Federal Ministry of Health

National Health Management Information System

Instructional Manual for Facility – based NHMIS tools

Acknowledgment

The National Health Management Information System, is intended to provide information on health service delivery and the health system that supports it in a timely and reliable manner. The continuous improvement in quality of health service and program planning is dependent on the reliability of the health information system.

The Federal Ministry of Health wishes to specially acknowledge the contribution of Malaria Action Program in State (MAPS) in providing technical assistance in the revision of this instructional manual. We also appreciate the contributions of GFATM, USAID, PATHS 2, PPRINN-MNCH and the UN system for supporting the Health Management Information System in Nigeria.

It is our hope that this instructional manual will encourage uniformity and good understanding on how to fill the NHMIS routine data collection tools as well as data transmission and management.

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Table of Contents

Introduction

THE HEALTH FACILITY DAILY GENERAL ATTENDANCE REGISTER

Context of use

- The daily general attendance register should be kept at the Records Department
- The health facility daily general attendance register should be completed by the officer in charge of records during each visit.
- The register ***must be filled at every contact of the patient/client with the health facility***. ***Please note that all patients/clients that come to the facility to access service must be entered into this register. However, patients coming in for wound dressing and follow up injections should not be registered again.***

Importance

- It is used to collect information on the utilization of health facility.
- It shows the distribution of people utilizing the facility by age and sex
- It is used for planning activities at the health facility.
- It is important for advocating for support and funding of health activities at the facility
- It aids follow-up of the patients attending for care at the facility

How to Fill the Daily General Attendance Register

The Daily General Attendance Register is grouped into three sections.

Head

This contains the identification and general information about the health facility;

1. State: Enter the name of the State in which the LGA is located.

2. LGA: Enter the name of LGA in which the ward is located.

3. **Ward:** Enter the name of the political ward in which the above Health Facility is located.

4. Health Facility: Enter the name of the Health Facility for which these records are being compiled.

5. Month/Year: Enter the month and the year for which the records are being entered on each sheet. ***Please note: each month should start on a new page.***

Body

This is made up of the various data elements which the register seeks to obtain for the patient/client.

6. Serial Number: This is the number given in the order in which patients/clients were seen during the day. The first person to receive any service in a month is given the number "1" and others follow in ascending order until the end of the month. At the beginning of each month, a new page of the register will be opened and the serial number begins from "1"again.

7. Date: Enter the date that the patient/client attended the health facility in the format - dd/mm/yy

8. Name of Patient/Client: Enter the name of the patient (surname first)

9. Patient/Client Card Number: Enter the patient's number from the patient's card

10. Date of Birth: Enter the patient's date of birth by day/month/year respectively. In the situation where the exact day and/or month of birth cannot be obtained, the year should be filled in.

11. Male: This column is sub - divided into five age grouping. Tick the appropriate age group of the male patient/client.

12. Female: This column is sub - divided into five age grouping. Tick the appropriate age group of the female patient/client.

13. Contact Address: Enter the residential address of the patient/client.

14. State of Origin: Enter the State of Origin of the patient/client

15. Telephone Number: Enter the telephone number of the patient/client.

16. First Contact with Facility: This column is sub - divided into two to indicate whether the patient/client is coming to this health facility for the first time ever. Tick 'Yes' if that is the first time ever the patient/client is coming to the health facility to access service or 'No' if otherwise.

17. Referred In: Record "Y" for Yes if the patient or client was referred in with a referral slip or note from another facility or community service or "N" for No if otherwise.

18. Information on Next of Kin: This column is sub - divided into four to indicate Name, Relationship with Client, Contact Address and Telephone number of the next-of-kin.

Name: Enter name of next-of-kin of the client/patient in the column.

Relationship with client: Enter relationship between the next-of-kin and the client (e.g. Husband, Wife, Child etc.) in the column.

Contact Address of Next–of–Kin: Enter the contact address of the patient/client's next-of-kin in the column.

Telephone Number: Enter the telephone number of the next-of-kin to the patient/client in the column.

Tail

This contains the authentication part of the register.

19. Name of Reporting Officer: Enter the name of reporting officer on the last sheet used for the month

20. Designation: Enter the designation (e.g. OIC, Facility M&E e.t.c.) of the reporting officer on the last sheet used for the month.

21. Signature: Enter Signature of Reporting Officer on the last sheet used for the month.

22. Date: Enter the date this tail end (authentication part) of the register was filled.

THE HEALTH FACILITY DAILY OUT-PATIENT DEPARTMENT (OPD) REGISTER

Context of use

- The Daily OPD Register should be kept at the Outpatient Department
- The health worker attending or the record officer attached to the OPD department should complete the health facility daily OPD register.
- The register should be filled as the health worker is attending to the patient/client and completed immediately after the investigation and/or treatment for the patient/client.
- Start each month on a new sheet of the register.

Importance

- It is used in collecting information on the outpatient services provided at the facility
- It is used for planning activities at the OPD
- It shows the drugs needs/used at the OPD
- It exposes the disease pattern at the health facility
- It is important for advocating for support and funding of health activities at the facility
- It aids follow-up of the patients attending for care at the facility

How to fill the Daily OPD Register

The daily OPD register is grouped into three sections.

Head

This contains the identification and general information about the health facility;

1. State - Enter the name of the State in which the LGA is located.

2. LGA – Enter the name of LGA in which the ward is located

3. Ward – Enter the name of political ward in which the above Health Facility is located

4. Health Facility – Enter the name of the Health Facility for which these records are being compiled.

5. Month/Year – Enter the month and the year for which the records are being entered on each sheet.
Please note: each month should start on a new page.

Body

This is made up of the various data elements which the register seeks to collect about the patient/client.

6. ***Serial No. –*** This is the number given in the order in which clients were seen during the day. The first person to receive services in a month is given the number 1 and others follow in ascending order until the end of the month. At the beginning of each month, a fresh sheet of the register will be used and the serial number begins from "1"again.

7. Date - Enter the date of consultation in the format- day/month/year – (**dd/mm/yy**)

8. Name of Patient/Client - Record the name of the patient/client (surname first).

9. Patient number - Enter the client's number as stated in his/her OPD card.

10. Sex (F/M) - Write M for male client/patient and F for female client/patient.

11. Age Enter the patient's age in years as at last birthday, in months for children less than a year and in days for children less than a month. Indicate "y" , "m" and "d" for years, months and days respectively.

12. Type of attendance - Tick (✓) "New" if the patient is attending the OPD for the first time on the episode of presenting complaints and tick (✓) "Follow up" for a follow up patient on the same episode of presenting complaint.

13. **Presenting complaints** – In concise terms, write the complaints the patient presents during consultation e.g. Abdominal pain, fever.

14. Diagnosis - Write the diagnosis made by the attending health worker.

15. Type of laboratory investigation done - List the laboratory investigation(s) done as requested by the attending health worker

16. Drugs Given- List the prescribed drugs and put a tick on those dispensed to the client/patient in the facility. *Please note that when ORS is given for treatment of diarrhoea and recorded in this column, it should be indicated whether the ORS was low osmolar or not.*

17. Outcome of visit- Tick (√) the appropriate cell/box for the outcome of the visit. (NT) for Not Treated, (T) for Treated, (A) for Admitted and (D) for Discharged. For Referred Out (RO), write "FT" for patients referred for further treatment, "ADR" for patients referred out due to Adverse Drug Reaction specifying class of drug (e.g. ADR – antimalarial), and "PRC" for women referred out for pregnancy – related complications.

Please note that more than 1 row on the register can be used for a patient if needed. However, if more than 1 row is used, care should be taken not to put ticks or entries in all the rows used for the patient thereby causing multiple counting.

Malaria:

This column is further divided into five columns

18. **Clinical Diagnosis only:** This column should be filled ONLY if ***NO malaria test (microscopy or RDT) was done prior to giving treatment for malaria***. Tick (√) the appropriate column for patients under five (5) years, tick in"<5 yrs" for those 5 years and above ***excluding*** pregnant women, tick in "≥ 5yrs") and for pregnant women, tick in "PW".

19. Laboratory Diagnosis of Malaria: *This column should be filled ONLY* ***when malaria tests (microscopy or RDT) are done before malaria treatment is given.***

RDT – If RDT (malaria Rapid Diagnostic Test) was done for the patient, write *"+ve*" for positive result and *"-ve*" for negative result under the appropriate age column (i.e <5 yrs or ≥5 yrs)**.**

Microscopy – If Microscopic examination for malaria parasite was done for the patient, write *"+ve*" for positive result and *"-ve*" for negative result under the appropriate age column (i.e <5 yrs or ≥5 yrs)**.**

20. **Confirmed Uncomplicated Malaria:** This column should be filled ONLY ***when laboratory diagnosis for malaria reports positive and there are no medical complications*****.** Tick (√) the appropriate column; for patients under five (5) years, tick in"<5 yrs"; for those 5 years and above and female not pregnant, tick in "≥ 5yrs" and for ***ALL*** pregnant women that are found to be positive when tested for malaria, tick (√) the column"PW".

21. Severe Malaria: This column should be filled ONLY ***when laboratory diagnosis for malaria reports positive and there are medical complications (convulsion, vomiting, severe anaemia etc)*****.** Tick (√) the appropriate age column; for pa ents under five (5) years, d(√)"<5 yrs" and for those 5 years and above tick (√) "≥ 5yrs". *Please note that pregnant women diagnosed with severe malaria are included in ≥5yrs*

22. ***Tick if ACT is given -*** If Artemesinin based Combination Therapy (ACT) is given to the patient, then record in this column. Tick (√) the appropriate age column; for pa ents under five (5) years, and for those 5 years and above .

23. ***Tick if any other antimalarial is given*** – If any antimalarial is given other than ACT (e.g. Quinine) is given to the patient, tick (√) this column. *Note: this column is not disaggregated by age.*

HIV Counselling and Testing

24. HIV counsel, test & result: Tick (√) in the appropriate age group for a ***MALE*** patient/client that was counselled, tested for HIV and received the result irrespective of the outcome.

25. HIV test result: positive: Tick (√) in the appropriate age group for the ***MALE*** patient/client that was screened for HIV and the test result was positive.

26. **Female non-pregnant - HIV counsel, test & result:** Tick (√) in the appropriate age group for a ***Non-pregnant FEMALE*** that was screened for HIV and received the result irrespective of the outcome.

27. **Female non-pregnant - HIV test result: positive:** Tick (√) in the appropriate age group for a ***Non-pregnant FEMALE*** that was screened for HIV and the test result was positive.

28. **Couple Counselling & Testing**: Tick (√) if a client and his/her partner were counselled and tested for HIV at the same time at the health facility. *Note* Bracket (**}**) the rows for the clients that make a couple and place just one tick for all the "couple" in this column.

29. **Couple Sero–discordant test**: Tick (√) if a client and his/her partner that were tested for HIV at the same time were sero–discordant (i.e. one tested HIV positive while the other tested HIV negative).

HIV Clinical care & treatment: This section is further divided into two columns and is *filled if HIV clinical care and treatment service was given to the patient during that visit to the Health Facility:*

30. **HIV positive and receiving CTX:** Tick (√) in the appropriate age category- less than 15 years and 15 years and above if the HIV positive MALE OR FEMALE patient/client received CTX (Cotrimoxazole) in the health facility that day within the month of reporting.

31. **Receiving ARV refill:** Tick (√) in the appropriate age category- less than 15 years and 15 years and above if the HIV positive MALE OR FEMALE patient/client received ARV (Antiretroviral) refill in the health facility that day within the month of reporting.

SRH/HIV Integration: This section is further divided into four sections

32. **HCT clients provided with SRH/HIV integrated Services:** Tick (√) if the MALE OR FEMALE patient/client is a HCT client that also accessed SRH/HIV Integrated Services (Family Planning method and STI) during the visit.

33. **HCT clients referred for Family Planning method**: Tick (√) if the MALE OR FEMALE HCT patient/client was referred to access Family Planning method.

34. **HCT clients screened for STIs:** Tick (√) if the MALE OR FEMALE HCT patient/client was also screened for STIs.

35. **HCT clients treated for STIs:** Tick (√) if the MALE OR FEMALE HCT patient/client was also treated for STIs.

TB/HIV*:* This section is sub divided into three sections

36. **Clinically screened for TB*:*** Tick (√) if the HCT client was clinically screened for TB

37. ***TB clinical screening score (Enter 0 or +1):*** This column will be filled if the HCT client was clinically screed for TB. Enter score '0' if the screening result was negative or '+1' if the clinical screening revealed symptoms or signs of TB infection.

38. **HIV positive receiving ART and TB treatment**: Tick (√) if the client is HIV positive and is receiving both ART and TB treatment.

Tail: This contains the authentication part of the register.

Name of Reporting Officer: Enter the name of reporting officer on the last sheet used for the month

Designation: Enter the designation (e.g. OIC, Facility M&E e.t.c.) of the reporting officer on the last sheet used for the month.

Signature: Enter Signature of Reporting Officer on the last sheet used for the month.

Date: Enter the date this tail end is filled.

THE HEALTH FACILITY DAILY IN-PATIENT CARE (IPC) REGISTER

Context of Use

- The Daily IPC register should be kept at the In-Patient Ward
- The health facility daily IPC register should be completed by the officer attending to the patient during admission or by the record officer attached to the In–Patient Care unit.
- The register should be filled as the officer is attending to the Patient and completed immediately after the investigation and/or treatment of Patient.

Importance

- It is used in collecting information on the inpatient services provided in the facility.
- It is used for planning activities at the IPC Ward
- It shows the drugs needs/used at the IPC Ward
- It shows the type of diseases treated at the health facility
- It shows the bed utilization (occupancy rate)
- It is important for advocating for support and funding of health activities at the facility
- It aids follow-up of the patients attending for care at the facility

An inpatient is a person who occupies a bed in a health facility for the purpose of treatment. Where a patient is admitted on the expectation that he or she will remain overnight, but the patient dies or is discharged before the midnight census, the patient should still be regarded as an inpatient, whether or not a hospital bed is occupied or treatment is provided. However, patients who are held for observation in the Emergency Department or other observation areas, pending a decision whether to admit to an inpatient bed should ***NOT*** *regarded as inpatients.*

How to Fill the Daily IPC Register

The daily IPC register is grouped into three sections:

Head

This contains the identification and general information about the health facility;

1. State: Enter the name of the State in which the LGA is located.

2. LGA: Enter the name of LGA in which the ward is located.

3. **Ward:** Enter the name of ward in which the above Health Facility is located.

4. Health Facility: Enter the name of the Health Facility for which these records are being compiled.

5. Month/Year: Enter the month and the year for which the records are being entered on each sheet.

Please note: each month should start on a new page.

Body

This is made up of the various data elements which the register seeks to obtain for the patient.

6. Serial Number: Enter serial number according to how patients are admitted. Numbers are entered in ascending order in this column

7. Date of Admission: Enter the date of admission of the patient in dd/mm/yy

8. Name of Patient: Enter the name of the patient (surname first)

9 Patient Number: Enter the patient's number from the patient's card

10. Sex: Enter the patient's sex either male (M) or female (F)

11. Age: Enter the patient's age in years as at last birthday, in months for children less than a year and in days for children less than a month. Indicate "y", "m" and "d" for years, months and days respectively.

12. Diagnosis: Enter the diagnosis made by the health worker on admission of the patient.

12. Admission Outcome: Enter as appropriate under each item. This column is sub- divided into four: A. Absconded (ABC), b. Discharged (DC), c. Referred (R) and d. Dead (D). In this section one of these four columns is filled by writing the date depending on the outcome for the patient. For example if the patient dies while on admission the column "Dead (D)" is filled by writing the date but if the patient is discharged home in good condition, the column "Discharged (DC)" is filled by writing the date in the format – dd/mm/yy.

13. Laboratory test (Specify): Enter the type of laboratory test carried out on the patient and indicate the result.

14. Drugs given (Specify): Enter the drugs prescribed by the health worker and put a tick on those dispensed.

Note: ***Since a new month is expected to be filled on new sheets, information of patients that are still on admission at the end of the month should be moved into the new sheet for the following month. However, serial numbers should not be assigned to them and they should not be counted as part of the new admissions for that following month.***

Tail

This contains the authentication part of the register.

15. Name of Reporting Officer: Enter the name of reporting officer on the last sheet used for the month

16. Designation: Enter the designation (e.g. OIC, facility M&E e.t.c.) of the reporting officer on the last sheet used for the month.

17. Signature: Enter Signature of reporting Officer on the last sheet used for the month.

18. Date: Enter the date this tail end is filled.

THE HEALTH FACILITY DAILY ANTE NATAL AND POST NATAL CLINIC (ANC & PNC) ATTENDANCE REGISTER

Context of use

- It will be used by the health care worker providing ANC services in the Health Facility
- It should be filled daily by the health care worker when such a service is provided. In the case that services are provided on certain days, the register is only required to be filled on such days.
- Register is kept in the section that provides ANC services.
- All ANC components and activities are dependent on the accuracy and quality of data recorded in the register
- A record personnel will be responsible for collecting the register from the unit at the end of the month and use such entries to complete the ANC section of the health facility summary form

Importance

- Used to document ANC health services provided to pregnant women in the health facility
- Used to prepare summary forms for onward transmission to the LGA
- Provide in a single location data on ANC services
- Used to determine the utilization of ANC services
- Provides the Health facilities with a picture of the health status of the communities within their catchment areas.
- Enables facilities take appropriate action based on the information generated

How to Fill the Daily ANC Register

The register is divided into 3 sections:

- The head or identification section
- The body contains the information regarding the various clients who receive ANC services
- The tail which details authentication of the information recorded in the register

HEAD

This contains the identification and general information about the health facility:

1. State - Enter the name of the State in which the facility is located.

2. LGA – Enter the name of LGA in which the facility is located

3. Ward – Enter the name of political ward in which the Health Facility is located

4. Health Facility – Enter the name of the Health Facility for which these records are being compiled.

5. Month/Year – Enter the month and the year for which the records are being entered on each sheet.
Please note: each month should start on a new page.

BODY

6. **S/N:** Record the serial number given to a client when entering the data into the register. The first person to receive services in a month is given the number 1 while others follow in an ascending order until the end of the month.

7. Date: Record the date that the patient/client attended the health facility in the format - dd/mm/yy

8. Name of client: Record the name of patient/client by capturing the surname first.

9. Client number: This is stated as the number given to client on their first visit to the clinic. Simply check the number from the client ANC card and record it.

10. Age: This is the age of the client as at last birthday in years and this can be obtained from the ANC card given to the mother during her first visit.

11. Type of visit: Tick (√) in the appropriate column as applicable whether the client is coming for antenatal clinic or post natal visit. This section is meant to state the type of visit of the client. The client may either be attending either the antenatal or post natal clinic.

12. Parity: This is the number of times the woman has carried a pregnancy beyond 28 weeks . It is obtained from the ANC card.

13. Antenatal clinic attendance: This column is meant to describe whether the client is visiting the facility for antenatal care for the first time or on subsequent visit or follow up for this present pregnancy;. Tick (√) in the appropriate column; new (N) for first visit or revisit (R) for follow up.

14. Age of pregnancy (in wks.): This is the gestation period of the pregnancy. Record the age of pregnancy in weeks.

15. No. of antenatal clinic visit(s) to date: This is the number of times a pregnant woman has visited the health facility for antenatal care in the present pregnancy. Record from the ANC card the number of visits the woman has had to date e.g. 1 for the first visit, 2 for second visit, 3 for third visit etc. Note that this is inclusive of the visit on the day of reporting.

16. ANC HIV counselling and testing: This column is sub–divided into three and is used to record HCT services rendered to ANC clients. The first column (Previously known HIV positive status); tick (√) if the pregnant woman knows that she is HIV positive. The second column (ANC HIV counselled, tested and received result); tick (√) if the pregnant woman was counselled, tested and she received her result during that ANC visit. The third column (HIV test result positive); tick(√) if the HIV test result of the client done in that ANC visit is positive.

17. ANC HIV Partner Testing: This column records the HIV status of partners' of ANC clients and it is sub – divided into two. The first column (partners of HIV positive pregnant women); tick (√) appropriately (tested negative or tested positive) if the test result of the partner of HIV positive pregnant woman is positive or negative. The second column (partners of HIV negative pregnant women); tick(√) appropriately (tested negative or tested positive) if the test result of the partner of HIV negative pregnant woman is positive or negative.

18. Syphilis Testing and Treatment: This column is sub – divided into two. Column 18a; Tick(√) as appropriate (not done, positive or negative) the result of the syphilis test done for the pregnant woman during that ANC visit. Column 18b; Tick (√) if the pregnant woman was treated for syphilis during that ANC visit.

19. HB/PCV: In this section, record the result of the Hb/PCV test done for the antenatal client during that visit and also indicate if the pregnant woman is anaemic or not.

20. Urinalysis: In this section, record the result for urine test for sugar and protein done for the client during that visit. The result of the laboratory test is recorded in the appropriate column; in addition, indicate if there is protein in the urine of the pregnant woman in column 20 (proteins).

21. LLIN given: Tick (√) if long lasting insecticidal net is given to the client during the antenatal visit.

22. Doses of IPT given: IPT (Intermittent Preventive Therapy) is given to pregnant mothers at least two times in the course of pregnancy at quickening (usually at 16 weeks of gestation) to prevent malaria in pregnancy. The column is sub–divided into two. First column (1^{st}); Tick (√) if the client received the 1^{st} IPT dose during the visit. Second column (2^{nd}); Tick(√) if the client received the second dose of the IPT dose during visit.

23. Haematinics (Iron and folate): Tick (√) if IFAS (iron and folate supplementation) was given to the ANC client during the visit.

24. Tetanus Toxoid (TT): Tetanus toxoid is given to a pregnant woman to prevent tetanus infection. It also helps to prevent neonatal tetanus in the newborn. A woman of child bearing age requires 5 doses of TT to provide life time immunity from tetanus infection. Record the particular TT dose (TT1, TT2, TT3, TT4 or TT5) administered to the client during the visit. The table below is the recommended schedule for TT immunization.

TT1	At first contact with women of childbearing age or as early as possible during pregnancy (1^{st} dose at booking)
TT2	At least 4 weeks after TT1
TT3	At least 6 months after TT2
TT4	At least 1 year after TT3
TT5	At least 1year after TT4
Booster:	Every 10 years

25. Associated problems: Record the diagnosis made from presenting complaints of the pregnant woman associated with the pregnancy in this column. This can be obtained from the ANC card.

26. Outcome of visit: This section records the outcome of the visit with respect to the associated problems. Tick (√) as appropriate either; Treated (T), Not treated (NT), Admitted (A) or Referred out (RO). If client was referred out, state reasons for referral in the referred out column.

27. Postnatal visits: This is used to document a client who returns for post natal care. This column is divided into 2 (Mother & newborn and Newborn care).

The Mother & newborn column is further subdivided into three. Tick(√) as appropriate (1 day, 3 days and 7 days & after) the time interval after birth that the mother is returning for post natal visit.

The Newborn care column is subdivided into two. First column (Neonatal complications) - Tick(√) appropriately (Neonatal sepsis, Neonatal tetanus or Neonatal jaundice) if the baby presents with either of these conditions during the PNC visit.
Second column (KMC) - Tick(√) appropriately (admitted (A) or discharged (DS)), if a low birth weight baby given kangaroo mother care was admitted or discharged.

NB: *KMC is an intervention for Low birth weight (LBW) babies between 1.8kg – 2.5kg. If the LBW baby is Stable, the child is discharged from the health facility and mother can continue KMC at home. If baby has complications, the child is admitted in the health facility and KMC is continued, especially in health facilities that do not have incubators*.

TAIL

This contains the authentication part of the register.

28. Name of Reporting Officer: Enter the name of reporting officer on the last sheet used for the month

29. Designation: Enter the designation (e.g. OIC, Facility M&E e.t.c.) of the reporting officer on the last sheet used for the month.

30. Signature: Enter Signature of Reporting Officer on the last sheet used for the month.

31. Date: Enter the date this tail end is filled.

Daily Labour and Delivery Register

Context in which the tools will be used

- This register will be used by Health workers providing LD services and completed daily in the Health Care facility
- Information in the register pertains only to LD services provided at that facility
- Used to prepare HF monthly summary which tracks LD services
- The register is kept at the facility in the section that provides LD services

Importance of the Labour and Delivery Register

- Used to document Labour and Delivery services provided to women in the health facility
- Used to prepare monthly health facility summary for onward submission to the LGA
- Compiles Labour and Delivery data in a single location
- Used to determine the utilization of Labour and Delivery services
- Provides health facilities with a picture of the Labour and Delivery LD within their catchment areas.
- Enables facilities take appropriate action required in Labour and Delivery based on the information generated

How to Fill the Daily LDR Register

The register is divided into 3 sections:

- The head or identification section
- The body contains the information regarding the various clients who receive ANC services
- The tail which details authentication of the information recorded in the register

How to enter data into the register

HEAD

This contains the identification and general information about the health facility:

1. State - Enter the name of the State in which the LGA is located.

2. LGA – Enter the name of LGA in which the ward is located

3. Ward – Enter the name of political ward in which the above Health Facility is located

4. Health Facility – Enter the name of the Health Facility for which these records are being compiled.

5. Month/Year – Enter the month and the year for which the records are being entered on each sheet.
Please note: each month should start on a new page.

BODY

6. **S/N:** Record the serial number given to a client when entering the data into the register. The first person to receive services in a month is given the number 1 while others follow in an ascending order until the end of the month.

7. Date: Record the date that the patient/client attended the health facility in the format - dd/mm/yy

8. Name of client: Record the name of patient/client by capturing the surname first.

9. Patient number: Record the number assigned to the client as stated on the client's ANC card.

10. Age: Record the age of the client in years as stated on the client's ANC card

11. Type of Client (Booked/un-booked): A booked woman is one who has registered for antenatal and has made at least 2 ANC visits. Enter "Booked" for a previously booked client and "un-booked" for un-booked client

12. **Parity:** Enter the number of pregnancies the client has carried beyond 28 weeks. It is obtained from the ANC card

13. HIV Counselling, Testing at L&D: This column is divided into three. Tick(√) as appropriate (Previously known HIV positive status, HIV counselled, tested &received results or HIV tested positive at L&D).

14. Date of Delivery: Enter the date the baby was born in the order dd/mm/yy eg. 30/01/13

15. Mode of Delivery: (Write SVD, CS, AD as appropriate). Write the method of delivery – "SVD" for normal / Spontaneous Vaginal Delivery, "AD" for Assisted Delivery or "CS" for Caesarean Section.

16. Partograph used? (Y/N): Enter "Y" if partograph was used during delivery and "N" if partograph was not used.

17. Active Management of Third Stage of Labour (AMTSL) used?: Enter "Y" if Active Management of Third Stage of Labour (AMTSL) was done during labour and "N" if it was not.

18. Maternal Complications seen: Write the appropriate maternal complications seen during delivery.

APH *for Ante-partum Haemorrhage,* ***PPH*** *for post-partum Haemorrhage,* ***RPC*** *for Retained Product of Conception,* ***PL*** *for Prolonged Labour,* ***PET*** *for Pre-eclamptic Toxaemia,* ***ET*** *for Eclamptic Toxaemia,* ***RU*** *for ruptured uterus,* ***Sep*** *for Sepsis,* ***OL*** *for Obstructed labour,* ***Abt*** *for abortion,*

19. Pregnancy Outcome: This column captures information on the outcome of the pregnancy

19a. Mother: Alive or Dead and if dead, is MDA conducted?: Tick (√)the appropriate column to indicate the status of the mother after child birth (Alive or Dead and if Dead, whether Maternal Death Audit is conducted). For a mother who is alive, tick (√) appropriately to indicate their health condition following delivery (admitted, discharged or referred) Tick (√) if the mother is dead and enter "Y" if Maternal Death Audit was conducted or "N" if Maternal Death Audit was not conducted.

19b. Baby: This shows the status of the baby around delivery. For abortion enter either IA for Induced Abortion or SA for Spontaneous Abortion. Tick (√) appropriately to indicate the status of the baby after delivery (Preterm, Birth Asphyxia, Live birth, Still birth or Dead). ***An Abortion refers to the delivery of a foetus that has not reached 28 weeks of pregnancy. A preterm is a baby delivered before the thirty seven week of gestation. A Still birth refers to the delivery of a foetus that has been taken beyond 28 weeks of pregnancy that was born dead.***

For live birth babies, tick (√) appropriately the birth weight (<2.5 kg or ≥2.5 kg). For still births, write "FSB" for fresh and "MSB" for macerated still births. For babies that died after delivery enter a tick (√) appropriately indicating age at the time of death

20. Sex of baby (M/F): Enter sex of baby as appropriate. In the case of multiple births extra rows are used to document the status of each child M for male and F for female.However, the mother's information is only entered on the first row

21. Who took delivery of child? (Tick as appropriate): Tick (√) "Doctor, Midwife or Nurse" if delivery was taken by either a Doctor, Midwife or Nurse otherwise, tick (√) "Others (CHEW etc)" if birth was taken by others e.g. CHEWS.

22. Immediate Newborn Care Provided (Tick if Baby put to breast within 30 minutes and kept warm): Tick (√) if Baby was introduced to breast within 30 minutes of birth and kept warm

23. Exclusive Breast Feeding/LAM (Tick as appropriate): Tick(√) "counselled" if the mother was counselled for exclusive breast feeding/Lactational amenorrhoea (LAM) and tick (√) "Accepted" if the mother accepted to practice exclusive breast feeding / LAM.

24. Name of person who took delivery: Write the name of the person who took the delivery. If many, the name of the team leader should be written.

The Tail

This contains the authentication part of the register.

Name of Reporting Officer: Enter the name of reporting officer on the last sheet used for the month

Designation: Enter the designation (e.g. OIC, Facility M&E e.t.c.) of the reporting officer on the last sheet used for the month.

Signature: Enter Signature of Reporting Officer on the last sheet used for the month.

Date: Enter the date this tail is filled.

THE HEALTH FACILITY FAMILY PLANNING DAILY REGISTER

Context of use

- This register will be filled by the health care worker providing FP services.
- It will be filled daily by the health care worker when the service is provided; this may be immediately after providing service to the client or at the end of the clinic.
- The register is filled from the Family Planning /Client card
- The register is kept at the Family Planning clinic or at any point where Family Planning services is being offered. It is expected that information in the Family Planning card is confidential, and access to it should be limited to authorized persons.
- The person responsible for record keeping will collate all the information from the Family Planning register into the health facility monthly summary form.

Importance

- Used to document Family Planning services provided to clients in the health facility
- Used to prepare summary forms for onward transmission to the LGA
- Provide in a single location, data on Family Planning services
- Used to determine the utilization of Family Planning services
- Provides the health facilities with a picture of the FP status of the communities within their catchment areas.
- Enables facilities take appropriate action based on the information generated

How to fill the Family Planning Register

The register has three sections:

- The head or identification section
- The body contains the information regarding the various clients who received FP services
- The tail which details authentication of the materials listed in the register

HEAD

This contains the identification and general information about the health facility:

1. State - Enter the name of the State in which the LGA is located.

2. LGA – Enter the name of LGA in which the ward is located

3. Ward – Enter the name of political ward in which the above Health Facility is located

4. Health Facility – Enter the name of the Health Facility for which these records are being compiled.

5. Month/Year – Enter the month and the year for which the records are being entered on each sheet.
Please note: each month should start on a new page.

BODY

6. S/N: Record the serial number given to a client when entering the data into the register. The first person to receive services in a month is given the number 1 while others follow in an ascending order until the end of the month.

7. Date: Record the date of that the patient/client attended the health facility in the format - dd/mm/yy

8. Name of client: Record the name of patient/client by capturing the surname first.

9. Client number: Record the number given to client as stated on their Family Planning client card.

10. Address/Telephone Number: Record the address and telephone number of the client receiving the service.

11. SEX (gender): Record the sex of the client as appropriate under the column; "M" for male and "F" for female.

12. **Age**: Record the age of the client as at last birthday in years.

13. Source: If client is referred, record source of referral. Enter the codes (e.g. PNC- Post natal Clinic, HCT – Counselling and Testing Clinic e.t.c.) as indicated in the base of the each sheet of the register.

14. Parity (for females only): This is the number of times the woman has carried a pregnancy beyond 28 weeks it is obtained from the client's card.

15. Counselled on FP? : Record "Y" (yes) or "N" (no) if the client was counselled on FP during this visit or not.

16. ORAL PILLS: This column is divided into four. Record name of pill if client is receiving oral contraception for family planning. Tick (√) appropriately if the client was a new acceptor (NA) or a revisit (RV) in the health facility. Record the number of cycles given to the client in that visit.

17. INJECTION: This column is divided into three. Record name of injectable if client is receiving injectables for family planning. Tick(√) appropriately if the client was a new acceptor (NA) or a revisit (RV) in the health facility.

18. IUCD: This column is divided into two. First column (IN) - Tick(√) appropriately if the client was a new acceptor (NA) or a revisit (RV) in the health facility. Second column (OUT) – Tick(√) if the client had the IUCD removed.

19. CONDOMS: This column is divided into four. Record type of condom (F or M) if client received male or female condom for family planning in the health facility. Tick(√) appropriately if the client is a new acceptor (NA) or a revisit (RV). Record the number of satchets given to the client in that visit.

20. IMPLANT: This column is divided into four. Record type of implant given if client received implants for family planning. IN - Tick(√) appropriately if the client was a new acceptor (NA) or a revisit (RV) in the health facility. OUT – Tick if the client is removed the implants.

21. STERILISATION: Tick if the client was sterilized for family planning in that visit.

22. NATURAL METHODS: This column is subdivided into two. (i) Cycle beads - Tick(√) appropriately if the client was a new acceptor (NA) or a revisit (RV) in the health facility; (ii) Others - Tick(√) appropriately if the client was a new acceptor (NA) or a revisit (RV in the health facility).

23. NO. OF REFERRAL: This section is used to document referrals (out) made as an outcome of FP visits to the health facility. Tick appropriately if:

- OR = The client was referred for Oral Contraception.
- IJ = The client was referred for Injectables
- IP = The client was referred for Implants.
- IUCD = The client was referred for Intra uterine contraception device.
- SR =The client was referred for surgical procedure (sterilization).
- MR = The client was referred for Medical Conditions relating to FP

24. FP CLIENTS ACCESSED HCT SERVICE: Tick(√) if the FP client accessed HCT service during that visit.

HIV Counselling and Testing (at FP clinic)

25. HIV Counsel, Test and Result (Male): Tick(√) the appropriate age group of the male FP client if he was counselled, tested and received result for HIV.

26. HIV Test Result positive (Male): Tick(√) the appropriate age group of the male FP client if the HIV test done was positive.

27. HIV Counsel, test and Result (Female Non - pregnant): Tick(√) the appropriate age group of the non - pregnant female FP client if she was counselled, tested and received result for HIV.

28. HIV test result positive (Female Non - pregnant): Tick(√) the appropriate age group of the female non – pregnant FP client if the HIV test done was positive.

Tail

This contains the authentication part of the register.

29. Name of Reporting Officer: Enter the name of Reporting Officer on the last sheet used for the month

30. Designation: Enter the designation of the Reporting Officer on the last sheet used for the month.

31. Signature: Enter Signature of Reporting Officer on the last sheet used for the month.

32. Date: Enter the date this tail is filled.

PMTCT/ARV REGISTER (FOR PHCs)

Context of use

- The National Health Management Information System PMTCT/ARV register should be kept at the ANC department
- The National Health Management Information System PMTCT/ARV should be completed daily by the officer in charge of ANC at the end of work every day.
- Entries for a new month should be started on a fresh page.

Importance

- The register should be used to track the prophylaxis given to HIV positive pregnant women and the exposed-infants throughout the gestational and breast feeding period.
- It tracks HIV test of the infants up to 18 months
- It also tracks the HIV status outcome of the infant.
- It is useful in planning activities/interventions of PMTCT and tracking of defaulters.

How to fill the PMTCT/ARV REGISTER (FOR PHCs)

HEAD

This contains the identification and general information about the health facility:

1. State - Enter the name of the State in which the LGA is located.

2. LGA – Enter the name of LGA in which the ward is located

3. Ward – Enter the name of political ward in which the above Health Facility is located

4. *PHC Facility* – Enter the name of the Health Facility for which these records are being compiled.

5. Month/Year – Enter the month and the year for which the records are being entered on each sheet. Please note, a new month should start on a fresh page.

BODY

This consists of the various data elements which the register seeks to obtain.

6. S/N: Record the serial number given to a client when entering the data into the register. The first person to receive services in a month is given the number 1 while others follow in an ascending order until the end of the month.

7. Date: Record the date that the patient/client attended the health facility in the format - dd/mm/yy

8. PHC Card No.: Record the client's number as stated in his/her PHC card

9. ANC Reg. No.: Record the client's ANC registration number from the ANC card (for pregnant females only).

10. Unique ID Number: Enter the client's unique ID number where available

11. **Pregnant women time of HIV diagnosis:** This column is divided into four. Tick(√) appropriately (Previously, ANC, Labour & delivery or 72 hours Postpartum) depending on where the woman was first diagnosed with HIV.

N/B: *Pregnant women with previously known HIV status includes those On ART, On ART Refill or those on referral for HIV related services (with referral forms).*

12. **ART eligibility assessment:** This column is subdivided into three. Tick(√) as appropriate depending on the test the ART eligibility assessment was based; clinical staging if the eligibility was based **only** on clinical staging, CD4 testing if the eligibility was based **only** on CD4 testing or clinical staging and CD4 testing if the eligibility was based on **both** Clinical staging and CD4 testing.

13. **ARV Regimen at start:** This column is divided into five. Tick(√) as appropriate, the ARV regimen the pregnant woman started with: **ART** - for pregnant women who are already on antiretroviral treatment; **Triple** - for women who are taking 3 ARVs combination prophylaxis; **AZT** - for women who are giving single ARV only, **SdNVP in labour plus (AZT + 3TC) combination** - for unbooked pregnant women who came to deliver in the facility and lastly **SdNVP only**.

ARV Regimen: This section is divided into three - At ANC, in labour and Breastfeeding.

14. **At ANC**: This column is further divided into ten columns representing the age of the pregnancy from month 0 to month 9. This is to keep track of the AVR regimen the HIV positive pregnant is taking throughout the duration of the pregnancy till delivery. Record the drug code from the list provided at the bottom of the register and the date the drug was provided in the dd/mm/yy format (e.g. 1A – 23/02/13) for the type of regimen given to the client at each month's visit.

15. **In labour**: Record the drug code from the list provided at the bottom of the register and the date the drug was provided in the dd/mm/yy format (e.g. 1E – 24/05/13) for the type of regimen given to the client during labour.

16. **Breastfeeding:** Record the drug code from the list provided at the bottom of the register and the date the drug was provided in the dd/mm/yy format (e.g. 1C – 25/06/13) for the type of regimen given to the client while she was breastfeeding.

N/B: ARV DRUG CODES
1A—ZDV (Zidovudine)
1B—SdNVP (Single dose Nevirapine)
1C---Triple Regimen
1D---ART (Lifelong therapy)
1E---SdNVP in – labour + (AZT+3TC)
Please note that the ARV regimen given at start will also be documented in the appropriate month in the "ARV regimen" column

17. **HIV-exposed infant given SdNVP within 72 hours of life:** Tick (✓) in the appropriate column for the sex if the exposed infant was given SdNVP within 72hrs of life and put the date the child was started on SdNVP e.g. ✓- 21/03/13.

18. **HIV-exposed infant initiated on Cotrimoxazole Prophylaxis:**

    Less than 2 months: Tick (✓) and put the date the child was started on the cotrimoxazole prophylaxis e.g. ✓- 21/03/13 in the appropriate column for the sex if the exposed infant was initiated on cotrimoxazole prophylaxis less than 2 months from birth.

    Two months & above: Tick (✓) and put the date the child was started on the cotrimoxazole prophylaxis e.g. ✓- 21/03/13 in the appropriate column for the sex if the exposed infant was initiated on cotrimoxazole prophylaxis two months or more after birth.

19. **HIV-exposed infant on ARV prophylaxis and Breast feeding:** Write sex of child (M for male and F for female) and date ARV prophylaxis was commenced (e.g. M-26/3/13) in this column if infant is being breastfed and also on ARV prophylaxis.

Infant tested for HIV: This column is further divided into three:

20. **DNA-PCR**: Write sex of child (M for male and F for female) and date tested (e.g. M-26/3/13) in the appropriate sub – column with respect to when the DNA – PCR was done (within 2 months of birth if test was done in 2 months or less from birth or after 2months if test was done after 2 months from birth..

21. **HIV Rapid test:** Write sex of child (M for male and F for female) and date tested (e.g. M-26/3/13) in the appropriate sub – column with respect to when the HIV rapid test was done

22. **HIV-exposed infant tested HIV-negative to HIV Rapid test at 18 months** (Column 22): Write sex of child (M for male and F for female) and date tested (e.g. M-26/3/13) in this column if the HIV rapid test done for the infant at 18 months was confirmed negative.

Tail

This contains the authentication part of the register.

23. **Name of Reporting Officer**: Enter the name of reporting officer on the last sheet used for the month

24. **Designation**: Enter the designation (e.g. OIC, Facility M&E e.t.c.) of the reporting officer on the last sheet used for the month.

25. **Signature**: Enter Signature of Reporting Officer on the last sheet used for the month.

26. **Date**: Enter the date this tail is filled.

FACILITY DAILY/SESSION IMMUNIZATION TALLY SHEET

Context of use

- This tool will be used by the health care worker providing immunization services in the health facility.
- It will be filled **IMMEDIATELY** by the health care worker only when immunization services are provided according to the Antigen Administered and the Dose Scheduled for the child (CORRECT DOCUMENTATION OR RECORDING is a MUST).
- This Daily/Session Immunization Tally Sheet is kept at the facility in the section that provides immunization services & summarized at the end of the month as HF Tally Sheet Monthly Summary for onward transmission to the LGA level within the period of Reporting (Completeness & Timeliness as indicators) -
- Tally sheets should also be used to capture the number of children under 1 given vaccination at the fixed post(health facility) during the MNCH week.

Importance

- Used to document the number of clients administered with the various Antigens per session.
- Indicate the total number of clients per session administered with the various Antigens by Dose Type.
- Used to prepare the monthly Facility Immunization Summary.

How to fill the Facility Daily/Session Immunization Tally Sheet

Description of the tool:

It is divided into 3 parts (head, body and tail) which have to be filled

HEAD

This contains the identification and general information about the health facility:

1. State - Enter the name of the State in which the LGA is located.

2. LGA – Enter the name of LGA in which the ward is located

3. Month – Enter the month for which the records are being entered on each sheet. Please note, a new month should start on a fresh page.

4. Year – Enter the year for which the records are being entered on each sheet.

BODY

Date: Record the specific day of the month and year of the immunization session in this format: dd/mm/yy.

Session Type: Record whether session is Fixed or Outreach

Outreach Site name: For an outreach session, record the name of the settlement or community where the outreach session took place.

Antigens Administration: Tally **CORRECTLY & IMMEDIATELY** after administering the vaccine, according to the antigen(s) administered to each client and in the appropriate age group column. Please note the status of the woman being administered TT (either pregnant or non-pregnant). *Mark one circle for one client.*

Comment*:* Please write comments, if any for that Session.

Tail

The tail captures the identity of the health worker who made entries in the register as it is important to hold somebody responsible for the quality of data entered. The tail end of this form must be completed by the reporting officer to give credence to the data.

Health Officer Full Name: The name of the officer filling this register should be written across the dotted line.

Head of Unit Full Name: The name of the unit head should be written across the dotted line.

Signature of Health Officer: The officer filling this register should sign here with the date of signing.

Signature of Head of Unit: The unit head filling this register should sign here with the date of signing.

CHILD IMMUNIZATION REGISTER

Context in which the tool is used:

- This register is kept at the facility in the section that provides immunization services.
- It is used by the health care worker providing immunization services in the health facility to register new children that have come for immunization and also to update the vaccination status of already registered ones
- It will be filled and updated by the health care worker only when immunization services are provided to children.
- The register will be filled using information obtained from the child health card.
- The immunisation register is not used to fill the summary form but to provide a record of the child that has received immunisation in the health facility. The summary form is filled using the tally sheets that were described earlier in this manual.

Importance of the Immunization Register

- Used to document immunization services provided daily in the health facility.
- Can show the present immunization status of children seen in the health facilities.
- Helps the health worker to ensure that children receive the appropriate immunization services.
- Enables service providers to track clients in relation to the utilization of immunization services they receive.
- Used to verify the immunization section of the monthly summaries.

Description of the tool:

- The register is a separate register for recording immunization services rendered.
- It is divided into 3 parts (head, body and tail) which have to be filled.
- The head gives information on the health facility and its location including, State LGA and Ward. The head of this section also gives information on the Month and year in which the child receiving immunisation was born. In this register every child's entries are filled into the month in which the child was born. ***As a result of this it is expedient that a number of empty pages be left for children that may attend much later than expected. The number of blank pages left to take care of this is subject to the discretion of the health facility based on the usual number of persons seen in the health facility. In the case that a child presents at the health facility after the pages designated in the month of birth have been filled a loose sheet torn from the back of the register is brought forward and attached at the appropriate month and the child is filled in this part of the register***.
- The body gives information on the demographic characteristics and Immunization services provided to the client.
- All the immunization information for a client is entered in one row in the register.
- The tail authenticates the data collected by requiring the name, designation & signature of the reporting officer as well as that of the Unit head with the date of the last day of the month of report.

How to fill the Child Immunization Register:

HEAD

1. ***State*** - Enter the name of the State in which the LGA is located.

2. ***LGA*** – Enter the name of LGA in which the ward is located

3. ***Ward*** – Enter the name of political ward in which the above Health Facility is located

4. ***PHC Facility*** – Enter the name of the Health Facility for which these records are being compiled

5. **Birth Month:** Record the birth month for all the children that will be entered on the sheet.

6. **Birth Year:** Record the birth year for all the children that will be entered on the sheet.

IMPORTANT: ***Every child born within the same month and year is registered on the same sheet(s) of their month of birth irrespective of the month he/she comes in for the first immunization. On subsequent visit of the child for immunization services the child is traced back to his/her birth month. This also applies for children less than 1 year brought in during the MNCH week.***

BODY

7. S/N: Record the serial number given to a client when entering the data into the register. The first person to receive services in a month is given the number 1 while others follow in an ascending order until the end of the month.

8. Date: Record the specific day of the month and year the child is receiving an immunization service for the first time in the order – dd/mm/yy.

9. Child's Name: Enter the name of the child, surname first.

10. Child Card No: Enter the number seen on the child's health card.

11. Sex (M/F): Enter "M" if the child is a male or "F" if the child is a female in this column.

12. Child's Follow up address: Enter the residential address of the Child. Efforts should be made to ensure that the description here is such that the residence can be traced if the need for follow up occurs.

13: Phone Number: Write the phone number of the care giver or parent of the child.

14. D.O.B. (date of birth): Enter the child's date of birth by day/month/year format e.g. 31/03/2012.

OPV 0 (Birth): Record the date of administration of the birth dose of the OPV antigen in the DD/MM/YY format e.g. 21/07/12.

Hep B 0 (birth): Record the date of administration of the birth dose of Hep. B antigen in the DD/MM/YY format e.g. 21/07/12.

BCG: Record the date of administration of the BCG antigen in the DD/MM/YY format e.g. 21/07/12. BCG is administered to infants at birth.

OPV 1 (Oral polio): Record the date of administration of the first dose of the OPV antigen in the DD/MM/YY format e.g. 21/07/12.

Penta1: Record the date of administration of the first dose of Pentavalent vaccine administered to a child in the DD/MM/YY format e.g. 21/07/12. This dose should be given at the age of at least 6 weeks of birth.

PCV1: Record the date of administration of the first dose of Pneumococcal vaccine in the DD/MM/YY format e.g. 21/07/12. PCV1 is administered at least 6 weeks of age when introduced into the RI schedule.

OPV2 (Oral polio): Record the date of administration of second dose of OPV in the DD/MM/YY format e.g. 21/07/12. OPV2 is administered at least 10 weeks of age.

Penta2: Record the date of administration of the second dose of Pentavalent vaccine in the DD/MM/YY format e.g. 21/07/12. Penta 2 is administered at least 10 weeks of age

PCV2: Record the date of administration of the second dose of Pneumococcal vaccine in the DD/MM/YY format e.g. 21/07/12. PCV2 is administered at least 10 weeks of age when introduced into the RI schedule.

OPV3 (Oral polio): Record the date of administration of the third dose of OPV in the DD/MM/YY format e.g. 21/07/12. OPV3 is administered at least 14 weeks of age.

Penta 3: Record the date of administration of the third dose of Pentavalent vaccine in the DD/MM/YY format e.g. 21/07/12. Penta 3 is administered at least 14 weeks of age.

PCV 3: Record the date of administration of the third dose of Pneumococcal vaccine in the DD/MM/YY format e.g. 21/07/12. PCV3 is administered at least 14 weeks of age when introduced into the RI schedule.

Vitamin A (6-11months; 12-23months): This section is used to document the administration of vitamin A supplements to children between the ages of 6 and 23 months. It has two columns each to represent the age at which a child was given the vitamin A supplement. Record the date of administration of Vitamin A supplement in the DD/MM/YY format e.g. 21/07/12 in the appropriate age group columns written in the 12-23 months column

MEASLES 1: Record the date of administration of the first dose of Measles vaccine in the DD/MM/YY format e.g. 21/07/12. The first dose of measles vaccine is given at 9 months of age.

Yellow Fever: Record the date of administration of the Yellow Fever vaccine in the DD/MM/YY format e.g. 21/07/12. Yellow Fever vaccine is administered at 9 months of age.

MEASLES 2: Record the date of administration of the second dose of Measles vaccine in the DD/MM/YY format e.g. 21/07/12. Measles 2 is given at 18 months of age as a booster dose when introduced into the RI Schedule.

CONJUGATE A CSM: Record the date of administration of the Conjugate Cerebrospinal Meningitis A vaccine in the DD/MM/YY format e.g. 21/07/12. CSM is administered at 12 months of age when introduced in the RI schedule

DPT 1: Record the date of administration of the first dose of the Triple vaccine (Diphtheria, Pertussis and Tetanus vaccine) to infants before the introduction of the Penta vaccine in the DD/MM/YY format e.g. 21/07/12. This is given at least 6 weeks of age.

DPT 2: Record the date of administration of the second dose of the Triple vaccine (Diphtheria, Pertussis and Tetanus vaccine) to capture infants that received it before the introduction of the Penta vaccine. It is written in the DD/MM/YY format e.g. 21/07/12. This is given at least 10 weeks of age.

DPT 3: This column documents the date of administration of the third dose of the Triple vaccine (Diphtheria, Pertussis and Tetanus vaccine) in the DD/MM/YY format e.g. 21/07/12. This is given at least 14 weeks of age.

Hep B 1: Record the date of administration of the first dose of Hepatitis B vaccine in the DD/MM/YY format e.g. 21/07/12. It is given at 10 weeks of age.

Hep B 2: Record the date of administration of the second dose of Hepatitis B vaccine to infants in the DD/MM/YY format e.g. 21/07/12. It is given at 14 weeks of age.

Comments (IF ANY): This is a column that is used to explain the data seen in the other columns. Record the results of patient tracking such as (relocated, dead, refused etc.) and record “fully immunized” when the child completes his/her immunization. Also indicate if the child was given LLIN and date given. Efforts should be made to make the comments concise.

Tail

The tail captures the identity of the health worker who made entries in the register as it is important to hold somebody responsible for the quality of data entered. The tail must be completed by the reporting officer to give credence to the data.

Health Officer Full Name: The name of the officer filling this register should be written across the dotted line.

Signature of Health Officer: The officer filling this register should sign here with the date of signing.

Head of Unit Full Name: The name of the unit head should be written across the dotted line.

Signature of Head of Unit Officer: The unit head filling this register should sign here with the date of signing.

TETANUS TOXOID REGISTER FOR WOMEN OF CHILD BEARING AGE

Context in which the tool is used:

- This tool will be used by the health care worker to document the administration of tetanus toxoid to women of childbearing age.
- In the register each woman is placed in a single row and all vaccines given to her are entered into the row in the appropriate column
- The register will be filled using information obtained at the time of administration of the vaccine
- This register is kept at the facility in the section that provides immunization services.
- The immunisation register is not used to fill the summary form but to keep record of the women that have received tetanus toxoid immunisation in the health facility. The summary form is filled using the tally sheets that were described earlier in this manual.

Importance of the Immunization Register

- Used to document TT immunization administered to women of child bearing age.
- shows the TT immunization history of women given such services in the health facilities.
- Helps the health worker to ensure that women receive the tetanus toxoid when due
- Enables service providers to track clients in relation to the utilization of immunization services they receive.

Description of the tool:

- The register is a separate register for recording TT immunization services rendered.
- It is divided into 3 parts (head, body and tail) which have to be filled.
- The head gives information on the health facility and its location including, State LGA and Ward.
- The body gives information on the demographic characteristics and TT Immunization services provided to the client.
- All the immunization information for a client is entered in one row in the register.
- The tail authenticates the data collected by requiring the name, designation & signature of the reporting officer with the date of the last day of the month of report.

How to Fill the Tetanus Toxoid Register for Women of Child Bearing Age

This contains the identification and general information about the health facility:

1. ***State*** - Enter the name of the State in which the LGA is located.

2. ***LGA*** – Enter the name of LGA in which the ward is located

3. ***Ward*** – Enter the name of political ward in which the above Health Facility is located

4. ***PHC Facility*** – Enter the name of the Health Facility for which these records are being compiled.

5. ***Month/Year*** – Enter the month and the year for which the records are being entered on each sheet. Please note, a new month should start on a fresh page.

BODY

6. **DATE OF CLIENT VISIT:** Record the date when the women commenced the TT vaccine schedule and received TT1. The date should be written in the DD/MM/YY format e.g. 21/07/12.

7. **CLIENT'S CARD NUMBER:** Record the number of the client as seen on the health facility card.

8. **AGE IN YEARS:** Record the age of the client at her last birthday.

9. **CLIENT NAME:** Record the name of the woman (surname first).

10. **CLIENT's FOLLOW UP ADDRESS:** Enter the residential address of the woman or where she can usually be reached. Efforts should be made to ensure that the description here is such that the residence can be traced if the need for follow up occurs.

11. **CLIENT GSM NUMBER:** This is the usual GSM of the woman or client being provided with the services. If the woman does not have a phone number she may offer a number that she has access to.

12. **TETANUS TOXOID:** This is the section of the register that is used to document the doses of tetanus toxoid given to women of child bearing age. Record the date of administration of the TT dose (TT1, TT2, TT3, TT4 or TT5) appropriately. ***Please note that "P" is for pregnant women and "NP" is for non-pregnant women.***

Tail

The tail end of the form captures the identity of the health worker who made entries in the register as it is important to hold somebody responsible for the quality of data entered. The tail end of this form must be completed by the reporting officer to give credence to the data.

Health Officer's Full Name: The name of the officer filling this register should be written across the dotted line.

Signature of Health Officer: The officer filling this register should sign here with the date of signing.

MONTHLY FACILITY IMMUNIZATION SUMMARY

Context in which the tool is used:

- This tool will be used by the health care worker providing immunization services to summarise the number of each antigen administered per session.
- It is filled by the health care worker after each immunization session according to the antigen administered (CORRECT DOCUMENTATION OR RECORDING is a MUST).
- It is kept at the facility in the section that provides immunization services and summarized at the end of the month for onward transmission to the LGA level within the period of reporting

Importance of the Monthly Facility Immunization Summary

- Indicate the total number of clients per session administered with the various Antigen by Dose Type.
- Provides a monthly summary of the number of clients administered with the various Antigens.

How to fill the Monthly Facility Immunization Summary:

Description of the tool:

It is divided into 3 parts (head, body and tail) which have to be filled. This register is used to summarize the information on the immunization services provided in the health facility in the month. The information is captured from the immunization tally sheet and the child immunization register on a daily basis.

HEAD

This contains the identification and general information about the health facility

1. ***State*** - Enter the name of the State in which the LGA is located.

2. ***LGA*** – Enter the name of LGA in which the ward is located

3. ***Ward*** – Enter the name of political ward in which the above Health Facility is located

4. ***PHC Facility*** – Enter the name of the Health Facility for which these records are being compiled.

5. ***Month/Year*** – Enter the month and the year for which the records are being entered on each sheet. Please note, a new month should start on a fresh page.

BODY

This consists of the various data elements which the register seeks to obtain.

7. **Day of Month/Session:** Record the day of the month in which the immunization session was held in the format - dd/mm/yy
8. **Session Type:** Record whether session is Fixed, Outreach or Mobile

Antigens Administration: At the end of each session, record the number of antigen(s) administered during that session of immunization in the appropriate column by counting the number of tallies made in the tally sheet. In the case of TT, please note the status of woman (Pregnant or Not). Also note that

LLIN information could be gotten from the child immunization register by counting the number of children recorded to have been given LLIN on the day the session held.

Note: *Remember to record the total at the end of each sheet for each month for ease of transfer to the monthly summary form.*

Tail

The tail captures the identity of the health worker who made entries in the register as it is important to hold somebody responsible for the quality of data entered. The tail end of this form must be completed by the reporting officer to give credence to the data.

Health Officer's Full Name: The name of the officer filling this register should be written across the dotted line.

Signature of Health Officer: The officer filling this register should sign here with the date of signing.

Head of Unit's Full Name: The name of the unit head should be written across the dotted line.

Signature of Head of Unit: The unit head filling this register should sign here with the date of signing.

Health Facility GMP (Growth Monitoring and Promotion) Daily Register

Context of use

- This tool will be used by the health care worker providing growth monitoring and promotion services in the health care facility
- It will be filled daily by the HCW when such a service is provided. In situations where services are provided on certain days, the register is only required to be filled on such days
- The register will be filled using information obtained from child health card
- The register is kept at the facility in the section that provides growth monitoring services
- A records personnel or persons responsible for record keeping in the facility will be responsible for collecting the register from the unit at the end of the month and use such entries to complete the growth monitoring section of the health facility summary form (NHMIS 001)

Importance

- Used to document growth monitoring and nutrition health services provided to children under five in the health facility
- Used to prepare certain section of health facility summary forms for onward submission to the LGA
- Provide in a single location data on all growth monitoring services
- Used to determine the utilization of growth monitoring services
- Provides the health facility with a picture of the nutritional status of the communities within their catchment areas.
- Enables facilities take appropriate action in the communities based on the information generated

Description of the tool:

- The register is basically made on one A3 sheet
- It has three sections:
    - The head or identification section
    - The body which contains the information regarding the various clients that receives growth monitoring and nutrition services
    - The tail which details authentication of the materials listed in the register

HEAD

This contains the identification and general information about the health facility;

1. State - Enter the name of the State in which the LGA is located.

2. LGA – Enter the name of LGA in which the ward is located

3. Ward – Enter the name of political ward in which the above Health Facility is located

4. Health Facility – Enter the name of the Health Facility for which these records are being compiled.

5. Month/Year – Enter the month and the year for which the records are being entered on each sheet.
Please note: each month should start on a new page.

BODY

- The body is made up of rows and columns
- Each row represents a single visit of a client receiving growth monitoring services
- Each column represents either demographic information on the client or events and services provided

Explain the meaning of the standard curves

- ❖ If growth charts are not interpreted accurately, incorrect information can be given to a mother, leading to worry and loss of confidence.
- ❖ Growth charts can reflect past and present conditions, including food intake and health status.
- ❖ A child who is undernourished for a long time will show slow growth in length or height. This is referred to as stunting or very short height for age.
- ❖ A shorter child generally weighs less than a taller child of the same age and so may be on different lines on the growth chart for weight. This is normal.
- ❖ What is most important is to see that the curve follows a trend that indicates the child is growing and there is no growth problem.
- ❖ Good feeding practices—both before the child is 6 months old and after complementary foods have been introduced—can help prevent growth faltering in both weight and length as well as the tendency to overweight.

Interpret individual growth curves.

- ❖ There are four curves on this chart. The line labeled 0 is the median, which is, generally speaking, the average. It is also called the 50th percentile because the weights of 50 percent of healthy children are below it and 50 percent are above it.
- ❖ Most healthy children are near this median curve, either a little above or below it.
- ❖ The other lines, called z-score lines, indicate distance from the average. A point or trend that is far from the median, such as +3 or -3, usually indicates a growth problem.
- ❖ The growth curve of a normally growing child will usually follow a track that is roughly parallel to the median. The track may be above or below the median.
- ❖ A child whose weight-for-age is below the -2 z-score line (third line from the top) is underweight. A genetically or naturally small child may be near this curve but still be growing well.
- ❖ The bottom line (-3) indicates very low weight for age or severe underweight. A child near this line is probably not healthy and needs attention

6. **S/No**: Record the number assigned to a client when entering the data into the register. The first person to receive services in a month is given the number 1 and others follow in ascending order until the end of the month. At the beginning of each month when a new page of the register is opened the serial number again begins from 1.

7. **Date:** This is the day when the client received services and is entered as day/month/year (dd/mm/yy) e.g. 21/09/10**.**

8. **Name of client:** This is the name given at birth and should be recorded surname first.

9. **Sex (F/M):** Here is stated the sex of the child. Record "M" for males and "F" for females.

10. **Client number:** Record the number given to the client in the Child health card.

11. **Date of birth:** Record the date of birth of the child in dd/mm/yy.

12. **Age in months:** Record the age of the child in months. This register is expected to be for children below 5 years of age hence, the maximum number expected in this column is 59 months

13. **Type of visit (N/R):** A client may either be attending for the first time or coming for a follow up visit. Tick as appropriate - "N" for first time visits and "R" for follow up visits.

14. **Breast feeding:** This section is used to record the breastfeeding status of the child at the time the child reports for growth monitoring. Tick appropriately:

- **Exclusive BF**: for children who are on exclusive breast feeding
- **BF + Water**: for the children who are still breast feeding but are also given water
- **Partial BF**: for persons still breastfeeding but also taking alternate milk or supplementary food.

Only one of them should be ticked according to the breastfeeding status of the child.

15. **Stopped BF Y/N:** This is used to determine whether the child is still being breastfed or not. Write **Y** if the child has stopped breastfeeding and **N** if the child is still breastfeeding. For children that have stopped breastfeeding (i.e. those with "Y"), please record the age the child stopped breastfeeding beside the "Y".

16. **Height:** This is the measurement of the height of the child in centimetres (cm) to identify the persons who are below the expected height for their age. It is expected to be measured every visit. Record the height of the child in cm.

17. **Weight (kg):** This is the measurement of the weight in kilograms (kg) to identify the children who are below the expected weight for their age. It is expected to be measured every visit. Record the weight of the child in kg.

18. **Nutritional Status:** This section is used to record the nutritional status of the child on that day. Tick (√) the appropriate column (above the line or below the line)

19. **Vitamin A supplement (6-11, 12-59 months):** This is used to document whether the child was provided Vitamin A during the visit. Tick (√) the appropriate age group (6-11, 12-59 months) if Vitamin A was given to the child during that visit.

20. **Child received Deworming Tablet (12–59 months)**: Record "Y" if the child was given deworming tablet during that visit and "N" if not.

21. **Child referred/admitted into CMAM programme Y/N:** Record Y/N as applicable if the child was referred or admitted into CMAM (Community Management of Acute Malnutrition) programme.

22. **Severe Acute Malnutrition (SAM):** This column is divided into two**.** (i) Eligibility for SAM treatment – Tick(√) as appropriate (admitted in HF (OTP), Referral to other HF (SC) and Not eligible). (ii) Outcome of treatment - tick(√) as appropriate the outcome of the SAM treatment. *The treatment outcomes are Recovered (Re), defaulted (Df), death(Dth) and Normal (Nr).*

Tail

This contains the authentication part of the register.

23. **Name of Reporting Officer**: Enter the name of reporting officer on the last sheet used for the month

24. **Designation**: Enter the designation (e.g. OIC, Facility M&E e.t.c.) of the reporting officer on the last sheet used for the month.

25. **Signature**: Enter Signature of Reporting Officer on the last sheet used for the month.

26. **Date**: Enter the date this tail is filled.

TUBERCULOSIS CLINIC SUSPECT REGISTER (NTBLCP/TB2)

Context of use

This tool is used to collect information on the TB suspect. It provides detailed information on the suspect. The General Health Care Worker (GHW) providing Directly Observed Treatment Short Course (DOTS) services in the health facility should handle this tool.

Importance

- Data collected from TB suspects are recorded in this tool.
- It will provide an estimate of the total number of TB suspects that came into the facility for diagnosis within a quarter, their source of referral, and the result of their Acid Fast Bacilli (AFB) test.

Description of the tool

This Register must be filled when the sputum specimen is collected for diagnosis and later when the health worker receives the result, as follows:

1. The Head section is for identification and general information. It enables us to understand the State, LGA, name of the facility, and ward where the facility is situated.
2. The middle part is the body of the form and has 18 data elements of all the details of the suspect.
3. The tail of the form is for authentication for whoever is responsible for filling and verifying this form, including the date the data is captured.

How to enter information into the tool

Section A: Identification

1. **Name of State:** Enter the name of the State for which this suspect register is compiled.
2. **Name of LGA:** Enter the name of the Local Government Area.
3. **Name of health facility:** Enter the name of the health facility where this data is generated
4. **Name of the ward:** Enter the name of the political ward where the health facility is located**.**
5. **Health Facility Code:** Enter the code for the health facility.

Section B: Data elements

6. **Sputum Identification Number:** This is the registration number of the sputum specimen at time of collection. The number on the sputum container is derived from the "TB Clinic Sputum Register": First letter of the facility name/Number of patient in the current month/month/ number of specimen. For example, the 3 sputum specimens that were taken from a suspect at Alafara Clinic in August, being the 56th patient that was screened that month, would be labelled: A/56/08/1, A/56/08/2, and A/56/08/3 respectively.
7. **Full Name**: Write the suspect's full name, surname first.

8. **Age:** Age of patient. Estimate, if not known.
9. **Sex:** Write letter “M” if patient is a male and letter “F” if patient is a female.
10. **Address:** The patient’s full address where patient could be found if he/she does not return to the health unit to commence treatment.
11. **Source of referral:** Enter the source of referral for the TB suspect. A TB suspect could be referred to the DOTS clinic from the OPD, by the Community Volunteer (CV), or from the ART clinic.
12. **Date of collection:** Write the date that each of the three sputum sample was collected in this column.
13. **Date sputum result released:** The date the results of the sputum are received by the health worker is written in this column.
14. **AFB Result:** Write the result of the sputum from the lab for each of the sputum specimen collected in this column. Positive result should be written in red and negative result in blue.
15. **Known HIV Status:** Write letter “Y” if HIV status is of the suspect is known and “N” if not known at the moment
16. **HIV on ART**: Indicate by ticking if patient is on ART.
17. **Counselled:** Write “Y” if suspect was counselled for HIV and “N” if declined counselling.
18. **Tested Y/N:** Write letter “Y” if suspect was tested for HIV and “N” if not.
19. **HIV Result:** Tick as appropriate (√) for posi ve HIV, Nega ve HIV or unknown
20. **LGA TB Registration Number:** Immediately the sputum result is out, register this patient in the LGA TB Register if there are two positive results in the case of diagnosis and write the LGA TB Register number in this column; and if it is for follow-up write the patient’s LGA TB Register number also in this column.
21. **Remark**: Write any relevant remark in this column. Indicate here whether the suspect was found to be TB +ve, counselled and referred for/started on TB treatment.
22. **Name of reporting officer:** Enter the name of the reporting officer
23. **Designation of reporting officer:** Enter the designation of the reporting officer
24. **Signature:** This is the reporting officer’s signature.
25. **Date:** Insert the date of the report.

HEALTH FACILITY TUBERCULOSIS CENTRAL REGISTER (NTBLCP/TB8)

Context

This tool is used to record information on a TB patient registered for treatment. The source of data is the TB Treatment card. This tool should be handled by the Health Care Worker (HCW) providing Directly Observed Treatment Short Course (DOTS) services in the health facility.

Importance of the tool

- Data on registered TB patients are recorded in this tool.
- It will provide an estimate of the total number of registered TB patients that were treated in the facility within a quarter, type of TB patient, treatment outcomes, and TB/HIV collaborating indicators.

Description of the tool

The TB Central Register is a two page document. In order to keep track of all patients with Tuberculosis, all newly diagnosed patients and all those already on treatment should be registered in the LGA Tuberculosis Central Register.

The Tuberculosis Treatment Card provides information necessary to complete the Register. Make sure that the information on Tuberculosis Treatment Card is correct before entering it into the LGA TB Central Register.

- The Head section is for identification and general information on the State, LGA, name of the facility, and ward where the facility is situated, including month and year.
- The middle part is the body of the form and has 36 data elements of all the details of the TB patient.
- The tail of the form is for authentication for whoever is responsible for filling and verifying this form, including the date the data is captured.

How to enter information into the tool

Section A: Identification

1. **Name of State:** Enter the name of the State for which the "suspect register" is compiled.
2. **Name of LGA:** Enter the name of the Local Government Area.
3. **Name of the ward:** Enter the name of the political ward where the health facility is located**.**

4. **Name of health facility:** Enter the name of the health facility where this data is generated.
5. **Month/Year:** Enter the month and year.
6. **Serial Number:** Enter the number serially for each registered patients.
7. **Date of Registration**: Write the date you are registering the patient in the Register in this column in dd/mm/yy format

8. LGA TB No: Give a new LGA TB Number to each patient being registered and write this number in this column. Start with the number "0001" at the beginning of each year. Start each new quarter/year on a new page. A guideline for allocating registration numbers to patients is as follows: Every patient must be duly registered in the LGA Central Register by the TBLS. See allocation of registration numbers under Leprosy Information Systems on how to allocate numbers.

Guidelines for registration of transferred-in patients and those who interrupt treatment.

- Patients who are duly transferred to another LGA, should be re-registered with new registration number in the new LGA. The old TB no, should be entered in the Remarks column of the Register in the new LGA. Patients transferred within the LGA should retain their old number.
- Patients who default from treatment and return to same clinic still with negative smear result shall continue treatment. They shall also retain their former registration number. However, if the patient's smear result becomes or remains positive, after at least one month treatment and 2 or more months interruption, re-register the patient as Return After Default and re-treatment regimen.

9- 12. Name, Sex, Age, Address: This information can be collected from the Treatment Card. Make sure that they are entered correctly. Name should be surname first and age should be recorded in months for children less than 1 year.

13. **Treatment Unit/Health Facility**: Write the name of the health unit where the patient will receive treatment during intensive phase.

14. **Type of facility**: Write "Private" if the health unit is a private health care provider, "Prison" if the health unit is at the prison and "Public" if it is public health facility.

15. **Treatment Category:** Enter the treatment regimen prescribed for the patient in this column thus, Short Course for New patients – CAT 1 or Re- treatment – CAT 2.

16. Date Treatment Started: Look at the drug administration table at the lower half of patient's Tuberculosis Treatment Card. Check the date and month treatment started and enter it into this column.

17. **DOT by TS/CV:** Write "Y" if the daily drug administration is being observed by a treatment supporter (TS) or a community volunteer (CV) and "N" if not or if the observation is done at the health unit.

18. ***Disease Site P/EP:*** Write "P" if the patient has pulmonary tuberculosis. Write "EP" if the patient has extra-pulmonary tuberculosis.

19. Type of Patient: Look into the patient's Tuberculosis Treatment Card under type of patient to determine whether the patient is New (N), Relapse (R), Failure (F), Return after Default (RAD), Transferred in (T) or Other (O). Write the appropriate code indicating the type of patient in the Register.

20. Result of Sputum Examination (Smear (if available)/ According to the duration of treatment:

• Write the results of the patient's pre-treatment sputum examination result and corresponding laboratory serial number (0[negative], SC [scanty],"1-9", +, + +, or + + + [positive]).

• Do the same for results of sputum examination, as appropriate, at 2nd or 3rd (for Category 1 or Category 2 respectively), 5^{th} and 7^{th} month of treatment.

• If the direct smear at the end of 2 months remains positive, draw a right slash "/" in the "result" and "lab no" boxes in the appropriate column and then enter the result and lab no. in the corresponding space above the slash. According to the guidelines, the direct smear examination is repeated after the extension of treatment for 4 weeks. This result as well as lab number are entered in the corresponding space below the slash.

21. Treatment Outcome and Date: *Determine the outcome of treatment for each patient and record the date patient completed treatment, died, defaulted or transferred out, in the appropriate column.*

At the end of the treatment course in each individual patient, the LGTBLS should record the treatment outcome as follows:

Smear result at completion: Record appropriately the date the smear result at completion was collected.

Negative (Cured): A patient who is smear-negative at (or one month prior to) the completion of treatment and on at least one previous occasion.

Not done (treatment completed): A patient who has completed treatment but in whom smear result is not available at end of 7th month.

Positive (failure): A patient who remains or becomes again smear – positive at 5 months or later, after starting treatment.

Died: A patient who dies for any reason during the course of chemotherapy.

Defaulted: A patient whose treatment has been interrupted for more than 2 consecutive months before the end of course of treatment.

Transferred out: A patient who has been transferred to another treatment centre in another LGA/State and whose treatment results are not known.

However, please note that this is a temporary treatment outcome. As much as possible the outcome of treatment should be obtained from the LGA/State where the patient was transferred to.

22. TB/HIV Activities

HIV tested (Y/N): Enter "Y" with the date of HIV test e. g. Y – 22/03/13 if the TB positive patient was tested for HIV, "N" if not.

HIV Pos TB referred for HIV care: Enter "Y" with the date of referral e. g. Y – 22/03/13 if the HIV positive TB patient was referred for HIV care or "N" if not.

HIV Pos on ART: Enter "Y" with the date of commencement of ART if the TB patient is on ARV or "N" if not.

HIV Positive non-ART: Enter "Y" if HIV positive TB patient is not on ART or "N" if he/she is.

HIV Negative: Enter "Y" if TB client was tested HIV negative, or "N" otherwise.

HIV Unknown: Enter "Y" if HIV status of the TB client is unknown, or "N" otherwise.

CPT Enter "Y" with the date of commencement of CPT if the HIV positive TB patient is on CPT or "N" if not on CPT

23. **Remarks:** Enter any useful or helpful information in this column.

24. **Name of reporting officer:** Enter the name of the reporting officer.

25. **Designation of reporting officer:** Enter the designation of the reporting officer.

26. **Signature:** This is the reporting officer's signature.

27. **Date:** Insert the date of the report.

HEALTH FACILITY LEPROSY CENTRAL REGISTER (NTBLCP/LEP3)

Context of use

This tool is used to record information on a Leprosy patient registered for treatment. The source of data is the Leprosy Treatment card. This tool should be handled by the General Health Care Worker (GHW) providing Leprosy treatment services in the health facility.

Importance

- Data on registered Leprosy patients are recorded in this tool.
- It will provide an estimate of the total number of registered Leprosy patients that were treated in the facility within a quarter.

Description of the tool

The Leprosy Central Register is a two page document and extent from the left hand corner to the right. In order to keep track of all patients with Leprosy, all newly diagnosed patients and all those already on treatment should be registered in the LGA Leprosy Central Register.

The Leprosy Treatment Card provides information necessary to complete the Register. Make sure that the information on Leprosy Treatment Card is correct before entering it into the LGA Leprosy Central Register.

- The Head section is for identification and general information on State, LGA, name of the facility, and ward where the facility is situated, including month and year.
- The middle part is the body of the form and has the data elements of all the details of the Leprosy patient.
- The tail of the form is for authentication for whoever is responsible for filling and verifying this form, including the date the data is captured.

How to enter information into the tool

Every patient who is starting treatment for leprosy within the LGA should be put in the LGA Leprosy Central Register (NTBLCP/LEP4). The Register is useful for the collection of information on newly detected cases, disability and child proportion among new cases and the prevalence rate. The monitoring of treatment, evaluation of treatment outcome (cohort analysis) as well as prevention of

impairments and disabilities.The information necessary for the completion of the Register is taken from the Leprosy Record Card (LEP3). Make sure the information in the patient record card is complete before writing it in the Register.

Section A: Identification

1. **Name of the state:** Enter the name of the state for which this suspect register is compiled.
2. **Name of LGA:** Enter the name of the Local Government Area.
3. **Name of the ward:** Enter the name of the political ward where the health facility is located**.**
4. **Name of health facility:** Enter the name of the health facility where this data is generated.
5. **Month/Year:** Enter the month and year.
6. **Serial Number:** Enter the number serially for each registered patients.
7. **Date of registration:** The date the person is entered into the Register in dd/mm/yy format
8. **Registration Number:** On registration, the LGTBLS will assign a number to each patient who is being registered. This number will also be written on the leprosy record card and the appointment card.

Start with the number one at the beginning of each year.

The subsequent numbers should follow serially. Registration numbers are allocated as follows: *National TB and Leprosy Control Programme, Nigeria Workers' Manual 5th ed. May 2008* 52. **Guidelines for allocating registration numbers to patients:**

Every patient must be duly registered in the LGA Central Register by the TBLS. There are ten digits or boxes (as in treatment appointment card) to be used for registration number of patients:

The first two numbers are the STATE codes

The next two numbers are the LGA codes

The next two numbers are the last two digits of the year of registration,

The last four numbers are the patient codes.

The patient's number is according to the serial number in the LGA Central Register.

Patients who are duly transferred to another LGA, should be removed from the Register, and should be re-registered with new registration number in the new LGA. The old TB no, should be entered in the

remarks column of the Register in the new LGA. Patients transferred within the LGA should retain their old number.

The STBCO should list all the LGAs in his state in alphabetical order and give them code numbers serially. At the clinic, the patients should be serially numbered from 0001.

Example, 17/04/02/0001 is a registration number for a patient in Jigawa state (State code number 17, LGA Code number 04; registered in 2002 (the last two digits of year 2002 is 02) and patient‟s serial number is 0001) .

9. **Name:** The full name of the patient
10. **Sex:** M for male F for female
11. **Age:** This is the age at which the patient started taking Multi Drug Therapy (MDT).
12. **Address in full**: Describe patients resident using street number or landmark
13. **Name of clinic;** The name of the clinic where he/she is receiving MDT
14. **Classification:** ***TBLS should first confirm the classification*** and then enter either PB or MB
15. **Date of start of treatment:** Enter the date the patient started taking MDT in dd/mm/yy format
16. **Disability grade at start of treatment:** Enter the grade for each eye, hand and foot from the front page of the leprosy record card
17. **Category of patient:** Enter the category by ticking the appropriate column:

    NEW a person who has never taken any leprosy treatment before (DDS or MDT)

    RELAPSE AFTER PB a person who has **completed a six-month course of PB-MDT** but is now reporting back with active leprosy that has been confirmed at the TBL referral Hospital.

    RELAPSE AFTER MB a person who has **completed a twelve-month course of MB- MDT** but is now reporting back with active leprosy that has been confirmed by the TBLS

    RE-ADMISSION AFTER DDS a person who was treated with DDS monotherapy and is now reporting with signs of active leprosy

    TRANSFER IN a person on MDT transferred from another LGA
18. **TREATMENT AFTER DEFAULT** a person who started MDT (PB or MB**) BUT DID NOT COMPLETE THE COURSE** who is now reporting with signs of active leprosy.
19. **Year:** Enter year
20. **Treatment received:** Fill in the year the patient is taking treatment. When you reach the beginning of another year, start a new line for that year.

21. **Treatment outcome:** Put the date the patient was removed from the Register in the appropriate box.
22. **Treatment completed:** the person has completed a full course of either PB or MB MDT.
23. **Default** the person has missed appointments and is unable to completetreatment within the time limit

For PB – missing 4 months renders it impossible to complete within 9 months, For MB – missing 7 months renders it impossible to complete within 18 months.

24. **Died:** the person died before completing his MDT.
25. **Transfer out:** the person is transferred to another LGA or State.
26. **Impairment grade at end of treatment:** Insert the impairment grade from the back page of the record card. Remember that this assessment is done just before the person is released from treatment.
1. **Remarks:** Insert any notable or important information here. e.g. If transferred, where to? Listed for surgery

SUMMARY FORMS

NHMIS QUARTERLY FORM for HEALTH FACILITIES

Context of use

This tool is used to summarize at the end of the quarter, services offered in the health facility, monitoring and supervisory visit made to the facility, health facility staff trained and community involvement in the administration of the facility. The tool should be handled by the record officer or whoever is designated to function as the record officer. The tool is carbonized i.e. as you write a carbon copy is produced underneath. At the end of the quarter, original copy of the tool will be forwarded by the designated record officer to the LGA leaving behind the duplicate copy as an evidence of health facility based activities.

Description of the tool

The tool is basically, like every other tool, structured in three parts:

Section A: Head section is for identification and general information on the health facility that generates this data, the ward, the LGA and State where the facility is situated, the month and year for which data is captured.

Section B is the body of the form which takes in the data elements.

The tail of the form is for authentication for whoever is responsible for filling and verifying this form.

How to enter information into the tool

Section A: Identification

Health facility: - Enter the name of the health facility for which this summary data is compiled.

Political ward: Enter the name of the political ward in which this health facility is located.

LGA: Enter the name of the Local Government Area in which the political ward is located**.**

State: Enter the name of state in which the LGA is located**.**

Health facility code: Enter the unique ID code of the health facility

Quarter: Tick appropriate for which this report is being compiled**.**

Year: Enter the year for which the report is being compiled.

Public: Tick if the health facility is owned by the government either s**t**ate or LGA.

Private: Tick if the health facility is private**l**y owned e.g**.** by individual, communities, non-governmental organizations or missions.

Health services offered

For items 1-16, tick yes if the health service is offered or no if the health service is not offered.

Monitoring and Supportive Supervision

For items 17 – 19, tick either Yes or No as appropriate

Capacity Building

For items 20 -22, enter total of health facility staff trained as indicated within the quarter

Service Delivery and Community Participation

For item 23, enter total number of health care workers that provided service in the health facility within the quarter, for items 24 – 26; tick either Yes or No as appropriate.

Tail

The tail of the form captures the identity of those who filled and verified the form. It is important to hold somebody responsible for the quality of data entered. The tail must be completed otherwise the data entered is unacceptable, null and void.

Form completed by -------. Write down the name of the officer filling this form in the dotted space provided.

Designation ------- Write down the title of the officer filling this form in the dotted space provided. Please note that this form is expected to be filled by the JCHEWs.

Signature ------ The officer filling this form should indicate his/her signature in the dotted space provided.

Date ----- The day, month and year this form is completed should be written in the dotted space provided e.g. 3/11/10.

Form verified by -------. Write down the name of the officer verifying this form in the dotted space provided.

Designation -------. Write down the title of the officer verifying this form in the dotted space provided. Please note that this form is expected to be verified by a superior officer to the JCHEWs.

Signature ------ The officer verifying this form should indicate his/her signature in the dotted space provided.

Date ----- The day, month and year this form is verified should be written in the dotted space provided e.g. 3/11/10.

HEALTH FACILITY MONTHLY SUMMARY FORM

Context of use

This tool is used to summarize at the end of the month all daily health activities that have taken place in the health facility within the month. This tool should be handled by the record officer or whoever is designated to function as the record officer. The tool is carbonized i.e. as you write a carbon copy is produced underneath. At the end of the month, original copy of the tool will be forwarded by the designated record officer to the LGA leaving behind the duplicate copy as an evidence of health facility based activities.

Importance

- Data collected from the health facility monthly summary form at the end of the month is summarized by the tool.
- It provides at a glance, the summary of health activities that have taken place in the health facility for that month.
- For each health facility, health indicators of interest can be generated
- Based on the health indicator generated, action plans can be formulated to address the situation by health facility and the LGA.

Description of the tool

The tool is basically, like every other tool, structured in three parts:

Section A: Head section is for identification and general information on the health facility that generates this data, the Ward, the LGA and State where the facility is situated and the month and year for which data is captured.

Section B is the body of the form which takes in the data elements.

The tail end of the form is for authentication for whoever is responsible for filling and verifying this form.

How to enter information into the tool

Identification

Health facility: Enter the name of the health facility for which this summary data is compiled.

Political ward: Enter the name of the political ward in which this health facility is located.

LGA: Enter the name of the Local Government Area in which the political ward is located**.**

State: Enter the name of state in which the LGA is located**.**

Health facility code: Enter the unique ID code of the health facility

Month: Enter the month for which this report is being compiled.

Year: Enter the year for which the report is being compiled.

Public: Tick if the health facility is owned by the government, either state or LGA.

Private: Tick if the health facility is privately owned e.g. by individual, communities, non-governmental organizations or missions.

Beds: Enter the number of beds in the facility

Health Facility Attendance

1. **Facility Attendance**: Information for this data element is obtained from the daily general attendance register in the facility by counting the ticks in the columns according to males and female and by age groups. The total is obtained by adding all the columns for male and female.

2. **OPD Attendance**: information for this data element is obtained from the OPD Register by entering total number of patients seen at the OPD within the month of reporting.

Maternal Health (Ante & Post Natal Care)

3. **Antenatal attendance (total)**: Enter the total number of pregnant women that attended the health facility for antenatal care services in the month. This is obtained from the health facility ante-natal care services register by counting no. of ticks in column 11 (ANC).

4. **Ante-natal first visit before 20 weeks:** Enter the total number of pregnant women that attended the health facility for ante-natal care services in the month that were attending for the first time before the gestational age of twenty weeks. This is obtained from the health facility ante-natal care services register by counting no. of ticks in column 13a with gestational age of less than twenty weeks in column 14.

5. **Ante-natal first visit 20 weeks or later:** Enter the total number of pregnant women that attended the health facility for ante-natal care services in the month that were attending for the first time with the gestational age of twenty weeks or above. This is obtained from the health facility ante-natal care services register by counting no of ticks in column 13a with gestational age of twenty weeks or more in column 14.

6. **Ante-natal first visit (total):** Enter the total number of pregnant women that attended the health facility for ante-natal care services in the month that were attending for the first time. This is obtained from the health facility ante-natal care services register by counting no. of ticks in column 13a.

7. **Pregnant women that attended ante-natal clinic for the fourth visit during the month** (Note: the Focused Antenatal Clinic visits should also be emphasised here): Enter the total number of pregnant women that attended the health facility for ante-natal care services in the month that were attending for the fourth visit. This is obtained from the health facility ante-natal care services register by counting the number of "4"(s) in column 15.

8. **ANC Syphilis test done:** Enter the total number of pregnant women that attended the health facility for ante-natal care services in the month tested for syphilis. This is obtained from the health facility ante-natal care services register by counting no of ticks in column 18a (positive and negative).

9. **ANC Syphilis test positive**: Enter the total number of pregnant women that attended the health facility for ante-natal care services in the month and tested positive for syphilis. This is obtained from the health facility ante-natal care services register by counting no. of ticks in column 18a (positive).

10. **ANC syphilis case treated**: Enter the total number of pregnant women that attended the health facility for ante-natal care services in the month, tested positive for syphilis and were treated. This is obtained from the health facility ante-natal care services register by counting no. of ticks in column 18b.

11. **Pregnant women who received malaria IPT1 this month**: Enter the total number of pregnant women who received 1st dose of intermittent preventive treatment for malaria in the health facility in the month. This is obtained from the health facility ante-natal care services register column 22a.

12. **Pregnant women who received malaria IPT2**: Enter the total number of pregnant women who received 2nd dose of intermittent preventive treatment for malaria in the health facility ante-natal care services register in the month. This is obtained from the health facility register ante-natal care services register column 22b.

13. **Pregnant women who received LLIN**: Enter the total number of pregnant women who received LLIN for the prevention of malaria in the health facility in the month. This is obtained from the health facility ante-natal care services register column 21.

14. **Pregnant women who received IFAs (Iron and Folic Acid supplements)**: Enter the total number of pregnant women who received IFAs in the health facility in the month. This is obtained from the health facility ante-natal care services register column 23.

15. **Postnatal attendance-total**: Enter the total number of women that attended the health facility for postnatal care services in the month. This is obtained from the health facility post natal care services register by counting no. of ticks in column 11 (PNC).

16. **Postnatal attendance within 1 day of delivery**: Enter the total number of women and baby that attended the health facility for postnatal care services in the month. This is obtained from the health facility ante and post natal care services register by counting no. of ticks under mother & newborn subsection (1day) in column 27.

17. **Postnatal attendance within 3 days of delivery**: Enter the total number of women and baby that attended the health facility for postnatal care services in the month. This is obtained from

the health facility ante and post natal care services register by counting no of ticks under mother & newborn subsection (3 days) in column 27.

18. **Postnatal attendance ≥7 days of delivery**: Enter the total number of women and baby that attended the health facility for postnatal care services in the month. This is obtained from the health facility ante and post natal care services register by counting no of ticks under mother & newborn subsection (7 days & after) in column 27.

Maternal Health (Labour and Delivery)

19. **Deliveries - total**: Enter the total number of deliveries that took place in the health facility in the month. This is obtained from the health facility labour and delivery register by counting the number of entries in the register.

20. **Deliveries – SVD (Spontaneous Vaginal Delivery)**: Enter the total number of deliveries that were spontaneous vaginal deliveries in the health facility in the month. This can be obtained from the health facility labour and deliver register by counting the "SVD" entries in Column 15.

21. **Deliveries - assisted**: Enter the total number of deliveries of babies born after the 37th week of gestation whose birth were assisted that took place in the health facility in the month. This is obtained from the health facility labour and delivery register by counting the "AD" entries column 15.

22. **Deliveries - caesarian section**: Enter the total number of deliveries of babies by caesarian section in the health facility in the month. This is obtained from the health facility labour and delivery register by counting the "CS" entries in column 15.

23. **Deliveries - complications**: Enter the total number of deliveries of babies during which complication occurred in the health facility in the month. This is obtained from the health facility labour and delivery register by counting all entries in column 18.

24. **Deliveries - preterm**: Enter the total number of deliveries of babies born before the 37th week of gestation that took place in the health facility in the month. This is obtained from the health facility labour and delivery register by counting number of ticks in column 19b (preterm).

25. **Deliveries by HIV positive women**: Enter the total number deliveries of babies born by HIV positive women. This is obtained from the health facility labour and delivery register by counting number of ticks in column 13a & 13c.

26. **Live birth by HIV positive women**: Enter the total number of live births by HIV positive women. This is obtained from the health facility labour and delivery register by counting number of ticks in column 13a & 13c with ticks in column 19b (live births).

27. **Deliveries amongst HIV positive women – Booked**: Enter the total number of deliveries by HIV positive women who were already booked for delivery in the health facility (a booked pregnant woman is one who had been attending antenatal in the health facility prior to delivery).

28. **Deliveries amongst HIV positive women – Unbooked**: Enter the total number of deliveries by HIV positive women who were unbooked for delivery in the health facility (an unbooked pregnant woman is one who has not been attending antenatal in the health facility prior to delivery). This is obtained from the health facility labour and delivery register by counting the number of "unbooked" in column 11 with of ticks in column 13a or 13c.

29. **Deliveries monitored using a partograph**: Enter number of deliveries monitored using a partograph. This is obtained from the health facility labour and delivery register by counting the number of Yes (Y) in column 16. (A partograph is a tool developed by WHO to monitor, document and manage labour. It gives a complete picture of how the mother, baby and labour progress are. It also provides guidelines on when labour is no longer "normal" and what to do. It helps give continuity in care.)

30. **Deliveries taken by a skilled birth attendant**: Enter number of deliveries taken by skilled birth attendants. This obtained from the health facility labour and delivery register by counting the number of ticks in column 21a.

Tetanus Toxoid (For women of child bearing age)

31 - 35. Number of pregnant or non-pregnant women respectively that received doses of tetanus toxoid (TT1, TT2, TT3, TT4 or TT5): Enter the total number of pregnant or non pregnant women who received doses of tetanus toxoid (TT1, TT2, TT3, TT4 or TT5) in the health facility in the month. This is obtained from the health facility monthly immunization summary by totalling the respective TT doses by pregnant and non - pregnant.

Pregnancy Outcome –Live Births

36. **Number of live births**: Enter the number of male and female babies born alive with weight < 2.5kg or ≥2.5kg in the columns provided in the health facility summary form in the month and add the values for the two columns to get the total number of babies. This is obtained from the health facility labour and delivery register by counting the number of males and females with weight < 2.5kg or ≥2.5 kg.

Pregnancy Outcome – Still Births

37. **Still births**: Enter the total number of babies (male and female) that were born dead in the health facility in the month. This is obtained from the health facility labour and delivery register by counting the total number of such babies either recorded as FSB or MSB in column 19b (still birth).

38. **Fresh still births (FSB)**: Enter the total number of fresh still births (male and female) that were recorded in the health facility in the month. This is obtained from the health facility labour and delivery register by counting the total number of entries recorded as "FSB" in column 19b (still birth).

39. **Abortions (Induced)**: Enter the total number of pregnant women with induced abortion recorded in the health facility in the month. This is obtained from the health facility labour and delivery register by counting the total number of entries "IA" in column 19b (Abortion).

40. **Abortions (Total)**: Enter the total number of pregnant women that had abortions in the health facility in the month. This is obtained from the health facility labour and delivery register by counting all entries (both "IA" and "SA") in Column 19b (Abortion).

Pregnancy Outcome - Complications

41. **Birth Asphyxia**: Enter the number of babies (male and female) born with birth asphyxia in the health facility in the month. This is obtained from the health facility labour and delivery register by counting the number of ticks in the column birth asphyxia under pregnancy outcome.

42. **Neonatal sepsis**: Enter the total number of babies born with neo-natal sepsis, male and female in the health facility in the month. This is obtained from the health facility ante natal and post natal register by counting the number of such babies in the post natal column with such complications.

43. **Neonatal tetanus**: Enter the total number of babies born with neo-natal tetanus, male and female, in the health facility in the month. This is obtained from the health facility ante natal and post natal register by counting the number of such babies in the post natal column with such complications.

44. **Neonatal jaundice**: Enter the total number of babies, male and female, born with neo-natal jaundice in the health facility in the month. This is obtained from the health facility ante natal and post natal register by counting the number of such babies in the post natal column with such complications.

45. **Low Birth weight babies placed in KMC**: Enter the total number of babies born with low birth weight placed on KMC. This is obtained from the health facility ante natal and post natal register by counting number of ticks in the PNC column KMC (A)

46. **Low Birth weight babies discharged after KMC**: Enter the total number of babies born with low birth weight discharged after being admitted onto the KMC program. This is obtained from the health facility ante natal and post natal register by counting number of ticks in the PNC column KMC (DS)

Immunization

47. **OPV 0 (birth)**: Enter the total number of babies given the birth dose of OPV within 2 weeks of birth in the health facility (for both fixed and outreach sessions) in the month. This is obtained from the total of OPV 0 column of the Monthly Facility Immunization Summary at the end of the month.

48. **Hep. B 0 (birth)**: Enter the total number of babies given the birth dose of Hep.B within 2 weeks of birth in the health facility in the month. This is obtained from the total of Hep.B 0 (birth) column of the Monthly Facility Immunization Summary at the end of the month

49. **BCG**: Enter the total number of babies less than one year given BCG in the health facility in the month. This is obtained from the total of the BCG column of the health facility Monthly Immunization Summary at the end of the month

50. **OPV 1 (1st dose)**: Enter the total number of babies (6 weeks to 11 months and 12 to 23 months) that are given the first dose of OPV antigen in the health facility, fixed and outreach respectively, in the month. This is obtained from the total of the OPV 1 column of the health facility monthly immunization summary at the end of the month.

51. **Hep. B 1**: Enter the total number of babies (6 weeks to 11 months and 12 to 23 months) given the first dose of Hepatitis vaccine Hep. B 1 in the health facility, fixed and outreach respectively, in the month. This is obtained from the total of the Hep B1 column of the Monthly Facility Immunization summary at the end of the month

52. **Penta 1**: Enter the total number of babies (6 weeks to 11 months and 12 to 23 months) that are given the 1st dose of Penta antigen in the health facility, fixed and outreach respectively, in the month. This is obtained from the total of the Penta 1 column of the health facility monthly immunization summary at the end of the month.

53. **DPT 1**: Enter the total number of babies (6 weeks to 11 months and 12 to 23 months) that are given the 1st dose of DPT antigen in the health facility, fixed and outreach respectively, in the month. This is obtained from the total of the DPT column of the health facility monthly immunization summary at the end of the month. (Note: DPT is not given in health facility already using the pentavalent vaccines).

54. **PCV1**: Enter the total number of babies (6 weeks to 11 months and 12 to 23 months)) given the first dose of PCV in the health facility, fixed and outreach respectively, in the month. This is obtained from the total of the PCV1 column of the health facility monthly immunization summary at the end of the month.

55. **OPV2**: Enter the total number of babies (10 weeks to 11 months and 12 to 23 months) given the second dose of OPV antigen in the health facility, fixed and outreach respectively, in the month. This is obtained from the total of the OPV 2 column of the health facility monthly immunization summary at the end of the month.

56. **Hep. B 2**: Enter the total number of babies (10 weeks to 11 months and 12 to 23 months) given the first dose of Hepatitis vaccine Hep. B 1 in the health facility, fixed and outreach respectively, in the month. This is obtained from the total of the Hep B1 column of the Monthly Facility Immunization summary at the end of the month.

57. **Penta 2**: Enter the total number of babies (10 weeks to 11 months and 12 to 23 months) given the 2nd dose of Penta in the health facility, fixed and outreach respectively, in the month. This is obtained from the total of the Penta 2 column of the health facility monthly immunization summary at the end of the month.

58. **DPT2:** Enter the total number of babies (10 weeks to 11 months and 12 to 23 months) given the second dose of DPT in the health facility, fixed and outreach respectively, in the month. This obtained from the total of DPT 2 column of the Monthly Facility Immunization summary at the end of the month.

59. **PCV2**: Enter the total number of babies (10 weeks to 11 months and 12 to 23 months) given the second dose of PCV in the health facility, fixed and outreach respectively, in the month. This is obtained from the total of the PCV 2 column of the Monthly Facility Immunization summary at the end of the month.

60. **OPV3:** Enter the total number of babies (14 weeks to 11 months and 12 to 23 months) given the third dose of OPV in the health facility, fixed and outreach respectively, in the month. This is obtained from the total of the from the OPV 3 column of the Monthly Facility Immunization summary at the end of the month.

61. **Penta 3**: Enter the total number of babies (14 weeks to 11 months and 12 to 23 months) given the third dose of Penta in the health facility, fixed and outreach respectively, in the month. This is obtained from the total of the Penta 3 column on the Monthly Facility Immunization summary at the end of the month.

62. **DPT 3:** Enter the total number of babies (14 weeks to 11 months and 12 to 23 months) given the third dose of DPT in the health facility, fixed and outreach respectively, in the month. This is obtained from the total of DPT 3 column of the Monthly Facility Immunization summary at the end of the month

63. **PCV3**: Enter the total number of babies (14 weeks to 11 months and 12 to 23 months) given the third dose of PCV in the health facility, fixed and outreach respectively, in the month. This is obtained from the total of the PCV 3 column of the Monthly Facility Immunization summary at the end of the month.

64. **Measles 1 dose**: Enter the total number of babies (9 to 11 months) given the first dose of Measles in the health facility (fixed and outreach). This is obtained from the total of the column measles 1 of the Monthly Facility Immunization summary at the end of the month.

65. **Fully immunised < 1 year**: Enter the total number of babies < 1 year fully immunized in the health facility, fixed and outreach, in the month. This is obtained from the child immunization register by tracing back to the birth month of children expected to be fully immunized during the month of reporting.

66. **Yellow fever**: Enter the total number of babies (9 to 11 months) given the Yellow Fever vaccine in the health facility, fixed and outreach in the month. This is obtained from the total of the column Yellow fever of the Monthly Facility Immunization summary at the end of the month.

67. **Measles 2 dose**: Enter the total number of babies (18 to 23 months) given the second dose of Measles in the health facility, fixed and outreach, in the month. This is obtained from the total of the column Measles 2 of the Monthly Facility Immunization summary at the end of the month.

68. **Conjugate A CSM**: Enter the total number of babies (12 months old) given the Conjugate A CSM vaccine in the health facility, fixed and outreach, in the month. This is obtained from the total of the column Conjugate A CSM of the Monthly Facility Immunization summary at the end of the month.

Nutrition

69. **Children 0-59 months weighed - total**: Enter the total number of children aged 0 – 59 months that were weighed in the health facility in the month. This is obtained from the health facility growth monitoring and promotion register by counting the total number of entries in column 17 and matching it with the sex in column 9. That is, count the number of males (m) in column 9 weighed as shown in column 17. Similarly count the number of females (f) in column 9 weighed as shown in column 17.

70. **Children aged 0-59 months below the bottom line**: Enter the total number of babies, male and female, aged 0-59 months that were weighed in the health facility in the month and whose weight in their growth chart were below the bottom line. This is obtained from the health facility growth monitoring and promotion register by counting the number of males (m) in column 9 with weight below the bottom line in column 18b. Similarly count the number of females in column 9 with weight below the bottom line in column 18b.

71. **Children aged 0-6 months exclusively breastfed**: Enter the total number of babies, male and female, aged 0-6 months that attended the health facility in the month and were reported to be exclusively breastfed. This is obtained from the Nutrition and Growth Monitoring (0-5 years) Information register by counting the number of males (m) in columns 9 exclusively breast fed as shown in column 14a. Similarly count the number of females in column 9 exclusively breast fed as shown in column 14a.

72. **Children aged 6-11 months given Vitamin A**: Enter the total number of babies, male and female, aged 6-11 months that were given Vitamin A in the health facility in the month. This is obtained from the Nutrition and Growth Monitoring (0-5 years) Information register by counting the number of males (m) in column 19 and inserting in the male column of the summary form and counting the number of females (f) in column 19 and inserting in the female column of the health facility summary form. Add up the data in the male and female columns of the summary form to get the total.

73. **Children 12-59 months given Vitamin A**: Enter the total number of babies, male and female, aged 12-59 months that were given Vitamin A in the health facility in the month. This is obtained from the Nutrition and Growth Monitoring (0-5 years) Information register by counting the number of males (m) in column 19 and inserting in the male column of the summary form and counting the number of females (f) in column 19 and inserting in the female column of the health facility summary form. Add up the data in the male and female columns of the summary form to get the total.

74. **Children 12-59 months given deworming medication**: Enter the total number of children, male and female, aged12 59 months that were given deworming medication in the health facility in the month. This is obtained from the Nutrition and Growth Monitoring (0-5 years) Information register by counting the number of males (m) in column 20 and inserting in the male column of the summary form and counting the number of females (f) in column 20 and inserting in the female column of the health facility summary form. Add up the data in the male and female columns of the summary form to get the total.

75. **Children <5 years placed on treatment for severe acute malnutrition (OTP &SC)**: Enter the total number of children, male and female, aged <5 years that were placed on treatment for severe acute malnutrition (OTP) & SC in the health facility in the month. This is obtained from the Nutrition and Growth Monitoring (0-5 years) Information register by counting the number of males (m) in columns 22 (eligible for SAM program) and inserting in the male column of the summary form and counting the number of females (f) in column 22 (eligible for SAM program) and inserting in the female column of the health facility summary form. Add up the data in the male and female columns of the summary form to get the total.

76. **Children <5 years discharged (as healthy) from treatment for severe acute malnutrition (Recovered)**: Enter the total number of children, male and female, aged <5 years that were discharged (as normal/healthy) from the treatment for severe acute malnutrition (recovered) in the health facility in the month. This is obtained from the Nutrition and Growth Monitoring (0-5 years) Information register by counting the number of males (m) in columns 22 (outcome of treatment) and inserting in the male column of the summary form and counting the number of females (f) in column 22 (outcome of treatment) and inserting in the female column of the health facility summary form. Add up the data in the male and female columns of the summary form to get the total.

77. **Children admitted into CMAM Program**: Enter the total number of children, male and female, admitted into CMAM Program in the health facility in the month. This is obtained from the Nutrition and Growth Monitoring (0-5 years) Information register by counting the number of males (m) in column 21 and inserting in the male column of the summary form and counting the number of females (f) in column 21 and inserting in the female column of the health facility summary form. Add up the data in the male and female columns of the summary form to get the total.

78. **Children defaulted from CMAM Program**: Enter the total number of children, male and female, defaulted from CMAM program in the health facility in the month. This is obtained from the Nutrition and Growth Monitoring (0-5 years) Information register by counting the number of males (m) in columns 22 (outcome of treatment) and inserting in the male column of the summary form and counting the number of females (f) in column 22 (outcome of treatment)` and inserting in the female column of the health facility summary form. Add up the data in the male and female columns of the summary form to get the total.

Malaria Prevention (LLIN)

79. **Children under 5 years who received LLIN (this month)**: Enter total number of children given LLIN in the Health facility in the month. This is obtained from the total of the column LLIN in the Monthly Facility Immunization summary at the end of the month.

Child Health and IMCI

80. **Diarrhoea <5 years- new case**: Enter the total number of children aged less than five years, male and female respectively, that were new cases of diarrhoea seen in the health facility in the month. This is obtained from the health facility outpatient register. The child is categorised as being new if column 12 (new) is ticked; then count the number of male (m) children < 5 years in column 10 with diagnosis of diarrhoea in column 14. Similarly count the number of female (f) children < 5 years in column 10 with diagnosis of diarrhoea in column 14.

81. **Diarrhoea new cases <5 years - given oral rehydration preparations (low osmolar ORS):** Enter the total number of children aged less than five years, male and female, that were new cases of diarrhoea seen and given low osmolar ORS in the health facility in the month. This is obtained from the health facility outpatient register. The child is categorised as being new if column 12 (new) is ticked; then count the number of male (m) children < 5 years in column 10 with diagnosis of diarrhoea in column 14 given ORS as indicated in column 16. Similarly count the number of female (f) children <5 years in column 10 with diagnosis of diarrhoea in column 14 given ORS as indicated in column 16.

82. **Diarrhoea new cases <5 years - given ORS and zinc supplementation**: Enter the total number of children aged less than five years, male and female, that were new cases of diarrhoea seen and given ORS + zinc supplementation in the health facility in the month. This is obtained from the health facility outpatient register. The child is categorised as being new if column 12 (new) is ticked; then count the number of male (m) children < 5 years in column 10 with diagnosis of diarrhoea in column 14 given ORS and zinc as indicated in column 16. Similarly count the number of female (f) children <5 years in column 10 with diagnosis of diarrhoea in column 14 given ORS and zinc as indicated in column 16.

83. **Pneumonia new cases <5 years**-: Enter the total number of children aged less than five years, male and female, that were new cases of pneumonia seen in the health facility in the month. This is obtained from the health facility outpatient register. The child is categorised as being new if column 12 (new) is ticked; then count the number of male (m) children <5 years in column 10

with diagnosis of pneumonia in column 14. Similarly count the number of female (f) children <5 years in column 10 with diagnosis of pneumonia in column 14.

84. **Pneumonia new case <5 years given antibiotics (amoxyl DT**): Enter the total number of children aged less than five years, male and female, that were new cases of pneumonia seen and given amoxyl DT in the health facility in the month. The child is categorised as being new if column 12 (new) is ticked; then count the number of male (m) children <5 years in column 10 with diagnosis of pneumonia in column 14 and given amoxyl DT as indicated in column 16. Similarly count the number of female (f) children <5 years in column 10 with diagnosis of pneumonia in column 14 and given amoxyl DT as indicated in column 16.

85. **Measles new cases <5 years**: Enter the total number of children aged less than five years, male and female, that were new cases of measles seen in the health facility in the month. This is obtained from the health facility outpatient register. The child is categorised as being new if column 12 (new) is ticked; then count the number of male (m) children <5 years in column 10 with diagnosis of measles in column 14. Similarly count the number of female (f) children <5 years in column 10 with diagnosis of measles in column 14.

Family Planning

86. **Clients counselled**: Enter clients (male and female) counselled on family planning methods in the health facility in the month. This can be obtained from the health facility family planning register by counting number of "Y" in column 15.

87. **New Family planning acceptors**: Enter clients (male and female) that are new acceptors of any of the family planning methods in the health facility in the month. This can be obtained from the family planning register by counting number of males and females respectively in Column 11 with ticks under new acceptors (NA) in all the columns of the family planning methods (columns 16 – 22). Please note that any client that accepts sterilization (Column 21) is categorized as new acceptor in that month.

88. **FP clients accessing HCT services**: Enter family planning clients - male and female that accessed HCT services in the health facility in the month. This can be obtained from the family planning register by counting the number of males in column 11 with ticks in Column 24. Similarly count the number of females in column 11 with ticks in Column 24.

89. **Individuals referred for FP services from HCT**: Enter the HCT clients – male and female referred for family planning services in the health facility in the month. This can be obtained from the health facility family planning register by counting the number of males in column 11 with "HCT" in Column 13. Similarly count the number of females in column 11 with "HCT" in Column 13.

90. **Individuals referred for FP services from ART (ART Refill)**: Enter the ART clients – male and female referred for family planning services in the health facility in the month. This can be obtained from the health facility family planning register by counting the number of males in

column 11 with “ART” in Column 13. Similarly count the number of females in column 11 with “ART” in Column 13.

91. **Females aged 15-49 years using modern contraception:** Enter the total number of females clients aged 15-49 years using modern contraception in the health facility in the month. This can be obtained from the health facility family planning register by counting the number of females in Column 11 within the age group of 15 to 49 years in Column 12 that had ticks in any of family planning methods (Columns 16 – 22) under new acceptors (NA) or revisit (RV) including ticks in Column 21.

92. **Persons given oral pills**: Enter the total number of clients given oral pill cycle sachets in the health facility in the month. This can be obtained from the health facility family planning register by counting the number of ticks in both new acceptors (NA) and revisit (RV) in Column 16. (*Note: Only female clients use oral pills).*

93. **Oral pills cycle (sachets) dispensed**: Enter the total number of oral pill satchets dispensed in the health facility in the month. This is obtained from the health facility family planning register by taking the total of the quantity of oral pills dispensed in the month in column 16 (QTY).

94. **Injectables given**: Enter the total number of clients given injections for family planning in the health facility in the month. This is obtained from the health facility family planning register by counting the number of ticks in Column 17 (NA and RV).

95. **IUCD inserted**: Enter the total number of clients that had IUCD inserted for family planning in the health facility in the month. This is obtained from the health facility family planning register by counting the number of ticks in Column 18 (NA and RV).

96 **Implants inserted**: Enter the total number of clients that had implants inserted for family planning in the health facility in the month. This is obtained from the health facility family planning register by counting the number of ticks in Column 20 – IN (NA and RV).

97. **Sterilization**: enter the total number of clients that had sterilization done for family planning in the health facility in the month. This is obtained from the health facility family planning register by counting the number of ticks in Column 21.

98. **Male Condoms distributed**: Enter the total number of male condoms distributed in the health facility in the month. This is obtained from the health facility family planning register by totalling the quantity for male condoms (m) in column 19.

99. **Female Condoms distributed:** Enter the total number of female, condoms distributed in the health facility in the month. This is obtained from the health facility family planning register by totalling the quantity for female condoms (f) in column 19.

100. **Individuals referred for FP services from PMTCT (HIV+ Pregnant Women)**: Enter the total number of pregnant women referred from PMTCT clinic for family planning services in the

health facility in the month. This can be obtained from the health facility family planning register by counting the number of "PMTCT" in Column 13.

Referrals

101. **Referral in**: Enter the total number of patients referred in from other health facilities in the month. This is obtained from the health facility general attendance register by counting the total number of ticks in column 17.

102. **Referral out**: Enter the total number of patients referred out for further management from the health facility in the month. This is obtained from varying health facility registers by counting the total number of entries in the column "referred out" in all applicable registers and totalling all.

103. **Malaria cases referred for further treatment**: Enter the total number of malaria cases referred out for further management from the health facility in the month. This is obtained from the health facility OPD register by counting the total number of cases diagnosed with malaria in column 14 with "FT" as outcome of visit in column 17 (RO)

104. **Malaria cases referred for adverse drug reaction**: Enter the total number of malaria cases referred out for further management from the health facility in the month. This is obtained from the health facility OPD register by counting the total number of cases diagnosed with malaria in column 14 with "ADR" as outcome of visit in column 17 (RO)

105. **Women referred out for pregnancy related complications**: Enter the total number of pregnant women referred out for pregnancy related complications from the health facility in the month. This can be obtained from both the health facility ANC register by counting the number of women referred out due to complications and in the OPD register by counting the total of "PRC" as outcome of visit in column 17 (RO); Add up the two values to obtain the total in the month.

106. **Women seen and referred for obstetric Fistula (VVF&RVF)**: Enter the total number of women seen and referred out for obstetric fistula care in the health facility in the month. This can be obtained from the health facility OPD register by counting the total number of women that presented with leaking urine and/or faeces in column 13 and were referred out for further treatment ("FT") in column 17 (RO).

Non-communicable diseases

107. **Coronary heart disease new cases:** Enter the total number of new coronary heart disease cases, male and female, seen in the health facility in the month. This is obtained from the health facility outpatient register by counting the number of males (m) in column 10 with diagnosis of coronary heart disease in column 14. Similarly count the number of females (f) in column 10 with diagnosis of coronary heart disease in column 14. The patient is categorised as being new if column 12 (new) is ticked.

108. **Diabetes mellitus new cases**: Enter the total number of new diabetes mellitus cases, male and female, seen in the health facility in the month. This is obtained from the health facility

outpatient register by counting the number of males (m) in column 10 with diagnosis of diabetes melitus in column 14. Similarly count the number of females (f) in column 10 with diagnosis of diabetes in column 14. The patient is categorised as being new if column 12 (new) is ticked.

109. **Hypertension new cases:** Enter the total number of new hypertension cases, male and female, seen in the health facility in the month. This is obtained from the health facility outpatient register by counting the number of males (m) in column 10 with diagnosis of hypertension in column 14. Similarly count the number of females (f) in column 10 with diagnosis of hypertension in column 14. The patient is categorised as being new if column 12 (new) is ticked.

110. **Sickle cell disease new cases**: Enter the total number of new sickle cell disease cases, male and female, seen in the health facility in the month. This is obtained from the health facility outpatient register by counting the number of males (m) in column 10 with diagnosis of sickle cell disease in column 14. Similarly count the number of females (f) in column 10 with diagnosis of sickle cell disease in column 14. The patient is categorised as being new if column 12 (new) is ticked.

111. **Road traffic accident case:** Enter the total number of new cases of road traffic accident, male and female, seen in the health facility in the month. This is obtained from the health facility outpatient register by counting the number of males (m) in column 10 with diagnosis of road traffic accident in column 14. Similarly count the number of females (f) in column 10 with diagnosis of road traffic accident in column 14. The patient is categorised as being new if column 12 (new) is ticked.

112. **Home accident case**: Enter the total number of new cases of home accident, male and female, seen in the health facility in the month. This is obtained from the health facility outpatient register by counting the number of males (m) in column 10 with diagnosis of home accident column 14. Similarly count the number of females (f) in column 10 with diagnosis of home accident in column 14. The patient is categorised as being new if column 12 (new) is ticked.

113. **Snake bites new cases**: Enter the total number of new cases of snake bites, male and female, seen in the health facility in the month. This is obtained from the health facility outpatient register by counting the number of males (m) in column 10 with diagnosis of snake bites in column 14. Similarly count the number of females (f) in column 10 with diagnosis of snake bites in column 14. The patient is categorised as being new if column 12 (new) is ticked.

114. **Asthma new cases**: Enter the total number of new cases of Asthma, male and female, seen in the health facility in the month. This is obtained from the health facility outpatient register by counting the number of males (m) in column 10 with diagnosis of asthma in column 14. Similarly count the number of females (f) in column 10 with diagnosis of asthma in column 14. The patient is categorised as being new if column 12 (new) is ticked.

115. **Arthritis new cases**: Enter the total number of new cases of arthritis, male and female, seen in the health facility in the month. This is obtained from the health facility outpatient register by

counting the number of males (m) in column 10 with diagnosis of arthritis in column 14. Similarly count the number of females (f) in column 10 with diagnosis of arthritis in column 14. The patient is categorised as being new if column 12 (new) is ticked.

Sexually Transmitted Infections

116. **STI treated-new cases**: Enter the total number of new cases of sexually transmitted disease seen in the health facility and treated in the month. This is obtained from the health facility outpatient register by counting the number of patients with diagnosis of STI in column 14 and outcome of visit (treated) ticked in column 17. The patient is categorised as being new if column 12 (new) is ticked.

117. **Male Urethritis-new cases:** Enter the total number of new cases of male urethritis seen in the health facility in the month. This is obtained from the health facility outpatient register by counting the number of males (m) in column 10 with diagnosis of male urethritis in column 14. The patient is categorised as being new if column 12 (new) is ticked.

Laboratory

118. **ANC anaemia test done**: Enter total number of pregnant women for which Hb/PCV test was done in the health facility in the month. This is obtained from the health facility ante natal care register column 19 by counting the number of women that had Hb/PCV test done.

119. **ANC anaemia test positive**: Enter total number of pregnant women for which the Hb/PCV test indicated presence of anaemia in the health facility in the month. This is obtained from the health facility ante natal care register column 19 by counting the number women that their Hb/PCV test indicated presence of anaemia.

120. **ANC proteinuria test done**: Enter total number of pregnant women for which proteinuria test was done in the health facility in the month. This is obtained from the health facility ante natal care register column 20 by counting the number of women that had urinalysis test done.

121. **ANC proteinuria test positive**: Enter total number of pregnant women on which proteinuria test done was positive in the health facility in the month. This is obtained from the health facility ante natal care register column 20 (proteins) by counting the number of women that tested positive for protein in urine.

122. **HIV rapid antibody test done**: Enter total number of patients/clients on which HIV rapid antibody test was done in the health facility in the month. This is obtained from the health facility OPD (for male & female non pregnant) and ANC (for female pregnant clients) registers. In the OPD register count the total number of ticks in column 24 (for males) and column 26 (for female non pregnant) for all age groups. In ANC register count the number of ticks in column 16 (ANC HIV counselled, tested and received results). The addition of the values from both registers is recorded here.

123. **Sputum AFB-new diagnostic test done (include relapse):** Enter the total number of new patients on which sputum AFB diagnostic test was done including those that had relapse in the health facility in the month. This is obtained from the health facility TB register column 14 by counting number of patients that their 1st sputum specimen was taken in the month.

124. **Sputum AFB-new diagnostic test done (include relapse)-tested positive**: Enter the total number of new patients on which sputum AFB diagnostic test was done including those that had relapse and tested positive for HIV in the health facility in the month. This is obtained from the health facility TB register column 14 by counting number of patients that had the result of their 1st sputum specimen taken in the month being positive.

In-patient

125. **Functional beds**: Enter the total number of beds that are in good condition and can be used in the health facility in the month.

126. **In-patient days - total**: Enter the total number of in-patient days spent in the health facility in the month. This is obtained from the health facility IPC register by subtracting the day the patient was admitted(column 7) from the day of discharged(column 13).

127. **In-patient discharges - total**: Enter the total number of in-patient discharged in the health facility in the month. This is obtained from the health facility IPC register by counting the total number of discharges in the health facility in the month in column 13 (DC & R).

Inpatient Admissions

128. **Total admissions**: Enter the total number of admissions, male and female within the respective age groups, seen in the health facility in the month. This is obtained from the health facility inpatient care register by counting the number of males (m) in column 10 with respective age category according to the age of patient as shown in column 11. Similarly count the number of females (f) in column 10 with respective age category according to the age of patient as shown in column 11.

Pharmaceutical services

129. **Prescriptions issued**: Enter the total number of prescriptions issued in the health facility in the month. This is obtained from the health facility OPD register column 16 and IPC register column 15 by counting the number of patients that had prescriptions.

130. **Items dispensed**: Enter the total number of items dispensed in the health facility in the month. This is obtained from the health facility register OPD column 16 and IPC register column 15 by counting the number of various drug items dispensed. ***Note: each type of drug item dispensed is counted once irrespective of the number of patients it was dispensed to.***

131. **Antibiotics prescribed**: Enter the total number of various antibiotics prescribed in the health facility in the month. This is obtained from the health facility OPD register column 16 and IPC

register column 15 by counting the various antibiotics prescribed. ***Note: each type of antibiotic is counted once irrespective of the number of patients it was prescribed to.***

132. **Injectables prescribed**: Enter the total number of various injectables prescribed in the health facility in the month. This is obtained from the health facility OPD register column 16 and IPC register column 15 by counting the various injectables prescribed. ***Note each type injectable is counted once irrespective of the number of patients it was prescribed to.***

Adverse Drug Reaction

133. ***Adverse Drug Reactions (ADRs) reported following immunization:*** Enter the total number of clients immunized and reported back with adverse drug reaction seen in the health facility in the month. This is obtained from the health facility outpatient register by counting the number of clients with diagnosis of ADR immunization in column 14 and in the health facility IPC register by counting the number of clients with diagnosis of ADR immunization in column 12.

134 ***Adverse Drug Reactions (ADRs) reported following use of antiretrovirals:*** Enter the total number of patients given antiretrovirals and reported back with adverse drug reaction seen in the health facility in the month. This is obtained from the health facility outpatient register by counting the number of patients with diagnosis of ADR antiretrovirals in column 14 and in the health facility IPC register by counting the number of clients with diagnosis of ADR antiretrovirals in column 12.

135 ***Adverse Drug Reactions (ADRs) reported following use of antimalarials:*** Enter the total number of patients given antimalarials and reported back with adverse drug reaction seen in the health facility in the month. This is obtained from the health facility outpatient register by counting the number of patients with diagnosis of ADR antimalarials in column 14 and in the health facility IPC register by counting the number of clients with diagnosis of ADR antimalarials in column 12.

136. **Antimalarials in the health facility with Mobile Authentication Service (scratch card):** Enter the total number of antimalarials with mobile authentication service in the health facility in the month.

MOBILE AUTHENTICATION SERVICE (MAS)PROCEDURE

- Scratch Technology at the back of the medicine
- Send the pin number that appears on the medicine as an SMS (phone)
- Send to a short-code 38353
- Wait for feedback (Genuine or not genuine)
- You will receive a message that confirms the genuineness of the medicine or otherwise

Mortality

137. **Total deaths**: Enter the total number of death male and female of all age groups indicated that occurred in the health facility in the month. This is obtained from various health facility register (LDR, OPD, IPC) by counting the number of males (m) and females (f) of the stated age groups.

Maternal Mortality

138. **Number of deaths of women relating to pregnancy**: Enter the number of deaths of pregnant women which occurred as a result of pregnancy in the health facility in the month. This can be obtained from the health facility LDR, OPD and IPC registers. In the LDR register count the total number of ticks in column 19a (dead).

139. **Maternal Deaths Audited**: Enter the number of deaths in pregnant women which occurred as a result of pregnancy in the health facility in the month. This can be obtained from the health facility LDR registers by counting the total number of ticks in column 19a (if dead, was MDA conducted).

140. **Causes of maternal deaths**: Enter the number of deaths in pregnant women with respect to the cause of death which occurred as a result of pregnancy in the health facility in the month. This can be obtained from the health facility OPD, IPC and LDR registers. In the LDR register, count the total number of ticks in column 19a (dead) with respect to maternal complications seen (column 18).

Neonatal Deaths (causes)

141. **Causes of Neonatal deaths**: Enter the number of deaths of neonates with respect to the cause of death which occurred in the health facility in the month. This can be obtained from the health facility OPD, LDR and IPC registers. In the LDR register, count the total number of ticks in column 19a (dead).

Under 5 mortality (causes)

142. **Causes of under 5 mortality**: Enter the number of deaths of children under 5 with respect to the cause of death which occurred in the health facility in the month. This can be obtained from the health facility OPD and IPC registers. In OPD register, count the number of children under 5 in column 11 with ticks in column 17 (D) by respective diagnosis in column 14.

HIV (HCT, ART, Clinical care, TB- HIV & PMTCT)

143. **Individuals HIV counseled, tested and received results**: Enter the number of male and non-pregnant female aged (less than 2 yrs, 2-14 yrs, 15-19 yrs, 20-24yrs, 50yrs and above) that were counselled for HIV, tested and who received results in the health facility in the month. This is obtained from the OPD register by counting ticks according to age grouping in column 24 (male) and 26 (female non pregnant). Add up the data in the male and female columns of the health facility summary form to get the total.

144. **Individuals HIV tested positive**: Enter the number of male and non pregnant female individuals aged (less than 2 yrs, 2-14 yrs, 15-19yrs, 20-24yrs, 25-49yrs, 50yrs and above) that tested positive for HIV in the month. This is obtained from the OPD register by counting ticks according to age grouping in column 25 (male) and 27 (female non pregnant) - add up the data in the male and female columns of the health facility summary form to get the total.

145. **Couples HIV counselled, tested and received their test results**: Enter the number of couples who were counselled, tested for HIV and received their test results. This can be obtained from the OPD register by counting the number of ticks in column 28.

146. **Couples HIV counselled, tested and received results that are sero-discordant**: Enter the number of sero-discordant couples who were counselled, tested for HIV and received their test results in the month. This can be obtained from the OPD register by counting the number of ticks in column 29.

147. **HIV positive patient receiving cotrimoxazole prophylaxis:** Enter the total number of patients that tested HIV positive receiving cotriomoxazole prophylaxis in the health facility in the month. This can be obtained from the OPD register by counting ticks according to age grouping in column 30 (male and female respectively). Add up the data in the male and female columns of the health facility summary form to get the total.

148. **ART patients receiving ARV refill**: Enter the total number of individuals receiving ARV refill in the health facility in the month. This can be obtained from the OPD register by counting ticks according to age grouping in column 31 (male and female respectively). Add up the data in the male and female columns of the health facility summary form to get the total.

149. **HCT clients provided with SRH/HIV integrated services**: Enter the total number of HCT clients provided with SRH/HIV integrated services in the health facility in the month. This can be obtained from the OPD register by counting ticks in column 32 (male and female respectively). Add up the data in the male and female columns of the health facility summary form to get the total.

150. **HCT clients referred for FP method**: Enter the total number of HCT clients referred for family planning service in the health facility in the month. This can be obtained from the OPD register by counting ticks in column 33 (male and female respectively). Add up the data in the male and female columns of the health facility summary form to get the total.

151. **HCT clients screened for STIs**: Enter the number of HCT clients screened for STI in the health facility in the month. This can be obtained from the OPD register by counting ticks in column 34 (male and female respectively). Add up the data in the male and female columns of the health facility summary form to get the total.

152. **HCT clients treated for STIs**: Enter the number of HCT clients treated for STI in the health facility in the month. This can be obtained from the OPD register by counting ticks in column 35 (male and female respectively). Add up the data in the male and female columns of the health facility summary form to get the total.

153. **FP clients provided with SRH/HIV integrated service**:

TB/HIV

154. **Individuals clinically screened for TB**: Enter the total number of individuals clinically screened for TB in the health facility in the month. This is obtained from the OPD register by counting the number of ticks in column 36.

155. **Individuals clinically screened for TB score 1+ (TB suspects)**: Enter the total number of individuals clinically screened for TB and scored 1+ in the health facility in the month. This is obtained from the OPD register by counting the number of "+1" in column 37.

156. **Registered TB patients screened for HIV**: Enter the total number of registered TB patients that were screened for HIV in the health facility in the month. This can be obtained from the health facility TB register by counting the number of "Y" in Column TB/HIV activities (HIV tested).

157. **Individuals started on TB treatment HIV negative**: Enter the total number of individuals started on TB treatment that were HIV negative in the health facility in the month. This can be obtained from the health facility TB register by counting the number of ticks in Column TB/HIV activities (HIV Neg).

158. **Individuals started on TB treatment HIV unknown**: Enter the total number of individuals started on TB treatment with their HIV status is unknown in the health facility in the month. This can be obtained from the health facility TB register by counting the number of ticks in Column TB/HIV activities (HIV Unknown).

159. **HIV positive clients attending HIV care and treatment services and receiving TB treatment**: Enter the total number of HIV positive clients and received HIV care and treatment (ART) as well as TB treatment in the health facility in the month. This is obtained from the OPD register by counting the number of ticks in Column 38.

160. **TB patients with HIV receiving ART**: Enter the total number of TB patients with HIV that received ART in the health facility in the month. This can be obtained from the health facility TB register by counting the number of ticks in Column TB/HIV activities (HIV Pos on ART).

161. **Co-infected persons on CPT**: Enter the total number of clients co - infected with both HIV and TB that were started on CPT in the health facility in the month. This can be obtained from the health facility TB register by counting the number of "Y" entries having start dates that falls within that month in Column TB/HIV activities (CPT).

PMTCT - Mother

162. **ANC women with previously known HIV status (At ANC)**: Enter the total number of pregnant women who attended ANC and knows their HIV status in the health facility in the month. This can be obtained from the ANC register by counting the number of clients that had ticks in Column 16 (Previously known HIV positive status) and Column 11 (ANC) concurrently.

163. **Pregnant women who received HIV counselling, testing and received results at ANC:** Enter the total number of pregnant women who were counselled and tested for HIV and received results

during antenatal (ANC) visits in the health facility in the month. This can be obtained from the ANC register by counting the number of clients that had ticks in Column 16 (ANC HIV counselled tested and received results) and Column 11 (ANC) concurrently.

164. **Pregnant women who received HIV counselling, testing and received results at L&D**: Enter the total number of pregnant women who were counselled and tested for HIV and received results during labour and delivery in the health facility in the month. This can be obtained from the L&D register by counting the number of ticks in Column 13b.

165. **Women who received HIV counselling, testing and received results at PNC:** Enter the total number of mothers who were counselled and tested for HIV and received results during postnatal (PNC) visits in the health facility in the month. This can be obtained from the ANC register by counting the number of clients with ticks in Column 16 (ANC HIV counselled tested and received results) and Column 11 (PNC) concurrently.

166. **Partners of HIV positive pregnant women tested HIV negative:** Enter the total number of HIV positive pregnant women whose partners tested HIV negative in the facility in the month. This can be obtained from the ANC register by counting the number of ticks in sub–column "Partners of HIV positive pregnant women (tested negative)" in column 17.

167. **Partners of HIV positive pregnant women tested HIV positive**: Enter the total number of HIV positive pregnant women whose partners tested HIV positive in the facility in the month. This can be obtained from the ANC register by counting the number of ticks in sub–column "Partners of HIV positive pregnant women (tested positive)" in column 17.

168. **Partners of HIV negative pregnant women tested positive**: Enter the total number of HIV negative pregnant women whose partners tested HIV positive in the facility in the month. This can be obtained from the ANC register by counting the number of ticks in sub–column "Partners of HIV negative pregnant women (tested positive)" in column 17.

169. **Partners of HIV negative pregnant women tested negative**: Enter the total number of HIV negative pregnant women whose partners tested HIV negative in the facility in the month. This can be obtained from the ANC register by counting the number of ticks in sub–column "Partners of HIV negative pregnant women (tested negative)" in column 17.

170. **HIV positive pregnant women assessed for ART eligibility by either clinical stage or CD4**: Enter the total number of HIV positive pregnant women who were assessed for ART eligibility by either or both clinical staging and CD4 testing in the facility in the month. This can be obtained from the PMTCT/ARV register by counting all the ticks in Column 12 of the register. Please note that only the ticks for women assessed in the reporting month should be counted; those for prior months should not be included.

171. **Pregnant HIV positive woman who received ARV prophylaxis for PMTCT (Triple)**: Enter the total number of HIV positive pregnant women who received ARV prophylaxis for PMTCT (Triple)

in the facility in the month. This can be obtained from the PMTCT/ARV register by counting the number of entries with code "1C" with dates that fall in the reporting month in the Column 14.

172. **Pregnant HIV positive woman who received ARV prophylaxis for PMTCT (SdNVP in labour + (AZT + 3TC))**: Enter the total number of HIV positive pregnant women who received ARV prophylaxis for PMTCT (SdNVP in labour + (AZT+3TC)) in the facility in the month. This can be obtained from the PMTCT/ARV register by counting the number of entries with code "1E" with dates that fall in the reporting month in the Column 14(labour).

173. **Pregnant HIV positive woman who received ARV prophylaxis for PMTCT (AZT)**: Enter the total number of HIV positive pregnant women who received ARV prophylaxis for PMTCT (AZT) in the facility in the month. This can be obtained from the PMTCT/ARV register by counting the number of entries with code "1A" with date that falls in the reporting month in the Column 14.

174. **Pregnant HIV positive woman who received ARV prophylaxis for PMTCT (SdNVP in labour only):** Enter the total number of HIV positive pregnant women who received ARV prophylaxis for PMTCT (SdNVP in labour only) in the facility in the month. This can be obtained from the PMTCT/ARV register by counting the number of entries with code "1A" with dates that fall in the reporting month in the Column 14(labour).

175. **Pregnant HIV positive woman who received ARV prophylaxis for PMTCT (Total)**: Enter the total number of HIV positive pregnant women who received any type of ARV prophylaxis for PMTCT in the facility in the month. This can be obtained from the PMTCT/ARV register by counting all the entries with dates that fall in the reporting month in the Column 14.

PMTCT – Infant

176. **Infants born to HIV infected women started on cotrimoxazole prophylaxis within 2 months**: Enter the number of infants (by male and female) that were born to HIV infected women and started on cotrimoxazole prophylaxis within 2 months of birth in the facility in the month. This can be obtained from the PMTCT/ARV register by counting the number of ticks with date entries that fall within the reporting month in sub–column "<2 month" (male) for male infants in Column 18. Similarly, count the number of ticks with date entries that fall within the reporting month in sub–column "<2 month" (female) for females.

177. **Infants born to HIV infected women started on cotrimoxazole prophylaxis 2 months & above**: Enter the number of infants (by male and female) that were born to HIV infected women and started on cotrimoxazole prophylaxis at 2 months or more after birth in the facility in the month. This can be obtained from the PMTCT/ARV register by counting the number of ticks with date entries that fall within the reporting month in sub – column "2 months & above" (male) for male infants in Column 18. Similarly, count the number of ticks with date entries that fall within the reporting month in sub–column "2 months & above" (female) for females.

178. **Infants born to HIV infected women who received an HIV test within two months of birth (DNA –PCR)**: Enter the number of infants (by male and female) that were born to HIV infected

women and were tested for HIV using DNA – PCR within 2 months of birth in the health facility in the month. This can be obtained from the PMTCT/ARV register by counting the number of entries "M" with dates that fall within the reporting month in Column 20 (within 2 months of birth) for male infants. Similarly, count the number of entries "F" with dates that fall within the reporting month in Column 20 (within 2 months of birth) for female infants.

179. **Infants born to HIV infected women who received an HIV test after two months of birth (DNA –PCR)**: Enter the number of infants (by male and female) that were born to HIV infected women and were tested for HIV using DNA – PCR after 2 months of birth in the health facility in the month. This can be obtained from the PMTCT/ARV register by counting the number of entries "M" with dates that fall within the reporting month in Column 20 (after 2 months) for male infants. Similarly, count the number of entries "F" with dates that fall within the reporting month in Column 20 (after 2 months) for female infants.

180. **Infants born to HIV infected women who received an HIV test at 18 months (HIV rapid test)**: Enter the number of infants (by male and female) that were born to HIV infected women and were tested for HIV using HIV rapid test at 18 months in the health facility in the month. This can be obtained from the PMTCT/ARV register by counting the number of entries "M" with dates that fall within the reporting month in Column 21(at 18 months)for male infants. Similarly, count the number of entries "F" with dates that fall within the reporting month in Column 21 (at 18 months)for female infants.

181. **Infants born to HIV infected women who tested negative to HIV Rapid test at 18 months:** Enter the number of infants (by male and female) that were born to HIV infected women and were negative tested for HIV using HIV rapid test at 18 months in the health facility in the month. This can be obtained from the PMTCT/ARV register by counting the number of entries "M" with dates that fall within the reporting month in Column 22 for male infants. Similarly, count the number of entries "F" with dates that fall within the reporting month in Column 22 for female infants.

182. **HIV exposed infants breast feeding and receiving ARV prophylaxis:** Enter the number of HIV – exposed infants (by male and female) that are being breastfed and also on ARV prophylaxis in the health facility in the month. This can be obtained from the PMTCT/ARV register by counting the number of entries "M" with dates that fall within the reporting month in Column 19 for male infants. Similarly, count the number of entries "F" with dates that fall within the reporting month in Column 19 for female infants.

TB/LP

183. **TB cases (all forms) notified**: Enter the number of all forms of TB cases (new smear positive and retreatment)) reported/registered in the health facility in the month.This can be obtained from the health facility TB Central register by counting the total number of cases registered in the facility register with dates in the reporting month from Column 7.

184. **TB cases successfully treated among all forms (cured and completed):** Enter the number of all forms of TB cases (new smear positive and retreatment) that are successfully treated (cure rate + treatment completion rate) among new smear positive and retreatment cases in the health facility in the month. This can be obtained from the health facility TB Central register by counting the total number of ticks under "cured" and "treatment completed" with date entries that falls within the reporting month..

185. **Individual suspects screened for TB**: Enter the total number of suspects that were screened for TB in the facility in the month. This can be obtained from the TB suspect register counting the total of persons entered into the TB suspect register with AFB results documented in Column 14 of the register with date entries that falls within the reporting month.

186. DR-TB suspects tested for DR-TB: You can obtain this information from the DR-TB suspect register by counting the total no of persons entered into the register with result being MTB positive from the Gene xpert result filled in the register.

187. Confirmed DR-TB patients enrolled for treatment: This information can be gotten from the treatment register domiciled in the DR-TB treatment centre. It can be gotten by counting the no of patient enrolled on treatment based on the gene expert result which shows MTB +ve and RIF +ve (Rifampicin resistant).

188. Leprosy cases registered: This is the total number of leprosy cases registered. This information can be obtained by counting the total number of leprosy patients registered.

189. Buruli Ulcer patients notified:

Malaria

Malaria testing

The source of the information for this part of the monthly summary form is the NHMIS Daily Outpatient Register.

190. **Persons with fever**: Enter the number of fever cases disaggregated by age (<5 years and ≥5 years) in the health facility in the month. This is obtained from the OPD register by counting the number of cases for under five years and then for five years and above for which fever was recorded in Column 13. The addition of these two should be written in the "Total" cell.

191. **Persons with fever and tested by RDT**: Enter the number of fever cases that were tested by RDT disaggregated by age (<5 years and ≥5 years) in the health facility in the month. This is obtained from the OPD register by counting all entries both "+ve" and "-ve" for under five years and then for five years and above in Column 19(RDT). The addition of these two should be written in the "Total" cell.

192. **Persons tested positive for malaria by RDT**: Enter the number of fever cases that tested positive for malaria by RDT disaggregated by age (<5 years and ≥5 years) in the health facility in the

month. This is obtained from the OPD register by counting the entries "+ve" for under five years and then for five years and above in Column 19(RDT). The addition of these two should be written in the "Total" cell.

193. **Persons with fever and tested by Microscopy (for malaria parasites)**: Enter the number of fever cases that were tested by malaria microscopy disaggregated by age (< 5 years and ≥ 5 years) in the health facility in the month. This is obtained from the OPD register by counting all entries both "+ve" and "-ve" for under five years and then for five years and above Column 19 (microscopy). The addition of these two should be written in the "Total" cell.

194. **Persons tested positive for malaria by microscopy**: Enter the number of fever cases that tested positive for malaria by microscopy disaggregated by age (< 5 years and ≥ 5 years) in the health facility in the month. This is obtained from the OPD register by counting all entries "+ve" for under five years and then for five years and above Column 19(microscopy). The addition of these two should be written in the "Total" cell.

Malaria in Pregnancy

195. **Pregnant women with clinically diagnosed malaria**: Enter the number of pregnant women that were not tested by either RDT or microscopy before a diagnosis of malaria was made in the health facility in the month. This can be obtained from the OPD register by counting the number of ticks in Column 18(PW).

196. **Pregnant women with confirmed malaria**: Enter the number of pregnant women that were tested and confirmed positive by either RDT or microscopy before a diagnosis of malaria was made in the health facility in the month. This can be obtained from the OPD register by counting the number of ticks in Column 20 (PW)

Malaria cases

197. **Persons with clinically diagnosed Malaria**: Enter the number of persons that were not tested by either RDT or microscopy before a diagnosis of malaria was made disaggregated by age (<5 years and ≥5 years) in the health facility in the month. This can be obtained from the OPD register by counting the number of ticks in Column 18[<5 yrs)] for under five years and Column 18 (≥5 yrs) for five years and above. The addition of these two should be written in the "Total" cell.

198. **Persons with confirmed uncomplicated malaria**: Enter the number of persons that were tested and confirmed positive (***in the absence of medical complications***) by either RDT or microscopy before a diagnosis of malaria was made in the health facility in the month. This can be obtained from the OPD register by counting the number of ticks in Column 20 (<5 yrs) for persons under 5 years and Column 20 (≥5 yrs) for persons 5 years and above. The addition of these two should be written in the "Total" cell.

199. **Persons with severe malaria**: Enter the number of persons that were tested and confirmed positive (***with medical complications***) by either RDT or microscopy before a diagnosis of malaria

was made in the health facility in the month. This can be obtained from the OPD register by counting the number of ticks in Column 21 (<5 yrs) for persons under 5 years and Column 20 (≥5 yrs) for persons 5 years and above. The addition of these two should be written in the "Total" cell.

Malaria Treatment

200. **Persons with confirmed uncomplicated malaria receiving ACTs**: Enter the number of persons that were tested and confirmed positive for malaria (***in the absence of medical complications***) by either RDT or microscopy and received ACTs. This can be obtained from the OPD register by counting the number of cases that had ticks concurrently in both Column 20 and Column 22 . Counts will be done in "<5 yrs" subsections for persons under 5 years and "≥5 yrs" and subsections for persons 5 years and above. The addition of these two should be written in the "Total" cell.

201. **Persons treated with ACT on the basis of clinical diagnosis only**: Enter the number of persons that were not tested by either RDT or microscopy before a diagnosis of malaria was made and that received ACTs. This can be obtained from the OPD register by counting the number of cases that had ticks concurrently in both Column 18 and Column 22. Counts will be done in "<5 yrs" subsections for persons under 5 years and "≥5 yrs" and subsections for persons 5 years and above. The addition of these two should be written in the "Total" cell.

202. **Persons with confirmed uncomplicated malaria treated with other antimalarials**: Enter the number of persons that were tested and confirmed positive for malaria (***in the absence of medical complications***) by either RDT or microscopy and received other antimalarials (non – ACTs). This can be obtained from the OPD register by counting the number of cases that had tick concurrently in both Column 20 and Column 23. Counts will be done for all cases (not disaggregated by age) and should be written in the "Total" cell.

Obstetric Fistula

203. **Women who reported leaking urine or faeces**: Enter the number of women who reported leaking urine or faeces in the health facility in the month. This can be obtained from the OPD register by counting the number of women that had leaking urine or faeces recorded in Column 13.

204 – 208; Please record "0" if obstetric Fistula services are not provided in your facility. For facilities providing fistula services information can be obtained from the relevant Fistula registers.

Commodity Availability

209 – 233; tick as appropriate "Yes" or "No". N/A is ticked only if the commodity is not supposed to be managed at that health facility. Information can be obtained from the health facility pharmaceutical inventory register.

Tail of Form

The tail of the form captures the identity of those who filled and verified the form. It is important to hold somebody responsible for the quality of data entered. The tail of this form must be completed, otherwise the data entered is unacceptable, null and void.

Completed by :

Designation **-----** Write down the title of the officer filling this form in the dotted space provided.

Name ----- Write down the name of the officer filling this form in the dotted space provided.

Signature ----- The officer filling this form should write down his/her signature in the dotted space provided.

Date ----- The day, month and year this form is completed should be written in the dotted space provided e.g 3/11/10.

Verified by:

Designation ----- Write down the title of the officer verifying this form in the dotted space provided.

Name ----- Write down the name of the officer verifying this form in the dotted space provided.

Signature ----- The officer verifying this form should write down his/her signature in the dotted space provided.

Date ----- The day, month and year this form was verified should be written in the dotted space provided e.g 3/11/10