provider) and the date the record was removed from the file.

On the return of the medical record to the MRU, the tracer card is placed inside the medical record folder. It can also be a printed card with the information recorded in the space provided. The next section is then used until the tracer is full and then discarded. Using the tracer makes it easier to find a medical record when it is not on file. Regardless of what size the card is, the destination of the medical record should always be written on the tracer card and crossed out when the medical record returns.

Patient Scheduling Procedures

The best way to manage the patient flow health center or hospital is to maintain an appointment list of patients who are returning for visits on certain days. Each area that sees patients should record on an appointment list or in the patient record when the patient is scheduled to return to the clinic for treatment, and issue an appointment card.

The appointment card is used to remind patients of their next appointment at the health facility. It is similar in size to the service ID card. The front side contains identifying information and the reverse includes space for 9 appointments. Service providers should complete the date and service for future appointments as needed.

The medical record clerks can then retrieve the records in advance of the patient appointment and route the records to the correct area for the patient's visit. Once the patient checks in at registration, they can go directly to the area where they will be treated. When pulling the records for the advance appointments, the clerk must fill out a Tracer Card for each chart that is pulled indicating the date and location where the chart will be sent. After the patient has been seen, the records are returned to the MRU. If the patient has more than one appointment, this should be noted on the Tracer Card and the treatment areas should be sure to forward the chart to other areas for the doctors or nurses to use to see the patient

Admission/Discharge procedure

If the patient is admitted - the nurse adds data relating to the nursing care plan and doctors record their notes on a patient's: past medical history, family medical history, history of present illness, physical examination, plan for treatment, and requests for laboratory/X-ray tests. The doctor and nurses continue to record, on a daily basis, writing notes on the patient's progress, medical findings, treatment (including prescriptions for medication), test results, and the general condition of the patient. Nurses record all observations, medications administered, treatment, and other services rendered by them to the patient. Other health professionals record their findings and treatment as required during the patient's hospitalization.

At discharge - when the patient is discharged, the doctor records, at the end of the progress notes, the condition of the patient at discharge, the prognosis, treatment, and whether the patient has to return for follow-up. In addition, the doctor should also write a discharge summary, and write, on the front sheet of the record, the principal diagnosis, other diagnoses, and operative procedures performed, and sign the front sheet to indicate responsibility for the information recorded under his signature.

Maintenance procedure

Even with the best preventative systems in place, medical records can be inadvertently lost, destroyed, or stolen. To limit or minimize the harm, systems must be in place and enforced which protect the records. One of the most physical security measures that must be in place is a record sign-out and sign-in system for all types of medical records. Clerks should monitor the sign-out process and assure that records are returned promptly.

Inside each MRD storage room, all medical records and documents must be secure and protected from unauthorized access. If multiple staff access to the store items, the records and documents must be in a separate locked area with access by selected staff. The storage building must protect records from the elements such as moisture and rodents. The storage area must be organized to facilitate the location and retrieval of information.

Culling procedure

This is the removal of medical records, which have not been used for a specified number of years, from the active record filing room. The facility should define a specific retention policy for different types of records based on national law and professional practice standards. The policy should be organized and storage boxes labeled with the content and year of documents.

The year of attendance should be manually searched from the medical records summary sheet through the filling shelves. This is used to indicate whether the medical record is active or inactive. An active MR is a record where the patient has not attended the facility for a specific number of years, five years for Ethiopia.

The aim of culling is to remove INACTIVE medical records from files to make more filing space. The culled records can then be stored in secondary storage or destroyed. Culling should be done every year. Once authorization is obtained to destroy medical records, acceptable methods of destruction should be used and records must be destroyed in a manner that makes it impossible to reconstruct and read the information. Records cannot be sold or disposed of in the garbage containers without some type of shredding or obliteration. Acceptable methods used today include shredding or incineration. It is recommended that a facility maintain documentation of the records/ documents that are destroyed and the date information destroyed.

The master patient index cards and destruction logs containing basic demographic information should be retained on a permanent basis.

Despite the actual difference in workload at health centers and health care facilities, these tasks are common to all and carried out every day. In order to carry out these activities, the departments should be well stuffed, and resourceful.

Medical records should be kept by the healthcare facility as long as required under the statute of limitations (retention for legal requirements) or the country's record retention regulation before determining a retention regulation.

Therefore, National and regional regulations for retention should be observed to archive medical records If these regulations are unknown, records are retained in active storage for 5 years after the last visit and retained in inactive storage for 10 years after the last visit or death.

CHAPTER 3

Registers & tally sheets and completion procedures

CHAPTER 3: REGISTERS & TALLY SHEETS AND COMPLETION PROCEDURES

A register is a form/tool that is used to record the abstract information from each service/ department. Every register has columns & rows. Each row contains information for one patient where the column contains information about that patient/client, and one piece of information per column is available. The register contains reportable and non-reportable data elements and is the data source for the computation of HMIS indicators. Most registers have a tally sheet, where those registers that do not have a tally have a box underneath each page for reportable data elements.

There are two types of registers classified based on the duration that the client/patient stays in the register or repetitive service given in a single row.

- **Serial (Case) Registers**: Each subsequent visit is registered as a new entry. E.g. OPD, VCT, Abortion registers, etc
- **Longitudinal Registers**: Each client stays in the register so long as s/he is in the service. E.g. EPI, ANC, FP, ART, TB, etc

All registers have some common elements/features, which include:

i. **Identification:**
   - Registration/Serial Number
   - Medical Record Number (MRN)
   - Name: clients' full name
   - Age: age in years/ in months
   - Sex: M for Male and F for Female

ii. **Address**: Region, Woreda, Kebele, Gott, and House number

iii. **Date**: All dates are written in the EC as Date/Month/Year (DD/MM/YY)

iv. **Instruction:** All registers have instructions on how each column is filled and health workers have to refer to it before filling the registers.

Tally sheets

Tally Sheet: is a piece of paper that is used to mark the number of clients that use specific services. The main purpose of the tally sheet is to simplify reporting. In tallying, each stroke represents a single unit to be counted in service; client/patient, dose, and others. The tally sheet is also used in data quality checks as triangulation with other recording tools. Example: Immunization tally, HTS tally, etc.

Archival procedures for registers and Tally sheets: National and regional regulations for retention should be observed. If these regulations are unknown, registers and tally sheets are retained in active storage for 2 years after the last entry in the register and retained in inactive storage for 7 years after the last entry in the register except for ART registers that should be retained for more years, not determined yet).

All registers and tally sheets are described as follows under each program area.

Reproductive, Maternal Newborn and Child Health

Maternal Health

Antenatal Care (ANC) Register

Purpose: The register is longitudinal and used to record antenatal care services provided to a client during a single pregnancy. This record follows the protocol of antenatal care for eight contacts and more during the current pregnancy. The first contact is recommended to be single contact in the first trimester, two contacts in the second trimester (at 20 and 26 weeks of gestation) and five contacts in the third trimester (at 30, 34, 36, 38, and 40 weeks). The table below describes the schedule of contacts.

Contacts	Gestational age of contact in weeks	Appointment schedule
	First Trimester	
1st	Up to 12	After 8 weeks
	Second trimester	
2nd	20	After 6 weeks
3rd	26	After 4 weeks
	Third trimester	
4th	30	After 4 weeks
5th	34	After 2 weeks
6th	36	After 2 weeks
7th	38	After 2 weeks
8th	40	

It is also used to record HIV assessment and follow-up, partner tests, and different counseling including care for child development.

Where used: Health Center / Medium clinic / Obs-Gyn specialty clinic, MCH specialty center, and all types of Hospitals

Format of instrument: Preprinted on standard A3 paper. On this register, a single client entry spans one page

Location in the facility: ANC service room.

Who maintains: Service provider completes the information required by the register as service is provided.

Data recording process on the register:

A Reproductive Health card (RH card) is a primary data source for the ANC register. Each client who received ANC service should be recorded in both the RH card and the ANC register using a single row and tallied immediately using the ANC Tally sheet. Please refer to the instructions in the register for details.

When the client visits at different times, the service provider should use the same entry of the register and record different visits on it.

Data compilation procedures:

The reportable data elements from the register are described in the table below.

S.N	Reportable data element	Disaggregation	Frequency	Level of Reporting
1	No. of pregnant women that received ANC first visit	Age, GA	Monthly	HP, HC, clinic, Hospital
2	No. of pregnant women that received four ANC visits	Age, GA		
3	No. of pregnant women that received Eight ANC visits	None		
4	No. of pregnant women tested for syphilis	Test result	Monthly	HC, clinic, Hospital
5	No. of reactive pregnant women treated for syphilis	None		
6	No. of pregnant women tested for hepatitis	Test result		
7	Total number of reactive pregnant mother treated for hepatitis	None		
8	Number of dewormed Pregnant mothers in the reporting period	None		
9	Number of pregnant women tested for HIV and know their result during pregnancy	None		
10	Number of new Positive women's during ANC	None		
11	Total Number of partners of pregnant tested and know their results	None		

Some of the reportable data elements are compiled directly from ANC tally sheets where others are directly collected from the register, which is summarized in the box at the bottom of each page of the ANC register

ANC tally sheet

ANC tally sheet is used to capture ANC reportable data elements from the ANC register. *The provider should tally immediately after service is provided, and the data elements are counted up and compiled at the end of the reporting period. The Tally is kept with a register until the whole pad is utilized and then moved to an archive maintained by HMIS in charge.*

Frequency of reporting: These data elements should be reported monthly

Delivery Register

Purpose: *the register is a case/serial register and used to* record intrapartum care provided to a client during a single delivery. It is used to capture data on labor, delivery and maternal outcome, maternal condition, and obstetric complications, newborn birth outcome, newborn problem identified treatment and its outcome, preventive services for newborn & mother for HIV+ care, and IPPFP provided.

Where used: Health Center / Medium clinic / Obs-Gyn specialty clinic, MCH specialty center, and all types of Hospitals

Format of instrument: Preprinted on standard A3 paper. The entry for a single client spans two pages.

Location in the facility: Delivery room.

Who maintains: Service provider completes the information required by the register as service is provided.

Data recording process on the register:

Each client for single delivery care should be recorded in the delivery register using a single row. This may be done based on the information on the reproductive health card(Integrated Antenatal, Labor, Delivery, Newborn, and Postnatal Care Card). Please refer to the instructions in the register for details.

Data compilation procedures:

The reportable data elements from Delivery register are the following:

S.No	Reportable data element	Disaggregation	Frequency	Level of Reporting
1	No. of births attended by skilled Health personnel	None	Monthly	HC, clinic, Hosp
2	No. of deliveries by cesarean section	None		
3	No. of women who received uterotonics with in one minute after delivery,	by Oxytocin, Mesoprostol, Ergometrin, others		
4	No. of institutional maternal deaths	None		
5	Number of live births	None	Monthly	HP, HC, clinic, Hosp
6	Number of still births	None		
7	Total number of newborns weighed	None		
8	No. of newborns whose weight is less than 2500gms	None		
9	No. of newborns whose weight is less than 2000gms	None		
10	Number of newborns who received Chlorhexidine (CHX)	None		
11	Number of newborn with sepsis/VSD	None	Monthly	HC, Clinic, Hosp.
12	Number of early neonatal deaths	None		
13	Number of women who received HIV test	Age		
14	Total IPPFP acceptors	Age & Method		
15	Total number of neonates resuscitated	None		
16	No. of women who tested HIV positive	Age	Monthly	HP, HC, clinic, Hosp.
17	Number of neonates treated for birth asphyxia & survived	None		
18	Number of birth notified	None		

How to count the reportable data elements

At the bottom of the delivery register, you will find boxes, which are used to enter the count of reportable data elements on the two pages of the register:

The left side of the Register: count of deliveries, Caesarean sections, live births, stillbirths, number of newborn weights recorded, number of newborns weighing < 2500 grams, Chlorohexidine, number of maternal deaths (during delivery), number of newborn deaths, and others.

The right side of the Register: Count of sepsis cases, resuscitated, resuscitated and survived, and others. These data elements are summed up from each page and reported at the end of the month.

Frequency of reporting: These data elements should be reported monthly.

Postnatal Care Register

Purpose: The register is a case/serial register and is used to record information about postnatal care provided to a client after all delivery services are completed. Care provided as part of delivery service is recorded in the delivery register, not in the postnatal register. The information it captures include data on PNC Visits, maternal health condition, and complication, HIV assessment & partner testing, counseling given on newborn, newborn problem identified, treatment and its outcome, and IPPFP methods provided.

Where used: Health Center / Medium clinic / Obs-Gyn specialty clinic, MCH specialty center, and all types of Hospitals

Format of instrument: Preprinted on standard A3 paper. On this register, a single client spans one page.

Location in the facility: Postnatal care room.

Who maintains: Service provider completes the information required by the register as service is provided.

Data recording process on the register:

Each client who received PNC care should be recorded in the PNC register using a single row. PNC related data is primarily recorded in the RH card and transferred to the PNC register beside the data that is directly recorded in the register.

Please refer to the instructions in the register for details.

Data compilation procedures

Reportable data elements from the PNC register

The following are the reportable data elements from the PNC register.

S.N	Reportable data element	Disaggregation	Frequency	Level of Reporting
1	Number of postnatal visits within 7 days of delivery	Period	Monthly	HC, clinic, Hosp
2	*Number of institutional maternal death*	None		
3	Number of women with PPH complication	Place of Delivery (home/ Facility)		
4	*Number of pregnant women who were tested for HIV and who know their results during post-partum period*	None		
5	Total IPPFP acceptors	Age & Method		
6	Number of sick young infants 0-2 months treated for Critical illness	By disease type:- Very sever Disease, Local bacterial infection (LBI) Pneumonia		
7	*Number of women tested positive for HIV*	None	Monthly	HP, HC, clinic, Hosp
8	Number of neonatal deaths in the first 24 hours of life/ institutional/	By period		
9	Number of Newborn weighing <2000gm and premature newborns for which KMC initiated	None		
10	Number of neonates treated for birth asphyxia & survived	None		
11	Number of births notified	None		

How to count the reportable data element

At the bottom of the PNC register, you will find boxes, which are used to enter the count of postnatal care for women who seek care after delivery services are complete.

- Count the number of postnatal visits within 7 days of delivery and write the corresponding figure by the period in the box. Similarly, all reportable data elements should be counted and summed up from each page and reported at the end of the month.

PMTCT Register

Purpose: The register is a longitudinal register and is used to record information about the PMTCT service provided to a client during a single pregnancy. It captures data on PMTCT related to pregnancy, labor and delivery, postnatal care, HIV and TB screening, HEI of DNA/ PCR results, AB test result, maternal viral load status, cohort follow up for mother and HEI PMTCT cohort.

Where used: Health Center / Medium clinic / Obs-Gyn specialty clinic, MCH specialty center, and all types of Hospitals

Format of instrument: Preprinted on standard A3 paper. The entry for a single client spans two pages.

Location in the facility: ANC, Delivery & ART service room.

Who maintains: Service provider completes the information required by the register as service is provided.

Data recording process on the register:

Each client who received PMTCT service should be recorded in the PMTCT register using a single row and tallied immediately using the PMTCT tally sheet. Please refer to the instructions in the register for details.

When the client visits at different times, the service provider should use the same register and record different visits for cohort follow-up for mother and HEI PMTCT cohort.

Data compilation procedures:

Reportable data elements from the PMTCT register are reported monthly from Health Centers/Clinics/Hospitals and the detail are indicated in the table below.

S.N	Reportable data element	Disagg.	Tally sheet
1	No. of HIV positive pregnant women who received ART during ANC for the first time	none	PMTCT Tally
2	No. of HIV positive Pregnant women who received ART during L&D for the first time	none	
3	No. of HIV positive Pregnant women who received ART during PNC for the first time	none	
4	No. of HIV-positive women who get pregnant while on ART and linked to ANC	None	
5	No. of HIV exposed infants who received Virological HIV test 0- 2 months of birth	Test Result	
6	No. of HIV exposed infants who received an Virological HIV test 2-12 months of birth	Test Result	

7	No. of infants born to HIV positive women started on co-trimoxazole prophylaxis within two months of birth	None	PMTCT Tally
8	No. of HIV exposed infants who received ARV prophylaxis	None	
9	No. of HIV exposed infants receiving HIV confirmatory (antibody test) by 18 months	Test Result	
10	No. of partners of pregnant, laboring and lactating women tested and know their results	HIV positive	
11	Number of adults who are currently on ART	Age, regimen type	PMTCT Tally
12	Number of PLHIV on ART documented as Lost/lost to follow up during the reporting period.	none	
13	Number of adults and children with HIV infection newly started on ART	Age, Pregnancy Status,	
14	Number of adults and children who are still on treatment at 12 months after initiating ART		
15	Number of persons on ART in the original cohort including those transferred in, minus those transferred out (net current cohort).	Age, Pregnancy Status	PMTCT Tally
16	Total number of adult and pediatric ART patients with an undetectable viral load <1000copies/ml in the reporting period		
17	Number of adult and pediatric ART patients with a viral load test in the reporting period.		
18	Number of PLHIV who were assessed/screened for malnutrition		
19	Number of PLHIV that were nutritionally assessed and found to be clinically undernourished	Age, Pregnancy, nutritional status	PMTCT Tally
20	Number of clients who were on ART and screened for TB during the reporting period		
21	Number of PLHIV women who are using modern family planning	Age & Method	

How to count the reportable data element *Left side of the Register*: At the bottom of the left side of the register, you will find boxes, which are used to record the count of the number of partners tested, and the number of partners +ve.

The right side of the register: Count and write the total number of maternal and HEI PMTCT cohort outcomes in the box corresponding to the arrows on each page of the register:

- Maternal PMTCT cohort outcomes -count the total number of women retained /Alive & On ART, Lost to follow up of appointment, Transferred Out, mothers with undetectable viral load(<1000 copy/ml), mothers Malnourished (< standard BMI), and number of deaths
- HEI PMTCT Outcomes – count number of HEI still on BF /Exposed/on CPT, positive infants Lost to Follow up of appointments, Discharged negative infants after Ab. test result at 18 months of age, Positive infants, Transferred Out, Malnourished(Underweight for age), and the number of infants died.

The PMTCT tally sheet is used to simplify reporting of PMTCT reportable data elements in the above from the PMTCT register. The provider should tally the above reportable data elements immediately after service is provided, and the data elements are counted up and compiled at the end of the reporting period. The Tally is kept with register until the whole pad is utilized, and then moved to an archive maintained by HMIS in-charge

Frequency of reporting: These data elements should be reported monthly.

Family Planning Register

Purpose: - Family planning register is a longitudinal register that is used to capture HMIS data related to family planning services. The register includes summary information for reporting FP data elements that are used for the calculation of indicators related to family planning.

Where used and location:- this register is used in the Health Center / Medium clinic /Obs-Gyn specialty clinic, MCH specialty center, and All types of Hospitals, and it is placed at the FP service room of the facility.

Format of instrument: - Preprinted on standard A3 paper. This specific register uses the entry for a single client spans two pages.

Who maintains: Health professionals attending FP service rooms complete the information required by the register as service is provided.

Data recording process on the register

Each client who has received FP services should be registered in the FP register. After the service is provided, the service provider should take the abstracted data elements from the women card (which is kept in the individual folder) to the family planning register then need to be tallied after the service using the FP tally sheet.

- **New acceptor**: refers to those acceptors who receive family planning services from a recognized program for the first time irrespective of the method used. This is not the number of consultations and emergency contraceptives. Each acceptor is enumerated once in the year, at the first consultation for contraception in the fiscal year (From Sene 21 of the previous year up to Sene 20 of the current year).
- **Repeat acceptor:** refers to those acceptors who receive family planning services from a family planning program previously irrespective of the method used. Long-acting FP method users are counted as repeat every year including routine checkups for ongoing use of a long-term method such as Implants, IUCD, TL, and Vasectomy.

A family planning client is considered as a new or repeats client only once in one Ethiopian fiscal year (From Sene 21 of the previous year up to Senie 20 of the current year). If the client gets registered as a new client in the reporting period then the client won't be considered as a new or repeat client till the end of the fiscal year. The end of the fiscal year registration should be started with a new page of the FP register denoting that it starts with the next fiscal year. Write the new fiscal year with a marker (BOLD WORDS). All clients in the previous fiscal year must be recorded once again in new pages of the register in use and considered as repeat clients in that new fiscal year.
Visit Number is used to record the visit number in the current fiscal year. Even though all the five rows are not finished in the fiscal year, we have to leave the remaining rows blank and re-register the client in a new row in the new fiscal year.

- Once the FP client is registered, one row is adequate to record services for one fiscal year.
- After the fiscal year is completed, the client should be registered again in the same registration book but with a different serial number and reported again in the new fiscal year as a repeat acceptor client.

Data compilation procedures:

Reportable data elements from the family planning register are:

S.No.	Reportable data element	Disaggregation	Frequency	Level of Reporting	Tally sheet
1	Number of new acceptors,	Age & Method	Monthly	HP, HC, clinic, Hosp	FP service tally
2	Number of repeat acceptors	Age & Method			
3	No. of clients tested for HIV	Age. Sex	Monthly	HC, clinic, Hospital	PITC tally
4	Clients testing positive for HIV (at HTS)	Age, Sex,			
5	Number of Family planning methods issued/dispensed	Method	Annual	HP, HC, clinic, Hospital	FP methods dispensed tally

Family planning service Tally

This is used to capture FP reportable data elements from the FP register. The provider should tally immediately after service is provided, and the data elements are counted up and compiled at the end of the reporting period.

Frequency of reporting: These data elements should be reported monthly.

Family Planning methods Dispensed Count tally sheets

This tally is used to count and record total FP methods issued during the month and reported annually

Both Tally is kept with a register until the whole pad is utilized and then moved to an archive maintained by HMIS in charge.

How to count the data:

- At bottom of the register: count and write the total count of FP (new & repeat) acceptors in the count box at the bottom of each page. The total count from each page should be equal to what we tallied on the FP tally sheet.
- On Tally sheets: tally the FP methods(oral contraceptives, Injectables, implants, IUCD, Vasectomy, tubal ligation, and others) issued corresponding to clients age category (10-14yrs, 15-19yrs, 20-24yrs, 25-29yrs, 30-49yrs).

Long-Acting Family Planning (LAFP) Removal Register

Purpose: The register is a longitudinal register and used to record information about long-acting family planning services provided to a client: It captures data on clients who have had long-acting family planning methods and returned for removal. It is also used to record information on HIV counseling and testing post-removal family planning services provided.

Where used: Health Center / Medium clinic / Obs-Gyn specialty clinic, MCH specialty center, and all types of Hospitals

Format of instrument: Preprinted on standard A4 paper. The entry for a single client spans one page.

Location in the facility: Family Planning service room.

Who maintains: Service provider completes the information required by the register.

Data recording process on the register:

A client's LAFP services for a single year are recorded on a single line in the register. After the year is completed, the client has registered again, on another line in the LAFP registration book. Data is abstracted from the woman's card and entered into the LAFP removal register. Please refer to the instructions in the register for detailed information.

Data compilation procedures:

Reportable data elements

S.No.	Reportable data element	Disaggregation	Frequency	Level of Reporting	Type of tally used
1	Total number of premature removal of LAFP within 6-month insertion	Method:Implants, IUCD, others	Monthly	HC, clinic, Hospital	None
2	Total LAFP removal in the reporting period	None			
3	Total number of clients tested for HIV	Age	Monthly	HC, clinic, Hospital	PITC tally
4	Total number of clients tested positive for HIV	Age			

How to count data elements at the bottom of the page

- For each LAFP method, count the number of premature LAFP removals performed (within 6 months of insertion), and count the number of LAFP removals performed (greater than 6 months of insertion) and write in the box
- Sum up the total LAFP removals performed and write in the box. Then summed up from each page and reported at the end of the month.

Comprehensive Abortion Care Services Register

Purpose: The register is a case/serial register and used to record information of single safe abortion and post-abortion care services, provided in accordance with the laws of Ethiopia. One row is used once for a single patient/client.

Where used: Health Center / Medium clinic / Obs-Gyn specialty clinic, MCH specialty center, and all types of Hospitals

Format of instrument: Preprinted on standard A3 paper. The entry for a single client spans one page.

Location in the facility: Comprehensive Abortion Care Room.

Who maintains: Service provider completes the information required by the register

Data recording process on the register:

Each client who received comprehensive abortion care services should be recorded once in a single row. Please refer to the instructions in the register for details. Women's card is also used in recording information about abortion services and transferred to Abortion register.

Data compilation procedures:

Reportable data elements from the comprehensive abortion care register

S.N	Reportable data element	Disaggregation	Frequency	Level of Reporting	Tally
1	Number of safe abortions care provided	age	Monthly	HC, clinic & Hosp	**Abortion Tally sheet**
2	Number of post abortions care provided	age			
3	Number of women receiving comprehensive abortion care	Trimester			
4	Number of women who were tested for HIV	Age			
5	Number of Positive HIV tests	Age			
6	Number of maternal deaths (institutional)	None			
7	Number of new and repeat family planning acceptors	Age, Method			

How to count the reportable data element at the bottom of the register

At the bottom of the register, you will find boxes to write/record the number of safe abortion and post-abortion care disaggregated by age of the women.

The abortion care tally sheet is used to capture reportable data elements from the comprehensive abortion care services register. The provider should tally the above reportable data elements immediately after service is provided, and the data elements will be counted up and compiled at the end of the reporting period. The Tally is kept with register until the whole pad is utilized, and then moved to an archive maintained by HMIS in-charge

Frequency of reporting: The data elements are reported monthly.

Child Health

Routine Immunization Register

Purpose: *It is a* longitudinal register, which is used to record information about infant immunization, growth monitoring and developmental milestone assessment services provided to infants. Its main purpose is to keep track of the antigens, neonatal tetanus, and associated services (nutrition and child developmental milestones) provided to each Child over time. One row is used to document all the required immunization service data for a single child.

Where used and location: Health Center, clinic and hospital, MCH specialty center, Pediatric specialty center, and outreach immunization sites. It is kept in the EPI room.

Format of instrument: Printed on standard A3 paper.

Who maintains: The register is completed by the service provider at the time of service provided.

Data recording process on the register:

The primary data source for the register is the infant's vaccine card. Please refer to the instruction page on the first page of the register. Both tally sheet and register are used for recording vaccination/immunization information.

Data compilation procedures:

Health care providers fill the tally sheet from the Routine immunization register for each vaccine, which is provided for infants. Tally is kept with a register until the whole pad is utilized and then moved to an archive maintained by HMIS in charge.

Reportable data elements

S.N	Reportable data element	Disagg.	Level of Reporting
1	BCG	None	HP, HC, Clinic, Hosp.
2	Hepatitis Birth Dose;'	By period	
3	OPV 1 & 3	None	
4	Pentavalent vaccine 1 & 3		
5	PCV vaccine 1 & 3		
6	Rota vaccine 1-2		
7	IPV		
8	Measles vaccine 1-2		
9	Fully immunized		
10	Protected at birth(PAB)		
11	Vaccine wastage rate	Type of vaccines	
12	Developmental milestone classification (ND, SD, DD for U5 (0-23) and (24-59)	**By Status:** **ND-**No Developmental Delay **SD-**Suspected Developmental Delay **DD-**Developmental Delay **Bye Age:** 0-23; 24-59	

Way of compiling the data elements from the tally sheet

The reportable data elements traced from the EPI tally sheet and the register would be counted for the respective vaccine provided for the infants.

Frequency of reporting: These data elements should be reported monthly.

Routine Immunization tally sheet

Purpose: Tally sheets are the forms that health workers use to document an immunization session, by making a record for every dose of vaccine given. It is used as the basis for monitoring and making regular summary reports of vaccine use.

Where used and location: Health Center, clinic and hospital, MCH specialty center, Pediatric specialty center, and outreach immunization sites. Tally sheets should be used for all sessions whether fixed, outreach, or conducted by a mobile team. And it is kept at the EPI room.

Data recording and compilation procedures:

On the tally sheet, tally the antigens given to the infant corresponding to the period and dose given immediately after the service. Then at the end of the month count and record to determine the number of infants who received each vaccine dose/antigens provided for, sum up, and transfer data elements to the reporting format accordingly. The Tally is kept with an Immunization register and Td Register at the EPI room until the whole pad is utilized and then moved to an archive maintained by HMIS in charge.

Tetanus diphtheria (Td) Register:

Purpose: Longitudinal record of Tetanus diphtheria (Td) vaccine provided to women (pregnant and non-pregnant). The record follows the protocol of a series of five dose Td vaccinations schedules.

Where used and location: In health centers, clinics, MCH specialty centers, and hospitals, and it is kept in EPI rooms.

Format of instrument: Preprinted on standard A4 paper.

Who maintains: service providers complete the registration at the time of service provision.

Data recording process on the register: Each woman who received the Td vaccine should be recorded in the register using a single row till she completes all 5 doses, and tallied immediately using an infant immunization tally sheet. Please refer to the instruction page on the first page of the register for a detailed recording process.

Data compilation procedures: The reportable data elements from the Td register/tally sheet include:

- Number of women who have received Td1, Td2, Td3, Td4, and Td5 vaccination each
- Td all doses given / doses opened/dose damaged/dose expired

These reportable data elements are compiled from the Infant Immunization tally sheet. The provider should tally immediately after service is provided, and the data elements are counted up and compiled at the end of the reporting period.

Frequency of reporting: This data element should be reported monthly.

Human Papillomavirus (HPV) Register:

Purpose: The register is a longitudinal register and the main purpose is to record doses of HPV provided to girls in early adolescence (before their first sexual contact) specifically for 14 years girls in schools and health facilities. The register captures doses of HPV provided to girls in schools and out of school.

Where used and location: In schools during vaccination campaigns, and health centers & hospitals, and it is kept at EPI rooms.

Format of instrument: Preprinted on standard A4 paper.

Who maintains: Service provider completes the information required by the register as service is provided.

Data recording process on the register: Each girl who received the HPV vaccine should be recorded in the register using a single row. Please refer to the instruction page on the first page of the register for a detailed recording process.

Data compilation procedures:

The reportable data elements from the HPV tally sheet includes:

S.No.	Reportable data element	Disagg.	Frequency	Level of Reporting
1	Number of girls 14 year of age who have received first dose of human papilloma virus vaccine	None	Monthly	HP, HC, clinics & Hosp
2	Number of girls 14 year of age who have received second dose of human papilloma virus vaccine in 6 months interval from the first dose			
3	HPV doses given /opened/damaged/expired			

The reportable data elements are compiled from the HPV register which is summed up in a box at the bottom of each page of the register and reported monthly.

IMNCI register (0-2 months)

Purpose: Integrated management of newborn and childhood illness (IMNCI) register is a serial register that is used to record clinical signs and symptoms, assessment (Diagnosis based on National classification of diseases), and treatment given or referral status of sick children of age 0-2 months.

Where used and location: facilities of any capacity – Health Center, clinic / pediatric specialty center, Hospitals. The register is kept in the under 5 years OPD rooms.

Format of instrument: Preprinted on standard A3 paper. The entry for a single child spans two pages.

Who maintains*:* Service provider completes the information required by the register as service is provided.

Data recording process on the register

The primary data source for the IMNCI register is the patient card/form. Please refer to the instruction page on the first page of the register.

Data compilation procedure

Reportable data elements

- Diseases/Diagnosis by Disease type
- Number of sick young infants 0-2 months treated for critical illness disaggregated by disease type
- Infants treated with Zinc and ORS for diarrhea

IMNCI (from 2 months to 5 years) Register

Purpose: Integrated management of newborn and childhood illness (IMNCI) register is a serial register that is used to record information about health care services given to children of age 2 months to 5 years old. It captures data on signs and symptoms of selected diseases and conditions, other problems, classification, treatment, counseling, and follow-up.

Where used and location: Health Center / Medium clinic/specialty clinic, MCH specialty center, and Hospitals. It is kept in under five OPD rooms.

Format of instrument: Preprinted on standard A3 paper. It has right and left parts, in which a single case will be registered from the left end to the right end,

Who maintains: Service provider completes the information while providing the service.

Data recording process on the register:

Each client who received IMNCI service should be recorded in the register using a single row.

In this register, some columns were separated by dot lines. In these boxes, two or three variables can be recorded. For example, the first column has two parts, In the upper box write the date of visit, and in the lower box serial number. The same rule applies for all columns with dots lines and variables are recorded as per their order on the top of the column. For further information, please refer to the instruction page.

Data compilation procedures;

Reportable data elements

- Diagnosis/diseases type disaggregated by age and sex
- Number of under 5 years children treated for pneumonia
- Number of children treated with Zinc and ORS for diarrhea disaggregated by ORS and Zinc or ORS only
- Number of children aged 0 to 59 months assessed for developmental milestone

All disease morbidity reports disaggregated by age, sex, and number of under years -children treated for pneumonia are compiled, and reported from NCoD/ESV-ICD 11 tally sheet. The NCoD/ESV-ICD 11 tally sheet is explained in the OPD register section.

The number of children treated with Zinc and ORS for diarrhea disaggregated type of treatment: treated by ORS & Zinc, and treated by ORS only as well as children aged 0 to 59 months assessed for developmental milestones are counted on every page of the register, and the total sum in the month is counted and reported.

Frequency of reporting: All data elements are reported monthly.

Neonatal Intensive Care Unit (NICU) Register

Purpose; The purpose of the NICU register is to record information about neonates who have been treated in the neonatal intensive care unit. Neonatal intensive care unit (NICU) is a unit where a health care provider provides treatment and care for babies who have problems such as prematurity and other severe problems. The register captures data that is related to the type of treatment provided and the treatment outcome of NICU management.

Where used and location: The service is only provided in Hospitals with NICU standards, which have trained manpower and allocated enough space as per the standard, with basic equipment as per the NICU level. t is located *around the delivery room/neonatal room/ intensive care unit (ICU)*

Format of instrument: Preprinted on standard A3 paper. It has a right and left part in which a single case is registered from the left end to the right end.

Who maintains: service providers complete the data after the service is provided.

Data recording process on the register:

The data source for the NICU register is the neonate's card. Please refer to the instruction page in the first page of the register.

Data compilation procedures:

Data element and way of counting its performance

The reportable data elements are collected from the boxes that are available at the bottom of each page in the register. No tally sheet for this register. Reportable data elements are compiled at the end of each month and be sent to the HMIS unit.

S.N	Reportable data element	Disagg	Frequency of reporting	Level of Reporting
1	Number of Newborn weighing <2000gm and premature newborns for which KMC initiated	None	Monthly	HC/Hosp
2	Number of Newborn weighing <2000gm and or premature	None		
3	Number of neonates resuscitated and survived	None		
4	Total number of neonates resuscitated	None		
5	Number of neonatal deaths	By age: within 24 hrs, 1-7 days, 7-28 days		Hospital
6	Total neonates admitted to NICU	None	Monthly	
7	Number of sick young infants 0-2 months treated for Critical illness	By disease type:- Very sever Disease, Local bacterial infection (LBI) Pneumonia		
8	Total neonates discharged during the reporting period	Treatment outcome	Monthly	Hospital

How to compile data elements

Count the number of neonates in each row at column 35 who weigh <2000gm and premature newborns for which KMC initiated and sum up at the end of each page.

Count the number of neonates who weigh <2000 gm and premature or count rows which have tick marks (√)) at Columns 24 and 25at the same time and sum up at the end of each page.

To compile resuscitated and survived the health care providers search and count the number of tick marks (√)) at column 48 and sum up at the end of each page

Count the number of dead neonates based on their age; first 24 hrs, 1-7 days, and 7-28 days

Adolescent Health Program

Integrated AYH Register

Purpose: Adolescent and Youth Health (AYH) is a serial register intended to capture HMIS data related to personal identification (columns 1-7), and the integrated AYH services (columns 8-29) provided, to target age groups during a single visit in a one-stop approach.

Where used/Location: In the Health Center / Medium clinic / Obs-Gyn specialty clinic, MCH specialty center, and all types of Hospitals where one-stop AYH service is started.

Data recording process:

Once the client is registered and receives the appropriate services the data are recorded based on the instructions found attached at the inside part of the cover page of the registration using a single row for a single visit.

Data compilation procedures:

The following are reportable data elements that are compiled from the Integrated AYH registers at Health Centers and Hospitals, and reported monthly:

S.N	Reportable data element	Disagg
1	Number of clients "referred" from	By HF type: youth center, school, internal referral, and Other Facility
2	Number of clients tested for HIV test	Age, Sex, HIV result
3	Number of new acceptors (F/P)	Age, method
4	Number of new acceptors (F/P)	Age, method
5	Number of safe abortions performed	Age
6	Number of safe abortion/emergency care performed	Age

As the register has no tally sheet, the data is compiled directly from the register. Here, there are two scenarios for compiling the AYH data: In the case of "One-stop service" is applicable the data is compiled directly from the register by counting or taking the figures from the boxes found in the register, at the bottom of each page. However, where "One-stop service" is not initiated, the data are compiled from the record or tally sheets of the respective service areas.

Nutrition Program

GMP and Under 5 Children Nutrition Screening Register

Purpose: Longitudinal register that record child who visited the health facility for growth monitoring and/or nutrition screening. All child less than 5 years at well baby will be recorded for GMP and other sick baby will consider for nutrition screening service.

Where used/ Location in the facility: Health Center / Medium clinic / Pediatric specialty clinic, Pediatric specialty center, and all types of Hospitals in Well-child Clinic; register may also be used during outreach activities.

Format of instrument: Preprinted on standard A3 paper. Column (10-34) will be used for GPM FOR 2 years and Column (35-59) will be used for Nutrition Screening and Developmental milestone assessment U5.

Who maintains: Service provider completes the information required by the register as service is provided. At higher capacity clinics, this may be done based on the information on the reproductive health card.

Data recording process on the register: Each client who received growth monitoring promotion and nutrition screening services should be recorded in the Comprehensive integrated nutrition and developmental milestone screening/Assessment register using a single row and tallied immediately using a CINUS Tally sheet. Please refer to the instructions in the register for details.

Data compilation procedures:

a. The sum of GMP Underweight classifications for children <2 Normal (N), Moderate underweight (MU), and severe underweight (SU) is counted and the total sum is recorded on each page of the register and reported at the end of the month

b. The sum of nutritional screening normal (N), MAM, SAM, and developmental milestone classification ND, SD, DD for U5 (0-24) and (25-59) is counted and the total sum is recorded on each page of the register and reported at end of month

c. The sum of the first and second dose of total vitamin A received for ages 6-11 and 12-59 is counted and the total sum is recorded on each page of the register and reported at the end of the month

d. On the last column(Action column) write the code of action taken 1 for referral, 2 for OTP, 3 for SC, 4 for TSFP, 5 for PSNP, and 6 for other options that will be written in each client row and linked accordingly.

Reportable data elements:

- GMP underweight classification for children under 2 (Normal (N), Moderate underweight (MU), and severe underweight (SU))
- Nutritional screening (Normal (N), MAM, SAM)
- Developmental milestone classification(ND, SD, DD for U5 (0-24) and (25-59)

S.N	Reportable data element	Disaggregation	Frequency of reporting	Level of Reporting	Tally
1	Number of children less than 2 years weighted during GMP session	Age and nutritional status	Monthly	HP/HC/ Hospital	CINuS tally
2	Total Number of children < 5 years screened for acute malnutrition	Age and nutritional status			
3	Developmental milestone classification (ND, SD, DD for U5 (0-23) and (24-59)	By Status: Normal, Suspected develop-mental, Developmen-tal Delay Bye Age :0-23 :24-59			

Routine Vitamin A Supplementation (VAS) and Deworming register

Purpose: Longitudinal record of child health supplemented with Vitamin A and dewormed. It is used to record both doses of Vitamin A, and Deworming for children under five years.

Where used/ Location in the facility: Health Center / Medium clinic / Pediatric specialty clinic, Pediatric specialty center, and all types of Hospitals in Well-child Clinic; register may also be used during outreach activities. The primary Place of this register in the health facility is nutrition room/well baby clinic/ GMP room.

Format of instrument: Preprinted on standard A3 paper. One row will use for one child for VAS and deworming based on their age. VAS will be given for child age for 6-59 months, while deworming started at 24 months to 59 months.

Who maintains: Service provider completes the information required by the register as service is provided.

Data recording process on the register:

Each client who received supplementation of VAS and/or deworming should be recorded in the vas and deworming register using a single row and tallied immediately using VAS and/or deworming Tally sheet. Please refer to the instructions in the register for details

Data compilation procedures:

a. The sum of the first and second dose of total vitamin A received for ages 6-11 and 12-59 is counted and the total sum is recorded on each page of the register and reported at the end of the month.

b. The sum of the first and second dose of deworming received for 24-59 is recorded on each page of the register and reported at the end of the month

Reportable data elements:

- Vitamin A supplementation, first and second doses
- Deworming, first and second doses

S.N	Reportable data element	Disaggregation	Frequency of reporting	Level of Reporting	Tally
1	Number of children who were provided with vitamin A supplementation	Age and dose	Monthly	HP/HC/ Hospital	VAS and deworming tally
2	Number of children aged 24-59 months de-wormed	Dose			

Comprehensive and integrated nutrition service for < 5-year children tally sheet

Purpose: Daily tally and count of weight for age category (based on Z score) of each child weighed, Daily tally and count of MUAC of each child that is nutritionally screened and supplemented with Vitamin A and dewormed, and daily tally developmental milestones for all <5 children.

Where used and Location in the facility: Health Center / Medium clinic / Pediatric specialty clinic, Pediatric specialty center and all types of Hospitals, and it is Kept with Comprehensive integrated nutrition and developmental milestone screening/Assessment register with which it is used.

Adolescent Nutrition Register

Purpose: Adolescent Nutrition Register is a longitudinal register intended to capture the HMIS data related to personal identifications, and adolescent nutrition services provided, namely doses of deworming given (columns 7-8), nutrition screening, and iron-folic acid (IFA) tablet given to the target groups during a single visit.

Where used/Located Health Center / Medium clinic / Obs-Gyn specialty clinic, MCH specialty center, and all types of Hospitals. The registration is maintained at the Adolescent tally sheet will be sent to and maintained at the HMIS unit

Data recording process:

The data relating to each client who received the services should be recorded based on the instructions attached at the inside part of the cover page of the registration using a single row. In case the space provided for the IFA service data is not adequate, a new row has to be used.

Data element and compilation procedures:

The following are reportable data elements that are compiled from the adolescent nutrition register.

- Adolescent and Youth Aged 10-19 screened for nutrition as Normal, Underweight, Overweight, Obese, Very Obese by age.
- Adolescents and Youth Aged 10-19 received one dose of deworming by age (10-14,10-14,15-19,15-19) and Sex.
- Adolescents and Youth Aged 10-19 received two doses of deworming by age (10-14,10-14,15-19,15-19) and Sex.
- Adolescent girls aged 10-19 years supplemented with IFA by age (10-14, 15-19).

These data elements are compiled using the Adolescent nutrition tally sheet, which is designed for this purpose. The tally is used to compile the count of each service by making a tally and recording the count of the tally in the respective rows in line to the respective disaggregated by age and/or Sex immediately after the services are provided. This tally is kept with the register until the whole pad is utilized.

Frequency of reporting: These data elements are reported monthly.

Pregnant and Lactating Women (PLW) Nutrition Screening Register

Purpose: - PLW Screening register is used to record information regarding screening of pregnant and lactating women for acute malnutrition.

Where used and location: this register is used at the health centers, clinics, and hospitals and it is kept at the department where the service is provided

Format of instrument: this is preprinted on standard A4 paper. It is a longitudinal register.

Who maintains: the register is completed by the service provider at the time of service provision.

Data recording process on the register:

Note: Under the nutritional screening section, the data elements that are required to be measured and documented during each month's nutritional screening period are available under the five rows provided. To fill each row please follow the instruction sheet provided.

Data compilation procedures:

Reportable data elements include:

- Total number of PLW screened for acute malnutrition
- Total number of PLWA with MUAC < 23 cm
- Total number of PLWA with MUAC >= 23cm
- Number of pregnant women de-wormed

Since there is no tally sheet for this service, one should count the aforementioned reportable data elements from the register.

Therapeutic feeding Program (TFP) register

Purpose:- it is a longitudinal register and it is used to record the therapeutic feeding that is provided for Children < 5 with Severe Acute Malnutrition (SAM). Data related to the admission and treatment outcome of children who have been admitted to TFP centers are recorded in this register.

Where used:- It is used at HC and Hospital levels, and kept at a department where the service is provided

Format for instruction:- pre-printed A3 paper.

Who maintains:- the service provider in the service room completes the register.

Recording procedure for TFP Register

For completing the registration, please refer to the instruction sheet. But focus on the following section

1. **Admission Section:**: In this section, we record information regarding the child at admission. To fill please refer to the instruction sheet on the front page of the register.
    - **WFH%:** This is to record the Weight-for-Height percentage that is plotted based on the measurements on columns 14 and 15 against the WHO WFH reference curve. It should be recorded as: <70%, 70%-80% or >80%
    - **Oedema (0, +, ++, +, +++):** column 17- is used to record the presence or absence of Oedema and its severity. If there is no bilateral pitting edema, write 0. If there is edema, use the following to denote the degree of edema:
        - += grade + (Mild :Both feet/ankles bilateral pitting Oedema)
        - ++= Grade ++ (Moderate :Both feet ,plus legs, hands or lower arms)
        - +++= Grade +++ (Severe : generalized bilateral pitting oedema, including both feet, legs, arms and face)
2. **Treatment outcome section:** To fill this section please refer to the instruction sheet.
    - **Recovered (Cured):** If the child is free from medical complications and has achieved and maintained sufficient weight gains. Malnourished Children admitted to feeding programmers are discharged with the following criteria: MUAC ≥11.0 cm AND ≥15% weight gain from admission weight with no edema for 2 consecutive visits (at hospital level WFH ≥85 %.).
    - **Died** = Child that has died while he was in the program. For out-patient programs, the death has to be confirmed by a home visit.
    - **Defaulter**: Patient that is absent for 2 consecutive weighings (2 days in in-patient and 2 weeks in out-patient), confirmed by a home visit.
    - **Non-responder**: Patient that has not reached the discharge criteria after 40 days in the in-patient program or 2 months in the out-patient program.
    - **Transfer Out**: Patient that has started the nutritional therapeutic treatment in your program and is referred to another site to continue the treatment.

Data compilation and reporting

Reportable data elements from the TFP register

S.N	Reportable data element	Disagg.	Frequency of reporting	Level of Reporting	Tally used
1	Total number of SAM at the beginning	None	Monthly	HP/HC/ Hospital	No tally
2	Total number of children with SAM admitted to TFP (OTP &SC) during the reporting period	None			
3	Total number of children who exit from severe acute malnutrition treatment	Outcomes: Recovered, died, Transferred out, defaulted, non-respondent, Medically transferred out, or unknown			

Note: - As the register has no tally sheet; the source for data compilation is the register only. At the end of the reporting month, compile the total number of cases of treatment outcome and fill in the box provided at the bottom of the register and count cases at admission for those who have WFH%<70, edema, and MUAC <11 cm during admission. Collect the total count from the box on the register, write in the monthly reporting format, and give it to HMIS focal to transfer it to the DHIS2 if the health facility starts to use the DHIS2.

MAM treatment for 6-59 months Register

Purpose*: A* series register for clients who developed Moderate acute malnutrition of children 6-59 months. It is used to capture information about the admission and discharge of children admitted with Moderate acute Malnutrition. This recording follows the nutritional screening protocol of child health care visits.

Where used and Location in the facility: Health Center / Medium clinic / Pediatric specialty clinic, Pediatric specialty center and all types of Hospitals, and it is kept at MCH service room

Format of instrument*:* Preprinted on standard A4 paper.

Who maintains*:* Service provider completes the information while service is provided.

Data recording process on the register:

A child with the age of 6-59 months who develops moderate acute malnutrition is recorded in this Registration Book for MAM treatment using a single row. Please refer to the instructions in the register for details.

Data compilation procedures*:*

At the end of the reporting period, the sum of Discharge outcomes (Cured, Died, Defaulted, Non-respondent, and transfer out) are counted and the total sum is recorded on each page of the register and then transferred to the reporting format at the end of the month.

Reportable data elements:

S.N	Reportable data element	Disagg.	Frequency of reporting	Level of Reporting
1	Total number of MAM at the beginning	None	Monthly	HP/HC/Hosp
2	Total number of children with MAM admitted during the reporting period	None		
3	Total number of children who exit from MAM treatment	outcome		

MAM treatment for PLW Register

Purpose: *A* series register, for pregnant and lactating women (PLW) who developed Moderate acute malnutrition. It is used to record information about admission (status and entry information) and discharge (exit information) of moderately acute malnourished PLW. This record follows the nutritional screening protocol of maternal health care visits.

Where used and Location in the facility: Health Center / all types of clinic/maternity specialty clinic, MCH specialty center and all types of Hospitals and in Maternity service room. The register may also be used during outreach activities

Format of instrument: Preprinted on standard A4 paper.

Who maintains: Service provider completes the information as service is provided.

Data recording process on the register:

Each PLW client who developed Moderate acute malnutrition should be recorded in the Registration Book for MAM treatment using a single row per client. Please refer to the instruction in the register for details

Reportable data elements:

S.N	Reportable data element	Disagg.	Frequency of reporting	Level of Reporting
1	Total number of PLW with MAM at the beginning	None	Monthly	HP/HC/ Hospital
2	Total number of PLW with MAM admitted during the reporting period	None		
3	Total number of PLW who exit from MAM treatment	outcome		

To report the given the data elements, the reportable data elements are summed up to the boxes at the bottom of each page in the register and compiled at the end of the reporting period.

Disease Prevention and Control

TB and leprosy prevention and control program

Unit TB Register

Purpose: The register is a longitudinal register and the main purpose is to record information about TB services, diagnosis, HIV/AIDS screening, intensive and continuation phase treatment follow up and treatment outcome.

Where used and location: Health Center, all types of Hospitals, any type of private clinic or medical center providing the special service. It is used at the TB/DOTS/follow-up treatment room of the facilities.

Format of instrument: Preprinted on standard A3 paper. The entry for a single client spans two pages.

Who maintains: TB care provider completes the data required by the register as soon as service is provided.

Data recording process on the register: Each client who received TB treatment service should be recorded in the TB register using a single row. Please refer to the instructions in the register for details.

Reportable data elements:

S.No	Data element	Disaggregation
1	Number of bacteriologically confirmed New Pulmonary TB cases detected and enrolled in the reporting period	Age and sex
2	Number of clinically diagnosed New pulmonary TB cases detected and enrolled in the reporting period	Age and sex
3	Number of clinically diagnosed new EPTB cases detected and enrolled in the reporting period	Age and sex
4	Number of RELAPSE (bacteriological confirmed and clinically diagnosed) TB cases in the reporting period	Age and sex
5	Number of notified TB cases from key affected population group	None
6	Total number of new bacteriologically confirmed TB cases (PTB+) enrolled in cohort in same month of previous EFY	None
7	Treatment outcome of new bacteriologically confirmed TB cases (PTB+)	Rx outcome
8	Total number of new clinically diagnosed pulmonary TB cases enrolled in the cohort in same month of previous EFY	None
9	Treatment outcome of new clinically diagnosed pulmonary TB cases (P/Neg)	Rx outcome
10	Total number of clinically diagnosed EPTB cases enrolled in the cohort (EPTB) in same month of previous EFY	None
11	Treatment outcome of clinically diagnosed EPTB cases (EPTB)	Rx outcome
12	Total number of RELAPSE TB cases enrolled in the cohort in the same month of previous EFY	
13	Treatment outcome of RELAPSE TB cases	Rx outcome
14	Number of all forms TB cases detected and registered on unit TB register who are initially referred by the community	None
15	Treatment success of TB patients who received community-based treatment support	None
16	Number of notified bacteriologically confirmed TB cases evaluated for drug susceptibility testing	Registration group

17	Number of TB cases with drug susceptibility testing result for at least rifampicin during the reporting period	Registration group
18	Number of TB cases (all forms) notified in public health facilities with initial referral by PPM sites for TB diagnosis or initiation of TB treatment	None
19	Number of test with rapid diagnostic tests (Xpert and others) at the time of diagnosis(initial diagnosis)	Age, Sex
20	Total number of new and relapse TB patients registered during the reporting period having a documented HIV test result	Age, Sex
21	Total number of HIV-positive new and relapse TB patients started on TB treatment during the reporting month who are already on ART	Age, Sex
22	Total number of newly tested HIV positive TB patients who began ART during the reporting month	Age, Sex
23	Number of notified all forms of TB cases screened for malnutrition	Screening result
24	Total number of AFB tests performed to diagnose TB	Method
25	Number of health facilities covered by AFB External Quality Assessment (EQA) scheme	None
26	Random Blinded Rechecking (RBR) for AFB diagnosis	None

These reportable data elements with disaggregation by age/sex group are compiled from the unit TB register. The provider should register immediately after service is provided, and the reportable data elements are counted up and compiled at the end of the reporting period. The register is kept in the TB room

Frequency of reporting: These data elements are reported monthly from Health Centers, Clinics and Hospitals.

TB contact register

Purpose: It is a longitudinal register and the main purpose is to record information about TB contact screening, diagnosis, and referral.

Where used and location: Health Center, all types of Hospitals, any type of private clinic or medical center providing the special service. It is used in the TB treatment room of the facilities.

Format of instrument: Preprinted on standard A3 paper. The entry for a single client spans two pages.

Who maintains: TB care provider completes the data required by the register as soon as service is provided.

Data recording process on the register: Each TB client who receives TB treatment service should be recorded in the registration book using a single row. Please refer to the instructions in the register for details.

Reportable data elements:

Sr #	Data element	Disaggregation
1	Total number of contacts with index of drug susceptible bacteriologically confirmed pulmonary TB cases	Age
2	Total number of contacts with index of bacteriologically confirmed DR-TB cases	Age
3	The number of contacts with index cases screened for TB	Drug-susceptible, DR-TB & Age,
4	Number of contacts with index of bacteriologically confirmed TB cases screened negative for TB	Age
5	Number of contacts screened negative for TB and others eligible and put on TPT in the reporting period	Age
6	Number of cohort of individuals started TPT 12 months prior to the reporting period	Age & regimen
7	Number of cohort of individuals who had completed TPT in the reporting period	Age & regimen

The provider should register data elements immediately after service is provided, and the data are counted up and compiled at the end of the reporting period. The register is kept in the TB room

Frequency of reporting: These data are reported monthly from Health Centers, Clinics and Hospitals.

MDR-TB Treatment register

Purpose: Longitudinal record of MDR-TB patient's demographic information, drug sensitivity test (DST), smear and culture result during treatment.

Where used: This register is used at MDR treatment initiating centers.

Format of instrument: Preprinted on standard A3 paper. The entry for a single client spans two pages.

Who maintains: TB care provider completes the information required by the register as service is provided.

Data recording process on the register:: TB client who is confirmed to be resistant TB and got treatment service should be recorded in the registration book using a single row. Please refer to the instructions in the register for details.

Data compilation procedures: Data are compiled monthly for analysis of cohorts completing the treatment in the current month. The reportable data elements are:

- Number of notified bacteriologically confirmed TB cases evaluated for drug susceptibility testing according to national policy disaggregated by registration group
- Number of TB cases with drug susceptibility testing result for at least rifampicin during the reporting period disaggregated by registration group
- Number of DR TB cases detected disaggregated by resistance type (Hr-TB, RR Only, MDR- TB, Pre XDR, and XDR TB cases), age (<15/=>15 years), and sex (male/female)
- Drug Susceptibility Test (DST) coverage for DR-TB patients (only by Treatment initiating center) by regimen types
- DR TB treatment interim result for a cohort of a patient registered 9 -12 months earlier disaggregated by regiment types, culture result status, and treatment outcome

- Final outcome DR-TB cases after 24 months of enrollment (to be reported only by DR TB treatment initiating centers) disaggregated by short term second-line anti-TB treatment regimen 24 months earlier and long term second-line anti-TB treatment regimen 36 months earlier.
- Number of DR- TB cases enrolled to second-line drugs screened for malnutrition during the reporting period

Sr #	Data element	Disaggregation	Frequency of the report	Level of report
1	Number of DR TB cases detected	Age, Sex Resistance type	Monthly	HC, Clinic, Hosp
2	Drug Susceptibility Test (DST) coverage for DR-TB patients	Regiment type	Monthly	Treatment initiating center
3	DR TB treatment interim result for cohort of patient registered 9 -12 month earlier	Regimen type, culture result &Rx outcome	Monthly	HC, Clinic, Hosp
4	Total number of cohort DR-TB cases started on short term second-line anti-TB treatment regimen 24 months earlier	Rx out come	Monthly	HC, Clinic, Hosp
5	Total number of cohort DR-TB cases started on long-term second-line anti-TB treatment regimen 36 months earlier.	Rx out come	Monthly	HC, Clinic, Hosp
6	Number of DR- TB cases enrolled to second line drugs screened for Malnutrition during the reporting period	Screening result	Monthly	

MDR-TB follow up register

Purpose: Longitudinal record of MDR-TB patient's demographic information, Contact person information, diagnosis/eligibility, intensive and continuation phase treatment, TB/HIV collaborative activities, close contacts, nutritional assessment, and DR TB treatment outcome.

Where used: This register is used at the MDR treatment initiating center and MDR treatment follow-up center. It is used to follow the MDR TB case's treatment progress up to the completion of the treatment.

Format of instrument: Preprinted on standard A3 paper. The entry for a single client spans two pages.

Who maintains: TB care provider completes the information required by the register as service is provided.

Data recording procedure: same procedure is followed as the MDR TB register.

Data compilation procedures: Data are compiled monthly for analysis of cohorts completing the treatment in the current month.

Leprosy register

Purpose: Longitudinal record of leprosy patient's demographic information, diagnosis, treatment, treatment outcome, and disability grade at end of treatment, as well as information about contacts and screening status of household contacts of the index case.

Where used: Health Center, all types of Hospitals of the leprosy treatment room.

Format of instrument: Preprinted on standard A3 paper. The entry for a single client spans two pages.

Who maintains: Service provider completes the information required by the register as service is provided.

Data recording procedure: the required data elements are recorded from the Leprosy patient record card to the register.

Data compilation procedures: Data are compiled monthly for analysis of cohort completing treatment in current monthly. Reportable data elements are indicated in the table below.

Sr #	Data element	Disaggregation	Frequency of the report	Level of report
1	Number of new Leprosy cases detected	Age, Sex and type of LP	Monthly	HC, Clinics, Hosp
2	Number of household contacts of leprosy cases registered	None		
3	Number of household contacts of leprosy patients that are screened for Leprosy	None		
4	Number of household contacts diagnosed with Leprosy cases	None		
5	Number of new leprosy cases with Grade II disability (MB+PB)	Age & Sex		
6	Result of new leprosy cohort cases registered during 16-18 months prior to the reporting period	Rx outcome		

Leprosy register for care after completion of treatment

Purpose: is to record data about basic individuals and services related to Leprosy and used to follow clients with diagnosis, treatment and monitor leprosy patient's disability grade at the end of treatment.

Where used and location: Health Center, all types of Hospitals. It is used in the leprosy treatment room of the facilities.

Format of instrument: Preprinted on standard A3 paper. The entry for a single client spans two pages.

Who maintains: Service provider completes the data required by the register as soon as service is provided.

Data recording process on the register: Each client who received leprosy treatment service should be recorded in the leprosy register for care after completion of treatment using a single row. Please refer to the instructions in the register for details.

Data compilation procedures:

Reportable data elements: there is no reportable data element from this register

HIV/AIDS Prevention and Control Program

HIV Testing Services (HTS) register

Purpose: It is a serial register and the main purpose is to record information about testing on HIV, STD, and TB screening and referral

Where used: VCT room of the Health Center, Hospitals, stand-alone VCT clinic and on any types of private clinic or center

Format of instrument: Preprinted on standard A4 paper. The entry for a single client spans a single page Who maintains: Service provider completes the data required by the register as soon as service is provided

Data recording procedure:

Each client who received HTS service should be recorded in the HTS register using a single row and tallied immediately using the HTS Tally sheet. Recording of all the data elements required in the register is recorded from the Laboratory request and result form. Please refer to the instructions in the register for details

Data compilation procedures:

Reportable data elements:-

- Clients receiving HIV test results (at VCT) disaggregated by age group (<1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49 and 50+), sex (M/F) and population

These reportable data elements are compiled from HTS tally sheets at the end of the reporting period.

HTS Tally

Purpose: HTS tally sheet is used to document HIV testing service data that include services in VCT room, and provider-initiated testing and counseling with test results. The tally sheets are completed from different registers that have a PITC service component like OPD register, IPD, TB, family planning, ANC, delivery registers, etc. The data elements are HTS Tests and its result as well as STI screening and their result disaggregated by age and sex. The age categories are: <1 year, 1-4 years, 5-9 years, 10-14 years, 15-19 years, 20-24 years, 25-29 years, 30-34 years, 35-39 years, 40-44years, 45-49 years and 50+ years

Where used and location in the facility: It is used at Health centers, hospitals, and clinics. It should be available at all service outlets including at VCT and ART service units.

Data compilation procedure

Reportable data elements are

- Clients receiving HIV test result (at HTS) disaggregated by age group, sex (M/F), HIV result and population group
- Number of STI cases tested for HIV disaggregated by sex and HIV test result

The reportable data elements from different service units such as OPD, IPD, TB, family planning, ANC, delivery registers, etc have to be summed up and reported by the end of each reporting period.

Frequency of reporting: These data elements are reported monthly.

Index Case Testing (ICT) Register

Purpose: Longitudinal record of HIV positive client's demographic information and service provided; record contact of index client (i.e., a person known to be HIV positive) demographic information and provide service such as HIV testing and result, linkage to care and treatment and information related with PrEP service for eligible HIV negative contact.

Where used and location: Health Center, all types of Hospitals, and at the clinic and specialty centers that are permitted to provide ART service. It is used at facilities ART rooms.

Format of instrument: Preprinted on standard A3 paper.

Who maintains: Service provider completes the information required by the register immediately after service is provided.

Data recording process on the register:

Each of the index cases is recorded on the ICT register along with their contact and service provided. Please refer to the instruction in the register for details on how to fill each column.

Index clients are a person known to be HIV positive while contacts are current or past sexual partner(s), biological children /parents (if index case is a child), or anyone with whom a needle was shared**.**

Data compilation procedure

Reportable data elements

S.No	Data element	Disaggregation	Frequency of the report	Level of report
1	Number of index cases offered	Age group & sex	Monthly	HC, Clinic, Hospital
2	Number of contact elicited	Age group & sex		
3	Number of contact tested and test result	Age group & sex		

These reportable data elements are compiled from ICT tally sheets which include the number of index cases offered, number of contacts elicited, accepted, tested, and positive result disaggregated by age group (<1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49 and 50+) and sex (M/F). The provider should tally immediately after service is provided, and the data elements are counted up and compiled at the end of the reporting period. The Tally is kept with a register until the whole pad is utilized, and then moved to an archive maintained by HMIS in charge.

Frequency of reporting: These data elements are reported monthly.

ICT Tally

Purpose: help to simplify compiling reportable data elements regarding ICT service cascade offered, accepted, elicited, new positive and known positive by sex and age category

Where used and location in the facility: Health Center, all types of Hospitals, clinic and on any types of private clinic or center, and it is used and kept with the ICT register with which it is used at facility ART room.

HIV self-testing (HIVST) register

Purpose: The register is a serial register and the main purpose is to record information about self-testing on HIV, HIV test kit distribution, linkage to care & treatment

Where used: ART room of the Health Center and Hospitals

Format of instrument: Preprinted on standard A4 paper.

Who maintains: Service provider completes the data required by the register as soon as service is provided.

Data recording procedure:

During client encounters, data should be recorded in the register. Please refer to the instructions in the register for details.

Data compilation procedures:

Reportable data elements

- Number of Individual HIV self-test KIT distributed directly assisted disaggregated by age group and sex
- Number of individual HIV self-test KIT distributed unassisted disaggregated by sex

The reportable data elements are counted directly from the register and the data elements are reported monthly.

Pre-exposure to HIV prophylaxis (PrEP) register

Purpose: A longitudinal record of client's follow-up on pre-exposure to HIV prophylaxis (PrEP).

Where used: ART room of the Health Center and all types of Hospitals

Format of instrument: Preprinted on standard A4 paper.

Who maintains: Service provider completes the information required by the register as service is provided.

Data recording procedure:

During client encounters, data should be recorded in the register. Please refer to the instructions in the register for details.

Data compilation procedures:

Data elements required for reporting

- PrEP_Current disaggregated by age group, Sex (M/F), and clients' Category (Female sex workers (FSW) or Discordant Couples)
- Three months' test result: (Positive, Negative, or Less than 3 months since PrEP initiation)
- Number of new PrEP cases disaggregated by age group, Sex (M/F), and client Category (Female sex workers (FSW) or discordant Couples)

These reportable data elements are counted or tallied during the reporting period based on exposure (those already initiated and newly exposed) by age group, sex, test result, and client category.

Post-exposure to HIV prophylaxis (PEP) follow up register

Purpose: It is a serial register used to record the client's information of demographic data, exposure status, baseline HIV status, PEP provision, exposed person follow-up.

Where used: Health Center and all types of Hospitals, The register is located in the ART room.

Format of instrument: Preprinted on standard A4 paper. On this register, a single client entry spans one page.

Who maintains: Service provider completes the information required by the register as service is provided.

Data recording process on the register: Data recorded from the patient card to register. Each row of the register is used for one client. Instruction for recording data is explained in detail on the register.

Data compilation procedures:

- Records are counted monthly from the PEP register.
- The sum of each data element is counted on every page.
- The data elements are the number of persons provided with post-exposure prophylaxis (PEP) for risk of HIV infection by exposure type.
    - Occupational
    - Non-occupational and
    - Sexual violence for eligible clients.

HIV positive client tracking register

Purpose: It is a serial register used to record HIV-positive clients' information on demographic data, date of HIV tested positive, entry point, date of linked to care and treatment, date of start on ART, initiation date, and outcome of the client.

Where used: Health Center, all types of Hospitals, and if permitted to provide the special service any clinic or center. The register is located at the entry point of the facility.

Format of instrument: Preprinted on standard A4 paper. On this register, a single client entry spans one page.

Who maintains: Service provider completes the information required by the register as service is provided.

Data recording process on the register:

Data is recorded from the patient card to register from each entry point. Each row of the register is used for one client and instruction for recording data is explained in detail on the register.

Data compilation procedures:

- Data is compiled and reported monthly from the HIV client tracking register.
- The sum of each data element is counted on every page.
- Reportable data elements are:
    - Number of newly identified positive adults and children linked to care and treatment by linkage outcome (Linked to care and treatment, Known on ART, Lost to follow up, Referred to another facility, Died and other)

ART Register

Purpose: Longitudinal record of client's baseline status, screening service, ART treatment follow-up, TB treatment, and other opportunistic infection treatment given.

Where used and location: Health Center, all types of Hospitals, and at the clinic and specialty centers that are permitted to provide ART service. It is used at facilities ART room

Format of instrument: Preprinted on standard A3 paper. The entry for a single client spans two pages.

Who maintains: ART data clerk completes the data elements on the register and periodically updates on daily basis.

Data recording process on the register:

The patient's demographic and clinical baseline status is obtained from the ART client intake form while the detail of subsequent follow-up status information is captured on the HIV care/ART follow-up form. The ART data clerk has to fill and update ART registers on daily basis using what is written on the ART intake form and the HIV care/ART follow-up form as a source document. In facilities where ART EMR software is used, what is written in hard copy needs to be also registered electronically. For details of how to fill each column of the register please refer to the ART register instruction.

Data compilation procedure

Reportable data elements from the ART register

Sr #	Data element	Disaggregation	Frequency of the report	Level of report	Tally sheet
1	Number of adults and children who are currently on ART	Age, Sex & Regimen	Monthly	HC, Clinics, Hosp	Currently on ART by regimen & DSD tally
2	Number of adults and children with HIV infection newly started on ART	Age, Sex & Pregnancy status	Monthly	HC, Clinics, Hosp	
3	Number of adults and children who are still on treatment at 12 months after initiating ART	Age, Sex & Pregnancy status	Monthly	HC, Clinics, Hosp	Clinical care tally sheet
4	Number of persons on ART in the original cohort including those transferred in, minus those transferred out (net current cohort).				
5	Number of ART clients restarted ARV treatment	Age, Sex			
6	Number of adult and pediatric ART patients with a viral load test in the reporting period	Age, Sex & Pregnancy status	Monthly	HC, Clinics, Hosp	Currently on ART & egimen tally
7	Total number of adult and pediatric ART patients with an undetectable viral load <1000copies/ml in the reporting period				
8	Number of PLHIV who were assessed/screened for malnutrition	Age, Sex & Pregnancy status			Clinical care tally sheet
9	Number of PLHIV that were nutritionally assessed and found to be clinically undernourished		Monthly	HC/Hosp	
10	Clinically undernourished PLHIV who received therapeutic or supplementary food	Age, Sex, Pregnancy status, & Nutritional status			Currently on ART & regimen tally
11	Number of newly enrolled ART clients who were screened for TB during the reporting period	Age, Sex & Pregnancy status	Monthly	HC, Clinics, Hosp	Clinical care tally sheet
12	Number of previously enrolled ART clients who were screened for TB during the reporting period				
13	Number of ART patients who started on TPT in the reporting period	Age, sex, and regimen type	Monthly	HC, Clinics, Hosp	
14	Number of ART patients who were initiated on any course of TPT 12 months before the reporting period				ART Register
15	Number of ART patients who started TPT 12 months prior to the reporting period that completed a full course of therapy	Age, sex, and regimen type	Monthly	HC, Clinics, Hosp	
16	Number of ART clients interrupted treatment by outcome	Age, Sex	Monthly		
17	Number of Women living with HIV aged 15-49 using any method of modern family planning	Age, Method	Monthly	HC, Clinics, Hosp	
18	Number of ART clients that received cervical cancer screening	Age, Sex, Screening result & Treatment type	Monthly	HC, Clinics, Hosp	

The first two reportable data elements are compiled from the ART register by conducting cohort analysis of survival rates using the form and procedure given by HIV programs. The remaining data elements are counted from registers and transferred to report format. Except for number of women using modern FP method the remaining data elements are disaggregated by age group (<1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49 and 50+) and sex (M/F). The number of women using the FP method is disaggregated by age (10-14, 15-19, 20-24, 25-29, and 30-49yrs) and FP methods (OCP, injectable, implant, IUCD, and other methods).

HIV clinical care tally

Purpose: This tally sheet is used to simplify reporting of the number of ART patients screened for TB, initiated on TPT, completed TPT, screened for cervical cancer and managed for cervical lesion, screened for nutritional status, and supplementation with food support for malnourished client disaggregated by sex and age (Male: <15 and 15+; Female: <15, 15-19, 20-24, 25-29, 30-49 and 50+) category.

Where used and location*:* Health Center, all types of Hospitals, and at the clinic and specialty centers that are permitted to provide ART service. It is used in the facility's ART room along with the ART register.

Currently on ART by regimen type and DSD tally sheets

Purpose: This tally sheet is used to simplify reporting of the number of ART clients by regimen category (as the first line, second line, and third line), number of viral loads tested, and result with suppressed viral load disaggregation by sex, pregnancy status and age(<1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49 and 50+) and number on specific regimen type disaggregated by sex and age category (<1, 1-4, 5-9, 10-14, 15-19 and 19+).

Where used and location*:* Health Center, all types of Hospitals, and at the clinic and specialty centers that are permitted to provide ART service. It is used in the facility's ART room along with the ART register.

Differentiated Service Delivery (DSD) register

Purpose: It is a longitudinal record of client's, helps to record information on differentiated models for PLHIV, ARV regimen and follow-up.

Where used: ART room of the Health Center and all types of Hospitals

Format of instrument: Preprinted on standard A3 paper.

Who maintains: The data clerk completes the information required on the register from the individual follow-up card and updates periodically. The update will be made based on refill managed by HEW (UHEP), peers, or the designated patient for community patient groups (as applicable) on the same day as ART is distributed to patients.

Data recording procedure:

Each PLHIV which is identified in a differentiated service delivery model is recorded in a single row in the register. The models are *Appointment Spacing Model (ASM), Fast-tracking ART (FTAR), Community ART group (CAG), Peer-led Community ART Distribution (PCAD), Advanced HIV disease (AHD) case models* and it is recorded by code in the register. The source of information is the ART follow-up form for the register.

Data compilation procedures:

Reportable data elements from DSD Register

Sr #	Data element	Disaggregation	Frequency of the report	Level of report	Tally sheet
1	Number of clients on ASM	Age group & Sex	Monthly	HC, Clinics, & Hosp.	Currently on ART by regimen & DSD tally
2	Number of clients on FTAR				
3	Number of clients on CAG				
4	Number of Peer-led Community ART Distribution (PCAD)				
5	Number of advanced HIV diseases (AHD)				

The reportable data elements are tallied from *"Currently On ART by Age, Sex and Regimen category and DSD Tally" by types of models (whether clients are on ASM, FTAR, CAG, and AHD) by age group (15-19, 20-24, 25-49, 50+) and sex.* The data clerk should tally immediately after service is provided or on daily basis at a high caseload facility and the data elements are counted up and compiled at the end of the reporting period. The Tally is kept with a register until the whole pad is utilized, and then moved to an archive maintained by HMIS in charge.

Hepatitis prevention and control

Hepatitis B Treatment Register

Purpose: It is a longitudinal register used to record hepatitis B infected individuals' demographic, baseline status, and follow-up status information.

Where used: Health Facility (Health Center, Hospitals/Private/NGO). The register is located at OPD or another place where the service is provided.

Format of instrument: Preprinted on standard A3 paper. On this register, a single client entry spans one page.

Who maintains: Service provider completes the information required by the register as service is provided.

Data recording process on the register:

Data is recorded from the patient card to register. Each row of the register is used for one client and instruction for recording data is explained in detail on the register.

Data compilation procedures:

- Data are compiled monthly from the monthly Hepatitis B screening and treatment register.
- The sum of each data element is counted on every page.
- Reportable data elements are;
    - The total number of individuals treated for Hepatitis B by sex and age (<15yr male & female and 15+yr male & female).

Hepatitis C Treatment Register

Purpose: It is a longitudinal register used to record hepatitis C infected individuals' demographic, baseline status, and follow-up status information.

Where used: Health Facility (Health Center, Hospitals/Clinic). The register is located at OPD or another place where the service is provided.

Format of instrument: Preprinted on standard A3 paper. On this register, a single client entry spans one page.

Who maintains: Service provider completes the information required by the register as service is provided.

Data recording process on the register:

Data is recorded from the patient card to register. Each row of the register is used for one client and instruction for recording data is explained in detail on the register**.**

Data compilation procedures:

- Data are compiled monthly from the Hepatitis C screening and treatment register.
- The sum of each data element counted on every page
- Reportable data elements are;
    - Total number of individuals treated for Hepatitis C by sex and age (<15yr male & female and 15+yr male & female).

Malaria Prevention, Control, and Elimination

Malaria Screening and Investigation Register

Purpose: The main purpose is to document malaria case management in targeted elimination Woreda. The register is a serial record of travel history, fever history, diagnosis, and treatment for malaria cases, index cases classification, notification, and investigation of foci. The register also documents the presence of other cases around the index case and helps to identify focus with ongoing transmission and inform interventions.

Where used and location: In health centers OPD rooms and health posts from malaria elimination Woreda".

Format of instrument: Preprinted on standard A4 paper.

Who maintains: Service provider completes the information required by the register as service is provided.

Data recording process on the register: Each malaria patient treated and managed in elimination 'Woreda' should be recorded in the malaria notification, screening, and registration register using a single row. Please refer to the instruction page on the first page of the register on the recording process of the register; the additional explanation for index case and focus for recording and reporting purpose is given.

1. **Index case:** A case in which the epidemiological characteristics trigger additional active cases or infection detection. An index case is eligible for investigation when the case's local address can be ascertained and for visitors if they have stayed 21 days or more in the area.
2. **Focus**: A defined and circumscribed area situated in a currently or formerly malarious area that contains the epidemiological and ecological factors necessary for malaria transmission.

Data compilation procedures: The sum of each reportable data element from the registered compiled and

reported. The reportable data element from malaria notification, screening, and registration register are indicated in the table below.

Sr #	Data element	Disaggregation	Frequency of the report	Level of report
1	Number of malaria cases with travel history	None	Monthly	HP & HC
2	Number of index cases investigated and classified	None	Monthly	HP & HC
3	Number of secondary cases	None	Monthly	HP & HC
4	Number of foci investigated and classified	None	Monthly	HP & HC

NCD prevention, Control, and Mental Health

Hypertension and Diabetes Screening Tally Sheet

Purpose: This tally sheet is standalone (i.e it is not attached with a register) and used to record the number of individuals screened for hypertension and diabetes mellitus disaggregated by sex and age (18-19, 20-29, 30-39,40-69 and .>=70yrs)

Where used and location in the facility: It is used at Health centers, hospitals, and clinics. It should be available at facility triage, OPD, EOPD, ART clinic, TB clinic, etc. It is also used at the health post

Format of instrument: Preprinted on standard A4 paper.

Who maintains: The service provider tally the data elements stated on the tally immediately after the service was provided or the latest on daily basis.

Data recording process on the register:

The patient form/card is the primary source for hypertension and diabetes mellitus screening related data elements and each of the screened clients have to be tallied using the standard format

Data compilation procedure

Reportable data elements

- Number of adults screened for hypertension by the result, sex and age disaggregation
- Number of individuals screened for diabetes mellitus disaggregated by the result, sex and age

These reportable data elements have to be summed up from hypertension and diabetes screening tally sheets placed at different service outlets in the facilities by the end of each reporting period using sex and age disaggregation (18-19, 20-29, 30-39,40-69 and .>=70yrs) as well as screening results. The Tally is kept at the designated service unit until the whole pad is utilized, and then moved to an archive maintained by HMIS in charge.

Frequency of reporting: These data elements are reported monthly.

Diabetes and Hypertension Treatment Register

Purpose: This register is a longitudinal register, which is used to register and follow up clients who are confirmed to have hypertension (HTN) or diabetes mellitus (DM) and are enrolled into care.

Where used/placed: At *NCD chronic care unit* of Health Center and all types of Hospitals

Format of instrument: Preprinted on standard A3 paper. The entry for a single patient spans one page.

Who maintains: Service provider completes the information required by the register as service is provided.

Data recording process:

The data relating to each client who received the services should be recorded based on the instruction attached at the inside part of the cover page of the registration using a single row.

Data element and compilation procedures:

Reportable data elements are:

Sr #	Data element	Disaggregation	Frequency of the report	Level of report
1	Number of confirmed hypertensive patient enrolled to care	Age, sex, Type of Rx. Timing of enrollment	Monthly	HC, Clinics, Hosp
2	Total number of cohort of hypertensive patients registered six months prior to the reporting period	None		
3	Treatment outcome of patient on hypertensive care at six month	Type of outcome		
4	Number of confirmed diabetic patient enrolled to care	Age, Sex; Type of DM Type of Rx		
5	Total number of cohort of diabetic patients registered six months prior to the reporting period	None		
6	Treatment outcome of patient on diabetic care at six month of care	Type of outcome		
7	Number of individuals in high CVD risk category	Risk category		

NB: Treatment outcome of diabetic care at six months: controlled, uncontrolled, loss to follow up, died, transfer out, and not evaluated

The reportable data elements are directly compiled from the register by the end of each reporting period (monthly).

Cervical cancer register

Purpose: is a serial register that is used to capture basic personal and service-related information of eligible women who received Cervical Cancer Screening and Treatment. It also helps to follow clients with suspicious cervical cancer treatment. Each row of the register is used for one client.

Where used/placed: The register is kept in a room where the service is provided by the Health Center, all types of Hospitals, and MCH clinics.

Format of instrument: Preprinted on standard A4 paper. The entry for a single patient spans one page.

Who maintains: Clinicians/Service providers working in the unit complete the data as a service is provided.

Data recording and compilation procedures:

All data elements recorded on the register are abstracted from the "Cervical Cancer Screening and Treatment Intake form". for detail on how to fill each column please refer to the register instruction.

Reportable data elements from the cervical cancer register

Sr #	Data element	Disaggregation	Frequency of the report	Level of report
1	Number of women age 30–49 years who have been screened for cervical cancer	Screening type: VIA, HPV, DNA	Monthly	HC, Clinic, Hosp
2	Number women aged 30 – 49 yr screened with HPV DNA for cervical cancer	Screening result		
3	Number women aged 30 – 49 yr screened with VIA for cervical cancer	Screening result		
4	Number of women aged 30-49 yr with precancerous cervical lesion received treatment	Rx type		
5	Number of women screened 1 year after treatment follow up	Screening result		

There is no standard tally sheet for this register. Therefore the reportable data elements are directly compiled from the register at the end of the reporting period.

Frequency of reporting: This data element should be reported monthly.

Mental Neurological & Substance Use Disorder Treatment Register

Purpose: This is a longitudinal register used to register and follow up clients who are confirmed to have mental, neurological, and substance use disorders and are enrolled into care.

Where used: All types of Hospitals, Health Center, and Specialty clinics. It is kept at the mental health unit or OPD

Format of instrument: Preprinted on standard A4 paper. The entry for a single patient spans two pages.

Who maintains: Mental health care provider completes the information required by the register as service is provided.

Data recording process on the register:

The data is abstracted from a patient form found in an integrated patient folder. for detail on how to fill each column please refer to the register instruction.

Data compilation procedures:

No reportable data elements are expected from this register. The facilities can track details of service provided and treatment outcomes of the patients and use it for internal monitoring purposes.

Reportable Data Element

There is no reportable data element from this register.

NTD prevention and Control

Trachomatous Trichiasis (TT) Surgery Register

Purpose: It is a serial register used to record data for patients whose Trachomatous Trichiasis corrective surgery is done.

Where used and location: *All* types of Hospitals and Health centers. It should be placed in a room where TT surgery is performed/optometry department/minor OR. If the TT surgery is performed at an outreach place, the register should be taken to the outreach site.

Format of instrument: Preprinted on standard A4 paper. The entry for a single patient spans one page.

Who maintains: Service provider completes the information required on the TT register as service provided.

Data recording process on the register:

All clients who received TT surgeries should be recorded in the TT surgery register. Please refer to the instruction in the register for details

Data compilation procedures:

Reportable data element

- Number of people with TT who received corrective TT surgery by age group (<15yrs and +15 yrs) and by sex (M/F). This data element counted and reported from the TT surgery register directly

Frequency of reporting: These data element are reported monthly.

Leishmaniasis Register:

Purpose: This register use is to capture data about basic personal and services related to leishmaniasis treatment and follow-up.

Where used and location: its use is limited at specific health facilities that provide leishmania treatment and follow-up.

Format of instrument: Preprinted on standard A3 paper. The entry for a single patient spans one page.

Who maintains: Service provider completes the information required by the register as service is provided.

Data recording process on the register: Each client who received Leishmaniasis treatment service should be recorded in the register using a single row on daily basis. Please refer to the instruction guide in the register for details

Data compilation procedures:

Reportable data elements

Sr #	Data element	Disaggregation	Frequency of the report	Level of report
1	Number of visceral leishmaniosis (VL) patients treated	Age, Sex, VL type, HIV status	Monthly	HC, Clinics, Hosp
2	Number of VL patients treated and Rx outcome	Rx outcome		
3	Number of cutaneous leishmaniasis (CL) treated	Age, Sex, CL type		
4	Number of VL patients treated and Rx outcome	Rx outcome		

NB: *Age (<5, 5-14 and 15+); VL type (primary, relapse, and post-Kala-Azar), and HIV status (Negative, Positive); treatment outcome: Cured, Defaulted, treatment failure, Death & Transfer out; Type of CL (primary and relapse);*

These reportable data elements with disaggregation are directly compiled from Leishmaniasis Register.

Medical Services

Central Register

Purpose:- Central register is a serial type and is used to record basic demographic, financing, and disability-related information about individual patients or clients who sought health services and visited the health facilities.

Where used and location:- Central register is used in health centers, clinics, and hospitals, and it is placed at the Medical Record Unit.

Format of instrument:- it is pre-printed on standard A4 paper and

Who maintains:- should be completed by MRU workers.

Data recording process: This register captures all individuals coming to the facility so that the total number of visits in the facility can easily be known and registered. For completing this register, please refer to the instruction sheet.

Data compilation and reporting procedure

Reportable data elements from the Central register

- Total number of Outpatient Visits disaggregated by age (<5, 5-10, 11-19, 20-29, 30-45, 45-65, & =>66 years) and sex (M/F)
- Total number of CBHI Members visit made to HF within a month (disaggregated by Indigent and paying)
- The actual number of fee waiver beneficiaries' in the health facility.
- Number of people with disabilities who visited health facility (from MRU)

Number of health insurance beneficiaries that visited HF in the reporting period. These reportable data elements are compiled from the central register and patient/client attendance tally sheet. The MRU workers complete the central register at the moment of the visit. The OPD visit disaggregated by age and sex are tallied and reported from the patient attendance tally sheet and other reportable data elements such as the number of CBHI members, fee waiver beneficiaries, and people with disabilities are counted on every page of the central register and the total sum of the month are reported. The register is kept at MRU until the whole parts are utilized, and then moved to an archive maintained by HMIS in charge.

Frequency of reporting: The data elements are reported monthly.

Patient/Client Attendance Tally Sheet

Purpose: it helps to compile OPD visit data disaggregated by age and sex from the central Register. The OPD visit data elements are tallied, added, and recorded on the count column in the tally sheet. The total sum of each data element is reported monthly.

Where used and location in the facility*:* It is used along with the central register in the MRU of all types of Health Facilities (HC/Clinics and Hospitals). It is also used in other service units like injection and dressing rooms, TB and ART

OPD Register

Purpose: OPD abstract register is a serial register. The register lists all patients who received outpatient services at the health facility. It is used for OPD visiting patients who are 5 years of age and older. Children under five years old are recorded in the IMNCI register where the service is provided (IMNCI unit).

Where used and location in the facility: Health Center/clinic/specialty clinic and All types of Hospitals. The register is kept in the OPD units of the facility.

Format of instrument: Preprinted on standard A4 paper.

Who maintains: Information for the register is abstracted from the patient form. The patient form and register are both completed by the service provider at the time of OPD service.

Data recording process on the register:

Each client who visited the OPD unit should be recorded in the register using a single row and tallied immediately using the NCoD (ESV-ICD 11) tally sheet. For detailed information please refer to the instruction page.

NB. In the diagnosis section, the clients are e record as

- New if the client visits for the new episode of illness
- Repeat if the client visits as a follow-up for the previous episode of illness

Data compilation procedures:

Reportable data elements

SN	Reportable data element	Disaggregation	Frequency	Level of reporting
1	ESV-ICD11/NCoD	Disease type by age & sex	Monthly	HP, HC, Clinic, Hospital
2	PITC	age, sex, HIV result, pop. category		
3	Road traffic accident	Category (pedestrian, motorcycle, Vehicle occupant		
4	Number of deaths at OPD within 24 hours	age, sex,		
5	Malaria Cases with travel history	none		

The number of road traffic accidents, malaria with travel history, and the number of deaths at OPD within 24 hours are counted on every page of the register and the total sum in the month is counted and reported.

NCoD /ESV-ICD 11 tally sheet

Purpose: This tally sheet is used to simplify reporting of morbidity and mortality data disaggregated by age, sex, and settings (OPD/IPD). The tally sheet is completed from OPD, IMNCI, IPD, Emergency and ICU/NICU registers. The age disaggregation is as follows: <1 year, 1-4 years, 5-14 years, 15-29 years, 30-64 years, and >=65 years. The total tallied events for each age and sex group are summed up and put in the "count" column. After registering each client on the register, the provider records the disease data on the NCoD /ESV-ICD 11disease tally sheet.

Where used and location in the facility: used in Health Centers, all types of Hospitals, and private clinics or centers. It should be kept in the outpatient and inpatient departments of the facility.

Reportable Data element

- All disease morbidity reports: disaggregated by age and sex
- Number of deaths/mortalities from specific disease: disaggregated by age and sex

IPD Register:

Purpose: Inpatient admission/discharge register is a serial register that lists all patients who received inpatient services at the health facility.

Where used and location in the facility: Health Center/clinic/specialty clinic and All types of Hospitals. This register is kept in all inpatient wards such as pediatric, medical, etc.

Format of instrument: Preprinted on standard A4 paper.

Who maintains: Information for the register is abstracted from the patient form. The patient form and register are both completed by the service provider in the inpatient wards.

Data recording process on the register: Each client who is admitted in IPD should be recorded in the register using a single row, and tallied immediately using IPD and NCoD/ESV-ICD 11 tally sheet.

Data compilation procedures: Reportable data elements are compiled from the register and IPD tally sheet.

Reportable data elements

SN	Reportable data element	Disaggregation	Frequency	Level of reporting
1	ESV-ICD11	Disease, age & sex	Monthly	HC, Clinic, Hosp
2	# of admission	None		
3	# of Discharge	None		
4	Length of Stay (in days)	None		
5	Inpatient Death	Within 24 hours or after 24 hours		
6	PITC	Age, sex, HIV result, Pop. category		
7	Death notifications given	None		
8	Number of beds in the reporting period	Nine		
9	Number road traffic injury cases	Accident type		

These reportable data elements are compiled from the inpatient tally sheet and register (HIV, TB, and road traffic accident data). The care providers record and tally immediately after service is provided and/or cases or events occurred. The data elements are counted up and compiled at the end of the reporting period. The Tally is kept with the register at the IPD room until the whole pad is utilized, and then moved to an archive maintained by HMIS in charge.

Exception: Total death in the facility is collected from different registers that include:

- Inpatient Register (excluding ICU deaths)
- Emergency Register (Emergency death)
- ICU Register (ICU death)
- OPD Register (OPD death)
- NICU (NICU death)
- Delivery Register (maternal death in the facility)

This reportable data element is compiled from the above-mentioned registers (IPD, OPD, ICU, Emergency, NICU, and Delivery). Except for the IPD register, all the rest does not have a tally sheet. Hence, the number of deaths from the departments will be counted up at the bottom of each page on the registers and compiled at the end of the month.

The total death in the facility is, therefore, the sum of deaths from mentioned registers for that specific period

Total death in the facility = Inpatient Death + Emergency Death + ICU death + OPD death + NICU death + Maternal death in the facility

Frequency of reporting: These data elements are reported monthly.

Intensive care unit (ICU) register

Purpose*:* The Register is a serial register and the main purpose is to record information about the Intensive Care Unit (ICU) services that include Diagnosis at admission, HIV test status, Intensive Mechanical ventilation, discharge information, death information (if occurred), and others.

Where used and location*:* It is used in all types of Hospitals where there is an ICU.

Format of instrument*:* Preprinted on standard A3 paper. The entry for a single client spans a single page.

Who maintains*:* Service provider completes the register as the service is provided.

Data recording process on the register:

Each client who is admitted to the ICU and all the services given should be recorded in the ICU register using a single row and tallied immediately using the ICU Tally sheet. Though there is a box in the ICU register to record the sum of the count at the bottom of each page, the tally sheet remains to be the main source for the reporting purpose to avoid counting errors. The number of clients tested for HIV and tested positive is counted from the register. The ICU register instruction has a detailed description of each column.

Data compilation procedures:

Reportable data elements

SN	Reportable Data element	Disaggregation	Frequency of report	Level of reporting	Talley Sheet
1	Total Death in ICU	Type	Monthly	HSP	IPD Tally
2	Total discharge from ICU	None			
3	Number of death	with or without MV, with 24hrs, beyond 24 hrs			
4	Total length of stay in the ICU (in days)	None			
5	Number of clients with mechanical ventilation	None			
6	Number of death notifications given	none			
7	Number of VAP cases	none			
8	Number of clients tested for HIV	HIV test result			

These reportable data elements are compiled from the ICU tally sheet and the ICU register (HIV data only). The data elements are counted up and compiled at the end of the reporting period. The Tally sheet is kept with a register in the ICU room until the whole pad is utilized, and then moved to an archive maintained by HMIS in charge.

ICU Tally

Purpose: it helps to record reportable data elements that are required for ICU services and for cases/events that occurred in the ICU as mentioned under the ICU Register. All reportable data elements are tallied, added, and recorded on the count column in the tally sheet. The total sum of each data element is reported. The number of clients tested for HIV and clients who tested positive are not included in the tally sheet and are counted and reported from the register.

Where used and location in the facility: It is used in all types of Hospitals where there is an ICU service.

Operation Room (OR) register

Purpose: The Register is a serial register and the main purpose is to record data from patients who have had an operation (major or minor surgery) in the facility.

Where used and location: It is used in all types of Hospitals and Health Centers which have surgery services. The register should be placed in Operation Theaters (both in minor and major OR rooms). It should be completed by service providers in the department.

Format of instrument: Preprinted on standard A4 paper. The entry for a single client spans a single page.

Who maintains: Service provider completes the register as the service is provided.

Data recording process on the register:

Each client and all the services given in the OR should be recorded in the OR register using a single row. The OR register should have a box at the bottom of each page to record the sum of the count of reportable data elements. The OR register instruction has a detailed description of each column.

Data compilation procedures:

Reportable data elements

- Number of Cataract surgeries performed (the report is the sum total of cataract surgeries listed under column 8)
- Number of Peri-operative deaths disaggregated by type of surgery (number of peri-operative deaths from Elective Surgeries and Emergency Surgeries)

These reportable data elements are compiled from the OR register. The provider should register immediately after service is provided and/or cases or events occurred. The data elements are counted on every page of the register and the total sum in the month is counted and reported. The register is kept until the whole pad is utilized, and then moved to an archive maintained by HMIS in charge.

Frequency of reporting: These data elements are reported monthly.

Surgery Ward register

Purpose: The Register is a serial register and its main purpose is to record and register data required from the surgical ward which include information about admission, post operation, PICT, TB Screening, discharge, and others

Where used and location: It is used in all types of Hospitals and Health Centers which have surgery services. The register should be placed in the surgical ward and should be completed by service providers in the ward.

Format of instrument: Preprinted on standard A4 paper. The entry for a single client spans a single page.

Who maintains: Service provider completes the data required on the register as the service is provided.

Data recording process on the register:

Each client and all the services given in the surgical ward should be recorded in the surgery register using a single row. The surgery register has count boxes at the bottom of the register, which helps to record the sum of the count of reportable data elements. The surgery register instruction has a detailed description of each column.

Data compilation procedures:

Reportable data elements

S.N	Reportable Data element	Disaggregation	Frequency of report	Level of reporting
1	Number of the pre-operative length of stay	Surgery type	Monthly	HC/Hospital
2	Number of major surgeries	Surgery type		
3	Number of days delayed for elective surgical admission	None		
4	Number of patients who were admitted for elective surgery	None		
5	Number of deaths notified (death notification paper provided)	None		

NB: Surgery Type: Elective, Emergency

These reportable data elements are compiled from the surgery register. The data elements are counted on every page of the register and the total sum of the month is reported. The register is kept until the whole pages are utilized, and then moved to an archive maintained by HMIS in charge.

Emergency register

Purpose: The Register is a serial register and its main purpose is to record data from patients who visited the emergency department in the facility. It captures data on mode of arrival, patient handover, source of referral, diagnosis on arrival. visit status, types of accident (if any), HIV testing, Diagnosis at disposition from ED, Disposition time, length of stay, and outcome at disposition. ,

Where used and location: It is used in Health Centers, Clinics, and all types of Hospitals. The register should be placed in the emergency department and it should be completed by service providers in the department whenever the service is given.

Format of instrument: Preprinted on standard A4 paper. The entry for a single client spans a single page.

Who maintains: Service provider completes the data required on the register as the service is provided.

Data recording process on the register:

Each client and all the services given in the emergency unit should be recorded in the emergency register using a single row. The emergency register has count boxes at the bottom of the register, which helps to record the sum of the count of reportable data elements. The emergency register instruction has a detailed description of each column.

Data compilation procedures:

Reportable data elements

S.N	Reportable Data element	Disaggregation	Frequency of report	Level of reporting
1	Total death in the emergency unit	Age (<15yrs, ≥15yrs), Sex Within 24hrs & ≥24 hours	Monthly	HC/Hospital
2	Number of emergency unit attendance	Stayed for < 24hrs & ≥24 hours		
3	Number of emergency cases referred	Pre, between facilities		
4	Number of deaths notified	None		
5	Number of road traffic injury cases	Accident type		

NB: Accident types: Vehicle occupant, motorcyclist, pedestrian, and other

These reportable data elements are compiled from the emergency register. The data elements are counted on every page of the register and the total sum in the month is counted and reported. The register is kept at the Emergency Room until the whole pages of the register are utilized, and then moved to an archive maintained by HMIS in charge.

Assistive technology registration rehabilitative center register

Purpose: it is the serial type of register and it is used to record clients who receive assistive technology in rehabilitation medical service for restoring and compensating for the loss of body functioning and preventing or slowing deterioration in functioning in every area of a person's life.

Where used and location: at the rehabilitation center in specialty centers (hospital) and it is kept at the service provision room in the rehabilitation center.

Format of instrument:- it is pre-printed on standard A4 paper and the entry for a single client spans a single page.

Who maintains:- the service provider at the rehabilitation center completes the register.

Data recording process on the register:

The client who receives the service should be recorded in the single row of the AT register and tallied immediately to the service provision. Please refer to the instruction sheet for detail information.

Data compilation procedure:

Reportable data elements:

- Number of clients registered for AT service disaggregated by age (<15 and >=15 years), sex, and disability type (physical impairment, mobility impairment, hearing impairment, visual impairment, and others).
- Number of clients receiving AT service disaggregated by age, sex, and disability type:

The reportable data elements are compiled from the AT register. The care provider records the data immediately after service is provided. The data elements are counted on every page of the register on the box provided and the total sum in the months is reported accordingly. The Tally sheet is kept with a register until the whole pad is utilized, and then moved to an archive and maintained by HMIS in charge.

Frequency of reporting:-These data elements are reported quarterly.

Assistive technology Tally sheet

Purpose: it helps to compile reportable data elements that are required for Assistive technology services as mentioned under the Assistive technology Register.

Where used and location in the facility*:* in the rehabilitation center and kept in the service provision room.

Liaison Referral in and out register

Purpose:-it is a serial type of register and it is used to document patients who are referred to other facilities for better medical care or follow-up care. The referral out can be to higher health facilities (for better care) or to lower health facilities for continuity of care. It is also used to document referred patients from other health facilities or from the community.

Where used:- at hospital and health center, and it is kept at Liaison department for Hospital and Outpatient Department for HC.

Format of instruction:- it is pre-printed on standard A4 paper and the entry for a single client spans on a single page.

Who maintains:- The service provider completes the information required by the register as service is provided.

Recording Procedure on this register

The client who transferred in and transferred out should be recorded in the single row of the register. For completing the registration please refer to the instruction sheet.

Data compilation and reporting procedure

Reportable data elements

S.N	Reportable Data element	Disaggregation	Frequency of report	Level of reporting
1	Number of people referred-in	Referral Type	Monthly	HC/Hospital
2	Number of people referred-out	Referral Type		
3	Number of people referred in	None		
4	Number of people that came to facility using ambulance	None		

NB: Types of referral: Emergency, None-emergency

Data compilation:- The register is the main source for compilation.

Count the total number of referral in and referral out; write the counted number of referrals in the box provided on the bottom page of the register (columns 10 and 11). Count the case referred with the ambulance and put the counted number in the provided box on the bottom of the register (column 17). After compiling the data in the register, write the total number of the data in the reporting format at the end of the reporting month.

Surgical Waiting List Register

Purpose: - Surgical waiting list register is used to record information about the number of clients on the waiting list for elective surgery.

Where used and location*:* the register is used at the hospital and kept in the hospital liaison office

Format of instrument: this register is preprinted on standard A4 paper. This specific type of register is a serial type of register.

Who maintains*:* the liaison officer is responsible for completing the information required by the register as service is provided.

Data recording process on the register

To fill the register please refer to the instruction sheet of the register.

Data compilation procedure:

Reportable data elements from the Surgical Waiting list register

- Number of patients who were admitted for elective (non-emergency) surgery
- Number clients on the waiting list for elective surgery disaggregated by Category (General surgery, Urology, Neurology, Orthopedics, Plastic, Ophthalmology, Gynecology, Pediatrics, and others)
- Delay for elective surgical admission (length of stay in number of days)

Note: since the register has no tally sheet, count the total sum of days the client waited for elective surgery from the register on column 15.

How to count:

The total number of days and number of patients who were admitted for elective surgery need to be counted and reported from the register at the end of each month while the last data element (client waiting list by category) is reported on a quarterly basis.

Note: - considering the reporting period, the level of reporting is from the hospital -woreda-zone-region-MOH.

Ambulance Call and Dispatch Service Register

purpose: - The ambulance call and dispatch service register is used to record information about calls for emergency ambulance service requests and the type of ambulance service provided.

Where used and location*:* this register is used in woreda health offices, hospitals, and in some areas at health centers and placed in the ambulance dispatch center.

Format of instrument*:* this is preprinted on standard A4 paper and this specific type of register is a serial type of register.

Who maintains*:* the call handler is responsible for completing the information required by the register as service is provided.

Data recording process on the register:

To fill this section please refer to the instruction sheet in the register provided

Data compilation procedure:

Reportable data elements from ambulance call and dispatch service register

- Total number of Ambulance dispatched in the reporting period - by the technician
- Total number of Ambulance requests get a response by type of case
- Total number of ambulance requests made during the reporting period

Note: Since there is no tally-sheet available for the ambulance service register, data compilation is by counting the total call, the cases for which ambulance was dispatched, and the professionals accompanying the ambulance dispatch as reportable data elements from the bottom of the register. The data elements should be reported monthly and the level of reporting is starting from the Woreda Health Office.

Health System related registers

Drug Dispensing Register

Purpose: Dispensing register is a serial register used to capture data elements for drug despising at dispensary units.

Where used and location: Health Center, clinics, and all types of Hospitals, and it is kept at the dispensing unit/pharmacy department.

Format of instrument: Preprinted on standard A4 paper

Who maintains: dispenser/pharmacist can dispense the medication.

Data recording process on the register:

The dispensary register should capture lists of all clients who are prescribed drugs at the facility. Please refer to the instructions in the register for details.

Data compilation procedures:

Reportable data elements

S.N	Reportable Data element	Disag	Frequency of report	Level of reporting
1	Total number of encounters with one or more antibiotics	None	Monthly	HC/Hospital
2	Total number of encounters			
3	Number of clients who received 100% of prescribed drugs			
4	Total number of clients who received prescriptions			
5	Number of medicine prescribed from facility-specific medicine list (FSML)			
6	Total number of medicine prescribed			

The reportable data elements are counted on every page of the drug dispensing register and the total sums in the month are counted and reported monthly.

Tracer drug availability Tally sheet:

Purpose: is used to follow the availability of tracer drugs on each day of the month. Each tracer drug is tallied against the days of the month based on its availability on that specific day.

Where used and location in the facility: Health Center, all types of Hospitals specific to Pharmacy unit/ department.

Reportable data element

Tracer drug availability: this data element is counted and reported from the drug availability tally sheet.

Frequency of reporting: The data elements are reported monthly.

Gender-Based Violence (GBV)

Purpose: Gender-Based Violence GBV register is a serial register used to capture a list of clients who get GBV related services. It is used to record data on demographic information, types of violence, examination and investigations conducted, and results.

Where used and location: Health Center, clinics, and all types of Hospitals, and it is kept in one-stop service areas and Maternal department

Format of instrument: Preprinted on standard A4 paper

Who maintains: Service provider completes the information required on the GBV register as service provided.

Data recording process on the register:

Each client who received GBV service should be recorded in the GBV register after the service is provided. Please refer to the instruction in the register for details

Reportable Data elements are:

- Number of GBV survivors disaggregated by Sex (M/F) and type of violence (Physical, sexual, Psychological, both physical & sexual violence)

The reportable data is counted on every page of the register and then the total sum in the month is counted and reported.

Frequency of reporting: These data elements are reported monthly.

Birth and Death Notification Forms

The information generated from Civil Registration and Vital Statistics is of critical importance for policy and planning in many sectors and is of particular importance to the health sector. The health sector is expected to notify births and deaths. Birth and death notification forms are used to notify births and deaths that occurred at health facilities respectively.

Where used and location:

Format of instrument: Preprinted on standard A4 paper with two copies

Who maintains: Service provider completes the information required and gives the first copy to the client.

Data recording process on the register:

The health care providers should notify (give the notification form to the clients) all births and deaths that occurred at the health facility, and record them in the delivery register (births) and OPD/IPD/Emergency/ Delivery/PNC registers (deaths) based on where the death happened.

Death notification form should be filled with all the causes of death in three levels (immediate, intermediate, and underlying) including other conditions that contributed to death based on ESV-ICD 11. If the case is maternal or neonatal death, other additional variables need to be recorded on the death notification form. When recording the causes of death, immediate causes of death need to be recorded first, followed by intermediate and underlying causes of death respectively. Please refer to the instructions in the respective registers for details.

Data compilation procedures:

- Number of births notified
- Number of deaths notified

Frequency of reporting: These data elements are reported monthly.

CHAPTER 4

Reporting tools and Procedures

CHAPTER 4: REPORTING TOOLS AND PROCEDURES

The Ethiopian HMIS is designed in a way that can capture data from all health institutions (health facilities and administrative health units) in the country, including MOH, NGO, private for-profit, and other governmental organizations. The HMIS report includes data elements regarding the services they provide, the disease cases they treat, mortality data, and administrative data such as human resources, finance, and logistics. Data from facilities are aggregated and reviewed on a monthly and/quarterly basis and are transmitted through an integrated channel to assure standardization, consistency, and quality control.

Reporting channel and period

HMIS reports of health institutions are transmitted through an integrated and one channel. An HMIS unit of health institutions is responsible for the overall management of HMIS data. Routinely collected data are collected from service units/departments and are compiled by Health Information System professionals working in HMIS units. Reporting to the next level follows the health system's hierarchy. Health posts submit their report to their cluster health center, which then compiles data from the health center and satellite health posts to send to Woreda Health Office. Woreda Health Offices compiles routine reports from the health centers and from the WoHOs and sends it to the ZHDs. Zonal Health Departments then send their report to the RHB and then to the MOH. For regions that have no functional WoHOs, health facilities send their report to ZHDs (Example: Addis Ababa city Administration). For regions that have no functional ZHDs, the WoHOs send their report to the RHB. A monthly report comprises data collected from the 21st of the previous month up to the 20th of the reporting period. Example: For Tikimt 2014 EC monthly report, the data should be collected from Meskerem 21 up to Tikimt 20, 2014 EC. The reporting channel and period of public, private health facilities, and administrative health units follow the prescribed schedule, as depicted in the table below.

Table 1: Reporting level and reporting period of public health facilities

S.No.	Type of Health care facility	Reporting level	The latest date that report should be submitted
1	Health posts	Cluster health center	24th of the month
2	Health Centers	Sub-city/woreda/town health offices	26th of the month
3	Primary Hospital	Zone/sub-city/woreda	26th of the month
4	General Hospital	Region/sub-city/Zone	26th of the month
5	Specialized Hospital	MoH	26th of the month

Table 2: Reporting level and time of private health facilities

S.No.	Type of Health care facility	Reporting level	The latest date that the report should be submitted
1	Primary clinic	Sub-city/woreda/town health offices	26th of the month
2	Medium clinic	Sub-city/woreda/town health offices	26th of the month
3	Specialty Clinic	Sub-city/ woreda/ town health offices	26th of the month
4	Speciality Center	Woreda/Region	26th of the month
5	Primary Hospital	Region/Sub-city	26th of the month
6	General Hospital	Region /Zone/Subcity	26th of the month
8	Specialized Hospital	RHB	26th of the month

Table 3: Reporting level and time of all health institutions

S.No	Type of Health care facility	Reporting level	The latest date report should be submitted
1	Health facilities	Sub-city/woreda/town health offices	26th of the month
2	Woreda Health Offices	Zonal Health Departments (Sub-cities)	2nd of the next month
3	ZHDs/Sub-cities	Regional Health Bureaus	5thof the next month
4	Regional Health Bureaus	FMOH	5thof the next month

HMIS Report types

The HMIS is designed to generate different types of reports that can capture important data elements to monitor and evaluate health programs.

Types of reports by period:

- Monthly reports
- Quarterly reports
- Annual reports
- Immediately/Weekly reports

Quarters for HMIS reporting

- Quarter 1:Sene 21 – Meskerem 20
- Quarter 2:Meskerem 21 – Tahsas 20
- Quarter 3:Tahsas 21 – Megabit 20
- Quarter 4: Megabit 21 – Sene 20

Types of reports by content

- OPD morbidity report
- IPD morbidity and mortality report
- Service reports
- PHEM reports

Each health facility is expected to submit service and disease reports on a monthly basis. In addition, diseases that are under surveillance should be reported on a weekly basis or immediately based on the types of reportable diseases seen in the facility.

Report Compilation Procedures

Health centers, clinics, and hospitals

- The report includes data on the services they provide, the disease cases they see, and administrative data such as human resources, finances, and logistics.
- Data are collected by health workers in each service unit or supporting department.
- Aggregate and review their data monthly or quarterly
- Data is transmitted through an integrated channel to assure standardization, consistency, and quality control.
- Report to their respective administrative office monthly, quarterly, and annually (Woreda, Zone, or Regional Health Bureau).
- They may also report to the local government or other partners.

Administrative health offices:

The administrative health offices (Woreda Health offices, Zonal health departments, and Regional Health Bureaus) aggregate the data they received from health facilities, adds their own data, monitors their own performance based on these reported data elements, and reports to the next level.

REFERENCE

1. MOH, (2014): Individual Medical Records, Addis Ababa
2. MOH, (2021): HMIS Indicators Reference Guide, Addis Ababa
3. MOH, (2021): Health Information System Strategic Plan (2020/21-2024/25), Addis Ababa

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