UNIT 7 REPORT WRITING AND IT SKILLS INCLUDING INTERPRETATION AND USE OF DATA

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7.0 INTRODUCTION

In the previous practical unit about tools and techniques of giving health educations, any activity carried out, at the end needs to be recorded and important findings to be reported. In this unit, we will discuss various aspects of records and reports.
Record keeping is one of the most important activity to be carried out, which reflect the work accomplishment. Let us learn in details about various records and reports.

7.1 OBJECTIVES

After completing this unit, you should be able to:

- ensure the availability of all the registers to be maintained at the health centre;
- appreciate the availability of all the equipment and drugs in working conditions;
- fill the records properly;
- prepare and send the report authority for the needful; and
- identify any endemic or outbreak of the disease and report immediately to the responsible authority.

7.2 FORMATS FOR REGISTERS, RECORDING AND REPORTING

Let us now learn how to prepare map of sub-centre and its area covered as given below:

7.2.1 Prepare the Map of Sub-Centre and its Area

- Identify villages to be covered by the sub-centre.
- Take help from AWWs, TBAs and MSS member etc from each village and prepare a map of entire sub-centre area.
- Identify community resources available in the sub-centre area (place for conducting group meetings (public/private), transport facility for referral, people who can help in organising various camps etc) Please refer to plotted map given in Block 3, Unit 3.

7.2.2 Village Register

The register is maintained to store the information regarding an overall picture of each village covered under the sub-centre area. The information needed to be recorded are:

- Number of households (a household is defined as consisting of those family members having a common kitchen).
- The population of each village.
- The population distribution according to age and sex.
- Number of Anganwadi centres with the name and address of AWWs.
- Number of private practitioners (Allopathic, Ayurvedic, Homeopathic, RMP etc).
- Dais in each village (name and address).
- Schools – location.
- Panchayat Bhawan – Name and address of the Sarpanch.
• M.S.S/Mahila Mandal members.
• Voluntary organisations, if any.
• Number of deep hand-pumps involved.

7.2.3 Household Survey Register

The information regarding each and every household is collected during household survey. After the initial survey, it should be revised after three years. The details of information, need to be collected and entered in the survey register are:

• eligible couples (ECs).
• pregnant mothers.
• pregnant mothers registered.
• pregnant mothers registered given full doses of TT.
• births.
• births registered.
• home deliveries.
• home deliveries conducted by TBAs.
• home deliveries conducted by ANM/LHV.
• deliveries conducted at PHCs/CHCs/Govt. hospitals/nursing homes.
• deliveries conducted by private practitioners.
• pregnant mothers referred as high risk cases.
• pregnant mothers who develop any kind of complication.
• abnormal deliveries.
• abortions.
• low birth weight babies born.
• newborns who had difficulty in breathing immediately after birth (did not cry immediately).
• neonatal deaths occurred.
• Any stillborn baby delivered.
• children upto one year of age.
• children below 3 years of age.
• children who have had frequent episode of diarrhoea.
• Any children referred due to dehydration.
• Number of children who have had frequent attacks of ARI.
• children referred to PHC/hospital for treatment of pneumonia.
• children suffering from malnutrition.
• children going to AW centre.
• children completely or fully immunised.

1 year
upto 3 years
upto 5 years
- women using oral pills.
- women who have undergone MTP.
- women who got Cu "T" inserted.
- couples using condom.
- women who had accepted sterilisation (tubectomy).
- men who have undergone vasectomy.
- women who are having signs and symptoms of RTI/STI.
- women/couples taking any treatment for RTI/STI.
- adolescents - i) Girls (10-19 years)
  ii) Boys (10-19 years)

### 7.2.4 Eligible Couple Register

Identify the number of couples where the wife's age is between 15–45 years from household survey register and enter in this register with address. The family status with parity and age of the youngest child should also be mentioned. The couples if using any contraceptives also need to be recorded along with the details of contraceptives methods being used.

### 7.2.5 Cumulative Family Folder/Record

**Family Folder**

1) Name of Head of Family (HoF) __________________
2) House No. __________________
3) Family No. __________________
4) Family Unique ID __________________
5) Type of Family __________________
6) Religion __________________
7) Caste __________________
8) B.P.L* (Y/N)** __________________
9) Details of family members

<table>
<thead>
<tr>
<th>Name of family</th>
<th>AGE</th>
<th>SEX</th>
<th>Rel. with HoF</th>
<th>Age at marriage</th>
<th>Edn</th>
<th>Occupation</th>
<th>Income</th>
<th>Ht</th>
<th>Wt</th>
<th>No. of meals/ Day Large + small</th>
<th>Any health problem member</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

*BPL- Below Poverty Line

**Y/N - Yes/No
10) Birth and Death data
   a) Any birth in last 12 months (Y/N) __________________
      i) Number __________________
      ii) Sex __________________
   b) Any death in last 12 months (Y/N) __________________
      i) Number __________________
      ii) Sex __________________

11) Communication facility available (Y/N) __________________
   a) Newspaper __________________
   b) Phone __________________
   c) TV/Radio __________________
   d) Other (specify) __________________

12) Social Pathology

<table>
<thead>
<tr>
<th>Addiction</th>
<th>No</th>
<th>Unique ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Widow</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delinquent behaviour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13) Environment
   a) Type of House
      i) Pukka __________________
      ii) Kuchha __________________
      iii) Semi Pukka __________________
   b) Total living area/sq feet __________________
   c) Type of
      i) Attached __________________
      ii) Semi Attached __________________
      iii) Detached __________________
   d) Electricity supply (Y/N)
      If Yes - Official / Non-Official __________________
   e) Ventilation
      i) Adequate __________________
      ii) Not Adequate __________________
Report Writing and IT skills including Interpretation and Use of Data

f) Lighting
   i) Adequate
   ii) Not Adequate

g) Source of water supply: Tap/Bore/other

h) Water Storage : Safe/Unsafe
   i) Waste Water Drainage: Sewerage/Drain/soak pit/open

j) Refuse : Open field/ Municipal Van

k) Sanitary latrine : Yes/No

l) Pet Animal : Yes / No
   If Yes, Pet is kept
   i) Inside House
   ii) Outside House

14) Family Planning

<table>
<thead>
<tr>
<th>Contraceptive Method Used</th>
<th>Unique ID of EC</th>
<th>Duration of Use</th>
<th>Satisfied</th>
<th>Not Satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OCP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cu-T</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vasectomy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tubectomy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

15) Maternal Health and Contraception register

a) Antenatal Records
   1) Unique ID No of woman
   2) Name of the antenatal mother
   3) Husbands name
   4) Residential address
   5) Age (yrs)
   6) L.M.P
   7) E.D.D
   8) MAMTA Card Present(Y/N)
   9) Gestational age at registration
   10) No. of ANC visits done
11) Lab Investigations
   a) Hb __________________
   b) Urine Albumin __________________
   c) Urine sugar __________________
   d) Blood grouping /typing __________________

12) Tetanus Toxoid Vaccine
   a) I Dose __________________
   b) II Dose __________________
   c) Booster __________________

13) Any disease during Pregnancy (Anaemia/H.T/Any other specify) __________________

14) Treatment taken __________________

b) Natal Records

1) Place of Delivery (Institutional/ Home) __________________

2) Delivery conducted by
   a) TBA/Untrained TBA __________________
   b) ANM __________________
   c) LHV __________________
   d) Community Health Nurse __________________
   e) Doctor __________________

3) Any complications during delivery (Y/N) __________________

If yes specify __________________

c) Postnatal Records

1) No. of days in hospital __________________

2) No. of visits for post natal check up __________________

3) Any complication (Y/N) __________________

4) Initiation of Breastfeeding __________________

d) Contraception Register

1) Temporary method
   a) Female - Oral Pills __________________
      IUD __________________
   
   b) Male - Nirodh/condom __________________
2) Permanent Method
   a) Vasectomy for male
   b) Tubectomy for female

e) Child Health Register (Under Five Years)
   1) Unique ID of child
   2) Name of the child
   3) Fathers name
   4) Mothers name
   5) Residential address
   6) Age
   7) Sex
   8) Date of birth
   9) Birth weight (kg)
   10) Place of birth (Institutional/home)
   11) Initiation of Breastfeeding
   12) Exclusive breastfeeding till age (in months)
   13) Age of weaning
   14) Immunisation Card (Y/N)
   15) BCG
   16) HEP (birth dose)
   17) OPV (Zero dose)
   18) Penta 1/OPV 1
   19) Penta 2/OPV 2
   20) Penta 3/OPV 3
   21) Measles 1
   22) Vit A OPV/DPTB Mesales 2
   23) DPT 2nd

7.2.6 Sub-Centre/FRU Clinic Register

This register is maintained for keeping records of patients attending the sub-centre clinics. The attendance in antenatal, immunisation, family planning clinics should not be registered in this record. The columns essential for this register are:
7.2.7 Death Register

All deaths occurring in the area covered by the sub-centre are entered in this register. The items of information to be recorded include:

- Date of death: ………………………
- Name and address: …………………
- Age: ………………………………..
- Sex: ………………………………..
- Cause of death: ……………………..

7.2.8 Stock Register

Records of particulars related to all items provided and utilised at sub-centre should be maintained.

a) Drugs:

<table>
<thead>
<tr>
<th>Date</th>
<th>Previous Balance</th>
<th>Quantity Received</th>
<th>Quantity Used</th>
<th>Balance in Hand</th>
<th>Expiry Date</th>
<th>Remarks</th>
</tr>
</thead>
</table>

b) Inventory of Vaccines and Drugs

<table>
<thead>
<tr>
<th>S. No</th>
<th>Item</th>
<th>Unit</th>
<th>Requirement Assessed Last Year</th>
<th>Actual Quantity Received Last Year</th>
<th>Surplus of Shortage Last Year</th>
<th>Requirement for Current Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>ORS packet</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Metronidazole tablets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Cotrimoxazole</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Paracetemol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Chloroquine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Antiseptic solution</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Uristix</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 8     | DD kits             |      |                                 |                                   |                               |                               | (Disposable Delivery Kits)
<table>
<thead>
<tr>
<th>S. No</th>
<th>Item</th>
<th>Opening Balance</th>
<th>Received</th>
<th>Total</th>
<th>Consumption</th>
<th>Balance</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>IFA large</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>IFA small</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Vitamin A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Cotrimoxazole</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>ORS packets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Methylergometrine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Cholorophenarnamine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Paracetemol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Anti-spasmodic tablets</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Inj Methylergometrine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Mebendezole</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Syringes and needles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Vaccine day carrier</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Steriliser Autoclave</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Choloramphenicol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Public Health Skills

16 Centrimide powder

17 Povidine ointment 5%

18 Cotton bandage

19 Contraceptives
   i) Nirodh
   ii) Oral pills
   iii) IUDs

20 Disposable Delivery Kit

21 Chloroquine Tablets

Note: Antibiotic list to be included along with any other drugs as per Government approval

d) Vaccine Received from PHC

<table>
<thead>
<tr>
<th>S. No</th>
<th>Name of vaccine Weekly Session 1 Date/Dose</th>
<th>Vaccine Received for Weekly Session 2 Date/ Dose</th>
<th>Vaccine Received for Weekly Session 3 Date/ Dose</th>
<th>Vaccine Received for Weekly Session 4 Date/ Dose</th>
<th>Vaccine Received for Weekly</th>
<th>Vaccine Received Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>DPT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>OPV</td>
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</tr>
<tr>
<td>3</td>
<td>DT</td>
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<tr>
<td>4</td>
<td>TT</td>
<td></td>
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<tr>
<td>5</td>
<td>BCG</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Measles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Pentavalent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7.2.9 Register for Recording Consultative Process

As an important member of the health team you have to conduct meetings with village working team constituted for each village and with other members of the group of that village. The details of the meetings are recorded of each meeting in the register. The following information needs to be entered:
7.2.10 Referral Register

The details of the referred cases should be entered in the register. This will also help to undertake follow-up of the referrals made.

<table>
<thead>
<tr>
<th>Date</th>
<th>Name &amp; Address</th>
<th>Age</th>
<th>Sex</th>
<th>Complaints</th>
<th>Reasons for Referral</th>
<th>Referred to</th>
<th>Follow-up Actions Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

7.2.11 Live Birth Report

Serial No _________________

Registration Unit/Village/Taluq/Tehsil/Block/Thana/District

Town/Municipality

1) Date of Birth:

2) Sex - Male/Female

3) Name of Child

4) Place of Birth

5) Permanent residential address

6) Father's
   i) Name
   ii) Literacy
   iii) Occupation
   iv) Religion

7) Mother's
   i) Name
   ii) Literacy
   iii) Occupation
   iv) Religion

8) Age of mother in completed years at confinement

9) Order of birth

(Number of Live births including birth registered)
Public Health Skills

10) Type of attention at delivery
11) Informant's
   i) Name
   ii) Address

Date__________________ Signature or thumb mark of the informant

7.2.12 Still Birth Report

Serial No __________

Registration Unit/Village/Taluq/Tehsil/Block/Thana/District

Town/Municipality ____________________________________________________________________

1) Date of Birth
2) Sex - Male/Female
3) Place of Birth*
4) Permanent residential address
5) Father's
   i) Name
   ii) Literacy
   iii) Occupation
   iv) Religion
6) Mother's
   i) Name
   ii) Literacy
   iii) Occupation
   iv) Religion
7) Age of mother in completed years at confinement
8) Type of attention at delivery+
9) Informant's
   i) Name
   ii) Address

Date__________________ Signature or thumb mark of the informant

* If the delivery took place in the hospital or any other institution, write "hospital" or "institution" giving its name, otherwise give full address of the place of birth.
+ If the delivery was conducted in a hospital or maternity home, write the name of institution otherwise mention whether it was conducted by a qualified or unqualified midwife and give her name.
Note:

1) In the case of illegitimate birth the word “illegitimate” should be entered in the remarks column and no person’s name should be entered as that of the father, unless there is a joint request of the mother and the person acknowledging himself to be the father of the child.

2) In the case of multiple births make separate entry for each and a reference in the remarks.

3) If the person is a non-worker insert the word “Nil” in the column for occupation.

7.2.13 Death Report

Serial No _______

Registration Unit/Village/Taluq/Tehsil/Block/Thana/District

Town/Municipality ________________________________

1) Date of death
2) Full name of the deceased
3) Place of death
4) Name of the father/husband
5) Age
6) Sex - Male/Female
7) Marital Status
8) Occupation
9) Religion
10) Nationality
11) Permanent residential address+
12) Cause of death*
13) Whether medically certified (Yes/No)
14) Kind of medical attention received, if any
15) Informant's
   i) Name
   ii) Address

Date __________________ Signature/thumb mark of the informant

+ The address of the parent, in the case of a child, husband/late husband in a case of married women/widow and deceased if independent, is to be given in this column.

* Whether the cause of death is medically certified the cause marked (-) in the medical certificate for No 8/8A is to be entered here.
**Note:**

1) If the deceased was over 1 year of age, give age in completed years. If the deceased was under 1 year of age give age in completed months and if below 1 month give age in completed number of days and if below one day in hours.

2) If the person is a non-worker insert the word “Nil” in the column for occupation.

### 7.2.14 Daily Diary

The daily diary is maintained by the Health Team Members in which the daily activities are performed in the field as well as the clinic with regard to immunisation, antenatal checkup and follow-up, distribution of contraceptives, follow-up of IUD and OP cases, identification of PID. RTI/STI cases, birth and death reported, malaria cases etc. The meetings conducted with the village working team and the group of village representatives should also be mentioned in the diary.

The daily diary will enable to update all the register to be maintained and will also be helpful in preparation of the monthly report. It is easy to carry one daily diary instead of all the registers when one goes on home visits/meetings.

### 7.2.15 Monthly Report for Sub-Centre

**General Information**

1) State: ________________________________

2) District: ________________________________

3) PHC: ________________________________

4) Sub-centre: ________________________________

5) Population of PHC: ________________________________

6) Population of sub-centre: ________________________________

7) Reporting for the month of: ________________________________

8) Eligible couples (as on 1st April of the year): ________________________________

<table>
<thead>
<tr>
<th>S. No</th>
<th>Services</th>
<th>Performance in Corresponding Month of Last Year</th>
<th>Performance in the Reporting Month</th>
<th>Cumulative Performance in Corresponding Month of Last Year</th>
<th>Cumulative Performance till Current Month</th>
<th>Planned Performance in Current Month</th>
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<tbody>
<tr>
<td>1</td>
<td>Antenatal Care</td>
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<td>Antenatal Cases</td>
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<td>a) Total</td>
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<td>b) &lt; 12 weeks</td>
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<td>1.2</td>
<td>No. of pregnant women who had 3 check-ups</td>
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<td>1.3</td>
<td>Total no. of high risk pregnant women referred</td>
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<td>1.4</td>
<td>No of TT Doses</td>
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<td>i) TT 1</td>
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<td>ii) TT 2</td>
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<td>iii) Booster</td>
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<td>1.5</td>
<td>No. of pregnant women under treatment for anaemia</td>
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<td>1.6</td>
<td>No. of pregnant women given prophylaxis for anaemia</td>
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<td>Natal Care</td>
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<td>2.1</td>
<td>Total No. of deliveries</td>
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<td>Home Deliveries</td>
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<td>a) (i) by ANM</td>
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<td>(ii) by LHV</td>
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<td>b) by TBA</td>
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<td></td>
<td>c) Untrained Birth Attendant</td>
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<td>2.3</td>
<td>Deliveries at sub-centre</td>
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<tr>
<td>2.4</td>
<td>Complicated Deliveries referred to PHC/FRU</td>
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<tr>
<td>3</td>
<td>Maternal Deaths</td>
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<td>3.1</td>
<td>During pregnancy</td>
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<td>3.2</td>
<td>During delivery</td>
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<td>3.3</td>
<td>Within 5 weeks of delivery</td>
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<tr>
<td>4</td>
<td>Postnatal Care</td>
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<tr>
<td>4.1</td>
<td>No of women given 3 post natal check-ups</td>
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### Public Health Skills

<table>
<thead>
<tr>
<th>4.2</th>
<th>Complications referred to PHC/FRU</th>
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<tr>
<th>5</th>
<th>RTI/STI</th>
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<tr>
<td>5.1</td>
<td>Cases</td>
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<tr>
<td></td>
<td>a) Detected</td>
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<tr>
<td></td>
<td>b) Treated</td>
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<td></td>
<td>c) Referred</td>
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<tr>
<th>6</th>
<th>Pregnancy Outcome</th>
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<tbody>
<tr>
<td>6.1</td>
<td>a) Live births</td>
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<tr>
<td></td>
<td>b) Still births</td>
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<thead>
<tr>
<th>6.2</th>
<th>Order of Birth in 3</th>
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<tr>
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<td>(a)</td>
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<tr>
<td></td>
<td>a) 1st</td>
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<td>b) 2nd</td>
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<td></td>
<td>c) 3rd</td>
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<thead>
<tr>
<th>6.3</th>
<th>Newborn status at birth</th>
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<tbody>
<tr>
<td></td>
<td>a) less than 2.5 kg</td>
</tr>
<tr>
<td></td>
<td>b) 2.5 kg or more</td>
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<td></td>
<td>c) No. of high risk newborns referred to PHC/FRU</td>
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<thead>
<tr>
<th>7</th>
<th>Immunisation</th>
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<tr>
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<td>Infant 0-1 year</td>
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<tr>
<td></td>
<td>BCG</td>
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<tr>
<td></td>
<td>DPT 1</td>
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<td>DPT 2</td>
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<td>DPT 3?</td>
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<td>OPV 0</td>
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<td>OPV 1</td>
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<td>OPV 2</td>
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<td>OPV 3</td>
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<td>Measles</td>
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<thead>
<tr>
<th>7.2</th>
<th>Children more than 18 months</th>
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<tr>
<td></td>
<td>DPT Booster</td>
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<tr>
<td></td>
<td>OPV Booster</td>
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<td></td>
<td>Children more than 5 years DT</td>
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<td>7.3</td>
<td>Children more than 10 years TT</td>
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<td>7.4</td>
<td>Children more than 16 years TT</td>
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<tr>
<td>7.5</td>
<td>Adverse reaction reported after immunisation</td>
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<td>7.6</td>
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<td></td>
<td>Vitamin A administration (9 months to 3 years)</td>
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<tr>
<td>9</td>
<td>Childhood Diseases</td>
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<tr>
<td>9.1</td>
<td>Vaccine preventable diseases</td>
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<tr>
<td></td>
<td>a) Diphtheria</td>
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<tr>
<td></td>
<td>i) Cases detected</td>
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<td>ii) Treated</td>
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<td></td>
<td>iii) Referred</td>
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<td></td>
<td>iv) Deaths</td>
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<td></td>
<td>b) Poliomyelitis (AFP)</td>
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<td>i) Cases detected</td>
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<td>ii) Treated</td>
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<td>iii) Referred</td>
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<td>iv) Deaths</td>
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<tr>
<td>9.2</td>
<td>c) Neonatal Tetanus</td>
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<tr>
<td></td>
<td>i) Cases detected</td>
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<td>ii) Treated</td>
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<td>iii) Referred</td>
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<td>iv) Deaths</td>
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<td>d) Measles</td>
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<td>i) Cases detected</td>
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<td>ii) Treated</td>
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<td>iii) Referred</td>
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<tr>
<td></td>
<td>iv) Deaths</td>
</tr>
</tbody>
</table>
9.3 ARI under 5 years (Pneumonia)
   a) Treated with Cotrimoxazole
   b) Referred to PHC/FRU
   c) Deaths

9.4 Acute Diarrhoeal Diseases under 5 years
   a) Treated with ORS
   b) Referred to PHC/FRU
   c) Deaths

<table>
<thead>
<tr>
<th>10</th>
<th>Child Deaths</th>
<th>M</th>
<th>F</th>
<th>M</th>
<th>F</th>
<th>M</th>
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11. Contraceptive Services

11.1 Eligible couples contacted

11.2 Male sterilisation
   a) Total no. of cases motivated
   b) No. of cases followed up

11.3 Female sterilisation
   a) Total no. of cases motivated
   b) No. of cases followed up

11.4 Total IUD insertion
   a) Cases followed up
   b) Complication
   c) Discontinued
      i) Removed
      ii) Expelled

11.5 Total Oral Pill Users
   a) Old users
7.3 DATA SOURCE, COLLECTION AND ENTRY, ANALYSIS AND REPORTING

7.3.1 Concept of Data

Data consists of observation of attributes or events that carry little meaning when considered alone, data as collected are inadequate for planning. Data need to be transformed into information by reducing them, summarising them and adjusting them for variation so that comparisons over time and place are possible. Data not transformed into information is of little value to guide decision makers, policy makers, planners, administrators and health care personnel.

7.3.2 Components of Health Information System (HIS)

A comprehensive health information system requires information and indicators on the following subjects:

a) demography and vital events
b) environmental health statistics
c) health status: mortality, morbidity, disability and quality of life.
d) health resources: facilities, beds, manpower.
e) utilisation and non-utilisation of health services: attendance, admission and waiting lists.
f) indices of outcome of medical care.
g) financial statistics (cost, expenditure) related to the particular objective,

7.3.3 Uses of Health Information

- to measure the health status of the people and to quantify their health problems and medical and health care needs.
- for local, national and international comparisons of health status.
- for planning, administration and effective management of health services and programmes.
Public Health Skills

- for assessing whether health services are accomplishing their objectives in terms of their effectiveness and efficiency.
- for assessing the attitudes and degrees of satisfaction of the beneficiaries with the health system.
- for research into particular problems of health and disease.

7.3.4 Sources of Health Information Data

- Census
- Registration of vital events
- Sample Registration System
- Notification of diseases
- Hospital records
- Disease registers
- Record linkage
- Epidemiological surveillance
- Other health service records
- Environmental health data
- Health manpower statistics
- Population surveys
- Other routine surveys related to health
- Non-quantifiable information

7.3.5 Community Health Assessments

Typically use both primary and secondary data to characterise the health of the community:

- **Primary data** are collected first-hand through surveys, listening sessions, interviews, and observations
- **Secondary data** are collected by another entity or for another purpose
- **Indicators** are secondary data that have been analysed and can be used to compare rates or trends of priority community health outcomes and determinants

Community health assessment indicators should be

- Methodologically sound (valid, reliable, and collected over time)
- Feasible (available or collectable)
- Meaningful (relevant, actionable, and ideally, linked to evidence-based interventions)
- Important (linked to significant disease burden or disparity in the target community)

Please refer Course 3, Block 1, Unit 1 for more details on Community need assessment.
Data and indicator analyses provide descriptive information on demographic and socioeconomic characteristics; they can be used to monitor progress and determine whether actions have the desired effect. They also characterise important parts of health status and health determinants, such as behaviour, social and physical environments, and healthcare use.

### 7.3.6 Analysis and Reporting

Data obtained is subsequently classified, analysed and tested for accuracy by statistical methods. Statistical data once collected, must be arranged purposively in order to bring out important points clearly and strikingly. The data can be presented in the form of tables, charts, diagrams, graphs, pictures and special curves.

a) **Tables**: Tables are devices for presenting data simply from masses of statistical data.

   Tabulation is the first step before the data is used for analysis or interpretation.

   The general principles of tables are to be applied while preparing.

   - should be numbered
   - title must be given (brief and self-explanatory)
   - heading of columns/row should be clear and concise
   - data to be presented as per size/importance, chronologically, alphabetically/geographically.
   - to present % average place them as close as possible
   - table should not be large.
   - may be presented in vertical or horizontal arrangement.
   - footnotes may be given.
   - Tables can be simple table or frequency distribution table.

b) **Charts and Diagrams**: They are useful method of presenting simple statistical data which have a powerful impact. Key points to be remembered are they have to be kept simple to avoid misinterpretation. Accuracy and details must be kept in mind. They can be presented as bar charts (simple bar chart, multiple bar chart & component bar chart), histogram, line diagram, pictogram (representing data in the form of pictures).

### 7.4 USE OF HMIS AND MCTS DATA FOR PUBLIC HEALTH ACTION

You have read in theory Course 1, Block 5 Unit 4 about Health Management Information System in details. Here we will discuss HMIS and The Mother and Child Tracking System (MCTS) for public health action.

#### 7.4.1 Health Management Information System (HMIS)

A Health Management Information System (HMIS) is a process whereby health data (input) are recorded, stored, retrieved and processed for decision-making (output). Decision making broadly includes managerial aspects such as planning,
organising and control of health care facilities at the national, state and institution levels. As per WHO guidelines evaluation of HMIS is to be done in the areas of data generation and report compilation, data utilisation, details about computer hardware and software, training and monitoring.

HMIS is primarily concerned with health care delivery issues like - antenatal care, immunisation, disease control programmes and administrative issues like reporting, inventory management, financial management, and vehicle and personnel management issues.

A computerised management information system can

- help improve the health system;
- aid the workers in providing services, data collection, storage, analysis and dissemination of information. The HMIS has undergone three generation evolution over the years reflecting the advancement in information technology as well as changing perceptions of the users of HMIS.

**Output of the HMIS : Output of HIMS are:**

- Work plan generated each month after the data has been updated. The work plan lists the monthly activities by house and contains updated information about all the individuals including the under-five children, pregnant women, eligible couples, and geriatric age-group in the house.
- It also serves as a tool for monitoring of the workers by the medical officer and the supervisors.
- Other outputs include monthly reports, lists for immunisation and contraceptive services, and performance indicators of workers, sub-centers and PHCs.
- Annual performance review of each worker is done based on the indicators generated from the HMIS.

**Purpose of HMIS**

- to support health workers in delivering health care services to the population.
- to support programme managers in monitoring and supervision of the workers.

The costs were classified into two broad categories:

1) **Capital cost** -

- Consists of those items which have a life of more than one year and represent an initial investment.
- Training cost and software development was treated as a capital cost with life of ten years.
- Data transfer was also considered as a one-time investment with a life of 20 years.
- Space is available at the health care centres.
- It is then converted to equivalent annual costs based on their useful life years and a discount rate of 5%.
2) Recurrent costs (consumables & salaries) -
   - Include those items that have less than one year of life and largely consisted of human resource cost and cost of consumables like paper, cartridges, electricity etc.
   - Minimum of two set of computers and printers required to house the database and facilitate easy working.
   - The time required for training and database transfer needs to be kept in mind.
   - The time spent by workers in planning their work, record keeping, report preparation at sub-center level, compilation at PHC level as well as review by medical officer should be considered.
   - The costs of maintenance, stationery, electricity.
   - The cost of time spent by all human resources was estimated based on their current salary structure under GOI.

7.4.2 Mother and Child Tracking System (MCTS)

The Mother and Child Tracking System is a beneficiary-specific database for MCH services delivered through the Indian public health system. It was launched in 2009 as part of a global trend towards harnessing e-health innovations in improving service delivery, and India's existing HMIS was not meeting the service delivery needs of FHWs. It has "objectives, scopes, and implementation timelines and milestones, as well as measurable outcomes and service levels". It is designed to capture and track all pregnant women (from conception up to 42 days post-partum) and all newborn children (up to 5 years of age).

Objectives:

Its objectives are to ensure that:
   - all pregnant women receive their full Antenatal Care (ANC) and Postnatal Care (PNC) services at the due times;
   - institutional deliveries for pregnant women, particularly for high risk mothers, are encouraged; and
   - all children receive the full immunisation schedule at the due times.

Workplan

- Beneficiary and service delivery data are written by FHWs on registers and formats and then transferred to the nearest PHC for entry into the MCTS portal by DEOs.
- All health facilities, from the State to the most peripheral HSCs, are mapped in the portal, which also maps FHWs to specific HSCs.
- The data enables the MCTS to generate work plans for FHWs, detailing forthcoming service delivery needs, such as antenatal check-ups or immunisation sessions, on a per-beneficiary basis.
- Supervisory officials can also generate reports from the MCTS web portal that indicate MCTS performance (beneficiary registration rates) or service delivery performance (e.g. % of children fully immunised).
- Success of the MCTS as a data system relies heavily on processes and practices at the village/ HSC level.
Public Health Skills

- The field-level data collection, consolidation and transfer activities ultimately determine MCTS data quality.
- Low data completeness rates leads to poor performance numbers.
- Reason for incomplete MCTS portal data is the incompleteness of the primary data source.
- There was an absence of standardisation in the data tools, and data processes.
- The MCTS has developed an inbuilt mechanism for generating a due list of beneficiaries before each immunisation session. MCTS training among service delivery, supervisory and data entry staff was inconsistent.

Challenges:

- Irregular electricity supply, inconsistent internet connectivity and the slow speed of the MCTS web portal were some of the challenges faced by block-level facilities, which act as the primary MCTS data entry points.
- Hurdles to implementation include -
  - clearly define Standardised data tools and processes.
  - standardise registers and formats to meet the needs of the MCTS portal and the service delivery needs of FHWs.
  - clearly defined standardised data processes and guidelines for staff at the most peripheral levels of the health system.
  - guidelines should clearly lay out a plan for data collection, consolidation, and transfer to the data entry point, with stipulated timelines.

Fig. 7.1: Mother and child tracking system: data flow
7.4.3 Nursing Technology and Information System

Information system in nursing technology are the practical realities of how professions change and how to support innovation in practice. Issues for nursing information are ownership and accessibility.

Nursing in yesteryears:

- Traditionally the nursing professions was perceived to be data gatherers rather than data users.
- The traditional training of nurses did not prepare the profession well for data analysis and using quantitative methods to present the case for change.
- Decision making was characterised by professional judgement based on observation with the reporting systems based on the traditional nursing hierarchy.
- The lack of supporting quantifiable data and nursing view not supported led to frustration, as the nursing view often reflected the complex realities of health care.
- Nursing information includes data collected by nurses; data used by nurses; data about nursing activity; and data about the nursing resource.
- Patients, nurses, midwives and health visitors can benefit from it but there are challenges ahead.

Nursing now and in future:

- Computer technology is a reality of our modern world.
- It gives us a tool which can be used to help us cope with the complexity and efficiency which is often required in many areas of work.
- The use of the computer frees the person from the drudgery of repetitive labour to allow more time and effort to be available for the more personal skills to find expression.
- It has now been recognised the need for nurses to develop skills in handling information; deciding what information they need to collect to do their jobs; how to analyse it, present written reports well supported by both quantifiable and qualitative data.
- Recording assessment data using a computer keyboard allows just as much caring communication between nurse and clients as writing it down on a form.
- The critical factor is not the method of recording but the interpersonal skills and motivation of the nurse.
- The nursing profession is at last beginning to appreciate the role which the new technology can have in improving the service provided to patients.
- Implementation of computers to clinical practice will help nurses maintain control of their own professional contribution in health care settings.
- Knowledge based systems are set to become a major component in the nurse's ability to take on this role.
7.5 GENERAL REPORT WRITING SKILLS FOR FACILITY RELATED FORMATS INCLUDING COMMON LIST OF HOUSEHOLDS, REPORTS, FORMATS TO HIGHER FACILITIES, REGISTERS

It is very important that a good report be written and presented with the data collected, tabulated and analysed. The steps of writing a good report are:

- Plan - write down purpose, headings, introduction and need. It saves time.
- Write first draft
- Write a summary
- Edit - editing several times, the report gets better. Prune sentences to 15–10 words on average, link them with sentence connectors, punctuate properly, use everyday vocabulary, avoiding or explaining any social care jargon

Check for errors, seek second opinion from colleague and ask if the report makes any sense for the purpose it is prepared.

- Avoid irrelevant, inappropriate information, meaningless phrases and illogical conclusions.
- Training is the key to producing good reports.
- Poor language skills can affect the quality of reports.
- Need to be able to write reports that can be taken seriously in court.
- Take care of spelling, as they can be atrocious when spelt wrongly.
- Learn the art of critical analysis.
- Take time to write good quality reports.
- More critical judgement is needed.
- Maximise professional opinions and observations.
- Place the report in an appropriate environment for logical use.

7.6 LET US SUM UP

It is very important that the Community Health Nurse and her team understands the importance of record writing and reporting. A well maintained record and report written as per the guidelines and principles will help one and all in proper decision making for the clients under their care.

7.8 KEY WORDS

ANC : Antenatal Care
ANM : Auxillary Nurse Midwife
ARI : Acute Respiratory Infection
AW : Anganwadi
AWW : Anganwadi Worker
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCG</td>
<td>Bacilli, Calmette and Guerin</td>
</tr>
<tr>
<td>BPL</td>
<td>Below Poverty Line</td>
</tr>
<tr>
<td>CHC</td>
<td>Community Health Centre</td>
</tr>
<tr>
<td>DEO</td>
<td>Data Entry operator</td>
</tr>
<tr>
<td>DD Kits</td>
<td>Disposable Delivery Kits</td>
</tr>
<tr>
<td>DT</td>
<td>Diphtheria, Tetanus</td>
</tr>
<tr>
<td>DPT</td>
<td>Diphtheria, Pertussis and Tetanus</td>
</tr>
<tr>
<td>DPTB</td>
<td>Diphtheria, Pertussis</td>
</tr>
<tr>
<td>EC</td>
<td>Eligible Couple</td>
</tr>
<tr>
<td>EDD</td>
<td>Expected Date of Delivery</td>
</tr>
<tr>
<td>FHW</td>
<td>Female Health Worker</td>
</tr>
<tr>
<td>FRU</td>
<td>First Referral Unit</td>
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<tr>
<td>GOI</td>
<td>Government of India</td>
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<tr>
<td>HIS</td>
<td>Health Information System</td>
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<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
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<tr>
<td>HoF</td>
<td>Head of Family</td>
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<tr>
<td>HSC</td>
<td>Health Sub-centre</td>
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<tr>
<td>HT</td>
<td>Hypertension</td>
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<tr>
<td>IFA</td>
<td>Iron and Folic Acid</td>
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<tr>
<td>LHV</td>
<td>Lady Health Visitor</td>
</tr>
<tr>
<td>LMP</td>
<td>Last Menstrual Period</td>
</tr>
<tr>
<td>MCTS</td>
<td>Mother and Child Tracking System</td>
</tr>
<tr>
<td>MSS</td>
<td>Mahila Swasthya Sangh</td>
</tr>
<tr>
<td>MTP</td>
<td>Medical Termination of Pregnancy</td>
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<tr>
<td>RTI</td>
<td>Reproductive Tract Infection</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted Infection</td>
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<tr>
<td>IUD</td>
<td>Intra Uterine Device</td>
</tr>
<tr>
<td>OP</td>
<td>Oral Pills</td>
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<td>OPV</td>
<td>Oral Polio Vaccine</td>
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<td>PHC</td>
<td>Primary Health Centre</td>
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<tr>
<td>PID</td>
<td>Pelvic Inflammatory Disease</td>
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<tr>
<td>PNC</td>
<td>Postnatal Care</td>
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<td>RMP</td>
<td>Registered Medical Practitioner</td>
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<td>TBA</td>
<td>Trained Birth Attendant</td>
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<tr>
<td>TT</td>
<td>Tetanus Toxoid</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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7.8 ACTIVITY

On the Visit to Health Centre
1) Prepare a village map of the health centre you have visited.
2) Fill a sample stock register of the centre for the month you have visited.
3) Go for home visiting and prepare full family folder of that family.
4) Identify the health needs of the family priority wise.
5) Prepare a monthly report of the health centre and send it to the next authority.
6) Prepare the weekly report of your health centre.
7) Prepare a weekly work plan of the health centre.

7.9 REFERENCES

1) www.ncbi.nlm.nih.gov › NCBI › Literature › PubMed Central (PMC)
   https://books.google.co.in/books?isbn=8190867512

2) www.communitycare.co.uk/2010/07/28/how-to-write-a-good-report/Anita Pati. How to write a good report


