Streamlined records benefit maternal and child health care

In order to simplify the collection, recording and reporting of information on maternal and child health care in a rural area of India, a home-based mother and child card and a tally sheet were introduced. This has made it possible for the community to evaluate the services provided.

Health information is vital not only for central policy-making and planning but also for the monitoring and evaluation of services in communities. In India, data are collected in vast amounts but are mostly incomplete, unreliable and unused. The number of health programmes has increased over the years, and the people who implement them at grass-roots level often feel overburdened with the collection and recording of data.

A cumbersome system...

A study was made of information relating to maternal and child health which was recorded in five of the eight primary health centres in Ambala District, Haryana, India. Vital events were grossly underreported. Whereas the records showed a birth rate of 18 per 1000 and an infant mortality rate of 20 per 1000 live births, a sample survey of households indicated values of 34.4 per 1000 and 51 per 1000 respectively.

A review of the recording and reporting system was conducted in ten subcentres, each serving some 5000 people in four to six villages. The registers maintained by health workers were examined, and the opinions of these workers, as well as those of their supervisors and of medical officers, were sought on the information system, the difficulties of recording and reporting, and ways of improving the system.

The health workers maintained separate registers of records relating to families, births, deaths, couples eligible for family planning, antenatal women, postnatal matters, immunization, stocks of medicines, and patients, and a diary of visits was also kept. Similar entries were often made in several registers. For example, births were recorded in the births, immunization, postnatal, eligible couples, and family registers; if a baby died, an entry was also made in the deaths register.

All records were incomplete, and this was especially true of the family register. The health workers felt that the procedure was too cumbersome and time-consuming. There were no printed forms, and shortages of stationery led to registers being
maintained on loose sheets. The supervisors experienced difficulty in acquiring information from the health workers.

...simplified

Given the above findings it was decided to simplify the collection and reporting of information. A home-based mother and child card, modelled on previously developed record cards (1-3), and a tally sheet were introduced in ten subcentres after the staff had been retrained. The family register, diary of visits, and registers of patients and stocks were retained. The card, which was given to every pregnant mother at the time of registration, had sections dealing with the following matters: identification data and previous obstetric history; events of current pregnancy and delivery; child’s growth chart; child’s immunization record; contraceptive use; mother’s health status; and referral advice. The tally sheet provided a record for each village of items for which data were obtained.

Separate family registers were established for each village and alphabetical lists of heads of household were drawn up. The information entered in these registers covered immunization status, pregnancies, contraceptive use and vital events. The family registers were completed within a month at the beginning of the year.

Thereafter, information on vital events and services rendered was recorded every day in the diaries of house visits and the patients’ registers. Each service, whether provided during house visits or in clinics, was recorded on home-based mother and child cards. At the end of each day, information from the diaries and patients’ registers was entered in the family register, and the tally sheets were completed. On the last day of each month the tally sheets were given to the supervisors, who discussed them with the health workers and compiled reports for submission to the medical officers of the primary health centres.

Fourteen health workers were interviewed after six months: all said that the new system was simpler and that information retrieval and reporting were easier than formerly. However, of the 14 family registers inspected, only seven had been kept up to date. The tally sheets were properly completed by all workers but the under-reporting of vital events continued, with values of 24.4 per 1000 for the birth rate and 22.5 per 1000 live births for the infant mortality rate.

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Most governments have adopted primary health care and have given special attention to the involvement of communities in the planning, implementation and evaluation of services. In general, however, little information on health is available for use by members of communities, and what is gathered by health workers is, for the most part, transmitted only to the central authorities.

In the present case a bottom-up approach was used to develop a community-based information system, the ideas for which came from health workers. Previous duplication of records was avoided, as was
the need to retrieve information from various sources for the purpose of making reports. The introduction of tally sheets saved a lot of time. Supervisors received performance data at village level and were enabled to compare coverage in difficult and remote villages with that in subcentre villages.

The main advantage of the system is that mothers are given a card detailing the services rendered. In this way, information is transmitted to the community. The card also helps to coordinate the efforts of various agencies providing maternal and child health services: by consulting it, each provider can discover what services have already been obtained. In addition, the card is an educational tool, reminding mothers about the services needed by them and their children, and it serves as a check-list for health workers in respect of services that have to be provided. The community can use the home-based information for evaluating the services provided to mothers and children. An evaluation in the areas of two primary health centres covering nearly 200,000 people revealed that 46% of antenatal women had been given a home-based mother and child card during the first year of the programme.

A major drawback was that senior administrators gave little attention to data on vital events; they were more interested in service statistics, especially those related to family planning. Health workers consequently received the impression that the collection and reporting of data on vital events were not important activities. Vital events were grossly underreported, even after the introduction of simplified procedures. In order to strengthen the information system, commitment at the highest level and improved supervision are essential.

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References