

Assessment of the Record-keeping and Reporting System of Bangladesh Health and Population Sector Programme in the Community

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Glossary

AHI	Assistant Health Inspector
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BCC	Behaviour Change Communication
BCG	Bacillus of Chalmette Guerin
CC	Community Clinic
CG	Community Group
CMWRA	Currently-married Women of Reproductive Age
CPR	Contraceptive Prevalence Rate
DFP	Directorate of Family Planning
DGHS	Directorate General of Health Services
DOTS	Directly-observed Treatment Short Course
DPT	Diphtheria, Pertusis and Tetanus
EDD	Expected Date of Delivery
ED&PT	Early Diagnosis and Prompt Treatment
EIS	Epidemiological Information System
EPI	Expanded Programme on Immunization
ESP	Essential Services Package
FGD	Focus-group Discussion
FHC	Family Health Card
FPI	Family Planning Inspector
FRO	Field Research Officer
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
GR	Geographical Reconnaissance
HA	Health Assistant
HI	Health Inspector
HPSP	Health and Population Sector Programme
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
ICPD	International Conference on Population and Development
LMP	Last Menstruation Period
MDT	Multiple Drug Therapy
MIS	Management Information System
MOHFW	Ministry of Health and Family Welfare
MO	Medical Officer
ORP	Operations Research Project
PNC	Post-natal Care
SACMO	Sub-Assistant Community Medical Officer
TB	Tuberculosis Bacillus
TT	Tetanus Toxoid
UHC	Upazila Health Complex
UH&FWC	Union Health and Family Welfare Centre
UMIS	Unified Management Information System

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Executive Summary

The Health and Population Sector Programme (HPSP) of the Ministry of Health and Family Welfare (MOHFW), Government of Bangladesh, initiated the process of discontinuing doorstep delivery of selected health and family-planning services since 1998. Instead, it was decided to offer services from a Community Clinic (CC) for every 6,000 rural population. Although the process of setting up of 18,000 CCs has been continuing, a mix of both old and new service-delivery systems is currently in place. The new record-keeping and reporting system is designed to deliver selected health and family-planning services at the doorstep, deliver immunization services at the outreach centres, known as Expanded Programme on Immunization (EPI) spots, and support patient management at CCs when these become operational.

The Operations Research Project (ORP) of the ICDDR,B: Centre for Health and Population Research worked jointly with the MOHFW in designing and finalizing the new record-keeping and reporting system, and intensively monitored the implementation process in 22 upazilas of two districts. The monitoring process was carried out to identify the changes needed to make the Unified Management Information System (UMIS) tools user-friendly for the service providers, find out the implementation barriers, and assess to what extent the new system can support the operational management of services and what modifications are required.

This study was conducted to assess the status and use of the new record-keeping and reporting system. Nine Field Research Officers (FROs) of the ORP monitored the record-keeping and reporting activities of the Health Assistants (HAs) and Family Welfare Assistants (FWAs) during February 2000-March 2001 at the community level. During monitoring, several methods were used for collecting data on the use of designated registers and reporting formats in two districts. The methods included direct observations, focus-group discussions, validation, meetings, and review workshops in each district.

Data collected showed that the service providers had accepted the new system. The new record-keeping and reporting tools helped them perform their duties and responsibilities, and reduced their workload to a great extent. The majority of them could correctly complete their record-keeping and reporting tools. Omissions in filling-in process of all the respective record-keeping and reporting tools occurred included: putting tick mark instead of actual number, use of self-made codes, and non-compliance of instructions of the manual. Continuation of the number of registers and cards from the previous system, including inadequate training and supervision, contributed to the occurrence of omissions. The Follow-up Register was a useful tool to plan weekly follow-up visits for the drop-outs and unwilling cases. The service providers and their supervisors did not properly understand its importance and usefulness.

Yearly collection of population-based data under the Geographical Reconnaissance (GR) update provided an area profile with denominators to evaluate the progress of selected ESP indicators in a specific year. But the national-level decision-makers and local-level managers made little or no effective use of GR data for programme planning at their respective areas mainly due to a large volume of data and long duration of the data-collection process. The availability of population-based data and their use to plan follow-up visits need to be emphasized.

In addition to the UMIS tools, the HAs and FWAs used several other tools in the functional CCs. The use of additional tools differed in terms of numbers between the ORP area and the non-ORP area. No service providers could tell exactly about the utility of additional tools and registers. The design of these tools was not uniform in both the areas. The use of additional tools needs close examination, and attention should be paid to bring uniformity and to reduce the workload of service providers.

The recommendations of this study can be implemented in phases during new replenishment of the UMIS tools, keeping in pace with the transition in service-delivery from the old home-based system to the new CC-based system.

Introduction

The Health and Population Sector Programme (HPSP) of the Ministry of Health and Family Welfare (MOHFW), Government of Bangladesh (GoB), has already initiated the process of discontinuing doorstep delivery of selected health and family-planning services carried out by the Health Assistants (HAs) and Family Welfare Assistants (FWAs) during the past two decades. The system is now being replaced by weekly doorstep follow-up visits with the functioning of Community Clinics (CCs). Since the CCs are to be made functional in phases over 2-3 years, the delivery of selected health and family-planning services at the doorstep and immunization services at the outreach sites will continue to be provided by the HAs and FWAs at the community level. The CC, the lowest level of health facility as proposed in the HPSP, is a permanent outlet for one-stop provision of essential health and family-planning services, namely Essential Services Package (ESP), for an average rural population of 6,000. Of proposed 18,000 CCs all over the country, the construction of 13,500 CCs is expected to be completed by 2003. A total of 3,315 (24%) CCs have so far been completed and reported to be functional [1]. The remaining 4,500 CCs will function within the existing infrastructure of Union Health and Family Welfare Centres (UH&FWC) at the union level and of Upazila Health Complexes (UHCs) at the upazila level [2]. A unified management structure for delivering health and family-planning services at the upazila level and below has been instituted, and a revised job description of staff has been introduced.

The Operations Research Project (ORP) of the ICDDR,B: Centre for Health and Population Research has been collaborating with the MOHFW in the organization and management of CCs to make them operational [3]. The introduction of CCs has effected a change in the service-delivery system. The new system warrants both HAs and FWAs to be the key service providers at the CCs, a major deviation from their previous nature of job. In the past, both HAs and FWAs had a separate work unit, followed a different work routine of visiting each household, and used a separate record-keeping and reporting system.

The HAs used two bound registers and 20 different loose forms for record-keeping and five formats for reporting services offered at the household level. The FWAs used one FWA Register daily for record-keeping and a monthly reporting format known, Monthly Progress Report Form-1 (MIS Form-1), to report their monthly performance of services [4]. With the integration of essential health and family-planning services at the grassroots level, the record-keeping and reporting system has been unified and named as Unified Management Information System (UMIS). The UMIS Unit of the Directorate General of Health Services (DGHS), under the MOHFW, introduced a new system of record-keeping and reporting to be used at the community level. Two types of record-keeping and reporting tools have been introduced at this level. Under the new system, data on services provided at the doorstep and CCs will be collected on a daily basis. Population-based data will be collected on a yearly basis. The following record-keeping and reporting tools have been introduced at the community level:

Record-keeping tools of use

Frequency

- | | |
|--|----------------|
| 1. Geographical Reconnaissance (GR) Register | Yearly |
| 2. Daily Service Register | Daily |
| 3. Follow-up Register | Daily |
| 4. Family Health Card | As appropriate |

Reporting tools

- | | |
|--|---------|
| 1. Mouza wise Geographical Reconnaissance Report (GR) of Ward/Community Clinic | Yearly |
| 2. Yearly Morbidity Report of Ward/Community Clinic | Yearly |
| 3. Epidemiological Information System Report 1 | Weekly |
| 4. Monthly Performance Report (UMIS Reporting Form 1) | Monthly |

The ORP actively collaborated with both UMIS unit and MOHFW in designing, pilot-testing, and finalizing all the above tools, and in preparing a number of orientation manuals and user's guideline for providing orientation to the relevant staff to facilitate the quick implementation of the system. The ORP supplied the UMIS tools in 22 upazilas of Chittagong and Jessore districts for one year since February 2000. The MOHFW also entrusted the ORP to intensively monitor the implementation of the UMIS tools in 22 upazilas. The objectives of this monitoring were to identify the changes needed to make the UMIS tools user-friendly for the service providers, find out the implementation barriers, and assess to what extent the new record-keeping and reporting tools were able to support the operational management of services at the community level.

This paper reports on the status of use of the new record-keeping and reporting tools at the community level.

Objectives

The study assessed the status of using new record-keeping and reporting system at the community level. The specific research questions to be answered in this study were:

- Whether the designated tools have been actually introduced?
- Whether the service providers have been using the designated tools?
- What was the extent of omissions committed by the service providers?
- Whether the service providers have been using any additional tools and the reasons along with UMIS tools?
- What were the areas that required further modifications for effective implementation of the UMIS?
- What were the specific recommendations of service providers to improve the UMIS further?

Materials and Methods

Several methods were used for collecting data while monitoring the use of new record-keeping and reporting tools in 14 rural upazilas of Chittagong district and in 8 upazilas of Jessore district described as ORP areas in this paper. Since there were only a few functional CCs in the two districts, one functional CC in the ORP area and one in the non-ORP area were observed.

The ORP deployed 9 Field Research Officers (FROs) to monitor the record-keeping and reporting activities of both HAs and FWAs. Each FRO was assigned for 2 or 3 upazilas. A sample of HAs and FWAs from each upazila was monitored in their respective upazila. Data were collected during February 2000-March 2001. The detailed description of each methodology used in the study is highlighted below.

Observations: The FROs observed the filling-in process of different record-keeping and reporting tools by the HAs and FWAs during their GR updating period and home visits at the EPI spots and CCs.

During the GR updating period at the household level, the filling-in process of GR Register was observed for 28% pairs of the total HAs and FWAs in both the districts. Twenty percent of the HAs and 15% of the FWAs could observe the filling-in process of Daily Service Register and Follow-up Register during their home visits and their visits to the EPI sites in both the districts. A structured monitoring checklist was used for collecting the needed information. Due to the inadequate number of functional CCs, the activities of HAs and FWAs were observed for one week at two functional CCs--one day each for HA and FWA at CC and weekly-mandated follow-up visit in the field. Recorded data were verified in the field to validate the recording of services offered at the selected CCs.

Focus-group discussions: Four focus-group discussions (FGDs) were held with the HAs and FWAs in randomly-selected four upazilas of Chittagong and Jessore districts. Each FGD was participated by 5-6 randomly-selected HAs and FWAs. Twenty-four pairs of the HAs and FWAs participated in the FGDs in each district. The FGDs were held at the H&FWC of their respective union.

In-depth interviews: The service providers were also interviewed to know the problems of working with the UMIS tools at the UHC. The District and 22 Upazila Health and Family Planning Managers attended a one-day review workshop in Jessore and Chittagong districts. The workshop was organized to identify the problems faced during the implementation of the new record-keeping and reporting tools to know as to how these were resolved, and to elicit suggestions for their further modifications. Additional tools and formats in use were also reviewed.

Limitations

The FROs could monitor hardly 20% activities of HAs and FWAs in both districts as they were also to keep themselves involved in other monitoring activities. Since there were not too many operational CCs, therefore, only two operational CCs—one each from ORP area and non-ORP area—was observed.

Results

Use of record-keeping tools

The introduction of the new system started with collection of yearly population-based data and simultaneous record-keeping of the mandated services offered at the community level.

Geographical Reconnaissance (GR) Register

The GR Register is to be used by a pair of HA and FWA for collecting yearly population-based data. There are 16 major indicators in the GR register which include: age and sex, total number of household members, total number of population, number of currently pregnant women, breast-feeding practice for children aged up to 6 months, sources of drinking water, sanitation, immunization status of children aged 12-23 months, vitamin A received, women Tetanus Toxoid (TT), use of family-planning methods by currently-married women of reproductive age (CMWRA) along with sources of contraceptives, and births and deaths occurred in households during past one year. In addition, information on occurrence of each of 14 selected diseases during the past two weeks among any member of the households was also collected (Appendix 1).

While visiting the households for collecting population-based data, a team of HA and FWA was supposed to carry with them a GR Register and several other registers individually for different purposes. For example, they are required to carry the Daily Service Register for recording all services offered to clients and the Follow-up Register to record relevant information of a client who needs subsequent follow-up visits. Besides, the team had to carry the Family Health Cards (FHCs) to issue to all families to retain and produce it to the service providers whenever services required by any family member.

During monitoring, the FROs observed that all the four designated tools, such as GR Register, FHC, Daily Service Register, and Follow-up Register, were carried by 174 pairs of HAs and FWAs in 1,658 households in both the districts (Fig.1).

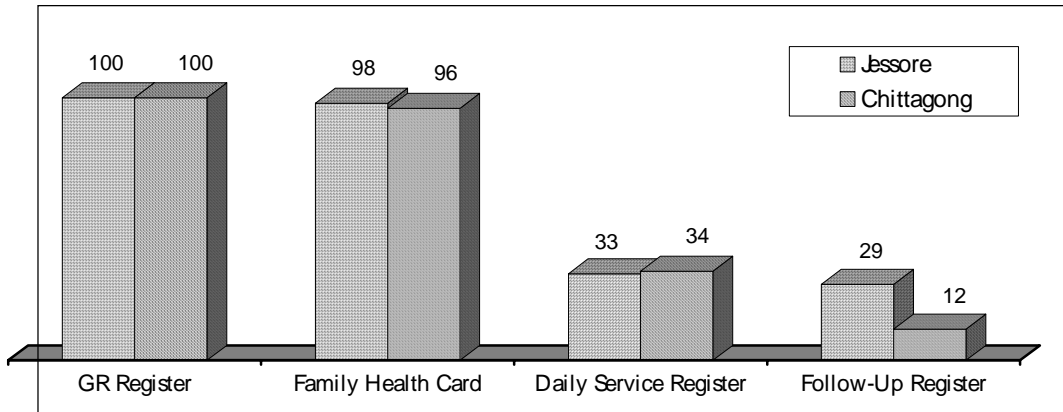


Fig. 1. Percentage of UMIS tools carried by HAs and FWAs during GR Update 2000 by district

The Daily Service Register and the Follow-up Register were less carried in both the places because of high emphasis from the supervisors and programme managers on the GR component of the system and, possibly, to avoid the load of carrying several registers at a time.

The HAs and FWAs are also mandated to fill in the FHCs, Daily Service Register, and Follow-up Register while collecting and recording yearly population-based data in the GR Register. Since the HAs and FWAs were assigned to conduct the GR and to provide services simultaneously, the FROs observed whether they filled in other tools at the time of conducting GR and the role of each of them during the filled-in process. Figure 2 presents the results of observations on filling in the record-keeping tools.

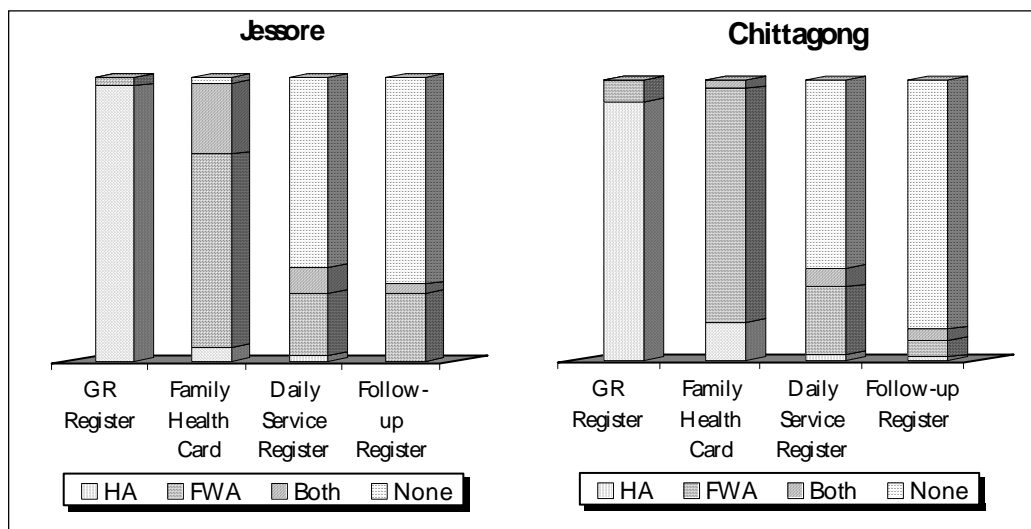


Fig. 2. Percentage of service providers filled in UMIS tools during GR Update 2000 by district

The overall practice to fill in the Daily Service Register and Follow-up Register was very low in both the districts, because there was no clear-cut instruction from the supervisors. The provision of services during this period, which received a low priority, could have contributed to this low practice. It was observed that the HA and FWA divided their responsibilities. The HA took the major role in filling in the GR Register in both the places mainly because the HAs were more experienced in collecting population-based data, and activities, such as yearly GR update, have been conducted by them routinely since early 1960. The FWAs took the major role in filling in and distributing the FHCs in both the districts. In a quarter of households, it was shared by both FWAs and HAs in Jessore district.

The FROs also recorded the omissions committed by the HAs and FWAs during the fill-in process of the GR Register in 1,658 households of both the districts. The nature of omissions by districts is presented in Fig. 3.

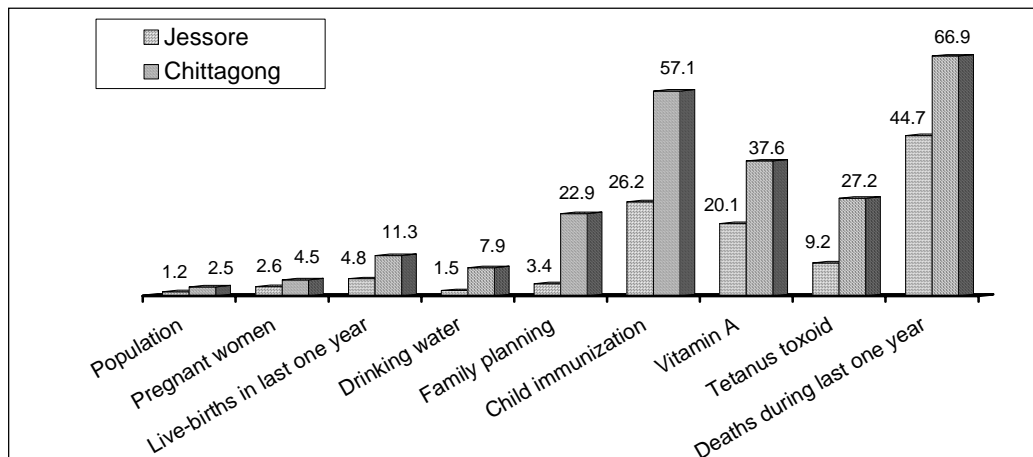


Fig. 3. Percentage of omissions committed by service providers in selected sections of GR Register by district

No major omissions, committed by the HAs and FWAs, on population and pregnant women were observed. Rates of omissions in recording live-births, family planning, immunization, vitamin A, women TT, and deaths were higher in Chittagong than that in Jessore. The nature of omissions committed mainly included the high use of tick marks instead of the actual numbers to be recorded and non-compliance of instructions in the manual, possibly, because of inadequate probing and supervision. Moreover, the number of vacancies of HAs and FWAs was higher in Chittagong division than that in Khulna division. The upazila managers had to manage a full coverage of the area with the existing workforce, which, in turn, might have contributed to increased workload for the workers of Chittagong. A high rate of omissions was found in probing deaths occurred during the past one year in both the areas. It was observed

that the use of reference period of one year was not strictly followed in both the places. The possibility of under-reporting of infant deaths also cannot be ruled out. Although the use of daily record-keeping tools started along with the collection of population-based data, the full-scale use of these tools on a daily basis started only after the completion of collection of the population-based data.

Daily Service Register

ESP services offered to any client should invariably be recorded first in the Daily Service Register. All the HAs and FWAs were mandated to use this register at the doorstep, EPI spot, and CC separately to record particulars of a client, such as serial number, household number, village name, name of client, age, sex, reasons for visit, service provided/referred, supplies distributed, and fees collected (Appendix 2).

Recording of particulars of 411 clients at the doorstep and 1,058 clients at 152 EPI spots was observed in both the districts. In addition, recording of particulars of 53 clients at two CCs in the ORP area was monitored. The omissions in recording are presented in Table 1.

Table 1. Percentage of omissions in different sections of Daily Service Register

Sections	Jessore			Chittagong		
	Doorstep (n=64)	EPI spot (n=90)	CC (n=23)	Doorstep (n=347)	EPI spot (n=968)	CC (n=30)
Sex	13	0	0	25	9	0
Age	67	49	0	37	28	3
Reasons for visit	22	7	0	23	16	7
Services offered	53	36	0	40	27	7
Supplies given	23	0	0	18	15	0

Overall omissions during the use of Daily Service Register at the doorstep and EPI spots were high compared to those at CCs in both the districts. The nature of omissions included: putting tick mark instead of writing sex, actual age, keeping the designated column blank, use of self-made codes, and non-compliance of instructions in the user's manual. Although putting tick mark in the appropriate age group is unlikely to cause any major problem, this may have implications on the quality of data. The actual reasons for visits were not written in the case of about less than a quarter of clients at the doorstep and EPI spots in both the places. The HAs and FWAs had a tendency to use different codes or abbreviations for the same purpose. For example, some HAs and FWAs either wrote EPI in place of TT or kept the space blank. The

HAs and FWAs were supposed to write the actual purpose of visits, but they considered it redundant, as the service offered was indicative of the purpose of visit. The HAs and FWAs were supposed to write the name of drug or contraceptive supplied to clients in the supply column, but they did not follow the instructions, as suggested in the manual, in 15-18% cases in Chittagong district and in 23% cases in Jessore district.

The HAs and FWAs in recording information committed few omissions in the Daily Service Register at the CC in the ORP area. The nature of problems was, however, different in the CC of the non-ORP area. Until the day of observation, the HA and FWA received only one Daily Service Register which is about a year after its introduction in the non-ORP area. Inadequate supply of Daily Service Registers compelled both HA and FWA to use the same register.

Follow-up Register

Both HAs and FWAs were supposed to use and maintain the Follow-up Register to list those clients/patients who required special attention and follow-up visits at their home. The Register has 7 sections (Appendix 3). The use of all the 7 sections is very important to plan weekly follow-up visits and target clients at the doorstep and in areas with functional CCs. The 7 sections are briefly described below.

- a. **Follow-up list:** The list contains the names of all pregnant women and eligible children for immunization and distribution of vitamin A capsules, names of users of injectables, and names of malaria, filaria, kala-azar, tuberculosis bacillus (TB) and leprosy patients. By reviewing this section of the Follow-up Register, the list is supposed to be prepared before making the schedule of any follow-up visits in the areas with functional CCs or at the doorstep.
- b. **List of pregnant women and child birth:** The list contains serial number, household number, date of enlistment, name of woman and her husband, name of the village, last menstruation period (LMP), expected date of delivery (EDD), date of TT immunization, antenatal care (ANC) provided by Family Welfare Visitor (FWV)/Sub-Assistant Community Medical Officer (SACMO)/Medical Officer (MO), date(s) of delivery, pregnancy outcome, delivery attended by, place of delivery, name and sex of the newborn. The FWAs are supposed to fill in the pregnant list during antenatal care service provided at the CC or at the doorstep, and record such services received from the H&FWC.
- c. **List of EPI and vitamin A distribution:** The list contains serial number, household number, date of enlistment, name of baby, name of father, name of village, sex, date of birth, date of immunization, and date of vitamin A distribution. The HAs are supposed to record the date(s) of every dose of

immunization and vitamin A distribution during EPI services provided at the CC and EPI spot.

- d. List of injectable acceptors:** The list contains serial number, household number, name of acceptor and her husband, name of village, date of first dose, and name of injectable brand. The FWAs are supposed to record date(s) of all subsequent doses at the CC or doorstep.
- e. List of malaria/filaria/kala-azar patients:** The list contains serial number, household number, date of enlistment, name of patient, name of father/husband, name of village, sex, age, disease, follow-up date, i.e. due date and actual date for follow-up visits, and remarks. The HAs are supposed to record the particulars of patient(s) of malaria/filaria/kala-azar during the follow-up visit at the doorstep.
- f. Death list:** The list contains serial number, household number, date of information collection, name of deceased, sex, name of father/husband, name of village, date of death, age at the time of death, and reason(s) of death. The HAs and FWAs are supposed to record the particulars of all deaths occurred in their working areas during their home visit in a specific period.
- g. Behaviour change communication (BCC) activities:** The list contains date and address of meeting place, number of attendees with sex, topics discussed, material used, name and designation of facilitator. The HAs and FWAs are supposed to record the particulars of BCC activities during the conduct of meeting at the CC or at doorstep.

The filling-in-process in the Follow-up Register of the particulars of 179 pregnant women, 397 injectable contraceptive acceptors, 31 patients of malaria, filaria, and kala-azar, 86 death cases, and 81 sessions of BCC activities was observed at the doorstep in both the districts. There was no major difference between HA and FWA with regard to omissions committed in the lists of pregnant women and childbirth, injectable contraceptive, patients of malaria/kala-azar/filaria, death, and BCC activities in both the districts. Table 2 presents the findings of filling in those sections of the Follow-up Register.

Table 2. Percentage of omissions in different sections of Follow-up Register

Section	Percentage of omissions
List of pregnant women and childbirth	n=179
a. Date of last menstrual period	42
b. Expected date of delivery	49
c. Tetanus toxoid given	22
d. Dates of antenatal care given	72
List of injectable contraceptive	n=397
a. Date of the first dose of injection	19
b. Brand name of injectables	19
c. Date of subsequent doses	25
List of malaria/kala-azar/filaria	n=31
a. Date of follow-up	43
List of deaths	n=86
a. Name of parent/husband	6
List of BCC activities	n=81
a. Place/attendees/agenda	12
b. Method used/name of facilitators	33

The HA and FWAs were mandated to ask all pregnant women about date of LMP, and then calculate EDD, number of TT doses received and number of times they received ANC from the FWV/SACMO/MO, and record the response in this respective columns of the list. Rate of omissions in recording the date of LMP, EDD and ANC were quite high compared to TT given in the section of the pregnant women and childbirth. The recording on TT given on the list of pregnant women and childbirth was not filled-in for nearly one quarter of the pregnant women due to negligence. Since TT is given at the EPI sites the service providers preferred to use the women TT Register under the previous system.

The FWVs were authorized to push the first dose of injectables and the trained FWAs were allowed to push all subsequent doses. Therefore, information on the brand name and the date of first dose was needed to be collected from the FWVs to calculate the dates of all subsequent doses. The FWAs can also get this information from the FHCs retained by the clients.

Dates of follow-up visits for malaria, filaria and kala-azar patients were also dependent on the information available at the UHCs.

Rate of omissions in recording the required information in the death list was below 10%.

The section of BCC activities also had high omissions due to perceived confusion about the term, methods and material, used.

The use of Follow-up Register was not started in the functional CC of non-ORP area until the day of observation discussed in detail later. One Follow-up Register issued in February 2000 was kept in the locker. Both HA and FWA informed that there was no instruction to use it.

Family Health Card

The FHC was distributed to every household by the HA and FWA during their GR round in both the districts. The FHC can also be used daily for recording services received from any facility depending on the carrying rate, and is expected to be updated by the service provider at any facility. The introductory and relevant sections of the FHCs were filled up at the time of distribution. The findings on the use of the FHC to be described in another report.

Field verification

The recorded data about selected clients from the Daily Service Register and Follow-up Register used in the CCs were verified in both ORP area and non-ORP area. The objective was to verify the recorded data at the household level to ascertain their accuracy. Five clients each from Bacillus of Chalmette Guerin (BCG), Diphtheria, Pertusis Tetanus (DPT)-3, Measles, TT, Acute Respiratory Infection (ARI), ANC3+ and injectable contraceptive from the Daily Service Register and Follow-up Register were selected for verification in a specific month.

There were problems to get complete address of clients in the non-ORP area as the service providers did not record it properly in the Daily Service Register. Moreover, they did not use the Follow-up Register to record the necessary information of respective clients. As a result, four month's data of other record-keeping tools were consulted to get the desired number of clients to be validated. Nevertheless, some clients could not be traced out due to incomplete address in the non-ORP area. There was, however, no problem to track the required number of clients in the ORP area.

Follow-up visits

According to job descriptions [5], both FWA and HA should spend one day per week to make follow-up visits for drop-outs listed in the Follow-up Register in the area with a functional CC. The provision of follow-up visits has been made under the assumption that such visits would help reduce the number of drop-outs in child immunization, TT vaccination, pregnant women receiving ANC and postnatal care (PNC), injectable contraceptive users, cases of person under directly-observed treatment short course (DOTS) for TB, multiple drug therapy (MDT) for leprosy, and early diagnosis and prompt treatment (ED&PT) for filariasis.

The ORP staff accompanied both FWA and HA during their planned follow-up visits to the ORP area and the non-ORP area. Table 3 shows the results of activities carried out and use of Follow-up Register during routine follow-up visits by the FWAs and HAs in both ORP and non-ORP areas. There was some deviation with regard to the time of starting and ending of follow-up visits and the number of households visited. None of the HA or FWA carried the Follow-up Register with them, rather a diary was carried by the FWA in non-ORP area.

Table 3. Plan and coverage of follow-up visits by HAs and FWAs in ORP area and non-ORP area with a functional CC

Plan and coverage of follow-up visits	Non-ORP area		ORP area	
	HA	FWA	HA	FWA
Plan of follow-up visits				
Time of starting follow-up visit	10.00 a.m.	9.30 a.m.	8.30 a.m.	9.30 a.m.
Total no. of households visited	10	45	50	52
Follow-up Register carried	No	No	Yes	Yes
Additional tools carried	No	Diary	No	No
Coverage of follow-up visits				
ANC client	1	2	10	14
TT immunization client	0	0	8	6
PNC client	0	0	2	1
Injectable client	0	1	4	15
Oral pill client	0	18	0	3
Condom client	0	1	0	2
Motivation to come to CC	Yes	Yes	Yes	Yes
Time of ending follow-up visit	2.15 p.m.	3.30 p.m.	3.00 p.m.	1.30 p.m.

Only three pregnant women were contacted by the HA and FWA in non-ORP area. The FWA contacted 20 family-planning clients, and provided primarily oral pills and condoms, including one due dose of injectable at home. Both HA and FWA also carried out some motivational activities for the promotion of CC.

The situation was little different in the ORP area. Although there was no difference between the HA and the FWA in terms of the number of households visited, but both HA and FWA contacted some clients of ANC, TT immunization, and contraceptives. The FWA contacted 14 ANC and 20 family-planning clients. The injectable clients were mostly contacted by the FWA as they were trained to push all subsequent doses of injectable for a long time in the ORP area.

Use of additional tools

With the introduction of the new UMIS, all performance related tools were supposed to be obsolete, except EPI tally sheet, financial and logistics-related tools. It was observed that some performance-related tools were being used. Several reasons were identified for using such tools. One reason was that the UMIS unit did not adequately address some management issues, such as attendance register, inspection register, and medicine stock and distribution register for the functional CC.

Some tools were used as a convention and for meeting the sporadic demand of the higher authority. Moreover, some tools were used for meeting the special needs of vertical programmes, such as TB and leprosy. Table 4 shows the results of observations on using the types of additional tools in both ORP area and the non-ORP area.

Table 4. Types of additional tools used in both ORP area and non-ORP area

Type of tools	ORP area		Non-ORP area
	Doorstep	EPI spot CC	
EPI Register		✓	✓
Women TT Register		✓	✓
Birth Format	✓		✓
Death Format	✓		✓
Diary			✓
Stock Balance Register			✓
Medicine Stock and Distribution Register			✓
Attendance Register			✓
Meeting Resolution Book			✓
Inspection Register			✓
Field Movement Register			✓
FHC Distribution Register			✓
Inventory Register			✓
EPI Card		✓	✓
TT Card		✓	✓
Injectable Card	✓	✓	✓
Referral slip for ARI			✓
Referral slip			✓
EPI Monthly Immunization Report			✓
MIS-1	✓		✓
Birth and Death Report			✓
Letter Receiving and Distribution Book			✓
Total	4	5	11

Reasons for use of additional tools

Twenty-one additional tools were used by the HAs and FWAs at the community level. The use patterns of additional tools were not uniform between the ORP area and the non-ORP area. Some additional tools were actually needed, and some were being used as requirement according to the guidelines for CC and for non-issuance of any explicit instructions from the UMIS unit. The reasons for using these additional tools are discussed below.

EPI Register and Women TT Register: The previous EPI Register and the Women TT Register are almost identical with the two sections of the Follow-up Register, i.e. list of pregnant women and list of EPI and vitamin A capsule distribution. But there was an insufficient number of pages in the section EPI and pregnant women and no section at all to record TT of unmarried women and non-pregnant women in the Follow-up Register.

Birth and Death Format: Although birth and death-related information was actually available in the section on pregnant women and newborns of the Follow-up Register. Some upazila managers instructed the HAs and FWAs to record all births and deaths on a separate form.

According to the guideline for CCs, a diary is to be used for recording daily activities in areas with a functional CC. The FWA maintained a separate diary with names of injectable clients in non-ORP area. However, information on injectable clients was actually available from the Follow-up Register. Other than diary, a Stock Balance Register and a Medicine Stock and Distribution Register were maintained to record information on the quantity of medicines and contraceptives received from the upazila store and distributed from the CC. An Inventory Register was maintained with information on inventory of all assets lying at the CC. The use of an Attendance Register to record daily attendance/holiday/leave of service providers, a Meeting Resolution Register to record minutes of meetings to be held at CC, a Field movement Register to record field movement of service providers of CC, an Inspection Register to record supervisory remarks, and another register to record letters received and dispatched were maintained as recommended in the guideline for CCs. A FHC Distribution Register was found to record the distribution of FHCs from the CC in the non-ORP area.

Although the FHC can provide similar information recorded in the EPI, TT, and Injectable Cards, Referral slips for ARI, and other reasons and monthly EPI report, there were no instructions to discontinue these cards in the non-ORP area. However, the EPI and TT cards were used in some upazilas. The FWAs still used the MIS Form-1, a monthly reporting format for them in the previous system, to indent and collect contraceptives. Separate sets of birth and death reports were used for sending those to the Sanitary Inspector (SI) each month.

Use of reporting formats

The UMIS unit has introduced three reporting formats: Mouza wise Geographical Reconnaissance Report (GR) of Ward/Community Clinic (GR Report 1), Yearly Morbidity Report of Ward/Community Clinic (Morbidity Report 1), and Monthly Progress Report (UMIS Reporting Form 1)—first two are to be filled in on a yearly basis and last one on a monthly basis. The yearly reports are to be prepared based on population-based GR data, including morbidity among household members recorded in the GR Register. The monthly report is to be prepared based on information recorded in the Daily Service Register and Follow-up Register at the end of each month.

Mouza wise Geographical Reconnaissance Report (GR) of Ward/Community Clinic (GR Report 1)

It was not possible to observe whether the yearly GR report was correctly prepared. The HAs took more initiatives than the FWAs to prepare the report mainly because they were more experienced in preparing the GR report as they were involved with this activities since the beginning of their job. Both HA and FWA felt the need of a tally sheet to prepare the report correctly (Appendix 4).

Yearly Morbidity Report of Ward/Community Clinic (Morbidity Report 1)

It was also not possible to observe whether the yearly morbidity report was correctly prepared. Although the HAs took more initiatives to prepare the report, they were, however, confused about the use of tally marks while collecting information (Appendix 5).

Epidemiological Information System (EIS) Report 1

In the previous system, the HAs were used to collect data on six specified diseases, such as diarrhoea, dysentery, pneumonia, tetanus, polio, and measles, through daily house-to-house visits. The UMIS unit did not discontinue the use of Epidemiological Information System (EIS). Compilation of data in this format was done weekly, and the compiled report was then sent to the Assistant Health Inspector (AHI). The HAs were found to fill out this format from the Daily Service Register to complete this report.

Monthly Progress Report (UMIS Reporting Form 1)

The FWAs and HAs are responsible for preparing the monthly progress report at the end of each month. The monthly progress reporting format comprises 7 sections (Appendix 6). Based on the records of respective Daily Service Register and Follow-up Register, the HAs and FWAs should compile different sections of the monthly progress format using loose sheets. It was observed that the FWAs filled in the family-planning section, while the HAs filled in the child and mother care section independently. Other sections of the report were jointly prepared by the HAs and FWAs.

The filled-in copy of the monthly progress report was not available at the CC in the non-ORP area. Both HA and FWA informed that there was no instruction from any level to keep copies of the same. The AHI and Family Planning Inspector (FPI) only countersigned the UMIS Reporting Form 1, which was then sent to the UH&FWC. After repeated search with the EPI technician, FWV, and statistician, a copy could be collected from the Health Inspector (HI) of the non-ORP area. No information was available on distribution of vitamin A capsules and the number of BCG in the Daily Service Register at the non-ORP area. The HA informed that there was no supply of vitamin A, but the column to report distribution was filled in only to maintain the performance.

As the number of clients who received ESP services received main attention while designing the UMIS reporting format, logistics and supply-related information was made a part of it. There were some problems in this section as the logistics for FWAs and HAs from the UHC were managed separately. The process of unification of health and family-planning stores was in progress, and CCs are yet to be established nationwide. According to directives of the UMIS Unit, until a CC is made fully operational, the 'ward' of a union is considered to be a reporting unit. Some upazilas adopted different measures locally for distributing specific supplies to the HAs and FWAs, including use of various formats used by the Directorate of Family Planning (DFP).

Problems and limitations of record-keeping and reporting tools

Based on the observations and FGDs with the HAs and FWAs, the problems of yearly and daily record-keeping and reporting tools are summarized below.

Geographical Reconnaissance (GR) Register

The HAs and FWAs reported in the FGDs that the volume of information requirement under the new UMIS system has increased compared to the previous GR update. Other than updating household numbering, information on population by age and sex, pregnancy, status of child and TT immunization, total number of CMWRAs, method-wise users of family-planning and sources of contraceptives, breast-feeding, water and sanitation, total number births and deaths, and data on 14 diseases for each member of the family during the GR round takes an enormous time. Moreover, distribution of FHCs to each household has been added along with the GR activities. Most HAs and FWAs informed that they did not update the area map. Both HAs and FWAs were confused about 14 days' recall period during collection of morbidity data as they did not follow properly the instruction manual. The majority of the household members could not define 14 diseases and 14 days' recall period. The HAs and FWAs reported that the community people were not certain what to report as morbidity, as such information might not be reliable. The same situation happened with the collection of information relating to deaths.

The GR Register had no provision to record dates of data collection, information on public utility, and total number of households, and had inadequate space in the column of head of household's name. Data on population by age and sex group were believed to be complex. The HAs and FWAs were both confused while collecting data on exclusive breast-feeding status for children aged up to 6 months. There was also inadequate space in every cell in most columns of the GR Register. The HAs and FWAs opined that it was not possible to record longitudinal data of a particular family. Because of over emphasis on data collection from each and every household during the GR update, service provision at the doorstep received low priority. There was limited use of GR data at the local level. Initially both HAs and FWAs forgot to collect morbidity data in most households, as the morbidity section is in the last part of the register.

Mouza wise Geographical Reconnaissance Report (GR) of Ward/Community Clinic (GR Report 1)

Both HAs and FWAs felt the need of a tally sheet to prepare the report correctly and quickly.

Yearly Morbidity Report of Ward/Community Clinic (Morbidity Report 1)

The utility of morbidity data was not clear to the HAs and FWAs, because the majority of the respondents were not very clear what to report as diseases and their definition for each member appeared to be unclear. Thus, the quality of data remained questionable as opined by most HAs. It was also not clear whether two weeks' recall period was uniformly used.

Daily Service Register

During the FGDs, the HAs and FWAs informed that the Daily Service Register was designed to record particulars of all clients visiting the service centre each time. There was a practical problem especially in the case of family-planning users, no matter whether the client was a new or old and whether she needed any follow-up visits or not. Particulars of these clients are to be written in this register and in the Follow-up Register. They suggested incorporating name of fathers/husbands in the Daily Service Register.

The date of service provided is located at the top of every page. If an HA or FWA finishes his/her day's work in the middle of a page, the date of services provided on the following day has to be written on the next page resulting of misuse of page. The monthly serial number was not recorded, as the majority of HAs and FWAs did not feel its necessity. Space in the columns of serial number and household number was small. It was difficult to record the household number if the client did not bring the FHC at the service centre. The column on service provided/referred was not used. The HAs and FWAs faced difficulty in compiling daily activities due to lack of a separate sheet in the register.

Follow-up Register

There is an inadequate number of pages in the sections on the list of pregnant women and EPI of newborns and distribution of vitamin A capsule. It was not possible to record block-wise information of child and women immunization like the previous EPI Register and TT Register. There was no provision to record the registration number to identify the targeted children and to record the non-pregnant/unmarried women for TT immunization. There was difficulty to calculate the actual date of measles. There was no provision to record information on the number of women received more than 3 ANC visits. The injectable list had no provision to record the identification number to identify the targeted clients. There was no section to record information on TB leprosy patients who needed follow-up visits. There was confusion about fill-in procedure of the material used column in the list of BCC activities.

Monthly Performance Report (UMIS Reporting Form 1)

It was not possible to get the total number of CMWRAs, new and old contraceptives users and method-wise clients referred for contraception on a monthly basis. The contraceptives prevalence rate (CPR) could not be calculated to monitor progress. It was not possible to monitor the EPI and TT coverage due to absence of denominators for children aged less than one year, women aged 15-49 years, and pregnant women. Although diarrhoea by type needed to be reported but it was not possible due to lack of provision in data collection. Compilation of disease profiles by age and sex was difficult. There was no provision to aggregate the clients treated for various diseases. Although data on births and deaths were collected but were not reported on a monthly basis. Without a tally sheet, it was difficult to compile and prepare this report.

Lessons Learned

The new UMIS record-keeping and reporting tools were well-accepted. Other than the GR Register and FHC, the Daily Service Register and Follow-up Register were not carried during the GR update due to more weight. Four to five months were required to complete the GR. The usual routine work of the HAs and FWAs also hampered during the GR round. There was little or no supervision by the upazila officials. Only in a few cases, the HI, AHI, and FPI went to the field to observe the GR activities. Moreover, involvement of the HAs and FWAs in special programmes, such as, preparation of voters list, participation in National Immunization Days (NIDs), and responses to additional data requirement from the DGHS and DFP demanded more time to complete the GR.

The omissions committed in the Daily Service Register by the HAs and FWAs were due to lack of motivation, and knowledge, and use of self-made codes. Inadequate training and insufficient supervision also contributed to committing the omissions. The quality of information, recorded in the Daily Service Register, has some programmatic implications for the policy-makers.

The Follow-up Register is an important tool to plan follow-up visits for drop-outs and unwilling cases. Although the HAs and FWAs reported that the follow-up list in the register was useful, there were some problems in using it, because a new list has to be prepared while going out for weekly follow-up visits. Moreover, there was no provision to record the names of unmarried and non-pregnant women for giving TT. Some upazilas were still using the old EPI and TT Register due to an inadequate number of pages of the EPI and pregnant women section in the Follow-up Register. The importance of the Follow-up Register was not clearly understood by the service providers and their supervisors.

Continuation of some record-keeping and reporting tools of the previous system was an additional workload for the HAs and FWAs. The upazila managers felt more comfortable to use the old EPI and women TT Register in the review meeting. As a result, the HAs and FWAs were reluctant to fill in the Follow-up Register. The shortage of pages in some sections and continuation of some previous registers also contributed to low use of the Follow-up Register.

In addition to the UMIS tools, 11 tools in the ORP area and 19 in the non-ORP area were used in the functional CC. Five additional tools in the EPI spot and 4 in the doorstep were also used. Some performance-related reporting tools were used, and most of these were used unnecessarily along with the UMIS tools as a convention at the community level.

Transaction of logistics for the FWAs and HAs from the UHC was addressed separately, since the process of unification of health and family-planning stores in progress. The HAs and FWAs were working independently, since CCs are yet to be established nationwide. Some upazilas adopted

various measures locally to distribute specific supplies for the HAs and FWAs, including various formats used by the Directorate of Family Planning. The HAs and FWAs maintained a separate register for stock and distribution of contraceptives and medicines.

Recommendations

A provision should be made to record dates of data collection, and also to record information on public utility and total number of households in the GR Register. The column 'Head of the household's name' should be expanded. Grouping of data on age-specific population should be: 0-11 month(s), 1-4 year(s), 5-14 years, 15-49 years, and 50+ years. Longitudinal data of a particular family should be recorded. The GR round should be completed in 1-2 month(s), and data from the GR should be used at the community level. To facilitate the compilation of yearly reports, a provision of tally sheet should be considered. Decision is needed about the volume of morbidity data to be collected. The potential of using community volunteers in collecting information identical to the GR and for visual display on the community map should be explored.

The Daily Service Register should be modified according to the problems identified. Only a monthly serial number can fulfill the requirement, so there is no need to expand the columns. The name of the person who came to receive service instead of husband's/father's name along with village name in column number 4 will be sufficient. The column of reasons for visit can be merged with the column of service given/referred to address the problem. A separate tally sheet for compiling daily activities may be introduced. Omissions may have occurred due to inadequate training and insufficient supervision. A minimum of two days training with emphasis on filling-in practice and strengthening the supervision system at the CC, EPI spot, and doorstep will reduce omissions during filling-in the Daily Service Register.

The recommendation of block-wise registration of women and children is still possible in the Follow-up Register. A 25% increase to accommodate pregnant women and 75% increase to accommodate children aged less than one year should be made. A separate section to record the names of unmarried and non-pregnant women should be included. There is a need for on-the-job training to calculate EDD and dates of immunization dose. The concerned officials should not use the old EPI and women TT Register in the review meeting. A calendar of English and Bangla year may also be incorporated in the Follow-up Register. Provision to record more than 3 ANC visits is needed. Inclusion of a separate section to record TB and leprosy will require decision from policy-makers.

Methods and materials should be mentioned clearly in the list of BCC activities of the Follow-up Register. In addition to flip-chart, leaflet, poster,

common methods, such as, lecture, group discussion, etc., may be mentioned at each page to remind the concerned staff.

To develop and institutionalize a system of routine follow-up visits, rapid collection of population-based data on some key ESP indicators for identifying clients/patients requiring follow-up support is critical. The GR register can provide a population-based baseline status of a number of health and family-planning indicators on a yearly basis. This includes age and gender distribution of total population, number of children aged less than one year and less than 5 years, vaccination coverage, pregnancy prevalence, CPR, population under DOTS, ED&PT, and MDT.

As the clients in need of follow-up visits are not clustered, there will be an operational problem to segment and reach them. The existing GR Register with minor modifications could be merged with the Follow-up Register to transform these into one Enumeration Register to collect population-based information with a provision of yearly update. The FWAs and HAs can simultaneously prepare the list of all "intended clients/patients" who will require follow-up support while collecting population-based data in the Follow-up Register. The list will include names of children aged under one year for immunization, women for TT immunization, pregnant women for ANC and PNC visits, users of injectables for ensuring subsequent doses, and cases of TB to provide DOTS, leprosy to provide MDT and kala-azar. This would also provide an opportunity to ascertain the trends of new acceptance and drop-outs in contraceptive use at least on a quarterly basis, which has been a recent concern. This may take about two months during the first year and one month in subsequent years to complete the job. The completeness of such enrollment may be debatable, but it certainly will improve over the years. The revised Follow-up Register can be used by the HAs and FWAs at the community level to plan limited follow-up visits to provide or refer for subsequent services for all cases requiring to be followed up.

The availability of eight person-days for follow-up visits either by HA or FWA per month would yield 24 person-days in three months. This would mean that approximately 50 households would need to be contacted on each day. During the visits, there will be an opportunity to ensure full coverage of clients/patients requiring follow-up visits, identify new cases of pregnancy, and ascertain both new and old cases of contraceptive users. Simultaneously, they will be able to collect all birth and death-related information.

The Enumeration Register will have to be designed and tested. There will be no problem with the indicators generated on a monthly basis under the current system. Other than the indicators generated on a monthly basis, the suggested key ESP indicators can be generated on a quarterly basis.

There is a need to have a denominator in the UMIS Reporting Format to calculate the coverage of some selected key ESP indicators. The problem of denominator may be addressed by making use of GR data. New and old users of family planning should be incorporated into the reporting format. The referral

column may be divided for method-specific referral performance. Compilation of age-specific diseases treated may be dropped. Diarrhoeal cases may be reported by type instead of only diarrhoea in the diseases treated section. A diseases-specific total column should be added in this section. A separate section to report monthly births and deaths should be included. A daily tally sheet may be developed to compile daily activities from the Daily Service Register and Follow-up Register, so that the monthly performance report can easily be prepared.

Following the International Conference on Population and Development (ICPD), gender and poverty-related issues have received global attention. Both the issues are quite important, and are not addressed through the regular information system. Data by gender issue in the diseases treated section is currently available in the system. However, data on the gender issue can be generated with revision in the section of childcare by gender, service provided during follow-up visits of TB and leprosy cases, participation of females on BCC activities, etc. Reporting on the poverty issue is difficult to be generated through the regular reporting system. This issue can certainly be addressed through periodic surveys.

Designs of additional tools are not uniform. The new record-keeping and reporting tools with some modifications and inclusion of some sections can replace most additional tools. There is an urgent need to review their usefulness and relevance in light of the operational guidelines for the CCs. Although there is a clear instruction for the service providers about local retention of monthly performance report at the CC level, but the current focus seems to be reporting to the next higher level. Involvement of Community Group (CG) in monitoring the performance of CC is worth considering, and steps are needed to educate the CG about systematic monitoring.

The Bangladesh Health and Population Sector programme has successfully passed the stage of development of record-keeping and reporting tools and operational manuals. Much more needs to be done. The actual potential of the information system is yet to be adequately explored. The system is dynamic, but requires revision from time to time according to the need of the programme.

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Geographical Reconnaissance (GR) Register

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Name of worker:	
Community Clinic:	
Ward no.	Union:
Thana:	District:
Month:	Year:

Appendix 1

Yearly Morbidity Tally Sheet

(To be filledup by Health Assistant and Family Welfare Assistant)

Community Clinic: Ward no. Union: Thana: District:

Total number of households visited	Name of diseases	Number of cases					Source of treatment			
		Male		Female		Total	Govt. hospital or clinic		Non-govt./private hospital or clinic	
		Tally	Total	Tally	Total		Tally	Total	Tally	Total
Tally										
	1. Diarrhoea									
	2. Dysentery									
	3. Pneumonia									
	4. Tuberculosis									
	5. Polio									
	6. Leprosy									
	7. Malnutrition									
	8. Anaemia									
	9. Goitre									
	10. Tetanus									
	11. Malaria									
	12. Filariasis									
	13. Nightblindness									
	14. Measles									
Total										

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Daily Service Register

(To be filled up by workers of Field/Community Clinic)

Name of service provider:	
Designation:	
Name of CC:	
Ward no. :	Union:
Thana:	District:
Month:	Year:

Date:/...../.....

SL. no.	Household no.	Name of patient	Name of village	Sex		Age					Weight	Reasons	Service provided/refer	Supply provided	Service charge*
				Male	Female	0-11 month(s)	1-4 year(s)	5-14 year(s)	15-49 year(s)	50+ year(s)					
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16

* Whenever necessary

Follow-up Register

(To be filled up by workers of Field/Community Clinic)

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Name of service provider:	
Designation:	
Name of CC:	
Ward no.	Union:
Thana:	District:
Month:	Year:

Appendix 3

List of Pregnant Women and Child Birth

(To be filled up by HA/FWA)

Sl. no.	House hold no.	Date of enlistment	Name of woman and her husband	Name of village	LMP	EDD	TT Immunization					ANC provided by FWV/SACMO/MO			Date of delivery	Outcome result*	Delivery attended by	Place of delivery	Newborn			
							1 st	2 nd	3 rd	4 th	5 th	1 st	2 nd	3 rd					Name	Sex		
																				Boy	Girl	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	

*Outcome result = Live-birth (mature), live-birth (premature), abortion and still-birth.

List of EPI and Vit-A Distributed

0-11 months* aged baby

(To be filled by HA/FWA)

Sl. no.	House hold no.	Date of enlistment	Name of baby	Name of father and village	Sex		Date of birth	Date of TT					Vit-A	
					Boy	Girl		BCG	DPT/Polio			Measles/Polio-4		
									1st	2nd	3rd	Due date		Actual date
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15

*11 month =11 months 29 days

4.1.1.2 Death List

(To be filled up by HA/FWA)

Sl. no.	House hold no.	Information collection date	Name of deceased	Sex		Name of father/husband	Name of village	Date of death	Age at death	Reasons of death
				Male	Female					
1	2	3	4	5	6	7	8	9	10	11

Yearly Morbidity Report of Ward/Community Clinic
(To be compiled by Health Assistant and Family Welfare Assistant)

Month: Year:

Ward no. Community Clinic: Union: Thana: District:
.....

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Total number of households visited	Name of diseases	Number of cases		Source of treatment	
		Male	Female	Govt. hospital or clinic	Non-govt./private hospital or clinic
	1. Diarrhoea				
	2. Dysentery				
	3. Pneumonia				
	4. Tuberculosis				
	5. Polio				
	6. Leprosy				
	7. Malnutrition				
	8. Anaemia				
	9. Goitre				
	10. Tetanus				
	11. Malaria				
	12. Filariasis				
	13. Nightblindness				
	14. Measles				
Total:					

.....
Signature
Family Welfare Assistant
Date: / /

.....
Signature
Health Assistant
Date: / /

Appendix 6

UMIS/Field/CC/Report Form No 1(C)
Page No.3/3

5 Monthly Performance Report

(To be filled up by HA and FWA)

Month Year

Community Clinic Ward no.....

Union Thana..... District.....

1. Family-planning services

Family-planning methods given				Side-effect management (Injectables)	Referred		Total service charge*
Pill	Condom	Injectables	Total		For family-planning method	For side-effect Management	

2. Child care (EPI and vitamin A)

BCG	DPT+POLIO-1	DPT+POLIO-2	DPT+POLIO-3	Measles+POLIO-4	Vitamin A	Total service charge*

3. Mother care

ANC			TT given										Iron and folic acid given	Refer for ANC/ PNC	PNC	Field Worker conducted delivery at home	Total service charge*
			Pregnant women					Non-pregnant women									
1st	2nd	3rd	1st	2nd	3rd	4th	5th	1st	2nd	3rd	4th	5th					

4. BCC activities

BCC Session				Others
Clinic	School	Uthan Shova	Film show	

5. Services during follow-up visits

EPI drop out	Pregnant women	Family-planning method drop out	DOTS cases treated	Other follow-up

* Where applicable

6. Diseases treated

Name of disease	Age group										Ref-erred	Total service charge*
	0-11 month(s)		1-4 year(s)		5-14 year(s)		15-49 year(s)		50+ year(s)			
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female		
1. Diarrhoea												
2. Dysentery												
3. Malaria	Uncomplicated											
	Severe											
	Treatment											
4. Intestinal worm												
5. Peptic ulcer												
6. Tuberculosis												
7. AR	Cough and cold											
	Pneumonia											
	Severe pneumonia											
	Very severe											
8. Skin disease												
9. Jaundice												
10. Tetanus (excluding neonatal)												
11. Tetanus neonatal												
12. Nightblindness												
13. Goitre												
14. Anaemia												
15. Malnutrition												
16. Asthma												
17. Measles												
18. Chicken pox												
19. Conjunctivitis												
20. Ear infection												
21. Dental disease												
22. Acute flaccid												
23. Poisoning												
24. Injury												
25. Gynecological												
26. Leprosy												
27. Filariasis												
28. Kala-azar												
29. RTI/STD												
30. PUO (fever)												
31.												
32.												
33.												

* Where applicable

7. Logistics and supply

Items	Opening balance	Received	Total	Distribution	Adjustment	Closing balance	Demand for next month
1. Condom (pcs)							
2. Contraceptive pill (low dose)							
3. Contraceptive injection vial/ampul)							
4. 1% Genson violet							
5. Antacid tab							
6. Atropine tab							
7. BB oil							
8. Chloroquine tab							
9. Cotrimoxazole tab							
10. Cotrimoxazole (paediatric) tab							
11. Ferrous sulphate							
12. Ethambutol tab (400 mg)							
13. Furacin tub (antiseptic cream)							
14. Isoniazid tab (100 mg)							
15. Isoniazid tab (300 mg)							
16. Metronidazole							
17. Neobacrin ointment							
18. ORS (0.5 l)							
19. Paracetamol							
20. Pyrazinamide tab (500 mg)							
21. Phenoximethyl penicilin tab							
22. Quinine Inj							
23. Quinine Tab							
24. Rifampicin tab (150 mg)							
25. Rifampicin tab (450 mg)							
26. Streptomycin inj (1gm)							
27. Paracetamol syrup							
28. Salbutamol syrup							
29. Vermactin tab							
30. Vitamin A liquid (child 100, 000 IU)							
31. Vitamin A cap (200, 000 IU)							
32. Whitfield ointment tube							
33.							
34.							
35.							

Report Prepared by

1) Sign
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2) Sign
Health Assistant

Attested by

1) Sign
Family Planning Inspector

2) Sign
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