Module 9
Part 1 - Antenatal Care

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**Antenatal Care**

### 9.1 WHAT ARE THE TOOLS USED FOR DATA COLLECTION?

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

**Primary Tools**

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

**Secondary Tools**

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

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**Data collection and monitoring tools**

<table>
<thead>
<tr>
<th>Antenatal Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Tools</strong></td>
</tr>
<tr>
<td>1. Antenatal Care Register</td>
</tr>
<tr>
<td>2. Antenatal Care Tally Sheet</td>
</tr>
<tr>
<td>3. Reproductive Health Report</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Secondary Tools</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Antenatal Card</td>
</tr>
<tr>
<td>2. Tetanus Toxoid Card</td>
</tr>
</tbody>
</table>
9.2 WHO IS RESPONSIBLE FOR COLLECTING THE DATA?

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

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

9.3 WHAT DATA SHOULD BE COLLECTED AND HOW?

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

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

9.3.1. Antenatal Register

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

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

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

> **Risk Factors**

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

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

> **Service delivery**

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

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

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

> **Pregnancy Outcome**

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

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

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

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

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

An Illustrated Guide to the Antenatal Register and Antenatal Tally Sheet, and an explanation of the information that should be recorded in each, is shown at the end of the module.
9.4 HOW AND WHEN SHOULD THE DATA BE REPORTED?

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

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

9.4.1 Weekly Report

The clinic supervisor is responsible for ensuring complete and timely submission of the Weekly Reproductive Health Report from each section. The number of new antenatal visits, before and after the first trimester, should be reported in the corresponding table in the weekly form using the Antenatal Register. The remaining information in the table, relating to RPR screening, detection of high-risk pregnancy and abortion complications, should be reported using the front page of Antenatal Tally Sheet. The reverse of the Antenatal Tally Sheet should be used to complete the section concerning coverage of antenatal services as reported at the time of delivery. All entries should be appropriately disaggregated by age (<18, ≥18) and status (refugee and national).
If there is more than one antenatal clinic in the camp, the information from each unit should be combined to create one weekly report for the entire camp. Photocopies of the weekly form may be required to assist units compile their individual reports prior to aggregation into the camp totals.

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

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

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

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

### Antenatal Care

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

* Disaggregated by antigen, as specified in national schedule
### Illustrated Guide to Antenatal Register

#### A Registration:

- **Serial No.:** Enter sequence number in register
- **Antenatal No.:** Enter unique identifying number
- **Name:** Print name of expectant mother
- **Age:** Enter age (in years)
- **Status:** Classify as Refugee (Ref) / National (Nat)
- **Address:** Print Camp Address (Refugee) / Nearest Village (National)
- **Date of visit:** Enter date (dd/mm/yy)
- **Marital Status:** Classify as Married / Single / Widowed / Separated

#### B Obstetric History:

- **Gravidity:** Number of pregnancy
- **Parity:** Number of previous deliveries
- **No. of children:** Number of surviving children
- **LMP:** Date of Last Menstrual Period (dd/mm/yy)
- **EDD:** Expected Delivery Date (dd/mm/yy)
- **Gest. Age:** Gestational Age in weeks (XX / 36)
- **Stillbirth:** Number of stillbirths (see glossary)
- **Abortion:** Number of abortions (see glossary)
- **Caesarian Section:** Number of caesarian sections
- **Last born:**
  1. Birth date
  2. Alive / Dead:
**RISK FACTORS AND SERVICES:**

**Risk Factors and Services:**

For each antenatal visit:

1. **Date:**
   - >Enter date (dd/mm/yyyy)

2. **Gest age:**
   - > Enter gestational age

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

4. **ANC RF:**
   - Enter antenatal risk factor abbreviation from list (to be adapted):
     - X = No risk factor
     - A = Anaemia
     - O = Oedema
     - P = Proteinuria
     - H = High BP (above 140/90)
     - U = Not gaining weight
     - APH = Antepartum Haem.
     - M = Abnormal Lie (after 32 weeks)
     - Ot = Other

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

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

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

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

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

**PREGNANCY OUTCOME:**

**Compl/Un-Compl.:**
- > Enter delivery complication abbreviation from list (as indicated):
  - X = No complication
  - PPH = Postpartum Haem.
  - E = Eclampsia
  - PS = Puerperal Sepsis
  - OL = Obstructed Labour
  - B = Breech
  - T = Third Degree Tear
  - Ot = Other

**Delivery:**
- > Enter date of delivery (dd/mm/yyyy)
## Health Information System

**Daily Reporting Form**

### 9.1 Antenatal Tally Sheet

<table>
<thead>
<tr>
<th>Organisation:</th>
<th>Location:</th>
<th>Reporting period:</th>
</tr>
</thead>
</table>

#### Part B: Technical Sections

<table>
<thead>
<tr>
<th>Category</th>
<th>Refugee &lt; 18</th>
<th>Refugee ≥ 18</th>
<th>National &lt; 18</th>
<th>National ≥ 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of first antenatal visits &lt; 1st trimester</td>
<td>0000 0000 0000 0000</td>
<td>0000 0000 0000 0000</td>
<td>0000 0000 0000 0000</td>
<td>0000 0000 0000 0000</td>
</tr>
<tr>
<td>Number of first antenatal visits &gt; 1st trimester</td>
<td>0000 0000 0000 0000</td>
<td>0000 0000 0000 0000</td>
<td>0000 0000 0000 0000</td>
<td>0000 0000 0000 0000</td>
</tr>
<tr>
<td>Number of repeat antenatal visits</td>
<td>0000 0000 0000 0000</td>
<td>0000 0000 0000 0000</td>
<td>0000 0000 0000 0000</td>
<td>0000 0000 0000 0000</td>
</tr>
<tr>
<td>Number of syphilis tests conducted</td>
<td>0000 0000 0000 0000</td>
<td>0000 0000 0000 0000</td>
<td>0000 0000 0000 0000</td>
<td>0000 0000 0000 0000</td>
</tr>
<tr>
<td>Number of syphilis tests positive</td>
<td>0000 0000 0000 0000</td>
<td>0000 0000 0000 0000</td>
<td>0000 0000 0000 0000</td>
<td>0000 0000 0000 0000</td>
</tr>
<tr>
<td>Number of syphilis positive contacts treated</td>
<td>0000 0000 0000 0000</td>
<td>0000 0000 0000 0000</td>
<td>0000 0000 0000 0000</td>
<td>0000 0000 0000 0000</td>
</tr>
<tr>
<td>Number of high-risk pregnancies detected</td>
<td>0000 0000 0000 0000</td>
<td>0000 0000 0000 0000</td>
<td>0000 0000 0000 0000</td>
<td>0000 0000 0000 0000</td>
</tr>
<tr>
<td>Number of abortions</td>
<td>0000 0000 0000 0000</td>
<td>0000 0000 0000 0000</td>
<td>0000 0000 0000 0000</td>
<td>0000 0000 0000 0000</td>
</tr>
</tbody>
</table>
A  HEADER:

Organisation:
Print name of health partner

Location:
Print name of Camp and Reporting Unit

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

NOTES
It is the responsibility of a designated ANC staff member to ensure each tally sheet is maintained correctly. A new sheet should be used if any one of the tally sections is filled. No single tally sheet should be used for more than one reporting week.

B  SERVICE PROVISION:

Strike a tally corresponding to:

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

> Status (Refugee / National);

> Age (< 18, ≥ 18; for refugees only)

C  NUMBER BOXES:

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

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

NOTES
It is the responsibility of the designated ANC staff member responsible for the form to convert tallies to numbers PRIOR to submission at the end of the week.
The clinic supervisor should check a random sample of 10 - 20 tally conversions for accuracy at the end of each week.
For each pregnancy outcome entered in the Antenatal Register, review the antenatal history and tally below if standards of care have been met.

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

### Number of pregnant women at time of delivery who:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Refugee &lt; 18</th>
<th>Refugee ≥ 18</th>
<th>National &lt; 18</th>
<th>National ≥ 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received 4 or more antenatal visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Received 2 doses of tetanus toxoid vaccine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Received at least 2 doses of fansidar</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were screened for syphilis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Received 1 dose of mebendazole</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Received 1 insecticide treated net (ITN)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Refugee D E Part Two: Technical Sections
**SERVICE COVERAGE:**

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

- **Standard of care during antenatal period***:
  - At least 4 antenatal visits
  - 2 doses of TT vaccine
  - 2 doses of malaria prophylaxis
  - 1 dose of deworming
  - 1 insecticide treated net

- **Age (< 18, ≥ 18; for refugees only)**

* should be adapted to Ministry of Health guidelines

**NOTES**

Coverage of antenatal care services are recorded among refugees only.

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

**NUMBER BOXES:**

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

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

**NOTES**

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

The clinic supervisor should check a random sample of 10 - 20 tally conversions for accuracy at the end of each week.
Module 9
Part 2 - Delivery Care

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ILLUSTRATED GUIDES

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> Illustrated Guide to Reproductive Health Report .................................... 46
9.6 WHAT ARE THE TOOLS USED FOR DATA COLLECTION?
The data collection tools used in delivery care are shown below. They are classified as follows:

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

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

> Data collection and monitoring tools

<table>
<thead>
<tr>
<th>Delivery Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Tools</strong></td>
</tr>
<tr>
<td>1. Delivery Register</td>
</tr>
<tr>
<td>2. IPD (Pregnancy) Register</td>
</tr>
<tr>
<td>3. IPD Register</td>
</tr>
<tr>
<td>4. Reproductive Health Report</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Partograph</td>
</tr>
<tr>
<td>2. Apgar Scoring Chart</td>
</tr>
<tr>
<td>3. Antenatal Card</td>
</tr>
<tr>
<td>4. Ward Book and Clinical Notes</td>
</tr>
</tbody>
</table>
9.7 WHO IS RESPONSIBLE FOR COLLECTING THE DATA?

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

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

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

9.8 WHAT DATA SHOULD BE COLLECTED AND HOW?

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

9.8.1 Delivery Register

The comprehensive reporting of births has two important purposes:

1. Population Data:

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

2. Birth Certification:

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

Careful attention should be made to ensure that double-reporting of births does not occur. This is particularly the case for referrals between camps for advanced care and management of delivery complications. Irrespective of the delivery location, every birth should be reported within the weekly statistics in the mother’s camp of origin.
> Registration
At registration, basic identifying information, an obstetric history and vital maternal and fetal signs should be recorded. The same antenatal number should be used as was issued as in the Antenatal Register and on the Antenatal Card.

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

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

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

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

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

> Newborn Status
Newborn sex and condition should be assessed immediately after delivery and indicated in the register with a written remark and the Apgar Score. The Apgar Score (a number between 1 and 10) is designed to quickly evaluate a newborn’s physical condition after delivery and to determine
any immediate need for extra medical care. It should be determined by delivery room staff at one and five minutes of age. The Apgar criteria and scoring chart should be clearly visible on the wall of every delivery room (see Secondary Tools: Apgar Score). Only the five-minute score should be entered into the register.

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

9.8.2 IPD Registers

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

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

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

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

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

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

Notes

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

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

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

9.9.1  Weekly Report

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

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

9.9.2  Monthly Report

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

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

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

> Indicator Summary

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

#### A  BASIC INFORMATION:

- **Serial No.:**
  - Enter sequence number in register
- **Antenatal No:**
  - Enter unique identifying number
- **Name:**
  - Print name of expectant mother
- **Age:**
  - Fill age (in years)
- **Status:**
  - Classify as Refugee (Ref) / National (Nat)
- **Address:**
  - Print Camp Address (Refugee) / Nearest Village (National)
- **Date of admission:**
  - Enter date (dd/mm/yy)
- **Time of admission:**
  - Enter time (hh:mm)

#### B  OBSTETRIC HISTORY:

- **Gravidity:**
  - Number of pregnancy (see glossary)
- **Parity:**
  - Number of previous deliveries (see glossary)
- **No. of children:**
  - Number of surviving children
- **LMP:**
  - Date of Last Menstrual Period (dd/mm/yy)
- **EDD:**
  - Expected Delivery Date (dd/mm/yy)
- **Gest. Age:**
  - Gestational Age in weeks (XX / 36)
- **Blood Pressure:**
  - Enter Blood pressure of mother (mmHg)
- **Fetal HR:**
  - Enter Fetal heart rate (beats per minute)
- **Presentation:**
  - Classify as Cephalic / Breech / Oblique / Transverse
- **RPR:**
  - Enter date of test in column that corresponds with result (-ve / +ve).

#### NOTES

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

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

<table>
<thead>
<tr>
<th>Date of delivery</th>
<th>Time of delivery</th>
<th>Mode of delivery</th>
<th>Location</th>
<th>Att’d by skilled hlth worker</th>
<th>Normal Delivery</th>
<th>Delivery compl.</th>
<th>Stillbirth</th>
<th>Was referral needed?</th>
<th>Sex (M / F)</th>
<th>Apgar Score</th>
<th>Condition</th>
<th>Birth Weight</th>
<th>Vitamin A</th>
<th>Name of newborn</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NEWBORN CONDITION:**

- **Newborn sex:**
  - Enter Male (M) / Female (F)

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

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

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

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

- **Name:**
  - Print name of person who conducted delivery (or for deliveries outside maternity unit, name of person who updated information)
Module 9
Part 3 - Postnatal Care

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9.12  Who is responsible for collecting the data? .............................................. 28
9.13  What data should be collected and how? .............................................. 28
9.14  How and when should the data be reported? ......................................... 31
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9.11 WHAT ARE THE TOOLS USED FOR DATA COLLECTION?

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

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

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

> Data collection and monitoring tools

**Postnatal Care**

<table>
<thead>
<tr>
<th>Primary Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Postnatal Register</td>
</tr>
<tr>
<td>2. Reproductive Health Report</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Postnatal Appointments Books</td>
</tr>
<tr>
<td>2. Antenatal Card</td>
</tr>
<tr>
<td>3. Clinical Notes</td>
</tr>
</tbody>
</table>
9.12 WHO IS RESPONSIBLE FOR COLLECTING THE DATA?

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

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

9.13 WHAT DATA SHOULD BE COLLECTED AND HOW?

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

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

9.13.1 Postnatal Register

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

> Registration

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

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

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

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

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

> Secondary Tools

Postnatal Appointments Book

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

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

The community health team should make further enquiries at home, seek the reasons why the mother did not attend for the visit, and provide health education to encourage re-attendance. This process is essential to ensure that outstanding visits are completed before 6 weeks after delivery and that postnatal care meets recommended standards.
Discharge
The expected date of discharge from the programme should be fixed at the time of registration and postnatal visits scheduled and followed up accordingly in the intervening weeks. Most postnatal mothers will be discharged six weeks after delivery. This deadline is flexible, however, and staff should consider other factors when determining the exact date. For example:

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

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

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

9.13.2 Postnatal Appointments Book
In order to trace individual mothers who do not attend for scheduled visits, an appointments book should to be kept alongside the postnatal register (refer to Secondary Tools Box). This tool facilitates the early identification of defaulters and provides a means to trace and return individuals to the clinic in a timely and consistent manner, therefore increasing adherence to the recommended postnatal visit schedule.
9.14 HOW AND WHEN SHOULD THE DATA BE REPORTED?

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

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


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

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

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


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

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

<table>
<thead>
<tr>
<th>Objective</th>
<th>Indicator</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Evaluate the effectiveness of interventions and service coverage</td>
<td>Coverage of postnatal care</td>
<td>HIS</td>
</tr>
</tbody>
</table>
### Illustrated Guide to Postnatal Register

#### A

<table>
<thead>
<tr>
<th>Serial No.</th>
<th>ANC No.</th>
<th>Name</th>
<th>Age</th>
<th>Status (Ref / Nat)</th>
<th>Address</th>
<th>Date of delivery</th>
<th>Mode of delivery</th>
<th>Delivery Compl.</th>
<th>Newborn Sex (M / F)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**REGISTRATION:**

- **Serial No.:**
  - Enter sequence number in register
- **ANC No.:**
  - Enter unique identifying number
- **Name:**
  - Print Name of mother
- **Age:**
  - Fill Age (in years)
- **Status:**
  - Classify as Refugee (Ref) / National (Nat)
- **Address:**
  - Print Camp Address (Refugee) / Nearest Village (National)
- **Date of delivery:**
  - Enter date (dd/mm/yy)
- **Mode of delivery:**
  - Spontaneous Vaginal Delivery (SVD) / Vacuum Extraction (VE) / Forceps (F) / C-Section (CS)
- **Delivery compl.:**
  - Enter abbreviation to indicate presence of delivery complication (refer to delivery register)
- **Newborn sex:**
  - Enter Male (M) / Female (F)

#### B

**ATTENDANCE HISTORY:**

For each postnatal visit, enter:

- **Date:**
  - Enter date (dd/mm/yy)
- **PNC RF:**
  - Enter postnatal risk factor abbreviation from list (to be adapted):
    - X = No complication
    - PPH = Postpartum Haem.
    - PS = Puerperal Sepsis
    - A = Anaemia
    - L = Lactational Prob.
    - CS = Cord Sepsis
    - E = Eclampsia
    - Ot = Other
- **Comment:**
  - Enter comment on timing of postnatal visit according to recommended schedule

**NOTES**

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

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

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

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

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

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

NOTES

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

Repatriation is included within referral as a reason for exit.
Module 9
Part 4 - Family Planning

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9.17 Who is responsible for collecting the data? .................................................... 38
9.18 What data should be collected and how? ....................................................... 38
9.19 How and when should the data be reported? .................................................. 41
9.20 How should the data be interpreted and used? .............................................. 43

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9.16 WHAT ARE THE TOOLS USED FOR DATA COLLECTION?

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

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

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

<table>
<thead>
<tr>
<th>Data collection and monitoring tools</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Planning</strong></td>
</tr>
<tr>
<td><strong>Primary Tools</strong></td>
</tr>
<tr>
<td>1. Family Planning Register</td>
</tr>
<tr>
<td>2. Family Planning Appointments Book</td>
</tr>
<tr>
<td>3. Reproductive Health Report</td>
</tr>
<tr>
<td><strong>Secondary Tools</strong></td>
</tr>
<tr>
<td>1. Family Planning Card</td>
</tr>
<tr>
<td>2. Contraceptive Methods Calendar</td>
</tr>
<tr>
<td>3. Reporting Calendar</td>
</tr>
</tbody>
</table>
9.17 **WHO IS RESPONSIBLE FOR COLLECTING THE DATA?**

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

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

9.18 **WHAT DATA SHOULD BE COLLECTED AND HOW?**

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

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

9.18.1 **Family Planning Register**

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

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

> **Types of method**

The types of method should be listed in the register according to both their generic classification and the trade-names used within each country. Different types of information should be recorded, according to the type of method that is issued:
• For oral contraceptives, enter the number of cycles provided;
• For injectable contraceptives, enter the number of the dose provided;
• For condoms, enter the number of pieces provided;
• For intra-uterine devices, enter the date of insertion;
• For sterilization, enter the date on which the procedure was accepted AND the date on which the procedure was performed

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

> Country Considerations

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

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

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

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

<table>
<thead>
<tr>
<th>Classification</th>
<th>Sub-Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Oral</td>
<td>COCP* - High Dose</td>
</tr>
<tr>
<td></td>
<td>COCP* - Low Dose</td>
</tr>
<tr>
<td></td>
<td>Progestogen Only Pill (POP)</td>
</tr>
<tr>
<td></td>
<td>Emergency Contraceptive Pill (ECP)</td>
</tr>
<tr>
<td>2. Injectable</td>
<td></td>
</tr>
<tr>
<td>3. Implantable</td>
<td></td>
</tr>
<tr>
<td>4. Inter-uterine</td>
<td></td>
</tr>
<tr>
<td>5. Condom</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td>6. Sterilization</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Female</td>
</tr>
</tbody>
</table>

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

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

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

9.18.2 Family Planning Appointments Book
In order to track the number of users who do not return for scheduled appointments in a methodical and predictable manner, an appointments register should be maintained. This helps family planning counsellors to confirm whether or not a client has attended for a scheduled visit on time (see Secondary Tools: Family Planning Appointments Book).
If client discontinues a method, a cross (or “X”) should be written in the column corresponding to the type of method. The date on which the client discontinued should also entered in the column corresponding to the type of user (see Illustrated Guide to Family Planning Register). A user who opts to restart a method after discontinuation is termed a new user. A group exercise on how to calculate and interpret the indicators is given on the CD-ROM which accompanies this manual.

9.19 HOW AND WHEN SHOULD THE DATA BE REPORTED?

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

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

9.19.1 Weekly Report

The clinic supervisor is responsible for ensuring complete and timely submission of the Family Planning report. The number of new, repeat and discontinued users of each type of family planning method should be carefully retrieved from the register and reported in the family planning table.
In addition, the number of units of each contraceptive method distributed should be entered into the last column of the report.

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

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

An Illustrated Guide to the Family Planning report, and an explanation of how the information should be reported from daily sources, is given at the end of the module.
9.20 HOW SHOULD THE DATA BE INTERPRETED AND USED?

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

9.20.1 Standards and Indicators

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

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

## Indicator Summary

<table>
<thead>
<tr>
<th>Objective</th>
<th>Indicator</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Evaluate the effectiveness of interventions and service coverage</td>
<td>Contraceptive prevalence rate</td>
<td>UNHCR/UNICEF/UNFPA</td>
</tr>
<tr>
<td></td>
<td>Proportion of all family planning users who are host nationals</td>
<td>HIS</td>
</tr>
<tr>
<td>4. Ensure that resources are correctly targeted to areas and groups of greatest need</td>
<td>Proportion of family planning users who are under 18</td>
<td>HIS</td>
</tr>
<tr>
<td></td>
<td>Proportion of condom users who are under 18</td>
<td>HIS</td>
</tr>
<tr>
<td></td>
<td>Proportion of discontinued users who are under 18</td>
<td>HIS</td>
</tr>
</tbody>
</table>
# Illustrated Guide to Family Planning Register

## REGISTRATION:

<table>
<thead>
<tr>
<th>Serial No.</th>
<th>FP Code No.</th>
<th>Name</th>
<th>Age</th>
<th>Sex (M / F)</th>
<th>Status (Ref / Nat)</th>
<th>Address</th>
<th>Date of visit</th>
<th>Re-visit (Y / N)</th>
<th>Marital Status</th>
<th>No. of children</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**A**

### REGISTRATION:

- **Serial No.:**
  > Enter sequence number in register

- **FP Code No.**
  > Enter unique identifying number

- **Name:**
  > Print Name of client

- **Age:**
  > Fill Age (in years)

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

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

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

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

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

## TYPE OF METHOD:

For each postnatal visit, enter:

- **COCP Low Dose:**
  > Enter number of cycles supplied

- **COCP High Dose:**
  > Enter number of cycles supplied

- **POP:**
  > Enter number of cycles supplied

- **ECP:**
  > Enter number of pills supplied

- **Injectable:**
  > Enter number of the dose injected

- **IUCD:**
  > Enter date of insertion

- **Male Condom:**
  > Enter number of pieces supplied

- **Female Condom:**
  > Enter number of pieces supplied

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

### NOTES

If client discontinues a method, a cross (X) should be entered in the column corresponding to the type of method. The date of discontinuation should also entered in the column corresponding to the type of user (see section C).
### FAMILY PLANNING METHOD

<table>
<thead>
<tr>
<th>type of User</th>
<th>COCP Low Dose Micro-gynon Nordette</th>
<th>COCP High Dose Lo-Femenal</th>
<th>POP Micro-val Micro-lut</th>
<th>ECP Postinor-2</th>
<th>Injectable Depo-Provera</th>
<th>Implantable Norplant</th>
<th>IUCD</th>
<th>Condom Male</th>
<th>Sterilisation Date of acceptance</th>
<th>Date of procedure</th>
<th>Type of User</th>
<th>Next appt. date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

### TYPE OF USER:

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

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

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

---

### DEFINITIONS OF TYPES OF USER

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

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

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

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

#### 9.0 Reproductive Health

#### 9.1 Antenatal Care

**9.1a**

<table>
<thead>
<tr>
<th></th>
<th>Refugee</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt; 18</td>
<td>≥ 18</td>
</tr>
<tr>
<td>First antenatal visit &lt; 1st trimester</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First antenatal visit &gt; 1st trimester</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repeat antenatal visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of syphilis tests conducted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of syphilis tests positive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of contacts of syphilis positive cases treated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of high-risk pregnancies detected</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of abortions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Refugee</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt; 18</td>
<td>≥ 18</td>
</tr>
<tr>
<td>Received 4 or more antenatal visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Received 2 doses of tetanus toxoid during antenatal period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Received at least 2 doses of fansidar during antenatal period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were screened for syphilis during antenatal period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Received 1 dose of mebendazole during antenatal period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Received 1 ITN* during antenatal period</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 9.2 Delivery Care

<table>
<thead>
<tr>
<th></th>
<th>Refugee</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt; 18</td>
<td>≥ 18</td>
</tr>
<tr>
<td>Live births</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Still births</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Birth Weight (&lt; 2500g)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attended by a skilled health worker**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of obstetric complications treated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of caesarean sections performed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* ITN = Insecticide Treated Net ** excluding TBA
A  **HEADER:**

**Organisation:**
Print name of health partner

**Location:**
Print name of Camp and Reporting Unit

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

**NOTES**
The dates of the reporting weeks are shown in the Reporting Calendar. It is important that all staff are aware of these dates, and that copies the calendar are distributed to all antenatal clinics.
The clinic supervisor is responsible for coordinating the complete and timely submission of all sections contributing to the weekly report.

B  **ANTENATAL CARE:**

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

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

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

**NOTES**
To ensure that antenatal service coverage is reported fully and accurately, clinic staff should update pregnancy outcome in the Antenatal Register at the end of each day.
Details should be obtained for all women who have delivered on the maternity ward, using information in the Delivery Register.

C  **DELIVERY CARE:**

Complete Table 9.2, using the delivery register.

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

<table>
<thead>
<tr>
<th>Refugee</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 18</td>
<td>&lt; 18</td>
</tr>
</tbody>
</table>

Attended for 3 postnatal visits within 6 weeks of delivery

---

### 9.4 Family Planning  (see separate reporting pad)

---

### 9.5 Sexual and Gender Based Violence (SGBV)

<table>
<thead>
<tr>
<th>Refugee</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 18</td>
<td>&lt; 18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
</table>

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

* of an incident occurring; ** PEP = Post Exposure Prophylaxis; *** ECP = Emergency Contraceptive Pill
D **POSTNATAL CARE:**
Complete Table 9.3, using the Postnatal Care register

**NOTES**
Entries with dates of discharge that falls within reporting week are eligible for reporting.
Only those which achieve 3 visits, on time, within 6 weeks should be reported.

E **FAMILY PLANNING:**
Family Planning data should be entered into a separate report (see next page).

F **SGBV:**
Complete Table 9.5, using the SGBV register and/or individual case records.
### 9.4 Family Planning

#### Health Information System (HIS)

**Reporting Form**

<table>
<thead>
<tr>
<th>Organisation:</th>
<th>Location:</th>
<th>Reporting period:</th>
</tr>
</thead>
</table>

**Health Information System**

**Part Two: Technical Sections**

> Illustrated Guide to Family Planning Report

<table>
<thead>
<tr>
<th>Report Users</th>
<th>New Users</th>
<th>Refugees</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;18</td>
<td>≥18</td>
<td></td>
</tr>
<tr>
<td>COCP* - low dose (Micro-gynon; Nordette)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COCP* - high dose (Lo-femenal)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>POP** (Microlut; Norplant)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injectable (Depo-Provera)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implantable (Norplant)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-Uterine Device (IUD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom (Male)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sterilisation (Male)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sterilisation (Female)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cumulative number at start of period (a)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cumulative number at end of period (a + b - c)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quantity of each method distributed during period*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>cycles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>doses (mL)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>implants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IUDs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pieces</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sterilisations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sterilisations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Users (b)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discontinued (c)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repeat Users</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refugee ECP*** (Postinor-2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Implantable (Norplant)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cumulative number at start of period (a)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cumulative number at end of period (a + b - c)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quantity of each method distributed during period*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>doses (mL)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>implants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IUDs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pieces</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sterilisations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sterilisations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Include methods given to all types of users

---

**Notes:**
- COCP: Combined Oral Contraceptive Pill
- POP: Progesterone Only Pill
- ECP: Emergency Contraceptive Pill

---

**VI-50**
A  HEADER:

Organization:
Print name of health partner

Location:
Print name of Camp and Reporting Unit

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

B  NUMBER OF USERS:

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

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

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

C  NUMBER OF METHODS:

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