Session 2 A

The Primary Register

The Design and Management of Recording Registers
Rationalizing Primary Registers

- It is “easy” to rationalise registers – we have done it so many times already. Tamilnadu, Rajasthan, West Bengal, Orissa, Bihar..Madhya Pradesh…. And NHSRC too…

- Every health sector reform programme since 1988 has always had a component of strengthening HMIS…But each time it is rediscovered anew…

- At one level the register is a trivial issue and at another level it is impossible….well, almost…

- One needs to define the “problematic”- to theorise it .. Then build on what is available – the alternative – a central register model is dangerous.
Three Dimensions of Health Register.....

For a peripheral outreach health worker
1. Records the work I have done... the service register
2. Help me keep track of clients who need follow up... the tracking register.
3. Generate data needed for reporting to higher authorities. – the reporting function.

For a hospital or health facility:
1. Record of services registered.
2. Keep track of patients for follow up
3. Generate data for reporting upwards and for local data analysis- the management function.
Recording Services rendered.

- Essentially a Line List of Services Given /Health Events.
- Six to ten columns:
  1. Name of person,
  2. age of person,
  3. sex,
  4. Identification No if any (not to be filled up then)
  5. community/economic status/rural or urban ??- in hospital this would come from registration counter
  6. service rendered (immunisation, ANC, contraceptive distribution, sputum collected, or blood tested, assisted delivery, curative care rendered etc.)
  7. to 10: Remarks/other dimensions- eg in labour room register- type of delivery, complication, breastfeeding in first hour, weight of child-relates to outcome of care and health data needed for follow up
In the hospital out patient

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Name of person,</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Identification No.( case sheet no.)- this would be able to get community, urban- rural and BPL status.</td>
</tr>
<tr>
<td></td>
<td>Age of person,</td>
</tr>
<tr>
<td></td>
<td>sex,</td>
</tr>
<tr>
<td></td>
<td>Diagnosis- one of the accepted statements with codes</td>
</tr>
<tr>
<td></td>
<td>service rendered: investigation ordered, prescription given, procedure done, follow up date</td>
</tr>
<tr>
<td></td>
<td>Other Health Data Needed for follow up- in case there is no retrievable case sheet system</td>
</tr>
</tbody>
</table>
The ANM has to visit many villages and would therefore need something very portable— a single book— not a set of 18 registers— to carry to each place.

Normally she enters it in a diary and then comes back to center and enters it into appropriate registers.

- Since the diary is not formatted— she would miss out on many data elements and then try to fill it up from memory.
- Cross-posting could be difficult— since there are no reference numbers and providing numbers itself could be a challenge.
- And entering directly into the tracking register is impossible too-

Solutions: 1. Monthly Service Register or 2. One Register or two registers per anganwadi-1000 population with all three components in them or 3. Set of five registers with all three components in each
The tracking function:

- Whom to track? For what to track?
- A series of services have to be given. To ensure all elements of the package are actually delivered – over repeated visits.
- First five columns same as service delivery register.
- Then one column for each service- with or without date on which the service was delivered. Instead of yes or no one can write the date.
- One column each for derivative data- eg full immunisation, ante-natal care in first trimester- for ease of computing from tracking register.
Monthly Computing format

- There should be a computing form in each register.
- Preferably bound as part of the service delivery register.
- One computing form for each month - identical with reporting format. Except that one could get disaggregated data, where relevant, and sum up the data to be reported.
- Part of the numbers would come from service delivery register and part would come from tracking register, and part would be a combination of both. Go back and improve these two registers so as to make computing easy.
The Bind: organisation of records- for the sub-center

Kept at the sub-center.

- Demographic data base plus eligible couples- gives to base line figures and the ID nos.- also captures baseline changes- births, deaths, marriages, migrations.- Filled up once a year and then updated.

- The Pregnancy Tracking Register.

- The Child Tracking Register

- The Labour Room Record- for home and SC

Taken with her to the service delivery point.

- The Service Delivery Register- line list of services given.

- The Daily Events Register- Line list of Births, Deaths, Marriages, Also records: Meetings, OP cases, home visits.- may separate these if she is the official data collector for births and deaths.

There are many alternative ways of doing this.
The Organisation of records in the hospital

- Ideally through a Hospital management information system.
- Or else service delivery registers for each ward/activity
- Case sheets and data bases for tracking patients
- And then a mechanism of facility level aggregation.
God... at least in HMIS... lives in the details...!!!

Thank You