Islamic Republic of Afghanistan
Ministry of Public Health

National Health Management Information System

-

Procedures Manual

Part I & II

March ۲۰۱۱
Hoot ۱۳۸۹

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Islamic Republic of Afghanistan
Ministry of Public Health

Foreword

The Ministry of Public Health is pleased to present the most recent revised version of the National Health Management Information System (HMIS). The initial HMIS was launched late ۲۰۰۳/۱۳۸۲. It was based on the ۲۰۰۳ version of the Basic Package of Health Services for Afghanistan (BPHS). A first revision took place in ۲۰۰۶/۱۳۸۵ incorporating changes suggested during an evaluation of the HMIS and the changes made to the BPHS ۲۰۰۵/۱۳۸٤, and the Essential Package of Hospital Services ۲۰۰۵/۱۳۸٤.

Over the past years, the Afghan HMIS has been mentioned as example in several international events and has proven to be an extremely useful management tool for the MoPH and its partners. Maintaining the quality and usefulness of the HMIS requires regular updating, and the present version takes into account the recent changes in policies and strategies, in particular the updated BPHS ۲۰۱۰. This new version also takes into account the feedback of users at local, provincial and national level.

I would like to express my appreciation to the members of the HMIS Task Force, who oversaw the implementation of the HMIS. The MoPH is also grateful to the many Afghan and international organizations and individuals who provided assistance and support in planning, developing, and finalizing the HMIS for Afghanistan over the past years. We are especially grateful for the sustained technical and financial assistance of the World Health Organization, Eastern Mediterranean Regional Office and of the United States Agency for International Development through the Technical Support to the Central & Provincial Ministry of Public Health (Tech-Serve) Program, implemented by Management Sciences for Health, which allowed the development, publication and distribution of the Procedures Manual of the National HMIS.

The MoPH warmly recommends its partners to use the HMIS as an important tool that will help promote the ongoing development of the health system of Afghanistan for the benefit of the Afghan people.

Dr. Suraya Dalil
Acting Minister of Public Health
Kabul, Afghanistan
April ۲۰۱۱

Acknowledgements

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Abbreviations and Acronyms

ADB	Asian Development Bank
AFB	Acid-fast bacillus
AIDS	Acquired Immune Deficiency Syndrome
ALOS	Average Length Of Stay (in hospitals)
ANC	Antenatal Care
ANV	Antenatal Visit
ARI	Acute Respiratory Infections
BCG	Bacillus of Calmette Guérin
BEmOC	Basic Emergency Obstetric Care
BHC	Basic Health Center
BHH	Baseline Household Survey
BPHS	Basic Package of Health Services
CAAC	Catchment Area Annual Census
CBC	Community Based Care
CEmOC	Comprehensive Emergency Obstetric Care
CHC	Comprehensive Health Center
CHS	Community Health Supervisor
CHW	Community Health Worker
CMP	Couple Months Protection
CMW	Community Midwife
CPR	Contraceptive Prevalence Rate
CSO	Central Statistics Office
CTC	Community Treatment Center (Nutrition)
CYP	Couple Years Protection
D&C	Dilatation and Curettage
DD	Diarrheal Diseases
DEWS	Disease Early Warning System
DH	District Hospital
DOTS	Directly Observed Treatment Short-course (Tuberculosis)
DPT	Diphtheria – Polio – Tetanus vaccine (replaced by PENTA)
DPT۳	Third dose of DPT vaccine (replaced by PENTA۳)
EC	European Commission
ECG	Electrocardiogram
EDL	Essential Drug List
EmOC	Emergency Obstetric Care
ENT	Ear Nose Throat
EPHS	Essential Package of Hospital Services
EPI	Expanded Program on Immunization
EU	European Union
FHAG	Family Health Action Group
FP	Family Planning
FSR	Facility Status Report
GCMU	Grants and Contracts Management Unit
GMP	Growth Monitoring and Promotion
HF	Health Facility (MHT, HSC, BHC, CHC, DH, PH, RH)
HFA	Health Facility Assessment
HHS	Household Survey
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMIR	Hospital Monthly Inpatient Report
HMIS	Health Management Information System
HP	Health Post

HRD	Human Resources Development
HSC	Health Sub-Center
HSR	Hospital Status Report
ID	Identification
IMR	Infant Mortality Rate
INH	Isoniazide
ITN	Insecticide Treated Nets
IUD	Intra Uterine Device
Lab	Laboratory
LBW	Low Birth Weight
MAAR	Monthly Aggregated Activity Report
MAR	Monthly Activity Report (Health Post)
MD	Medical Doctor
MHT	Mobile Health Team
MIAR	Monthly Integrated Activity Report (outpatients in facilities)
MMR	Maternal Mortality Rate
MoPH	Ministry of Public Health
MSH	Management Sciences for Health
MUAC	Mid-Upper Arm Circumference
MW	Midwife
NGO	Non-Governmental Organization
Ob/gyn	Obstetrics and Gynecology
OPD	Out-patient Department
ORS	Oral Rehydration Salts
PENTA	Pentavalent vaccine (Diphtheria, Tetanus, Pertussis, Hepatitis B, Hemophilus Influenza b)
PENTA٣	Third dose of PENTA
PF	Plasmodium Falciparum
PH	Provincial Hospital
PPHCC	Provincial Public Health Coordination Committee
PPHD	Provincial Public Health Director
PPHO	Provincial Public Health Office
PNC	Post Natal Care
PNV	Post Natal Visit
PV	Plasmodium Vivax
REACH	Rural Expansion of Afghanistan's Community Health
RH	Regional Hospital
RRS	Routine Reporting System
SP	Sulfadoxine + pyrimethamine
SS	Sputum smear (TB diagnosis)
STD	Sexually Transmitted Diseases
STG	Standard Treatment Guidelines
STI	Sexually Transmitted Infections
TB	Tuberculosis
Tech-Serve	Technical Support to the Central & Provincial Ministry of Public Health
TT	Tetanus Toxoid
TT٢	Second dose of TT
U٥MR	Under Five Mortality Rate
UN	United Nations
UNFPA	United Nations Family Planning A……
UNICEF	United Nations Children Emergency Fund
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization
WRA	Women of Reproductive Age

Introduction

I. HMIS: Development, Accomplishments and Challenges

I.a. Development of HMIS ٢٠٠٣/١٣٨٣

In March ٢٠٠٣, the MoPH had published its first version of the Basic Package for Health Services, describing the core of primary health care services that should be available to all Afghans. Since many of these services were to be implemented through different contracting mechanisms (Private Partnership Agreements and performance based grants), the need for a sound information system that would allow the MoPH to monitor progress of the BPHS implementation by its partners became all the more urgent.

Like many other parts of the health system, the HIS had suffered greatly over the last ٢٣ years of turmoil. Despite obvious difficulties, efforts were made by the Ministry of Health and its partners to maintain at least a minimum of information flow. Early in ١٩٩٩, a Task Force was formed, resulting in an HIS for outpatient visits that was implemented starting in March ٢٠٠٠. The Afghanistan National Health Resources Assessment (ANHRA), conducted in the summer of ٢٠٠٢, found that about ٢/٣ of all functioning facilities had copies of the HIS forms available. However, few of the reports were finding their way to the central HIS unit in the MoH. The data collected were inconsistently used for action at the local level and focused principally on reporting disease morbidity rather than on providing data about services and resources that might be helpful in improving health services management.

The planned rapid expansion of health services under different grants programs to NGOs called for an HMIS that allowed following the progress of BPHS implementation. Starting early in ٢٠٠٣, a revived HMIS Task Force collaborated with various other technical Task Forces to define policies and protocols for individual interventions. Given that there was no functioning uniform data aggregation and processing system, the Task Force decided to take the following approach:

١. Define indicators for each of the components of the BPHS;
٢. Review existing data collection and report forms for appropriateness;
٣. Draft new reporting forms;
٤. Draft new data collection forms.

After review of the data collection tools in use by the various implementers of the BPHS, the MoPH decided not to impose standard data collection tools for fear of disrupting what was already working. It did, however, introduce the indicators for BPHS and developed standard reporting forms containing the minimum information that needs to be collected, analyzed and reported routinely.

I.b. The early implementation of the HMIS

The early implementation of the HMIS was a success: in early ٢٠٠٣, updated information from about ٥٪ of facilities was readily available at the MoPH; by late ٢٠٠٥, ٧٠٪ of all facilities targeted for early implementation (about ٨٠٪ of the total) were submitting timely routine reports to the MoPH.

User feedback provided insights on the advantages of the HMIS over the previously used HIS:

١. Forms and definitions are in line with the BPHS
٢. Data quality is improved:
    a. Clear guidelines for indicator definition and use
    b. Data collection limited to what is needed for BPHS
    c. Standard tools for tallying
٣. Data collection plus transmission procedures are standardized and simple
٤. Data presentation and use is promoted
٥. Computers are used efficiently at provincial and central levels to facilitate data analysis and communication
٦. Data on health infrastructure, needed to obtain the indicators, can be maintained
٧. Supervision can be readily strengthened and standardized.

I.c. Development of the HMIS ٢٠٠٥/١٣٨٥

In late ٢٠٠٤, the HMIS Task Force evaluated the early implementation of the HMIS, assessing actual implementation and problems encountered at community, facility and provincial/NGO level in three provinces, as well as at the national level. In early ٢٠٠٥, evaluation results were used to revise existing forms and guidelines.

Based on recommendations from the users, more detailed guidelines for analysis and use of data at the local level were developed and tested.

The forms and guidelines were further revised to conform to the BPHS ٢٠٠٥/١٣٨٤, and additional indicators, forms and guidelines were developed to allow monitoring the EPHS ٢٠٠٥/١٣٨٤ for inpatient care, and the EPHS module was incorporated into the HMIS database in ٢٠٠٦/١٣٨٥.

The transmission of electronic data was refined, and protocols were developed to allow Provincial Public Health Offices to aggregate provincial data from different NGOs in the province before sending the aggregated data to the MoPH.

By late ٢٠٠٩, regular routine service statistics from more than ٨٠٪ of all facilities were available at the central level.

I.d. Development of the HMIS ٢٠١١/١٣٩٠

A regular revision of the HMIS was scheduled to follow the revision of the BPHS, the revised version of which became available in July ۲۰۱۰. Supporting the BPHS was the development of MoPH National Core Indicators. These reflected the core priorities of the MoPH and are consistent with the evolving implementation strategies of national programs.

Between July and December ۲۰۱۰, the HMIS Taskforce oversaw an in-depth review of the BPHS and EPHS HMIS using internationally standardized questionnaires. This included the analysis of the quality of data collected against selected core indicators, a review of the organizational, behavioral and individual constraints to the use of data across all tiers of the health sector and an analysis of the type, frequency and flow of data and reports required within the health sector and an analysis of the morbidity data from both the EPHS and BPHS facilities. There was broad stakeholder engagement to guide the development of the revised HMIS including:

- MoPH directorates and departments through personal interview of key personnel and workshops;
- PPHO, implementing NGOs, and HF of six provinces through structured questionnaires and focus group discussions;
- HMIS Taskforce members reviewed and organized results of the above;
- Analysis of a ٥٪ sample of ۳۱,۷۸۳ cases categorized as "Other – Unlisted diagnosis" out of a total of ۹٥,۲۲۳ outpatient visits during the months of Saratan and Qaws ۱۳۸۹ in ۲۹ facilities;
- Analysis of ۱۸,۱۹٦ inpatient cases of which ۸,۲۷۸ initially classified as "All other new inpatient cases" during the months of Saratan and Qaws۱۳۸۹ in ۳ DH, ۳ PH, ۲RH and one National Hospital.

A core group designated by the HMIS Taskforce drafted revised forms and corresponding guidelines, which were reviewed with MoPH, NGOs and selected PPHO in three workshops during December ۲۰۱۰ – January ۲۰۱۱.

Between September ۲۰۱۰ and March ۲۰۱۱, the different HMIS database modules were reviewed, normalized, and adapted to the updated forms and reports.

Starting April ۲۰۱۱, the HMIS (۲۰۱۱/۱۳۹۰) was rolled out throughout Afghanistan.

I.e. Working principles for revising the HMIS

In order to ensure consistency between HMIS revisions, the HMIS taskforce in ۲۰۱۰ applied similar working principles to those used in the initial development of the HMIS. These principles include:

١. Any data to be recorded at a service level must be able to be used by both the staff and the community to analyze and improve the provision of health services within their community.

٢. Where possible proposed changes should simplify the existing system.

٣. Any changes or developments in data recording and reporting should be made to improve the provision of care at the patient and community level, particularly for those populations who are most vulnerable and most in need.

٤. Great prudence should be applied when making changes to components of health information systems that are working fairly well. Proposed changes should focus on components that are need improvement.

٥. Efforts should be made to make better use of existing data at all levels through practical analysis and improved presentation of data.

٦. Modest use of computerization should be encouraged and supported for data base maintenance and report generation, and should match the locally available IT infrastructure.

٧. Improvement in health data generation and use at the various service levels should be undertaken in support of efforts to improve service task performance and should be seen as a by-product of such performance improvement. Care should be taken to share information in a non-threatening way: encouraging improvement and not laying blame.

I.f. Criteria for Health Indicator selection

National Health Indicators, in particular those obtained through routine reporting systems, were chosen for national use with consideration to the following criteria:

١. *Relevant* – The indicators should reflect the national health priorities, policies and strategies, and in particular the BPHS and EPHS, to ensure usefulness for decision making across all tiers of the health system.

٢. *Representative* – The indicators should be able to measure health status or service performance beyond the immediate event or task being reported.

٣. *Reliable* – The indicator definition is precise, allows precise measurement of changes over time.

٤. *Valid* – The indicator should measure what it is intended to measure.

٥. *Useful for action at the recording level* - The data needed for the indicator is useful for the person doing the recording (manager, staff, community leader or patient) and the recorded data contributes to taking necessary action in regard to the case, family, community or district being served

٦. *Ease of Generation and Measurement.* – Core indicators should be selected that allow for the feasible collection of reproducible data in a timely and accurate way.

٧. *Understandable* - The indicator should deal with a single clear idea that everyone will see as an important measure.

٨. *Ethical* - Data collection, including the choice of the data source, computation of the indicator and its use should not conflict with accepted ethical values and should conform to MoPH values.

II. Purpose of the Procedures Manual

This document provides an overview of the national Health Management Information System (HMIS) and describes the procedures to be used for data collection, processing, reporting and use through the MoPH feedback mechanism. This manual also includes samples of each of the principal reporting formats and provides detailed instructions for their completion and use. In addition, it contains the priority indicators selected for monitoring progress in the implementation of the BPHS/EPHS. Given the dynamic nature of effective information systems, it is important to update this reference document when information systems procedures change. The major revisions of this Procedures Manual will follow the regular updates of the BPHS/EPHS.

III. Organization of the Procedures Manual

This manual is organized into three sections.

Section ١: Provides an overview of the system, identifying and defining the principal indicators collected by the system whilst describing the general data management procedures.
Section ٢: Provides detailed descriptions of the forms used for data recording, tallying, and reporting.
Section ٣: Which is a supporting manual to the main HMIS procedures manual describes how to represent and analyze the data, including how to calculate the BPHS/EPHS indicators. It also provides examples on how to use the information. For ease of use, section three has been transferred to a separate manual.

Section ١ - Overview of the HMIS

١,١. Definition of HMIS

The HMIS is a system based on qualitative and quantitative indicators in which routine health information is collected, processed, analyzed, interpreted, disseminated, and used to improve the provision of health services according to the MoPH's priorities and ultimately to improve the health of the population. In addition, the information generated can be used for research and training purposes.

١,٢. The Content of HIS and HMIS

An information system consists not only of numbers, proportions, and ratios. Quantitative indicators are not the end measure of the system, but actually trigger further questions, which are often more qualitative in nature. Equally important indicators of health service performance are the perceptions and subjective experience of the health workers, the patients or clients, and the community members. A well-designed information system will capture different kinds of data and ensure they are reviewed and used at all levels of the health system.

In Afghanistan, the MoPH information system contains the following components:

١. Surveillance reports to communicate epidemic information about notifiable and newly emerging diseases that require immediate action. This component is called the Disease Early Warning System (DEWS)
٢. Periodic Reports (Monthly, Quarterly, Semi-Annual, Annual) to transmit data between service levels. This component is the Health Management Information System (HMIS)
٣. Results of periodic national and sub-national surveys and evaluations (e.g., household surveys, facility assessments) This component is partly addressed by application of the National Monitoring Checklist and several periodic data collection exercises like the Third Party Evaluations.
٤. Qualitative information collected from communities, health workers and program staff through both formal and informal channels.
٥. Demographic data and vital statistics are obtained through the Central Statistics Office (CSO)

As part of a larger Health Information System (HIS), the HMIS proper mainly addresses the periodic routine reports, including the data collection tools needed to compile the reports.

١,٣. The purpose of the HMIS

Afghanistan's Health Management Information System is designed to:

١. Help health workers better manage their services and health facility supplies and resources;
٢. Help health workers in their efforts to organize and monitor health

development work in their communities;

٣. Provide data to provincial MoPH and NGO managers for supervision and other supportive action;

٤. Provide data to provincial and national program staff, and to donors for planning, monitoring and evaluation.

١,٤. Overview of the HMIS forms

١,٤,١. Forms drafted and in use

Pictorial Tally Sheet
Monthly Activity Report (Health Posts) - MAR
Monthly Aggregated Activity Report – MAAR

General Register – Facilities
Monthly Facility Tally Sheet
Monthly Integrated Activity Reports (Hospital OPD/CHC/BHC/SHC/MHT) – MIAR
Facility Status Report (CHC/BHC/SHC/MHT) – FSR

Catchment Area Annual Census (CAAC)
Pictorial Data Collection Sheet
CAAC Report – Village Level/Facility Level

Hospital Monthly Inpatient Report (Hospitals and larger facilities with inpatient care) – HMIR
Hospital Monthly Tally Sheet
Hospital Status Report (Hospitals) – HSR

The previously included Notifiable Disease Report has been transferred to and incorporated into DEWS.

١,٤,٢. Areas for future development

Future development of the HMIS incorporates both the development of data collection tools and the information products and forums for reporting and decision making. Integration of information from across the MoPH will be a key feature of the future development of the HMIS.

Incorporation of registration tools and report forms of vertical programs. A newly developed TBIS is being implemented, and the TBIS database module will be integrated into the general HMIS database, allowing simultaneous quarterly transmission of data.

Inventory control registration and report tools (all levels)

Standardized registration tools at the facility level (MHT, SHC, BHC, CHC, Hospitals)

Supervisory checklists

The production of standardized MoPH program activity reports, epidemiological reports triangulating data and information from the surveillance system and strengthening the use of data through process improvement methodology will be a priority for the continued development of the HMIS,

١,٥. The Process of the HMIS (Data Flow)

The HMIS should not be seen only as a mechanism for collecting information and passing it to successively higher levels. Information should be used at the level at which it is collected. The HMIS involves the following processes: collection of data, processing it for conversion into useful information, analyzing and discussing it for assessing the current status of services and using it to set appropriate strategies and targets for health service improvement. The flowchart in Figure ١ shows the different steps in data collection and transmission, as well as analysis and feedback.

١. At the level of Health Posts, male and female CHWs keep a record of activities and the HSC/BHC/CHC/DH collects monthly summary reports. Pictorial data recording and reporting forms have been developed, taking into account that many of the health workers at this level may be functionally illiterate. A standard Monthly Activity Report (MAR) summarizes the data on the activity in the Health Post, and is transmitted to the CHC/BHC/DH, where the MARs of all Health Posts in the catchment area are aggregated into the Monthly Aggregated Activity Report (MAAR).

   The Health Posts, with the cooperation of the CHS of the HSC/BHC/CHC/DH, will collect data on the communities served by their activities through the Catchment Area Annual Census (CAAC). This census will help measure progress towards population-based objectives. The CHS of the HSC/BHC/CHC/DH will assist the Health Posts in analysis and interpretation of this data.

٢. Health workers in HSC/BHC/CHC/Hospitals record encounters in registers and cards (OPD, TB, EPI, ANC-Delivery-Neonatal, and FP). Hospitals will use records for both OPD and IPD.

٣. To complete the picture obtained from aggregating the mini-surveys of the Health Posts, the HSC/BHC/CHC/Hospitals will also collect data on the communities directly served by their activities through a CAAC.

٤. At the end of each month, HSC/BHC/CHC/Hospitals tally their data from registers and other records and transfer the information to monthly reporting forms. One Monthly Integrated Activity Report (MIAR) form combines the tallies from different outpatient registers and cards. One Monthly Hospital Inpatient Report (HMIR) combines the information on inpatients. Health Post monthly reports are aggregated by the HSC/BHC/CHC to complete the picture of the BCH/CHC catchment area. The aggregated report is sent on to the

PPHO/NGO before the ٧th day of each month. The reports facilitate the use of data at the facility level.

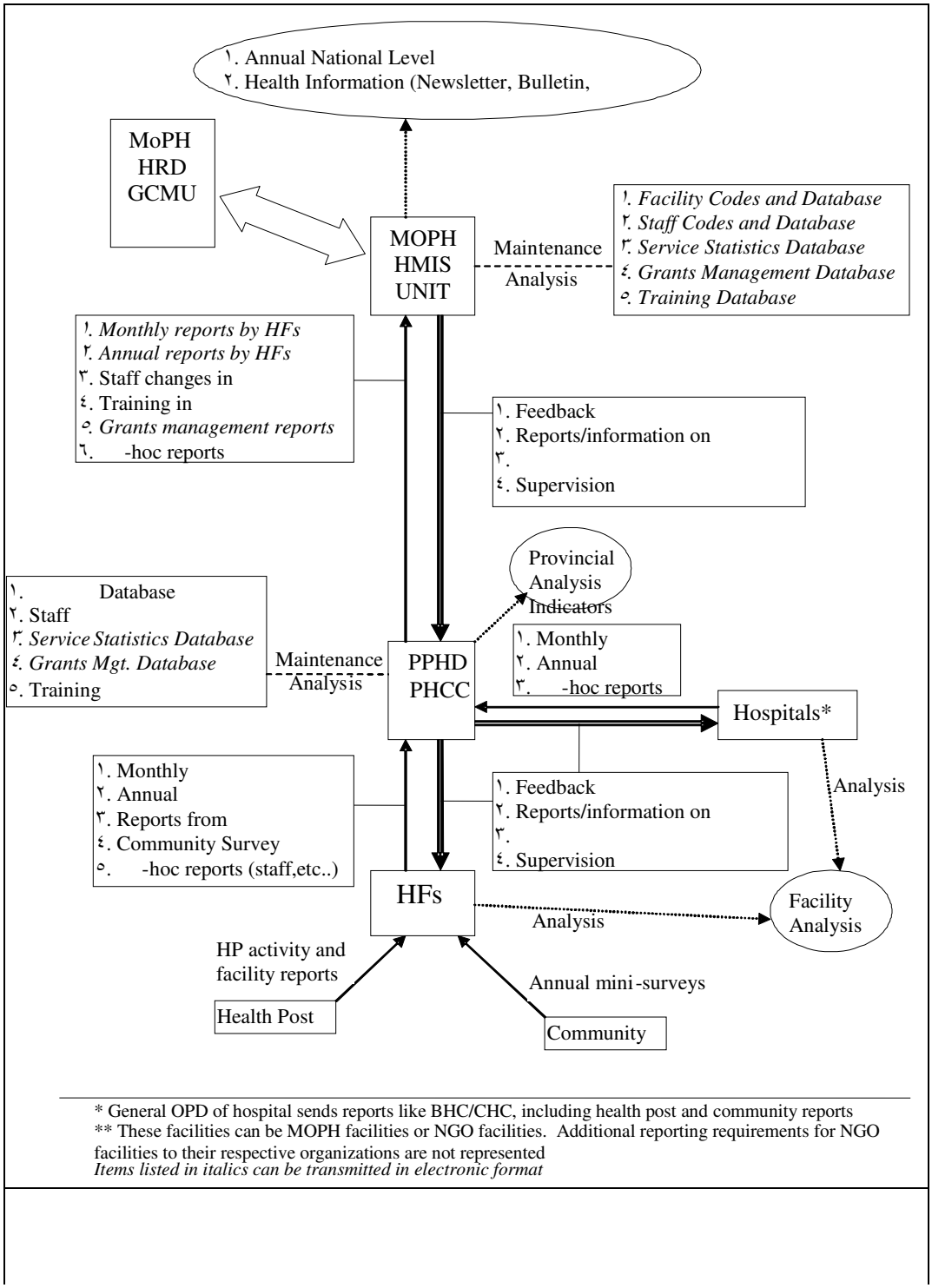


Figure ١ – HMIS Data Flow

٥. Special reports for vertical programs (TB, EPI and others) are sent to corresponding program officers in the MoPH. TBIS will be integrated as a separate module into the HMIS database.

٦. Every six months, a Facility Status Report (Hospital Status Report for hospitals) on health services, infrastructure, equipment, staffing, etc… is compiled by the in-charge of each facility and sent to the PPHO/NGO. In the present version of the HMIS, FSR and HSR are reported six-monthly.

٧. At the provincial level, reports are received and registered to allow for monitoring of completeness. A register is kept for this purpose. Health facilities are contacted for missing reports and errors in the reports. Using the same MIAR form, individual reports are aggregated by type of facility.

٨. At the provincial level, several databases are maintained. Databases can be in paper or electronic format, but most PPHCCs will have access to the necessary electronic resources. Data is consolidated at this level and consolidated monthly reports are forwarded to the central HMIS Unit of the MoPH. If computerization is available, data will be entered in the computer at provincial level by the HMIS officer or the lead NGO and data can be forwarded electronically.

٩. At the provincial level, monthly or quarterly, data is analyzed by facility and written feedback is sent to each facility. With computerization, the content of many of these reports can be produced automatically. Before each supervisory visit, the HMIS data of the concerned facility should be reviewed to facilitate performance assessment and customize the supervisory visit. The information should be discussed with the staff. The final responsibility for the process lies with the Provincial Public Health Director; technical implementation lies with the Provincial HMIS Officer or assistant officer, or the lead NGO for that province.

١٠. At the provincial level, grants data is recorded and quarterly reports are sent to the central level before the end of the first month of the new quarter.

١١. At least once a year, all facility in-charges should meet at the provincial level for the planning meeting. This meeting should include analysis of data, interpretation of trends, and prioritization of activities and setting of targets for the next year. National level indicators, as well as indicators specific for each province, are monitored and discussed at this level.

١٢. At the central HMIS Unit, all reports of all provinces are combined in a national Service Statistics Database. At this level, facility and staff databases are also maintained, as well as a grants management database. One important function of the national HMIS Unit is giving unique facility codes and staff codes that facilitate maintenance of the databases. Facility codes are void of any meaning, other than being a unique identifier: facility types change, province and district boundaries change. The HMIS Unit coordinates closely with the HRD to maintain unique staff ID numbers for all MoPH and NGO health personnel working in Afghanistan. The HMIS Unit maintains close coordination with the Human Resources Department, Personnel Management Department, and the Grants and Contract Management Unit, to ensure unique coding of staff, grants, etc… and maintain department specific databases that are linked to the HMIS database.

١٣. Every six months, or at least once a year, reports are sent to each province. Once a year, a report on the trends of the national level indicators is produced. Other information material can be produced as well. The HMIS unit prepares material for the Annual National Health Planning meeting, where PPHD and NGOs from each province convene. The National meeting will take place after a similar meeting in each province. Necessary budget for this meeting should be secured at the national level.

١٤. Computerization allows the MoPH to ensure that all implementing agencies, PPHOs and NGOs, have the most recent data available. Whenever NGOs submit electronic data to the PPHO, they will receive a new analysis copy of the data base that contains their own data as well as all other data in the province. Whenever PPHOs submit electronic data to the MoPH, they will receive a new analysis copy of the data base that contains their own data as well as all other data in the country. The routine reports included in the analysis database facilitate the interpretation and use of data at the PPHO and NGO level. The degree and vehicle of electronic data transmission may vary by province, depending on available local expertise.

١,٦. HMIS functions by health system level

١,٦,١. Health Post Level

Data collection

- Pictorial tally sheet
- Annual Census of catchment area population tally-sheet (CAAC)

Data use

- Analysis with assistance from HSC/BHC/CHC/DH during supervisory visits
- Planning of activities with assistance from HSC/BHC/CHC/DH
- Match performance (MAR) with coverage (CAAC)

Reports

- Monthly Activity Report (MAR) with HSC/BHC/CHC/DH
- CAAC – Health Post Level Report
- Feedback to Community Health Committees

١,٦,٢. HSC/BHC/CHC Level

Data Collection

- Data collection of activities in register(s) and patient card(s)
- Tally sheets
- Inventory records on essential drugs and supplies, equipment and staff
- Yearly census of households in catchment area CAAC

Data Use

- MIAR analysis – functioning of facility
- MAAR analysis – functioning of community based activities supervised by the facility
- CAAC analysis – cross check between activities and coverage
- Facility Status Report analysis – availability & accessibility of care
- Investigation of notifiable diseases (through DEWS) – containment of epidemics
- Supervision of and feedback to Health Posts – improve performance of community-based activities
- Feedback to community health committees
- Monthly, quarterly and annual activity planning

Reports

- Monthly Integrated Activity Report (MIAR)
- Monthly Aggregated Activity Report of Health Posts (MAAR)
- Facility Status Report (FSR)
- Annual Census Report (CAAC – Facility Level Summary Report)
- Notifiable Diseases Report (through DEWS)

١,٦,٣. Hospital Level

Data Collection

- Outpatients: see HSC/BHC/CHC level
- Inpatients registers and records

Data Use

- Outpatients: see HSC/BHC/CHC level
- Health Posts: see HSC/BHC/CHC level
- HMIR analysis – functioning of inpatient departments
- Hospital Status Report analysis – availability & accessibility of care
- Investigation of notifiable diseases (through DEWS) – containment of epidemics
- Feedback to hospital boards
- Monthly, quarterly and annual activity planning

Reports

- Monthly Integrated Activity Report (MIAR)
- Hospital Monthly Inpatient Report (HMIR)
- Monthly Aggregated Activity Report of Health Posts (MAAR)
- Hospital Status Report (HSR)
- Annual Census Report (CAAC – Facility Level Summary Report) – for the district hospitals
- Notifiable Diseases Report (through DEWS)

١,٦,٤. Provincial Level[١]

Data Storage

- Status of facilities
- Staffing of facilities
- Service Statistics
- Grants Management
- Training

Data Use

- Aggregation and/or computerization of:
  - Monthly Integrated Activity Reports
  - Hospital Monthly Inpatient Reports
  - Monthly Aggregated Activity Reports
  - Catchment Area Annual Census
  - Facility and hospital status reports
- Analysis and feedback to facilities
  - Supervision
  - ٦ monthly or quarterly meetings
  - Written feedback reports
- Provincial annual planning and progress monitoring
- Follow-up on Notifiable Diseases Report (DEWS)

[١] Each lead NGO grant/contract performs the same functions as the Provincial Level, in close collaboration with the PPHO to avoid unnecessary duplication.

Reports

- Aggregated MIARs
- Aggregated HMIRs
- Aggregated MAARs
- Aggregated CAAC
- Staffing changes
- Aggregated facility and hospital status reports
- Grants report
- Notifiable disease reports (through DEWS)

١,٦,٥. National Level

Data Storage

- Facility Codes and Database
- Staff Codes and Database
- Service Statistics Database
- Grants Management Database
- Training Database

Data Use

- Analysis and calculation of national indicators
- Feedback to provinces:
  - Supervision
  - Written reports
  - Annual planning meeting
  - Information on request
- Follow-up on notifiable diseases reports

Reporting

- Annual progress report on health status (BPHS indicators)
- Health information (e.g., Newsletters)
- Standard reports for use by other departments (HRD/GCMU/PLO)

١,٧. Priority diseases, services and interventions

The reporting of morbidity is limited to the priority diseases included in the BPHS and EPHS.

For **outpatient reporting**, an assessment in ٤ DH, ١١CHC and ١٤ BHC in the provinces of Balkh, Ghazni, Herat, Kabul, Laghman, and Nangarhar of outpatient visits for the months of Saratan and Qaws of ١٣٨٩, showed that out of ٩٥,٢٢٣ OPD visits ٣١,٧٨٣ (or ٣٣٪) were classified as "Other". Analysis of a systematic random sample of ١٤٢٥ "Other", showed that ١٦٪ should have been classified under an existing heading. Based on the analysis of the ٨٤٪ remaining "Other", a new list of priority conditions for OPD Morbidity is included in this version of the HMIS:

١. ARI - COUGH & COLD
٢. ARI - ENT
٣. ARI - PNEUMONIA
٤. DIARRHEA - ACUTE WATERY, WITHOUT DEHYDRATION
٥. DIARRHEA - ACUTE BLOODY, WITHOUT DEHYDRATION
٦. DIARRHEA WITH DEHYDRATION
٧. SEVERELY ILL PATIENT
٨. VIRAL HEPATITIS
٩. MEASLES
١٠. PERTUSSIS
١١. DIPHTHERIA
١٢. NEONATAL TETANUS
١٣. TETANUS
١٤. ACUTE FLACCID PARALYSIS
١٥. MALARIA
١٦. URINARY TRACT INFECTIONS
١٧. MENTAL DISORDERS
١٨. TRAUMA
١٩. TB SUSPECTED CASE
٢٠. PEPTIC DISORDER
٢١. MUSCULOSKELETAL
٢٢. HYPERTENSION
٢٣. ANEMIA
٢٤. GASTRO-INSTESTINAL WORMS
٢٥. SKIN – INFECTION
٢٦. SKIN – OTHER
٢٧. PELVIC INFLAMMATORY D.
٢٨. SEXUALLY TRANSMITTED D.
٢٩. EYE INFECTION
٣٠. ORO-DENTAL CONDITIONS
٣١. MICRO-NUTRIENT DISORDERS
٩٩. OTHERS/UNLISTED DIAGNOSES

For **inpatient reporting**, the analysis of ١٨,١٩٦ inpatient cases in ٣ DH, ٣ PH, ٢RH and one National Hospital in the months of Saratan and Qaws of ١٣٨٩ showed that, after reclassification, only ١٩٪ could be qualified as "Others". Several existing categories containing more than ١٠٪ of all inpatient cases, were split up. Based the analysis the in-patient morbidity listing was adapted as follows:

١. Weapon wounded
٢. Road traffic accidents
٣. Occupational injuries
٤. Burns, scalds & frostbite

٥ Fractures& dislocations
٦ Cerebral Concussions
٧. Other injuries
٨. Cerebro-vascular accidents
٩. Ischemic Heart Diseases
١٠. Other Cardiovascular
١١. Meningitis/encephalitis
١٢. Epilepsy & convulsions
١٣. Other Neurological
١٤. Diabetes & related
١٥. Micronutrient deficiencies
١٦. Acute abdomen
١٧. Peptic disorders
١٨. Other Gastro-intestinal
١٩. Abdominal Hernia
٢٠. Liver, gall bladder & pancreas
٢١. Urinary tract infections
٢٢. Other Uro-genital conditions
٢٣. Pelvic Inflammatory disease
٢٤. Dysentery (all types)
٢٥. Diarrhea (except dysentery)
٢٦. Malaria
٢٧. Tuberculosis
٢٨. Typhoid
٢٩. Musculo-skeletal infections
٣٠. Sepsis
٣١. Other infectious
٣٢. Common Mental Problems
٣٣. Substances abuse
٣٤. Severe Mental Problems
٣٥. Respiratory tract infections
٣٦. ENT
٣٧. Other Respiratory Conditions
٣٨. Eye conditions
٣٩. Skin conditions
٤٠. Obstetric & pregnancy related
٤١. Gynecological (non pregnant)
٤٢. Neonatal conditions
٤٣. Musculoskeletal
٤٤. Surgical cases (unspecified)
٩٩. All other new inpatient cases

Many more conditions exist; these may be included or replace the ones included at present in future revisions, reflecting change in priorities of the MoPH over time.

Likewise, the services and interventions that are monitored through the HMIS are limited to those that focus on the priority target groups and conditions of the BPHS and EPHS. They are:

- Nutritional status of children

- Family planning
- Pre- and Post-natal care
- Obstetric care
- Neonatal care
- Essential drugs and supplies
- Immunizations
- Laboratory for tuberculosis, malaria and HIV
- Tuberculosis case finding and treatment
- Community health
- Mental health
- Surgical interventions
- Blood transfusion

Standard case definitions corresponding to priority diseases, services and interventions are given in Annex ٣.

١,٨. Computerization of the HMIS system

The HMIS system allows for data entry into a database routine at different levels where data gets aggregated. Separate manuals describe in detail the data entry and analysis procedures[٢], the HMIS database maintenance[٣], and the HMIS database replication and synchronization process[٤]. We limit ourselves here to a general overview of how data is transmitted.

A short early trial with a web-based data base proved unfeasible in Afghanistan. A less fancy, but more solid and flexible system that can adapt itself to the different degrees of computer capacity in the provinces, has been developed.

The HMIS Unit in the MoPH maintains the Master copy of the databases. It assures the integrity of reference and lookup files, and aggregates the data from NGOs and PPHOs into one general database. It distributes updated copies of the Master (replicas and analysis copies) to NGOs and PPHOs to promote analysis and use of data for action at the provincial and sub-provincial level. The MoPH/HMIS integrates new data of all replicas into the Master.

١,٨,١. Definition of terms

Certain terms are used to identify the different copies of the HMIS database that are used at different levels for different purposes.
Analysis copy: a copy of the Access database and the corresponding Excel report pivot tables. It does not allow entering new data, but allows analysis of the data it already contains
Replica: any copy of the database that allows entering of new data and analysis for synchronization with another replica. Any NGO and/or PPHO that collects data from ١٠ facilities or more qualifies for a replica. Those having fewer facilities transmit data manually to the next level.
Synchronization: computerized aggregation of data from different HMIS sources into the general HMIS database, called the hub.
Hub: a copy of the general HMIS database that aggregates data from several replica or lower-level hubs. Hubs are located in the HMIS Unit of the MoPH (Master) and in those provincial offices that qualify for the hardware and maintenance requirements (Provincial Hub).

١,٨,٢. Requirements for installing a provincial hub.

Specific requirements exist for a PPHO to obtain an official Provincial Hub of the HMIS database to allow aggregation of the data of one province (NGOs and MoPH facilities) into one provincial hub before sending the data on to the MoPH in Kabul. A formal agreement is signed between the HMIS Unit of the MoPH and the PPHO that requests a hub of the database. The terms of the agreement are as follows:

١. Minimum requirements for receiving a Provincial Hub:

---

[٢] <Reference of the Manual>
[٣] <Reference of the Manual>
[٤] <Reference of the Manual

a. Provincial Hub = More than one Replica in the province

٢. System Requirements
   a. Minimum requirements
      i. Laptop (preferred)
      ii. Desktop (if no laptop available since desktops make updates and occasional troubleshooting more difficult)
      iii. Accessories
         ١. Sustainable electricity
         ٢. Stabilizer
         ٣. UPS
      iv. ٢٥٦ MB Ram
      v. Processor ٢ GHz
      vi. CD ROM writer
      vii. Available USB port
      viii. ٥ GB available on Hard Drive at all times
      ix. Network Interface Card
      x. Must have a C drive (multiple drives are okay, but must have a C drive)
   b. System requirements will be vetted by the MoPH/HMIS before the PPHO can be considered for receiving a HMIS hub.

٣. Software
   a. MS Office ٢٠٠٧
   b. Anti-virus software
   c. WinZip ١٤ or higher

٤. Maintain computer properly
   a. Do not install, uninstall, or otherwise alter the MS Office software other than installing routine updates from Microsoft
   b. Do not alter computer hardware configuration after initial installation
   c. Do not move the database or individual files from the initial folder

٥. Bring computer to MoPH for updates and maintenance as needed.

٦. Must assign an HMIS officer who will be dedicated to managing the database. See attached minimum requirements. If the HMIS Officer changes, the updated information must be forwarded to their contact at the Customer Service Team within one week of the change. (See attached contact list)

٧. Make the HMIS officer available for initial training in Kabul and periodic training thereafter as needed. You are encouraged to cross-train your staff to promote the institutionalization of the skills.

٨. Include maintaining and updating the database as part of the job description of the HMIS officer.

٩. Must notify a responsible member of Customer Service Team within two days at the first sign of trouble with the database. Contact list is attached.

١٠. Non-compliance that causes data corruptions requiring MoPH resources to correct will be charged accordingly at the discretion of the MoPH/HMIS.

١١. A ٤٨ hours notice is required before canceling a training session. A penalty fee will be imposed for no-shows at the discretion of the MoPH/HMIS.

١٢. In case of non-compliance with any of the above, the Provincial Health Office will have one month to Failure to comply within one month of observed non-compliance will void this agreement.

Similar requirements exist for a PPHO or an NGO to obtain a data-entry replica of the database. The PPHO or NGO should be managing the HMIS reports of at least seven facilities in order to qualify for a separate data-entry replica.

A data analysis copy allowing running of the routine reports and creation of custom reports on already entered data can be obtained from the MoPH/HMIS on request.

١,٨,٣. PPHO manages a hub (Ideal).

For this set-up, PPHOs need to qualify for a hub. In March ٢٠٠٦, only ٢ PPHOs qualify.

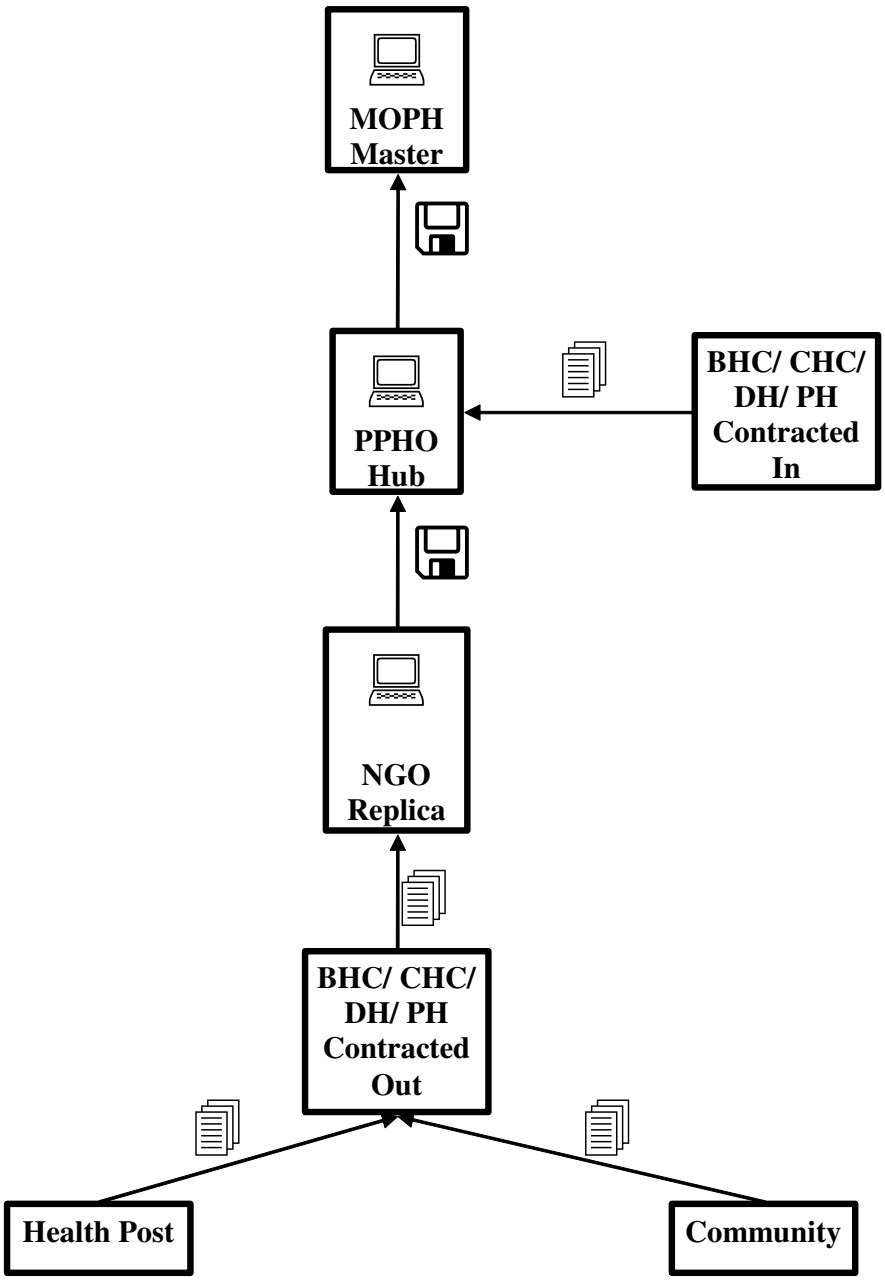


Figure ٢ - Computerization of HMIS: Ideal situation

Health Posts and Community information (CAAC) arrive at facility level in paper format. The Facility sends paper reports to the NGO (for contracted-out facilities) or to the PPHO (for contracted-in facilities). The NGO or the PPHO enters the received information in a replica. The NGO sends a CD to the PPHO, where the replica is synchronized and the NGO receives a new replica and analysis copy, both of which include the most recent data of the NGO along with all data from other NGOs.

١,٨,٤. PPHO has a replica, but no hub (most common).

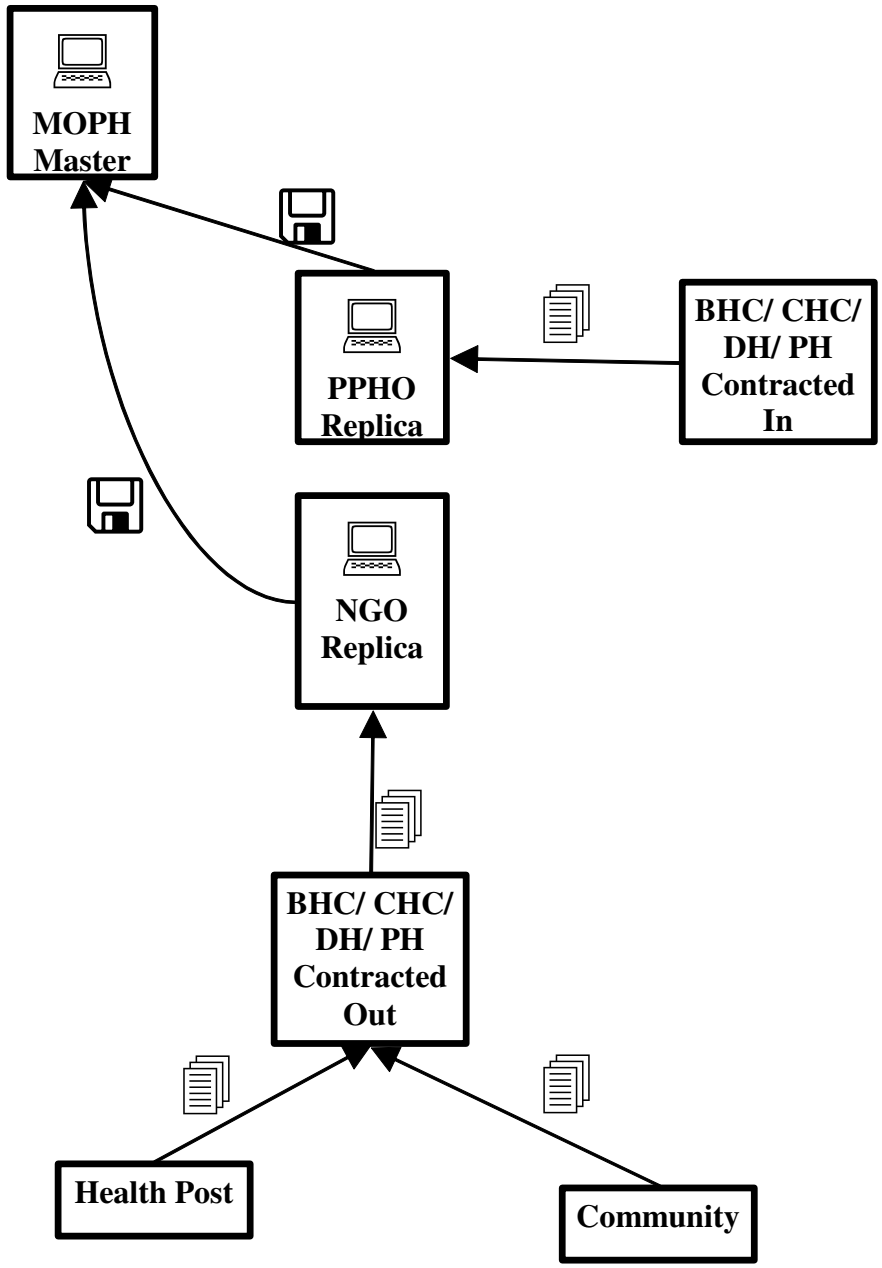


Figure ٣ - Computerization of HMIS: Most common situation

Health Posts and Community information arrive at the facility level in paper format. The Facility sends paper reports to the NGO (for contracted-out facilities) or to the PPHO (for contracted-in facilities). The NGO or the PPHO enter the received information in their respective replica. The NGO and the PPHO send the replica to the MoPH, where it is synchronized with the Master hub. The PPHO and the NGO receive a new replica (including an analysis copy), both of which include the most recent data of the NGO along with all data from other NGOs.

١,٨,٥. PPHO only has an analysis copy (less common)

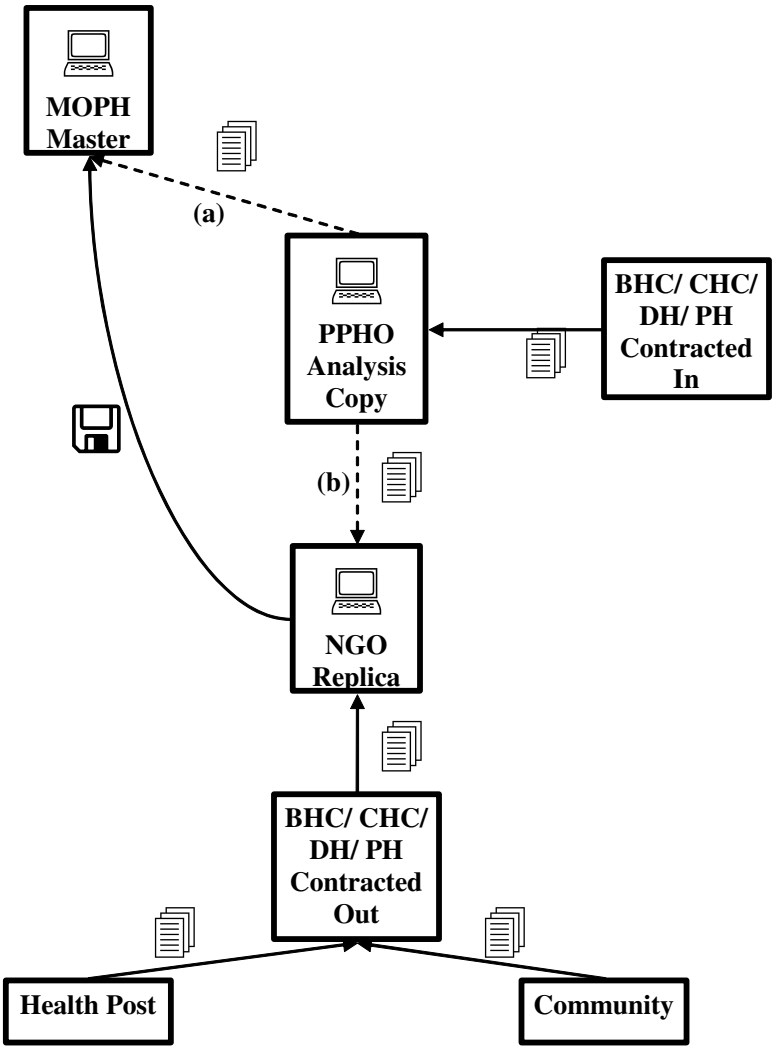


Figure ٤ - Computerization of HMIS: Less common situation

Health Posts and Community information (CAAC) arrive at facility level in paper format. The Facility sends paper reports (including aggregated HP reports) to the NGO (for contracted-out facilities) or to the NGO. The NGO enters the received information in a replica. The NGO sends the replica to the MoPH, where it is synchronized with the Master hub. Both the PPHO and the NGO get a new replica and analysis copy, both of which include the most recent data of the NGO along with all data from other NGOs. For the PPHO, there are two possibilities:

a. The PPHO sends paper facility reports to the MoPH, where the information is entered into the database and the PPHO receives a new analysis copy, which includes the most recent data of the PPHO along with all data from other NGOs.
b. The PPHO sends paper reports to the lead NGO. The NGO enters the information in its replica before sending it to the MoPH. The PPHO receives a new analysis copy, which includes the most recent data of the PPHO along with all data from other NGOs.

١,٩. Calendar conversions

Afghanistan uses an adapted Persian Calendar, also called the Shamsi calendar, in which the new year starts on ٢١ of March. The dates on the HMIS forms are in the Shamsi format. Punctual reporting, such as the Notifiable Diseases Report, needs to be converted to the exact Gregorian date. For routine reporting of monthly or quarterly aggregates, a conversion is made in which Shamsi months and Gregorian months are matched. Since each Shamsi month contains about ١٠ days of one Gregorian month and ٢٠ days of the next Gregorian month, each Shamsi month is matched with the Gregorian month of which it contains ٢٠ days. Figure ٥. shows the conversion for monthly and quarterly reports between Gregorian and Shamsi calendars.

Month			Afghan Quarter
Gregorian	**Dari**	**Pashtu**	
April	Hamal	Wray	١
May	Sawr	Ghwayay	
June	Jawza	Ghbargolay	
July	Saratan	Chingash	٢
August	Assad	Zmaray	
September	Sunbullah	Wazhay	
October	Mizan	Tala	٣
November	Aqrab	Laram	
December	Qaws	Lindey	
January	Jadi	Marghomay	٤
February	Dalwa	Salwagha	
March	Hut	Kab	

Figure ٥ – Calendar Conversions by month and quarter

Section ٢ – Detailed description of forms

٢,١. Notifiable Diseases Summary Report

The Notifiable Diseases are now reported to through the Disease Early Warning System (DEWS).

٢,٢. Health Post Pictorial Tally Sheet

٢,٢,١. Health Post Pictorial Tally Sheet – Guidelines for use

١. Purpose of the Form

This pictorial form is used to record information about monthly household visits and services provided by Community Health Workers (CHWs). Because many CHWs have limited literacy, this form uses graphic depictions of the services provided by the CHWs. The Community Health Supervisor (CHS) will ensure correct use fo the Pictorial Tallysheet during the routine supervisory visits. At least once a day, and if possible whenever a family visit or patient visit takes place, a tally will be put in the row corresponding to the running month in the appropriate column(s). If one row is not enough for one month recording, CHWs can use another row, as many as needed. If more than one CHW, e.g, one male and one female CHW, are jointly responsible for the same Health Post catchment area like couple or brother and sister, only one tally sheet should be filled out for that area to avoid duplication of reporting. If male and female CHWs are responsible for the same Health Post catchment area, but do not live together, each complete a separate tally-sheet. At the end of each month, both tallies are integrated into one MAR with the help of the CHS.

٢. Lay-out of the Form

This document is a two-page form printed double-sided on A-٤ paper. The form contains columns for data points and rows for each month of a six month period. The column headings contain pictures that match the corresponding entries in the CHW pictorial register.

٣. Data Sources

The data for this report comes from the CHW activities. It is recommended that the tally sheet be filled out after each client visit or service provided, or at least at the end of each day.

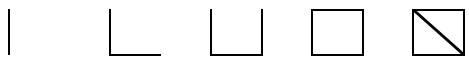
٤. Who prepares

Each CHW fills out the pictorial tally sheet. One form is used for each HP catchment area each month. If necessary, the CHS will assist the CHW to fill out the pictorial tally sheets during monthly visits. If necessary, general information can be filled out in advance by the CHS.

٥. Definitions

This form is the key data collection instrument to collect most of the data required to calculate the indicators for the HMIS for the village level.

A tally marks can be put as simple traits: ||| and for ease of counting totals, group tallies by fives, as shown: 𝍸. The following way of tallying can also be used:



Definitions of all of the BPHS indicators and the data required to calculate them are included in Annexes ١ and ٢. Only some indicators make sense at individual community level service delivery points.

٦. Instructions

This form has a total of ٢٩ pictorial entries pertaining to maternal and child health. It is used by CHWs to tally the information from their individual villages/catchment areas.

Sheet (١)

General information

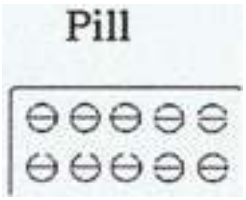
Facility Code and Name: Write the MoPH code number and name of the facility supervising the CHW
CHW Code and name: Write the code number and name of the CHW
Month and Year: write the month number for which the data is being reported (in most cases, this will be the previous month) and the ٤ digit Afghan Shamsi year for which the data is being reported.

Total families/clients seen

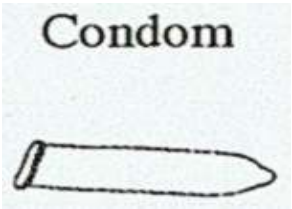
Family Visit

Family Visit: Put a tally mark each time a family visited the CHW or was visited by the CHW this month, irrespective of the number of family members being visited in each single time. One family visiting several times is marked each time, e.g., a woman visiting for contraception is one tally, a child of the same family visiting on another time is another tally. Note that one family visit can have several entries under each service.

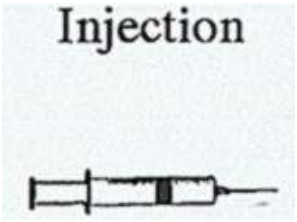
Reproductive health



١. **Pill:** Put a tally mark for each cycle of pills given to the client (women/family) by the CHW this month.

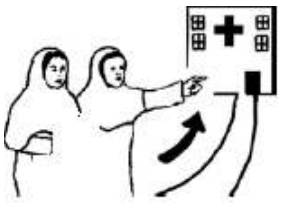


٢. **Condom:** Put a tally mark for each ١٢ (dozen of) condoms given to the client (women/family) by CHW this month



٣. **Injection:** Put a tally mark for each single contraceptive injection given to the client by the CHW this month

٤. Antenatal Visit (ANV): Put a tally mark for each pregnant woman who was attended by CHW for ANV during this month irrespective of round of ANV visits. At least one of the following interventions by a CHW will be considered as ANV: a) screening and orienting on the ٥ major complications (see CHW manual), b) supplying Ferr+Folic if applicable, c) counseling Balanced Diet, d) Birth Plan. This does not include those ANC attended by HFs or referred by the CHW to HFs for ANC.



٥. Normal delivery referred: Put a tally mark for each pregnant woman who was referred to the facility for delivery during this month.

٦. Obstetric/delivery complications Referred: Put a tally mark for each woman from the catchment area who is referred for an obstetric complication during the month.

٧. Postnatal Visit (PNV): Put a tally mark for each woman who was attended by CHW for PNV at home (including neonatal check) only **within ٤٨ hours° of birth** during this month. This does not include those PNC attended by HFs or referee for PNC to a HF by CHW.

٨. TB Referred: Put a tally mark for each new suspected TB case who was indentified and referred by CHW to the health facility during this month. "Suspected TB" refers to anybody whose cough lasts for two weeks or more. This does not include those TB cases which are under DOTS of CHW.

Referred for EPI

٩. Children referred for EPI: Put a tally mark for each child under the age of ١ year referred for EPI vaccination with any of the EPI antigens (BCG, PENTA, polio or measles) during this month. This includes children referred for routine vaccination at facilities, during outreach activities or during campaigns, when they take place.

° CAH Strategy

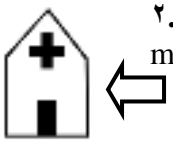
١٠. Women referred for TT: Put a tally mark for each woman referred for a Tetanus Toxoid injection (TT١, TT٢, TT٣ or any otherTT injection) during this month. This includes women referred for vaccination at facilities, during outreach activities or during campaigns, when they take place.

Sheet (٢)

Facility Code and Name: Write the MoPH code number and name of the facility supervising the CHW
CHW Code and name: Write the code number and name of the CHW
Month and Year: Write the month number for which the data is being reported (in most cases, this will be the previous month) and the ٤ digit Afghan Shamsi year for which the data is being reported.

< ٥ –Children under five years of age Case management

١. Child screened with MUAC: Put a tally mark for each < ٥ child screened for MUAC by the CHW during the month. A child can only be tallied once in each month. *If the same child comes back for screening in the same month, do not tally that child again.*



٢. Referred: Put a tally mark for each child referred to a facility for malnutrition treatment during the month.

ARI

٣. Treatment for ARI: Put a tally mark for each child seen and treated for ARI in the community this month. This includes children with pneumonia. See ARI – Pneumonia definition in Annex ٣.

٤. Referrals for ARI: Put a tally mark for each child seen and referred to a facility for ARI this month

Acute Diarrhea

٥. Treatment for acute diarrhea: Put a tally mark for each child seen and treated for acute diarrhea in the community this month. This includes both non-dehydrated and dehydrated children.

٦. Referrals for diarrhea: Put a tally mark for each child seen and referred to a facility for acute diarrhea this month.

Malaria

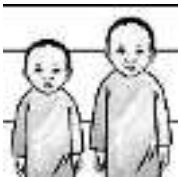
٧. Treatment for Malaria: Put a tally mark for each child seen and treated for malaria in the community this month.

٨. Referrals for Malaria: Put a tally mark for each child seen and referred to a facility for malaria this month

Under ٢ Growth Monitoring:

٩. Number of Weighing Session: Put a tally mark for each weighing session held by CHW this month in order to weigh children of under two years of old for growth monitoring.

١٠. Number Weighed: Put a tally mark for each child of <٢ years old being weighed during each weighing session this month.



١١. Number Gained Weight: Put a tally mark for each child of <٢ years old who is being weighed and adequately **gained weight** this month.

Mortality at home/community

١٢. Maternal Death at Home: Put a tally mark for each woman from the catchment area who died during pregnancy, delivery or within ٤٢ days after delivery, except those who died from trauma or accidents. DO NOT put a tally if the woman died in a health facility or a hospital.

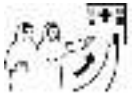
١٣. Under ٥ Death at Home: Put a tally mark for each child that died at home before the age of ٥ of any cause. DO NOT put a tally if the child died in a health facility or a hospital. Neonatal death at home should be tallied here and also in the next cell.

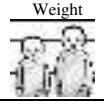
١٤. Neonatal Death at Home: Put a tally mark for each newborn that died within ٢٨ days of birth at home. DO NOT put a tally if the newborn died in a health facility or a hospital or those deaths occurred at home delivery attended by skilled birth attendants from clinic and dead body was seen/observed by clinic staff. Note: also tally the Neonatal Death at Home under the Under ٥ Death at Home in the previous cell.

٧. Submission Guidelines

The CHW prepares the CHW pictorial tally sheet for the village/catchment area and gives it to his/her supervisor, who reviews and corrects the sheet with the CHW for missing data and other anomalies. Where the CHW needs assistance to fill out the tally sheet, the supervisor will fill out the tally sheet jointly with the CHW. The CHS copies the totals for each entry and summarizes the data on the MAR for the health post (see instructions for the MAR) for upward submission. The supervisor retains the tally sheet in chronological order among his/her records.

۲،۲،۲. Pictorial Tally Sheet for CHWs - Form

CHW Pictorial Tallysheet					**Government of the Islamic Republic of Afghanistan / Ministry of Public Health**							
Facility ID and Name:					**Health Post Code and Name**					**CHW Code and Name:**		
TT Referred 	EPI Referred 	TB Referred 	PNV at home 	Delivery Complications Referred 	Normal Deliveries Referred 	ANV at home 	**Family Planning**			Family Visit 	Month	Year
							Injection 	Condom 	Pill 			

Neonatal Death at Home 	<٥ Death at Home 	Maternal Death at Home 	<٢ Growth Monitoring 			< ٥ case management								Month	Year
						Suspected Malaria 		Acute Diarrhea 		ARI 		Referred 	Screened with MUAC 		
			# Gained Weight 	# Weighed 	# Weighing session 										

٢,٣. Monthly Activity Report – Health Posts (MAR)

٢,٣,١. MAR – Guidelines for use

١. Purpose of the Form

This reporting form has been designed to consolidate into one document most of the data about health services provided by one Health Post (CHWs). This form is compiled by the CHS from the CHWs' pictorial tally sheets.

٢. Lay-out of the Form

This document is a ١-page form printed on A-٤ paper. The form consists of the following ١٠ sections:

A. Family Planning
B. Maternal Health
C. Nutrition
    C١. Acute Malnutrition
    C٢. Growth Monitoring and Promotion
D. Communicable diseases
E. Under Five Morbidity and Mortality
F. Stock-out Essential Drugs
G. Community Health
H. Report Transmitted
I. Report Received/Aggregated
J. Comments

٣. Data Sources

The data for this report comes from the following sources:

١. CHW Activity Tally Sheets
٢. CHW Stock Tally Sheets, where available, or from the CHW's memory if no Stock Tally Sheets are present

٤. Person who prepares

CHWs fill out the pictorial tally sheets and the CHS enters them onto the MAR form. Use one MAR for each Health Post. If necessary, the CHS will assist the CHW to fill out the pictorial tally sheets before filling out the MAR.

٥. Definitions

This form is the key data collection instrument to collect most of the data required to calculate the indicators for the HMIS for the Health Post level.
Definitions of the indicators and the data required to calculate them are included in Annex ١ and ٢.

٦. Instructions

This form has a total of ١٠ sections (A to J). It is used to collect information from individual Health Posts

General information

Province Code & Name: Write the province code and name
District Code & Name: Write the district code and name
Facility Name: Write the full name of the health facility supervising the CHW, followed by "HSC", "BHC" , "CHC", or "DH"
Facility code: Write the ID code assigned by the MoPH to this facility
Month: Write the month number (Shamsi calendar) for which the data is being reported (in most cases, this will be the previous month)
Year: Write the ٤ digit year (Shamsi calendar) for which the data is being reported.
Code & Name of Health Post: Write the name and code number of the health post.
Total Number of Family Visited: total number of families that visited or were visited by the CHW this month. This is taken from the monthly tally sheet "Family Visit".

A. Family Planning

A ١. # Units by Method

For each method listed, record from the tally sheet the total number units distributed this month.

B. Maternal Health

١. # of Normal Deliveries Referred: all normal deliveries, without suspicion of complication, that were referred to a facility by the CHW.

٢. Number of Obstetric complications referred: all deliveries/pregnancies that were referred to a facility because of suspicion of possible complication. Obstetric complications refers to the seven main causes of maternal death: (١) Haemorrhage (ante or post-partum), (٢) Prolonged/obstructed labour, (٣) Post-partum sepsis, (٤) Complications of abortion, (٥) Pre-eclampsia/ eclampsia, (٦) Ectopic pregnancy, (٧)Ruptured uterus

٣. Maternal deaths: all deaths of a woman while pregnant or within ٤٢ days of termination of pregnancy from any cause related to or aggravated by the pregnancy or its management, but not those who died from trauma or accidents. Only the deaths that occurred in the community are recorded, not the deaths that took place in a facility.

٤. Neonatal deaths: all newborns born alive who died within ٢٨ days of birth. Only the deaths that took place in the community are recorded, not those that took place in a facility.

C. Nutrition

C ١. Acute Malnutrition

From the activity tally sheet, record the number of children under ٥ years of age whose MUAC was taken that month. Transfer these numbers into the following boxes.

١. # Children Screened with MUAC : all children checked for malnutrition during the month using the MUAC

٢. ## children referred due to Nutrition problem: number of children who were referred to a facility for suspected nutrition problems

C ٢. Growth Monitoring & Promotion

From the activity tally sheet, record the number of children under ٢ years of age who attended weighing session each month. Transfer these numbers into the following boxes.

١. # Number of weighing sessions: the number of weighing sessions as indicated in the

pictorial tallysheet

٢. **# Number of children weighed:** the number of children that were weighed

٣. **# Number with adequate weight gain:** the number of children that adequately gained weight

D. Communicable diseases

١. **Referred for EPI (<١):** Number of children under the age of one referred for vaccination with any of the EPI antigens. This includes referral for routine immunization at facilities, as well as rounding up for outreach immunization and campaigns.

٢. **Women referred for TT:** Number of women referred for TT vaccination. This includes referral for routine immunization at facilities, as well as rounding up for outreach immunization and campaigns.

٣. **Patients referred for TB:** Number of suspected TB patients referred for diagnosis.

E. <٥ Morbidity and mortality

In this section, record the information about priority diseases morbidity during the month. This information is gathered from the CHW tally sheet. Standard case definitions are given in Annex ٣. For each disease, mark the number of children treated by the CHW and the number of children referred.

١. **ARI:** Number of children treated and referred for acute respiratory infections by the CHW. This includes children with pneumonia.
٢. **Acute diarrhea:** Number of children treated and referred for acute diarrhea by the CHW. This includes both non-dehydrated and dehydrated children.
٣. **Malaria:** Number of children treated and referred for suspected malaria by the CHW.
٤. **Died at home:** Write the number of children <٥ that died at home from illness or accidents under "treated".

F. Status of stock of Essential Drugs

This information is gathered from the Health Post stock record or tally sheet, where available. If no stock records are used, the form is filled out based on the recollection of the CHW: prompt the CHW for each of the four drugs.

F١. Mark the presence of the drug in the last month: Go through the stock tally sheet (and check the shelves where drugs may be kept for day to day distribution) and place a cross (☒) in the box to the left of any of the following indicator drugs which were not present for one day or more during the month. Situations in which a couple of tablets remain but not a number sufficient to serve one patient (child) should also be considered as a stock out of an essential drug. If the drug was present every single day of the month, a tick-off (☑) should be placed in the box to the left of the name of the drug:

☒ = during the last month, this drug was not present one day or more

☑ = during the last month this drug was present every single day

Although the stock position of all drugs should be monitored regularly, the following is the list of essential drugs for which stock-outs should be reported monthly:

١. Chloroquine
٢. Cotrimoxazole
٣. Oral contraceptive
٤. ORS
٥. Zinc tablets
٦. Vitamin A

F٢. Comments about stock situation: Use this space to note any special drug stock problems – this could include overstocks, under-stocks or expiring drugs that have been destroyed. Also the reason for stock outs cited by the CHW can be put here.

G. Community Health

No. of community meetings with Health Committee: the number of meetings of the community health committee organized or assisted by the CHW. This can be obtained from a special log, where it exists, or by asking the CHW.

Number of FHAG active: the number FHAG (not number of FHAG members) that is active in the catchment area of the health post. *Active* here refers to a group of women who are selected by CHW and have taken the FHAG official training and started reporting to their supervisor.

H. Report Submitted

This section should be completed to trace the submission of the report. The boxes should be filled by the supervisor who prepared the report.
Name: Enter the name of the supervisor who prepared the report,
Designation: Enter the designation of the person submitting the report.
Signature: Sign the report.
Date Submitted: Write the date that the completed report was submitted.

I. Report received/aggregated

Date Received: The in-charge at the facility level who receives the report of the individual Health Post should note the date that the report was received.
Date aggregated: The person at the facility level who completes the aggregation of the data of all the Health Posts of the facility should enter the date on which this report was aggregated into the MAAR.

J. Comments

Use this space to note special activities or problems in the community during the reporting period or to explain significant trends or anomalies in morbidity or service delivery. Continue on the back of the form if required. This is an important mechanism to communicate important issues between supervisor and CHW and to explain variations of health problems and service trends. Before going on a supervisory visit, the CHS should check the most recent MAR of the concerned health post to be aware of any special problems.

٧. Submission Guidelines:

The individual reports are to be prepared by the CHS supervising the CHWs and transmitted to the in-charge of the facility. The in-charge of the facility must review the reports for

missing data and other anomalies and note any comments about important trends or problems in the catchment area. The in-charge of the facility makes sure that the reports from all Health Posts linked to his/her facility are aggregated into the MAAR (see instructions for MAAR), checked for completeness, and contain comments on important trends or problems. A copy of each individual MAR should be kept in a chronological file within the facility for future reference during supervision. The MAAR should be dispatched to the PPHD within ٧ days of the end of each month, along with the MIAR (see also next chapter).

٢,٣,١. MAR – Form

Monthly Activity Report - Health Post
MAR

Government of the Islamic Republic of Afghanistan
Ministry of Public Health

			District Code & Name	**Province Code & Name**
Year	**Month**	**Facility Code**		**Facility Name**
				Code & Name of Health Post
				Total Number of Family Visited

	B. Maternal Health		**A. Family Planning**
	١. # of Normal deliveries Refereed by CHW	**# of units**	**A١. Methods distributed**
	٢. Number of Obstetric complications referred		١. Oral Pills (cycle)
	٣. Number of maternal death		٢. Condoms (dozen)
	٤. Number of neonatal deaths		٣. Injectables (injection)
	٥. ANV at home		
	٦. PNV at home		

	C٢.Nutrition Growth Monitoring & Promotion		**C١.Nutrition Acute Malnutrition**
	١. Number of Weighing Sessions		١. # Children Screened with MUAC
	٢. Number of children Weighed		٢. # children Referred for malnutrition
	٣. Number with adequate weight gain		

		E. <٥ Morbidity and Mortality		**D. Communicable diseases**
Referred	**Treated**	**Health Problem**		١. Referred For EPI (<١y)
		١. ARI		٢. Women Referred for TT
		٢. Acute diarrhea		٣. Referred for TB
		٣. Malaria		
		٩٩. Died at home		

			F. Status of Stock of Essential Drugs
			F١. Put "√" for presence and "X" for absence of the drug in the last month
	٤. ORS		١. Chloroquine
	٥. Zinc tablets		٢. Cotrimoxazole
	٦. Vitamin A		٣. Oral Contraceptive
			F٢. Comments about stock

			G. Community Health
			١. Number of meetings with Health Committee
			٢. Number of FHAG active
	I. Report Received/Aggregated By		**H. Report Transmitted By**
	Date received		Name
	Date aggregated		Designation
			Date

J. Comments
Any special activities or problems, significant anomalies or trends in morbidity and service delivery

٢,٤. Monthly Aggregated Activity Report – Health Posts (MAAR)

٢,٤,١. MAAR – Guidelines for use

١. Purpose of the Form

This reporting form has been designed to consolidate into one document most of the data about health services provided by the Health Posts (CHWs) of one HSC/BHC/CHC/DH. This form is compiled by the CHS or other designated staff from the MARs of the individual Health Posts that are supervised by that HSC/BHC/CHC/DH.

٢. Lay-out of the Form

This document is a ١-page form printed on A-٤ paper. The form consists of the following ١٠ sections:

A. Family Planning
B. Maternal Health
C. Nutrition
    C١. Acute malnutrition
    C٢. Growth Monitoring and Promotion (GMP)
D. Childhood Immunization
E. Under Five Morbidity and Mortality
F. Stock-out Essential Drugs
G. Community Health
H. Report Transmitted
I. Report Received/Aggregated
J. Comments

٣. Data Sources

The data for this report comes from the MAR of the health posts of that HSC/BHC/CHC/DH.

٤. Person who prepares

The Community Health Supervisor or the in-charge of the HSC/BHC/CHC/DH aggregates the information from all MARs of the Health Posts supervised by that facility.

٥. Definitions

This form is the key data collection instrument used to collect most of the data needed to calculate HMIS community level indicators for the catchment area of the HSC/BHC/CHC/DH.
Definitions of all indicators and the data required to calculate them are included in Annex ١ and ٢.

٦. Instructions

This form has a total of ١٠ sections (A to J). It is used to aggregate information from individual Health Posts at the facility level. If many MARs need to be aggregated into one MAAR, one can use a copy of MAAR as a draft tally sheet before filling out the MAAR that will be forwarded as report.

General information

Province Code & Name: Write the province code and name
District Code & Name: Write the district code and name
Facility Name: Write the full name of the health facility that is supervising and reporting, followed by "HSC", "BHC", "CHC", or "DH"
Facility code: Write the facility ID code assigned by the MoPH to this facility
Month: Write the month number (Shamsi calendar) for which the data is being reported (eg. The previous month)
Year: Write the ٤ digit year (Shamsi calendar) for which the data is being reported.
Total number of health posts: Write the total number of Health Posts that submitted a MAR (even the ones that did not report on all sections/activities)
Total number of families visited: Write the total number of families visited by the CHWs this month (sum of the totals on the individual MARs).

A. Family Planning

 # HP Write the number of Health Posts that reported on Family Planning activities this month (when not all Health Posts deliver Family Planning services, this number may differ from the total number of health posts that have submitted a MAR,). This number is sum of all MARs that reported a number in this section, including if that number is zero. Blanks are not counted. In the table below, the #HP equals ٥, since ٥ reported. Health Post ٣ left the cells in the MAR blank, and is thus not counted

Health Post	Pill	Condom	Injection
Health Post ١	٤٥	٥٥	١٢
Health Post ٢	٥٦	٦	٠
Health Post ٣			
Health Post ٤	٠	٣٤	٣٥
Health Post ٥	٣	٠	٠
Health Post ٦	٠	٠	٠

Table ١: FP reporting in MAAR

A١. Units distributed
Sum of the numbers in the individual Health Post reports for each of the indicated methods. The total for the health posts listed in Table ١ are: Pill ١٠٤, Condom ٩٥ and Injection ٤٧ items and those are the numbers to be put in MAAR.

B. Number of Posts with Obstetric Referral

 # HP Write the number of posts that reported on Maternal Health activities this month (when not all CHWs are addressing obstetrical cases, this number may differ from the total number of health posts that have submitted a MAR,) This number is sum of all MARs that reported a number in this section, even if that number is zero. Blanks are not counted.

١. **Normal deliveries Referred by CHW** : Sum of the numbers in the individual MARs
٢. **Obstetric complications referred**: Sum of the numbers in the individual MARs
٣. **Number of Maternal deaths**: Sum of the numbers in the individual MARs
٤. **Number of Neonatal deaths**: Sum of the numbers in the individual MARs
٥. **ANV at home:** Sum of the numbers in the individual MARs

٦. **PNV at home:** Sum of the numbers in the individual MARs

C. Nutrition

C ١. Acute malnutrition

 # HP Write the number of posts that reported on Nutrition screening activities this month (when not all CHWs are screening under fives for nutrition, this number may differ from the total number of health posts that have submitted a MAR,) This number is sum of all MARs that reported a number in this section, even if that number is zero. Blanks are not counted.

Add up the number of children under ٥ years of age whose MUAC was taken each month, as reported on the MARs. Transfer the totals into the following boxes.

١. **Total ## Children screened with MUAC** : Sum of the numbers in the individual MARs
٢. **Number of referred**: Sum of the numbers in the individual MARs

C ٢. Growth Monitoring and Promotion (GMP)

 # HP Write the number of posts that reported on GMP activities this month (when not all CHWs are performing GMP, this number may differ from the total number of health posts that have submitted a MAR,) This number is the sum of all MARs that reported a number in this section, even if that number is zero. Blanks are not counted.

١. **Number of Weighing Sessions:** Sum of the numbers in the individual MARs
٢. **Number of children Weighed:** Sum of the numbers in the individual MARs
٣. **Number with adequate weight gain:** Sum of the numbers in the individual MARs

D. Communicable diseases

 # HP Write the number of posts that reported on Communicable diseases this month (when not all CHWs are participating in immunization activities, this number may differ from the total number of health posts that have submitted a MAR,) This number is sum of all MARs that reported a number in this section, even if that number is zero. Blanks are not counted.

١. **Referred For EPI (<١y) :** Sum of the numbers in the individual MARs
٢. **Women Referred for TT:** Sum of the numbers in the individual MARs
٣. **Referred for TB:** Sum of the numbers in the individual MARs

E. <٥ Morbidity and Mortality

 # HP Write the number of posts that reported on Under Five Morbidity and Mortality this month (when not all CHWs are seeing sick children, this number may differ from the total number of health posts that have submitted a MAR). This number is sum of all MARs that reported a number in this section, even if that number is zero. Blanks are not counted.

For each Priority Health Problem write the sum of the numbers treated and referred, as recorded on the individual MARs. For the Deaths of children under ٥, write the total in the column “Treated”.

F. Status of Stock of Essential Drugs

 # HP Write the number of posts that reported on Status of Stock of Essential Drugs this month (when not all CHWs have drugs or reported on stock, this number may differ from the total number of health posts that have submitted a MAR.) This number is sum of all MARs that reported a number in this section, even if that number is zero. Blanks are not counted

Then, for each of the listed drugs, write the sum of the number of ticked off boxes (☑) for each drug in the individual MARs

Example:

Health Post	Vitamin A	Zinc tablets	ORS	Oral Contraceptive	Cotrimoxazole	Chloroquine
Health Post ١	☑	☑	☒	☑	☑	☑
Health Post ٢	☒	☒	☒	☒	☒	☒
Health Post ٣	☒	☑	☒	☒	☑	☒
Health Post ٤	☑	☒	☒	☑	☒	☒
Health Post ٥						
Health Post ٦	☑	☒	☑			☑

Table ٢: Reporting Presence of Medicine in MAAR

١. # HP is ٥, since five HPs out of total ٦ active health posts have reported drug status either presence or absence
٢. Put the number of health posts reporting the presence of drugs ☑ next to each drug, in the example Vit-A ٣, Zinc ٢, ORS ١, Cotri. ٢ and Chloroquine ٢.

F٢. Comments about stock situation: Use this space to note any special drug stock problems – this could include overstocks, under-stocks or expiring drugs that have been destroyed. If the space provided is too small, add a separate page.

G. Community Health

 # HP Write the number of posts that reported on Community Health activities this month (when not all CHWs engaged in community activities, this number may differ from the total number of health posts that have a MAR,) This number is sum of all MARs that reported a number in this section, even if that number is zero. Blanks are not counted.

١. **Number of meetings with Health Committee**: Sum the numbers in the individual MARs
٢. **Number of FHAG active:** Sum the numbers in the individual MARs

H. Report Submitted

This section should be completed to trace the submission of the report. The boxes should be filled by the health worker in charge of the facility that prepared the report.
Name: Enter the name of the health worker who was in charge of the facility at the time the report was submitted,
Designation: Enter the designation of the person submitting the report.
Signature: Sign the report.
Date Submitted: Write the date that the completed report was submitted (i.e., mailed or dispatched by courier).

I. Report received/aggregated

Date Received: The in-charge at the provincial level who receives the report should note the date that the report was received.

Date aggregated: The person at the provincial level who completes the aggregation or entry of data into the computer should enter the date on which the report was aggregated /entered.

J. Comments

Use this space to note special activities or problems in the communities during the reporting period or to explain significant variations, trends or anomalies in morbidity or service delivery by the Health Posts. Continue on the back of the form if required. This is an important mechanism to communicate significant issues to the PPHO and to explain variations of health problems and service trends.

٧. **Submission Guidelines**:

The in-charge of the facility must review the reports of individual Health Posts for missing data and other anomalies and note any comments about important trends or problems in the catchment area. The in-charge of the facility makes sure that the reports from all Health Posts linked to his/her facility are aggregated, checked for completeness, include comments on important trends or problems and that a copy of the MAAR is dispatched to the PPHO within ٧ days of the end of each month, along with the MIAR of the facility. A copy of each report should be kept in a chronological file within the facility.

٢,٤.٢. MAAR – Form

Monthly Aggregated Activity Report - Health Post
MAAR

Government of the Islamic Republic of Afghanistan
Ministry of Public Health

District Code & Name			**Province Code & Name**		
Year	**Month**	**Facility Code**	**Facility Name**		
			Number of Health Post Submitted MAR		
			Total Number of Family Visited		

	:#HP / B. Maternal Health		**:#HP / A. Family Planning**
	١. # of Normal deliveries Refered by CHW	**# of units**	**A١. Units distributed**
	٢. Number of Obstetric complications referred		١. Oral Pills (cycle)
	٣. Number of maternal death		٢. Condoms (dozen)
	٤. Number of neonatal deaths		٣. Injectables (injection)
	٥. ANV at home		
	٦. PNV at home		

	:#HP / C٢.Nutrition GMP		**:#HP / C١.Nutrition Acute Malnutrition**
	١. Number of Weighing Sessions		١. # Children Screen with MUAC
	٢. Number of children Weighed		٢. # children Referred for malnutrition
	٣. Number with adequate weight gain		

		:#HP / E١. <٥ Morbidity and Mortality		**:#HP / D. Communicable diseases**
Referred	**Treated**	**Health Problem**		١. Referred For EPI (<١y)
		١. ARI		٢. Women Referred for TT
		٢. Acute diarrhea		٣. Referred for TB
		٣. Malaria		
		٩٩. Died at home		

			:#HP / F. Status of Stock of Essential Drugs
F١. Put number in front of each drug for number of HPs that reported presence of the drug in the last month			
	٤. ORS		١. Chloroquine
	٥. Zinc tablets		٢. Cotrimoxazole
	٦. Vitamin A		٣. Oral Contraceptive
F٢. Comments about stock			

	:#HP / G. Community Health
	١. Number of meetings with Health Committee
	٢. Number of FHAG active

I. Report Received/Aggregated By		**H. Report Transmitted By**	
	Date received		Name
	Date aggregated		Designation
			Date

Any special activities or problems, significant anomalies or trends in morbidity and service delivery

٢,٥. OPD Patient Register - Facilities

٢,٥,١. OPD Patient Register – Guidelines for use

١. Purpose of the Form

This recording form will assist health workers to record outpatient visits in MHTs, SHCs, BHCs, CHCs, hospital OPD and Hospital emergency rooms and to maintain data about the number and types of cases. It may also help staff maintain a visit history for individual cases.

To date, no standard format has been decided upon. Different kinds of registration books are being used throughout the country. The presence of various stakeholders in the health sector, each with different needs, currently makes it impractical to impose one standard format.

Therefore, at present, the form described below is based on minimal requirements as defined by the HMIS Task Force. Facilities already successfully using a different form can continue using that form on the condition that it captures the minimal data required.

٢. Lay-out of the Form

The form is a large table, with each row designed to store information about a single new case. Columns correspond to information about the patient and the services delivered, and a minimum of writing should be required to fill out the form. The register can either be pre-printed or the columns traced on a standard register book by health workers themselves.

٣. Data Sources

The data for this report comes from the health workers' consultations with patients and their caretakers.

٤. Preparation and Submission

This form is maintained at the health facility on a continuous basis. It is filled out during the course of patient visits. This form is not transmitted, it stays at the health facility. It is used to fill out the monthly tally sheet of the facility.

٥. Definitions

New case OPD morbidity: a patient in a health facility is diagnosed with an episode of an illness for the first time. Many health problems may be of short duration and can thus be recorded as a new case the next time a patient comes with the same diagnosis. Some problems, however, last longer-- in some instances, a lifetime. Table ٨ in Annex ٣, gives the time that should elapse before a patient presenting with the same disease can be considered a "new case."

Re-attendance: patients seen for follow-up of a specific health problem previously diagnosed at the facility. This includes patients presenting with the same problem within the period that should elapse before the problem can be considered a new case.

Referred in: A patient who has been referred to this facility by a CHW or another facility. A patient can be referred for a particular reason and also be seen for something else, e.g., a child referred to the facility for acute watery diarrhea and also checked for nutrition status will be tallied as "Referred in" in the row labeled "Patients", for "Diarrhea, Acute Watery", and will be tallied as "New" under the Nutrition Status.

Referred out: A patient who has been referred to another facility for services which are not available in this HF.

Family planning new case: For family planning, this corresponds with a "new user" in FP terminology. A "new case" for FP is:

- A client who had never used a family planning method before and starts using one, regardless of whether the client came to this facility before; this client is also marked "new" in the Patient/Clients;
- A client who discontinued (see below) a method and starts a new one, or re-starts the same one, regardless of whether the client came to this facility before; this client is also marked "new" in the Patient/Clients.

Are not considered "new case", but considered "Re-attendance" under Family Planning:

- A client who came to this facility for one method and switches to another method without "discontinuation" as defined below in "Family Planning Discontinued", is marked as a "Re-attendance" for the new method. Remark that this client of course abandons the first method, but she/he switches to the new method without interrupting the contraceptive protection. This client is marked as "re-attendance" under Patients/Clients as well.
- Also, a user who is using a method, but went previously to another facility for supplies, is considered "re-attendance" when she/he comes to another facility for renewal, without discontinuing FP. This client is marked as "new" under Patients/Clients.

Family planning discontinued: a client is considered to have discontinued using the family planning methods listed in the table below according to the boxed criteria:

Pills	Did not come back for one month after the last scheduled appointment. Pill users are given an appointment to come back for a check-up and a new stock of pill cycles. If the user does not come back on the date of the appointment, or within ٣٠ days after the date of that appointment, she is considered "discontinued" for oral contraception.
Injectables	Did not come back for one month after the last scheduled appointment. Injectable contraception users are given an appointment to come back for check-up and a new injection. If the user does not come back on the date of the appointment, or within ٣٠ days after the date of that appointment, she is considered "discontinued" for injectable contraception.
IUD	When an IUD is removed or ejected and no other method is accepted.
Condom	Did not come back for the last scheduled appointment. Condom users are given an appointment to come back for new supply of condoms. If the user does not come back on the date of the appointment, or stops using condoms without starting another method, she/he is considered "discontinued" for contraception for condoms.

Family planning re-attendance: a user who comes for a new supply of the same family planning method or one who comes for the initial supply of another method without having discontinued (see above) the previous method, regardless of the fact that she/he received the previous supply at this particular clinic.

٦. Instructions

At the beginning of each month
Start a new page in the register by writing the month and year at the top of the page.

At the beginning of each day
Date: Draw a line underneath the previous day's final entry and write the current date in the SN and Name columns.

During each consultation

SN: If this is the first client in the day, write the next available annual serial number. If this is the first patient of the year, start with number ١. Use a line for each case and each patient. For example, if a mother comes for family planning and skin infection and brings a long a young child who is seen for cough, you will have to make two entries for mother for her two cases and one entry for child.

Name: Write the full name of the patient.
Address: Write at least the village name. If the patient is from another district or province, include the district and province name.
Age: Write the age of the patient. Only put "Y" for year, "M" for month and "D" for day.
Sex: Mark "M" for male and "F" for female.
Case Type: If this is a new case (see Definitions), place a tick mark (✓) in the column "**New**"; if this is an old case (see Definitions), place a tick mark (✓) in the column "**Old.**"

Referred In: Tick if the patient was referred to the facility by a Health Post or another facility.

Health Problem/Diagnosis: This column should contain a brief description of the health problem that brought the patient to the health facility. If the patient presents with multiple health problems, note the diagnosis that motivated the patient to seek care. You should try to be brief with your description so that it fits within the box provided. If the patient comes for more than one complaint, you may, if necessary, continue your entry on the following row.

Disease Code: If the **Health Problem/Diagnosis** is a new case of one of the priority diseases, write the corresponding code number. Standard case definitions of the priority illnesses are given in Annex ٣. Enter ٩٩ for health problems that are not listed as priority health problems. Leave blank for nutrition, maternal and neonatal care visits.

Treatment/Advice: Record a brief note about the therapy provided, drugs prescribed or other action taken to solve the patient's health problem. Record ٣ key drugs given, even those prescribed from bazaar.

Referred to: If the patient requires care or examinations unavailable in the health facility, note the name of the facility to which he or she has been referred.

At the end of each month

Draw a line under the last entry of the month. Under the line, write "Monthly Total <month name>" in the "**SN**" and "**Name**" columns. Enter the following in the respective columns on the row below:
SN: subtract the last SN of the previous month from the last SN of this month
Cases Type/New: sum of all new cases of this month
Cases Type/Old: sum of all old cases of this month
Referred In: sum of all cases that have a tick in this column
Referred To: sum of all cases that have a tick in this column
Fill out the monthly tally sheet.

٢,٥,٢. OPD register – Form template

Referred to	Treatment/ Advice	Disease Code	Health problem/ diagnosis	Case Type		Referred from	Sex	Age Y/M/D	Address	Name	SN
				Old	New						
-	ORS	٤	Diarrhea/ no blood		✓	CHW	M	٣ Y	Boyna Qara	Abdul Ali	١
-	Chloroquine	١٥	Malaria		✓	-	F	٢ Y	Qurbaka Khana	Miriam	٢
	Feeding advice		Moderate malnutrition	✓							
	Amoxicillin	٢	Ear infection	✓		-	M	٥ M	Boyna Qara	Hussain	٣
	Breast feeding	٤	Diarrhea/ no blood		✓		F	٢٥ D	Deh Bala	Najla	٤

٢,٦. Monthly Integrated Activity Tally Sheet – Facilities OPD

٢,٦,١. MIAR Tally Sheet – Guidelines for use

١. Purpose of the Form

This form has been designed to tally patient visits at MHTs, HSCs, BHCs, CHCs, the outpatient department of Hospitals, and the emergency room of Hospitals. All Obstetric related information is entered on this form as well.

٢. Lay-out of the Form

This document is a ١-page form printed on A-٣ paper so that the different sections are not separated. The form consists of the following main sections:

A. OPD Morbidity
B. Children Checked for Nutrition Status
C. Maternal and Neonatal Care

٣. Data Sources

In facilities where registers are kept, the data tallied on this sheet is collected from existing registers such as the OPD Register, Nutrition Surveillance Register/Child Clinic Register, the Antenatal Care Register, the Maternity Register, and the Family Planning Register. This tally sheet can be filled out using the existing MoPH register under the condition that the column "Referred In" be added to the register (see Recommended Content for Registers).

If no register is in use, the tally sheet should be filled out at the end of each patient visit.

٤. Who prepares

Where registers are used, staff responsible for the register of different services tallies the data related to their own activities (e.g., the ANM for maternity care and ANC services).

Where no registers are used, staff seeing patients will tally at the end of each patient visit.

٥. Definitions

This form is the key data collection instrument used to tally most data required on the facility's Monthly Integrated Activity Report.

New case OPD morbidity: a patient in a health facility is diagnosed with an episode of an illness for the first time. Many health problems may be of short duration and can thus be recorded as a new case the next time a patient comes with the same diagnosis. Some problems, however, last longer-- in some instances, a lifetime. Figure ٨ in Annex ٣ gives the time that should elapse before a patient presenting with the same disease can be considered a "new case."

Re-attendance: patients seen for follow-up of a specific health problem previously diagnosed at the facility. This includes patients presenting with the same problem within the period that should elapse before the problem can be considered a new case.

Referred in: a patient who has been referred to this facility by a CHW or another facility. A patient can be referred for a particular reason and also be seen for something else, e.g., a child referred to the facility for acute watery diarrhea and also checked for nutrition status will be tallied as "Referred in" in the row labeled "Patients", for "Diarrhea, Acute Watery", and will be tallied as "New" under the Nutrition Status.

Referred out: a patient who has been referred to another facility for services which are not available in this HF.

Family planning new case: For family planning, this corresponds with a "new user" in FP terminology. A "new case" for FP is:

- A client who had never used a family planning method before and starts using one, regardless of whether the client came to this facility before; this client is also marked "new" in the Patient/Clients;
- A client who discontinued (see below) a method and starts a new one, or re-starts the same one, regardless of whether the client came to this facility before; this client is also marked "new" in the Patient/Clients.

Are not considered "new case", but considered "Re-attendance" under Family Planning:

- A client who came to this facility for one method and switches to another method without "discontinuation" as defined below in "Family Planning Discontinued", is marked as a "Re-attendance" for the new method. Remark that this client of course abandons the first method, but she/he switches to the new method without interrupting the contraceptive protection. This client is marked as "re-attendance" under Patients/Clients as well.
- Also, a user who is using a method, but went previously to another facility for supplies, is considered "re-attendance" when she/he comes to another facility for renewal, without discontinuing FP. This client is marked as "new" under Patients/Clients.

Family planning discontinued: a client is considered to have discontinued using the family planning methods listed in the table below according to the boxed criteria:

Pills	Did not come back for one month after the last scheduled appointment. Pill users are given an appointment to come back for a check-up and a new stock of pill cycles. If the user does not come back on the date of the appointment, or within ٣٠ days after the date of that appointment, she is considered "discontinued" for oral contraception.
Injectables	Did not come back for one month after the last scheduled appointment. Injectable contraception users are given an appointment to come back for check-up and a new injection. If the user does not come back on the date of the appointment, or within ٣٠ days after the date of that appointment, she is considered "discontinued" for injectable contraception.
IUD	When an IUD is removed or ejected and no other method is accepted.
Condom	Did not come back for the last scheduled appointment. Condom users are given an appointment to come back for new supply of condoms. If the user does not come back on the date of the appointment, or stops using condoms without starting another method, she/he is considered "discontinued" for contraception for condoms.

Family planning re-attendance: a user who comes for a new supply of the same family planning method or one who comes for the initial supply of another method without having discontinued (see above) the previous method, regardless of the fact that she/he received the previous supply at this particular clinic.

IMPORTANT: If a patient is considered "new" for any reason, (s)he should be counted as "new" in the row "Patients,"e.g., a woman who comes for a postnatal follow-up visit (re-attendance in "Postnatal visit") and starts using Injectable contraceptives ("New Cases" in "Injectable"), is considered "new" in the row "Patients".

٦. Instructions

General information

Province name & code: Write the name and the Geocode of the province where the facility is located. Use official reference lists to find the name and Geocode.
District name & code: Write the name and the Geocode of the district where the facility is located. Use official reference lists to find the name and Geocode.
Facility Name: Write the name commonly used to designate this facility
Facility Code: Write the ID code the MoPH assigned for this facility
Year: Write the ٤ digit year (Afghan Shamsi calendar) for which the data is being reported.
Month: Write the month number (Afghan Shamsi calendar) for which the data is being reported (usually this will be the month prior to the current month)

Patients/Clients: put a tally mark in the appropriate column for each patient that visits. This includes OPD/Morbidity, Nutrition status, Maternal and Neonatal care, dressing, and Immunization sections both in the facility or in the community as out-reach activity. A Patient/Client is tallied as "new" if (s)he is considered "new" for any reason. Some examples:

- a person comes for a re-supply of condoms but also for a new complaint, such as a respiratory infection, this person qualifies as a "new" Patients/Clients, a "new" ARI, and a "re-attendance" for condoms;
- a person who comes for a re-supply of condoms and also for further treatment of a respiratory infection for which (s)he had been seen four days ago is tallied as "re-attendance" under Patients/Clients, "re-attendance" under ARI, and "re-attendance" under condoms;
- a ٦ weeks old child brought for a first injection of PENTA is tallied in the age group ٠-١١ months for PENTA, and also tallied as "new" for Patients/Clients;
- a ١٤ weeks child coming for a third injection of PENTA is tallied in the age group ٠-١١ months for PENTA and also as "re-attendance" for Patients/Clients;
- a patient comes for follow-up sputum slides after starting TB treatment, (s)he will be tallied under the respective Laboratory Exams, but also as "re-attendance" under Patient/clients.
- A person comes for injection next day for diagnosed Pneumonia. S/he is tallied in "٩٩.Other" for injection in dressing room, but also as "re-attendance" under Patient/clients and "re-attendance" under "٣. Pneumonia".
- A midwife attends a normal delivery at home. The newborn died after ١٠ minutes because of low-birth weight and hypothermia at the presence of midwife. She is tallied in new Patient/clients, also in normal delivery at home for her normal delivery, and also in newborn alive and finally in neonatal death (٤ tallies)

A. OPD Morbidity

In this section, record information about morbidity and visits to your facility during the month. Case definitions of the priority diseases are given in Annex ٣. For facilities using OPD registers, this information is gathered from the OPD register. For facilities using only a family card, this information is tallied at the time of the visit. New cases are tallied by the age and gender groups indicated. Note that only new cases of *priority health problems* (listed separately in this section) need to be tallied by disease; all other new cases are grouped together under code ٩٩. Old cases are tallied by priority disease or under code ٩٩ regardless of age or gender and are reported in the column "Re-attendance".

Use the A٢ Comments section to highlight any unusual cases that you treated or to explain any disease trends that you have noticed in your facility.

B. Nutrition Status

No acute malnutrition: number of children situated at ٨٠٪ or above the median weight for height curve, If MUAC is used, the number of children that fall in the Green zone.
Moderate acute malnutrition: number of children situated between ٧٠-٧٩٪ of the median weight for height curve, If MUAC is used, the number of children that fall in the Yellow zone.
Severe acute malnutrition: number of children situated below ٧٠٪ of the median weight for height curve, monthly total of the column "Severely Malnourished" and/or bilateral pedal edema, If MUAC is used, the number of children that fall in the Red zone.

IMPORTANT: If a child comes to the facility as a patient for the first time or comes more than ٣ months after a previous check-up, the visit is tallied as "New" in both the nutrition section and the Patient/client section. However, a child coming for check-up within ٣ months of a previous nutrition status check-up visit is tallied as "Re-attendance" in the Nutrition Status section and the Patient/clients section.

C. Maternal and Neonatal Care

C ١. Family Planning Clients Seen

For each family planning method listed, tally the new and continuing (Re-attendance) clients that visited the facility during this month.

The **'##'** column refers to the actual number of units of contraceptives distributed:

- number of dozens of condoms (condoms should be distributed by dozen, equaling a month's supply);
- number of cycles of oral contraceptives distributed;
- number of injections of injectable contraceptives given;
- number of IUDs implanted;
- number of permanent contraceptive interventions of male or female clients performed, only used for referral to hospitals and CHC that perform them. The hospitals and CHC that perform them noted these on the HMIR.

This information has been added to the number of visits in order to more accurately calculate

CYP, since information from bulk distribution centers (i.e., warehouses) hardly reflects the actual number used. It allows one to evaluate the contribution of each facility to the total provincial/ national CYP.

'**New Cases**' refers to all clients who have been registered as family planning users in your health facility for the first time. This includes first ever users of contraceptives. "New Cases" does not, however, include users who have changed methods during the month without interrupting coverage, or who are being provided contraceptives because they are passing through the catchment area and normally receive family planning services elsewhere, or who recently came to your facility from another facility.

"Re-attendance" is tallied for each family planning client visit that is not a "new case" and did not discontinue. (see Definitions)

C ٢. Pre-natal and post-natal care:

- **١. First antenatal visit:** In the column "New Cases," record the number of newly registered pregnant women who joined the Ante-natal clinic during the month. There is no "Re-attendance" for first antenatal visits. If (pre)-eclampsia is detected, this should be marked under the **٢,٦,١,٦.C٣. ٣. Major complications**. Upon first detection, this is listed as a new case, follow-on visits for control of (pre)-eclampsia is listed under re-attendance. First ANC refers to a first visit of a pregnant woman during the pregnancy irrespective of gestational age.
- **٢. Other antenatal visit:** any other antenatal visit; there are no "New Cases" for these antenatal visits.
- **٣. First Post-natal visit:** Recorded from Post-natal Clinic Cards, where they exist, or from the family card during the visit. In the column "New Cases," record the number of women who joined the first Post-natal visit by skilled personnel by this clinic during this month. There is no "Re-attendance" for first postnatal visits. First PNC refers to a first visit of women within ٤٢ days after delivery.
- **٤. Other Post-natal visit:** any other postnatal visit; there are no "New Cases" for these postnatal visits.

C ٣. Obstetric Care. Gather this data from the Maternity Register, where it exists. Make sure to record the deliveries assisted by trained staff in each facility. Record births assisted by trained facility staff at home separately. The total number of births in the community can be determined during the Annual Catchment Area Census, allowing these figures to be compared later.

In some CHCs and most hospitals, women will be hospitalized for at least a few hours while giving birth. To avoid double counting, a new section has been added in the HMIR, where hospitals and CHC with in-patient care should report Obstetric and Neonatal conditions and cases. The section in the MIAR is kept for those facilities that do not use the HMIR.

- **١. Normal Delivery:** all the vaginal deliveries requiring no intervention more complicated than an episiotomy, including those that require suturing of first and second degree perineal tears. Normal Delivery does *not* include the use of forceps or a vacuum extractor. Count Normal Deliveries at "a. Facility" and "b. Home" separately. Note that even at **home**, only those deliveries that are assisted by trained facility staff (Midwife and Doctor) during official or unofficial working hours are recorded. It does not include those deliveries attended by facility staff at their private clinic. Deliveries that took place

without the trained staff present are not recorded.

- ٢. **Assisted Delivery:** all vaginal deliveries that require more than an episiotomy, i.e. use of forceps or vacuum extractor; suturing of third and fourth peritoneal tears. Any of these deliveries can also involve major or other complications, which need to be recorded under the appropriate entry. Count Assisted Deliveries at "a. Facility" and "b. **Home**" separately. Note that even at **home**, only those deliveries that are assisted by trained facility staff during official or unofficial working hours are recorded. It does not include those deliveries attended by facility staff at their private clinic. Deliveries that took place without the trained staff present are not recorded.
  The sum of ١.**Normal Deliveries** and ٢. **Assisted Deliveries** gives the total number of deliveries that took place for this facility during the period (i.e. were assisted by trained staff of this facility).

- ٣. **Major complication**: all women presenting with major obstetric complications. This includes women who delivered at the facility, as well as those who delivered elsewhere but were referred to the facility post partum for major complications. Major Obstetric Complications refers to ٧ major causes of maternal death: (١)Haemorrhage (ante-, intra- or post-partum), (٢) Prolonged/obstructed labour, (٣) Post-partum sepsis, (٤) Complications of abortion, (٥) Pre-eclampsia/eclampsia, (٦) Ectopic pregnancy, (٧)Ruptured uterus.
- ٤. **Other complications**: all women presenting with obstetric complications not due to any of the seven major causes. This includes women who delivered at the facility, as well as those who delivered elsewhere, but who were referred to the facility post partum for other complications. Examples of Other Complications that might be registered are third and fourth degree lacerations, cervical tear, shoulder dystocia, premature rupture of membranes, malaria in pregnancy, HIV, etc. Remember that episiotomy as well as first and second degree lacerations are considered "normal delivery" in this classification and should not be counted here.
- ٥. **Maternal death due to major complications**: all women who presented a major complication and died while pregnant or within ٤٢ days of termination of pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. This includes only the deaths investigated by the staff of the facility, not maternal deaths reported by others.
- ٦. **Maternal death due to other complications:** all women who presented a complication other than the major complications and died while pregnant or within ٤٢ days of termination of pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. This includes only the deaths investigated by the staff of the facility, not maternal deaths reported by others
- ٧. **Cesarean section:** all women who underwent cesarean section in this facility
- ٨. **Other obstetric surgery:** all women who underwent surgery for any of the obstetric complications listed above. Note: episiotomy and the repair of first and second degree lacerations are considered "normal delivery" and should not be counted here.

C ٤. Neonatal Care.

- ١. **Newborn alive**: all newborns who were alive at birth, even including those who died within minutes or hours after birth.
- ٢. **Low birth weight (<٢٥٠٠)**: all newborns weighing less than ٢٥٠٠ grams at birth.
- ٣. **Neonatal complication:** all neonates that were ill or presented other complications (e.g. hypothermia, infection, sepsis).

- **٤. Neonatal deaths**: all newborns born alive that died within ٢٨ days of birth. This should include also newborns that were not delivered with assistance of the clinic staff, but were seen or whose dead was investigated by staff from your facility in the facility, but not cases that are only reported to you. It also includes those deaths occurred at home delivery attended by skilled birth attendants and dead body was seen by them.
- **٥. Still births**: all newborns that were not alive at birth.

This concludes the instructions for the Monthly Integrated Tallysheet. Other entries in the MIAR are taken from specific tally sheets and reports (Lab, EPI, TB, etc.)

٢,٦,٢. MIAR Tally Sheet - Form

MIAR Tally Sheet
Facilities OPD - Page ١

GOVERNMENT OF THE ISLAMIC REPUBLIC OF AFGHANISTAN
MINISTRY OF PUBLIC HEALTH

Year	Month	Facility Code	Facility Name

Referred Out	Referred In	Reatten-dance	New					MHT HSC BHC CHC RH, PH, DH (OPD)	Facility Type
			Total New	>= ٥		< ٥			
				F	M	F	M		
								Patients/Clients	

A١. OPD Morbidity									
								١. COUGH & COLD	ARI
								٢. ENT	
								٣. PNEUMONIA	
								٤. ACUTE WATERY	DIARRHEA
								٥. ACUTE BLOODY	
								٦. W DEHYDRATION	
								٧. SEVERELY ILL PATIENT	
								٨. VIRAL HEPATITIS	
								٩. MEASLES	
								١٠. PERTUSSIS	
								١١. DIPHTHERIA	
								١٢. NEONATAL TETANUS	
								١٣. TETANUS	
								١٤. ACUTE FLACCID PARALYSIS	
								١٥. MALARIA	
								١٦. URINARY TRACT INFECTIONS	
								١٧. MENTAL DISORDERS	
								١٨. TRAUMA	
								١٩. TB SUSPECTED CASE	
								٢٠. PEPTIC DISORDER	
								٢١. MUSCULOSKELETAL	
								٢٢. HYPERTENSION	

MIAR Tally Sheet
Facilities OPD - Page ٢

GOVERNMENT OF THE ISLAMIC REPUBLIC OF AFGHANISTAN
MINISTRY OF PUBLIC HEALTH

Year	**Month**	**Facility Code**	**Facility Name**

Referred Out	**Referred In**	**Reatten-dance**	**New**					MHT HSC BHC CHC RH, PH, DH (OPD)	**Facility Type**
			Total New	>= ٥		< ٥			
				F	**M**	**F**	**M**		
								٢٣. ANEMIA	
								٢٤. GASTRO-INSTESTINAL WORMS	
								٢٥. SKIN – INFECTION	
								٢٦. SKIN – OTHER	
								٢٧. PELVIC INFLAMMATORY D.	
								٢٨. SEXUALLY TRANSMITTED D.	
								٢٩. EYE INFECTION	
								٣٠. ORO-DENTAL CONDITIONS	
								٣١. MICRO-NUTRIENT DISORDERS	
								٩٩. OTHERS/UNLISTED DIAGNOSES	
								B. Nutrition Status	
								١. No acute malnutrition	
								٢. Moderate Acute Malnutrition	
								٣. Severe Acute Malnutrition	

MIAR Tally Sheet
Facilities OPD - Page ٣

GOVERNMENT OF THE ISLAMIC REPUBLIC OF AFGHANISTAN
MINISTRY OF PUBLIC HEALTH

Year		**Month**	**Facility Code**		**Facility Name**

Referred Out	**Referred In**	**Reattendance**	**New Cases**	**C. Maternal & Neonatal Care**	
				## Units	**C١. Family planning**
					١. Oral (cycle)
					٢. Injectable (injection)
					٣. IUD (insertion)
					٤. Condoms (Dozen)
					٥. Permanent (case)
					C٢. Pre- and Post-Natal
					١. Antenatal Visit- First
					٢. Antenatal Visit -Other
					٣. Postnatal Visit -First
					٤. Postnatal Visit -Other
					C٣. Obstetric Care
				١,١. Facility	١. Normal Delivery
				١,٢. Home	
				٢,١. Facility	٢. Assisted Delivery
				٢,٢. Home	
					٣. Major complication
					٤. Other Complication
					٥.Maternal Death due to Major
					٦. Maternal Death due to Other
					٧. Cesarean section
					٨. Other obstetric surgery
					C٤. Neonatal Care
					١. Newborn Alive
					٢. Low Birth Weight
					٣. Neonatal Complication
					٤. Neonatal Death
					٥. Stillbirth

٢,٧. Monthly Integrated Activity Report – Facilities OPD (MIAR)

٢,٧,١. MIAR – Guidelines for use

١. Purpose of the Form

This reporting form has been designed to consolidate into one document most of the data about health services offered at the MHT/HSC/BHC/CHC level and the outpatient hospital level. This form is used by MHTs, HSCs, BHCs, CHCs, Hospital outpatient departments and Hospital emergency rooms.

٢. Lay-out of the Form

This document is a 2-page form printed on A-٤ paper, so that the different sections are not separated. The form consists of the following main sections:

A. Morbidity of Priority Health Problems
B. Nutrition status
C. Maternal & Neonatal health
D. Stock-outs of Essential drugs and commodities
E. Immunizations
F. Laboratory Exams
G. Tuberculosis
H. Community Health
I. Report Transmitted
J. Report received/Aggregated
K. Comments

٣. Data Sources

The data for this report comes from ١٠ principal sources:

١. OPD Tally sheet
٢. The Antenatal Care Register
٣. The Maternity Register
٤. EPI register
٥. Nutrition Surveillance Register/Child Clinic Register
٦. Stock Register
٧. Family Planning Register
٨. Lab Register
٩. TB Register
١٠. HIV Register

Some organizations use different registers for each of these data sources; others combine some of the data sources into one form. Use the form in your facility which corresponds with the listed data source. The MoPH is testing a tally sheet in conjunction with a patient card for the sections A, B and C of this report. If the tally sheet is used, write totals in the corresponding boxes of the MIAR. If the MIAR tally sheet is not used, refer to the instructions for filling out the MIAR tally sheet in this manual for each of the corresponding boxes in the MIAR form.

٤. Person who prepares

Staff responsible for the various services contribute the data related to their own activities (e.g., the midwife for data on obstetric care, the Lab technician for laboratory data, etc.). The senior staff member of the facility team reviews the report for accuracy and completeness before signing it and sending it to the PPHO. OPD attached to Hospitals should also complete a Monthly Integrated Activity Report in addition to the Hospital Monthly Inpatient Report. Hospital maternity wards (district, provincial, regional) should use the MIAR for all obstetric services, except for caesarean and other obstetric surgery services.

٥. Definitions

This form is the key data collection instrument to collect most data required to calculate HMIS indicators for the MHT/HSCBHC/CHC and outpatient hospital level. At the provincial health office level, data from the forms of all facilities is aggregated to calculate the indicators at the provincial level. Definitions of all of the indicators and the data required to calculate them are included in Annex ١ and ٣.

٦. Instructions

This form has a total of ١١ sections (A to K).

General information

Province name & code: Write the name and the Geocode of the province where the facility is located. Use official reference lists to find the name and Geocode.
District name & code: Write the name and the Geocode of the district where the facility is located. Use official reference lists to find the name and Geocode.
Facility name: Write the full name of the health facility reporting
Facility code: Write the ID code assigned by the MoPH to this facility
Month: Write the number of the month (Shamsi calendar) for which the data is being reported (usually this will be the month prior to the current month)
Year: Write the ٤ digit year (Shamsi calendar) for which the data is being reported.
Facility Type: Circle the appropriate type of facility, for hospitals, circle the type of hospital: H١ for regional/national hospitals, H٢ for provincial hospitals, H٣ for district hospitals.

Patients/clients: Totals for the corresponding row and column in the MIAR Tally Sheet are written in each cell. Write the sum of the four preceding columns under the column labeled "Total new."

A. OPD Morbidity

In this section, record information about morbidity and visits to your facility during the month. This information is gathered from the OPD tally sheet (see guidelines for MIAR tally sheet). Totals for the corresponding row and column in the Tally Sheet are written in each cell. Write the sum of the four preceding columns under the column labeled "Total new."

Use the comments section to highlight any unusual cases that you treated or to explain any disease trends that you have noticed in the catchment area of your facility.

B. Nutrition Status

Write the totals of the corresponding cells of the tally sheet in each cell.

C. Maternal Health

Write the totals of the corresponding cells of the tally sheet in each cell.

D. Status of Stock of Essential Drugs

Go through the stock register (and check shelves where you may keep drugs for day to day distribution) and place a cross (☒) in the box to the left of any of the indicator drugs (listed below) which was not present for one or more days during the month. In situations which a couple of tablets of a drug remain, but not a number sufficient to serve at least one adult patient, should also be considered as the drug not being present. If the drug was present every single day of the month, a tick-off (☑) should be placed in the box to the left of name of the drug name:

☒ = during the last month, this drug was not present one day or more

☑ = during the last month this drug was present every single day

Although the stock position of all drugs should be monitored regularly, the following is the list of essential drugs for which the stock status should be reported monthly:

Acetyl Salicylic Acid/Paracetamol (if at least one is available on each day of the month, mark ☑)
Mebendazole
Amoxicillin/Ampicillin (if at least one is available on each day of the month, mark ☑)
INH
Rifampicin
Amp. Diazepam
Inj. Lidocaine
Metronidazole
Co-trimoxazole
Anti-hypertensives
Oral contraceptive
Injectable contraceptive
Condoms
IUD
TT vaccine
PENTA vaccine
ORS
Zinc tablets
Vitamin A
Ferrous Sulfate + folic acid
Oxytocine
Chloroquine
Artesunate + SP

Amitriptiline/Fluoxetine(if at least one is available on each day of the month, mark ☑)
Gloves

D٢. Comments about stock situation: Use this space to note any special drug stock problems – this could include overstocks, understocks, expiring drugs that have been destroyed, drugs that were received in bad condition. If there is not enough space to explain the comment, add a separate sheet explaining the situation to the MIAR.

E. Immunizations

E١. Childhood Immunizations: Record in the boxes the total number of doses of **PENTA ٣** administered by age group. "Total" is the sum of all children who received PENTA٣: (٠-١١) + (١٢-٢٣). This information can be found in the EPI Monthly Vaccination Activity Report. Similarly, from the same report note for each age group, the first doses of **Measles** administered. "Total" is the sum of all children: (٠-١١) + (١٢-٢٣) who received the first dose of **Measles vaccine**.

E٢. TT Immunizations

Record the total number of Tetanus Toxoïd immunizations given to pregnant women and non-pregnant women separately. In the column **TT٢**, list the number of TT٢ doses given. In the column **>TT٢**, list the sum of all TT shots given after the second shot (TT٣,TT٤, …) This information should be calculated from the EPI monthly tally sheet.

F. Laboratory Exams:

Although many facilities conduct a number of other lab tests that should be recorded in the laboratory register, only the following tests and test results should be reported because they confirm diagnoses of priority health problems. Break up the total number by male and female. If necessary, use a separate tally sheet to abstract the data from the laboratory register.

F١. Blood

- **١. Total malaria slides examined:** total blood slides examined from for malaria
- **٢. Total PF positive:** slides positive for Plasmodium Falciparum
- **٣. Total other Positive:** slides positive for Plasmodium Vivax or other plasmodia, but negative for Plasmodium Falciparum
- **٤. Total HIV Examined:** Total number of individuals who have been tested for HIV by one or more rapid HIV tests[٦] in the last month.
- **٥. Total HIV positive:** Total number of those confirmed to be reactive for HIV by three serial rapid HIV tests in the last month.

F٢. Sputum

- **١. Total AFB slides examined:** all sputum slides examined for AFB
- **٢. Total AFB positive:** number of slides found AFB +

G. *Tuberculosis*

[٦] Standard testing algorithm of NACP suggests three serial rapid HIV tests to confirm HIV positive cases. It should be specified if an individual received the complete series of three serial rapid HIV tests.

This section is only filled out if the facility is involved in tuberculosis diagnosis and treatment.

G١. Case detection

- **١. Number of new smear (+) cases**: from the Health Facility TB register, Type of patients, New: Sum of male and female pulmonary SS (+) cases.
- **٢. Number that started treatment**: from the Health Facility TB register, Date Treatment Started: all smear (+) patients with a treatment start date within the past month and a pre-treatment positive lab result.

G٢. Treatment complete and cured

Number of cases completed treatment and smear (-): from the Health Facility TB register, from sections of Before treatment, ٥ Months, ٨ Months, End of Treatment: all initially smear (+) patients that completed their treatment and tested negative either in month ٥th or month ٨th.

H. *Community Health*

١. **No. of community meetings held with the community health committee**: number of meetings held in which the facility staff went to a village to meet with the health committee or the health committee members come to health facility for meeting.

٢. **Number CHWs visited for supervision:** obtained from the CHW supervisory log. The number of CHWs visited in the field and the number of CHWs who came to the monthly meeting in the facility.

I. Report Submitted

These details should be completed to trace the submission of the report. The boxes should be filled by the health worker in charge of the facility who prepared the report or checked the report for completeness before sending it to the PPHO.

Name: Enter the name of the health worker who was in charge of the facility at the time the report was submitted, and who checked the report for accuracy and completeness.

Designation: Enter the designation of the person submitting the report.

Date: Write the date that the completed report was submitted (i.e., mailed or dispatched by courier).

Signature: Sign the report.

J. Report received/aggregated

Date Received: The in-charge in the Provincial Health Directorate (or NGO) who receives the report should note the date that the report was received at the office. This should be recorded in the dispatch/receipt register.

Date aggregated: The person who completes the aggregation of the data on paper or the entry of the data onto the computer should enter the date that the report was aggregated/entered.

K. Comments

Use this space to note special activities or problems in the MHT/HSC/BHC/CHC or community during the reporting period or to explain significant variations, trends or anomalies in morbidity or service delivery. Add an extra sheet, if required. This is an important mechanism to communicate significant issues to your supervisor and to explain your variations of health problems and service trends.

٧. **Submission Guidelines**:

This report is to be prepared by the staff member responsible for each of the key service areas included: Ante-Natal Clinic, Maternity, Nutrition/Child Clinic, Reproductive Health service, Laboratory, and Pharmacy. The data are reported from all OPDs: Hospitals, CHC, BHC, HSC, MHTs. For hospitals, the emergency room also fills out this form; the in-charge of the hospital combines the data of the OPD and the emergency room into one MIAR. The in-charge of the health facility must review the report for missing data and other anomalies, note any comments about important trends or problems in the catchment area and dispatch it to the PPHO within ٧ days of the end of each month. A copy of each report should be kept in a chronological file within the facility.

٢,٧,٢. MIAR – Form

Monthly Integrated Activity Report **Government of the Islamic Republic of Afghanistan**

MIAR – Page ١ **Ministry of Public Health**

		District Name & Code				Province Name & Code	
Year		Month	Facility Code			Facility Name	

Referred Out	Referred In	Reatten-dance	New					MHT HSC BHC CHC RH, PH, DH (OPD)	Facility Type
			Total New	>= ٥		< ٥			
				F	M	F	M		
								Patients/Clients	
								A١. OPD Morbidity	
								١. COUGH & COLD	ARI
								٢. ENT	
								٣. PNEUMONIA	
								٤. ACUTE WATERY	DIARRHEA
								٥. ACUTE BLOODY	
								٦. W DEHYDRATION	
								٧. SEVERELY ILL PATIENT	
								٨. VIRAL HEPATITIS	
								٩. MEASLES	
								١٠. PERTUSSIS	
								١١. DIPHTHERIA	
								١٢. NEONATAL TETANUS	
								١٣. TETANUS	
								١٤. ACUTE FLACCID PARALYSIS	
								١٥. MALARIA	
								١٦. URINARY TRACT INFECTIONS	
								١٧. MENTAL DISORDERS	
								١٨. TRAUMA	
								١٩. TB SUSPECTED CASE	
								٢٠. PEPTIC DISORDER	
								٢١. MUSCULOSKELETAL	
								٢٢. HYPERTENSION	
								٢٣. ANEMIA	
								٢٤. GASTRO-INTESTINAL WORMS	
								٢٥. SKIN INFECTION	
								٢٦. SKIN OTHER	
								٢٧. PELVIC INFLAMMATORY D.	
								٢٨. SEXUALLY TRANSMITTED D.	
								٢٩. EYE INFECTIONS	
								٣٠. ORO-DENTAL CONDITIONS	
								٣١. MICRONUTRIENT DISORDER	
								٩٩. OTHERS/UNLISTED DIAGNOSES	
								A٢. Remarks:	
								B. Nutrition Status	
								١. No acute malnutrition	
								٢. Moderate Acute Malnutrition	
								٣. Severe Acute Malnutrition	

Monthly Integrated Activity Report **Government of the Islamic Republic of Afghanistan**
MIAR – Page ٢ **Ministry of Public Health**

D. Stock status Essential Drugs/commodities	Referred Out	Referred In	Re-atten dance	New Cases	C. Maternal & Neonatal Care	
Acetyl Salicylic Acid/Paracetamol					## Units	**C١. Family planning**
Mebendazole						١. Oral (cycle)
Amoxicillin/Ampicillin						٢. Injectable (injection)
INH						٣. IUD (insertion)
Rifampicin						٤. Condoms (Dozen)
Amp. Diazepam						٥. Permanent (case)
Inj. Lidocaine						**C٢. Pre- and Post-Natal**
Metronidazole						١. Antenatal Visit - First
Co-trimoxazole						٢. Antenatal Visit - Other
Anti-hypertensives						٣. Postnatal Visit - First
Oral contraceptive						٤. Postnatal Visit - Other
Injectable contraceptive						**C٣. Obstetric Care**
Condoms					١,١.Facility	١. Normal Delivery
IUD					١,٢. Home	
TT vaccine					٢,١.Facility	٢.Assisted Delivery
PENTA vaccine					٢,٢.Home	
ORS						٣. Major complication
Zinc tablets						٤. Other Complication
Vitamin A						٥.Maternal Death due to Major
Ferrous Sulfate + folic acid						٦. Maternal Death due to Other
Oxytocine						٧. Cesarean section
Chloroquine						٨. Other obstetric surgery
Artesunate + SP						**C٤. Neonatal Care**
Amitriptiline/ Fluoxetine						١. Newborn Alive
Gloves						٢. Low Birth Weight
D٢. Comments about stock						٣. Neonatal Complication
						٤. Neonatal Death
						٥. Stillbirth

E. Immunizations			
Total	**١٢-٢٣ m**	**٠-١١ m**	**E١. Childhood**
			1. PENTA٣
			2. Measles (first dose)
>TT٢	**TT٢**		**E٢. TT Immunization**
			١. Pregnant women
			٢. Non-Pregnant women

F. Laboratory Exams		
Female	**Male**	**F١. Blood**
		1. Total malaria slides examined
		2. Total PF positive
		3. Total other positive
		4. Total HIV examined
		5. Total HIV positive
		F٢. Sputum
		1. Total AFB slides examined
		2. Total AFB positive

G. Tuberculosis	
G١. Case detection	
	1. Number of new smear (+) cases
	2. Number that started treatment
G٢. Treatment complete and cured	
	1. Number of cases completed and smear (-)

H. Community Health	
	١. Number of meetings with community health committee
	٢. Number of CHWs seen for supervision

I. Report Transmitted	
	Name
	Designation
	Date
	Signature

J. Report Received/Aggregated	
	Date Received
	Data aggregated/computerized

Any special activities or problems, significant anomalies or trends in morbidity and service delivery **K. Comments:**

٢,٨. Facility Status Report – MHT/HSC/BHC/CHC (FSR)

٢,٨,١. FSR – Guidelines for use

١. Purpose of the Form

This form is used to report on the physical facility and human resources available at the MHT/HSC/BHC/CHC. This form also captures some activities of the MHT/HSC/BHC/CHC that are not directly related to providing health services. The local health workers and provincial level health authorities use this information to assess the adequacy of physical facilities and human resources to ensure the provision of uninterrupted health services. While usually required on an annual basis, during periods of rapid expansion of or change in health services, the MoPH may require the report on a six-monthly basis.

٢. Lay-out

The form is an A٤ two page (three sides) form, printed in landscape mode.

The form contains ٦ sections:

A. General Facility Information
B. Human Resources
C. Equipment status
D. Services provided
E. Remarks and observations
F. Submission

٣. Data Sources

The data for the form comes from
١. Inventory Register
٢. Visitor's Book
٣. Facility inspection
٤. Various activity records (e.g Health Education)
٥. Staff records
٦. Diary or register of IEC and other activities

If records are not available or incomplete, the in-charge of the facility will personally check the accuracy of the required information. If data is not available for a reporting period, the in-charge will note "NA" in the corresponding entry.

٤. Who Prepares

The in-charge of the MHT/HSC/BHC/CHC prepares this form in two copies. When reporting annually, one copy is submitted to the PPHD office by ٧th of Hamal of each year or, when reporting six monthly by the ٧th of the month after the last month in the reporting period. Another copy is filed at the MHT/HSC/BHC/CHC.

٥. Definitions

MD medical doctor
CHW community health worker

٦. Instructions

A. General Facility Information

١. Province Code & Name: Write the Geo-code and the name of the province where the facility is located
٢. District Code & Name: Write the Geo-code and the name of the district where the facility is located
٣. Facility Code & Name: Write the MoPH ID code and the name of the MHT/HSC/BHC/CHC
٤. Type of facility: Circle MHT, HSC, BHC, or CHC
٥. Period: Write the months (from… to ….) and the year (of……) for which the report is being prepared. Dates should reflect the Afghan Shamsi calendar. When the report is prepared annually, note that this year is not the same as the year in which you are preparing the report. For example, if you are preparing the report in the month of Hamal of ١٣٨١, write ١٣٨٠ here because the report you are preparing is for year ١٣٨٠.
٦. Building: A building is considered ***temporary*** if the building's original and permanent future intended use was/is use for something other than a health facility. Examples of temporary buildings are schools or other public buildings used as health facilities, rented houses, shops, or other buildings. A building is considered ***permanent*** if the original or permanent future use is as a health facility.
٧. Main construction material: Circle "concrete" or "other." "Concrete" means having at least a concrete base and concrete supporting beams for the walls and roof (in theory, earth-quake proof). The "concrete" reflects the Dari term "پخته" and the "other" reflects the Dari term "خام".
٨. Main source of drinking water: The usual source of drinking water. If a facility normally uses a water tap, except for the dry months, when it uses a well, the main source of drinking water is the water tap. ***Safe*** means water obtained from a covered deep well, a tube well with a covered base, piped water, and/or chlorinated water from closed containers. ***Other*** means all other sources.
٩. Main source available: Write the number of months the main source of drinking water is available; write "١٢" if the source is available throughout the year.
١٠ Electricity: Circle YES if available, even only a few hours a day, and NO if not available at all.
١١. If Electricity is YES, indicate the **main source of electricity** by ticking any one of the options. If the facility usually relies on line electricity, and has generator backup, only line should be ticked.
١٢. Indicate the **Average hours per ٢٤ hours** that electricity from the main source is available, e.g., if line electricity is available six hours a day and a generator is used two hours a day on average, write "six"
١٣. On drivable road: Circle YES or NO to indicate whether or not the facility is located on a drivable road.
١٤. If not, walking time from road: If the facility is not located on a drivable road, write the number of hours and minutes needed to walk to the nearest drivable road, e.g., ٩٠ minutes, note as ١ hour ٣٠ minutes. A road is any road that is regularly used by motorized vehicles, regardless of its shape or condition.
١٥. Referral facility name & code: Write the name and the MoPH ID code of the most frequently used referral facility--the general facility (hospital) that is most often used for

complicated cases. Many facilities can use a specialized hospital (e.g., eye hospital) for specific cases – do not write the name of this hospital.
١٦. Latrine for use by patients: circle YES if there are latrines for patients, NO if not. If the facility has latrines for use by staff of the facility only, the answer should be NO.
١٧. If Yes, type: If YES is circled, mark the type of latrine. ***Open*** means that flies and other animals have access to the waste, e.g., as in the traditional Afghan latrines. ***Closed*** means that flies and other animals have no access to the waste, e.g., VIP latrines, flush latrines, …
١٨. Separate latrine for male and female: Circle YES if there are ***separate*** latrines for men and women, circle NO if there are not.
١٩. No. of Beds: Write the number of patient beds currently available at the HSC/BHC/CHC.
٢٠. Waste disposal: Circle YES or NO as to whether the facility has a special area for medical waste.
٢١ If YES, type: Mark the type of waste disposal. ***Incinerator*** means a special device to completely burn the medical waste. ***Burn and bury*** means a place where waste is accumulated, then burned and buried at regular intervals. ***Other*** means any other waste disposal method other than the aforementioned or no disposal method.
٢٢. Communication: Mark ***Radio*** and/or ***Telephone*** if they are available. Write the facility phone number if it is property of facility not of the personnel.
٢٣. Transportation: Mark the appropriate. ***Ambulance*** means a vehicle that can transport a patient. Mark whether the vehicle is usable of not. ***Motorbike*** refers to a motorbike for outreach activities. ***Other*** means any other means of transport for a patient (including transport by animals). ***None*** means that no transport for patients is available.

B. Human Resources

B ١. Facility Staff Status

The staff categories listed are those listed in the BPHS for MHT, HSC, BHC, CHC. Write down the number of female and male staff in each category based on their gradation degree not on the position filled.
Refresher training: Write the number of staff in each category who attended at least one full day job related training/seminar during the last reporting period.
٦. MD Specialist: any MD specialist like Surgeon, Anesthetist, Pediatrician, Gynecologist
١٢. Support staff: includes administrator, cleaners, guards, cooks, drivers, etc…

B ٢. Community Health

Write the number of **CHWs**:
"**ever trained**": number of CHWs that finished the third phase of training. This is the total number of CHWs so far trained in the health facility catchment area irrespective of implementer after MoPH approved CHW recruiting policy. For example; ٥ CHW was trained by NGO "Y" in ٢٠٠٢, ٦ CHW was trained by NGO "Z" in ٢٠٠٦ and ٣ CHW was trained by NGO "X", now ever trained CHWs are ٥+٦+٣=١٤, write "١٤". This includes drop out.
"**active**": number of CHWs active in the catchment area of the facility and supervised by its staff. CHWs are considered "active" after they finish the first Phase of CHW training and are deployed in a health post.

B ٣. Supervision

Write the number of supervisory visits performed during the last reporting period by the implementer and by others (MoPH, UN agency, donor) at this facility. Count only supervisory visits, not monitoring or evaluation visits.

C. Equipment status

For each kind of equipment listed, mark the number of units present in the facility. The exact number is important for the facility in-charge. At the provincial and national levels, the exact number of some of the equipment may lose its importance during analysis. For larger facilities, the in-charge may have to sum up reports from different departments.
Usable: some parts or accessories may be missing but the equipment can still be used for its basic functions, e.g.. some clamp or forceps of the Minor Surgery Kit may be missing, but the kit can still be used; however, if only a scalpel and needle holder are left, the kit is no longer usable.
Not usable: pieces are missing or broken to the extent that the equipment cannot be used for its basic function.

١. Scissors: Record only those Scissors that are available for immediate use without having to open a set. Don't record those are inside the sets.

٢. Dressing forceps: Record only those Dressing forceps that are available for immediate use without having to open a set. Don't record those are inside the sets.

١٨. Midwifery kit: see contents in BPHS ٢٠١٠ guideline, Annex C.

D. Services provided

Mark whether or not each listed service was provided on a regular basis during the last month of reporting period in the ***Facility*** and community by the facility staff and **CHWs** supervised by the facility staff. Note; activities under *D٣. Maternal and Neonatal health* at community level record just those services performed by the facility staff which is taking place during an out-reach or at home delivery by skilled birth attendants (SBA).

D ١. General Curative

٢. IMCI implemented means that all modules of the IMCI are being implemented: ARI, Diarrhea, Fever & Malaria case management, EPI, growth monitoring. All of the separately mentioned modules need to ticked off as well. If IMCI is not completely implemented, IMCI should not be ticked off, but the specific services (ARI, DD, malaria, EPI, Growth monitoring) that are provided need to be ticked off.

D٨. IEC Activities

This includes all forms of IEC activities: posters and pictures displayed at the facility or in community gathering places, or at meetings, talks, etc. on any of the mentioned subjects.

D ٩. Community supervision:

١. Number of Health Post Active: Write the number of Health Posts active and reporting to this facility. Active refers to a HP has CHW who has finished first phase of training and reported in the last month.
٢. Number of Health Posts Supervised twice: Write the number of Health Posts supervised at least twice this reporting period. If CHW attend the monthly meeting in a health facility is also count supervision.

E. Remarks and observations

Write all notable achievements, observations or experiences regarding the functioning of the facility during the last reporting period in this space. For example, if the facility was closed for a period of time, mention this as well as the reason for the closure, or, if no CHWs were trained, mention the reason and suggest a remedy.

Finally, the in charge of the facility should verify the accuracy of the report and nd write his/her **name** and **designation**, as well as the **date** the report was completed , and sign.

F. Submission guidelines

Two copies of this report should be filled out by the in-charge of the clinic. When reporting annually, one copy is sent to the PPHD/NGO by the ٧th of Hamal of each year; another copy is filed and kept in the facility. When reporting every ٦ months, the report is sent by the ٧th of the month after the last month of the reporting period.

٢,٨,٢. FSR – Form

Facility Status Report – FSR **GOVERNMENT OF THE ISLAMIC REPUBLIC OF AFGHANISTAN**

Page ١ of ٣ **MINISTRY OF PUBLIC HEALTH**

A. General Facility Information						
١. Province Code & Name		٢. District Code & Name				
٣. Facility Code &Name	٤. Type of facility MHT SHC BHC CHC	٥. Period …..To…….From ……Of				
٦. Building	٦,١. Temporary	٦,٢. Permanent:	٧. Main construction material Concrete Other			
٨. Main source of drinking water Safe Other			٩. Main source available …….. months per year			
١٠. Electricity No Yes	١١. Main source of electricity Line Generator Solar Wind		١٢. Average hours/٢٤ hours……..			
١٣. On drivable road No Yes	١٤. If not, walking time from road …..Hrs ……..Min		١٥. Referral facility name & code			
١٦. Latrine for use by patients No Yes	١٧. If Yes, type: Closed Open		١٨. Separate latrine for male and female No Yes			
١٩. No of beds		٢٠. Waste disposal No Yes	٢١. If yes, type: Incinerator Burn and Bury Other			
٢٢. Communication	٢٢,١.Telephone: If yes:Phone# ٢٢,٢. Radio ٢٢,٣. None		٢٣. Transportation	٢٣,٢.Motorbike ٢٣,٣.Other ٢٣,٤.None		

B. Human Resources							
B ١. Facility Staff status							
Type	***Male***	***Female***	***Refresh***	***Type***	***Male***	***Female***	***Refresh***
1. Nurse				١٠ Community Health Supervisor			
2. Assistant nurse				١١. Vaccinator			
3. Midwife				١٢. Support Staff			
4. Community midwife							
5. MD General				***B ٢. Community Health***			
٦. MD Specialist				1. CHWs ever trained			
٧.Pharmacist				2. CHWs trained and active			
٨. Laboratory Technician				***B ٣.Supervision***	***Implementer***		***Other***
٩. Pharmacy Technician				١. Number of supervisory visits			

C. Equipment status					
# Not Usable	***# Usable***	***Type***	***# Not Usable***	***# Usable***	***Type***
		١٤. Vaccine carrier(+ice packs)			1. Scissors
		١٥. Otoscope			2. Dressing forceps
		١٦. Flashlight			٣. Thermometer
		١٧. Suction			٤. Clean delivery kit
		١٨. Midwifery kit			٥. ORS measuring jug
		١٩. Sterilizer			٦. MUAC tape
		٢٠. OPD Examining table			٧. Stethoscope
		٢١. Oxygen gauge & cylinder			٨. Sputum and blood specimen bottles
		٢٢. Neonatal resuscitation trolley			٩. Vision testing chart
		٢٣. Hemoglobin meter			١٠. Sphygmomanometer
		٢٤.Hand crank/electrical centrifuge			١١. Salter scale
		٢٥. Blood cross matching set			١٢. Adult weight scale
		٢٦. Microscope			١٣. EPI Cold box/refrigerator
D. Services provided					
Community	***Facility***	***D ٤. Infectious Diseases***	***Community***	***Facility***	***D ١. General Curative***
		1. TB detection & referral			1. Curative OPD
		2. TB labdiagnosis			2. IMCI implemented
		٣. DOTS			3. ARI Case Management
		٤. Malaria lab diagnosis			4. DD Case Management
		D ٥. Mental health			5. Malaria Case Management
		١. Awareness raising			6. Minor surgery (Incision, Drainage, suture)
		٢. Case detection			***D ٢. Child Health***
		٣. Treatment and follow-up			1. Routine Growth Monitoring
		D ٦.Family planning			2. Community Therapeutic Center
		1. Oral contraceptives			3. Child Immunization (EPI)
		2. Injectable contraceptives			***D ٣. Maternal Health***
		3. IUD			1. Antenatal care
		4. Condoms			2. TT immunization
		D ٧. Disability services			3. Delivery by trained staff
		١. Awareness raising			٤. Manual Removal of Placenta
		٢. Case detection			٥. Removal of retained products
		٣. Referral			٦. Assisted Vaginal Delivery
					٧. Blood Transfusion

	D ٩. Community Health Worker Supervision	***Community***	***Facility***	***D ٨. IEC Activities***
	١. Number of Health Post Active			1.Obstetric complication and birth preparedness
	٢. # of Health Post Supervised at least twice			٢. Family Planning
				٣. Nutrition
				٤. IMCI
				٥. Injection Safety

E. Remarks and observations

F. Submission

	Position		Name
	Date		Signature

٢,٩. Hospital Monthly Inpatient Report (HMIR)

٢,٩,١. HMIR – Guidelines for use

١. Purpose of the Form

The purpose of this form is to report about inpatient activities, services, morbidity and mortality at district, provincial and regional hospitals. The primary focus is on inpatients and referral services.

The hospitals report **maternity care, outpatient services, and laboratory services** using the same Monthly Integrated Activity Report (MIAR) that is completed by BHCs and CHCs.

٢. Lay-out of the Form

The form contains nine sections:

A. Indoor patients
B. Nutrition of under fives
C. Imaging services
D. Other Surgical services
E. Stock status of hospital drugs
F. Cases and deaths of priority diseases
G. Obstetrics & Neonatal
H. New inpatient cases
I. Comments
J. Report submission

٣. Data Sources

The data for the form comes from:

- Indoor Patient Registers of each departments (including nutrition)
- Daily Indoor Patient Census of each departments
- Operating Theatre Registers
- X-ray and Ultrasound Register
- Pharmacy

٤. Who prepares

This form is mainly used to report information about referral services provided at district, provincial and regional hospitals. The document is prepared by the staff of the various departments and then compiled under the supervision of the Hospital Director. The report is sent to the PPHO by the ٧th day of each month. The PPHO/NGO enters all hospital data into the HMIS database and sends a quarterly electronic copy to MoPH/HMIS

٥. Definitions

Most of the terms on this form are self-explanatory. There are two calculated entries:

Number of Patient Days: This number is an indicator of the volume of in patients who are treated during a given month. An example for the calculation of this indicator is included below in the Detailed Instructions.

Average length of stay: This number is an indicator of the efficiency of hospitalization. To calculate this indicator, take the sum of the duration of hospitalization (the number of calendar days a patient stays in the hospital) for all patients who were discharged and died during the month and divide it by the total number of patients discharged and died during that

month. An example for the calculation of this indicator is included below in the Detailed Instructions.

٦. Detailed Instructions

General information

Province Code & Name: Write the Geo-code and the name of the province where the hospital is located
District Code & Name: Write the Geo-code and the name of the district where the hospital is located
Hospital Name: Write the name of the hospital
Facility Code: Write the MoPH ID code that identifies the Hospital
Type of hospital: Tick RH (National/Regional/specialized hospital), PH (Provincial hospital, DH (District hospital)

A. In Patients

Using the InPatient Register, provide a summary of patient movements during the month in the categories listed below. For each of the listed categories, write the total number of children under five male and female separately, females over five and males over five.

١. **Admissions**: all patients admitted as inpatients. Note that maternal and neonatal data related to deliveries performed at the hospital are defined on the **MIAR**. However, those hospitalized are included in the general admission register and counted here.
٢. **Referred-in**: count those who have been referred-in from other health facilities
٣. **Number of Patient days**: Each morning, at ٨ O'clock (or a given time, but the same time every day or night), add together the number of patients who are hospitalized at that time. Note that some patients (normal deliveries) will only stay a few hours. Some of them will be counted and some of them will not be counted, the total will closely reflecting the total full patient days for these types of patients. See Figure ٦ below for an example.

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
6	7	8	4	4	8	8	5	5	6	7	9	10	7	8	5
17	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**	**Tot**
3	4	4	6	7	7	7	7	8	5	8	8	8	5	x	191

Figure ٦ - Number of patient days: Calculation example

For example, if there were ٦ people on the ١st, ٧ on the ٢nd, ٨ on the ٣rd, etc., the number of patient days would be ٦+٧+٨+etc… or at total of ١٩١. In the example, the month has only ٣٠ days, so day ٣١ is not counted. The number of daily inpatients should be obtained from the census conducted each morning. The number of patient days per month when combined with the number of available beds during the same period allows calculation of the bed occupancy rate.

٤. **Average length of stay**: sum of the number of days stayed in the hospital (from the date of admission) for all patients who were discharged (or died) during the month divided by the total number of patients who were discharged (or died) during that month. In the example given in Figure ٧, ٢٣ patients were discharged or died during the month and they

stayed in the hospital for a total of ١٥٥ days: an average length of stay of ٦.٧ days (see Figure ٧ below).

Average Length of Stay (ALOS)		
Number of patients discharged or died	Number of days each patient stayed	Average Nubmer of Days Hospitalized (ALOS)
||||| ||||| ||||| ||||| ||| (٢٣)	٧+١٥+٤+٣+٨+٧+٥+٦+٦+٧+٩+١٠+٧+٨+ ٥+٨+٤+٣+٦+٧+٧+٨+٥ (= ١٥٥)	١٥٥/٢٣ = ٦,٧

Figure ٧ - Average length of stay: Example calculation

٥. **Discharged/Outcome:** Note the total number of inpatients discharged. For the discharged patients, write the total that corresponds to each category:
   ١. **Recovered/improved**: inpatients that were discharged because their status improved, including those who need some further ambulatory care
   ٢. **Absconded/defaulted**: patients that are no longer hospitalized, but whose whereabouts are unknown. Ideally, this number should be zero.
   ٣. **Not Improved**: patients who were discharged without improvement in status. This includes patients whose status did not improve, for whom no further treatment is useful.
   ٤. **Referred-out**: those patients who have been referred to other medical facilities for more specialized care.
   ٥. **Deaths:** all inpatients who died in the hospital before being discharged, or who were dead when being discharged. These are the patients that have been counted at least once as occupying a bed before being discharged. It includes the deaths reported in sections G. Maternal and Neonatal and F. Cases and deaths of priority diseases <٥ of this form.

B. Nutrition of under fives

Only malnourished children who need hospitalization are taken into account. Ambulatory screening and treatment of the nutritional status of children under five is noted in the MIAR.

١. **Admitted**: Number of malnourished children admitted into the hospital
٢. **Improved**: Number discharged with improvement
٣. **Defaulter**: dropped out, left the hospital before being discharged
٤. **Referred out**: Number of hospitalized malnourished children referred to other facilities for more specialized care
٥. **Deaths**: number of malnourished children who died

C. Imaging services

Using the imaging department records, report the number of images taken during the month according to the following categories:

١. Chest x-ray
٢. Abdomen x-ray
٣. Skeletal x-ray
٤. Ultrasound
٥. Other

D. Surgical interventions

Using the operation theatre (OT) register, record the total number of surgical interventions of the following types that were performed during the month. This section gives more details on cases listed under H. New Inpatient Cases that need surgical intervention. Be sure to sort them out by Major and Minor interventions

Major surgery is generally done under general anesthesia with respiratory assistance. Even when using regional/spinal anesthesia, surgery is considered major if penetration of a body cavity (e.g. abdomen, thorax, skull) is involved or extensive orthopedic surgeries on the extremities, like joint replacements, bone reconstruction, internal and external fracture fixations. Likewise when significant resection or changes to the anatomy are involved or organs are removed, like amputations of arms or legs. Neurosurgery is considered major independent of the anesthesia used. Major surgery always requires a dedicated intervention room.

Minor surgery is generally done under local or regional anesthesia. Certain interventions are never considered minor surgery regardless of the type of anesthesia (see above under Major surgery). Minor surgery does not require a dedicated intervention room, as long as standard infection control criteria are respected during the procedure. Examples include: removal of foreign bodies that do not penetrate abdomen, thorax or skull; nasal cautery; removal of warts and verrucae; removal of toenails; excisions of lipoma, intradermal naevi, papilloma, dermatofibroma, sebaceaous cysts; aspiration of joints, cysts, bursae, hydrocoele; incision of abscesses,cysts, thrombosed piles; hormonal implants; nail bed ablation; wound suturing.

١. **Gynecological**: all gynecological interventions, except obstetric interventions, which are already captured in section G. Obstetics & Neonatal. This includes all interventions on the female genital tract and breast.
٢. **ENT** includes all surgical interventions on ears, nose and throat
٣. **Eye** includes all surgical interventions on the eye
٤. **Orthopedic**: all orthopedic and traumatic surgery not pertaining to any of those listed under ١,٢,٣.
٥. **Abdominal**: all non-obstetric, non-gynecological abdominal surgery
٦. **Others**: any surgical intervention, not listed under D١, D٢, D٣, D٤, D٥.
٧. **Total**: total of the above
٨. **Post operative deaths**: number of patients who die within ١٠ days of surgery
٩. **Post operative complications**: number of patients who have complications of the surgical intervention: local or general infection; bleeding; re-intervention.
١٠. **Blood transfusions**: the number of patients who received a blood transfusion. This also includes patients who undergo cesarean sections and other obstetric surgery.
١١. **Blood transfusion reactions**: number patients with adverse reactions following blood transfusion. This also includes patients who undergo cesarean sections and other obstetric surgery.

E. Stock status of hospital drugs

Go through the stock register (and check the shelves where you may keep some drugs for day to day distribution) and place a cross (☒) in the box to the right of any of the following indicator drugs that were not present for one or more days during the month. Situations, in which a couple of tablets of a drug remain, but not a number sufficient to serve an adult patient, should also be considered as the drug not being present. If the drug was present every single day of the month, a tick-off (☑) should be placed in the box to the left of the name of the drug:

☒ = during the last month, this drug was not present one day or more
☑ = during the last month this drug was present every single day

Although the stock position of all drugs should be monitored regularly, the following is the list of essential drugs whose stock status should be reported monthly:

ACT
Atropine inj
Benzyl Penicilline inj
Digoxine
Ergometrine inj
Furosemide inj
Gentamycine inj
Iodine poluvidone
Ketamine inj
Lidocaine ٥٪ spinal inj
Magnesium Sulphate
Morphine inj
Naloxone inj
Hydralazine inj
Oxygen
Pethidine inj
Phenobarbital inj
Quinine inj
Ranitidine inj
Ringer lactate IV
Salbutamol inj
Sodium chloride IV

F. Cases and Fatalities for Priority Diseases

Using the in patients register, note the total number of admissions and deaths for the following priority diseases/health problems. To simplify calculation, record only the total deaths and total admissions during the month – even if some of the deaths may have been from admissions during previous months. Be sure to focus on admissions and death in <٥ children for Diarrhea, ARI with pneumonia (as per IMCI classification), Measles, and Other (all cases that are not diarrhea, ARI or Measles). Include in this section under the relevant problem, the number of neonatal deaths listed under G٣,٤. Death

Note under **< ٢٤h** the number of deaths occurring within ٢٤ hours of admission to the hospital, under **>٢٤h**, deaths occurring after ٢٤ hours of admission.

Note: any death after hospitalization occurring in the hospital is considered hospital death.

Note that the cases counted in this section are also listed under **H. New Inpatient Cases** and **G٣. Neonatal care** where appropriate.

G. Obstetrics & Neonates

This section contains details of cases listed under **H.٤٠ Obstetric & pregnancy related** and H.٤٢ Neonatal conditions. Note that hospitals report obstetric and neonatal cases and conditions in the HMIR.

G ١. Family Planning

All permanent family planning methods (tubal ligation, vasectomy).

G ٢. Obstetrics

- **١. Normal Delivery:** all the vaginal deliveries requiring no intervention more complicated than an episiotomy, including those that require suturing of first and second degree perineal tears. Normal Delivery does *not* include the use of forceps or a vacuum extractor. Note that normal delivery cannot have deaths – deaths are listed under G٢,٣ Major complications or G٢,٤ Other complications.

- **٢. Assisted Delivery:** all vaginal deliveries that require more than an episiotomy, i.e. use of forceps or vacuum extractor; suturing of third and fourth perineal tears. Any of these deliveries can also involve major or other complications, which need to be recorded under the appropriate entry. Note that assisted deliveries cannot have deaths – deaths are listed under G٢,٣ Major complications or G٢,٤ Other complications.
  The sum of **١.Normal Deliveries** and **٢. Assisted Deliveries** gives the total number of deliveries that took place for this facility during the period (i.e. were assisted by trained staff of this facility).

- **٣. Major complication**: all women presenting with major obstetric complications. This includes women who delivered at the facility, as well as those who delivered elsewhere but were referred to the facility post partum for major complications. Major Obstetric Complications refers to ٧ major causes of maternal death: (١)Haemorrhage (ante-, intra- or post-partum), (٢) Prolonged/obstructed labour, (٣) Post-partum sepsis, (٤) Complications of abortion, (٥) Pre-eclampsia/eclampsia, (٦) Ectopic pregnancy, (٧)Ruptured uterus.
- **٤. Other complications**: all women presenting with obstetric complications not due to any of the seven major causes. This includes women who delivered at the facility, as well as those who delivered elsewhere, but who were referred to the facility post partum for other complications. Examples of Other Complications that might be registered are third and fourth degree lacerations, cervical tear, shoulder dystocia, premature rupture of membranes, malaria in pregnancy, HIV, etc. Remember that episiotomy as well as first and second degree lacerations are considered "normal delivery" in this classification and should not be counted here.

- **٥. Cesarean section:** all women who underwent cesarean section in this facility. Note that Cesarean section cannot have deaths counted – deaths are listed under G٢,٣ Major complications or G٢,٤ Other complications.

G ٣. Neonatal Care.

- **١. Newborn alive**: all newborns who were alive at birth, even including those who died within minutes or hours after birth.
- **٢. Low birth weight**: all newborns weighing less than ٢٥٠٠ grams at birth.
- **٣. Neonatal complication:** all neonates that were ill or presented other complications (e.g. hypothermia, infection, sepsis).
- **٤. Neonatal deaths**: all newborns born alive that died within ٢٨ days of birth. This should include also newborns that were not delivered in the hospital, but were seen and died in the hospital, but not cases that are only reported to the hospital staff.
- **٥. Still births**: all newborns that were not alive at birth.

H. New Indoor Cases of Morbidity

Using the indoor patient register, tally up the number of cases admitted during the month for each of the priority health problems/diseases listed. Include only inpatients, do not include outpatients. The "new" wants to stress that this is a new case admitted, even if the same patient comes back with the same problem. Case definitions are given in Annex ٣.

I. Comments

Any comments that may help clarify incomplete data or particular trends observed can be mentioned here.

J. Report Submission

This section should be filled out by the person responsible for submitting and receiving the report.

Report Submitted

These details should be completed to trace the submission of the report. The boxes should be filled by the hospital in-charge who prepared the report or checked the report for completeness before sending it to the PPHO.

Name: Enter the name of the hospital in-charge at the time the report was submitted,

Designation: Enter the designation of the person submitting the report.

Date: Write the date that the completed report was submitted (i.e., mailed or dispatched by courier).

Signature: Sign the report.

Report received/aggregated

Received by: Initials of the person at the PPHO who receives the report

Date Received: The in-charge in the Provincial Public Health Office who receives the report should note the date that the report was received at the office. This should be recorded in the dispatch/receipt register.

Aggregated/computerized by: Initials of the person(s) who aggregates/computerizes the report.

Date aggregated: The person who completes the aggregation of the data on paper or the entry of the data onto the computer should enter the date that the report was aggregated/entered.

٧. **Submission Guidelines**:

This report is to be prepared by the staff member responsible for each of the key service areas included. The data are reported from all Inpatient departments. The in-charge of the hospital must review the report for missing data and other anomalies, noting any comments about important trends or problems in the catchment area and dispatch it to the PPHO within ٧ days of the end of each month. A copy of each report should be kept in a chronological file within the hospital.

٢,٩,٢. HMIR - Form

Hospital Monthly Inpatient Report **GOVERNMENTOF THE ISLAMIC REPUBLIC OF AFGHANISTAN**
HMIR - Page ١ of ٣ **MINISTRY OF PUBLIC HEALTH**

	District Name & Code			**Province Name & Code**	
Year	**Month**	**Facility Code**			**Hospital Name**
☐ Regional (RH)	☐ Provincial (PH)	☐ District (DH)			**Hospital Type**

B. Nutrition of under fives		**A. Indoor patients**				
	١. Admitted	**=>٥ M**	**=>٥ F**	**<٥ M**	**<٥ F**	
	٢. Improved					١. Admissions
	٣. Defaulted					٢. Referred-in
	٤. Referred out					٣. Number of patient days
	٥. Deaths					٤. Average length of stay
C. Imaging services						٥. Discharged/Outcome
	١. Chest x-ray					٥,١ Recovered/Improved
	٢. Abdomen x-ray					٥,٢ Absconded/defaulted
	٣. Skeletal x-ray					٥,٣ Not improved
	٤. Ultrasound					٥,٤ Referred-out
	٥.Other					٥,٥Dead

E. Stock of essential hospital drugs		**D. Other surgical interventions**			
	ACT	**Total**	**Minor**	**Major**	
	Atropine inj				١. Gynecological
	Benzyl Penicilline inj				٢. Orthopedic/trauma
	Digoxine				٣. ENT
	Ergometrine inj				٤. Eye
	Furosemide inj				٥. Abdominal
	Gentamycine inj				٦. Others
	Iodine poluvidone				٧. Total
	Ketamine inj				٨. Post operative deaths
	Lidocaine ٥٪ spinal inj				٩. Post operative complication
	Magnesium Sulphate				١٠. Blood Transfusions
	Morphine inj				١١. Blood transfusion reactions
	Naloxone inj	**G. Maternal & Neonatal**			
	Hydralazine inj	**Death**	**Admit**		**G١. Family Planning**
	Oxygen				١. Permanent
	Pethidine inj				**G٢. Obstetrics**
	Phenobarbital inj				١. Normal Delivery
	Quinine inj				٢. Assisted Delivery
	Ranitidine inj				٣. Major complication
	Ringer lactate IV				٤. Other complication
	Salbutamol inj				٥. Cesarean Section
	Sodium chloride IV				**G٣. Neonatal Care**

F. Cases and deaths of priority diseases <٥						
Death		**Admit**	**Problem**			
>٢٤h	**< ٢٤h**					
			١. Diarrhea			٣. Neonatal complication
			٢. Pneumonia			٤. Neonatal death
			٣. Measles			٥. Still birth
			٤. Other			

Year	Month	Facility Code	Hospital Name

H. New Inpatient Cases

Death	Referr. Out	Referr. In	Total	>= ٥		< ٥		Priority health problem/disease
				F	M	F	M	
								١. Weapon wounded
								٢. Road traffic accidents
								٣. Occupational injuries
								٤. Burns, scalds & frostbite
								٥ Fractures& dislocations
								٦ Cerebral Concussions
								٧. Other injuries
								٨. Cerebro-vascular accidents
								٩. Ischemic Heart Diseases
								١٠. Other Cardiovascular
								١١. Meningitis/encephalitis
								١٢. Epilepsy & convulsions
								١٣. Other Neurological
								١٤. Diabetes & related
								١٥. Micronutrient deficiencies
								١٦. Acute abdomen
								١٧. Peptic disorders
								١٨. Other Gastro-intestinal
								١٩. Abdominal Hernia
								٢٠. Liver, gall bladder & pancreas
								٢١. Urinary tract infections
								٢٢. Other Uro-genital conditions
								٢٣. Pelvic Inflammatory disease
								٢٤. Dysentery (all types)
								٢٥. Diarrhea (except dysentery)
								٢٦. Malaria
								٢٧. Tuberculosis
								٢٨. Typhoid
								٢٩. Musculo-skeletal infections
								٣٠. Sepsis
								٣١. Other infectious
								٣٢. Common Mental Problems
								٣٣. Substances abuse
								٣٤. Severe Mental Problems
								٣٥. Respiratory tract infections
								٣٦. ENT
								٣٧. Other Respiratory Conditions
								٣٨. Eye conditions
								٣٩. Skin conditions
								٤٠. Obstetric & pregnancy related
								٤١. Gynecological (non pregnant)
								٤٢. Neonatal conditions
								٤٣. Musculoskeletal
								٤٤. Surgical cases (unspecified)
								٩٩. All other new inpatient cases

I. Remarks

J. Report submission	
Report Submitted	**Report Received/aggregated**
١. Name	٥. Received by
٢. Function	٦. Date received
٣. Date	٧. Aggregated/computerized by
٤. Signature	٨. Date aggregated/computerized

٢,١٠. Hospital Status Report Form (HSR)

٢,١٠,١. HSR – Guidelines for use

١. Purpose of the Form

The purpose of this form is to report on the physical facility and human resources available at the Hospital. This form also captures some hospital activities that are not directly clinical activities. The hospital staff and provincial level health authorities use this information to assess the adequacy of physical facilities and human resources to ensure the provision of uninterrupted health services at the hospital. While usually required on an annual basis, during periods of rapid expansion of or a change in the level of health services, the MoPH may require the report to be submitted on a six-monthly basis.

٢. Lay-out

The form is an A٤ two page (four sides) form, printed in landscape mode.

The report contains ٧ sections:

A. General Hospital Information
B. Human Resources
C. Supervision
D. Equipment list
E. Services provided
F. Remarks and observations
G. Report submission

٣. Data Sources

The data for the form comes from

١. Inventory Register
٢. Visitor's Book
٣. Facility inspection
٤. Various activity records (e.g Health Education)
٥. Staff records
٦. Diary or register of IEC and other activities

If records are not available or are incomplete, the in-charge of the facility will personally check the accuracy of the required information and complete the information. If data is ultimately not available for a reporting period, the in-charge will note "NA" in the corresponding entry.

٤. Who Prepares

The in-charge of the hospital prepares two copies of this form. When reporting annually, one copy is submitted to the PPHO by the ٧th of Hamal each year, or, when reporting six monthly, submitted by the ٧th of the month after the last month in the reporting period. Another copy is filed at the hospital for future reference.

٥. Definitions

MD medical doctor
CHW community health worker

٦. Instructions

A. General Facility Information

١. Province Code & Name: Write the Geo-code and the name of the province where the hospital is located
٢. District Code & Name: Write the Geo-code and the name of the district where the hospital is located
٣. Hospital Code & Name: Write the MoH ID code and the name of the hospital
٤. Type of hospital: circle H١ (National or specialized hospital), H٢ (Regional or provincial hospital, H٣ (District hospital)
٥. Period: Write the months (from… to ….) and the year (of……) for which the report is being prepared. Dates should reflect the Afghan Shamsi calendar. When the report is prepared annually, note that this year is not the same as the year you are preparing the report. When you are reporting more frequently, the same is true for the first reporting period of the year. For example, if you are preparing the report in the month of Hamal of ١٣٨١, write ١٣٨٠ here because the report you are preparing is for year ١٣٨٠.
٦. Building: A building is considered ***temporary*** if the building's original and permanent future intended use was/is use for something other than a health facility. Examples of temporary buildings are tents and prefab structures used while the hospital building is being renovated or enlarged, schools or other public buildings used as health facilities, rented houses, shops, or other buildings. A building is considered ***permanent*** if the original or permanent future use is as a health facility.
٧. Main construction material: circle concrete or other. "Concrete" means having at least a concrete base and concrete supporting beams for walls and roof (in theory, earthquake proof. The "concrete" reflects the Dari term "پخته" and the "other" reflects the Dari term "خام".
٨. Main source of drinking water: this refers to the usual source of drinking water. If a facility normally uses a water tap, except for the dry months, when it uses a well, the main source of drinking water is the water tap. ***Safe*** means water obtained from a covered deep well, a tube well with a covered base, piped water, and/or chlorinated water from closed containers. ***Other*** means all other sources.
٩. Main source available: Write the number of months the main source of drinking water is available, write "١٢" if the source is available throughout the year.
١٠ Electricity: circle YES if available, even only a few hours a day, and NO if not available at all.
١١. If Electricity is YES, indicate the **main source of electricity** by ticking any one of the options. If the facility relies usually on line electricity, and has generator backup, only line should be ticked.
١٢. Indicate the **Average hours per ٢٤ hours** that electricity from the main source is available, e.g., if line electricity is available six hours a day and a generator is used two hours a day on average, write "six"
١٣. On drivable road: Circle YES or NO to indicate whether or not the facility is located on a drivable road.

١٤. If not, walking time from road: If the answer is "No," write the number of hours and minutes needed to walk to the nearest drivable road, e.g., ٩٠ minutes, note as ١ hour ٣٠ minutes. A "drivable road" is any road regularly used by motorized vehicles, regardless of its shape or condition.
١٥. Referral facility name & code: write the name and the MoPH ID code of the most frequently used referral facility–the general facility (hospital) that is most often used for complicated cases. Many facilities can use a specialized hospital (e.g., eye hospital) for specific cases – do not write the name of this hospital.
١٦. Latrine for use by patients: circle YES if there are latrines for patients, NO if not. If the facility has latrines for use by staff of the facility only, the answer should be NO.
١٧. If Yes, type: If YES is circled, mark the type of latrine. ***Open*** means that flies and other animals have access to the waste, e.g., the traditional Afghan latrines. ***Closed*** means flies and other animals have no access to the waste, e.g., VIP latrines, flush latrines, etc.
١٨. Separate latrine for male and female: circle YES if there are ***separate*** latrines for men and women, circle NO if there are not.
١٩. No. of Beds: Write the number of patient beds currently available at the hospital for each of the wards. This includes both occupied and unoccupied beds.
٢٠. Waste disposal: Circle YES or NO as to whether the facility has a special area for medical waste.
٢١ If YES, type: mark the type of waste disposal. ***Incinerator*** means a special device to completely burn the medical waste. ***Burn and bury*** means a place where waste is accumulated, then burned and buried at regular intervals. (Beware that an oven-like construction is often referred to as "incinerator" in Afghanistan when it really is a "burn and bury.") ***Other*** means any other than the afore-mentioned or none.
٢٢. Bathroom: Circle it if facility has bathroom for patient use.
٢٢. Communication: Mark ***Radio*** and/or ***Telephone*** if they are available. Write the hospital phone number if available and is property of facility not of the personnel
٢٣. Transportation: Mark the appropriate. ***Ambulance*** means any vehicle that can transport a patient. Mark whether the vehicle is usable of not. ***Motorbike*** refers to a motorbike for outreach activities. ***Other*** means any other means of transport for a patient (including transport by animals). ***None*** means that no transport for patients is available.

B. Human Resources

The staff categories listed are those listed in the BPHS and EPHS for hospitals. Note that a DH has staff required for BPHS and additional staff for the EPHS. Write down the number of female and male staff of each category based on their actual graduate degrees not the position s/he assigned, e.g. in case of staff scarcity if a female nurse is hired instead of a midwife, write female nurse not midwife. Write the number of staff in each category who are certified according to the new MoPH certification rules and the number of staff who attended at least one refresher training during the last reporting period.

B ٢. Physicians

١٢. Other Medical Specialist: any MD specialist who is not a Surgeon, Anesthetist, Pediatrician, Orthopedist, ObGyn, or Dentist.

B ٤. Technical staff

٣٤. Technical assistants: any technical person hired to assist technically Lab, X-Ray, Pharmacy, or physiotherapy technicians.

B ٥. Support Staff

٣٦. Administrative staff: any clerks, computer operators, accountants, etc. The in-charge of the administration of the hospital is listed under management.

٣٨. Technical maintenance: any technical person for maintenance like plumber, electrician smith etc.

C. Supervision

Write the number of supervisory visits to this facility performed during the last reporting period by the PPHO and by others (NGO, UN agency, donor). Count only supervisory visits, not monitoring or evaluation visits.

D. Equipment list

For each of the listed types of equipments, write the number that are present in the facility. The actual number is useful for the in-charge of the hospital. For several items, the actual number becomes less useful for provincial and national analysis. For larger facilities, the in-charge will have to sum reports from different departments.

Usable: The equipment is new and complete, or some parts or accessories may be missing but the equipment can still be used for its basic functions, e.g., some clamp or forceps of the Minor Surgery Kit may be missing, but the kit can still be used; however, if only a scalpel and needle holder are left, the kit is no longer usable.

Not usable: pieces are missing or broken to the extent that the equipment cannot be used for its basic function.

Recommended contents of several of the kits are listed in BPHS ٢٠١٠, Annexes B,C,D, and E.

E. Services provided

Mark whether or not each listed service was provided on a regular basis during the last month of reporting period in the ***Facility*** and community by the facility staff and **CHWs** supervised by the facility staff. Note; activities under *D ٣. Maternal and Neonatal health* at community level record just those services performed by the facility staff which is taking place during an out-reach or at home delivery by skilled birth attendants (SBA).

E ١. General Curative

٢. IMCI implemented means that all modules of the IMCI are being implemented: ARI, Diarrheal, Fever & Malaria case management, EPI, growth monitoring. All of the separately mentioned modules need to be ticked off as well. If IMCI is not completely implemented, IMCI should not be ticked off, but the specific services (ARI, DD, malaria, EPI, Growth monitoring) that are provided need to be ticked off.

E ٢. Child Health

٤. Management of severely ill child means the treatment of referred, severely ill children (IMCI classification).

E ١٠. Community services

١. Number of Health Post Active: Write the number of Health Posts active and reporting to this facility. Active refers to a HP which has a CHW who has finished the first phase of training and has reported in the last month.

٢. Number of Health Posts Supervised twice: Write the number of Health Posts supervised at least twice this reporting period. If a CHW attend a monthly meeting in a hospital this is also counted as supervision.

F. Remarks and observations

Write all notable achievements, observations or experiences regarding the functioning of the hospital during the last reporting period in this space. For example, if the hospital was closed for a period of time, mention this as well as the reason for the closure, or, if no CHWs were trained, mention the reason and suggest a remedy.

Finally, the in charge of the hospital should verify the accuracy of the report and write his/her **name** and **designation**, as well as the **date** of the submission of the report, and sign.

١٥. Submission guidelines

Two copies of this report should be filled out by the in-charge of the clinic. When reporting annually, one copy is sent to the PPHD/NGO by the ٧th of Hamal of each year; another copy is filed and kept in the facility. When reporting every ٦ months, the report is sent by the ٧th of the month after the last month of the reporting period.

٢,١٠,٢. HSR – Form

Hospital Status Report –HSR
HSR - Page ١ of ٤

GOVERNMENT OF THE ISLAMIC REPUBLIC OF AFGHANISTAN
MINISTRY OF PUBLIC HEALTH

A. General Facility Information			
	٢. District Code & Name		١. Province Code & Name
			٣.Hospital Code &Name
…..To……From :Month ……Of : Year	٥. Period	National/specialist (H١) Provincial/regional (H٢) District (H٣)	٤. Type of Hospital
Stone Mud Concrete ٧. Main construction material		٦,٢.Temporary: ٦,١.Permanent:	٦. Building
٩. Main source available …….. months per year		Other Safe	٨. Main source of drinking water
……..١٢. Average hours/day	Wind Solar Generator Line ١١. Main sources of electricity		Yes No ١٠. Electricity
١٥. Referral facility name & code	…..Hrs ……..Min ١٤. If not, walking time from road		Yes No ١٣. On drivable road
No Yes ١٨. Separate latrine for male and female	Open Closed ١٧. If Yes, type:		Yes No ١٦. Latrine for use by patients
١٩,٥. Other	١٩,٤. Surgery	١٩,٣. Adult Internal ١٩,٢. Ob&Gyn ١٩,١.Pediatric	١٩. No of beds
Other Burn and Bury Incinerator ٢١. If yes, type			No Yes ٢٠. Medical waste disposal
			٢٢.Bathroom
٢٤.١.Ambulance: Usable □ Not Usable □ ٢٤. Transportation ٢٤.٤.None ٢٤.٣.Other ٢٤,٢.Motorbike		٢٣.١.Telephone: If yes: Phone #: …….. ٢٣. Communication ٢٣.٣. None ٢٣.٢. Radio	

B. Human Resources							
Refresh	*Female*	*Male*	*Type*	*Refresh*	*Female*	*Male*	*Type*
			٢٧. Pharmacy technician				***B ١. Management***
			٢٨. X-ray technician				1. Hospital Director
			٢٩. Lab Technician				2. Medical Director
			٣٠. Blood bank technician				3. Nursing Director
			٣١. Dental Technician				٣. Administrator
			٣٣. Vaccinator				***B ٢. Physicians***
			٣٣. Nutrition worker				5. Surgeon
			٣٤. Technical assistants				6. Ophthalmologist
			٣٥. Community Health Supervisor				٧. ENT
			B ٥. Support Staff				٨. Anesthesiologist
			٣٦. Administrative Staff				9. ObGyn
			٣٧. Storekeeper				10. Pediatrician
			٣٨. Technical maintenance				11.Radiologist
			٣٩. Cleaners, waste & grounds				١٢. Other Medical Specialist
			٤٠. Laundry				١٣. General MD
			٤١. Cook				١٤. Stomatologist
			٤٢. Drivers				***B ٣. Nurses & Midwives***
			٤٣. Guards and porters				١٥. Midwifes
			٤٤. Tailor				١٦. Nurse operating theatre
			٤٥. Mullah				١٧. Nurse surgical ward
			٤٦. Barber				١٨. Nurse internal ward
			٤٧. Mortician				١٩. Nurse pediatric ward
			B ٦. Community Health				٢٠. Nurse anesthetic
			٤٨. CHWs ever trained				٢١. Nurse ER and OPD
			٤٩. Trained CHWs and active				٢٢. Assistant Nurse
C. Supervision							٢٣. Nurse Nutrition
			١. Number of supervisory visits by implementer				***B ٤. Technical staff***
			٢. Number of supervisory visits by other				٢٤. Psychiatrist
							٢٥. Physiotherapist
							2٦. Pharmacist

D. Equipment list					
# Not Usable	***# Usable***	***Type***	***# Not Usable***	***# Usable***	***Type***
		٣٠. Ob/gyn table			١. Computer
		٣١. D&C set			٢. Printer
		٣٢. Minor surgical set			٣. Stabilizer
		٣٣. Laparatomy set			٤. Radio
		٣٤. Caesarean/hysterectomy set			٥. Telephone
		٣٥. Obstructed labour set			٦. Water purification
		٣٦. Episiotomy set			٧. Fire extinguishers
		٣٧. Amputation set			٨. Vehicle, ٤ wheel drive
		٣٨. Laryngoscope set			٩. Ambulance, ٤ wheel drive
		٣٩. Endo-tracheal introducer			١٠. Vaccine Refrigerator
		٤٠. Vacuum extractor (childbirth)			١١. Blood refrigerator
		٤١. Incubator Neonatal (Van Hemel)			١٢. Food refrigerator
		٤٢. X-Ray machine			١٣. Cooking stove
		٤٣. Infant warmer			١٤. Water heater
		٤٤. Ultrasound machine			١٥. Sphygmomanometer adult
		٤٥. Brown frame			١٦. Sphygmomanometer child
		٤٦. Microscope			١٧. Stethoscope
		٤٧. HB meter			١٨.Vision Chart
		٤٨. Urine sticks			١٩. Thermometer
		٤٩. Blood transfusion set			٢٠. Child scale
		٥٠. Cross match test			٢١. Height measuring scale
		٥١. Blood HIV test			٢٢. Suction machine
		٥٢. Blood Hepatitis B&C test			٢٣. ECG machine
		٥٣. VDRL test			٢٤. Fetal stethoscope
		٥٤. Glucose Test (strip)			٢٥. Ambubag & Guedel
		٥٥. NG tube (child size)			٢٦. Operating table & accessories
		٥٦. Measurement board			٢٧. Otoscope
		٥٧. Fetal Heart Monitoring Machine			٢٨.Phototherapy Machine
					٢٩. Autoclave

E. Services provided

community	facility	E ٧.Surgery	community	facility	E ٤. Maternal Health	community	facility	E ١. General Curative
		١. Closed fractures and dislocations (minor)			١. Antenatal care			١. Curative OPD
		٢. Lacerations and soft tissue injury			٢. TT immunization			٢. IMCI implemented
		٣. Acute osteomyelitis			٣. Basic EmOC			٣. ARI Case Management
		٤. Rheumatoid arthritis			٤. Comprehensive EmOC			٤. DD Case Management
		٥. Amputation			٥. Blood transfusion			٥. Malaria Case Management
		٦. Burns			٦. Blood storage			٦. Minor surgery (I&D, suture)
		٧. Superficial abscesses, cysts and tumors			٧. Neonatal resuscitation			٧. Major surgery
		E ٨. Mental health			**E ٥.Family planning**			٨. Detoxification of Substance Abuse services
		١. Common Mental Disorder			١. Oral contraceptives			**E ٢. Child Health**
		٢. Severe Mental Disorder			٢. Injectable contraceptives			١. Routine Growth Monitoring
		E ٩. IEC Activities			٣. IUD			٢. inpatient treatment of severe malnutrition
		١. Obstetric complications & birth preparedness			٤. Condoms			٣. Child Immunization
					٥. Tubal ligation			٤. Management of severely ill child (IMCI)
		٢. Family Planning			٦. Vasectomy			**E ٣. Infectious Diseases**
		٣. Nutrition			**E ٦. Radiology**			١. TB detection & referral
		٤. IMCI			١. Thorax x-ray			٢. TB lab-diagnosis
		٥. Injection Safety			٢. Abdomen x-ray			٣. DOTS
		٦. Mental Health			٣. Extremities x-ray			٤. Malaria lab diagnosis
		E ١٠. Community Health Worker Supervision			٤. Ultrasound			٥. HIV/AIDS diagnosis
		١. Health Posts active						
		٢. Health Posts supervised at least twice						

F. Remarks and observations

G. Report submission

	Designation		Signature
	Date		Name

۲,۱۱. Catchment Area Annual Census Tally Sheet (CAAC)

۲,۱۱,۱. Background

The CAAC has been introduced to improve the management capacities of the health workers at all levels of the system. The BPHS and EPHS introduced the notion of coverage to evaluate the impact of the proposed interventions. Coverage has been a key notion of the EPI program in Afghanistan. Catchment areas (and catchment populations) vary with the type of facility; the BPHS/EPHS state the recommended population to be covered by each type of facility. In general, the catchment area is the area covered directly with services by that facility. For a HP, the catchment area is the area directly covered by the one or two CHWs working in that HP. This area may be a village or a part of a village, or several smaller villages. At the HP level, the CAAC will also help the CHWs draw the community map for their catchment area. For a HSC/BHC/CHC/DH out patient care, the catchment area is the area directly covered by that facility and by the HP reporting to that facility. For DH inpatient care, the catchment area is the district. For PH inpatient care, it is the province. The catchment population is the population living in that area. Depending on targets defined for different services, the whole catchment population or part thereof can be the target population for certain services.

Purpose: The catchment area annual census (CAAC) identifies the total population and the number of people in important age groups who require health services. These numbers are essential to interpret data that is collected in health posts and health facilities and will be used at the health post, health facility, provincial and national levels. In addition, from the CAAC local death rates in these age groups can be determined so that health services can be improved and fewer people will die. It also counts the number of couples who use birth spacing methods and children who are fully vaccinated.

Who should do CAAC and where? CHWs and CHSs. CHW is doing CAAC in his/her catchment area, and CHS is responsible for the immediate catchment area of a health facility. *Immediate catchment area* here refers to the nearby areas of the health facility where no CHW is needed. CAAC will not be conducted in areas where there is no CHW and no immediate access to a health facility. If an area without immediate access to a health facility not covered by a CHW is identified, this is indicative of the recent recruitment and training of a new CHW for that area.

۲,۱۱,۲. CAAC – Guidelines for use

A Purpose: The CAAC pictorial tally sheet is used by the CHW and Health Facility (HF) staff to collect information about the total population and the number of people by age group who are living in the catchment area of the health post (HP) and HF. Because there may be more than ۱ CHW per health post there may be more than ۱ CAAC pictorial tally sheet per HP.

B. Process: The CAAC pictorial tally sheet is a tally sheet for the entire catchment area of the health post (HP) and immediate catchment area of the health facility (HF). The information is recorded by the CHW and HF staff during the first visit to a house. Each house in the catchment area must be visited for census by the CHW once during the first ۳ months of each Shamsi year. At that same visit on another piece of paper the CHW will record

information for the community map because this information is different from CAAC information. Once the data collection completed, CAAC tally sheet will be collected by the CHS who will sum the totals for each box on a CAAC Report (CAACR). Once all houses in the catchment area have been visited, the census is complete for that year. A new one will begin the following year at the beginning of the Shamsi year. If during the ٣ months there is insufficient space on the tally sheet, a second tally sheet can be used, but please be sure to mark the same year on the two forms.

C. Detailed instructions

Year: The Shamsi year will be written by the CHS when the form is distributed to the CHW.

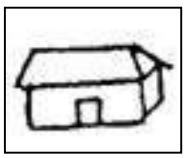
District Name and ID: Both the name of the district and the ID number will be recorded by the CHS on each tally sheet.

Health Facility Name and ID: Both the name of the health facility (HF) and the ID number will be recorded by the CHS on each tally sheet.

Health Post Name/ID: Both the name of the health post and the ID number will be recorded by the CHS on each tally sheet.

CHW Name/ID: Both the name of the CHW and their ID number will be recorded by the CHS on each tally sheet.

Household: Record the number of household you conduct the census. Considering the Afghan culture, *Household* here refers to a group of family members who live together, eat around one tablecloth and share common hearth and economy. This is not a physical structure of a house like Hawly or Qalaa.



Population: Record the number of people living in this household. Do not record any family member (s) who is married and do not live with this household anymore, for example, son or daughter who is married and lives elsewhere.

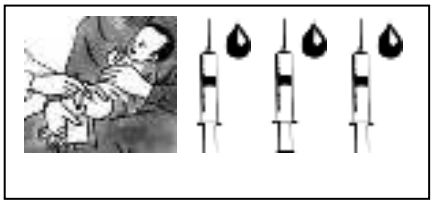
Number of living Children: Record the number of *living* children in each age group who live in the house. Do not record those who died in this box. If the mother is unsure of the age, ask questions about when the child was born in relation to community events that occurred approximately ١ year ago or ٢ years ago e.g. Eid. If the information is too difficult to obtain, look at the child and assess into which age group the child fits. Use the activities listed in each age category to help you.

Less than ١٢ months: Record the number of children living in the house who were born in the last year and are younger than ١ year old (١١ months and ٢٩ days). Most children in this age group are unable to walk but some can crawl on all ٤ limbs.

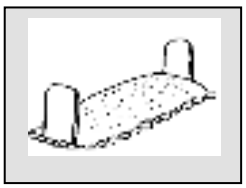
١٢-٢٣ months: Record the number of children living in the house ٤erdfcfdre٤٥ who were born between ١ and ٢ years ago and who are less than ٢ years old and more than ١١ months old. The young ones in this age group can pull themselves up to a standing position and the older ones can walk. Do not record children less than ١٢ months here.

٢٤-٥٩ months: Record the number of children living in the house who were born ٢ or more years ago but less than ٥ years ago. Do not record children less than ٢٤ months here.

Fully vaccinated infants and toddlers: At each house record the number of children aged ١٢ – ٢٣ months who are living in the house and are fully vaccinated at the time of the visit. "Fully vaccinated" means the child has received BCG at birth, ٣DPT or ٣DPTHIB vaccines and ١ measles vaccine. Vaccination is confirmed through vaccine card not recall.

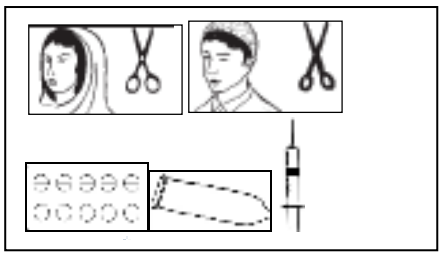


Deaths during the last year: At each house record the number of deaths in each age group during the ١٢ months before your visit to the house. At each visit to a house ask about the ١٢ month period before your visit. Note that <١ death includes neonatal death (on the ٢nd page of this tally-sheet). For example, if there is a neonatal death in a household, tally it twice, in the <١ death and neonatal death.

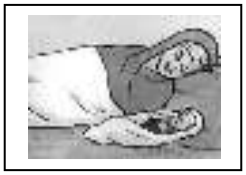


Number Married Women Aged ١٥-٤٩ years: At each house record the number of married women living in the house. Record all women who are married, even if the husband no longer lives in the house.
***Note**: you can record a woman who is married and less than ١٥ years old, because she is eligible for key health services like FP and TT.*

Number of couples using any modern method of contraception: At each household record the number of married women living in the house who are using a modern method of birth spacing at the time of the visit. These include pills, injections, IUDs, sterilization operations for either husband or wife, or condoms used by the husband.

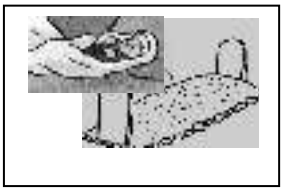


Maternal and Neonatal death: For this part only record deaths of mothers and babies that occurred as mentioned below.



Number of maternal deaths in the last year: At each household record the number of women who were living in the house and who died while pregnant or giving birth or within ٦ weeks (٤٢ days) after giving birth. Record only the women who died during the ١٢ months before your visit to the household anywhere from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

Number of baby deaths less than ٢٨ days old: At each house record the number of babies who died in the household within ٢٨ days of being born. Record only the babies who died anywhere during the ١٢ months before your visit to the household. Note that this is part of <١ death (on the ٣rd page of this tally-sheet). For example, if there is a neonatal death in a household, tally it twice, in the <١ death and neonatal death.



٢,١١,٣. CAAC - Form

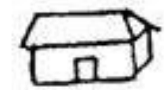
Tally Sheet CAAC
Page ١ of ٣

GOVERNMENT OF THE ISLAMIC REPUBLIC OF AFGHANISTAN
MINISTRY OF PUBLIC HEALTH

Year |_|_|_|_|

District name and ID: ________________
Health Post Name and ID: ___________________

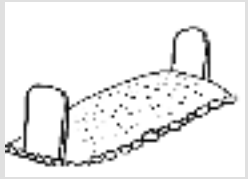
HF Name and ID:_________________
CHW Name and ID: ___________

Number of Household	Household
....	
Number of people in this household	**Population**
....	

.....	

Tally Sheet CAAC **GOVERNMENT OF THE ISLAMIC REPUBLIC OF AFGHANISTAN**
Page ٢ of ٣ **MINISTRY OF PUBLIC HEALTH**

Year |_|_|_|_|	District name and ID: _____	HF Name and ID:_____
	Health Post Name and ID: _____	CHW Name and ID: _____

		**Number Living**	**Age group**
			 <١ year
			 (١ – ٢ years) (١٢-٢٣ months)
			  ٢ – ٥ years (٢٤-٥٩ months)

GOVERNMENT OF THE ISLAMIC REPUBLIC OF AFGHANISTAN
MINISTRY OF PUBLIC HEALTH

Year |_|_|_|_|

District name and ID: _____

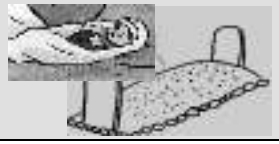
Health Post Name and ID: _____

HF Name and ID:_____

CHW Name and ID: _____

Number of married women Living in this household

Married Women ١٥-٤٩ yrs



Neonatal death

Maternal death

	....	....	Maternal and Neonatal death

٢,١٢. Catchment Area Annual Census Report – HP (CAACR)

٢,١٢,١ CAACR – Guidelines for use

A. Purpose: The purpose of the CAACR is to combine the CAAC information for each health post.

B. Process: The CAACR will be completed by the CHS during the ٤th month of the Shamsi calendar. One CAACR will be used for each health post. The CHS will sum all CAAC pictorial tally sheets pertaining to one health post. After ٣ months the CHS will take the CAAC tally sheet from the CHWs. A new CAAC pictorial tally sheet will be provided to all CHWs at the start of the Shamsi calendar. One copy of CAACR is kept by CHW for his/her use and the second copy is sent to HF for aggregation.

C. Detailed instructions

Ensure that all the identifying information for the CAAC is completed – the year of the pictorial CAAC. Include the district name and code, and the province name and code. Write the health facility name and code as well as the health post name and code. Please see example below:

	١.Year ١٣٨٩
٢. District Code & Name ٢٨٠٦ *Waras*	**٢. Province Code & Name** ٢٨ *Bamyan*
٣. Facility Code ١٧٤١	**٣. Facility Name** Band Kosa
٤. Health Post Code ٣٠٠٥	**٤. Name of Health Post** *Daraz Qul*

For each item on the CAAC pictorial tally sheet, calculate the total and write it in each box. For each item calculate a combined total of all the CAAC pictorial tally sheets pertaining to the health post. Transfer the number to the appropriate item on the CAAC Report.

For example: For each health post count the number of household and population and similarly add together the number of living children less than ١٢ months old from all the CAAC pictorial tally sheets pertaining to that health post. Suppose there are ٢ CHWs for a health post and they provided ٢ different pictorial tally sheets. On the first sheet there are ٣٥ children aged less than ١٢ months and on the second CAAC there are ٢٥ children aged less than ١٢ months. The total number of children less than ١٢ months old for that health post is ٢٥+٣٥=٦٠. Write "٦٠" next to ١١,١. on the CAACR (below). Repeat for the other age groups. Once this is complete, add the numbers for all ٣ age groups to get a total number of children under ٥ years of age. In this example the total is ٦٠+٩٠+١١٠=٢٦٠.

١١. Number of Living Children	
١١,١. Number of children less than ١٢ months old	٦٠
١١,٢. Number of children ١٢-٢٣ months old	٩٠
١١,٣. Number ٢٤-٥٩ months old	١١٠
١١,٤. Number of children less than ٥ years old	٢٦٠

Similarly, write the total number in each age group that are fully vaccinated next to ١٢,١. Write the total number of deaths in each age group next to ١٣,١, ١٣,٢ and ١٣,٣. Similar to what was done in ١١,٤, count a total of the numbers written in ١٣,١, ١٣,٢ and ١٣,٣.and write it in ١٣.٤. This represents the number of deaths in children under ٥ years old.

The next topic is married women. Next to ١٤,١, write the total number of married women from the pictorial CAAC tally sheets. Write the total number of couples who use modern birth spacing methods next to ١٤,٢.

For ١٥,١ record the total number of women who died while giving birth or within ٦ weeks after birth.

In ١٥,٢ record the total number of newborn deaths (babies less than ٢٨ days old).

Write your name, ID code, and designation next to ١٦,١ and ١٦,٢. Write the date the report was written next to ١٦,٣. Give the report to the health facility administrator.

٢,١٢,٢. CAACR - Form

CAAC-R
Health Post Level

GOVERNMENT OF THE ISLAMIC REPUBLIC OF AFGHANINSTAN
MINISTRY OF PUBLIC HEALTH

١.Year	**٢. Months for this CAAC**		
٣. Province Code & Name		**٤. District Code & Name**	
٥. Facility Name		**٦. Facility Code**	
٧. Name of Health Post		**٨. Health Post Code**	
٩. Total Household		**١٠. Total Population**	

١١. Number of Living Children	
	١١,١. Number of children less than ١٢ months old
	١١,٢. Number of children ١٢-٢٣ months old
	١١,٣. Number of children ٢٤-٥٩ months old
	١١,٤. Total Number of children less than ٥ years old
١٢. Number of Children Fully Immunized	
	١٢,١. Number children ١٢-٢٣ months old that are fully vaccinated
١٣. Deaths in Children in last ١٢ months	
	١٣,١. Number of deaths of children less than ١٢ months
	١٣,٢. Number of deaths of children ١٢-٢٣ months old
	١٣,٣. Number of deaths of children ٢٤ – ٥٩ months old
	١٣,٤. Total number of deaths of children less than ٥ years old
١٤. Married Women	
	١٤,١.. Number of married women
	١٤,٢.. Number of couples currently using modern birth spacing method
١٥. Neonatal and Maternal deaths in last ١٢ months	
	١٥,١. Number of maternal deaths (during pregnancy, delivery or within ٤٢ days after delivery
	١٥,٢. Number of newborn deaths (babies less than ٢٨ days old)
١٦. Reported By	
	١٦,١. Name (ID)
	١٦,٢. Designation
	١٦,٣. Date
١٧. Comments	
Any special activities or problems, significant anomalies or trends in morbidity and service delivery	

٢,١٣ Catchment Area Annual Census Report Health Facility (CAAC-AR)

٢,١٣,١. CAAC-AR – Guidelines for use

A. Purpose: CAAC - AR provides CAAC information at the level of the health facility. This provides denominator information for the health facility as well as selected indicators as described previously.

B. Process: Community Health Supervisor (CHS) will collect all CAAC-R and once the census is complete he/she will sum all CAAC-R to produce the aggregated report – CAAC-AR. One copy of this report is then sent to HMIS at the provincial and national levels.

C. Detailed description

The form is very similar to the CAAC-R except that the information is aggregated at the health facility level. The same items are used. No further description is provided here.

٢,١٣,٢ Catchment Area Annual Census Aggregated Report (CAAC-AR)

CAAC- AR
Health Facility Level

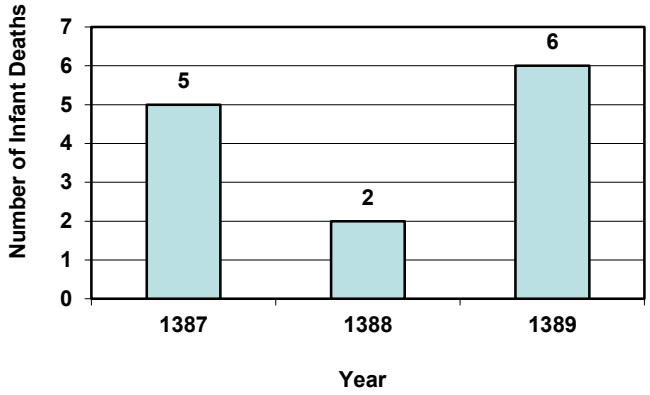
GOVERNMENT OF THE ISLAMIC REPUBLIC OF AFGHANINSTAN
MINISTRY OF PUBLIC HEALTH

١.Year			
٢. Province Code & Name		**٣. District Code & Name**	
٤. Health Facility Name		**٥. Health Facility Code**	
٦. Total Household		**٧. Total Population**	
٨. Number of Living Children			
٨,١. Number of children less than ١٢ months old			
٨,٢. Number of children ١٢-٢٣ months old			
٨,٣. Number of children ٢٤-٥٩ months old			
٨,٤. Total Number of children less than ٥ years old			
٩. Number of Children Fully Immunized			
٩,١. Number children ١٢-٢٣ months old that are fully vaccinated			
١٠. Deaths in Children in last ١٢ months			
١٠,١. Number of deaths of children less than ١٢ months			
١٠,٢. Number of deaths of children ١٢-٢٣ months old			
١٠,٣. Number of deaths of children ٢٤ – ٥٩ months old			
١٠,٤. Total number of deaths of children less than ٥ years old			
١١. Married Women			
١١,١. Number of married women			
١١,٢. Number of couples currently using modern birth spacing method			
١٢. Neonatal and Maternal deaths in last ١٢ months			
١٢,١. Number of maternal deaths (during pregnancy, delivery or within ٤٢ days after delivery			
١٢,٢. Number of newborn deaths (babies less than ٢٨ days old)			
١٣. Reported By			
١٣,١. Name (ID)			
١٣,٢. Designation			
١٣,٣. Date			
١٤. Comments			
Any special activities or problems, significant anomalies or trends in morbidity and service delivery			

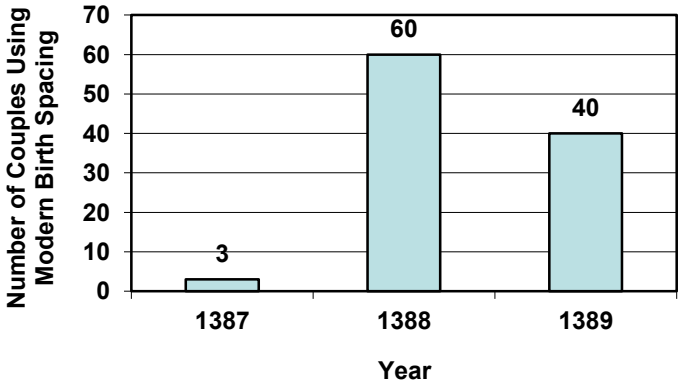
٢,١٣.٤ CAAC Information CHWs and CHSs May Find Useful

After the form is complete you can use the information to compare numbers from ١ year to the next. Comparing the numbers is useful to identify if particular problems need to be looked at more closely. To follow the information you can make a simple chart like the ones below.

Number of infant deaths: This chart shows that there were fewer infant deaths in ١٣٨٨ compared to ١٣٨٧. Infant deaths increased again in ١٣٨٩. What can be done to improve this?



Number of married couples using birth spacing: This chart shows that the number of married couples who use birth spacing increased a lot from ١٣٨٧ to ١٣٨٨ and then it decreased in ١٣٨٩. What can be done to improve this?



For more detail on data use, please refer to the ٢nd volume of this manual which is called data use manual.

Annex ١ – Indicators for the BPHS/EPHS[٧]

Not all indicators can be measured at all levels of the service delivery system, since not all levels are offering a complete range of services. The denominator of several of the indicators needs to be adapted to reflect either out-patient or in-patient care where appropriate. The routine service reporting system can only give proxy-indicators for the population-based indicators. Suggestions on how to calculate proxies are listed in Annex ٢, the reference number (Ref) is the same in Annex ١ and Annex ٢

	Ref	Indicator	Definition	Source	Frequency
Maternal	١	Total First Ante-Natal Care	Number of new antennal care (ANC) visits by health facilities	HMIS	Monthly
	٢	Total first Post-Natal Care	Number of postnatal care (PNC) visits by health facilities	HMIS	Monthly
	٣	Total Institutional Deliveries	Number of assisted and normal deliveries attended and CSs by skilled attendants at health facilities	HMIS	Monthly
	٤	Total home deliveries by clinic staff	Number of assisted and normal deliveries at home by clinic staff	HMIS	Monthly
	٥	Normal deliveries referred by CHW	Number of normal deliveries referred by CHWs	HMIS	Monthly
	٦	Complicated deliveries referred by CHW	Number of complicated deliveries referred by CHWS	HMIS	Monthly
	٧	Maternal deaths at the clinics	Number of maternal deaths at clinics	HMIS	Monthly
	٨	Maternal deaths at the community	Number of maternal deaths reported at the community by health posts	HMIS	Monthly
	٩	Health Facility with comprehensive EmOC services	Number of health facilities with eight EmOC signal functions per ٥٠٠ ٠٠٠ population (perform manual removal of placenta, perform removal of retained products, and perform assisted vaginal delivery plus blood transfusion and surgery)	HMIS	Semiannual
	١٠	Health Facility with basic EmOC services	Number of health facilities with six EOC signal functions per ٥٠٠ ٠٠٠ population (perform manual removal of placenta, perform removal of retained products, and perform assisted vaginal delivery)	HMIS	Semiannual
	١١	Knowledge about danger signs of pregnancy	Proportion of pregnant women who can name danger sign (s) of pregnancy.	HHS	Annually/ Biannually

	Ref	Indicator	Definition	Source	Frequency
Reproductive Health	١٢	Total Couple year of protection (CYP) provided by Health Facilities	Number of couples received family planning services by health facilities and protected for one year	HMIS	Monthly
	١٣	Total Couple year of protection (CYP) provided by Health Posts	Number of couples received family planning services and protected for one year - by health posts	HMIS	Monthly
	١٤	Availability of modern contraceptives	Proportion of service delivery points offering at least ٣ modern contraceptive methods	HMIS	Monthly
	١٥	Knowledge about modern contraceptives	Proportion of women of child bearing age who can identify at least two forms of modern contraceptives	AHS	Annually
Child Morbidity and Mortality	١٦	Neonatal deaths at the clinics	Number of Neonatal deaths reported by clinics	HMIS	Monthly
	١٧	Neonatal deaths at the community	Number of Neonatal deaths reported at community by health posts	HMIS	Monthly
	١٨	Still births at the clinics	Number of stillbirths occurred at the clinics	HMIS	Monthly
	١٩	Proportion of Low-Birth-Weight (LBW)	Proportion of life-births in health facility weighing <٢٥٠٠ gr	HMIS	Monthly
	٢٠	Children <١ year received PENTA٣ vaccine	Number of children less than ١٢ months of age who received Penta٣ vaccines	HMIS	Monthly
	٢١	Children <١ year received Measles vaccine	Number of children less than ١٢ months of age who received Measles vaccines	HMIS	Monthly
	٢٢	Children <٢ yr received PENTA٣	Number of children between age of ١٢ -٢٣ months who are fully vaccinated against Penta٣ vaccines	HMIS	Monthly
	٢٣	Women of CBA received TT٢	Number of CBA women who received TT٢ vaccine	HMIS	Monthly
	٢٤	Acute malnutrition in under ٥ years	No of under ٥ years old children who MUAC is yellow or red	HMIS	Monthly
	٢٥	Moderate acute malnutrition under ٥ years	No of under ٥ years old children who MUAC is yellow	HMIS	Monthly
	٢٦	Severe acute malnutrition under ٥ years	No of under ٥ years old children who MUAC is red	HMIS	Monthly
	٢٧	Exclusive breast-feeding children aged ٠-٦ months	Percentage of children aged ٠–٦ months (٠-١٨١ days) who are exclusively breastfed during the last ٢٤ hours	NRVA	Annually/Biannually
	٢٨	Complementary feeding practices of children ٦-٢٤ months	Percentage of children aged ٦–٢٤ months (١٨٢ –٧٣٠ days) who received breast milk and appropriate complementary foods during the last ٢٤ hours	NRVA	Annually/Biannually
	٢٩	Use of iodized salt	Proportion of households using iodized salt	AHS	Annually/Biannually

	Ref	Indicator	Definition	Source	Frequency
	٣٠	Vitamin A supplementation for children aged ٦-٥٩ months	Proportion of children ٦ to ٥٩ months that have received vitamin A supplement within last ٦ months	NRVA	Annually/Biannually
	٣١	Success rate of malnutrition management	Proportion of under fives hospitalized for malnutrition that were discharged successfully	HMIS	Annually/Biannually
	٣٢	Number of acute diarrhea all types in the under ٥ years by HFs	Number of children under the age of ٥ years who report at least three loose stools in the last ٢٤ hrs.	HMIS	Monthly
	٣٣	Measles Incidence rate (per ١٠٠,٠٠٠ population)	The number of new cases registered from measles in a specific year, expressed per ١٠٠,٠٠٠ population, for a given country, territory, or geographic area.	HMIS	Monthly
	٣٤	Number of pneumonia in the under ٥ years	Number of children under the age of ٥ years who report cough with chest in-drawing and tachpneia.	HMIS	Monthly
	٣٥	Appropriate care seeking for childhood illness	Percent of children with ARI, diarrhea measles, malnutrition or fever(malaria) seeking proper treatment	AHS	Annual
	٣٦	Number of reported measles cases	Number of children presented with measles cases during a given period of time.	HMIS	Monthly
Tuberculosis	٣٧	Case notification rate in new sputum smear positive pulmonary TB cases (from HMIS)	The rate of new smear-positive TB pulmonary cases (AFB+) that are reported in a given period of time.	HMIS	Quarterly
	٣٨	No. of CHCs, DHs, and PHs offering active diagnosis and treatment of TB	Number and percentage of CHC, DH and PH that offered diagnosis and treatment to at least one TB patient during the quarter	HMIS	Quarterly
	٣٩	New TB suspected cases reported	Number of TB suspected cases reported by health facilities	HMIS	Quarterly
	٤٠	New pulmonary TB cases detected	Number of new smear-positive cases (AFB+) detected at the health facilities	HMIS	Monthly
	٤١	Pulmonary TB cases completed treatment and cured (Cure Rate, from HMIS)	Percentage of new patients with sputum (AFB+) that started treatment, cured	HMIS	Monthly
	٤٢	Health Facilities with DOTS services	Proportion of health facilities with DOTS services	HMIS	Semiannually
	٤٣	Number of all TB cases reported	Annual number of all forms of TB cases (new + relapse) reported	TBIS	Quarterly
	٤٤	Notification rate of TB for all types	Annual number of notified TB cases, all forms (new + relapse) ,per ١٠٠,٠٠٠ population	TBIS	Annually

	Ref	Indicator	Definition	Source	Frequency
Malaria	٤٥	Malaria Slide or rapid diagnostic testing positivity rate	Percentage of malaria positive slides among all slides taken.	HMIS	Quarterly
	٤٦	Use of ITNs by children in endemic areas	Percentage of children age ٠–٢٣ months who slept under an insecticide-treated net (in malaria risk areas) the previous night	AHS	
	٤٧	Number of reported Malaria cases confirmed	Number of people presented with Malaria during the given period of time.	HMIS	Monthly
HIV/AIDS	٤٨	Percentage of donated blood units screened for HIV	Percentage of the number of donated blood units screened for HIV in blood centers or blood screening laboratories the total number of blood units donated	Blood Bank	Quarterly?
	٤٩	HIV seroprevalence amongst blood donors	Percentage of the total number of HIV positive blood units amongst the total number of blood units donated.	Blood Bank	Quarterly
	٥٠	Estimated number of PLHIV	Annual estimated number of people living with HIV	HIV/AIDS	Annual?
	٥١	Reported number of people receiving ART	Reported number of people living with HIV receiving antiretroviral therapy	HIV/AIDS	Annual?
Mental Health	٥٢	Number of people accessing health facilities for mental health services	Number of people accessing health facilities for mental health services	HMIS	Monthly
Access	٥٣	Active Male CHWs	Number of male CHWs who completed ١st phase of training and reported that month	HMIS	Semi-annual
	٥٤	Active female CHWs	Number of female CHWs who completed ١st phase of training and reported that month	HMIS	Semi-annual
	٥٥	Percentage of BPHS and EPHS facilities with at least one Female Health Worker	Percentage of BPHS and EPSH facilities has at least a female doctor or midwife or female nurse.	HMIS	Semiannual
	٥٦	Total # of active Health Facilities Registered	Number of active health facilities registered with MoPH HMIS department	HMIS	Monthly

	Ref	Indicator	Definition	Source	Frequency
	٥٧	Number of active Provincial Hospitals	Number of provincial hospitals submitting HMIR	HMIS	Monthly
	٥٨	Number of active District Hospitals	Number of district hospitals submitting HMIR	HMIS	Monthly
	٥٩	Number of active CHC	Number of CHCs that submits MIAR	HMIS	Monthly
	٦٠	Number of active BHC	Number of BHCs that submits MIAR	HMIS	Monthly
	٦١	Number of active Sub-HC	Number of Sub-HCs that submits MIAR	HMIS	Monthly
	٦٢	Number of active Mobile Health Team (MHT)	Number of MHTs that submits MIAR	HMIS	Monthly
	٦٣	Number of active Health Posts (HPs)	Number of health posts reported in MAAR	HMIS	Monthly
	٦٤	Proportion of health facilities with an active community health shuras	Proportion of health facilities that have community health shura that meet on a monthly basis	HMIS	Monthly
	٦٥	Total patients/clients visit	Total # of patients/clients seen by BPHS and EPHS HFs	HMIS	Monthly
	٦٦	Family visits by HPs	Total # of families visited by CHW	HMIS	Monthly
	٦٧	Under ٥ Patient visits by health post	Total # of under ٥ patients visit by health post	HMIS	Monthly
	٦٨	Under ٥ Patient visits by health facility	Total # of under ٥ patients visit by health BPHS and EPHS facilities	HMIS	Monthly
	٦٩	Under ٥ female Patient visits by health facility	Total # of under ٥ female patients visit by health facility	HMIS	Monthly
	٧٠	Over ٥ Female Patients visits by health facility	Total # of over ٥ female patients visit by health facility	HMIS	Monthly
	٧١	Number of Afghans who have access to basic health services covered by contracts (Contractual Coverage)	Number of people living in the areas covered by grant agreements	HMIS	annual
	٧٢	Blood transfusion Capacity	Proportion of facilities that are able to perform blood transfusion	HMIS	Semiannual
	٧٣	Functioning blood bank	Proportion of facilities that have a functioning blood bank	HMIS	
	٧٤	Functioning laboratory	Proportion of facilities that have a functioning laboratory	HMIS	Semiannual

	Ref	Indicator	Definition	Source	Frequency
	٧٥	Population with access to local health services	Proportion of a given population that can be expected to use a specified facility, service, etc., taking into account barriers to access, usually measured within a ٢ hour by walking to a health facility. Definition determined by special MoPH committee.	HHS	Annual/ Biannual
	٧٦	Number of service delivery points providing FP counseling and/or FP products	Number of service delivery points providing FP counseling and/or FP products	HMIS	Monthly
	٧٧	Access to any public health facility within one hour walking	Number of people living within one hour walking to BPHS and EPHS HFs	NRVA	
Performance Monitoring	٧٨	% of Provincial Hospitals submitting report	Percentage of provincial hospital registered with MoPH submitting HMIR	HMIS	Monthly
	٧٩	% of District Hospitals submitting report	Percentage of district hospital registered with MoPH submitting HMIR	HMIS	Monthly
	٨٠	% of CHC submitting report	Percentage of CHCs registered with MoPH submitting MIAR	HMIS	Monthly
	٨١	% BHC submitting report	Percentage of BHCs registered with MoPH submitting MIAR	HMIS	Monthly
	٨٢	% of Sub-HC submitting report	Percentage of Sub-HCs registered with MoPH submitting MIAR	HMIS	Monthly
	٨٣	% of Mobile Health Team (MHT) submitting report	Percentage of Mobile Health Team registered with MoPH submitting MIAR	HMIS	Monthly
	٨٤	% of BPHS Report Submission Rate	Percentage of BPHS facilities registered with MoPH submitting MIAR	HMIS	Monthly
	٨٥	% of EPHS Report Submission Rate	Percentage of EPHS facilities registered with MoPH submitting HMIR	HMIS	Monthly
Efficiency	٨٦	Average # of people received health care services daily through clinics and direct outreach workers	# of clients visit at BPHS and EPHS facilities (OPD patients visit and IPD admission)	HMIS	Monthly
	٨٧	No. of Active Beds available	Number of available beds reported	HMIS	Simi annual
	٨٨	Hospital beds per ١٠,٠٠٠ population	The number of hospital beds available per every ١,٠٠٠ inhabitants in a population, at a given year, for a given country, territory, or geographic area.	HMIS	Semi annual

	Ref	Indicator	Definition	Source	Frequency
	٨٩	No. of Admissions by hospitals	Number of patients admitted as inpatients	HMIS	Monthly
	٩٠	No. of Referrals served by EPHS and BPHS	Number of patients referred-in in to this facility by lower level HFs for needed health services	HMIS	Monthly
	٩١	Number of hospital deaths	Number of inpatients died at the hospital after being admitted as in-patient.	HMIS	Monthly
	٩٢	Number of Patients Days	Number of patients days at hospitals within a given time.	HMIS	Monthly
	٩٣	Total Patients Discharged	Number of patients discharged from hospital within a given time.	HMIS	Monthly
	٩٤	Total Surgical Interventions	Number of surgical interventions reported at the hospitals in a given time	HMIS	Monthly
	٩٥	Average length of stay	Average number of days that patients remain hospitalized. Calculated monthly.	HMIS	Monthly
	٩٦	Bed occupancy rate	The proportion of available beds that were occupied during a given time	HMIS	Monthly
	٩٧	Post operative complication rate	Proportion of surgical interventions that develops complications including infection, bleeding etc within ١٠ days of the intervention	HMIS	Monthly
	٩٨	No. of Cesarean Sections	Number of c-section reported at hospitals in a given time.	HMIS	Monthly
Quality	٩٩	Blood transfusion reaction rate	Proportion of transfusions that have an incompatibility reaction	HMIS	Monthly
	١٠٠	Percentage of BPHS health facilities with at least one essential drug stock out	Proportion of BPHS health facilities with at least on essential stock out	HMIS	Monthly
	١٠١	Average time of stock out of essential medicines.	average number of days during a period of time in which one or more essential drug (s) was not available in the stock to serve an adult patient	IMAT	Quarterly
Human Resourc	١٠٢	Number of female participants by training session within a given period of time	Number of female participants received training on a subject.	Training DB	annual

	Ref	Indicator	Definition	Source	Frequency
	١٠٣	Number of male participants by training session within a given period of time	Number of male participants received training on a subject.	Training DB	annual
	١٠٤	Physicians per ١٠,٠٠٠ population	The number of physicians available per every ١٠,٠٠٠ inhabitants in a population, at a given year, for a given country, territory, or geographic area.	HMIS	annual
	١٠٥	Nurse per ١٠,٠٠٠ population	The number of nurses available per every ١٠,٠٠٠ inhabitants in a population, at a given year, for a given country, territory, or geographic area.	HMIS	annual
	١٠٦	Midwife per ١٠,٠٠٠ population	The number of midwives available per every ١٠,٠٠٠ inhabitants in a population, at a given year, for a given country, territory, or geographic area.	HMIS	annual
	١٠٧	Availability of recommended staffing according to BPHS and EPHS	Proportion of facilities with recommended staffing	HMIS	Semi annual
Demographic	١٠٨	Number of primary health care and health centers per ١٠ ٠٠٠ population.	Number of BPHS and EPHS health facilities per ١٠,٠٠٠ populations.	HMIS	Annually
	١٠٩	Crude Birth Rate per ١٠٠٠ population	The ratio between the number of live births in a population during a given year and the total mid-year population for the same year, usually multiplied by ١,٠٠٠.	CSO	Annual/ Biannual
	١١٠	Crude Death Rate per ١٠٠٠ population	The ratio between the number of deaths in a population during a given year and the total mid-year population for the same year, usually multiplied by ١,٠٠٠.	CSO	Annual/ Biannual

	Ref	Indicator	Definition	Source	Frequency
	١١١	Population growth rate	The annual average rate of change of population size, for a given country, territory, or geographic area, during a specified period. It expresses the ratio between the annual increase in the population size and the total population for that year, usually multiplied by ١٠٠. The annual increase in the population size is defined as a sum of differences: the difference between births less deaths and the difference between immigrants less emigrants, in a given country, territory or geographic area at a given year.	CSO	Annual/ Biannual
	١١٢	Population male < ١٥ years %	The percentage of total population of a country, territory, or geographic area, under ١٥ years of age, total or a given sex and at a specific point of time, usually mid-year.	CSO	Annual/ Biannual
	١١٣	Population female < ١٥ years %	The percentage of total population of a country, territory, or geographic area, under ١٥ years of age, total or a given sex and at a specific point of time, usually mid-year.	CSO	Annual/ Biannual
	١١٤	Population male ٦٥ + years %	The percentage of total population of a country, territory, or geographic area, ٦٠ (٦٥+) years of age and over, total or for a given sex and at a specific point of time, usually mid-year.	CSO	Annual/ Biannual
	١١٥	Population female ٦٥ + years %	The percentage of total population of a country, territory, or geographic area, ٦٠ (٦٥+) years of age and over, total or for a given sex and at a specific point of time, usually mid-year.	CSO	Annual/ Biannual
	١١٦	Total fertility rate per women	The number of births a woman would have by the end of her reproductive life if she experienced the currently prevailing age-specific fertility rates from age ١٥ to ٤٩ years.	NRVA	Annual/ Biannual
Socioeconomic	١١٧	% of Net primary school enrollment ratio Male	he number of children of official primary school age (according to ISCED٩٧١) who are enrolled in primary education as a percentage of the total children of the official school age population. also includes children of primary school age enrolled in secondary education. or Enrolment of the official age-group for a given level of education (primary) expressed as a percentage of the corresponding population.	NRVA	Annual/ Biannual
	١١٨	% of Net primary school enrollment ratio Female		NRVA	Annual/ Biannual

	Ref	Indicator	Definition	Source	Frequency
	١١٩	% of Net secondary school enrollment ratio Male	The number of children of official secondary school age (according to ISCED٩٧١) who are enrolled in secondary education as a percentage of the total children of the official school age population. Or Enrolment of the official age-group for a given level of education (secondary) expressed as a percentage of the corresponding population.	NRVA	Annual/ Biannual
	١٢٠	% of Net secondary school enrollment ratio Female		NRVA	Annual/ Biannual
	١٢١	% of Population with sustainable access to improved water source	Population with improved drinking water sources, in a given year, expressed as a percentage of the corresponding population of that year, in a given country, territory, or geographic area. Access to safe drinking water sources is defined by the availability of at least ٢٠ litres of water per person per day from a source within ١ kilometer of walking distance. Improved drinking water sources are: household connection, public standpipe, borehole, protected dug well, protected spring, rainwater collection. Unimproved drinking water sources are: unprotected well, unprotected spring, rivers or ponds, vendor-provided water, bottled water, tanker truck water. Bottled water is not considered improved due to limitations in the potential quantity, not quality, of the water. Urban and rural area according to countries' own working definition.	NRVA	Annual/ Biannual

	Ref	Indicator	Definition	Source	Frequency
	١٢٢	% of Population with access to improved sanitation	Population with access to improved sanitation in a given year, expressed as a percentage of the corresponding population of that year, in a given country, territory, or geographic area. Excreta disposal systems are considered adequate if they are private and if they separate human excreta from human contact. Improved sanitation facilities are: connection to a public sewer, connection to a septic system, pour-flush latrine, simple pit latrine, ventilated improved pit latrine. Unimproved sanitation facilities are: public or shared latrine, open pit latrine, bucket latrine. Urban and rural area according to countries' own working definition.	NRVA	Annual/ Biannual
Health Expenditure	١٢٣	Gross domestic product per capita (US$ exchange rate)	Average annual gross domestic product (GDP) per capita at constant market prices for each year of the time period expressed in current US$ (see exchange rate).	NHA	Annual/ Biannual
	١٢٤	Total expenditure on health per capita (average US$ exchange rate)	Sum of general government health expenditure (GGHE) and private health expenditure (PvtHE) expressed as per capita, US$ exchange rate.	NHA	Annual/ Biannual
	١٢٥	General government expenditure on health per capita (average US$ exchange rate)	General government health expenditure (GGHE) expressed as per capita, US$ exchange rate	NHA	Annual/ Biannual
	١٢٦	Total expenditure on health as percentage of Gross domestic product	Sum of general government health expenditure (GGHE) and private health expenditure (PvtHE) expressed as percentage of GDP.	NHA	Annual/ Biannual
	١٢٧	General government expenditure on health as % of total health expenditure	General government health expenditure (GGHE) expressed as percentage of the total health expenditure (THE)	NHA	Annual/ Biannual
	١٢٨	Out-of-pocket expenditure as % of total health expenditure	Out-of-pocket expenditure, expressed as percentage of the total health expenditure (THE)	NHA	Annual/ Biannual

	Ref	Indicator	Definition	Source	Frequency
	١٢٩	General government expenditure on health as % of total government expenditure	General government health expenditure (GGHE) expressed as percentage of the total general government expenditure (GGE) that is spent on health.	NHA	Annual/ Biannual
	١٣٠	Ministry of health budget as % of government budget	Ministry of health budget expressed as percentage of government budget	NHA	Annual/ Biannual
Health Status	١٣١	Total Life expectancy at birth	The average number of years that a newborn could expect to live, if he or she were to pass through life exposed to the sex- and age-specific death rates prevailing at the time of his or her birth, for a specific year, in a given country, territory, or geographic area.	PRB	Annual/ Biannual
	١٣٢	Male Life expectancy at birth		PRB	Annual/ Biannual
	١٣٣	Female Life expectancy at birth		PRB	Annual/ Biannual
	١٣٤	Newborns with low birth weight %	Percentage of live born infants that weigh less than ٢٥٠٠ g, for a given time period.	NRVA	Annual/ Biannual
	١٣٥	Prenatal mortality rate per ١٠٠٠ live births	Number of deaths of fetuses weighing at least ٥٠٠ g (or when birth weight is unavailable, after ٢٢ completed weeks of gestation or with a crown-heel length of ٢٥ cm or more) plus the number of early neonatal deaths occurring during the first seven days of life, per ١٠٠٠ total births	NRVA	Annual/ Biannual
	١٣٦	Neonatal mortality rate per ١٠٠٠ live births	Number of deaths during the first ٢٨ completed days of life per ١٠٠٠ live births in a given year or other period.	NRVA	Annual/ Biannual
	١٣٧	Infant mortality rate per ١٠٠٠ live births	Infant mortality rate is the probability of a child born in a specific year or period dying before reaching the age of one, if subject to age-specific mortality rates of that period.	NRVA	Annual/ Biannual
	١٣٨	Under-٥ mortality rate per ١٠٠٠ live births	Under-five mortality rate is the probability of a child born in a specific year or period dying before reaching the age of five, if subject to age-specific mortality rates of that period.	NRVA	Annual/ Biannual
	١٣٩	Maternal mortality ratio per ١٠٠٠٠٠ live births	Number of maternal deaths per ١٠٠ ٠٠٠ live births during a specified time period, usually ١ year.	RAMOS	Annual/ Biannual

Annex ٢ – BPHS/EPHS Indicator Calculations Using the Routine HMIS

This annex lists examples of BPHS/EPHS indicators that can be calculated from the routine service reports of the HMIS, indicating which entries on what report forms can be used for the calculation. For several indicators proxy indicators are also indicated. Proxy indicators are indicators that come close to the listed indicator, but use a different numerator or denominator or both. Proxies can be helpful for indicators that either need population based surveys, or that change only slowly over time. A proxy-indicator does not replace the indicator, it provides some indication whether or not things are moving in the right direction.

No.	Definition	Source of data	Calculation
١	Number of new antennal care (ANC) visits by health facilities	MIAR: Section C. Maternal and Neonatal care, C٢. Pre and post natal, ١. Antenatal visit - First	Sum number of C٢,١. Antenatal Visit - First
٢	Number of postnatal care (PNC) visits by health facilities	MIAR: Section C. Maternal and Neonatal care, C٢. Pre and post natal, ٣. Postnatal visit - First	Sum number of C٢,٣. Postnatal Visit - First
٣	Number of assisted and normal deliveries attended and CSs by skilled attendants at health facilities	MIAR: Section C. Maternal and Neonatal care, C٣. Obstetric Care, ١. Normal Delivery, ١,١. Facility and ٢. Assisted Delivery, ٢,١. Facility. HMIR: G.Maternal & Neonatal, G٢. Obstetrics, G٢,١.Normal Delivery, G٢,٢.Assisted Delivery.	Sum total number of Normal deliveries and assisted deliveries at the health facility: **MIAR:** ١. Normal Delivery, ١,١. Facility and ٢. Assisted Delivery, ٢,١. Facility, plus **HMIR:** G٢,١.Normal Delivery, and G٢,٢.Assisted Delivery.
٤	Number of assisted and normal deliveries at home by clinic staff	MIAR: Section C. Maternal and Neonatal care, C٣. Obstetric Care, ١. Normal Delivery, ١,٢. Home and ٢. Assisted Delivery, ٢,٢. Home.	Sum total number of Normal deliveries and assisted deliveries at home: ١. Normal Delivery, ١,٢. Home and ٢. Assisted Delivery, ٢,٢. Home.
٥	Number of normal deliveries referred by CHWs	MAAR: Section B. Maternal Health, ١. # of Normal deliveries referred by CHW	Sum total of B١.# of normal deliveries referred by CHW
٦	Number of complicated deliveries referred by CHWS	MAAR: Section B. Maternal Health, ٢. # of Obstetric complications referred	Sum total of B٢. # of Obstetric complications referred
٧	Number of maternal deaths at clinics	MIAR: Section C. Maternal and Neonatal care, C٣. Obstetric Care, C٣,٥. Maternal death due to major, C٣,٦. Maternal death due to other. HMIR: G٢. Obstetrics, G٢,٣. Major complication, Death, G٢,٤. Other complication, Death	Sum total number of maternal deaths (MIAR: C٣. ٦ + C٣,٥+HMIR: G٢,٣+G٢,٤)

No.	Definition	Source of data	Calculation
٨	Number of maternal deaths reported at the community by health posts	MAAR: Section B. Maternal Health, ٣.Nubmer of Maternal deaths or CAAC: ١٢. Neonatal and pregnancy related death in the last ١٢ months, ١٢,١. Number of maternal deaths during birth of newborn or within ٦ weeks of delivery.	Sum total number of maternal deaths (MAAR: Section B.٣. Number of Maternal Death) or Sum total number of maternal deaths from CAAC, ١٢,١.
٩	Number of health facilities with eight EmOC signal functions per ٥٠٠ ٠٠٠ population (perform manual removal of placenta, perform removal of retained products, and perform assisted vaginal delivery plus blood transfusion and surgery)	HSR: E. Services provided, E٤. Maternal Health, E٤,٤. Comprehensive EmOC.	Sum total number of HSR reported E٤,٤. Comprehensive EmOC.
١٠	Number of health facilities with six EOC signal functions per ٥٠٠ ٠٠٠ population (perform manual removal of placenta, perform removal of retained products, and perform assisted vaginal delivery)	FSR: D. Services provided, D٣.maternal health, D٣,٣. Delivery by trained staff, D٣,٤. Manual removal of placenta, D٣,٥. Removal of retained products, D٣,٦. Assisted Vaginal Delivery.	Check if all the bellow services are available: FSR: D. Services provided, D٣.maternal health, D٣,٣. Delivery by trained staff, D٣,٤. Manual removal of placenta, D٣,٥. Removal of retained products, D٣,٦. Assisted Vaginal Delivery.
١٢	Number of couples received family planning services by health facilities and protected for one year	MIAR: Section C.Maternal and Neonatal Care, C١. Family Planning, ## of Units PLUS HMIR: Section G. Maternal & Neonatal, G.١. Family Planning, ١. Permanent	From MIAR, C١: multiply the ## for each method with the corresponding conversion factor ١. Sterilization = Case * ١٢,٥ ٢. IUD =##* ٣,٥ ٣. Depo-Provera (Injection) = ##/٤ ٤. Oral Contraceptives (pills) =##/١٥ ٥. Condoms =##*١٢/١٥٠ PLUS HMIR: G١,١. Permanent

No.	Definition	Source of data	Calculation
١٣	Number of couples received family planning services and protected for one year - by health posts	MAAR: Section A. Family Planning, A١. Units distributed(١-٣)	From MAAR, A١: Units distributed ١. Oral Contraceptives (pills)= number/١٥ ٢. Condoms = ## *١٢/١٥٠ ٣. Injections =## /٤
١٤	Proportion of service delivery points offering at least ٣ modern contraceptive methods	MIAR: D. Stock status Essential Drugs, Oral contraceptive, Inject able contraceptive, Condom, IUD. MAAR: F. Status of Stock of Essential Drugs, F.٣. Oral contraceptive.	Count if all all/one of the methods are available in the health facility/HP separately
١٦	Number of Neonatal deaths reported by clinics	MIAR: Section C. Maternal and Neonatal care, C٤. Neonatal Care, ٤. Neonatal death HMIR: G. Maternal & Neonatal, G٣. Neonatal Care, ٤. Neonatal death.	Sum total number of neonatal deaths (MIAR, Section C, C٤,٤.neonatal death Plus HMIR, G٣,٤. Neonatal death)
١٧	Number of Neonatal deaths reported at community by health posts	MAAR: Section B. Maternal Health, ٤. Number of neonatal deaths Or CAAC: ١٢. Neonatal and pregnancy related death in the last ١٢ months, ١٢,٢. Number of newborn deaths.	Sum total number of neonatal death (MAAR: Section B.٤. Number of neonatal deaths) OR CAAC: sum ١٢,٢. Number of newborn deaths
١٨	Number of stillbirths occurred at the clinics	MIAR: Section C. Maternal and Neonatal care, C٤. Neonatal Care, ٥. Stillbirth plus HMIR: G. Maternal & Neonatal, G٣. Neonatal Care, ٥.Stillbirth	Sum total number of stillbirth (MIAR, Section C, C٤,٥.stillbirth plus HMIR, G٣,٥.Stillbirth)
١٩	Proportion of lifebirths in health facility weighing <٢٥٠٠ gr	MIAR: Section C. Maternal and Neonatal care, C٤. Neonatal Care, ٢. Low Birth Weight plus HMIR: G. Maternal & Neonatal, G٣. Neonatal Care, ٢. Low Birth Weight MIAR: Section C. Maternal and Neonatal care, C٤. Neonatal Care, ١. Newborn Alive HMIR: G. Maternal & Neonatal, G٣. Neonatal Care, ١. Newborn Alive	Sum total number of Low Birth Weight (MIAR, Section C, C٤,٢.Low Birth Weight plus HMIR, G٣,٢.Low Birth Weight) dived by: Sum of MIAR: Section C. Maternal and Neonatal care, C٤. Neonatal Care, ١. Newborn Alive HMIR: G. Maternal & Neonatal, G٣. Neonatal Care, ١. Newborn Alive

No.	Definition	Source of data	Calculation
٢٠	Number of children less than ١٢ months of age who received Penta٣ vaccines	MIAR, Section E. Immunizations, E١. Childhood,١. PENTA (٠-١١ months)	Sum total number of ٠-١١ months from MIAR, Section E١,١. PENTA
٢١	Number of children less than ١٢ months of age who received Measles vaccines	MIAR, Section E. Immunizations, E١. Childhood, ٢. Measles,(٠-١١ months)	Sum total number of ٠-١١ months from MIAR, Section E١,٢. Measles
٢٢	Number of children between age of ١٢ -٢٣ months who are fully vaccinated against Penta٣ vaccines	MIAR, Section E. Immunizations, E١. Childhood, ١. PENTA,(١٢-٢٣ months) CAAC: ٩. Number of children fully immunized, ٩,١. Number of children ١٢-٢٣ moths old that are fully vaccinated.	Sum total number of ١٢-٢٣ months from MIAR, Section E١,١. PENTA
٢٣	Number of CBA women who received TT٢ vaccine	MIAR, Section E. Immunization, E٢. TT Immunization, ١. Pregnant women + ٢. Non-Pregnant women	Sum total number of TT٢ vaccines from (MIAR, Section E٢,١+٢
٢٤	No of under ٥ years old children who MUAC is yellow or red	MIAR, Section B. Nutrition status, B٢. Moderate Acute Malnutrition and B٣. Severe Acute Malnutrition, plus HMIR: B. Nutrition of under five, ١. Admitted	Sum Total New from MIAR, B١. Moderate Acute Malnutrition + B٢. Severe Acute Malnutrition + HMIR, B.١. Admitted
٢٥	No of under ٥ years old children who MUAC is yellow	MIAR, Section B. Nutrition status, B٢. Moderate Acute Malnutrition	Sum Total New from MIAR, B١. Moderate Acute Malnutrition
٢٦	No of under ٥ years old children who MUAC is red	MIAR, Section B. Nutrition status, B٣. Severe Acute Malnutrition HMIR: B. Nutrition of under five, ١. Admitted	Sum Total New from MIAR, B٢. Severe Acute Malnutrition + HMIR, B.١. Admitted
٣١	Proportion of under fives hospitalized for malnutrition that were discharged successfully	HMIR, Section B. Nutrition of under fives,٢. Improved	Sum total number of HMIR Section B. Nutrition of under fives,٢. Improved divided by total B.١.Admitted (B.٢./B.١.)

No.	Definition	Source of data	Calculation
٣٢	Number of children under the age of ٥ years who report at least three loose stools in the last ٢٤ hrs.	MIAR, SectionA١. OPD Morbidity, Diarrhea, ٤. Acute watery diarrhea, ٥.Acute bloody, ٦.W. Dehydration + HMIR: F. Cases and Death of priority diseases <٥, Diarrhea, Admitted.	Sum total number of diarrhea in MIAR, SectionA١. OPD Morbidity, Diarrhea, ٤ ,٥ , ٦ + HMIR, F.١. Diarrhea, Admit.
٣٣	The number of new cases registered from measles in a specific year, expressed per ١٠٠,٠٠٠ population, for a given country, territory, or geographic area.	MIAR, Section A١. OPD Morbidity, ٩.Measle PLUS HMIR: F. Cases and Death of priority diseases <٥, ٣. Measles	Sum number of total measles in MIAR, Section A١. OPD Morbidity, ٩.Measle + HMIR, F.٣.Measles, divided by concerned area population multiplied by ١٠٠٠٠٠
٣٤	Number of children under the age of ٥ years who report cough with chest indrawing and tachpneia.	MIAR, Section A١. OPD Morbidity, ٣. Pneumonia PLUS HMIR: F. Cases and Death of priority diseases <٥, ٢. Pneumonia	Sum < ٥ Male, < ٥ Female, and < ٥ from MIAR, A١,٣ Pneumonia + HMIR, F.٢. Pneumonia
٣٦	Number of children presented with measles cases during a given period of time.	MIAR, Section A١. OPD Morbidity, ٩.Measle PLUS HMIR: F. Cases and Death of priority diseases <٥, ٣. Measles	Sum number of total measles in MIAR, Section A١. OPD Morbidity, ٩.Measle + HMIR, F.٣.Measles
٣٧	The rate of new smear-positive TB pulmonary cases (AFB+) that are reported in a given period of time.	Taken from MIAR, G١. Tuberculosis G١,١. Number of new smear (+) cases	Take from MIAR, section G١.Case Detection,(١. Number of New Smear (+) Cases divide by Total population (CSO) * ١٠٠٠٠٠) Ex: (٥٠ SS+/٨٥٠٠٠ pop*١٠٠٠٠٠=٥٨,٨) which equals to ٥٨,٨ cases /١٠٠٠٠٠ population
٣٨	Number and percentage of CHC, DH and PH that offered diagnosis and treatment to at least one TB patient during the quarter	MIAR: Section F٢. Sputum, F٢,١ and G. Tuberculosis, G١.Case detection, ٢. Number that started treatment	Count number of CHCs, DHs, PHs had AFB exams and or treated at least one AFB positive, divide by total number of CHCs, DHs, and PHs submitted MIAR
٣٩	Number of TB suspected cases reported by health facilities	MIAR: Section A١. OPD Morbidity, ١٩. TB suspected cases	Sum Total New number of TB Suspected cases from MIAR, Section A١,١٩. TB suspected cases

No.	Definition	Source of data	Calculation
٤٠	Number of new smear-positive cases (AFB+) detected at the health facilities	MIAR: G.Tuberculosis, Section G١.Case Detection,١. Number of New Smear (+) Cases	Sum total from MIAR, G١,١ Number of New Smear (+) Cases
٤١	Percentage of new patients with sputum (AFB+) that started treatment, cured	MIAR: Section G١.Case Detection,١. Number of New Smear (+) Cases and MIAR: Section G٢.Treatment complete and cured, ٣.Number of Cases Completed and Smear (-)	MIAR, sum G٢,١ Number of Cases Completed and Smear (-) divide it by total G١,٢ Number that started treatment reported ٣ quarter back (e.g. If you are in Quarter ٤th, go back to Quarter ١st of that year) e.g. if it has been reported in month ١st Hamal, you will see the impact in month ١٠th Jaddi.
٤٢	Proportion of health facilities with DOTS services	FSR: Section D٤. Infectious Diseases, ٣. DOTS HSR: E.Services Provided, E٤. Infectious diseases, ٣.DOTS	Total sum of health facilities offered DOTS in FSR: Section D٤. Infectious Diseases, ٣. DOTS PLUS HSR E٤. Infectious diseases, ٣.DOTS divided by total number of HFs reported FSR
٤٣	Annual number of all forms of TB cases (new + relapse) reported	**Quarterly report on TB case registration: Block** ١: All TB cases registered**, Row:** sum of Male and Female, **Column**: TOTAL All cases.	**Quarterly report on TB case registration: Block** ١: All TB cases registered**, Row:** sum of Male and Female, **Column**: TOTAL All cases.
٤٤	Annual number of notified TB cases, all forms (new + relapse) ,per ١٠٠,٠٠٠ population	١**) Quarterly report on TB case registration: Block** ١: All TB cases registered**, Row:** sum of Male and Female, **Column**: TOTAL All cases. ٢**)** Total population of a given geographic area.	**Quarterly report on TB case registration: Block** ١: All TB cases registered**, Row:** sum of Male and Female, **Column**: TOTAL All cases. **Multiply by ١٠٠,٠٠٠/Total population of a given area**
٤٥	Percentage of malaria positive slides among all slides taken.	MIAR, F. Laboratory Exams, F١. Blood, ١. Total malaria slides examined and ٢. Total PF positive and ٣. Total other positive	Total Male from MIAR F١,٢. + F١,٣ divided by total Male from MIAR F١,١ Total Female from MIAR F١,٢. + F١,٣ divided by total Female from MIAR F١,١
٤٧	Number of people presented with Malaria during the given period of time.	MIAR: F. Laboratory Exams, F١. Blood, ٢. Total PF positive and ٣. Total other positive PLUS HMIR: H. New Inpatient Cases, ٢٦. Malaria	Sum MIAR, F١,٢.PF Positive + F١,٣. Total other positive + HMIR, H. ٢٦. Malaria

No.	Definition	Source of data	Calculation
٥٢	Number of people accessing health facilities for mental health services	MIAR, A١. OPD Morbidity, ١٧. Mental Disorders PLUS HMIR: H. New Inpatient Cases, ٣٢. Common Mental Problems + ٣٣.Substances abuse + ٣٤. Severe Mental Problems	Total number of by age and sex from MIAR A١,١٧ Mental disorders + HMIR, H.٣٢ + H.٣٣ + H.٣٤
٥٣	Number of male CHWs who completed ١st phase of training and reported that month	FSR: Section B. Human Resources, B٢. Community Health, ١. Trained CHWs active, Male and HSR: B. Human Resources, B٦.Community Health, ٤٩.Trained CHWs and active-Male Also from CHW database	Sum total number of active male CHWs reported in FSR: Section B٢,٢.Trained CHWS Active + HSR: Section B٦. ٤٩. Trained CHWs active, Male
٥٤	Number of female CHWs who completed ١st phase of training and reported that month	FSR: Section B. Human Resources, B٢. Community Health, ١. Trained CHWs active, Female and HSR: B. Human Resources, B٦.Community Health, ٤٩.Trained CHWs and active-Female Also from CHW database	Sum total number of active female CHWs reported in FSR: Section B٢,٢.Trained CHWS Active + HSR: Section B٦. ٤٩. Trained CHWs active, Female
٥٥	Percentage of BPHS and EPSH facilities has at least a female doctor or midwife or female nurse.	FSR: B. Human Resources, B١. Facility staff Status, ١. Nurse -female, ٣. Midwife, ٤. Community Midwife, ٥. MD General - female, ٦. MD specialist - Female and HSR: B. Human Resources, B١. Management, ٢. Medical Director - Female, ٣. Nursing Director - female, B٢,٥. Surgeon -female, ٦.Ophthalmologist - female, ٧. ENT -female, ٩. ObGyn-female ١٠. Pediatrician-female, ١٢. Other Medical Specialist - female, ١٣. General MD - female or B٣,١٥. Midwifes, Female nurses in ١٦, ١٧,١٨,١٩,٢١.	FSR: B. Check in Human Resources, B١. Facility staff Status, either B١,١ or B١,٣ or B١,٤ or B١,٥ or B١,٦ HSR: B. Human Resources, either B١,١, B١,٣ or B٢,٥,٦,٧,٩,١٠,١٢,١٣, or B٣,١٥, ١٦,١٧,١٨,١٩,٢١ equals to female.

No.	Definition	Source of data	Calculation
٥٦	Number of active health facilities registered with MoPH HMIS department	Facility history/common database	Count number of active health facilities for the same month of deferent types of health facilities
٥٧	Number of provincial hospitals submitting HMIR	HMIR	Count number of provincial hospitals submitted HMIR form in the given month
٥٨	Number of district hospitals submitting HMIR	HMIR	Count number of district hospitals submitted HMIR form in the given month
٥٩	Number of CHCs that submits MIAR	MIAR	Count Number of CHCs submitted MIAR in the given month
٦٠	Number of BHCs that submits MIAR	MIAR	Count Number of BHCs submitted MIAR in the given month
٦١	Number of Sub-HCs that submits MIAR	MIAR	Count Number of Sub-HCs submitted MIAR in the given month
٦٢	Number of MHTs that submits MIAR	MIAR	Count Number of MHTs submitted MIAR in the given month
٦٣	Number of health posts reported in MAAR	MAAR heading: Number of Health Post Submitted MAAR OR CHW Database	Sum total number of HPs reported in MAAR in the given month from "Number of Health Post Submitted MAAR" OR CHW Database
٦٤	Proportion of health facilities that have community health shura that meet on a monthly basis	MIAR: Section H. Community Health, ١. Number of meetings with community health committee	Count number of health facilities with have at least one meeting per month at MIAR: Section H. Community Health, ١. Number of meetings with community health committee divided by total number of health facilities submitted MIAR
٦٥	Total # of patients/clients seen by BPHS and EPHS HFs	MIAR: Patients/Clients HMIR: A.Indoor patients, ١. Admission	Sum total new, < ٥ and > ٥, male and female and revisits from MIAR Patients/Clients PLUS HMIR, A.١.
٦٦	Total # of families visited by CHW	MAAR heading: Total Number of Family Visited	Sum total from MAAR Total Number of Family Visited

No.	Definition	Source of data	Calculation
٦٧	Total # of under ٥ patients visit by health post	MAAR: E١. <٥ Morbidity and Mortality, ١. ARI, ٢.Acute diarrhea, ٣.Malaria, Treated	Sum E١,١, ٢, ٣ <٥ patients visit by health post
٦٨	Total # of under ٥ patients visit by health BPHS and EPHS facilities	MIAR: Patients/Clients < male and female HMIR: A.Indoor patients, ١. Admission <٥ male and female	Sum both under ٥ male and under ٥ female patients visit by health facility (MIAR, Patients/Clients + A.Indoor patients, ١.Admissions)
٦٩	Total # of under ٥ female patients visit by health facility	MIAR: Patients/Clients < ٥ female HMIR: A.Indoor patients, ١. Admission <٥ female	Sum under ٥ female patients visit by health facility (MIAR, Patients/Clients + A.Indoor patients, ١.Admissions <٥ female)
٧٠	Total # of over ٥ female patients visit by health facility	MIAR: Patients/Clients >٥female HMIR: A.Indoor patients, ١. Admission >٥ female	Sum > ٥ female patients visit by health facility (MIAR, Patients/Clients + A.Indoor patients, ١.Admissions >٥ female)
٧١	Number of people living in the areas covered by grant agreements	Grants summary	Sum population under each NGO contract (there is no standard definition)
٧٢	Proportion of facilities that are able to perform blood transfusion	FSR: D. Services provided, D٣. Maternal Health, ٧. Blood transfusion HSR: E.Services provided, E٤. Maternal Health, ٥. Blood transfusion	Sum number of services delivery points reported provision of blood transfusion in FSR: D٣,٧ + HSR: E٤,٥
٧٣	Proportion of facilities that have a functioning blood bank	HSR: E.Services provided, E٤. Maternal Health, ٦. Blood Storage	Sum number of services delivery points reported provision of blood storage in HSR: E٤,٦
٧٤	Proportion of facilities that have a functioning laboratory	FSR: D. Services provided, D٤. Infectious Diseases, ٢. Lab diagnosis or ٤. Malaria lab diagnosis HMIR: E. Services provided, E٣. Infectious Diseases, ٢. TB lab diagnosis or ٤. Malaria Lab diagnosis, or ٥. HIV/AIDS diagnosis	Sum number of HFs reported D٤,٢ or D٤,٤ in FSR and E٣,٢. or E٣,٤. or E٣,٥. in HSR
٧٦	Number of service delivery points providing FP counseling and/or FP products	MAAR: A.Family Planning, #HP MIAR: C١.Family planning, ١-٥	Sum total from MAAR A١, #HP + from MIAR for which the um total New cases and Reattendance for C١,١ + C١,٢ + C١,٣ + C١,٤ + C١,٥ is greater than zero

No.	Definition	Source of data	Calculation
٧٨	Percentage of provincial hospital registered with MoPH submitting HMIR	HMIR	Sum all provincial hospital submitted HMIR in the given period divided by total provincial hospital registered with MoPH
٧٩	Percentage of district hospital registered with MoPH submitting HMIR	HMIR	Sum all district hospital submitted HMIR in the given period divided by total district hospital registered with MoPH
٨٠	Percentage of CHCs registered with MoPH submitting MIAR	MIAR	Sum all CHCs submitted MIAR in the given period divided by total CHCs registered with MoPH
٨١	Percentage of BHCs registered with MoPH submitting MIAR	MIAR	Sum all BHCs submitted MIAR in the given period divided by total BHCs registered with MoPH
٨٢	Percentage of Sub-HCs registered with MoPH submitting MIAR	MIAR	Sum all Sub-HC submitted MIAR in the given period divided by total Sub-HC registered with MoPH
٨٣	Percentage of Mobile Health Team registered with MoPH submitting MIAR	MIAR	Sum all Mobile Health Team submitted MIAR in the given period divided by total Mobile Health Team registered with MoPH
٨٤	Percentage of BPHS facilities registered with MoPH submitting MIAR	MIAR	Sum all BPHS facilities submitted MIAR in the given period divided by total BPHS facilities registered with MoPH
٨٥	Percentage of EPHS facilities registered with MoPH submitting HMIR	HMIR	Sum all EPHS facilities submitted HMIR in the given period divided by total EPHS facilities registered with MoPH
٨٦	# of clients visit at BPHS and EPHS facilities (OPD patients visit and IPD admission)	١. MIAR: Section A, Patients/Clients -Under ٥ male female -Over ٥ male and female -re-attendance ٣. HMIR: Section A. Indoor Patients, ١. Admissions	Sum total number of OPD, IPD admissions and family visits of one month divide by number of days of that month (if quarter, divide by ٩٠ days)
٨٧	Number of available beds reported	HSR A. General Facility information, ١٩. No. of beds (١٩,١ to ١٩,٥)	Sum total number of bed from HSR A.١٩ (١٩,١ to ١٩,٥)

No.	Definition	Source of data	Calculation
٨٨	The number of hospital beds available per every ١,٠٠٠ inhabitants in a population, at a given year, for a given country, territory, or geographic area.	HSR A. General Facility information, ١٩. No. of beds (١٩,١ to ١٩,٥)	Total number of beds divided by a population, at a given year, for a given country, territory, or geographic area multiplied to ١٠٠٠٠
٨٩	Number of patients admitted as inpatients	HMIR: A. Indoor Patients, ١.Admissions	From HMIR: A١.Indoor Patients, ١. Admissions sum (All age and sex)
٩٠	Number of patients referred-in in to this facility by lower level HFs for needed health services	MIAR: A. Patients/Clients, Referred-in PLUS HMIR: A.Indoor Patients, Referred-In	sum all Referred-in from A. Patients/Clients of MIAR plus Referred-in from A.Indoor Patients of HMIR
٩١	Number of inpatients died at the hospital after being admitted as in-patient.	HMIS: A. Indoor Patients, ٥,٥. Deaths	From HMIR: A١.Indoor Patients, ٥,٥. Deaths sum (<٥ M + <٥ F +=>٥F+=>٥M)
٩٢	Number of patient days at hospitals within a given time.	HMIS: A. Indoor Patients, ٣. Number of patient days	From HMIR: A١.Indoor Patients, ٣. Number of patient days sum (<٥ M + <٥ F +=>٥F+=>٥M)
٩٣	Number of patients discharged from hospital within a given time.	HMIS: A. Indoor Patients, ٥.Discharged/Outcome	From HMIR: A١.Indoor Patients, ٥.Discharged/Outcome sum (<٥ M + <٥ F +=>٥F+=>٥M)
٩٤	Number of surgical interventions reported at the hospitals in a given time	HMIS: D. Other surgical interventions	HMIS: D. Other surgical interventions, sum Minor and Major for all diseases
٩٥	Average number of days that patients remain hospitalized. Calculated monthly.	HMIR: A. Indoor Patients, ٤.Average length of stay mean (<٥ M + <٥ F +=>٥F+=>٥M)	Average length of stay in HMIR: A. Indoor Patients, ٥.Average length of stay(<٥ M + <٥ F +=>٥F+=>٥M)
٩٦	The proportion of available beds that were occupied during a given time	HSR: HSR:A. General Facility Information, ١٩.No of beds and HMIR: A. Indoor Patients, ٣. Number of patient days (<٥ M + <٥ F +=>٥F+=>٥M)	Divide ٣. Number of patient days of that month by Sum of ١٩.No of beds, multiplied by ٣٠. (HMIR, A.٣/(HSR A.١٩.*٣٠)

No.	Definition	Source of data	Calculation
٩٧	Proportion of surgical interventions that develops complications including infection, bleeding etc within ١٠ days of the intervention	HMIR: D. Other surgical interventions and ٩. Post operative complication	(HMIR, D.٩. Post operative complication/HMIR, D. ٧.Total)
٩٨	Number of c-section reported at hospitals in a given time.	MIAR: C. Maternal and Neonatal Care, C٣. Obstetric Care, C٣,٧. Cesarean section HMIR: G. Maternal and Neonatal, G١.Family planning, ٥. Cesarean Section.	Sum MIAR, C٣,٧. Cesarean section, PLUS HMIR, G١,٥.Cesarean section
٩٩	Proportion of transfusions that have an incompatibility reaction	HMIR:D. Other surgical interventions, ١٠. Blood transfusion and ١١. Blood transfusion reaction	(HMIR:D.١١/D.١٠)
١٠٠	Proportion of BPHS health facilities with at least on essential stock out	MIAR: D. Stock status Essential Drugs	Count number of health facilities reported MIAR: D. Stock status Essential Drugs, sum (<٢٥)
١٠٤	The number of physicians available per every ١٠,٠٠٠ inhabitants in a population, at a given year, for a given country, territory, or geographic area.	FSR: B. Human Resources, B١. Facility staff Status, ٥. MD General and ٦. MD specialist HSR: B. Human Resources, B١. Management, ٢. Medical Director, B٢,٥. Surgeon, ٦.Ophthalmologist, ٧. ENT, ٩. ObGyn, ١٠. Pediatrician, ١٢. Other Medical Specialist, ١٣. General MD	(Total population of given area/FSR,B١,٥.+B١,٦. + HSR, B١,٢+B٢,٥.+B٢,٦.+B٢.٧.+B٢,٩.+B٢,١٠.+B٢,١٢.+B٢ .١٣) male and female
١٠٥	The number of nurses available per every ١٠,٠٠٠ inhabitants in a population, at a given year, for a given country, territory, or geographic area.	FSR: B. Human Resources, B١. Facility staff Status, ١. Nurse and HSR: B. Human Resources, B١. Management, ٣. Nursing Director, B٣,١٦, ١٧, ١٨,١٩,٢٠,٢١,٢٣.	(FSR,B١,١.+ HSR, B٣,١٦+B٣,١٧.+B٣,١٨.+B٣,١٩.+B٣,٢٠.+B٣,٢١.+B٣, ٢٣./Total population of given area)*١٠٠٠٠ male and female

No.	Definition	Source of data	Calculation
١٠٦	The number of midwives available per every ١٠,٠٠٠ inhabitants in a population, at a given year, for a given country, territory, or geographic area.	FSR: B. Human Resources, B١. Facility staff Status, ٣. Midwife, ٤. Community Midwife and HSR: B. Human Resources, B١. Management, B٣,١٥. Midwifes.	(FSR,B١,٣.+B١,٤.+ HSR, B٣,١٥/Total population of given area)*١٠٠٠٠
١٠٧	Proportion of facilities with recommended staffing	HMIS, Facility Status Report and Hospital Status Report	Check number of BPHS and EPHS HFs reported B. Human Resources according to BPHS and EPHS staffing recommendations for each type of HF.
١٠٨	Number of BPHS and EPHS health facilities per ١٠,٠٠٠ populations.	HMIS common	Total number of SHCs , BHCs , CHCs and DHs per total population multiplied to ١٠,٠٠٠

Annex ٣ – Definition of Terms (Including Standard Case Definitions)

١. New and Old Cases ("re-attendance" and case duration)

New Patient: any patient who comes to the clinic for a new disease episode or check-up. This includes patients who have been diagnosed in another facility and referred to this facility. It also includes patients who have previously been diagnosed at this facility, are coming back for follow-up but also present a new illness (or case).

Re-attendance Patient: any patient who comes to the facility for follow-up care or check-ups and does not present a new illness (or case).

New case: a patient is diagnosed with an episode of an illness for the first time in this health facility. Many problems are of short duration and can be recorded as a new case the next time a patient comes to the same facility with the same diagnosis. Several problems last longer, if not a lifetime. The table below gives the time that should elapse before a patient presenting with the same disease at the same facility can be considered a "new case." A patient referred from another facility is considered a "new case" in the facility to which (s)he has been referred.

Medical Cases	Case Duration								
	١ Week	٢ Weeks	٣ Weeks	١ Month	٢ Mths	٣ Mths	٦ Mths	١ Yrr	Life Long
Allergic rhinitis						✓			
Amebiasis		✓							
Anemia iron definciency						✓			
Arthritis									✓
Asthma									✓
Bronchiectasis									✓
Bronchitis acute		✓							
Bronchitis Chronic				✓					
Candidiasis		✓							
Cellulitis		✓							
Chicken pox			✓						
Colicystitis (non-lithiasis)	✓								
Conjunctivitis		✓							
Contact Dermatitis				✓					
COPD									✓
Cough & Cold	✓								
Cystitis acute		✓							
Dental abscess		✓							
Dental infection				✓					
Depression								✓	

Medical Cases	Case Duration								
	١ Week	٢ Weeks	٣ Weeks	١ Month	٢ Mths	٣ Mths	٦ Mths	١ Yrr	Life Long
Diabetes									✓
Diarrhea acute watery	✓								
Diarrhea with Dehydration	✓								
Diphtheria				✓					
Dysentery	✓								
Eczema				✓					
Epiglottitis		✓							
Epilepsy									✓
Flaccid paralysis – Acute									✓
Gastritis				✓					
Giardiasis		✓							
Gingivitis				✓					
Helminthiasis	✓								
Hemorrhoid		✓							
Herpes simplex (١st onset)		✓							
Herpes zoster				✓					
HIV/AIDS									✓
Hypertension									✓
Impetigo		✓							
Laryngitis		✓							
Leishmaniasis cutanious					✓				
Malaria	✓								
Malnutrition Moderate Acute						✓			
Malnutrition Severe Acute						✓			
Mastitis		✓							
Mastoiditis				✓					
Measles				✓					
Meningitis/Encephalitis								✓	
Mumps		✓							
Nephritis						✓			
Night-blindness (Vit-A)				✓					
Osteoarthritis								✓	
Osteomylitis								✓	
Otitis E□terna				✓					
Otitis media acute		✓							
Peptic Ulcer						✓			
Pertusis					✓				

Medical Cases	Case Duration								
	١ Week	٢ Weeks	٣ Weeks	١ Month	٢ Mths	٣ Mths	٦ Mths	١ Yrr	Life Long
Pharyngitis				✓					
PID		✓							
Pneumonia				✓					
Prostatitis		✓							
Psoriasis							✓		
Pyoderma		✓							
Rheumatoid Arthritis									✓
Ringworm					✓				
Salpingitis		✓							
Scabies		✓							
Scurvy						✓			
Sinusitis acute		✓							
Stomatitis		✓							
Tetanus				✓					
Tetanus Neonatal					✓				
Tonsillitis acute		✓							
Trachoma				✓					
Tuberculoses									✓
Typhoid Fever						✓			
UTI				✓					
Vaginitis				✓					
Vitiligo									✓
Viral Hepatitis								✓	

Re-attendance case: also sometimes referred to as "old case". Patients seen for follow-up of a specific health problem previously diagnosed at the same facility. This includes patients presenting with the same problem within the period that should elapse to be considered a new case. It does not include patients referred from another facility, who are noted as "new cases" in this facility. One patient can have several "cases," e.g., a patient previously diagnosed with malaria coming back for checkup is newly diagnosed with a skin infection; **the patient is marked as "new" patient**, as "re-attendance" for malaria and "new" for skin - infection diagnoses

Referred in: patients who have been referred to this facility by another facility or by HPs

Referred out: a patient who has been referred to another facility for more specialized services

Nutrition: A child that comes for the first time for check-up at this facility is tallied as "new." A child coming back for a check-up within ٣ months of a previous visit is tallied as "Re-attendance." If a child comes back more than ٣ months after a previous check-up, it is tallied as "New."

Family planning new case: For family planning, this corresponds with a "new user" in FP terminology. A "new case" for FP is:

- A client who had never used a family planning method before and starts using one, regardless of whether the client came to this facility before; this client is also marked "new" in the Patient/Clients;
- A client who discontinued (see below) a method and starts a new one, or re-starts the same one, regardless of whether the client came to this facility before; this client is also marked "new" in the Patient/Clients.

Are not considered "new case", but considered "Re-attendance" under Family Planning:

- A client who came to this facility for one method and switches to another method without "discontinuation" as defined below in "Family Planning Discontinued", is marked as a "Re-attendance" for the new method. Remark that this client of course abandons the first method, but she/he switches to the new method without interrupting the contraceptive protection. This client is marked as "re-attendance" under Patients/Clients as well.
- Also, a user who is using a method, but went previously to another facility for supplies, is considered "Re-attendance" when she/he comes to another facility for renewal, without discontinuing FP. This client is marked as "new" under Patients/Clients.

Family planning discontinued: a client is considered to have discontinued using the family planning methods listed in the table below according to the boxed criteria:

Pills	Did not come back for one month after the last scheduled appointment. Pill users are given an appointment to come back for a check-up and a new stock of pill cycles. If the user does not come back on the date of the appointment, or within ٣٠ days after the date of that appointment, she is considered "discontinued" for oral contraception.
Injectables	Did not come back for one month after the last scheduled appointment. Injectable contraception users are given an appointment to come back for check-up and a new injection. If the user does not come back on the date of the appointment, or within ٣٠ days after the date of that appointment, she is considered "discontinued" for injectable contraception.
IUD	When an IUD is removed or ejected and no other method is accepted.
Condom	Did not come back for the last scheduled appointment. Condom users are given an appointment to come back for new supply of condoms. If the user does not come back on the date of the appointment, or stops using condoms without starting another method, she/he is considered "discontinued" for contraception for condoms.

Family planning re-attendance: a user who comes for a new supply of the same family planning method or one who comes for the initial supply of another method without having discontinued (see above) the previous method, regardless of the fact that she/he received the previous supply at this particular clinic.

IMPORTANT: If a patient is considered "new" for any reason, (s)he should be counted as "new" in the row "Patients/Clients" e.g., a woman who comes for a postnatal follow-up visit (re-attendance in "Postnatal visit") and starts using Injectable contraceptives ("New Cases" in "Injectable"), is considered "new" in the row "Patients".

٢. Case Definitions

Cases are only tallied by sex and age if it is a NEW diagnosis for that patient and meets the case definition, otherwise they are only noted under "reattendance. Note that all case definitions in the OPD are "clinical" and thus would be considered as *"suspected"* diagnoses in most cases. Thus each diagnosis could be read as "*Suspected* diagnosis – new case," for example, "Anemia" would be considered "*Suspected* anemia – new case" and "Tuberculosis" is "Suspected tuberculosis – new case," etc. This should correspond to the final diagnosis/classification of the health worker and the treatment given. For instance, if malaria is suspected and treated even if the slide is negative, the diagnosis is "Malaria." If the case description refers to confirmed cases, as in some In-Patient Diseases, it will be explicitly mentioned in the guidelines.

NOTE: One patient can be tallied under more than one case, both in OPD and IPD.

a. OPD Morbidity in MIAR

ARI Cold/cough:	**Common cold** and **cough**, (**no pneumonia**). Running nose, cough, and low grade fever. Any ARI not covered under ENT or Pneumonia definitions and with the above mentioned symptoms, for example, **acute bronchitis, trachea-bronchitis**, etc... Most of these do not require antibiotic treatment, unless proven to be caused by bacteria.
ARI – ENT	**Acute otitis media**: Ear pain with red immobile eardrum or otorrhea for less than ١٤ days. **Mastoiditis**: Ear pain with swelling and pain behind the ear. **Sinusitis**: Pain and tenderness over the sinuses with purulent nasal discharge. **Streptococcal pharyngitis / tonsillitis**: Sore throat with cervical lymphadenopathy or pharyngeal exudates, and the diagnosis is not Diphtheria. **Pharyngeal abscess**: Sore throat with not being able to drink. **Epiglottitis**: Sudden onset of sore throat, hoarseness, stridor, drooling, fever > ٣٩C, and difficulty swallowing and breathing. (External otitis: Classify as "Skin - infection")
ARI - Pneumonia	In children <٥: Cough with chest indrawing and / or fast breathing: - ≥ ٦٠ /min in infants <٢ months, - above ٥٠/min in infants ٢-١٢ months, - above ٤٠/min in children > ١ year, In adults: crepitation or bronchial sounds on chest auscultation. Bronchiolitis is included here
Diarrhea - Acute watery without dehydration	Acute gastroenteritis, at least three loose stools in last ٢٤ hours, with or without fever, with or without mucous in the stool, without dehydration, without blood in the stool,

	duration less than two weeks.
Diarrhea - Acute bloody without dehydration	Acute bloody diarrhea with visible blood in the stool without dehydration. May be bacillary or amebic.
Diarrhea - Acute with dehydration	Acute diarrhea of any type with dehydration. Suspect cholera if severe dehydration or death from acute watery diarrhea in a patient aged five years or more
Severely Ill Patient	Any child <٥ that has one of the following alarm signs: - Diminished consciousness or unconscious - Convulsions - Pneumonia with stridor - Meningitis, meningo-encephalitis, stiff neck Any patient with high fever, meningitis, meningo-encephalitis, gastro-intestinal perforation and bleeding, shocks, persistent diarrhea with or without dehydration, unable to suck or drink, and any condition severely altering consciousness or vital signs, to the extent that hospitalization is required.
Acute Viral Hepatitis	An acute illness that includes acute jaundice, anorexia, nausea, malaise, extreme fatigue dark urine and right upper quadrant tenderness.
Measles:	Any person with fever of auxiliary temperature ٣٧,٥C or above during ٣ days and maculopapular (i.e. non-vesicular) generalized rash and one of these: cough, coryza (i.e. runny nose) or red eyes. Or any person in whom a clinician suspects measles infection.
Pertussis:	A person with a cough lasting at least two weeks with at least one of the following: Paroxysms of coughing, inspiratory "whoop", post-tussive vomiting (vomiting immediately after coughing), and without other apparent cause.
Diphtheria:	A person with laryngitis or pharyngitis or tonsilitis, and an adherent membrane of the tonsils, pharynx and/or nose.
Neonatal Tetanus:	Any neonate with a normal ability to suck and cry during the first two days of life and who between ٣-٢٨ days of age cannot suck normally, and becomes stiff or has convulsions or both.
Tetanus:	Disease characterized by hypertonia esp. of the extensor muscles (manifested by lock jaw, rhisus sardonicus, opisthotonus, etc), involuntary muscle spasm, no consciousness alterations, usually fatal if untreated, caused by the tetanus bacillus which enters through a wound. Age above one month.
Acute flaccid paralysis:	Any child under fifteen years of age with acute flaccid paralysis including Guillain Barre syndrome, or any person with paralytic illness at any age when poliomyelitis is suspected.
Malaria	Fever with any of the following: chills, sweats, myalgia,

	back pain, headache, nausea, vomiting. Sometimes the fever is periodic – cold stage, hot stage, sweating stage. In uncomplicated falciparum malaria, diarrhea and cough are common. Vivax has a chronic relapsing course associated with anemia and splenomegaly. Falciparum may lead to coma and death or may show resistance to anti-malarials If laboratory, provide a separate tally as P. Falciparum or P. Vivax in the lab section
Typhoid	Continuous high fever with any of the following: relative bradycardia, rose spots, prostration, diarrhea or constipation, abdominal pain, splenomegaly. If laboratory, a patient with fever and leucopenia and positive Widal test on the ٨th-١٠th day.
Urinary Tract Infections	Either upper or lower UTI, urinary frequency, dysuria, urgency, suprapubic pain, with or without fever, with or without loin or flank pain or costovertebral angle tenderness If laboratory, urine exam shows WBC++, RBC + / -
Mental Disorders	Anxiety, Depression, Paranoia, Hallucinations, Post Traumatic Stress Disorder, psychosomatic disease, insomnia, panic, hysteria, etc. which is the chief reason for the visit.
Trauma	Injuries and burns, from all causes (mines, wounds, fractures, concussions, cuts, luxations, frostbite)
Suspected Tuberculosis	Any patient with cough lasting for ٢ weeks or more, other common signs are blood in sputum, significant weight loss, fever/night sweats, Fatigue, Chest pain. (See NTP *Tuberculosis Guidelines ٢٠١٠)*
Peptic Disorder	Any condition linked to problems with gastric disorder: heartburn, dyspepsia, gastritis, peptic ulcer, esophageal reflux. Note that perforated ulcer, gastrointestinal bleeding come under *١. Severely Ill Patient*
Musculoskeletal conditions	Arthralgia, arthritis, rheumatoid arthritis, tendinitis, osteo-arthritis, back pain, low backpain, lumbago, sciatica, torticollis, muscle pain, neck pain, osteomyelitis, etc… Note that (suspected) bone fractures, luxations and torn ligaments should be categorized under *Trauma*
Hypertension	Any adult patient at rest with a diastolic blood pressure persistently ≥ ٩٠ mmHg and/or a systolic blood pressure ≥١٤٠ mmHg. "Persistently" refers to having ٣ separate measurements, at least ١ week apart each. But if a patient with blood pressure ≥ ١٤٠/٩٠ represents one or few of signs and symptoms such as headache, dizziness, tinnitus, nausea, vomiting and blurred vision in the first visit should be counted as hypertension.
Anemia	Patients suspected of anemia (general paleness, pale sclera, weakness, tiredness, rapid breathing, palmar pallor) or with laboratory confirmed anemia.

Gastrointestinal worms	Patients suspected having any kind of worm, including mine worm and tape worm.
Skin infection	Any kind of skin infection: dermatitis, cellulitis, abscess, external ear infection, scabies, impetigo, pyoderma, tinia, panaris, skin parasite, hordeolum
Skin other	Any other skin condition not requiring antibiotic treatment, for which the patient consults: acne, eczema, skin rash, allergic reactions, urticaria, psoriasis, …
Pelvic Inflammatory Disease	Inflammation of the uterus (endometritis), fallopian tubes (salpingitis), and/or tubo-ovarian abscesses. Often of infectious origin (STD): mostly bacterial, but also viral, fungal, or parasitic. But can also be of lymphatic origin, or after delivery, miscarriage, abortion, and hematogenic.
Sexually transmitted disease	Infectious vaginitis. Suspected or laboratory confirmed gonorrhea, syphilis, chlamidia, herpes genitalis, …. Note: when endometritis, salpingitis or tubo-ovarian abscesses are suspected, classify as PID)
Eye infection	Conjunctivitis, keratitis, trachoma,
Oro-dental	Any infection, inflammation or other condition affecting the oral cavity and teeth: caries, dental infection, gingivitis, tooth ache, tooth decay, dental abscess, thrush
Micronutritient disorder	All vitamins and minerals deficiency
Others	All unlisted diagnoses including unclear diagnoses and unlisted preventive visits such as also Mumps, chicken pox, constipation, COPD, dysmenorrhea, hemorrhoids, renal colic, undefined general symptoms like weakness, tiredness etc. BUT NOT those included under Nutrition and Maternal and Neonatal Care

b. Other case definitions

Nutrition	
Nutrition - No acute malnutrition:	Number of children situated at ٨٠٪ or above the median weight for height curve. Green in MUAC.
Nutrition - Moderate acute malnutrition:	Children that are situated between ٧٠-٧٩٪ of the median weight for height curve. Yellow in MUAC.
Nutrition - Severe acute malnutrition	Children that are situated below ٧٠٪ of the median weight for height curve, monthly total of the column "Severely Malnourished" and/or bilateral pedal oedema. Red in MUAC

Maternal health	
Antenatal care visit	A visit where a pregnant woman comes for check-up. The visit involves the following activities: - Checking of blood pressure and swelling of feet - Checking of protein in urine (where possible) - Checking general nutritional status, and anemia specifically - Provision of Iron-folate supplement, if it is applicable. - Tetanus Toxoid: A pregnant women needs to receive at least ٢ TT injections before delivery, unless the women has completed TT vaccines. - Detailed discussion of the birthing plan **First visit:** the first time a woman goes for pre-natal check up for this pregnancy. **Other visit:** any visit after the first initial visit of her pregnancy, regardless whether or not this woman came to this facility for the first visit or not. NOTE: in the case a woman goes to Facility ١ for the first ante-natal visit, she is noted "new" in Patients/Clients and "first ante-natal visit" in Pre-natal and Post-natal care. If she goes to Facility ١ for an other ante-natal visit, she is marked "re-attendance" in Patients/Clients and "Other ante-natal visit" in Pre-natal and Post-natal Care. If she goes to Facility ٢ for another ante-natal visit, she is marked "New" in Patients/Clients and "reattendance" in Pre-natal and Post-natal Care.
Post-natal care visit	The first contact within ٤٢ days after delivery is considered as a first PNC.
Assisted Delivery:	Vaginal delivery that requires forceps or vacuum extraction to complete vaginal delivery, without resorting to Caesarean section.
Major obstetric complications	Refers to ٧ major causes of maternal death: (١)Haemorrhage (ante or post-partum), (٢) Prolonged/obstructed labour, (٣) Post-partum sepsis, (٤) Complications of abortion, (٥) Pre-eclampsia/eclampsia, (٦) Ectopic pregnancy, (٧)Ruptured uterus.
Maternal death :	A maternal death is defined as the death of a woman while pregnant or within ٤٢ days of termination of pregnancy,

	irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. Maternal deaths in the HMIS include both: • Direct obstetric deaths are those resulting from obstetric complications of the pregnant state (pregnancy, labor, and the puerperium), from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above. • Indirect maternal deaths are those resulting from previous existing disease or disease that developed during pregnancy and which was not due to direct obstetric causes, but was aggravated by physiologic effects of pregnancy.
Maternal death due to major obstetric complications:	All women that presented a major obstetric complication (see above), and died **in the facility** while pregnant or within ٤٢ days of termination of pregnancy
Maternal death due to other complications:	All women that presented a complication other than the major obstetric complications (see above), and died **in the facility** while pregnant or within ٤٢ days of termination of pregnancy
Normal Delivery:	Vaginal delivery that does not require any intervention other than an episiotomy or suturing of ١st and ٢nd perineal tears.
Other obstetric complications	Refers to obstetric complications other than the seven major causes listed above. Example: third and fourth degree lacerations, cervical tear, shoulder dystocia, premature rupture of membranes, malaria in pregnancy, delivery by HIV+ mother, abortion, etc. Remember: episiotomy, first and second degree lacerations are considered "normal" in this classification
Haemorrhage (ante or post-partum)	Ante-partum hemorrhage: any bleeding before delivery. Post-partum Hemorrhage (PPH): Vaginal bleeding in excess of ٥٠٠ ml after childbirth. PPH can be immediate (within the first ٢٤ hours after childbirth) or delayed/ secondary (from days ٢ to ٤٢ postpartum).
Prolonged/obstructed labour	Prolonged latent phase: When cervical dilatation moves to the right of the alert line on the partograph. Prolonged active phase: The cervix has not dilated beyond ٤ cm after ٨ hours of regular contractions.
Post-partum sepsis	Sepsis within ٤٢ days after delivery
Complications of abortion	Any complication after incomplete or complete abortion (haemorrhage, infection, retained foetal tissue, …)
Pre-eclampsia	Hypertension after ٢٠ weeks of gestation, during labor, and/or within ٤٨ hours of childbirth, with proteinuria.
Eclampsia	Hypertension after ٢٠ weeks of gestation, during labor, and/or within ٤٨ hours of childbirth, with proteinuria and convulsions.
Ectopic pregnancy	A pregnancy in which implantation occurs outside the uterine cavity. The fallopian tube is the most common site of implantation.

Ruptured uterus	Separation of the uterine wall with passage of intrauterine contents into the abdominal cavity. It is characterized by intra-abdominal and/or vaginal bleeding and severe abdominal pain that may decrease after rupture.

Neonatal Care	
Newborn alive	All newborns that were alive at birth, even those that died within minutes or hours after birth
Low birth weight (<٢٥٠٠ grams):	All newborns weighing less than ٢٥٠٠ grams at birth.
Neonatal complication:	All neonates that were ill or presented other complications (e.g. hypothermia, infection, sepsis, apnea, difficulty breathing…).
Early neonatal deaths	All newborns born alive that died **in the facility or dead body were observed by SBA at home delivery** within ٧ days of birth even when the newborn dies a few minutes after birth. This should include all cases investigated by staff from your facility, but not cases that are only reported to you.
Neonatal deaths	All newborns born alive that died within ٢٨ days of birth. This includes the Early Neonatal Deaths. It also includes those death occurred at home delivery attended by skilled birth attendants and dead body was seen by SBA.
Still births:	The death of a fetus after ٢٢ weeks gestation (or weighing at least ٥٠٠ g or with a length of ٢٥ cm or more) before the complete expulsion or extraction from its mother. Any child that dies after complete extraction from its mother (either vaginally or through cesarean section) is considered a neonatal death, even if the child only lives for a few minutes.

c. Case definitions specific for in-patient care

١ **Weapon wounded**	All injuries/trauma due to weapons/unexploded ordinance (rifles, pistols, knives, mines, bombs, grenades, rockets, …) regardless whether the injury was intentional or not, and regardless of the body part injured. Note that many may require an entry under **D. Surgical Interventions**
٢ **Road traffic accidents**	All trauma due to accidents that happen due to traffic on the road/street. This includes pedestrians, bicycle riders and motor vehicle drivers and passengers. Note that many may require an entry under **D. Surgical Interventions**
٣ **Occupational injuries**	All injuries due to exercising one's occupation, but that are not weapon wounded or road traffic accidents. Note that many may require an entry under **D. Surgical Interventions**
٤ **Burns, scalds & frostbite**	All degrees of burns and frostbite. It includes burns/scalds due to contact with boiling liquid, open fire or hot surfaces. Includes also all degrees of frostbite. Note that many may require an entry under **D. Surgical Interventions**
٥ **Fractures & dislocations**	All bone fractures, open and closed, with or without displacement. All spraining or dislocations of joints. Note that many may require an entry under **D. Surgical Interventions**. Note also that any of these can also be an entry under ١-٤.
٦ **Cerebral concussions**	All cerebral concussions. Note that many may require an entry under **D. Surgical Interventions**
٧ **Other injuries**	All injury and trauma that does not fit under the classifications ١- ٦. This includes injuries due to falls, bites, fights, domestic violence, rape, etc… Note that many may require an entry under **D. Surgical Interventions**
٨ **Cerebro-Vascular Accidents**	All cerebro-vascular accidents: intra-cranial hemorrhage, cerebral embolism, cerebral aneurysm, transient ischemic attacks, stroke
٩ **Ischemic Heart Diseases**	All heart conditions related to or provoked by ischemia of the heart muscle: angina pectoris, myocardial infarction, acute coronary syndrome, …
١٠ **Other Cardiovascular**	All other cardiovascular conditions, including: cardiac arrhythmias of all kind, congestive heart failure, hypertension and hypotension, cardiogenic shock, hypovolemic shock, dilated cardio myopathy, rheumatic heart disease, valvular and septal defects, deep vein thrombosis, ….
١١ **Meningitis/encephalitis**	All forms of viral, bacterial meningitis or parasitic encephalitis, meningo-encephalitis, meningitis
١٢ **Epilepsy & Convulsions**	All types of epileptic episodes and convulsions, including febrile convulsions
١٣ **Other neurological**	All other neurological conditions, including coma without metabolic causes, multiple sclerosis, Parkison's disease, other demyelinating and degenerative diseases, …
١٤ **Diabetes & related**	All conditions related to the insulin-glucagon metabolism: diabetes mellitus of all types, complications of diabetes mellitus, leucine induced hypoglycemia, ….
١٥ **Micronutrient disorders**	All micronutrient disorders including anemia, thyroid disorders, Vitamin K deficiencies, other a- or hypervitaminoses, ….
١٦ **Acute abdomen**	All conditions with severe, acute abdominal pain, usually warranting intra-abdominal surgery, including acute appendicitis, peritonitis, bowel obstructions, torsions, perforations …. Note that most will require an entry under **D. Surgical Interventions**
١٧ **Peptic Disorders**	All conditions related to gastric acid dysfunctions: peptic ulcers, bleeding peptic ulcers, heart burn, gastritis, Zollinger-Ellison syndrome, ….
١٨ **Gastrointestinal others**	All non-infectious gastro-intestinal conditions not categorized under ١٦,١٧, including chronic GI diseases like Crohn, inflammatory bowel

	syndrome, hemorrhoids, colics, diverticulitis, fistula and polyps, ascitis….. Note that several may require an entry under **D. Surgical Interventions**
١٩ **Abdominal Hernia**	All forms of abdominal hernias: inguinal, umbilical, …
٢٠ **Liver, gall bladder and pancreas**	All diseases of liver, gall bladder and pancreas, except diabetes mellitus. This includes hepatitis, hydatid cysts of liver, cholecystitis, cholelithiasis, pancreatitis. … Note that several may require an entry under **D. Surgical Interventions**
٢١ **Urinary tract infections**	All infections of the upper or lower urinary tract, including orchitis and prostatitis.
٢٢ **Other Uro-genital disorders**	All uro-genital conditions not categorized under ١٦. This includes: kidney and bladder stones, urethral stones, nephrotic syndrome, renal failure, renal colics, prostate hyperplasia, varicocoele, hydrocoele, hypospadias, ….. Note that many will require an entry under **D. Surgical Interventions**
٢٣ **Pelvic inflammatory disease**	Female genital tract infection which includes endometritis, salpingitis or tubo-ovarian abscesses are suspected
٢٤ **Dysentery (all types)**	All types of diarrhea with blood in the stool
٢٥ **Diarrhea (exc. dysentery)**	All types of diarrhea without blood in the stool
٢٦ **Malaria**	All types and stages of confirmed malaria and its complications
٢٧ **Tuberculosis**	All types and stages of confirmed tuberculosis and its complications
٢٨ **Typhoid**	All cases of typhoid and para-typhoid fever and its complications
٢٩ **Musculo-skeletal infections**	All acute and chronic infections affecting the bone (osteitis), bone marrow (osteomyelitis), joints (septic arthritis), muscle (myositis, septic fasciitis). Note that many will require an entry under **D. Surgical Interventions**
٣٠ **Sepsis**	All other non-specified infections with generalized symptoms requiring hospitalization, including septic shock, septicaemia, ….
٣١ **Infectious others**	All other specified infections and infestations including brucellosis, cutaneous and visceral anthrax, leishmania, rabies, measles, rubella, flue. Note that several of these also need to be reported through DEWS
٣٢ **Mental common problems**	All mental disorders where the patient can carry out (be it with difficulty) daily activities: depression, anxiety disorders, conversion disorders, panic disorder, post-traumatic stress disorder, phobias, obsessive compulsive disorders
٣٣ **Substance abuse**	All conditions provoked by acute overdose or prolonged use of addictive substances, like heroin, opium, cannabis, alcohol, ….
٣٤ **Mental severe problems**	All mental disorders where a person has lost contact with reality and is severally handicapped in performing daily activities. This includes acute and chronic psychosis, schizophrenia, schizophreniform disorders, post-partum psychosis
٣٥ **Respiratory tract infections**	All respiratory infections from viral, bacterial or parasitic origin. This includes pneumonia, broncho-pneumonia, bronchiolitis, bronchitis, pleuritis, ….
٣٦ **ENT**	All conditions, infectious or other, acute or chronic pertaining to ears, nose, and throat. This includes: middle ear infections, pharingitis, tonsillitis, laryngitis, runny nose, epistaxis, sinusitis, mastoiditis, … Note that external ear conditions and conditions of the skin of the nose are put under "skin conditions".
٣٧ **Other respiratory tract conditions**	All non-infectious respiratory tract conditions that fall not under ENT, including: asthmatic conditions, chronic obstructive pulmonary disease, non-infectious pleural effusions, spontaneous pneumothorax,
٣٨ **Eye conditions**	All conditions pertaining to the eye and its mucous membranes, including conjunctivitis, dacryocystitis, trichiasis, trachoma in all its stages, corneal scars and ulcers, foreign bodies, cataract, glaucoma, ….
٣٩ **Skin conditions**	All infectious and non-infectious skin conditions, including: dermatitis, empyema, cellulitis, furuncles, carbuncles, skin abscesses, impetigo,

	phlegmone, warts, scabies, pemphygus, skin rash, urticaria, psoriasis, athlete's foot, tinea, favus, ….
٤٠ **Obstetric & Pregnancy related**	All conditions related to pregnancy and delivery, including permanent male or female contraception. Note that each case will have at least one entry under **G. Maternal & Neonatal**
٤١ **Non-obstetric gynecological**	All conditions affecting the female genital tract, not classified under ٢٢, ٢٣ or ٤٠. Note that many will require an entry under **D. Surgical Interventions**
٤٢ **Neonatal conditions**	All conditions pertaining to neonates, including the birth of a normal neonate, if it happens in the inpatient department. . Note that each case will have at least one entry under **G. Maternal & Neonatal**
٤٣ **Musculoskeletal**	All non-infectious and non-traumatic conditions affecting, bones, joints and muscles: rheumatic diseases, arthrosis, rheumatoid arthritis,
٤٤ **Surgical cases**	All cases not classified above that require surgical interventions. Note that most will require an entry under **D. Surgical Interventions**
٩٩ **Other**	All conditions that are not classified under ١-٤٤, including cancers and tumors, congenital disorders, oro-dental disorders,

٣. Couple Years Protection (CYP) and Couple Months Protection (CMP)

This is a useful (and perhaps the best) indicator available for comparative purposes. It is calculated by multiplying the number of contraceptive procedures performed or units of contraceptives distributed or sold during the year studied by the CYP conversion factor for that method.

The CYP conversion factors attempts to determine the equivalent number of couples protected for an entire year by a given quantity of contraceptives, taking account, whenever possible, of recommended use frequency, effectiveness, frequency of sexual contact for coitus-dependent methods, and wastage. Number of injections converts readily into estimates of the time period over which contraceptive protection is conferred. Estimates of protection provided by sterilization are dependent on the age of the person sterilized; however, average values can be used. Estimates for the length of time IUDs remain in place also vary, but generally fall within the range of ٢,٥-٣,٥ years. Other contraceptives, such as pill and condoms, must be calculated on the basis of quantities dispensed or sold, and in the case of condoms, on estimated coital frequency. Wastage is also a factor.

There are few reliable studies of contraceptive wastage. While there are strong indications of high wastage in many public programs where commodities are provided free to the family planning organization and the user, the amount of wastage appears to be significantly smaller in the commercial sector and contraceptives social marketing programs. For the time being, the HMIS uses the conversion factor associated with free condoms, free of charge.

Failure rates and frequency of intercourse vary significantly from country to country. Until specific figures for Afghanistan become available, generally accepted estimates will be used.

For practical purposes, the CYP is converted into the number of Couple Months of Protection (CMP) per unit of the procedure or product. This allows comparing effectiveness of birth spacing interventions between regions, types of facilities, and implementing agencies month by month.

The CYP and CMP per unit of the different methods as used in the HMIS are listed in the table below:

Method	CYPs	CMP per unit
Sterilization	١٢,٥	١٥٠ per procedure
IUD	٣,٥	٤٢ per insertion
Depo-provera	٤ injections = ١CYP	٣ per injection
Oral Contraceptives	١٥ cycles = ١ CYP	٠,٨ per cycle
Condoms	١٥٠ Condoms = ١ CYP	٠,٠٨ per condom

Annex ٤ – Population estimates (١٣٩٠, ٢٠١٠-٢٠١١)

The numbers, rates and ratios in this table are given for the year of ١٣٩٠ (٢٠١٠-٢٠١١). Updates will be available from the MoPH/HMIS on a yearly basis.

Name	Number	Definition and Calculation of proportion
Total population (TP)	٢٦,٤٨٧,٧٠٠	As Estimated by CSO
Crude Birth Rate (CBR)	٤٥,٨٢/١٠٠٠	The number of live births per thousand resident population per calendar year. For Afghanistan, this is ٤٨ per thousand
Number of live births per year (١)	١,٢١٣,٦٦٦	The number of live births occurring in the population each year. Obtained by multiplying the total population by the CBR (TP * CBR), for Afghanistan TP * .٠٤٥
Number of Stillbirths and Miscarriages per year	١٨٢,٠٥٠	The number of stillbirths and miscarriages that occur each year, expressed as a percentage of the number of live births. By convention the percentage is ١٥٪. (TP * .٠٤٥) * .١٥
Number of pregnancies per year (١)	١,٣٩٥,٧١٦	The number of live births occurring each year plus the number of miscarriages and stillbirths . For Afghanistan : (TP * .٠٤٥) + (TP * .٠٤٥ * .١٥) or (TP * .٠٤٥) * ١,١٥
Women of childbearing age (١٥-٤٩) (٢)	٥,٥٦٢,٤١٧	Women between the age of ١٥ and ٤٩ at any given time. For Afghanistan this is ٢١٪ of total population: TP * .٢١
Women pregnant at any given time (١)	٩٧٧,٠٠١	Number of pregnancies each year times the factor for duration of pregnancy, knowing that a certain number of pregnancies lasts less than ٩ months. The factor is set at .٧. For Afghanistan: ((TP * .٠٤٥) * ١,١٥) * .٧
Women of child bearing age, not pregnant	٤,٥٨٥,٤١٦	The total number of women of child bearing age minus the number of pregnant women at any given time. For Afghanistan: (TP * .٢١) - ((TP * .٠٤٥) * ١,١٥) * .٧
Neonatal Mortality Rate	٧٢,٨٢٠	The Number of Children that die before the age of ٢٨ days per thousand live births in a given year. For Afghanistan this is ٦٠ per thousand
Infant Mortality Rate	١٣٤,٧١٧	The number of children that die before the age of ١ year per thousand

		live births in a given year. For Afghanistan, this is ١١١ per thousand
Child Mortality Rate	١٩٥,٤٠٠	The number of children that die before the age of ٥ years per thousand live births in a given year. For Afghanistan this is ١٦١ per thousand
Children under the age of ١ [1]	١,١٦٥,٤٥٩	For Afghanistan this is ٤٪ of total population: TP * .٠٤٤
Children under the age of ٥	٥,٢٩٧,٥٤٠	For Afghanistan this is ٢٠٪ of total population: TP * .٢٠
Children under the age of ٦ months	٥٨٢,٧٢٩	For Afghanistan this is ٢,٢٪ of the total population TP * .٠٢٢
Children ٦ months to ٥٩ months of age	٤,٧١٤,٨١١	For Afghanistan this is ١٧,٨٪ of total population: TP * .١٧٨

[1] The proportion of all these groups is sometimes set at ٤٪ of the total population, to simplify calculations.
[2] The proportion of this group is sometimes set at ٢٠٪, to simplify calculations.