**ABSTRACT**

Hospital record is the most important document which gives information about the patient’s health in past and present. The aim is to have one record from conception to death. The National Health Policy of Nigeria, 2017 emphasizes that there should be electronic database at all health care systems up to district level by 2020. This study was conducted at selected public hospitals in Sokoto state to assess the usage and challenges in implementing electronic health management system. It was found that only 23% of the respondents were using Electronic Health Record (EHR) and the rest were using the manual record system. Hospitals where EHR was not implemented had about 96% respondents willing to shift to electronic method from the manual method. The reasons identified for delay in implementing EHR were lack of approval from authorities (15%), software not user friendly (80%) and lack of funds (5%). It was found that it is easier to use EHR in health centers with lesser number of patients when compared to health centers where large number of patients had to be examined every day. The other areas of concern were that the software should be user friendly along with proper training on using EHR, good and fast network connectivity which would enable quick access to the past records of the patient and also enable quick storing of records. Making EHR usage mandatory in all health centers will fasten the procedure to shift from manual to electronic system of health records and can further lead to inter-operability.

* 1. **Introduction**

Health Record of any individual is a record which maintains all health details of an individual from conception or birth till death of that individual. This record includes all health diagnosis reports, doctors’ review on the health of the individual, vaccination and also regular check- up done at home. Hospital records when maintained electronically helps the physicians in faster diagnosis and cuts down costs for unnecessary repetitive an Electronic Hospital Record (EHR) needs to be maintained with some standards, which will help health centers to maintain inter-operability. There is a need to have pre-defined standards for information capture, storage, retrieval, analytics and exchange and it includes text, images and clinical codes which are used globally. HIMSS defines inter-operability (2013) as the ability of different information technology systems and software applications to communicate, exchange data, and use the information that has been exchanged. Data exchange schema and standards should permit data to be shared across clinician, lab, hospital, pharmacy, and patient regardless of the application or application vendor. In a country like India in remote and hilly regions the access to networks is very low.

In the areas where interoperability is possible, use of similar structures and common vocabulary or codes will be better understood (example SOMED CT (Systematized Nomenclature of Medicine Clinical Terms) or ICD 10 (International Code for Diseases, Version 10).

To achieve complete inter-operability, multiple layers of network transfer protocol will be required along with standardized data information, description, vocabulary and code sets. This will also require continuous up gradation of the software, rules and regulations, codes and guidance from the authorities. Health Record Systems have to be secured by all means and cannot be accessed without proper authorization. Hence, the healthcare providers have to consider the following security measures:

* 1. Statement of problem

Electronic Health Records have been proposed by Ministry of Health Affairs, standards are being set, and both public and private hospitals have to implement the standards. Although electronic mode of patient registration, billing and accounting have been implemented we still find that patients have to physically carry all the records of test reports and the history of health while visiting the doctors. There is no interoperability available.

This study makes an attempt to assess the issues and challenges in implementing electronic hospital records.

* 1. **Purpose of study**

The purpose of this study is to find the prevailing health record system in public hospitals in Gagi general hospital sokoto. Further, to study the implementation of electronic health record system, its implications and barriers in implementation.

**1.4 Significance of the Study**

The health policies by the Government of Sokoto state aims at having complete EHRs at all health centers through the state. This study is conducted at few public hospitals from different administrative sections of Sokoto south local government which can be representative of the population. The study aims to bring out the experiences of the people using EHR to maintain health records, the problems if any, in using EHRs and the problems faced for implementing EHRs. This study will help various stakeholders involved in implementing EHRs to understand the problems faced in implementing and using EHRs.